

Foreign Policy and Global Health: Country Strategies¹

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Introduction

The world of global health is changing rapidly. Arguably since the 2000 G-8 Kyushu Okinawa Summit, there has been a significant shift in the global health landscape. Financially, there has been an incredible increase in monies pledged to global health rising from hundreds of millions to tens of billions. Institutionally, there has been the continuous expansion in the number as well as type of actors involved with global health such as the Global Fund to Fight HIV/AIDS, TB and Malaria, a public-private partnership, and the Bill & Melinda Gates Foundation, a private foundation. Since the Millennium Summit, the international development community has been galvanized around the Millennium Development Goals (MDGs) which include health goals to be achieved by 2015.

Another trend since 2000 has been the linking of foreign policy and global health². Recent writing and attention given to global health diplomacy, which refers to the ‘multi-level and multi-actor negotiation processes that shape and manage the global policy environment’, signifies the increased importance of this move to cross-sectoral coordination.³ In 2006, the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand issued a joint statement in Oslo highlighting the need to apply a health lens to foreign policy:

‘We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time...We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make ‘impact on health’ a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and

¹ I would like to acknowledge the comments of Nick Drager, Benedikte Dal, Joanne Hamilton, Matthias Helbe, as well as Ilona Kickbusch and Tom Novotny. I would also like to acknowledge the comments of participants at the Prince Mahidol Awards Conference, Jan 28-30 2008, where this paper was presented. Contact details: Devi.sridhar@politics.ox.ac.uk

² Kickbusch, I. 2008. Moving Global Health Governance Forward. In Buse K., Hein W., & Drager N. (eds). Making Sense of Global Health Governance- a policy perspective. Palgrave. Fidler, D. 2005. Health and Foreign Policy: A Conceptual Overview. The Nuffield Trust. Fidler, D. 2006. Health as foreign policy: harnessing globalization for health. Health Promotion International 21(1): 51-58. Fidler, D. 2009. Health and Foreign Policy: Vital Signs. World Today, February.

³ Kickbusch, I., G. Silberschmidt & P. Buss. 2007. Global Health Diplomacy: the need for new perspectives, strategic approaches and skills in global health. Bulletin of the WHO 85(3): 161-244.

development strategies, and to engage in a dialogue on how to deal with policy options from this perspective⁴.

The ministers outlined key areas that required concerted response (Table 1).

Table 1: Oslo Ministerial Declaration

Increase awareness of our common vulnerability in the face of health threats by bringing health issues more strongly into the arenas of foreign policy discussions and decisions, in order to strengthen our commitment to concerted action at the global level
Build bilateral, regional and multilateral cooperation for global health security by strengthening the case for collaboration and brokering broad agreement, accountability, and action
Reinforce health as a key element in strategies for development and for fighting poverty, in order to reach the Millennium Development Goals
Ensure that a higher priority is given to health in dealing with trade issues and in conforming to the Doha principles, affirming the right of each country to make full use of TRIPS flexibilities in order to ensure universal access to medicines
Strengthen the place of health measures in conflict and crisis management and in reconstruction efforts

In November 2008, a resolution on Global Health and Foreign Policy was adopted by the UN General Assembly. The resolution urges member states to consider health issues in foreign policy, and proposes that the annual ministerial review to be held at ECOSOC in 2009 focus on ‘Implementing the internationally agreed goals and commitments in regard to global public health.’

While there has been much interest in global health and foreign policy, there has been little data available in this area examining how countries are attempting to address the foreign policy-global health nexus. To address this gap, the World Health Organization (WHO) has brought together six country case studies of Norway, the UK, Switzerland, France, Brazil and Thailand on foreign policy and global health. This paper aims to serve as an introduction to these studies as well as outline the key issues raised by them. It firsts examines the key reasons why these countries have moved towards linking foreign policy and global health. It then describes the ways in which these governments are engaging both internally and externally and concludes by putting forth four key issues for discussion and for future research.

