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Health diplomacy:
European perspectives

Edited by: Ilona Kickbusch & Mihály Kökény

Abstract

Global processes – such as climate change, pandemics and modern societies' patterns of unsustainable consumption – gave health diplomacy new relevance, making it central to health governance at global and regional levels, and integral to foreign policy in many countries. This book is part of the WHO Regional Office for Europe's response to the WHO Regional Committee for Europe's 2010 request that it strengthen the capacity of diplomats and health officials in global health diplomacy. It presents 17 case studies that illustrate recent developments in the WHO European Region. The examples range from negotiating for health in the Paris Agreement on climate change and the pursuit of the Sustainable Development Goals, to placing antimicrobial resistance on the global agenda and showing the relevance of city health diplomacy. Chapters review subregional efforts in south-eastern Europe and central Asian countries; progress on road safety in the Russian Federation; experience with integrated health diplomacy in Malta and Switzerland; Germany's activities in the Group of 7 and Group of 20; the work of WHO country offices from a diplomacy perspective and the collaboration between WHO and the European Union; and training to increase capacity for health diplomacy in diplomats and health officials. A discussion of future challenges for health diplomacy concludes this unique compilation.

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Foreword

Health diplomacy has been carried out for over 150 years, but the term is relatively new. It relates in particular to health issues and determinants that cross national boundaries, are global in nature and require global agreements to address them.

In the WHO European Region, the environment and health process can be understood as a turning point in modern health diplomacy. In the late 1980s, European Member States initiated the first-ever collaboration to eliminate the most significant environmental threats to human health. A series of ministerial conferences, held every five years and coordinated by the WHO Regional Office for Europe, drives progress towards this goal.

This intersectoral approach heralded today's approach to health diplomacy. People have a better understanding of the role of multiple determinants of health and the necessary involvement of many non-health sectors and organizations in approaches to better health and well-being for all that involve the whole of government and the whole of society, and consider health in all policies. As this book shows, such broad approaches are essential in addressing current issues, such as fighting antimicrobial resistance and noncommunicable diseases or tackling the health problems of migrants and refugees.

WHO has long stated that the inequitable distribution of power, money and resources is one of the most serious threats to health. In January 2017, the World Economic Forum confirmed rising wealth inequality as the most significant trend that will challenge global development over the next 10 years, even though millions of people have been lifted out of poverty in the developing world. WHO's global and European reports on the social determinants of health[1,2] show that inequalities in wealth are accompanied by profound inequalities in health.

Health is one of the core components of development, and international health cooperation remains one of the unifying forces and a solid reference point for delivering fair health and social outcomes. Health diplomacy's core goals include more equitable improvement in populations' health and well-being. This was exemplified by the two-year process that developed Health 2020, the European policy framework and strategy for the 21st century, which put health equity at its centre. It also resonates through the United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals.

Today, health diplomacy is critical to lead us through a period of considerable uncertainty in Europe and the wider world. In the WHO European Region, much of health diplomacy deals with health challenges during the meetings of the WHO Regional Committee for Europe, and at other high-level events involving European Member States and a wide variety of participants. Today's health problems are complex, and these meetings have become increasingly important over recent decades. Delegations face extensive and

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[1] Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008 (http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf, accessed 9 May 2017).

[2] Review of social determinants and the health divide in the WHO European Region. Final report. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/en/publications/abstracts/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-final-report, accessed 9 May 2017).

complicated agendas, often having a political nature and requiring intensive preparation and significant intersectoral consultation.

Meeting and working together to achieve the Sustainable Development Goals and Health 2020 require more and more expertise from Member States, and from many state and non-state actors. They require close cooperation on health matters with the European Union and other European organizations. Public health professionals increasingly need a better understanding of the mechanisms of diplomacy, and diplomats engaged in health-related negotiations must be informed of the challenging dimensions of today's public health.

These developments led Member States to ask WHO to help in developing capacities in this area. To respond to this request, the WHO Regional Office for Europe commissioned executive training events (of 2–5 days) for European participants, including those from countries in the South-eastern European Health Network and the Commonwealth of Independent States. It also commissioned other interregional activities and global online courses. Across the Region, around 400 national delegates and WHO staff have participated in health diplomacy training so far. Public health professionals and diplomats attend these workshops together and learn from one another, especially during simulation exercises.

To further build capacity for health diplomacy the Regional Office now publishes this book, including case studies tailored to the European situation, to strengthen the consistency of education. I believe that the analysis and the lessons to be learned from these case studies will be of value to students and practitioners in this dynamic field, which can only increase in importance in the years ahead.

Dr Zsuzsanna Jakab
WHO Regional Director for Europe

Abbreviations

AFP	acute flaccid paralysis
AMR	antimicrobial resistance
APEC	Asia-Pacific Economic Cooperation
BAC	blood–alcohol concentration
BCA	biennial collaborative agreement
BRICS	association of five major emerging national economies: Brazil, the Russian Federation, India, China and South Africa
BSEC	Organization of the Black Sea Economic Cooperation
CCS	WHO country cooperation strategy
CINDI	Countrywide Integrated Noncommunicable Disease Intervention (programme)
CIS	Commonwealth of Independent States
CMO	Chief Medical Officer
CoE	Council of Europe
EAEU	Eurasian Economic Union
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
ECO	Economic Cooperation Organization
EU	European Union
FAO	Food and Agricultural Organization of the United Nations
GAMRIF	Global Antimicrobial Resistance Innovation Fund
GAVI	the Vaccine Alliance
GHG	greenhouse gas
GHSA	Global Health Security Agenda
G7	Group of 7
G8	Group of 8
G20	Group of 20
IHR	International Health Regulations
LMIC	low- and middle-income country

MDG	Millennium Development Goal
MDR-TB	multidrug-resistant tuberculosis
MoU	memorandum of understanding
NCD	noncommunicable disease
NGCAs	non-government-controlled areas (Ukraine)
NGO	nongovernmental organization
NIDs	national immunization days
NIS	newly independent states
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
OIC	Organization of Islamic Cooperation
OIE	World Organisation for Animal Health
OPV	oral polio vaccine
polio	poliomyelitis
POSE	polio outbreak simulation exercise
RHDC	regional health development centre
SCO	Shanghai Cooperation Organization
SDG	Sustainable Development Goal
SEEHN	South-eastern Europe Health Network
SIA	supplementary immunization activity
TB	tuberculosis
TEACH–VIP	training, educating and advancing collaboration in health on violence and injury prevention (curriculum)
TRACECA	Transport Corridor Europe–Caucasus–Asia
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund

1. Switzerland: global health begins at home – 10 years of health foreign policy, 2006–2016

Tania Dussey-Cavassini

Unilateralism does not work in health, in either the hospital ward or health policy-making by government. In fact, even governments cannot tackle the many challenges posed by global health on their own.

The past decades have highlighted the great impact of health issues on domestic and foreign policy. The HIV/AIDS epidemic of the end of the 20th century, severe acute respiratory syndrome in 2003, the spread of avian influenza in 2005 and the Ebola outbreak in 2014 have shown that internationally coordinated responses have become crucial in solving national and regional health challenges.[3] The growing significance of health has presented new challenges and new opportunities. Globalization and the internationalization of health concerns have generated considerable demand for coordination among all stakeholders. Clearly, public health and foreign policy can no longer be taken separately, as they are closely intertwined. Numerous particular and sometimes conflicting interests shape health policy, so developing such policies requires greater coordination and close cooperation among health, foreign, economic and development policies.

In 2006, based on the Federal Council Decree of 18 May 2006, Switzerland became the first country in the world to define common objectives for health and foreign policy between the Federal Department of Home Affairs, in charge of health and other domestic issues, and the Federal Department of Foreign Affairs. Based on this joint effort, the Federal Council (the Swiss Government) adopted the first Swiss Health Foreign Policy in 2012 *(2)*. It encompasses 20 goals in different areas of health, as well as several mechanisms for effective interministerial collaboration. In adopting the policy, Switzerland played a pioneer role in developing an instrument that ensures greater cooperation and coherence among the actors involved and strengthens partnerships.

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[3] The International Health Regulations (IHR) *(1)* represent an agreement between 196 countries, including all WHO Member States, to work together for global health security.

For the past 10 years, the Swiss Health Foreign Policy has proven an enabling instrument. Today, global health has become an essential pillar of foreign policy in Switzerland. It allows the country to respond to the increasing complexity and challenges of global health.

In this regard, the Swiss Health Foreign Policy serves as an important bridge between national, regional and global health policy priorities. Moreover, it helps Switzerland share its national policy goals and priorities at global level, and invites people in Switzerland to consider global health issues at national level.

The implementation of the Swiss Health Foreign Policy forms a constellation articulated with keywords, all of which start with the letter c. The diverse ministerial offices or Swiss federal bodies involved in the Swiss Health Foreign Policy **cooperate** on a daily basis. In my experience as a public servant, a coherent Swiss Health Foreign Policy demands frequent **consultations** and **collaboration** between governmental agencies. The latter is not instinctive; it is a **capability** that needs to be fostered by the common endeavour to defend and promote the defined objectives and interests of the state. Successful cooperation is based on a solid **confidence** level. The interagency consultation process cannot be reduced to a simple coordination exercise that consists of endless email trails, which add no specific value, just the mere mark of coordination or control. A foreign health policy functions efficiently when all actors know their **clients** or the main causes they serve. This helps them to shape their unique **contribution** to the conversation. The difficulty resides in joint efforts to make sure the diverse interests **converge** in one **coherent** policy. When a Swiss position has been consolidated, government agencies may claim that they have achieved the first important step that allows Switzerland to be a credible partner in the international arena. Of course, **contradictions** or even **conflicts** arise at times through the consultative process, but government agencies are responsible for addressing them by clinging to their joint commitment, and to cooperate to advance the Swiss Health Foreign Policy. The search for **consensus** or Swiss **compromise** is also one of the country's trademarks. It requires a certain level of **creativity** in problem-solving. When conversations have explored and exhausted the diverse opportunities lying ahead, and when close collaboration has brought all to a different level of understanding of the issue being addressed, only then have stakeholders reached the true value of **co-creation** and partnership.

