Global Health Diplomacy

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A variety of shifts emergent with globalization, which are reflected in part by nascent programs in “Global Public Health,” “Global Health Sciences,” and “Global Health,” are redefining international public health. We explore three of these shifts as a critical discourse and intervention in global health diplomacy: the expansion in non-governmental organization participation in international health programs, the globalization of science and pharmaceutical research, and the use of militarized languages of biosecurity to recast public health programs. Using contemporary anthropological and international health literature, we offer a critical yet hopeful exploration of the implications of these shifts for critical inquiry, health, and the health professions.

Key Words: biosecurity; global health diplomacy; NGO expansionism; pharmaceutical globalization

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Global health diplomacy is an emerging field that addresses the dual goals of improving global health and bettering international relations, particularly in conflict areas and in resource-poor environments. Although there are historical precedents for engaging in health diplomacy (Cohen 1999), there are many changes afoot in health development that suggest the need to define global health diplomacy as a new educational field that provides interdisciplinary training across academic and health institutions. The rise in programs variously called “Global Health,” “Global Public Health,” and “Global Health Sciences” attends to an increase in awareness of the effects of globalization on health and health delivery efforts (Brown, Cueto, and Fee 2006). Among the important trends accounted for in this shift are (1) the changing environment of funding for health development, particularly the growth in non-governmental structures that operate alongside traditional multilateral and bilateral organizations; (2) an increase in pharmaceutical and clinical research in global health; and (3) the emergence of new concerns for “biosecurity” in global health.

These trends mark a hopeful and yet somewhat ambiguous turning point in the pursuit of health and well being for the world’s poorest and under-resourced populations. The growth in Global Health programs is in part a response to these trends and in part the impetus for them. We envision Global Health Diplomacy as a field that focuses on training, research, and critical exploration, which combines understanding of international relations, culture, and politics with medicine and other health sciences to step beyond the disciplinary boundaries of each of these fields.

WHY HEALTH DIPLOMACY?

Understanding what this new discipline may encompass begins with a recognition that the most effective international health interventions are carried out in an ethical manner that is sensitive to historical, political, social, economical, and cultural differences between nations and peoples (Institute of Medicine). This understanding is further informed by recognition of the changing political environments, such as those in Bolivia, Ecuador, Brazil, and Venezuela; failed diplomacy and nation-building efforts, such as in Iraq; changing human security threats due to emerging and re-emerging infections, such as HIV/AIDS, tuberculosis (TB), and SARS; changing nuclear power structures, such as those in North Korea, Pakistan, and India; changing global health governance structures, such as the Global Fund for AIDS, TB, and Malaria (Buse and Lee 2005); changing environmental conditions that may affect long-term human welfare, such as global warming; and changing economic development conditions that have created
enormous disparities and questions of social justice in troubled African states, in regions of China, in India, in Indonesia, and elsewhere, and the persistent development and diplomatic uncertainties for countries of the former Soviet Union and the Middle East. These are complex problems that require improved leadership, training, and research in both health and international relations to bring about conflict resolution, equitable distribution of resources, and global improvements in human health and development.

The New Global Health Organizations

Multilateral development organizations such as the World Bank were established after World War II to augment peace and to support reconstruction and development of post-war Europe. They later grew to provide more than just direct assistance and became normative and information-generating organizations that drive health systems reform and provide extensive technical assistance to recipient countries. Later, as a result of the influence of dominant member states and the demands of global health problems, such as HIV/AIDS, TB, and malaria, these organizations changed even further (Brown, Cueto, and Fee 2006).

Historically, successes in health diplomacy have been seen in post-World War II redevelopment efforts under the Marshall Plan in Europe and in post-nuclear Japan through direct medical assistance by the U.S. military. Such diverse actors as Cuba (in providing direct medical assistance and training to poor nations), the Scandinavian countries (that contribute direct foreign assistance well above the recommended 0.7 percent of gross domestic product level) (Clemens and Moss 2005), and non-governmental organizations (NGOs) such as the Physicians for Social Responsibility (who won the 1985 Nobel Peace Prize for physician-to-physician interventions to reduce nuclear threats between the United States and the Soviet Union) have demonstrated other successes. Global peace and stability are surely served by such efforts, and it is now important to develop new skills based on historical evidence and a more nuanced understanding of multinationalism in the 21st century’s global health environment.

