



Global health diplomacy—reconstructing power and governance

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This is the third in a [Series](#) of three papers about political science and health

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Over the past two decades, global health diplomacy, foreign policy for health, and global health policy have changed substantially. Diplomacy is a constitutive part of the system of global health governance. COVID-19 hit the world when multilateral cooperation was subject to major challenges, and global health has since become integral to geopolitics. The importance of global health diplomacy, especially at WHO, in keeping countries jointly committed to improving health for everyone, has once again been shown. Through a systematic review, this Series paper explores how international relations concepts and theories have been applied to better understand the role of power in shaping positions, negotiations, and outcomes in global health diplomacy. We apply an international relations perspective to reflect on the effect that those concepts and theories have had on global health diplomacy over the past two decades. This Series paper argues that a more central role of international relations concepts and theories in analysing global health diplomacy would help develop a more nuanced understanding of global health policy making. However, the world has changed to an extent that was not envisioned in academic discourse. This shift calls for new international relations concepts and theories to inform global health diplomacy.

Introduction

The importance of global health diplomacy has been made clear during the COVID-19 pandemic. As always, the relevance of global health diplomacy comes to the fore in crisis situations. The response to the COVID-19 pandemic has put diplomacy centre stage in international organisations and high-level political gatherings, by engaging in crisis diplomacy and negotiating a joined-up response between countries who otherwise have strained relationships. As the Director-General of WHO, Tedros Adhanom Ghebreyesus, said: “no one is safe until everyone is safe”.¹

The intensified negotiation efforts—mainly under the backing of WHO—to ensure a collective response to the biggest pandemic since the 1918 influenza pandemic were initially stalled because of geopolitics, nationalism, and weak institutions. First and foremost, the diplomatic stand-off between the USA and China blocked agreements at WHO,² the UN Security Council,³ the Group of Twenty (G20),⁴ and the Group of Seven (G7).⁵

The unique multilateral agreement on health security (the International Health Regulations [IHRs] adopted in 2005) showed its fragility and was disregarded as many countries neglected to fulfil their obligations, closed borders, and blocked the export of critical medical supplies.⁶ WHO’s lack of authority and resources hampered advancement at the speed required, causing delays to their confirmation of human-to-human transmission of the COVID-19 virus and to the declaration of a public health emergency of international concern.^{7,8}

While international organisations were rapidly crafting a new governance mechanism—the Access to COVID-19 Tools (ACT) accelerator—to speed up the development, production, and equitable access to COVID-19 tests, treatments, and vaccines across the globe, high-income

countries (HICs) in particular embarked on a wave of vaccine nationalism, investing large sums of money to secure exclusive access to vaccines for their populations.⁹ In the face of supply constraints during the early roll-out of COVID-19 vaccines and as COVAX, the vaccines pillar of the ACT accelerator, distributed doses on the basis of the principle of equitable access and fair allocation, some key countries engaged in geopolitical vaccine diplomacy by sending doses to their friendly allies.¹⁰ During the COVID-19 pandemic, countries practised two types of health diplomacy: one with the aim to establish solidarity and equity, and the other to gain geopolitical advantage.¹¹

One key feature of diplomacy—next to representation and communication—is the art and practice of conducting negotiations. Bilateral diplomacy is at the core of foreign relations, whereas global diplomacy is practised within a well established multilateral system, whose key features were set with the creation of the UN and the Bretton Woods Institutions after World War 2. Within this system for negotiation, diplomats generally respect specific processes and apply agreed methods for reaching compromise and consensus. Former US Secretary of State, Henry Kissinger, emphasised that a legitimate order provides the context for diplomacy.¹² For global health, although previously accepted goals and architecture have been consistently challenged, the legitimate order still resides in multilateralism and first and foremost in WHO, because of WHO’s constitutional mandate for the establishment of norms and standards, high level of legitimacy through the representation of states, and unique treaty-making power. This role has been manifested again by the proposal to negotiate a global pandemic treaty.¹³