The eight points below illustrate the implementation of the Swiss Health Foreign Policy, describing how various government agencies have worked together to accomplish the objectives set by the Swiss Federal Council in March 2012.

Cooperation

The main actors closely involved in the Swiss Health Foreign Policy are the Federal Office of Public Health of the Federal Department of Home Affairs, and the Swiss Agency for Development and Cooperation and the Sectoral Foreign Policies Division of the Federal Department of Foreign Affairs *(2)*. They cooperate on a daily basis, bringing together their expertise to develop targeted synergies.

The competencies and concerns of various other federal authorities are also taken into account. These agencies include (in no particular order): the Directorate for European

Affairs; the United Nations and International Organizations Division; the Federal Statistical Office; the State Secretariat for Education, Research and Innovation; the State Secretariat for Migration; the Swiss Federal Institute of Intellectual Property; the Armed Forces Logistics Organization; the State Secretariat for Economic Affairs; the Federal Office for the Environment; the Swiss Agency for Therapeutic Products; the Federal Food Safety and Veterinary Office; the Swiss Alcohol Board; and the Federal Office for Agriculture *(2)*.

The main actors also cooperate with the stakeholders of the Swiss Health Foreign Policy and regularly convene some 50 civil-society organizations with an interest in international cooperation in the health sector. Networking events provide a platform for the important voice of civil society to discuss, shape and consolidate Switzerland's position in the international health context.

Client

The word client is not commonly used in public service, yet I think that it should inform the daily activities of government. As the Assistant Director-General of the Federal Office of Public Health in charge of international affairs, my main duty is to serve public health and global health, two faces of the same coin. My colleagues from other governmental agencies have different mandates that equally serve and complement the objectives of the Swiss Health Foreign Policy.

Switzerland's development cooperation has focused on strengthening health systems and improving the health of poor and vulnerable population groups. Particular efforts have been invested in enhancing maternal and child health, and sexual rights and reproductive health. The State Secretariat for Education, Research and Innovation contributes to the scientific and academic research in the field of health. The State Secretariat for Economic Affairs promotes trade interests, with pharmaceutical products accounting for 38% of Switzerland's exports *(3)*. The Swiss Federal Institute of Intellectual Property promotes appropriate protection for intellectual property as an incentive for research. With the Directorate for European Affairs, the Federal Office of Public Health seeks to establish a legal framework for collaboration with the European Union (EU) on public health. Finally (and not exhaustively), the Federal Department of Foreign Affairs promotes various Swiss interests, including the strengthening of international Geneva as a hub of health diplomacy and host to many international organizations and key stakeholders in global health.

Contribution

As a result of the diverse mandates of the Swiss Health Foreign Policy actors, their contributions form a large and colourful kaleidoscope, each actor playing her or his part according to her or his strength. Every government body is responsible for adding a financial and/or intellectual contribution to the conversation about the global challenge being addressed. Only then is the Swiss Health Foreign Policy shaped to foster higher achievements. Mere coordination or control cannot be the sole aim of the dialogue.

Only by these actors combining their efforts and diverse contributions can the many common challenges that all states face be tackled. This endeavour is essential in the targeted efforts still required to combat the three main poverty-related diseases (HIV/ AIDS, tuberculosis (TB) and malaria), the rise of noncommunicable diseases (NCDs), the ageing of populations, the shortage of health personnel and the increasing costs related to health care.

Beyond multilateral contributions, the Swiss Health Foreign Policy is also intended to strengthen Switzerland's relations with its key partners, the EU and neighbouring countries.

Consultation and collaboration

The main objective of all activities at international level is to promote Switzerland's various interests related to health. The consultative process among the Swiss Health Foreign Policy actors aims at defining the Swiss position at national and international levels. Interministerial working groups within the Federal Administration develop agreed positions on the most important issues that are discussed in multilateral forums such as the World Health Assembly, WHO's global governing body, which meets in Geneva every year.

Including other agencies' points of view and competencies requires openness and joint effort. While mostly constructive, these consultative processes can at times involve endless animated conversations that may demand additional care to be consolidated into a unique position. The latter is the result of internal negotiations that strike a fine balance between the various interests at stake in light of the objectives of the Swiss Health Foreign Policy.

Given the many pressing global health challenges, Switzerland defines its priorities based on the national objectives defined in its Health 2020 strategy *(4)*, which was approved by the Swiss Government in January 2013. The country's international activities are an extension of its national measures and thus enhance their importance and resonance.

Confidence

One of the key factors in the success of the Swiss Health Foreign Policy is the trust and understanding among the various government agencies that work together to achieve the 20 goals set by the Swiss Government in 2012 *(2)*.

The regular consultative processes and the intensity of close cooperation over the years build the level of confidence. The composition of the official delegations of Switzerland attending meetings of the governing bodies of international organizations is the best illustration of this multisectoral cooperation.

For example, Switzerland prides itself in bringing a diverse delegation to the World Health Assembly each year. Under the leadership of the federal councillor (minister) in charge of public health and other domestic issues, the Swiss delegation includes representatives of

the Federal Office of Public Health, the Swiss Agency for Development and Cooperation, the Federal Department of Foreign Affairs, the Permanent Mission of Switzerland to the United Nations Office and to the other international organizations in Geneva, the Federal Institute of Intellectual Property and the Federal Food Safety and Veterinary Office. The delegation operates like a sports team, each member being fully equipped and empowered to play a key part in the discussions, and ready to take part in the various negotiations that take place during the Health Assembly.

Consensus – compromise – creativity

The corporate culture in Switzerland is based on consensus, and fostered by the ability to discuss issues thoroughly and eventually come to a joint agreement. The respect for democracy and the integration of the diversity that forms the small state of Switzerland are at the core of Swiss culture. The Swiss communicate on a daily basis in three official languages (French, German and Italian), all civil servants expressing themselves in their mother tongue. I have always enjoyed the colourful and diverse languages that form the email trails, and our ability to switch languages when addressing an issue. The ability to build healthy compromises is also one of the competencies that Switzerland nurtures at home, and can use in international negotiations.

The Swiss Health Foreign Policy promotes objectives that may appear conflicting in areas such as the vast topic of access to medicine. In this regard, Switzerland promotes innovation, universal access to good-quality medicines and profitability. It also provides appropriate protection of intellectual property as an incentive for research. Equally, it addresses the needs of the least developed countries in the production and adequate distribution, pricing and marketing of vital medicines. Bridging these objectives often requires creativity.

For example, Switzerland supports research into, and the development of, new medicines and medical products for neglected diseases, which disproportionately affect people in low-income countries. It supports public–private partnerships such as the Drugs for Neglected Disease Initiative and the Medicine for Malaria Venture. Switzerland also contributes to funding an observatory for research and development, as well as a pool fund for research and development managed by the WHO specialized programme on tropical diseases.

Convergence

An illustration of the importance of making sure that various interests converge in a unique strategy is the efforts to lead locally and internationally in fighting antimicrobial resistance (AMR). AMR is a global health threat with many facets that is putting national public health systems to the test. It needs to be tackled at national and international levels through coordinated and collaborative action.

As a result of collective work involving WHO, the Food and Agriculture Organization of the United Nations (FAO), the World Organisation for Animal Health (OIE) and civil society, the World Health Assembly adopted a global action plan in 2015 calling for specific measures in key areas *(5)*.

In November 2015, the Swiss Government adopted an ambitious national strategy on AMR *(6)*. Converging in a One Health approach, the goal of the Swiss strategy is to maintain the efficacy of antibiotics for humans and animals. The Federal Office of Public Health, the Federal Food Safety and Veterinary Office, the Federal Office for Agriculture and the Federal Office for the Environment were involved in its development, and are now jointly responsible for its implementation.

Since AMR is a multisectoral issue of global concern, Switzerland is committed to international cooperation. This includes supporting the WHO global action plan *(5)* and working within the framework of the Global Health Security Agenda (GHSA) *(7)*. Switzerland also recently adopted a five-year national research programme on AMR *(8)* and is contributing to global initiatives in this regard to foster close dialogue and cooperation with the pharmaceutical industry.

Coherence

A specific health and public safety challenge for which Switzerland developed a coherent policy at national and international levels is illicit drugs and the rising epidemic of HIV/AIDS.

In the early 1990s, open drug scenes were one of the most urgent problems in Switzerland. Around this time, the country had the highest HIV transmission rate in Europe. The failure of repression to dissolve the drug scenes made it obvious that a new approach was needed. Public pressure led to a reorientation of Switzerland's drug policy and the introduction of a new policy based on the principles of health and human rights *(9)*. It has four pillars: prevention, therapy, harm reduction and law enforcement. The most important success from the change in policy was a significant reduction in number of infections with HIV/AIDS and hepatitis B and C, as well as drug-related deaths. Open drug scenes in Switzerland have largely disappeared and the number of crimes committed by users of illicit drugs has become insignificant.

To this day, this policy of four pillars, a balanced approach between demand and supply reduction, has proven its positive effects. It is also recognized at international level *(10)*. Harm-reduction measures are effective not only in improving the health of people affected, but also in terms of cost savings and public safety.

Today, about 29 million people still suffer from drug-use disorder worldwide, but only one sixth are in treatment *(11)*. The magnitude of the problem becomes even more apparent when one considers that almost half of those using drugs do so by injection. An important fraction also lives with HIV and other communicable diseases, and many share injecting equipment because of a lack of access to harm-reduction measures, such as clean needles and syringes. Five out of six people affected worldwide have little or no access to pain medication *(12)*. The lack of access to essential medicines due to overly restrictive drug-control policies remains an important issue to address. All should remember that the purpose of the international drug-control system is not prohibition, but the health and well-being of humankind *(13)*.