⁴ Lancet. 2007. Oslo Ministerial Declaration. Global Health: A Pressing Foreign Policy Issue of Our Time. Lancet 369(9570): 1373-78.

What has prompted the linking of foreign policy and global health?

Before describing the ways in which governments are addressing the links between health and foreign policy, it is important to look at why this change has occurred. In short, in an increasingly global world with challenges that easily transcend national boundaries, there has been the blurring of the traditional distinction between domestic and global security, and convergence of interest between Ministries of Public Health and Ministries of Foreign Affairs. The case study of Thailand by Atsavapranee argues that the government's foreign health policy has been 'directed and driven not so much by policy prescription but more by their [Ministry of Public Health & Ministry of Foreign Affairs] convergence of interests.'

Several issues have pushed the relationship ahead. First is the fear of disease epidemics such as HIV/AIDS, XDR-TB, and influenza, and their effect on domestic human security. In Thailand, global health has been driven more by the Ministry of Foreign Affairs, through the concept of human security as well as human rights and humanitarian principles, while the Thai government's health policy has been focused more predominantly on the promotion of health and well-being of its citizens. The cooperation between the two ministries largely revolves around infectious disease as well as trade. Within infectious disease, SARS was the catalyst that led to increased regional and global cooperation in disease control. In terms of the U.S., a former CDC official noted, 'Even if the U.S. was to close its borders 99%, if avian flu was transmissible human to human, it would take just over a week for it to reach the U.S. population.' He continued that the containment must start in developing countries, and thus fear should become a catalyst for the strengthening of health system capacity in surveillance, reporting and treatment. As Atsavapranee notes, '...it makes good economic sense for all countries to invest in effective and adequate infrastructures that contribute to the strengthening of college health security...As no country has enough capacity to cope on its own with a public health emergency of international concern, the response ought to be a shared responsibility of all.'

A second key issue of concern both to the health and foreign policy communities is intellectual property, ranging from improving access to essential medicines at affordable prices to establishing a fair and equitable system for virus and benefit sharing. A third area revolves around migrant workers and refugees who may not clearly belong to any one country but are in great need of health-care. In sum, the convergence of interest between public health and foreign policy officials over a set of key issues has led to greater cooperation and engagement both internally and externally.

How are countries responding internally?

In recognition of this, several governments have started to engage through creating national plans, inter-ministerial working groups, and/or shuffling staff among departments. Switzerland was the first country to have a formally adopted global health strategy in October 2006 (Table 2). The Swiss strategy is based on Switzerland's unique characteristics in that it has been a neutral player; Geneva has become the 'health capital' of the world; Switzerland has long tradition and experience in development cooperation; and the pharmaceutical and food industry play a central role in the country. The agreement between the Federal Office of Public Health (Department of Home Affairs) and the Swiss Department of Foreign Affairs involves daily coordination and communication, as well as roughly six inter-ministerial meetings at the Assistant-Secretary/Director-General level. A coordination office for international health issues has been established within the Ministry of Foreign Affairs, as well as a computer platform that is accessible to all interested services within the government administration. However, no additional resources were planned for the implementation of the agreement; rather it would draw on the existing budgets of the participating offices. The government supports its work through the establishment of the Global Health Program at the Graduate Institute of International and Development Studies in Geneva where the Swiss strategy is studied, and global health diplomacy courses are offered.

Similarly, the UK strategy on global health *Health is Global* was developed by an Interministerial Group for Global Health drawn from various departments including Health, International Development, and the Foreign & Commonwealth Office, and will be continually reviewed by this group. The new strategy was driven by two aims: first, to use health as an agent for good in foreign policy, and second, to ensure that the effects of foreign and domestic policies on global health are much more explicit and made more transparent. The five priority areas identified are similar to the Swiss agreement (Table 2). In contrast to the Swiss Agreement, the UK strategy outlines 41 specific commitments each led by a single government department, and notes that there will be an annual independent review of progress. The strategy is supported not only by the Interministerial Group, but also by devolved administrations in Scotland, Wales and Northern Ireland, and academic bodies such as the London School of Hygiene and Tropical Medicine, the Lancet, and the Royal College of Surgeons in Edinburgh. The UK Department of Health is also funding a new research centre at Chatham House on health and foreign policy to push forward research and thinking in this area.

