Health Diplomacy Workshop Outcomes

Workshop Summary

Keynote: The Challenge of Global Health Diplomacy

Laurie Garrett analyzed the events in the recent past that have led to the emergence of health as a foreign policy issue while challenging workshop participants to remain wary of health becoming subsumed by the national security agenda. The emergence of terrorism as a pressing global threat with the attacks in New York, Madrid, and London lent renewed importance to national security, and the subsequent emergence of biological threats as an aspect of terrorism brought health and disease into the security conversation. Since that time, natural disasters such as the 2004 tsunami and Hurricane Katrina have called into question the traditional concept of national security and the capacity of national governments to respond. The international community's response to the tsunami has proven to be faster and more effective than the internal U.S. response to Katrina. The threat of pandemic disease has further complicated security today, as this non-violent threat nonetheless has the potential to wreak damage similar to Katrina at a much greater scale. There is no structure in place at present dictating how the many entities involved in responding to a global pandemic – militaries, non-governmental organizations, volunteers, multilaterals – would respond. Individual countries, including the United States, remain underprepared to confront pandemic H5N1, with few means of coordinating an integrated response planned. Such emerging threats have begun to alter the conception of national security to include health and disease as a critical aspect. It remains to be seen if those in the health field can take advantage of this new focus without becoming subsumed in the overall discourse of the war on terror.

Session I: Health Diplomacy as Social Responsibility

The first workshop session focused on health diplomacy as a social responsibility, investigating the methods, institutions, and tradeoffs involved when health aid serves as a means of improving diplomatic relations. The speakers identified as one of the major challenges of health diplomacy the tension between health serving as the means to a policy goal and as an end to itself. All agreed that the world of global health today is populated by new players, demanding novel approaches in order to navigate the new landscape. Nonetheless, history has provided case studies that can serve to guide the development of health diplomacy.

Nils Daulaire provided a broad perspective of global health as a diplomatic tool, noting both its potential applications and the pitfalls attendant on this path. Foreign policy acts to achieve two primary goals: protection of national interest and projection of national values. Health can play a role in each of these goals, particularly four issues that demand attention: 1) global infectious disease, the ultimate asymmetric threat; 2) HIV / AIDS, which threatens national integrity in countries around the world; 3) child health, including lifelong morbidity caused by malnutrition; and 4) women's health, including

but not exclusively reproductive health issues which disproportionately affect the poor and unrepresented. Addressing such issues is arguably a question of national values, and can build relationships where traditional foreign policy has failed to do so. Doing so requires considering the underlying causes of disease and particularly avoiding three types of arrogance common to global health efforts: intellectual arrogance, moral arrogance, and operational arrogance. Collaborative engagement over health issues has the potential to fulfill both goals of foreign policy.

William Keck discussed Cuban medical diplomacy, noting that Cuba has long been anomalous in its health status, with metrics such as life expectancy and infant mortality equal to or better than those of most developed countries despite the country's low economic output. The healthcare system has been a priority of the government since the beginning of the revolution, and the focus on health was redoubled in the early 1980s with a strong focus on health promotion, disease prevention, and primary care at the family level. A second focus of the health system has been medical diplomacy, as the government has sent health professionals to underserved populations around the world, in response to specific crises or as part of national exchanges. The Cuban government recently expanded its medical diplomacy efforts by founding the Latin American School of Medicine (ELAM), which provides medical education free of charge to students from throughout the Americas, and by encouraging Venezuela to undertake medical diplomacy as well, on an even larger scale. The geographic and numerical expansion of Cuban medical diplomacy will test whether the Cuban system can be successfully adapted to diverse settings.

Jaime Sepulveda provided an overall perspective of health diplomacy, situating it within the framework of existing fields and activities. Health diplomacy can be considered both an ideal, as it is presented in the working paper, and a real activity - the realpolitik of governments negotiating within the WHO, for example. Though the current situation in global health is unique due to the pressures of globalization and the recent surge in funding and interest, it is not unprecedented. Throughout the 20th century, bilateral, multi-lateral, and non-governmental / philanthropic actors have played greater and lesser roles in global health and present several case studies that could illuminate current efforts (i.e., the Rockefeller Foundation, Cuba & Venezuela, PEPFAR). Presently, the bilateral approaches such as PEPFAR and non-governmental organizations such as the Gates Foundation are the dominant forces in global health. They bring into sharp relief the issue of sustainability, which is a critical consideration within health diplomacy. The field of global health has been preoccupied with debates of top down vs. bottom up and vertical vs. horizontal approaches, but such discussions are reductionist. The ideal approach would be a diagonal one, that is, the proactive, supply driven provision of a set of highly cost-effective interventions on a large scale in order to bridge health gaps. It is clear that globalization has led to the international transfer of risks and opportunities in the field of health as in many others. Health diplomacy is an exciting and necessary component of the new global health, which should incorporate new approaches to strengthening health systems as well as bolstering old approaches like the multilateral organizations.