At the United Nations General Assembly Special Session on the World Drug Problem *(14)*, which took place in April 2016, Switzerland promoted its coherent four-pillars policy throughout the discussions by focusing on people, not illicit drugs.

Finally, at the 2016 High-level Meeting on Ending AIDS *(15)*, Member States committed themselves to implementing an ambitious agenda to end the AIDS epidemic by 2030.

Switzerland co-facilitated the negotiations, which led to the adoption of a new and actionable political declaration *(16)*, including a set of specific, time-bound targets to help achieve this aim. The importance of including the fight against HIV/AIDS within a broader agenda for sexual and reproductive health and rights has been recognized, as have the links between the HIV/AIDS epidemic and the use of illicit drugs.

Conclusion: co-creation and new partnerships

In light of the similarities of the challenges that countries face, sharing good practices and exchanging experiences are essential and mutually beneficial tools. Only by working together and reinforcing bilateral and multilateral relations can countries improve population health. As stated at the beginning of this chapter, unilateralism is no longer a viable option.

Further, the recent adoption of the 2030 Agenda for Sustainable Development *(17)* implies a paradigm shift in the way that international actors, as well as governments, are called to address health and other challenges. The 2030 Agenda is universal in the sense that all states have committed to taking action. It is indivisible and integrated, which means collaborative approaches across sectors are required to address the different challenges.

More than ever, Sustainable Development Goal 3 (SDG 3) on health requires concerted action to improve the determinants of health and ensure that the provision of health-care services becomes and remains accessible, acceptable, appropriate and affordable, as defined by WHO in the right to health.

Health is no longer the sole duty of health ministries and specialized organizations. All stakeholders from various sectors are now required to act and work together in the spirit of collaboration and shared responsibility to address the many determinants of health. Continuous efforts are required to maintain a high level of protection also in the areas of food safety, chemicals, radiological protection, environmental protection and the safety of therapeutic products. A spirit of partnership and co-creation across all sectors is required to achieve the ambitious SDGs of the 2030 Agenda *(17)*.

The Swiss Foreign Health Policy, which fosters intergovernmental and multistakeholder coordination, serves as an important tool in Switzerland's efforts to contribute to the achievement of the 2030 Agenda at global, regional, national and subnational levels.

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2. United Kingdom: from declarations to deeds – catalysing international action to tackle drug-resistant infections

Heulwen E. Philpot & Sally C. Davies

The foundations

By 2020, one person could die of a drug-resistant infection every three seconds if no action is taken to quash the spread of AMR. Already, drug-resistant strains of TB, HIV and malaria kill 700 000 people every year *(1)*; sadly, this heartbreaking figure is likely to be a gross underestimation due to insufficient data. What looks like just another statistic on a page is really 700 000 mothers, fathers, husbands, wives, sons and daughters taken from their loved ones before their time, often with little warning. People have become so accustomed to being able to take a simple antibiotic treatment to stop infections in their tracks that when these treatments no longer work, the unnecessary loss of life can be much harder to bear. Modern medicine's armoury of drugs is rapidly shrinking, and all must act now to protect the health and wealth of nations.

Thankfully, international recognition of AMR as one of the gravest global health threats has grown significantly. This started with WHO, which began proposing resolutions on how to tackle aspects of AMR in 1998, although all Member States agreed on a milestone World Health Assembly resolution on AMR only in 2014. A year later, the Health Assembly agreed on a global action plan to tackle AMR *(2)* and crucial resolutions came from FAO and OIE. WHO's global action plan is now the blueprint for all countries to tackle AMR and calls on Member States to develop their own national action plans by May 2017 as One Health plans, involving not only all aspects of human health, but also animal, fish, agriculture and environmental health *(2)*.

Rush & Davies chronicled the journey that led to these seminal achievements *(3)*. While health and agricultural ministers recognized AMR as a threat to be tackled, heads of government had not yet truly owned the problem on a global scale. Without

that political momentum, national action simply was not being taken fast enough. This chapter describes how the consensus reached by Member States through United Nations specialized agencies was built upon to take this issue to where it needed to be: in the hands of every leader of every country. This could really be achieved in only one place: the United Nations General Assembly, which held the High-level Meeting on Antimicrobial Resistance in September 2016 *(4)*.

We who work in the AMR team in the United Kingdom Government called this journey the road to the General Assembly. Standing and reflecting on the other side of this milestone, one can see many parallels between a long and unpredictable journey and the diplomatic process of negotiating a United Nations declaration *(5)*. This chapter reflects on how the route was planned, what potholes were encountered or avoided and, most important, how other partners were encouraged to join us on this journey.

Learning from history

Rush & Davies *(3)* expanded on the lessons learned from the first leg of the journey: negotiating WHO, FAO and OIE resolutions. They identified certain key elements in achieving that early progress:

1. widespread domestic political support for the issue in any country trying to influence others;
2. a common understanding of the problem;
3. a clearly visible group of countries owning the issue, with cross-regional representation;
4. technical understanding of the organizational systems engaged; and
5. communication with a wide range of stakeholders.

Learning from the core of diplomats who had led the AMR negotiations in WHO, FAO and OIE helped lay the groundwork for the international engagement strategy. It was important to bear in mind the cultural differences between that context, in which discussions of health are the norm, and the more political culture of diplomacy at United Nations headquarters.

Widespread domestic political support for the issue

We knew we first needed to secure strong domestic political backing for our ambitious objectives. The United Kingdom had long advocated urgent action to address AMR, and senior political support from within its Government was essential to making progress. A 2013 report of the Chief Medical Officer (CMO) on AMR *(6)*, which catalysed the creation of the United Kingdom's first five-year AMR strategy, started the political conversation in Westminster. As evidence mounted of the grave threat that AMR posed to modern medicine, the CMO made a strong case for the inclusion of AMR on the National Risk Register of Civil Emergencies. This was successful and secured Government action, as it would always have a responsibility to do its utmost to mitigate that risk. More specifically, following some lively briefings from the CMO and a clear articulation of where they could add value, the then Prime Minister, David Cameron, and the then Chancellor of the Exchequer, George Osbourne, gave their personal backing.

Senior prioritization of the issue also enabled the Department of Health to secure funding for the Fleming Fund and the Global Antimicrobial Resistance Innovation Fund (GAMRIF). The Fleming Fund is £265 million of official development assistance (ODA) funding. Taking a One Health approach, the Fund focuses on improving laboratory capacity for diagnosis and surveillance of AMR in low- and middle-income countries (LMICs), where

drug-resistant infections are expected to have a disproportionate effect. GAMRIF is £50 million of ODA funding to create a focused and coordinated multilateral fund that will target neglected and underinvested areas of AMR research and development globally and provide funding to those who have struggled to access traditional sources of funding. This will be shaped by experts in the field to determine what is needed to tackle AMR.

These funds became central to the United Kingdom's diplomacy strategy; to support engagement with the funds and its wider international AMR strategy, it created a cross-government international AMR steering group, chaired by the Foreign Ministry and the United Kingdom's Ambassador to the United Nations in Geneva, Switzerland. This group convened all relevant departments of the United Kingdom Government and enabled them to orchestrate the delivery of an international engagement strategy, with each department playing its respective role and reaching out to its own stakeholder groupings.

This senior political support, backed up by real funding commitments, allowed us on the AMR team not only to prioritize the issue in the United Kingdom, but also to speak with integrity and authority when encouraging others to raise it with their heads of state or ministers of finance or development. This allowed us to build a confident international engagement strategy in the knowledge that we could count on the Prime Minister's support if we needed to escalate any issues. It also meant that he was ready to act on gaps in the United Kingdom's strategy and the need for improved evidence to build a common understanding of the problem. The CMO worked with cabinet secretaries so that the Prime Minister could commission an independent review of AMR by a globally recognized economist; this tactic had worked successfully for Lord Stern's review of climate change *(7)*.

A common understanding of the problem

Staff of the Department of Health knew they needed to improve understanding of the problem in political circles and thus develop a stronger economic case for action, particularly in LMICs, where AMR risked being seen as a pet project of developed western countries. The idea of an independent review on AMR was born to address this need; Lord O'Neill was appointed its chair. Lord O'Neill's previous work had spanned both of the Department's target audiences; he had been chief economist at Goldman Sachs, but also worked widely with emerging economies. He was a widely respected, plain-speaking economist who knew how to translate complex issues into politically relevant killer facts and, later, recommendations.

The scope of the review was intentionally global; Department staff knew a series of recommendations directed at only the United Kingdom Government would not be helpful. The review was therefore commissioned to find globally relevant solutions to the problem that could be applicable in a variety of settings, regardless of income level. The review produced a series of reports over its two-year life that looked at the problem of AMR from various angles, such as agriculture, infection prevention and drug development. All were informed by extensive research and engagement with LMICs to understand the challenge from their perspective and help develop the much-needed globally relevant recommendations.