Global health diplomacy covers a wide spectrum of issues related to health and health determinants, as health moves beyond the medical realm to become a

crucial element in foreign, security, and trade policy. At its core, global health diplomacy addresses issues that transcend national boundaries and require collective action. Efforts in global health diplomacy can be better understood by breaking it down into seven dimensions (panel 1).¹⁴ Tackling complex global health challenges calls for multi-actor and multilevel diplomacy that involves a wide array of actors, including informal diplomacy with non-state actors (such as non-governmental organisations, academia, foundations, and the private sector), and even more so, negotiations that take place in non-health focused, multilateral forums that can have a notable effect on health. One example is the negotiations on intellectual property that take place in the context of the World Trade Organisation (WTO). Ngozi Okonjo-Iweala, the Director-General of the WTO, has clearly stated that: “the health of populations is the business of the WTO. Trade can contribute to public health and the WTO can lead helping members access vaccines and medical supplies”.^{15,16}

International relations, diplomacy, and power

The discipline of international relations fundamentally deals with the inter-relationship between political entities, initially between states, and then extended to major international actors such as international organisations. Historically, international relations theorists have focused on war, peace, and security as the dominant issues of concern in an anarchical international system in which states operate. The global health system has not received the attention it deserves. Yet, the transnational nature of many health-related risks arising from the increased flow of goods, capital, services, people, technology, and information in the context of globalisation, along with the increased interconnectedness and interdependency in the world,¹⁷ pose important questions about the need for cooperation and the establishment of rules and behavioural norms to advance human health. Consequently, over the past two decades, health has become more integral to the foreign policy agenda in relation to security, development, economy, human rights, social justice, and global public goods.¹⁸ This change is also reflected in the increasing integration of development agencies into foreign ministries. As early as 2007, a group of foreign ministers launched the Global Health and Foreign Policy Initiative to make the case for health as a foreign policy issue and to ensure a regular debate of global health at the UN General Assembly.¹⁹ This increasing link between health, globalisation, and foreign policy brings global health diplomacy into analytical focus.

This Series focuses on the concept of power to provide greater insight into global health policy making and its challenges in improving health outcomes. To move from diplomacy as a category of practice to a category of analysis, and to conceive diplomacy as a profession, Sending and colleagues theorise that diplomacy is an “emergent phenomenon whose form changes over time”,²⁰ and as

Panel 1: Seven dimensions of global health diplomacy

Negotiating to promote health in the face of other interests

Upholding health interests in the face of geopolitical, ideological, or national interests, which might stand in the way of solutions that benefit all countries, especially in terms of global health diplomacy at WHO, which sets global norms and standards

Establishing new governance mechanisms in support of health

Creating new organisations (eg, UNAIDS, Global Fund, and Gavi, the Vaccine Alliance) in response to health challenges, or new governance models within intergovernmental organisations (eg, changing the modalities for the election of the Director-General of WHO, or establishment of the WHO Health Emergencies Programme)

Creating alliances in support of health outcomes

Forming alliances for mutual benefits or to achieve some common purpose, including political alliances (eg, Alliance for Multilateralism and the Non-Aligned Movement) using a system of bloc politics, or coming together as a regional group (eg, the EU and the Caribbean Community and Common Market), within which there is consensus on defending a common position in negotiations or votes

Building and managing donor and stakeholder relations

Global health diplomacy increasingly requires establishing and maintaining relationships with a wide array of actors in the global health arena, including a special relationship with key donors, which might be countries, private foundations, or other organisations or individuals

Responding to public health crises

As global interdependence and integration increase, health diplomacy is used increasingly often in dealing with public health crises in times of heightened threat and uncertainty

Improving relations between countries through health

Supporting health programmes, notably the US President's Emergency Plan for AIDS Relief or the engagement in medical diplomacy from China and Cuba, has been one common way to increase political reputation, improve relations with other states and actors, and help build alliances

Contributing to peace and security

Efforts to mitigate the effects of armed conflict on health, such as negotiating ceasefires to allow immunisation campaigns or other health interventions to take place

such it produces its own effects on world politics. Although diplomacy takes place within the context of existing power constellations between states, for this Series paper it is helpful to work with a conceptualisation of power more closely related to the diplomatic profession. Adler-Nissen explains that “diplomats find international relations [IR] theory strange”²¹ because the primary unit of analysis for

diplomats is relations, not states, and their job is to make those relations work. A relational view of power does not see power as a resource or substance that is being possessed in varying quantities, but rather as productive energy that simultaneously shapes and is shaped by relations. For instance, Barnett and Duvall conceptualise power as “the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate”,²² which seeks to encompass the social interaction and social constitution of power. In the deliberation, interpretation, and remaking of global health policies, the productive effect of diplomacy constitutes the basic political fabric of international relations in health.