Discussion ranged broadly, circling around several main questions. The first issue concerns the precise definition of health diplomacy, including how it differs from traditional diplomacy, whether it is distinct from health politics, and how it interacts with both state and non-state actors. While much of the discussion has focused on the new players in global health, states remain critically important in changing health outcomes. Research into historical examples and current NGOs would help to define the precise influence of these various players, providing a better framework for health diplomacy. The overall goal of health diplomacy should be improved health as measured by narrowing the life expectancy gap. Specific metrics would include child survival to age five as an indication of the health system and women's survival as an indicator of the health workforce. Beyond the players themselves, other critical areas of understanding include short vs. long term approaches and the mechanisms of globalization. In undertaking training, it will be critical to be aware of arrogance, to start training early, and to bring together multiple fields of inquiry. The close involvement of practitioners such as health attaches would enrich training, as would collaboration with schools of diplomacy and international relations.

Session II: Health Diplomacy with Cultural and Political Sensitivity

The main focus of this panel was considering the issues around training health professionals in diplomacy, specifically in the skills needed to implement health interventions within the overall framework of global health. Speakers highlighted the need for continued research into both global health challenges and the organizations at work in global health.

Gerald Keusch discussed the development of the Fogarty International Center at NIH as the major global health research center in the U.S., noting that progress on improving health has been driven by knowledge, making the continued generation of knowledge an essential aspect of all health endeavors. The training programs developed by FIC have been instrumental in increasing the capacity of developing countries to address their own health crises, while FIC's research agenda has driven the production of new knowledge in underfunded fields, such as stigma. Achieving equity in health requires maintaining a rigorous research agenda and doing so in a more collaborative manner (within NIH and across government agencies such as NIH and CDC) than the current status.

Adriana Petryna provided insight into the role of clinical research in the global health field, highlighting the effect of clinical research organizations (CROs) running large clinical trials in areas with little health infrastructure. CROs are adaptable, mobile, and in some ways parasitic, moving from country to country to find the desired population. Countries with crumbling public health systems make particularly appealing targets because the population is likely to contain more naïve patients. In the world of clinical research, the need to create the proper patient population dominates all other interests, leading to the pharmaceuticalization of public health. Patients are described in terms of their value to the study. Such studies can undercut the existing health care system and can siphon health professionals away from public practice. This takes place in a world that is

largely unregulated, leaving it up to individuals within the industry to make delicate ethical decisions as best they can.

Mark Nichter reviewed global health as part of the current biopolitical situation. The new world of global health is closely related to both security and politics, particularly the expansion of global commodity chains and the related threat of the spread of infectious disease. Globalization has created new communities of practice related to health while also enabling rumors to spread at an unprecedented pace. On the positive side, fear of disease has increased attention to neglected conflicts and poverty throughout the world. Health and disease have also created new forms of political activity, such as the unprecedented governmental actions taken as a result of SARS. Nine critical issues stand out in health diplomacy:

1. Language issues and the politics of representation.
2. Agenda setting policies and audits, particularly the danger that branded programs are so rigid in their implementation that they fail to solicit or respond to local input.
3. Learning to work at the local level as well as the state and national levels in countries with decentralized decision making.
4. Moving from an evidence-based medicine mindset to an evidence-based public health mindset, shifting from randomized clinical trials to an understanding of health as bio-social, not just biological.
5. Broadening sentinel surveillance to community-based surveillance.
6. Investing in networks without governing them, learning from the impact studies on international funding and conducting ethnographies on sudden influxes of funding.
7. Investing in the capacity building process.
8. Translational research, particularly building trust so that knowledge translation truly occurs. This requires understanding how people understand science.
9. Global health agenda at home – biosecurity within the U.S., sustaining the interest of the body politic in between disasters.

Discussion following the presentations focused on practical aspects of training. The issue of who to train was particularly debated. Incorporating health into traditional diplomacy training may have a greater transformational impact as opposed to the incremental impact of incorporating political relations into existing public health training. Discussants also noted that the growing burden of non-communicable disease in developing countries must be addressed in addition to the continuing challenge of infectious diseases.