The independent review was ultimately invaluable in shaping a common understanding of the size of the challenge if AMR were not tackled. Its early figures – warning that AMR could cost 10 million lives a year and US$ 100 trillion by 2050 *(8)* – quickly became the most widely quoted statistics in every speech, press release and national statement. The World Bank's recent report on AMR reconfirmed these figures and underlined that drug-resistant infections would have the greatest impact on the poorest countries in the world

(9). In addition to helping to quantify the human and economic cost of AMR, however, the review also devised a simple formula to explain how it could be tackled: reduce demand, increase supply and follow 10 simple recommendations. The recommended actions focused on reducing human and animal demand for antibiotics or increasing the supply of useful products *(10)*:

1. hold a massive global public awareness campaign;
2. improve hygiene and prevent the spread of infection;
3. reduce unnecessary use of antimicrobials in agriculture and their dissemination into the environment;
4. improve global surveillance of drug resistance in humans and animals;
5. promote new rapid diagnostics to cut unnecessary use of antibiotics;
6. promote the development and use of vaccines and alternatives;
7. improve the numbers, pay and recognition of people working in infectious disease;
8. establish a global innovation fund for early-stage and non-commercial research;
9. provide better incentives to promote investment for new drugs and improve existing ones; and
10. build a global coalition for real action via the Group of 20 (G20) and the United Nations.

This common understanding of the size of the problem and the building blocks to address it enabled diplomats and negotiators to explain in simple terms the action needed all over the world and at every level of government.

A clearly visible group of countries owning the issue

The Netherlands and Sweden had a long history of work on AMR; while this and domestic political support in the United Kingdom and a common understanding of the problem supported by the O'Neill review were critical foundation stones, they would not have moved the debate further forward on their own. They were all used to galvanize the support and commitment of a broader core group of geographically diverse countries. These countries really owned the responsibility for showing global leadership on AMR by implementing strong policies nationally but also supporting and encouraging their neighbours to see the reality of this threat.

In 2014–2016, the AMR action package under the GHSA *(11)* was the nucleus of this core group: an incredibly supportive group of 21 diverse countries with a common ambition to see an impactful United Nations declaration on AMR to drive forward implementation of WHO's global action plan *(2)*. The group formed a coalition that agreed on a set of priorities for inclusion in a declaration and then consistently spread the message that this was a global issue that had to be tackled multisectorally and which was a huge threat to the attainment of the SDGs if not tackled. Group members supported one another in many practical ways: committing to offer support to countries in their regions, meeting in person on the margins of international conferences, urging the three specialized agencies (WHO, FAO and OIE) to stay ambitious and even holding weekly teleconferences during the negotiations in the General Assembly in the summer of 2016 to share views on the text of the declaration as it developed.

Experts from this group of countries pooled their knowledge of the subject matter and of the United Nations system. The strong relationships built between the health diplomats in each country meant that, when AMR was also raised in discussions of the G20 and Group of 7 (G7), similarly ambitious wording was supported. In general, this occurred because the same people gave the same advice across the different multilateral forums. As a result, a clear thread can now be seen through the language used by the G7, G20 and United Nations. Crucial to the success of these partnerships was that relationships

between core countries were replicated among capitals and between permanent missions in Geneva and New York: that is, by the countries' diplomats. This meant that: capitals had a common view of policy objectives; experienced negotiators in Geneva could share their wisdom from WHO negotiations; and negotiators in New York ensured that all received regular news on what would be politically achievable in the United Nations system.

This grouping rapidly became bigger than just the GHSA AMR action package *(11)*, as helpful a catalyst as it was. Soon a strong core of countries was developed, all calling for an ambitious United Nations declaration. From New York, the appointed facilitator – Juan Gomez Camacho, Permanent Representative of Mexico to the United Nations – drove this ambition with skill and passion. Camacho had recently moved to New York from Geneva, so he had a background in health and was known for negotiating the complex WHO Pandemic Influenza Preparedness Framework.

These countries, united in purpose, demonstrated the universal nature of the threat of drug-resistant infections. Countries from sub-Saharan Africa, south-eastern Asia, Europe and Latin America all agreeing that something must be done was a powerful testament. Beyond just proof of the widespread nature of the threat, each country in the GHSA group could testify that action to reduce the spread of drug-resistant infections was possible and could work in a variety of settings with a variety of resource needs.

Ultimately, this chorus of diverse voices, augmented by those they convinced to join them, led to the successful negotiation of the United Nations declaration on AMR that could be agreed by all 193 Member States *(5)*.

Communicating with a wide range of stakeholders

The process of agreeing a United Nations declaration and securing strong commitments from the G7, G20 and the EU were vital to ensuring that governments prioritized the development and implementation of national action to tackle AMR. Nevertheless, government can only reach so far, and only the private sector and civil society can play certain roles.

Open dialogue with the pharmaceutical industry and the mutual understanding that preserving existing antimicrobials and reinvigorating the antibiotic pipeline is in everyone's interest comprised one of the greatest assets to this process over the course of 2016. The O'Neill review, with its ability to engage with the private sector in a way that is not always easy for United Nations organizations, dramatically helped this dialogue. In January 2016 at the World Economic Forum, this engagement led to the publication of the Declaration by the Pharmaceutical, Biotechnology and Diagnostics Industries on Combating Antimicrobial Resistance, or the Davos agreement, as it has become known *(12)*. In it, 98 companies and 11 trade associations committed themselves to reducing the development of AMR, increasing investment in research and development work for antimicrobials and diagnostics, and improving access to new and existing antibiotics. This was followed up in September 2016 by a roadmap signed by a smaller group of 13 companies committing to even more detailed actions to preserve antimicrobials: this was launched at the side event on AMR co-hosted by Kenya, South Africa and the United Kingdom during the General Assembly *(13)*.

These steps have helped to change the exchanges of blame that so often occur between sectors; setting aside questions of fault has enabled a better articulation of the roles that government and industry must play in unison to stop the rising tide of drug-resistant infections.

The dialogue with civil society, however, is at an earlier stage. Because AMR is a rare issue, mostly lacking a human face, the primary driving force comes from governments, rather than nongovernmental organizations (NGOs). Thus, the civil-society community seems to have either some mistrust of governments' intentions or uncertainty about where NGOs can add value. The voice of populations on the ground, however, must be heard in order for the movement to be sustainable and to ensure governments are held to account for acting on their commitments. Civil society will therefore have a crucial role in the next chapter.

Table 2.1 shows arguments encountered in this process and responses from the United Kingdom and like-minded countries to allay the concerns expressed.

Table 2.1. Arguments against global action on AMR and partners' responses

Argument	Response
AMR is only an issue in the developed world; LMICs have bigger problems.	AMR was long known to be a global issue, but data were lacking on where the burden would be greatest. The O'Neill review predicted that the burden would be greatest in LMICs and analysis by the World Bank Group, launched during General Assembly week, confirmed this (7–9). Statements from health ministers from LMICs such Kenya at the AMR side event during the week also went a long way towards changing the perception of the issue.
Reducing antimicrobial use in agriculture will decimate the industry and hinder economic growth.	Experience from a number of countries has shown this argument to be incorrect: for example, the Netherlands reduced its use of antibiotics in animals by 58% between 2009 and 2014 while maintaining a thriving veal, pork and poultry industry. Nevertheless, this is a sensitive topic, so it was more constructive to emphasize that the most important step for countries to take was to improve data collection and then steadily introduce national targets for reducing use.
Why should LMICs support the development of new antimicrobials when they will only go to those who can pay the highest price?	Understandably, some would expect any new antimicrobials to be prohibitively expensive. The O'Neill review, however, suggested that publicly controlled market-entry rewards be used to compensate companies for their research costs (10); this would enable governments to set the terms of access and stewardship, so LMICs would have access to new antimicrobials. While this was only one suggested solution, the United Kingdom stressed that the principles of access and stewardship of new drugs should be central to any model.
Why should LMICs put measures for antimicrobial stewardship in place when more people are dying from lack of access than AMR?	Access to medicines continues to be a contentious global issue, and all countries clearly agreed that more needed to be done to increase access to existing appropriate antimicrobials. There is nevertheless a clear case to be made that increasing access, without good stewardship practices, is counterproductive, because the drugs will lose effectiveness over time.

What was achieved and why it matters

By learning from the lessons of previous phases of global health diplomacy, building strong domestic support for action in the United Kingdom, consolidating a common international understanding of the problem through the O'Neill review, building a coalition of the willing and communicating with stakeholders from all sectors, together all parties involved achieved something truly momentous. The General Assembly's High-level Meeting on Antimicrobial Resistance *(4)* was only the fourth such meeting on a health issue in the history of the United Nations.

By the terms of the General Assembly declaration *(5)*, Member States are now committed to developing multisectoral national action plans on AMR in line with the WHO global action plan *(2)*. Endorsing a concerted One Health approach – which linked various sectors and actors in defence of human, animal and environmental health – they also agreed to mobilize adequate, predictable and sustained resources to implement their plans and pledged to raise awareness of AMR around the world.

Further, they called on the United Nations Secretary-General to establish an ad hoc interagency coordination group to provide practical guidance on approaches needed to ensure sustained effective global action to address AMR and to report back to the General Assembly in two years.

In his opening remarks at the High-level Meeting, Secretary-General Ban Ki-moon said, "We are losing our ability to protect both humans and animals from life-threatening infections" *(14)*. He warned that if AMR was not dealt with quickly and comprehensively, it threatened to make the provision of high-quality, universal health coverage (UHC) more difficult, if not impossible. Cautioning that such trends were undermining the hard-won achievements of the Millennium Development Goals, he urged global leaders to turn their commitments into swift, concerted action.

Eliciting such a statement as this from the United Nations Secretary-General only two years after the World Health Assembly adopted a resolution on the issue was unprecedented. High-level political support of this nature shows how much progress had been made towards underlining the need for multisectoral action both nationally and internationally, engaging a broader range of United Nations agencies outside the health and agricultural sphere, and setting AMR squarely within discussions of the SDGs.

This should be seen against the backdrop of strong words from G7 and G20 leaders, committing heads of government in these groups to even greater ambitions (Table 2.2). A traditionally economic forum, the G20 recognized the severity of the threat and commissioned the Organisation for Economic Co-operation and Development (OECD) and a group of other international organizations to bring to the 2017 summit, under Germany's presidency, further development options for addressing the market failure that discourages the development of new antimicrobials. These are ground-breaking statements; the dial is shifting.