Methods

This Series paper comprises three phases. First, we reviewed general overviews, introductory works, and previous systematic reviews on global health diplomacy to understand the key concepts and debates.^{23–27} A common theme that such resources point to is the shortage of analytical rigour and theorising about global health diplomacy, which highlights the opportunity to use international relations theoretical knowledge and analytical concepts to explain global health diplomacy more effectively. Second, we conducted a systematic review to explore how international relations concepts and theories have been applied to understand the role of power in influencing positions, negotiations, and outcomes in global health diplomacy. Last, we reflected on what effect those contributions have had on global health diplomacy in the past two decades from an international relations perspective, during which global health policy making and foreign policy for health changed substantially in the context of the evolving nature and functioning of global health diplomacy and its increasing scale and intensity.²⁸

Our review process was conducted in 2020 during the COVID-19 pandemic, therefore further research will be required to fully reflect the increasing interest in global health by international relations scholars. Some international relations scholars have highlighted the relevance of international relations insights to understand the global politics of promoting health and prevent diseases.^{29–31} Complementary to these efforts, this Series paper aims to identify and analyse the international relations insights from a subset of contributions in relation to the understanding of global health diplomacy in global health policy making before COVID-19. By looking at global health diplomacy and governance in the past two decades, we aim to reflect on ways through which the application of international relations concepts and theories in analysing global health diplomacy can support both the academic and policy communities in addressing this crisis and can contribute to advancing global health.

Search strategy and selection criteria

Keyword searches were conducted in the English language in ProQuest, Wiley, and Web of Science

databases in July, 2020, to cover a range of literature in political science and international relations, social science and humanities, and global health journals, using the following search terms: “health diplomacy” OR “disease diplomacy” OR “medical diplomacy” OR “vaccine diplomacy” OR “mask diplomacy” AND “power”. The search terms were based on the focus of this Series (the role of power), and commonly used terms that relate to the concept of health diplomacy. Searches were limited to peer-reviewed journal articles and book reviews; they were not limited to any time period. The searches produced 140 results in ProQuest, 84 results in Wiley, and 31 results in Web of Science—adding up to 255 results. One book review and three book reference lists from peer-reviewed journals were found in the search results due to matching keywords. These results were substituted by the scholarly books that caused their appearances in the search results. 14 duplicates were removed from the dataset, leaving 241 articles and books.

The abstracts of the articles and books were then reviewed for conformance with inclusion criteria. Inclusion criteria were guided by the core focus of this Series, and comprised: (1) related to the practice of diplomacy in global health policy making; (2) explicit reference to international relations concepts or theories; and (3) extensive application of international relations concepts or theories to provide insights to the understanding of positions, negotiations, and outcomes in global health diplomacy. 192 articles that did not meet the first two criteria were eliminated. Of the 49 articles and books subjected to a more extensive review, the content was read and 30 articles and books that met the third criterion were identified. Those articles and books were then included in the review (appendix pp 1–4).

Global health diplomacy: international relations concepts and theories

The study of international organisations is one of the most important areas in which international relations has been applied to understand the role of power in global health diplomacy. This area of study shows key efforts in global health diplomacy, including negotiation to uphold health interests, establishment of governance mechanisms, and creation of alliances in global health policy making. Applying the traditional international relations concepts of anarchy^{32,33} and international regime³⁴ allows for analytical rigour in deducing possible global health diplomacy outcomes. More importantly, the increasing recognition of international organisations as actors in international relations theory means that international organisations are not just platforms for diplomacy, but increasingly play an active role in international politics by shaping agendas and influencing negotiations. Global health has shown that state-centric international relations theorising needs to include international organisations such as WHO and non-state actors to increase its explanatory power.³⁵

See Online for appendix

Global health diplomacy at WHO has particular relevance because of its inclusive nature (composed of 194 member states), its unique role in setting norms and standards, and its ability to adopt binding instruments. To understand how WHO promotes health outcomes through global health diplomacy, international relations scholars have researched how the WHO Secretariat and its leadership can act on its constitutional mandate if this mandate clashes with the interests of member states (some of which are major funders for WHO).³⁶ These scholars have studied how the WHO Secretariat can affect the behaviour of states through creating,

disseminating, and redefining norms in the international system,³⁷ how WHO seeks to claim authority and legitimacy in the absence of direct authority over its member states,³⁸ and how negotiation processes at WHO address the perceived benefits of negotiating parties.³⁹ Often, these global health diplomacy efforts operate through forms of power that are not very obvious or through very subtle and indirect dynamics, such as the power of norms, discourse, expertise, and moral authority, or the institutional power inherent in rules and decision making processes. Health diplomacy at the governing bodies of international organisations—not only WHO