<u>Who to train</u>
Medical professionals
Social science / public policy diplomats

<u>Who to deliver training</u>
Mix of health professionals, diplomatic professionals, and experts from fields of anthropology, law, economics, etc.

Core competencies

- Health sciences
  - Epidemiology
  - Patterns of disease
- Social sciences + economics
  - History – what has worked; what hasn't
  - Health economics
  - Comparative politics – how health fits within the political structure
- International relations
  - Framing of political problems
  - International law
  - Moral impulse behind diplomacy
- Operations
- Communications

Case studies

- China admitting to SARS
- International Health Regulations
- Framework Convention on Tobacco Control
- Balancing individual and country needs in Zimbabwe
- Family planning in Bangladesh

Sources

Jonathan Mann curriculum at Harvard
Kevin Cahill humanitarian diplomacy curriculum
Lord Nigel Chris report on humanitarian aid to Africa
Canadian Senate report on aid to Africa
University of Michigan crash course in dealing with multilaterals (funded by Ford)

Session III: Health Diplomacy as Political Negotiation

The final workshop session focused on health diplomacy as political negotiation, with the speakers debating the interactions between global health diplomacy and politics. Given that the purpose of health diplomacy includes political ends, the extent to which the field itself is political and the interactions of health with governance will be critical to determine. Governance is particularly important given the rise of non-state actors and the current situation of open-source anarchy in global health.

David Fidler analyzed the workshop working paper, highlighting tensions between this concept of diplomacy and traditional political thinking. Understanding the language and actions of traditional diplomacy is essential to conceptualizing any new subset of the discipline, including health diplomacy. Normatively, the purposes of diplomacy are to create institutions that would allow states to settle disputes and to generate conditions that reduce the divergence of national interest (i.e. economic interdependence or ideological homogeneity.) The current conceptualization of global health diplomacy projects a much

greater role for diplomacy as a political change activity that can assure good government, improved international relations, and reduced conflict while continuing to be non-political at its core. The working paper fails to explain how the rise of global health in foreign policy will transcend existing norms to make a tangible political impact. It also conflates three separate but related ideas: politics, diplomacy, and governance. These can be envisioned as concentric circles expanding from governance to diplomacy to politics. Diplomacy is concerned with the articulation, advancement, and defense of national interest by an official representative of a state, which takes place without a recognized supra-authority. International governance relates to the interaction of organizations, laws, and regimes, while global governance includes both state and non-state actors. Health diplomacy may be too narrow of a term for the inherently political and governance-related activity that is described. Perhaps the true intention of global health diplomacy is to build governance mechanisms through diplomatic channels. The area of global health is currently confronting two specific anarchy issues: old school anarchy – how to get states to give up power to international organizations – and open-source anarchy – how to integrate new non-state actors such as the Gates Foundation or celebrities into existing structures. Several on-going situations offer potential insight into these issues, including the upcoming International Health Regulations, pandemic flu preparedness, biological weapons governance, anti-microbial resistance (XDR-TB), intellectual property and access to health technologies (withholding of flu samples), and women's health issues.

Delon Human explored the definition of health diplomacy, noting that it is being defined dynamically and is generally considered the use of healthcare to promote state diplomacy. Health diplomacy is the current hot topic in the field of global health. If properly developed, health diplomacy has the potential to address seven critical focus areas in global health. These are: 1) the inclusion and training of new non-state actors, particularly health professional organizations, NGOs, patient organizations, and private healthcare companies; 2) training in partnering and network leveraging, the strength of which was evident in the creation and passage of the FCTC; 3) an innovative fire walling of global health from politics, which includes incorporating regions that are not covered by the WHO due to politics (i.e. Taiwan) and creating political rewards for long-term investments in health; 4) fixing the critically broken issues, such as the gaps in the global network of the International Health Regulations, management of chronic disease, and expansion of counterfeit drugs and devices; 5) amplifying the existing resources of ethics and human rights to facilitate health diplomacy; 6) incorporating cultural and linguistic sensitization into the curriculum, and; 7) addressing gender power in global health.