The agreement of the 2016 General Assembly declaration was surrounded by widespread media coverage, 12 side events on AMR during General Assembly week and endorsements from civil society, industry and academe. The directors-general of WHO, FAO and OIE all addressed the High-level Meeting, with one of the most impactful statements coming from FAO Director-General José Graziano da Silva: "Antimicrobial medicines used for

Table 2.2. G7 and G20 commitments on AMR in 2016

Text	Content
G20 leaders' communique, Hangzhou, China, 5 September (15)	"46. Antimicrobial resistance (AMR) poses a serious threat to public health, growth and global economic stability. We affirm the need to explore in an inclusive manner to fight antimicrobial resistance by developing evidence-based ways to prevent and mitigate resistance, and unlock research and development into new and existing antimicrobials from a G20 value-added perspective, and call on the WHO, FAO, OIE and OECD to collectively report back in 2017 on options to address this including the economic aspects. In this context, we will promote prudent use of antibiotics and take into consideration huge challenges of affordability and access of antimicrobials and their impact on public health. We strongly support the work of the WHO, FAO and the OIE and look forward to a successful high-level meeting on AMR during the UN General Assembly. We look forward to the discussion under the upcoming presidency for dealing with these issues."
G20 finance ministers' and central bank governors' communique, Chengdu, China, 24 July (16)	"18. We will support the ongoing G20 work on Antimicrobial Resistance (AMR) under the working arrangement of next year's G20 Presidency to explore measures to address the potential market failure."
G7 Ise-Shima Leaders' Declaration, Ise-Shima, Japan, 26 May (17)	"We commit to promote Universal Health Coverage (UHC) as well as endeavour to take leadership in reinforcing response to public health emergencies and antimicrobial resistance (AMR) which could have serious impacts on our economies. We also emphasize promoting research and development (R&D) and innovation in these and other health areas."
G7 health ministers' communique, Kobe, Japan, 12 September (18)	The communique committed to a series of detailed actions, including promoting integrated and aligned surveillance of AMR and antimicrobial use among human beings and animals, defining evidence-based targets for reducing use, encouraging each other to enrol in the Global Antimicrobial Resistance Surveillance System and considering providing support to LMICs to develop capacities for monitoring and surveillance of AMR and antimicrobial use.

growth promotion should be phased out immediately" (19). Such a concrete statement from the leader of the global agricultural organization sent a very clear message to stakeholders that AMR is not just an issue of human health; all sectors have a role to play. Such a statement was a testament to the progress in the global debate and the increased understanding of both the urgency and the multisectoral nature of this threat.

The progress made so far is just the beginning, not the grand finale, but is also a line in the sand. With such high-level international recognition, the problem can no longer be ignored, and all parties must now invest all their energy in ensuring the delivery of these commitments, providing both support and challenge in equal measure.

Challenges and opportunities ahead

One of the most powerful achievements of the United Nations declaration (5) is the call for the Secretary-General and WHO to set up an ad hoc interagency coordination mechanism. Ensuring that this group has the right structure, scope and influence will be crucial to Member States' implementation of the declaration. In the United Kingdom, the Government believes that this group should have a broad membership, beyond just the usual tripartite of WHO, FAO and OIE, as crucial as they are; it should include independent members, and representatives of civil society and the private sector. This mechanism would benefit from a robust, well informed chair to hold the United Nations system to account and avoid the risk of the system simply talking to itself. To be impactful, this mechanism will need senior buy-in from all key agencies and the backing of the new United Nations Secretary-General and WHO Director-General, and will need to avoid duplication with other systems as far as possible. AMR should be woven into SDG indicators wherever possible, and the joint external evaluations of countries' implementation of the IHR should be used to collect further data on national capability and need.

One of the few criticisms of the declaration in the media and academe was that it did not set global goals or ambitions. Although this would have been nearly impossible at its first United Nations hearing, the United Kingdom Government sees this as key, alongside surveillance and data collection. This coordination mechanism could explore the feasibility of setting global ambitions around which all actors could coalesce and ensure that progress can be measured.

We on the AMR team in the Department of Health hope that, when AMR returns to the General Assembly's agenda in 2018, every Member State will have a national action plan, improved global surveillance will show the size of the challenge, antibiotic use for growth promotion in agriculture will be nearly eradicated, the most remote communities will have increased access to antimicrobials and the pipeline of antimicrobial treatments will be reinvigorated.

Global leaders have now publicly committed to addressing this threat; the world is watching and all – governments, business and individuals – must act.

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3. Germany: putting health on the G7 agenda

Björn Kümmel

Global health was a central leitmotif of Germany's G7 Presidency in 2015. Not only health policy-makers and expert communities, but also many representatives of civil society highly commended this distinct focus on the central challenges of global health policy. After all, many of them had previously called for health to be awarded a greater role in the G7 context.

One frequently asked question is therefore what prompted Germany to place health topics so prominently on the G7 agenda and what concrete added value the engagement with health topics in the G7 framework can bring. The engagement with health topics during Germany's G7 Presidency was no novelty. While the G7 (until 2014, the Group of 8 (G8)) is known to have started as a forum that focused on global economic issues, as well as financial and currency aspects, the range of issues it covers has substantially broadened since its establishment in the mid-1970s.

By the time the HIV/AIDS, TB and malaria epidemics peaked in the late 1990s, the G8 already had an explicit health focus. The G8 summit held in Okinawa, Japan in 2000 addressed this central challenge, with far-reaching implications for the global health architecture. To control the epidemics, the G8 heads of state and government had proposed a new form of partnership initiative. Two years later, the Global Fund to Fight AIDS, Tuberculosis and Malaria was set up, a success story that continues to this day. Several more G8 presidencies went on to shine a light on various health issues. The German Presidency in 2007, for instance, focused on strengthening health systems and, with the International Health Partnership and Providing for Health, initiated two major instruments for coordinating Member States in the quest to strengthen health systems.

While the discussion of global health topics was not new, many health experts sensed a fresh, remarkable quality in the priorities set by the German G7 Presidency in 2015, the motto of which was: "Think ahead. Act together" *(1)*. From the very start, Germany saw its G7 Presidency as both an opportunity and a responsibility actively to shape global health policy, with its partners.

At the end of January 2015, the Vaccine Alliance (GAVI) held a pledging conference in Berlin under the patronage of Federal Chancellor Angela Merkel *(2)*. In her speech, Chancellor Merkel explained that 2015 was a crucial year for sustainable development. She was pleased to host the GAVI replenishment as the first event of her G7 Presidency and outlined the Presidency's key global health priorities. Chancellor Merkel added that including health was a tradition, citing as a case in point the G8 summit in Heiligendamm, Germany that saw the pledging of US$ 60 billion by 2015 to the fight against HIV/AIDS, malaria and TB and the strengthening of health-care systems necessary to do so. She also referred to the 2010 G8 summit in in Muskoka, Canada, which had committed to mobilizing an additional US$ 5 billion by 2015 to improve maternal and child health. Despite the impressive track record of G8 health initiatives and the welcome progress made, global health policy was still beset by numerous challenges that the international community had to face head-on: specifically, the need for greater investments in prevention and research. While every effort had to be made to tackle the Ebola crisis, in the medium and long terms the international community had to strengthen its health-care systems, give incentives for research into neglected diseases and the development of medicines and, above all, strengthen its response capacities in order to be better prepared to deal with comparable crises in the future.

At the GAVI pledging conference *(2)*, the Chancellor had unveiled the Federal Government's six-point plan to improve the response to international health emergencies:

1. to establish a rapid-response pool of doctors and medical staff (white helmets) for deployment to areas with health emergencies;
2. to provide more medical equipment (including field hospitals, mobile laboratories and personal protective equipment) that could be transported more rapidly to these areas;
3. to establish a fund to disburse immediate financial aid;
4. to adjust the organizational structure of the United Nations to bring it into line with the global challenges posed by epidemics;
5. to strengthen the primary health-care system in states at special risk; and
6. to put in place additional incentives to foster research and the production of medicines and vaccines against neglected diseases.

The GAVI pledging conference in Berlin was only the start of health-themed events of the German G7 Presidency. The Chancellor's participation as an invited speaker in the 2015 World Health Assembly in Geneva, Switzerland in May was a strong political signal, meant to carry far beyond the Geneva scene. Her speech, as G7 President, was particularly noteworthy for her strong support of WHO at a time of intense international criticism over its handling of the Ebola crisis. The Chancellor said *(3)*: "We need some kind of global disaster response plan. And the World Health Organization must play a key part in this". She went on to affirm: "In my opinion, WHO is the only international organization that enjoys universal political legitimacy on global health matters". With her statement, the G7 Presidency called on all Member States to back the ambitious reform agenda launched to strengthen WHO.

Health was a centrepiece of the G7 summit of heads of state and government held at Elmau, Germany in June 2015. Addressing key challenges in this field, the agenda included three health topics: AMR, Ebola virus disease and neglected tropical diseases. These issues shared two features. The first is the need for systemic approaches to address them. None can be resolved solely by choosing from the stock of classic public health measures. Each calls for cross-sectoral measures that take on board not only health, but also research, development policy, food and agriculture. Second, overcoming these three challenges requires measures that strengthen health-care systems across the board.

The need for a systemic, cross-sectoral approach that transcends the brief of any specific department and entails far-reaching societal implications shows that these challenges can only be resolved if heads of state and government are willing to commit themselves to resolving them over the long term. This was one of the reasons why many health experts so emphatically welcomed the German G7 Presidency's choice of concrete health priorities for the Elmau summit.