Panel 2: Examples of key international relations concepts applied to the analysis of global health diplomacy

Sovereignty⁵⁵

State sovereignty signifies the existence of an independent political community that has juridical authority over its territory. Within this territorial space, sovereignty means that the state has supreme authority to make and enforce laws. Outside the boundaries of the state, a condition of anarchy exists, which suggests that international politics takes place in an arena that has no overarching central authority above the individual collection of sovereign states.

International society⁵⁶ and international regime⁵⁷

International relations scholars have posed the question why sovereign states cooperate in the international arena without an effective centrally governed mechanism. International society theorists argue that a group of states with common interests and values see themselves as bound by a set of common rules to provide order, whereas regime theorists claim that states create and maintain a set of principles, norms, rules, and decision making procedures, as they see mutual interests in cooperating.

International organisation⁵⁸

There has been increasing recognition in international relations that international organisations are not simply vehicles by which interstate politics play out, nor are they just a set of institutional frameworks (principles, norms, rules, and decision making procedures) through which states act. The study of international organisational behaviour is important, as it examines how an international organisation secretariat acts according to its constitutional interests (health interest in the case of WHO) in the context of external constraints imposed by states due to various global geopolitical and economic circumstances.

Norms⁵⁹

There has been growing evidence that normative factors, whether they are soft behavioural expectations or hard international law, shape states' interests and behaviours (eg, in the event of an international disease outbreak). International relations scholars study changes in norms and how norms affect other features of the international system.

Regionalism⁶⁰

International relations scholars study the drivers, forms, evolution, and consequences of regionalism within the world

order. Regional integration was primarily seen as manifestations of global orders due to the growing interdependence fostered by economic globalisation. Given the changing political and geopolitical circumstances, international relations scholars argue that regional organisations have embraced new agendas to achieve social development through regional health diplomacy and governance, becoming actors in the remaking of global relations.

Soft power⁶¹ and smart power⁶²

To describe how power is changing in world politics since the end of the Cold War, international relations scholars have identified a shift from traditional hard power (eg, military strength, population, geography, and resources) to soft power in foreign policy. Soft power refers to a diplomatic approach to achieve particular objectives through co-option and attraction, rather than through coercion and payment. Smart power refers to a strategy integrating both hard power and soft power to influence other nations, such as combining the application of military operations and health interventions like polio vaccination campaigns in conflict-affected settings.

Niche diplomacy⁶³

This concept directs attention to the specific pattern of diplomatic orientation of middle powers in securing segmented niches in response to the changing international system in the aftermath of the bipolar order of the Cold War. International relations literature shows that middle powers direct their attention towards the domains where they hold a high degree of resources and reputational qualifications, emphasising their technical leadership and their role as catalyst and facilitator in international negotiations and coalition building.

Disaster diplomacy⁶⁴

A key question in the study of disaster diplomacy is how and why disaster-related activities do and do not lead to cooperation. Literature in disaster diplomacy generally concludes that disaster-related activities can sometimes catalyse short-term diplomacy when there is a pre-existing basis, but they do not create new, long-term diplomatic endeavours.

but also other global health organisations (eg, Gavi, the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria)—is a crucial area in which a more central role in using international relations insights would provide nuance in understanding global health policy making.

One of the most fundamental debates about global health diplomacy is the dynamic relationship between health being a foreign policy tool and foreign policy serving health goals.⁴⁰ Many international relations and global health scholars have discussed health diplomacy through the lens of soft power,^{41–45} smart power,^{46–48} or disaster diplomacy.⁴⁹ These scholars point to the efforts of global health diplomacy in improving relations between countries and contributing to peace and security. Public health advocates might argue that health should not be used for political purposes, but in an interdependent world, few initiatives serve a purely humanitarian objective. Ideally global health diplomacy should fit both health and foreign policy objectives, for instance by pursuing health as a niche diplomacy^{50,51} in the multilateral agenda. However, in a globalised world, the more relevant factors are the broader interests that transcend national boundaries.⁴⁰ Scholars who have applied an international relations approach to study national policy on global health⁵² or foreign policy for health^{53,54} often come to understand how interests are being shaped by norms, values, and identities among a range of diverse actors, including various ministries and non-state actors such as the private sector and non-governmental organisations, at the interface between the domestic and international levels.