Table 2: Comparison of Swiss Agreement and UK Strategy

Switzerland	UK
Protect Health Interests of Swiss Population	Better Global Health Security
Improve the General Health Situation	Stronger, Fairer and Safer Systems to Deliver Health
Improve the Effectiveness of International Collaboration in Health	More Effective International Organizations
Harmonize National and International Policies	Stronger and Fairer Trade for Better Health
Safeguard Switzerland's unique role as a host country to the international organizations and private health companies	Strengthening the Way We Develop and Use Evidence to Improve Policy and Practice

Other than Inter-Ministerial Working Groups and national strategies, two other models for formal collaboration are being considered in Thailand. The first is to send diplomats to work at the Ministry of Public Health and the second is to send health experts to work at the Permanent Mission in Geneva. While neither of the above models seems to have been put in place in Thailand yet, Brazil has experimented with yet another model of bringing health experts into the Ministry of Foreign Affairs. Finally, while France does not have an official health and foreign policy strategy, there has been much collaboration between the Ministry of Foreign and European Affairs and the Ministry of Health, and new coordination mechanisms across these and other relevant ministries. France has appointed 'thematic ambassadors' to work on specific health topics who are appointed by both the French Ministry of Foreign and European Affairs and the Ministry of Health. In addition, in many of the French embassies and missions, full-time health experts work within the diplomatic staff, and nine regional health advisors work within the diplomatic network in Asia and Africa. The awareness of the links between global health and foreign policy can also be attributed to having a former and current Ministers of Foreign Affairs with medical backgrounds, Dr. Douste-Blazy and Dr. Kouchner, and two units, UN/International Organizations and development and cooperation, within their ministry dealing with health issues.

How are governments responding externally?

Governments are also responding externally through both formal and informal mechanisms. However, there is some variance in the emphasis placed on various mechanisms in the six cases. Switzerland, the UK, and Norway have all committed to strengthening the existing international organizations and directly engaging in multilateral collaboration. As noted in Table 2, both the UK and Swiss strategy aim to strengthen international collaboration particularly the WHO. The UK strategy notes that the Foreign & Commonwealth Office will lead the UK's efforts to strengthen international institutions through reforming the UN system, as well as supporting the EU. Silberschmidt, the author of the Swiss paper, notes, 'The investment that Switzerland has decided to devote to health also involves closer cooperation with the WHO. For Switzerland, the institution is the crossroads: the most democratic, the most open and the most immediately accessible to strengthen dialogue between nations.' Similarly Norway seeks to strengthen multilateral structures and the health-related organisations within the UN such as WHO, UNICEF, UNDP, the World Bank, UNAIDS and others.

Norway has also played a key political advocacy role in raising awareness of health as a cross-cutting foreign policy issue in existing organisations such as the UN General Assembly and the EU. In fact, it was Norwegian Foreign Minister Jonas Gahr Støre who played a key role in the launch of the Oslo Foreign Policy and Global Health Initiative in 2006. Norway's High North policy which covers a range of foreign policy issues across the Norwegian-Russian border also includes special emphasis on building up public health expertise, the prevention of communicable disease, and improving the health of vulnerable groups such as children, young people and inmates in prison. Similarly, Norway played a key role in the establishment of the Convention on Cluster Munitions in December 2008 that bans all use, stockpiling, production and transfer of cluster munitions and has separate articles on assistance to victims, clearance of contaminated areas and the destruction of stockpiles.