Alternative funding structures, including private-public partnerships, have grown as a result of efforts to augment or bypass multinational organizations and bilateral structures. Disease-focused programs that address immunization (the World Health Organization [WHO] Polio Eradication Program) or epidemic diseases (the President’s Emergency Program for AIDS Relief and the Global Fund for AIDS, TB, and Malaria) have seldom taken a broad view of how these programs integrate across donors and within recipient national agencies. Public health infrastructure may have in fact been weakened by these disease-specific interventions (Justice 2006;
Garrett 2007). To offset some of these uncoordinated investment practices, the World Bank and the WHO, as well as donors who seek to integrate and coordinate health assistance, attempted the System Wide Approach with mixed results. Now, with so much investment from the private sector driving health agendas, the need for an understanding of how these investments are governed and held accountable is growing.

Historical perspectives are also needed in this process. New forms of governance are emerging by way of health development, but questions about how they integrate the complex and changing relationships between governments, advocacy groups, and multinational health organizations remain. Global health diplomacy may broaden this understanding and will perhaps help ensure better utilization of the new funding sources for health development.

Economic interest groups (such as the International Federation of Pharmaceutical Manufacturer’s Association, International Chamber of Commerce, International Tobacco Growers Association), and philanthropic organizations (such as the Rockefeller Foundation, the Rotary Club, the Bill and Melinda Gates Foundation) have added to a growing brew of international actors with varying agendas. Again, how these organizations interact with or fail to interact with governments in recipient countries is of concern. This question becomes particularly acute in countries where health care systems have deteriorated and they thus increasingly rely on donor resources (Nguyen 2005). We know that governance in modern states increasingly relies on regimes of surveillance, discipline, and power that are organized in and through health infrastructures, but we have little sense of how these governmentalities vary between the public and private sector, the size and capacity of NGOs, and the political commitments they demand. Global Health Diplomacy research might address how these interactions impact governance in addition to the reverse: how private and donor health assistance creates new notions of civil society, public responsibility, and the role of government.

In addition to the large private philanthropies that operate alongside multilateral organizations, there has been a tremendous growth in large and small religious groups as well as “mom and pop” fundraising entities who deliver care and services to target populations. Faith-based or faith-related NGOs have been providing various types of international assistance in both relief and health development projects throughout the globe for many years. They include not only Christian organizations but also the International Red Crescent and the Israeli Magen David Adom organizations. Groups such as Medicins sans Frontiers provide both long-term and very immediate assistance in disasters, and they have, in general, avoided governmental politics. Each of these groups, as well as bilateral donors,
can be more effective, less obtrusive, and more cognizant of working within and not on partners by having better-trained staff and volunteers. At the same time, the impact and increase in number of small-scale NGOs operating as “relief” and longer-term development aid agents (e.g., microfinance groups) has yet to be assessed. What impact do they have on national, local, and regional public health services? What impact do they have on local infrastructural growth and development? As globalization expands markets, opportunities, and health risks, health professionals must increasingly know more about not just the determinants of health in a global community but also about how to work across NGO and government health organizations, about the historical effectiveness or ineffectiveness of health assistance, and what forms health assistance might take in different environments.

Successful health development efforts have depended on functional and respectful relations among all the stakeholders, including donor and recipient governments, health care providers, local political leaders, and field-based NGOs. A capable health diplomat must have a sophisticated understanding of the structures, programs, approaches, and pitfalls surrounding these relationships to achieve success, whether working in the clinical setting or at the policymaking table.

The Role of Pharmaceutical and Bioclinical Research in Global Health

Over the past decade, the world has witnessed a tremendous growth in the expansion of biomedical clinical research beyond the borders of the industrialized centers of science. This expansion has taken place both in the public sector, as research institutes and universities continue to develop research programs in under-resourced countries, and in the private sector, as the pharmaceutical industry seeks new and naïve populations for drug trials (Petryna, Lakoff, and Kleinman 2007). The expansion of pharmaceutical and biomedical research can play an important role in disease eradication, particularly with the development of new vaccines and treatment programs for multidrug-resistant diseases. It can also play a critical role in stemming the outflow of local research and clinical expertise from the poorest countries. Investment in the development of collaborative research links between poor and wealthy nations can also result in opportunities for training and resource sharing.

However, the uneven applications of scientific research resources between developed and developing nations requires specific attention to the ethical questions of benefit sharing and resource allocation (Hayden 2007). The growth of pharmaceutical research and industry activities in global health should signal a need for a cautious embrace. We are already witnessing increasing risk of disparity in health services, as pharmaceutical interests
displace public health programs in the poorest countries. In some regions, patients are only able to access basic health care by enrolling in clinical trials (Petryna, Forthcoming). Concerns over the balance between market-driven research and local public health priorities, although often raised by individuals within these industries, seldom become the focus for more ethical practices. Establishing bioethical principles for not just benefit sharing but also for research agendas is a first step toward rectifying this, but training health and biomedical professionals and anthropologists in health diplomacy based on these principles may go further toward implementing change.