The search results of our systematic review indicate that existing literature on global health diplomacy primarily reinforces dominant voices and viewpoints in the international relations literature (panel 2). However, the results also show room for more extensive application of non-mainstream international relations scholarship in the analysis of global health diplomacy, and further engagement of scholars beyond dominant anglophone academic institutions and the dialogue in high-income countries. Critical scholarship in international relations represents a diverse set of views that challenge the theoretical and political status quo both in international relations theory itself and in international politics. For instance, regionalism examines the role of regional power or regional institutions in mediating and producing transnational norms through health diplomacy, rather than being receivers of global norms.^{65–68} A feminist approach challenges interstate level politics by highlighting the relational power between individuals of different genders and races, and prioritising collaboration over coercion and human security over national security.⁶⁹ Neo-Marxist and heterodox international relations theory⁷⁰ anchors on political values around societal equity, counter-hegemony, and radical redistribution of resources. The concept of

shadow diplomacy came from criticism of Western hegemony within the discipline of international relations, and suggests how international donors obscure structural power by subtly directing health initiatives, processes, and instruments.⁷¹ More analyses of global health diplomacy from these critical perspectives, especially from a decolonisation perspective in international relations that puts into question the whole concept of global health, would help make these power relations explicit.

Global health diplomacy: a sense of history A new decade, a new start: the expansion of health diplomacy (1998–2008)

At the beginning of the 21st century, health diplomacy moved centre stage as WHO played an increasingly active role in international politics, and its role as a norm-setter in global health was strengthened. Under the leadership of Director-General Gro Harlem Brundtland, WHO facilitated the adoption of the Framework Convention on Tobacco Control (FCTC) and the revision of the IHRs. These binding agreements initially strengthened the WHO Secretariat's political authority to promote health in the face of a broad range of social, economic, and political interests. The agreements also made countries recognise that they needed strong representation in Geneva to be able to conduct the many parallel negotiations under way. Health diplomacy is now a constant throughout the year—not only on occasion of the meetings of the WHO's governing bodies as it was in the past.

Following the severe acute respiratory syndrome outbreak in 2002–03, the political impetus was finally found to totally revise the IHRs. States are now required to notify WHO of all events that might constitute public health emergencies of international concern in accordance with a decision instrument. Subsequently, there is a legitimate expectation that no inappropriate trade and travel measures will be applied, so countries are not unfairly victimised. The revised IHRs give the WHO Director-General the political authority to declare public health emergencies of international concern, and to issue recommendations on how countries should handle such emergencies based on scientific principles and available evidence. It also grants WHO the authority to access and use non-governmental sources of surveillance information.⁷² Yet, the expert and normative power required of WHO to exercise the legal framework has been challenged, and the instrument has been insufficient for both the response to the Ebola virus in 2014 and SARS-CoV-2.

In 2003, WHO made use of its constitutional treaty-making power for the first time and adopted the FCTC. The FCTC is a landmark treaty, as it is the first and only international instrument that regulates the consumption and commercialisation of a legal consumer product.⁷³ Under neoliberal pressures, the WHO Secretariat was

able to present its anti-tobacco position as consistent with the prevailing neoliberal logic. The WHO Secretariat did so by strategically and explicitly opposing the tobacco industry and questioning its unethical actions as a legitimate exception to otherwise accepted business and market principles.⁷⁴ The process through which the FCTC was negotiated is noteworthy as it showed extensive multisectoral diplomacy in the complex environment of multiple legal frameworks and often competing government agendas.⁷⁵ Civil society also played an important role in shaping preferences of states during the negotiation.⁷⁶