While Brazil and Thailand have the same objective of multilateral impact in international negotiations, they have placed more emphasis on first cooperating through plurilateral mechanisms (i.e. clubs), which can be seen as formalized coalitions of like-minded countries, to reach a common position for international negotiations. Brazil particularly has been an active participant in clubs that have helped reach agreements on the Framework Convention on Tobacco Control, the Doha Declaration on TRIPS and Public Health, and the IGWG at WHO. Buss & Ferreira, the authors of the Brazil paper, note that the G20, IBSA (India, Brazil, South Africa), UNASUL (Union of South-American Nations), and CPLP (Community of Portuguese Speaking Countries) are actually the new priorities of Brazilian foreign policy. In fact, health

diplomacy in Brazil is included under the umbrella of 'South-South Cooperation' and involves strengthening health systems and their main institutions (Ministries of Health), as well as a range of other areas described in their paper. In contrast to international collaboration in health which focuses on strengthening international health institutions, the plurilateral model is a general feature of Brazilian foreign policy with health a major priority within it.

For example, the CPLP has eight countries as its members: Brazil, Portugal, East Timor, Angola, Mozambique, Guinea Bissau, Cape Verde and Son Tome Prince. The main goal of the cooperation is to strengthen health systems, primary health care policy, and Ministries of Health, as well as partner academic institutes such as the National Institutes of Health, the National Schools of Public Health, the Schools of Health Technicians, etc. The cooperation involves seven areas: development of the health workforce, information and communication, research and development, health production complex, epidemiological surveillance, emergency and disasters, and health promotion and health protection. In addition, there are several disease/thematic areas included (e.g. malaria, social determinants of health, health diplomacy).

Similar in range of activities, UNASUL includes the twelve South-American countries, and also involves strengthening health systems and services, as well as their related institutions. Two notable developments are the creation of the South-American Commission on Social Determinants on Health, and the South-American Council of Health consisting of Ministers of Health. The other way in which Brazil is involved with 'South-South Cooperation' is through FIOCRUZ which is now moving to establish a permanent office in Africa (Maputo) in agreement with the African Union. FIOCRUZ is also involved in public health training in Angola, Mozambique and Cape Verde, as well as a number of other activities (drug donation, capacity-building, etc.) with some UNASUL countries.

Similarly, in Thailand, Atsavapranee notes that after SARS in April 2003, the ACMEC cooperation strategy was adopted including Cambodia, Lao PDR, Myanmar, Thailand and Vietnam. Health is just one of the six sectors of cooperation among this group, and involves strengthening surveillance and response systems as well as preparedness measures. In May 2006, ACMECS convened a meeting on avian flu preparedness, and ACMECS has also been involved in the discussions surrounding influenza virus, vaccines and other benefit sharing.

Canali, the author of the France paper, emphasizes the leading role of the EU in global health and the mediating role among the interests of developing and industrialized countries that it can play on global health issues. The EU, which is a new form of governance much like a formalized and legal coalition, has already become a key player in global health. For example, in

2004-2005 the EU adopted the strategy and action plan for the fight against HIV/AIDS, TB and malaria, and after the Cairo conference, the Council developed a common position on EU commitments to sexual and reproductive health. In 2006, the EU approved a strategy and plan of action to address the human resource crisis in developing countries. In 2007, the EU adopted a strategic partnership with Africa which works to strengthen existing health systems and to create new health protection schemes, and the EU has most recently moved into examining the creation of health insurance systems in developing countries. The EU has also played a mediating role among the interests of developing and industrialized countries such as on the issue of access to essential medicines. The role of the EU in the WHO is one that needs further examination. While it is worth noting the emphasis on this regional collaboration, it should be not overstated as it is likely tied to France's presidency of the EU in 2008.

What might this mean for the future?

Given increased globalization and 'convergence of interest', there will likely be much more interaction in the future between ministries of health and other ministries, as well as increased priority given to health in foreign policy strategies. It might be that the U.S. is the next to develop a formal strategy. A recently released Institute of Medicine Report (2008) calls on the new U.S. President to highlight health as a pillar of U.S. foreign policy.⁵ The report recommends that the new President establish a White House Interagency Committee on Global Health which would be located within the National Security Council and thus have convening power and the ability to make recommendations directly to the President. The Committee would play a key role in ensuring coherence in foreign policy among various sectors such as trade, environment and security.