Vinh-kim Nguyen highlighted key contradictions and concepts in health diplomacy based on his work with communities of PWAs. Global health occupies a political space, as health interventions impact communities and countries far beyond specific disease outcomes. Consideration of health sovereignty implies that interventions can dispossess states of the power to deal with their own health problems. AIDS and access to ARVs have led to the emergence of a new therapeutic subjectivity, as patients became aware of their lack of access to treatment and adopted new tactics to demand treatment. Communities forged from this therapeutic citizenship are now even reproducing themselves. Beyond infected individuals, societies as a whole have been obliged to triage

their members, providing treatment for some conditions at the expense of others. The role of the modern state is to produce a health population, as its new form of power (biopower). Simultaneously, the involvement of non-state actors has created a situation of open-source anarchy that has yet to be fully examined. The critical anthropology of intervention measures begins to explore the dynamics of power and erasure of history at play in many health efforts and would help to illuminate health diplomacy. Training in health diplomacy should incorporate a wide range of political theories and skills as well as an understanding of the implications of biosocial change. Such training should also include people from developing countries so that they can join the international community with the same level of skill as their counterparts from developed countries.

Discussion following the speakers focused on the interaction of politics and health diplomacy as well as the need for new analytical spaces to form a field of health diplomacy. States clearly remain powerful forces in global health, but one of the most pressing questions of the day is the impact of non-state actors. Would health diplomacy be able to create a structure of accountability in such a fractured world? Moreover, is it possible to do so without being political? Maintaining health as the end goal and diplomacy as the means satisfied the issue of politics for some but not all participants. Participants disagreed on whether the debate over politics was strictly semantics, but did concur that creating health diplomacy requires a new space looking at the interactions between diplomacy and governance, a space where academics from diverse fields can agree on common concepts and language in order to develop the field. Moving forward, it will be critical to determine what the results of health diplomacy are and how those results will be useful. Global health diplomacy must fit within the rubric of governance. From this framework, health diplomacy training should be delivered to mid-level health care professionals and diplomats to start, with a focus on how to respond to health issues in real time.

Identification of Key Issues

Interaction of health and foreign relations

Though it is clear that health has become an aspect of the national security and international relations dialogue, the shape of that interaction and the role that health diplomacy should play in it are not yet clear. Workshop participants expressed hesitation over making health into a tool of foreign relations gains, suggesting that the ultimate goal of health diplomacy should be the betterment of health as measured by quantifiable metrics. The resulting challenge is how to integrate health into the existing established structures of diplomacy and governance. This requires presenting a clear idea of the benefits to the international relations community without compromising the goals of health diplomacy. On a practical level, the question of training health professionals versus diplomats and foreign relations experts remained unanswered. Participants suggested that health professionals might be more amenable to short-term training which could have an immediate impact, but that transformative effects would not occur until some type of health training was integrated into international relations.

Shifting world of global health

The changes in global health over the past decade have left the field larger, more dynamic, and more ungoverned than ever before. While multi-lateral organizations have worked to rebuild lost credibility, bilateral initiatives have increased and private philanthropy and non-governmental organizations have multiplied in both number and clout. For-profit clinical research organizations have also entered the picture, inadvertently displacing the crumbling public health systems in some countries. No overall entity serves to govern or even track this anarchic situation, leaving individuals to navigate it. A coherent framework for the myriad of entities active in global health would facilitate more effective progress towards global health goals.

Proposal for Further Action

The immediate outcome of the workshop will be a small panel in Washington DC to disseminate the workshop findings and integrate the diplomatic and legislative communities into this undertaking. The panel will advocate for concrete steps towards furthering health diplomacy, such as the formation of a Global Health Service Corps, while also laying out a template for the health diplomacy curriculum. This panel will be funded by the CDC and IGCC as an extension of the workshop.

Speakers

1. Issues in Global Health Diplomacy
    a. Fitzhugh Mullan, Global Health Service Corps
    b. Maurice Middleberg, Role of Global Health Council
2. Academic Response
    a. Ilona Kickbusch – Health Diplomacy with Multinational actors
    b. Tom Novotny –Health Diplomacy Training
        i. Why health diplomacy training
        ii. Workshop and workshop outcomes
        iii. Shape of training

Following the panel, a working group of experts from the workshop will be convened with two primary purposes: to develop an edited volume defining health diplomacy and to shape the curriculum for the Summer 2008 Training module. The module will take place over the course of two weeks. Potential working group participants include David Fidler, Jaime Sepulveda, Margaret Hamburg, and Daniel Wehrenfennig.

Proposed working group timeline
June 2007: Convene for initial meeting, determine major topics of papers for edited volume, approve logistical structure for training module.

July 2007: Solicit papers from any authors outside of the working group.

October 2007: Reconvene, review first drafts of submitted manuscripts. Circulate manuscripts to diplomacy consultants?

January 2008: Finalize manuscripts, release call for training applicants

April 2008: Select program participants?