Another milestone in global health governance was the WHO Pandemic Influenza Preparedness (PIP) Framework. During the avian influenza A (H5N1) outbreaks in late 2006, Indonesia refused to share virus samples with WHO by asserting sovereignty over viruses isolated within its territory, grounded on the Convention on Biological Diversity. The decision by the Indonesian authorities was driven by concerns that pharmaceutical companies in HICs would use the free access to virus samples from WHO to develop, patent, and sell vaccines at an unaffordable price.⁷⁷ Years of protracted negotiations at WHO resulted in the PIP Framework being adopted in 2011, which is the first international agreement facilitating the sharing of influenza viruses and access to vaccines and other benefits. The framework includes the pharmaceutical industry's agreement to provide monetary and in-kind contributions.⁷⁸

In 2001, the WTO adopted the Doha Declaration on the Trade Related Aspects of Intellectual Property Rights (TRIPS) and Public Health, which reaffirms the right of governments in bypassing patent rights to promote access to affordable medicines in the interest of public health. Going against the interest of industrialised economies and the multinational pharmaceutical industry, the moral claim of access to medicines as a human right by a coalition of civil society groups and low-income and middle-income countries (LMICs) changed global norms related to health and trade policies.^{79,80} The Doha Declaration also helped reassert WHO's authority to communicate with the WTO and its members to address the multidimensional challenge of policy coherence between trade and public health.⁸¹

In the past two decades, the number of actors involved in global health diplomacy increased exponentially. As Director-General Brundtland placed health at the centre of development, international organisations and national governments entered discussions with civil society, philanthropic foundations, and academics to find solutions to the greatest health challenges in response to the Millennium Development Goals (MDGs) adopted in 2000. Major public-private partnerships such as Gavi, the Vaccine Alliance, and the Global Fund were established, and a new funder entered the global health arena: the Bill and Melinda Gates Foundation.⁸² Currently, the Gates Foundation is the second largest contributor to the WHO

budget, after Germany.⁸³ The extensive involvement of private sector and civil society organisations in global health negotiations and global health partnerships have shown changes in the practice of global diplomacy beyond public authority and state representation. These global health negotiations show the larger ecosystem within which global health policies are made (including various ministries and groups that are stakeholders at the national level), and the role of non-state actors, such as non-governmental organisations, academia, foundations, and the private sector.

Consolidation and crisis of the rules-based governance system (2008–18)

Further consolidation of the global health governance system during the 2010s (before the COVID-19 pandemic) was important for global health diplomacy. An increasing number of actors got involved, there was a strong consolidation between the new organisations that had been created in the previous decade, and there was an influx of substantial financial resources to an increasing number of global health programmes—but not to the assessed contributions (countries' membership dues) of WHO.

The cracks emerged when the next crisis struck—the 2014 Ebola virus disease outbreak in west Africa. The delayed response from WHO⁸⁴ led to severe criticism and opened a debate on whether there should be a separate agency for global health security. The failure to recognise the effect of a long period of civil upheaval in the countries concerned, and the lack of cooperation with the humanitarian sector, led to the deployment of foreign militaries for logistical support and the creation of a temporary new entity—the UN Mission for Ebola Emergency Response—to coordinate the international response.⁸⁵

The need to reform the health security system and WHO led to a new intensification of global health diplomacy—to take stock of the global failures during the Ebola virus disease response and to prevent future outbreaks.⁸⁶ One outcome was a major shift in the governance of health security. Although the IHRs were not reopened for discussion, several new governance mechanisms were created by way of post-Ebola institutional and financial reforms. Most notable was the establishment of the WHO Health Emergencies Programme and the Contingency Fund for Emergencies to help respond to public health crises, and the introduction of a new tool, the Joint External Evaluation, to help countries assess their level of compliance with the IHRs.⁸⁷ There have also been calls to strengthen regional health governance and global-regional collaboration in view of the insufficient health emergency response capacity.⁸⁸

One of the most notable health diplomacy outcomes related to the Ebola health security crisis was that political attention to health increased substantially in political

bodies outside of the UN. Under the leadership of German Chancellor Angela Merkel, health was launched as a priority at the 2015 G7 Summit of Germany in Schloss Elmau, and then introduced at the 2017 G20 Summit in Hamburg.⁸⁹ For the first time, there was a meeting of G20 Health Ministers under the German Presidency, and subsequently a joint meeting of Health and Finance Ministers under the Japanese Presidency at the 2019 G20 Summit in Osaka.⁹⁰ The WHO Director-General is now a regular attendee of G7 and G20 meetings, and they are in regular contact with many heads of state and heads of government, especially in the current context of the COVID-19 pandemic. This approach of club diplomacy reaffirmed that addressing global health risks (especially pandemic preparedness, resilient health systems, and antimicrobial resistance), and promoting healthy lives and wellbeing through universal health coverage, is crucial to the global economy.