Four particular points emerge from this transition in the foreign policy/global health nexus. First, the increasing involvement of Ministries of Foreign Affairs raises questions regarding the ability of the WHO to adequately handle this transition. The main governing body of the WHO, the World Health Assembly, is made up of the health ministers of the 193 member countries. Despite its explicit focus on 'health', the WHO has become increasingly involved in negotiations such as those surrounding virus and benefit sharing, and intellectual property rights (IGWG) which are in the realm of foreign affairs. Given the increasing links between health and foreign policy, and the movement of Ministers and Ministries of Foreign Affairs into health,

⁵ IOM. 2008. The U.S. Commitment to Global Health: Recommendations for the New Administration.

there needs to be further discussion on reforming WHO governance and staffing to reflect this change.

The second relates to the way in which ‘second world’ countries are engaging globally. As the examples of Thailand and Brazil demonstrate, these countries have increasingly relied on clubs for agenda-setting, prioritizing key issues, and reaching a common position before negotiations in the WHO. Rather than focusing on strengthening the existing international institutions like the UK, Switzerland and Norway, Thailand and Brazil are focused on strengthening their own negotiating ability within these institutions, and thus on the informal plurilateral structures with like-minded countries. Further research on other key players such as India, South Africa and China is needed before jumping to generalization, but the two cases explored here provoke interesting questions on strategy.

The third point relates to academic research in this area. So far, there has been little research on the global health-foreign policy nexus driven largely by David Fidler, Ilona Kickbusch and Tom Novotny. While this paper attempts to take a step in examining country strategies, further research is needed on first, how these plans came into being, the so-called ‘unofficial story’, and second, how ‘effective’ they are. This will require some kind of agreement on definitions and indicators for ‘effectiveness’, and the development of qualitative and quantitative tools for measuring ‘inter-ministerial collaboration’ and inter-sectoral coherence.

The fourth point relates to the unintended consequences of the linking of health and foreign policy. As Larry Gostin⁶ has noted, ‘Do political leaders acknowledge, and act on, the evidence just presented that global health is in their national interest? The answer may be that States are beginning to understand that responding to health threats outside their borders serves their interests, but their engagement is relatively limited. And the sad truth is that the coincidence of interests is narrower than activists, and even scholars, have suggested.’ Gostin makes an important point. While translating health into national security and foreign policy language might attract attention from high levels of government, it seems to be only for a ‘few high-profile problems: AIDS, pandemic influenza and the Indian Ocean tsunami.’ In fact, Gostin notes that national security assessments offer ‘relatively narrow justifications for State action on global health.’ Thus, while health advocates might use the language of foreign policy as instrumental in gaining attention, this attention may not move into less glamorous areas such as health systems,

⁶ Gostin, L. 2008. Meeting Basic Survival Needs of the World’s Least Healthy People: Towards a Framework Convention on Global Health. *Georgetown Law Journal*, vol. 96.

malnutrition and water and sanitation. While the six country policies included in this WHO study illustrate the wider dimensions of health and foreign policy in rhetoric, it remains to be seen in practice whether concern extends beyond surveillance and control of infectious disease, since as Gostin notes, 'In many respects, States may be correct that true global engagement does not serve their interests.'

While health has always been a part of international relations, it is only in recent years that it has attracted much attention and started the move from an issue of 'low-politics' to one of 'high-politics.' While the strategies of the governments discussed in this paper point to the increasing central role health plays in national strategy, health is still not yet an issue at the heart of government policy. However, research and thinking by groups such as the Chatham House Centre on Global Health and Foreign Policy and the FIOCRUZ Centre for Global Health and International Cooperation can help it become an increasingly important part of it.