The G7 heads of state and government made decisions on all three of these topics raised at Elmau, setting the course for further G7 activities. To advance the fight against AMR and Ebola and implement the agreements made at Elmau, Germany's Federal Minister of Health, Hermann Gröhe, invited his G7 counterparts to a health ministers' conference in Berlin in autumn 2015. At the same time, the G7 science ministers met to discuss ways of pushing ahead with the fight against neglected tropical diseases internationally.

The health ministers first focused on concerted action against AMR, whose prevalence had massively increased and which affected developed and developing countries alike. As global progress against AMR requires human and veterinary medicine and the agriculture sector to work together along the lines of the One Health approach, what better way could be found to ensure the cross-sectoral cooperation required than by obtaining the personal commitment of those on whose desks all of these sectors ultimately converge – the heads of state and government?

The health ministers also discussed ways to kick-start and incentivize the development of new antibiotics and treatment methods, and tackled difficult aspects, such as restricting access to antibiotics by making them universally subject to prescription. The Federal Minister of Health personally championed this stance as the only way to ensure that the global good of effective antibiotics can be preserved for all people.

The second key topic of the G7 health ministers' conference was Ebola. The German G7 Presidency was convinced of the need for concerted efforts to ensure that the international community would be better prepared for future emergencies. The lessons learned from west Africa reaffirm that efficient and robust health-care systems are the key prerequisite for the rapid detection of, and response to, health crises. While the international community and the G7 can provide valuable input and assistance in building resilient national health systems, the countries themselves must take the decisive steps to implement the right to health and set up strong national health systems. This requires strong political leadership by national governments, improved coordination among the assisting partners and the involvement of civil society, including the local population and the private sector.

Germany's G7 Presidency stressed that WHO has a central role to play in fighting against cross-border health threats. Accordingly, WHO had to be properly resourced and fundamentally reformed, to re-establish its role as the guardian of global public health. In particular, WHO's capacity for emergency response had to be substantially strengthened.

Thus, the G7 health ministers met with WHO Director-General Margaret Chan to discuss approaches to assisting WHO to fulfil its operative leadership role in responding to health

emergencies. After all, the reforms needed to boost WHO's efficiency required the shared political will of WHO Member States. Considering the multitude of major global health institutions, Germany was convinced that a strong coordinator was needed in global health policy. With its global membership, WHO was the only international institution with universal political legitimacy in public health.

The concept of embracing responsibility for global health

Seeing that global health was a central issue for Germany's G7 Presidency, many health experts wondered how a set of health topics came to have such a prominent place on the agenda.

Identifying priorities for the G7 is the prerogative of the head of state and government of the country holding the presidency, and these are known to be in line with the signature priorities of the person concerned. Most topics nevertheless are the result of a rather traditional course of action and must be pursued to safeguard G7 continuity. Current circumstances dictate others, and a presidency would be remiss not to address them in the face of a concrete and urgent need for global action. This may have been an aspect in managing the Ebola crisis, but does not fully explain the intensity and determination of the discussion on the lessons to be learned from Ebola that Germany launched in the G7.

Like all the other G7 heads of state and government, the Federal Chancellor receives advice on priority-setting from her G7 Sherpa and his or her group of aides, and all government departments. In addition, prospective priorities must match Germany's broader national and international profile, and the pronounced health focus of Germany's G7 Presidency tallies with the new momentum that global health topics had gathered in German politics in preceding years. Global health policy had greatly increased in importance in German politics in the previous 15 years. Adopting a concept of, and strategy for, global health in 2013, the Federal Government explicitly acknowledged its responsibility and reaffirmed Germany's role as a reliable partner in the world *(4)*. Seen from this angle, Germany's making global health a key topic of its G7 Presidency comes as no surprise.

Since global health issues are closely intertwined with myriad other policy fields – such as development, security, trade, human rights, environment and food – both cross-sectoral and cross-departmental approaches are needed to resolve them. Against this background, the process of drafting a whole-of-government concept for global health helped those involved realize that it is not an isolated policy field, but an integral part of international policy. Indeed, the concept was instrumental in maximizing the coherence of the specialized policies involved in addressing aspects of global health policy. Further, interdepartmental exchange was expanded to guarantee the joint planning and coordination of Germany's contribution to global health.

In this concept, Germany illustrated the commitment it had endeavoured to fulfil throughout its G7 Presidency. Germany wants to play an active part in shaping the global order by championing a more equitable world order, the enforcement of human rights, sustainable development and the fight against poverty. Germany's commitment focuses on safeguarding the global commons. Health has a special role in this, since health forms a major part of the foundation of social, economic and political development and stability. Health and access to affordable health care are both prerequisites for and outcomes of social development, and critically contribute to the fight against poverty.

With this concept, Germany assigns to the United Nations a key role in resolving global challenges, particularly in the health field. Germany therefore wants to contribute to the reform and advancement of United Nations structures and specialized agencies, and commits to assuming greater responsibility on the level of the United Nations and its specialized agencies. This, too, became abundantly clear in the Federal Chancellor's address to the World Health Assembly *(3)*.

The Federal Cabinet's adoption of the concept of embracing responsibility for global health can be understood as a milestone that may also have been instrumental in recommending health as a candidate issue for the G7 Presidency. After all, the framework document on global health policy in Germany *(4)* was the first to be adopted by the whole Government. The concept illustrates Germany's ambition, demonstrated especially during the G7 Presidency, to take on an active role in the concrete shaping of global health-policy processes. In doing so, Germany wants to act in concert with its partners, particularly EU and G7 partners, and through an efficient multilateralism, embrace responsibility for improving health on a global scale. The continuing commitment by the many diverse German actors is to be coordinated even better to optimize the effectiveness of Germany's contribution.

The following three main principles guide Germany's engagement, as set out in this concept *(4)*.

1. Only global action will ensure comprehensive health protection locally, including in Germany. After all, while many health problems manifest locally, their root causes are actually complex global constellations.
2. Germany seeks to embrace its international responsibilities by providing experience, expertise and funding to improve global health.
3. Germany seeks to promote equitable, cooperative and effective action in international forums of global health policy, because strong international institutions are a prerequisite for effective and coordinated global action.

This reaffirms that Germany aspires to see the globalized, interdependent and multilateral world adopt rules-based governance, with a multilateral and global orientation pursued by legitimate and effective international institutions.

As outlined in the concept, Germany's contribution to global health policy focuses on five carefully selected areas in which the country is comparatively strong and can make a sustainable contribution to improving global health. Germany's G7 health priorities cover all five:

- providing effective protection against cross-border threats to health
- strengthening health systems throughout the world: facilitating development
- increasing intersectoral cooperation: interaction with other policy areas
- providing important impulses for global health through health research
- strengthening the global health architecture.

While the question of how health topics became a central item on the G7 Presidency agenda cannot be answered conclusively, the setting of priorities was the sole prerogative of the Federal Chancellor and these health priorities fit perfectly into Germany's stepped-

up commitment to global health policy overall. The strategic considerations that Germany had floated in its outward-facing concept of global health policy *(4)* laid the foundation for the consistent setting of health priorities agreed among the various actors across the Government in preparation for the G7 Presidency.

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4. Sweden: negotiating to put health in the SDGs and their wider context

Bosse Pettersson
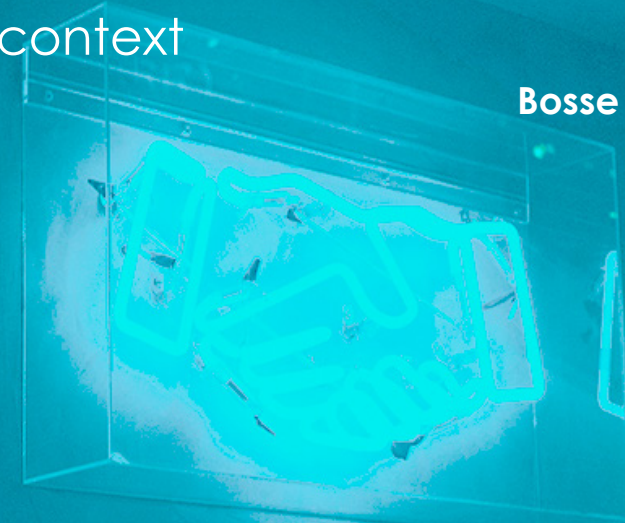
Introduction

This chapter is a mix of anecdotes and facts summarizing a background for, and the process of, Sweden's role in promoting health as a goal in its own right as part of the evolution of the SDGs in the United Nations 2030 Agenda for Sustainable Development *(1)*, succeeding the United Nations Millennium Development Goals (MDGs). The aim is to build a mosaic to illustrate some underlying factors, the structures in place and the process as such.

The work that led to SDG 3 on health cannot be seen in isolation, however. The contextual background is both much wider and goes back to the 1960s. The chapter focuses on a number of key factors and events, some public and some behind the scenes, to contribute to clarity. It is about setting the agenda, creating public opinion and international engagement, linking domestic and international policies, structures and leadership, building public health infrastructures and negotiating skills, and walking the talk. Only those who participated know exactly what happened behind the scenes, even if their stories vary with their personal interpretations. Why some arguments in the end led to certain positions and levels in the final text of SDG 3 can to a certain extent be deduced from political-science logic, but it is also left to the reader's own conclusions and experiences from different political contexts.

Background: United Nations and health

Health is nothing new in the United Nations and its specialized agencies, such as the United Nations Children's Fund (UNICEF) and WHO.

Health as a human right is stated in the Universal Declaration of Human Rights *(2)*. The WHO Constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" *(3)*.

The United Nations MDGs *(4)* took the role of health in human development a step further. They included three more specific health goals: reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases. With a so-called causes-of-causes approach to population health, the other five goals – on poverty, hunger, education, environment and functioning partnerships – could be considered as wider determinants of health.