An increasing number of health issues have been brought to the UN General Assembly and Security Council for discussion in New York, NY, and a crucial conceptual and political breakthrough was the adoption of the 2030 Agenda for Sustainable Development and the 17 Sustainable Development Goals (SDGs) in 2015. These goals are the outcome of a transparent, inclusive process of negotiation, and they set a very different universal development agenda from the MDGs.⁹¹ The novel open negotiation process based on Open Working Groups and thematic consultations fundamentally changed the power dynamics and gave LMICs much more weight than they previously had had.⁹² The fact that health has proved to be an integral component and outcome of every SDG that was negotiated explains the essential need to shift towards policy coherence and integrative diplomacy.⁹³ The diversity of interactions between state and non-state actors and many newly formed alliances in global health once again suggests that non-state actors can have a genuine effect on international politics.

In the context of this new constellation of power in global health, an important shift towards multi-stakeholder diplomacy is seen, by using universally accepted organisations (such as WHO) in parallel with platforms (such as the 2030 Agenda), and conducting increasingly health-related discussions in political groups such as Brazil, Russia, India, China, and South Africa (BRICS); the G7; and the G20. This rise of plurilateral diplomacy shows “how governance gaps could be closed in a manner that does not require extensive institutional frameworks or rigid legal mandates, but a flexible ‘web of contracts’ informed by overlapping memberships and cross-cutting interests”,⁹⁴ as international relations scholars have observed in environmental diplomacy. Nonetheless, such a web is dependent on the willingness of all parties to negotiate within the legitimate order—the years of the COVID-19 pandemic have shown this negotiation to be increasingly difficult.

The present phase of global health diplomacy

The world has clearly entered a new stage in the development of global health diplomacy. COVID-19 has led to a flurry of diplomatic activity on global health, involving heads of state and heads of government during a period when multilateralism is subject to substantial challenges. Many public health advocates want to see a concerted international response to the COVID-19 pandemic, as was the case two decades ago for the HIV and AIDS pandemic.⁹⁵ Yet, the rise of anti-establishment sentiments, lack of traction for a strong transnational civil society movement, absence of a hegemon supportive of global health, and a wide range of geopolitical challenges⁹⁶ are just some features showing how remarkably different the context for global health diplomacy is today.

The IHRs are being tested in the context of a pandemic that is greatly affecting HICs, and they have displayed a fragility and poor commitment to global health security norms.⁹⁷ The fact that there were no globally agreed frameworks or models for access to vaccines against pandemics that are not influenza⁹⁸ explains the unprecedented and continued challenge to negotiate fair and equitable access to COVID-19 vaccines. The protracted negotiation regarding a proposal to waive intellectual property rights related to COVID-19 vaccines and other technologies for the duration of the pandemic⁹⁹ once again brings to the fore the geopolitical divide between HICs and LMICs. This situation reasserts the argument that,¹⁰⁰ despite the development of a range of global health instruments, policy makers have not adequately addressed the political determinants of health.¹⁰¹ If crises are accepted not as static events, but as processes (as Gramsci viewed them), the key challenge for health diplomacy is how to navigate this interregnum period¹⁰² for promoting better health while a new world order is in the making.

Looking back at the changes in global health diplomacy over the past two decades informs us how international relations can contribute to policy making in the future. A post-Westphalian system¹⁰³ has not been established—to some extent quite the opposite has happened. Rising nationalism and distrust in global institutions¹⁰⁴ has further increased the tensions between national and global responses to the COVID-19 pandemic. This tension is most obviously manifested in vaccine nationalism,¹⁰⁵ in which national sovereignty and foreign policy positions in global health diplomacy compete with the solidarity efforts of WHO. One important research agenda for international relations in the future, which COVID-19 has highlighted, is the mechanisms through which nationalism and populism affect international cooperation.¹⁰⁶ Moreover, although the importance of the power of norms and international organisations as norm entrepreneurs have been shown, there is a risk of overstating their roles when subject to external pressures and constraints in the geopolitical reality, as WHO