There are additional risks that are emerging with the rise of global pharmacogenomics. Whereas research institutions in underserved nations can advance “equitable science” by ensuring inclusion of diverse ethnic and racial populations, the research can unintentionally racialize populations—transforming socially recognized diversity (Creole, mestizo, etc.) into bounded race categories. Pharmacogenetic research also runs the risk of minimizing the role of other environmental health risks in socially disadvantaged populations by prioritizing the genetic bases of disease over all other risks (Whitemarsh 2008).

The globalization of pharmaceutical industries raises other concerns over ensuring ethical standards for protecting human subjects in clinical research (Adams et al. 2005), creating the need for training in ethics, institutional review processes, and human rights assurance. The questions of what makes an intervention or research project just and fair and how such concern may be learned is seldom addressed in health sciences training. Further, we might ask what legal and ethical structures are in place to deliberate these relationships. Is international law the best way to ensure fairness and justice when it comes to medical research? If so, how can medical anthropologists and other health professionals play an informed role in establishing such legal structures? Global Health Diplomacy investigations might focus on such concerns, including on the health benefits that can accrue from research and health assistance conducted in an ethical and equitable manner.

The Role of Biosecurity in Global Health

The growing concern for human security over the past decade has found its way into global health in terms of “biosecurity” (King 2002; Lakoff 2007). Increasingly, funding for international health programs addresses concerns for global biological security, including reducing transmission risks from animal vectors of disease through pre-emptive measures. This concern also includes vigilance for biological threats and preparedness against the hostile use of biological weapons. Finally, biosecurity calls for preparedness in the
detection and prevention of fast-spreading infective agents such as the SARS coronavirus.

Biosecurity requires consideration of the critical relationships among economic systems, transportation systems, quarantine, and control systems and, above all, the international relations mechanisms that may be called into play when negotiating transborder biosecurity. How does preventive public health factor into risk management in resource-constrained environments? For example, will microcredit programs for small livestock projects become a victim of biosecurity measures? Whose security is being assured by global measures that may restrict the free movement of goods and people, and are these restrictions just and fair? What other concerns are overlooked when security and risk models are used as the paradigm for public health? There are complex ethical and political issues involved in controlling biosecurity threats, and there are important concerns that should be raised about the role of both medical anthropology and health professionals in efforts to deploy these. Whereas much of the neoliberal approach to health has transformed conditions that were once “criminalized” into conditions that are now “medicalized” from injection drug use to mental illness, the rise of biosecurity models actually reinsert paradigms of law enforcement back into health infrastructures; matters of economy, morality, and behavior are increasingly made to seem criminal under biosecurity regimes. A new training agenda in Global Health Diplomacy could serve the next generation of scholars and health care professionals to engage these programs in ways that are productive and useful from a health perspective yet vigilant about the unanticipated consequences they produce in sociological terms.

MEDICAL ANTHROPOLOGY AND GLOBAL HEALTH DIPLOMACY

Medical anthropology formally emerged as a sub-discipline in health half a century ago; it continues to embody the dual goals of analysis/critique and intervention using ethnographic methods. These methods can provide better understanding of the sources of human suffering and they can help identify the ways and means of reducing that suffering. Global Health Diplomacy combines intervention orientations with critiques that are emergent from social justice and critical medical anthropology to create new solutions in cross-border health programs. Medical anthropologists can benefit from exploration of the politics of diplomacy that target interventions by way of policymaking and agenda setting in global health. Moreover, in the rush to focus on the study of globalizations of science and technology within medical anthropology it is important to remember that traditional
international public health efforts are still deeply imprecated in these processes. Global health sciences that envision the growth and spread of bench sciences and laboratory investments in resource-poor settings must also attend to unresolved problems of failed development in public health that precede and follow technological aid (Crane 2007). The efforts to bring health care professionals together with foreign-policy professionals and medical anthropologists on this journey of discovery and critique depend in part on how well one can translate these concerns into realistic solutions. By bringing the languages of “diplomacy” into discussions and combining these framings with those of political science and international relations—in so far as practical approaches to enacting politics across cultural, national, and political divides are engendered—we believe that a field of Global Health Diplomacy can be an important contribution to the new and necessary perspectives in global health.

NOTES

1. Examples are found in early missionary work, colonial and post-colonial health development aid, faith-based and other non-governmental efforts, and now the new global health philanthropies.
2. Note that the new names may be more old wine in new bottles than we suggest here.
3. The University of California, San Francisco’s Global Health Sciences, in collaboration with the U.S. Centers for Disease Control and Prevention, and the Institute on Global Conflict and Cooperation ([IGCC] based at UC San Diego) have developed an academic initiative in Global Health Diplomacy.
4. Benjamin Hickler (UCSF, DAHSM) has been conducting research on this with support from IGCC.

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