The deadline for achieving the MDGs was 2015, and the work to set the post-2015 development agenda formally kicked off at the United Nations Conference on Sustainable Development, called Rio+20 *(5)*, held in Rio de Janeiro, Brazil in 2012 as follow-up of the 1992 conference in that city, at which the concept of sustainability gained global recognition.

In September 2015, heads of state from 194 countries met at United Nations headquarters and signed the new 2030 Agenda for Sustainable Development *(1)* with its 17 SDGs, health being the subject of SDG 3. A significant difference between the MDGs and SDGs is that the latter are universal, meaning that the 2030 Agenda should be implemented by countries. For this chapter, it has a specific connotation, since the Swedish national and international aspects of engagement for a broad sustainability approach are inextricably connected.

SDG 3 wording

The wording of SDG 3 – "Ensure healthy lives and promote well-being for all at all ages" (Box 4.1) *(6)* – is imperative but also aligns well with the intention of WHO's definition of health *(3)*. The term well-being was part of this definition from the beginning, but rarely appeared in political documents. A late exception is the WHO European health policy framework, Health 2020 *(7)*. This formulation captures what many understand about development. Well-being links to positive development, while avoiding disease has more of a negative connotation. SDG 3 can always be criticized for being utopian, like democracy, like human rights, but this is actually what a visionary development is about.

Box 4.1. SDG3 on health and well-being

> **Goal 3. Ensure healthy lives and promote well-being for all at all ages**
>
> 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births
>
> 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births
>
> 3.3 By 2030, end the epidemics of AIDS, TB, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases
>
> 3.4 By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being
>
> 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Box 4.1 contd

> 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents
>
> 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
>
> 3.8 Achieve UHC, including financial risk-protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
>
> 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
>
> 3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate
>
> 3.b Support the research and development of vaccines and medicines for the communicable and NCDs that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
>
> 3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small-island developing states
>
> 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks
>
> Source: United Nations *(6)*.

The Swedish case

Wider policy developments and changes of policy are rarely due to single events. In general, they are the outcome of complementary events forming an expanding policy stream. The following description tries to capture some of the key features behind Sweden's readiness to engage in the SDG development process.

Shedding light on Swedish engagement with the SDGs

Importance of history, opinion-building and forerunners

A good and thus health-enhancing environment was more or less taken for granted in Sweden after the 1950s. During the 1960s, however, environmental alarms hit society and mobilized people into protecting the physical environment. The mass media played a significant role in reporting and creating debate around green issues. Silent spring *(8)*, by Rachel Carson, the American marine biologist, caused tremendous alarm in Sweden about the use of pesticides killing birdlife and silencing nature by eradicating birdsong in early mornings.

The alarms continued for several years. At the beginning of the 1970s, the Swedish environmentalist Björn Gillberg washed his dirty shirts on a prime-time television programme with a cream substitute named Prädd. Gillberg aimed to increase awareness of the content of modern food. He succeeded. Not long afterward, the product disappeared from the market *(9)*.

A third example of a predecessor to the sustainability concept was the 1973 book *Brev till Columbus [Letter to Columbus] (10)* by the Swedish politician, diplomat and county governor, Rolf Edberg. It is a collection of fictional letters to Christopher Columbus, spanning nearly 500 years. They discuss how humankind gradually exploited nature, but still hoped that the world could be changed to become sustainable.

There are countless additional examples, illustrating that since the 1960s, there has been a never-ending and vital public debate that built opinion in Sweden about the environment. This made the environment – linked to survival, life, health and well-being – an issue for the population and thus of high and rapidly increasing political visibility.

A last and concurrent illustration is Professor Hans Rosling from the Karolinska Institute. His mantra was that the world is getting better, which he convincingly demonstrated with his animated Gapminder program, where statistics are turned into a living story related to daily life. Since it is both amusing and understandable to the ordinary person, Gapminder and Hans Rosling himself have been instrumental in raising awareness of global health with a sustainability dimension; even beyond his home country, he was listened to by high-level decision-makers *(11)*.

The international take-off of sustainability

The 1972 United Nations Conference on Human Environment, the first of its kind, was held in Stockholm. During its preparation, the concept of sustainable development was coined. Principle 3 (out of *26*) of the Stockholm Declaration expressed sustainability as: "The capacity of the earth to produce vital renewable resources must be maintained and, wherever practicable, restored or improved" *(12)*. The Declaration links sustainability to health: "The protection and improvement of the human environment is a major issue which affects the well-being of peoples and economic development throughout the world" *(12)*. The subjects of other principles ranged from human rights to the elimination of weapons of mass destruction.

Then followed the United Nations Conference on Environment and Development (the Earth Summit) in Rio de Janeiro in 1992, the Johannesburg Declaration on Sustainable Development of 2002, Rio+20 in 2012 and the concept that led to the 2030 Agenda *(1)*. In Sweden, the 1972 Conference became an inspiring and symbolic event. Swedish politicians at the highest level, such as Prime Minister Olof Palme, with other ministers and diplomats, had significant roles in the Conference. The media coverage was immense for the time and showed that a small country could put important issues on the international development agenda. Altogether it made a remarkable footprint for the years to come in elaborating a more sustainable society. Only two years later, in 1974, the first global oil crisis put the developed world on the spot and forced societies and their citizens to realize that the energy consumption from fossil fuels must be drastically reduced.

From the outset, health had been a priority of Swedish development-aid policy. Following the Stockholm Declaration, the human environment entered the foreign development agenda.

Paving the way: visibility, awareness-raising and building momentum

Following the 1972 Stockholm Declaration and the 1974 United Nations declaration, other events contributed to maintain the momentum around sustainability and health. With the other Nordic countries, in 1991 Sweden hosted the Third International Conference on Health Promotion: Supportive Environments, one of the five action areas in the Ottawa Charter for Health Promotion. A key input to the Conference was the World Commission on Environment and Development's report, *Our common future (13)*. The close informal collaboration between the Swedish core Conference team and WHO to take the Conference outcomes into the preparations of the Earth Summit one year later helped to make human health a priority in the Rio Declaration on Environment and Development *(14)*; its first principle is: "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature".

Directly linked to the SDG process was the 2013 initiative of the Swedish Society of Medicine to hold a big gathering in Stockholm on health goals beyond 2015 with global health groups that used social media: Twitter, Facebook, Instagram and YouTube. The meeting was backed by scientific, public administration, philanthropic, financial and commercial entities. The outcome statement, the Stockholm Declaration for Global Health, strongly argued for the inclusion of health in the SDGs, and was widely disseminated due to collaboration with *The Lancet* and others *(15)*.

Similarly, Sweden was invited to make presentations focusing on placing health on the post-2015 agenda at meetings and interregional events, such as an event in Istanbul, Turkey, the European Health Forum Gastein and the 64th session of the WHO Regional Committee for Europe in 2014.

The Swedish sustainable development landscape

This chapter presents a number of different but complementary features of the Swedish sustainable development landscape. Some were outcomes of systematic and long-term efforts and others were more ad hoc, but often aligned with the overarching sustainability concept.

The first coherent Swedish policy on sustainable development was submitted to the Riksdag [Parliament] in 2003 *(16)*. In 2006, the Government established four strategic challenges *(17)*, in which health is an explicit priority:

1. build a sustainable society
2. stimulate good health on equal terms
3. manage the demographic transition
4. promote sustainable growth.

An independent report from the German Sustainable Development Solutions Network *(18)* ranked Sweden number one worldwide among 147 countries with reporting capacity, according to the three different methods used, regarding prerequisites and possibilities to

accomplish the 17 SDGs and their 169 targets. This does not mean, however, that Sweden has mostly completed the implementation of the 2030 Agenda. There is potential for improvement in all 17 SDGs. Most critical is the growth of relative health inequalities in Sweden. This in turn is related to different SDGs, such as those on education, working environment and education, gender inequities and nutrition. The governmental Commission for Equity in Health, established in 2015, made its interim report *(19)* in 2016 and planned to present its definite proposals in May 2017, in which the SDGs were most likely to play a role.

Greening politics

Environmental degradation was the root of the establishment of the Green Party in Sweden, as part of a movement across western Europe. The Swedish Green Party was founded in 1981 as a response to the referendum on nuclear energy the previous year. The party entered the Riksdag in 1988. Over the years, other political parties assimilated much of green politics, which became an established component of Swedish politics, even in foreign affairs.

Much of the greening of politics is also closely linked with the wider determinants of health, although public health as such has never attracted the same political or public attention in either domestic politics or foreign affairs. Most attention has, of course, been paid to climate change, which increasingly affects the health of populations through heatwaves and other extreme weather events, but from a population-health perspective, structural issues on the sustainable health agenda also include healthy transport and food production and consumption. The link between health and environment becomes obvious when one looks at the series of WHO European ministerial conferences on environment and health, the most recent held in Parma, Italy in 2010 *(20)*.

Sweden's interaction with the global community, WHO and United Nations

Policy and structural mechanisms

In 2003, the Swedish Government initiated a mechanism to integrate a global dimension into national public administration and politics to record what was already happening in domestic administration, including a global dimension, and encourage increased activities for global development, thereby creating a coherent global development policy. The initiative was labelled the policy for global development *(21)* and the outcomes reported to the Riksdag every second year. Population health in different forms has been a part of the policy since its inception. In 2014, the Government renewed the policy with the clear strategic intent of making it a driver for implementation of the 2030 Agenda, which was further developed and concretized in 2015 *(22)*.

Sweden's strategies for collaboration with WHO

While Sweden's main principle is to give unearmarked extrabudgetary funding to WHO, a need to express Swedish priorities was identified, so collaboration strategies were made for 2011–2015 and 2016–2019 *(23,24)*. Beside topical priorities, such as NCDs and sexual and reproductive health and rights, the strategies give priority to health promotion as a cross-cutting issue. This approach falls directly in line with what became the final wording of SDG 3.