experienced in the USA–China stand-off during COVID-19. Furthermore, although soft power approaches have gained visibility in medical diplomacy,^{107,108} vaccine diplomacy,¹⁰⁹ and mask diplomacy¹¹⁰ during the COVID-19 pandemic, it has also become clear that health is no longer low politics, and health diplomacy is much more than a soft power tool with which to win friends and influence people in the international arena. Health diplomacy has moved to the highest level of government, and many different ministries have been engaged as trade flows, patent rights, border closures, economic effects, and access to vaccines move centre stage. Above all, the fact that the field of international relations has come up with so few studies of what happens within international organisations suggests there is a need to analyse the approaches of international organisational decision making.¹¹¹ Wider application of international relations theories¹¹² and analysis of COVID-19 politics¹¹³ might open avenues for understanding the new political and economic realities that shape national and geopolitical interests in global health negotiations.

Within international relations, there has been increasing recognition of the effect of colonialism on policy making and knowledge production.¹¹⁴ The recurring critique of global health diplomacy as centred around the security and economic interests of HICs remains relevant, as it could be argued that global health institutions implicitly provide an avenue to legitimise and reproduce existing power relations in the international system through which inequalities persist.¹¹⁵ This critique also applies to highly influential global health actors such as the Bill and Melinda Gates Foundation.¹¹⁶ Consequently, critical international relations theories, for instance from a securitisation¹¹⁷ or decolonisation¹¹⁸ perspective, especially as manifested in the inequity in COVID-19 vaccine distribution,¹¹⁹ are increasingly important for the understanding and analysis of global health diplomacy from a relational view of power. Leadership from LMICs is needed to both maintain the focus on health at the highest level of international politics and to address globalised health challenges in a fair manner.¹²⁰ There have already been some shifts through successes of African diplomacy—the heads of WHO, UNAIDS, and the WTO now come from the African continent; the move for a TRIPS waiver during the COVID-19 pandemic was initiated by India and South Africa;¹²¹ and one aspect of the focus of BRICS on multilateral reforms is to enable meaningful participation of LMICs in Africa.¹²²

This dynamic web of power relations is reshaping diplomacy and creating a new multilateral order. As the conflict between the USA and China left a void in global health diplomacy in 2020, the EU stepped in and has quickly become one of the most important partners of WHO, both politically and financially.¹²³ Furthermore, the proliferation of regional health initiatives during the COVID-19 pandemic reinforces the general trend in

diplomacy in which regions are taking a quasi-autonomous role in shaping global policies previously tackled in the framework of global multilateral institutions.¹²⁴ The African Union has moved to a strong new multilateralism at a regional level,^{125,126} which has important health components such as the African Vaccine Acquisition Trust and the Partnerships for African Vaccine Manufacturing. Middle powers have the opportunity to forge a new kind of multilateral cooperation in the midst of big power rivalries.¹²⁷ New alliances that emerged during the pandemic are reflecting on the increasing role of middle powers as facilitators or bridge-builders between great powers and smaller states on particular thematic issues.¹²⁸ One such key alliance with a strong health component at its centre is the recently revitalised Quadrilateral Security Dialogue (also known as QUAD).¹²⁹

One important development in the multilateral sphere is the endeavour to strengthen collective commitment through embarking on high level negotiations for a global pandemic treaty¹³⁰ that reflects the notion of a cosmopolitan moment (the idea that shared global risks involuntarily, unintendedly, and compulsorily connect actors across borders and compel them to act together).¹³¹ To learn from the COVID-19 pandemic, it is important to understand and respond to the relationship between risk and power in this complex, dynamic, and diversified ecosystem of global health. Understanding who defines risks, who makes decisions, and who bears consequences through the interface between science, business, and politics reveals the fundamental global disparities during the COVID-19 pandemic. Diplomats have the opportunity to shape a new concept of global health based on the understanding of a global risk society. Health diplomacy will come into its own when this new international instrument is negotiated.¹³²

The COVID-19 pandemic is generating increased interest from international relations scholars on health diplomacy,¹³³ and is showing us that some of the conceptualisations and critiques of global health diplomacy in the first two decades of this century do not hold up, because of various theoretical or methodological blind spots. The world has changed to an extent that was not imagined in academic discourse—neither in global health nor in international relations. It is now up to a new generation of diverse scholars—not burdened by the old models in international relations or global health—to conduct in depth empirical research and develop new international relations concepts and theories to inform global health diplomacy.

Contributors

Both authors contributed equally.

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