Ambassador for Global Health and top-level political engagement

In 2010, the Swedish Ministry of Foreign Affairs appointed Mr Anders Nordström Ambassador for HIV/AIDS *(25),* one of the first worldwide to take on that role. Although the initial focus was on HIV/AIDS, the post opened up for wider engagement and its title was changed to Ambassador for Global Health *(26)*.

When the post-2015 process started, windows of opportunity opened. United Nations Secretary-General Ban Ki-moon appointed the Swedish Minister for Foreign Affairs at the time, Ms Gunilla Carlsson, to the High-level Panel on Global Sustainability ahead of the 2012 conference in Rio de Janeiro, and to the High-level Panel on the Post-2015 Development Agenda as a member of the Secretary-General's core advisory group *(27)*. She made a significant contribution to the panel's comprehensive report *(28)*.

Partnership: Sweden and Botswana joining up for health in the post-2015 development agenda

Sweden and Botswana shared the burden of the work to elaborate health as a domain. One of the initiatives was to set up a website called *The world we want (29)*. More than 100 papers were submitted to the website, which more than 150 000 people visited, and 13 face-to-face consultations were organized worldwide.

The final high-level dialogue took place in Gaborone, Botswana in March 2013. This became a decisive moment in formulating what later turned out to be SDG 3.

Two different approaches on health in the global development agenda had been launched in different international forums, focusing on UHC and improved health and well-being. Seven health ministers advocated the UHC line in a commentary in *The Lancet (30)*. Sweden, through Anders Nordström, was the leading proponent for the health-and-well-being line. Nordström was also instrumental in authoring the meeting report *(31)*. A contradiction arose between the notion of maximizing health at all stages of life as a principle – "Maximizing health at all stages of life could be an overarching health development goal linked to the overall sustainable development agenda, which requires interventions from all sectors", a principle that can be described as the global development option – and the notion of UHC as a means to an end – "While some participants saw UHC as a means of achieving the high level health goals, others also saw it as a desirable outcome in its own right" *(31)*. According to the meeting report, no final conclusion on this matter was reached, but the text shows the lack of a unanimous understanding of UHC's components and content.

The comprehensive reports made to the United Nations Secretary-General gave priority to the health-and-well-being line. The final round of SDG negotiations at United Nations headquarters included no debate on the wording of SDG 3. Whether that is an expression of convincing argumentation, lack of controversy over health as a priority or lack of interest is not documented.

Implementation in Sweden

The Swedish Government established an implementation mechanism for the 2030 Agenda after the SDGs' adoption on 25 September 2015. According to the Swedish constitution, the Government makes all decisions collectively, so each minister is responsible for what falls within her or his portfolio. The Minister for Public Administration within the Ministry of Finance is responsible for coordinating domestic SDG implementation, while the Minister for International Development, Cooperation and Climate within the Ministry of Foreign Affairs is responsible for coordinating Swedish international policies regarding the 2030Agenda. In addition, all other ministers are responsible for SDGs related to their portfolios.

Before the implementation phase, the Ministry of Foreign Affairs took a key initiative. Almost parallel with the final United Nations consultation and negotiation of the SDGs in the spring of 2015, the ministry invited public, nongovernmental, academic and private domestic actors with both national and international remits to discuss and comment

on the proposed SDGs one by one, or in clusters. One meeting was devoted solely to SDG 3 and another to SDG 1 (on poverty). These consultations not only offered space for discussions across the whole of government and society, but also promoted readiness for implementation. In summer 2016, the Government commissioned the Swedish International Development Agency to gather about 50 state agencies to share initial experiences in implementing the SDGs.

At the adoption of the 2030 Agenda in New York, the Swedish Prime Minister Stefan Löfven initiated an informal high-level group with the heads of state of Brazil, Colombia, Germany, Liberia, South Africa, Timor-Leste, Tunisia and the United Republic of Tanzania to support continued high-level commitment to implementing the SDGs globally *(32)*. At the United Nations General Assembly in April 2016, the group made a joint statement on the necessity of implementing the 2030 Agenda and all Member States' responsibilities to move forward in the interest of a better world. The group members called on all world leaders to follow their example and put in place strong national overarching political frameworks and implementation mechanisms *(33)*.

In addition, a national high-level advisory council, the 2030 Agenda delegation, was established in Sweden to stimulate and support national implementation. It comprises representatives from the public and private sectors, academe and NGOs *(34)*. The delegation has the mandate to work across the government, but also to stimulate the autonomous subnational political levels (municipalities and county councils/regions). The delegation is placed in the Ministry of Finance. The responsible minister and the delegation are supported by a secretariat with nine staff. In March 2019, the delegation will deliver its final report to the Government on how Sweden will accomplish the 17 SDGs *(35)*.

The Government commissioned 80 central state agencies to analyse how their current work contributes to accomplishing the SDGs, as well as potential further needs in terms of, for example, expanded remits or resources, to increase their efficiency in implementing the SDGs within their remit. One concrete outcome from the National Board of Health and Welfare was the decision to show in all forthcoming reports how the subject relates and contributes to the fulfilment of the SDGs *(36)*. Based on its review and analysis of the state agencies' reports, the delegation concluded that two perspectives need to be elaborated and strengthened *(37)*:

- vertical, with a focus on governance and management; and
- horizontal, based on anchoring and ownership, as well as wide participation and dialogue.

The Swedish national 2030 Agenda process is continuously progressing. By the end of January 2017, directors-general of 40 state agencies agreed on a joint statement of strategic intent. The main message is their commitment to leadership and promise to implement the 2030 Agenda according to the responsibilities of their agencies. Further, they commit to collaboration across agencies based on equal footing and mutual support. Priorities will be published in an annual work plan, which will be continuously monitored *(38)*.

Concluding remarks

The 2030 Agenda and its SDGs are doubtless living things throughout the whole of Swedish society. This chapter aimed to describe the background and different features in the Swedish context, why and how the SDGs are a political priority both nationally

and internationally, and how these contexts are connected. In the Swedish case, the early wake-up call on environmental degradation in the 1960s created momentum for expanding the response to the threat into building capacity, forming structures and developing policies. Even if health has not been the most prominent among the SDGs, the 2030 Agenda processes have made the case stronger. All 17 SDGs offer a unique opportunity to promote health locally and globally by putting public health and its social, political, economic, cultural, commercial and gender determinants in the overall political context of the United Nations 2030 Agenda.

Is this lip service or true commitment? This question must be repeated over and over. In the end, it is all about power. The 2030 Agenda cannot be fulfilled without more equitable and gender-equal societies. Sweden can showcase hundreds of examples of political statements, such as Prime Minister Löfven speaking at the World Economic Forum, Her Royal Highness Crown Princess Victoria becoming a United Nations ambassador for the SDGs, and Minister of Public Health Gabriel Wikström devoting his speech at the World Health Assembly to SDG 3 and other goals determining public health *(39–41)*. There is no reason to doubt their honesty, good will or intentions, but walking the talk is the only way to make real change. Sweden has many pieces in place that form a comprehensive public health infrastructure. That is a good foundation for getting things done.

This chapter will have a short shelf-life. New 2030 Agenda initiatives are coming up day by day. I hope that they can expect a long and sustainable life. On 12 February 2016, professors Peter Friberg, Göran K. Hansson and Göran Thomson, all with international scientific reputations in public health, published an article in *Dagens Nyheter*, the biggest morning newspaper in Sweden *(42)*. Their message was the creation of a new institute: the Swedish Institute for Global Health Transformation. Funding is in place; it is organized under the Swedish Royal Academy of Science with the mission of contributing to strengthening Sweden's global efforts for sustainable public health. The link to implementing the 2030 Agenda is a platform for this enterprise. This is an example of what science, entrepreneurship and determination can do for the public good.

The Swedish SDG concept cannot and should not be copied. All copies have lower quality than the original. If the concept can inspire and encourage others to build or refine their own copies, then new originals will appear!

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5. Eurasia: the role of regional organizations and blocks in health diplomacy and governance

Haik Nikogosian

The architecture of health diplomacy is increasingly multifaceted in the 21st century. It has been built in various bilateral and multilateral settings both within and outside platforms with an explicit focus on health. It has also become increasingly multisectoral, as negotiating for, and promoting, health in the face of often competing agendas within and between governments requires the involvement of various other sectors and, in many instances, the government as a whole. These developments have brought an expansion of actors for health nationally and internationally, contributing also to the expansion of governance space for health.

The literature describes the role of global organizations with a definite or well recognized health mandate in this space relatively well. One recent phenomenon, however, is the firm voice for health evolving in regional and subregional organizations and blocs with broader political, economic and security mandates. This coincides with the growing attention that health is receiving in foreign policy from the economic, security and social justice angles *(1)*. Amaya et al. *(2)* argue that regional organizations can serve as a space in which countries can position themselves in the multilateral arena through what can be termed regional health diplomacy, and Kickbusch & Cassar Szabo *(3)* say that regional organizations' stand on health can make a notable contribution to governance for global health.

Another important angle is that the membership of these entities may or may not be confined to one WHO region. Cross-regional membership is less studied from the viewpoint of traditional structures and mechanisms in international health.

This chapter aims to review the role of regional multistate organizations and blocs in health diplomacy and governance from a Eurasian perspective, with a particular focus on those embracing the eastern part of the WHO European Region. It discusses several such

entities, including those not strictly contained, but nevertheless strongly represented, within the Eurasian space. The term regional organizations encompasses all of these entities, including an association of five major emerging national economies – Brazil, the Russian Federation, India, China and South Africa (BRICS) – which is not formally registered as an organization. This chapter does not provide an exhaustive list; other multistate entities may, with time, raise their voice for public health and international health cooperation in the Region.

Asia-Pacific Economic Cooperation

Asia-Pacific Economic Cooperation (APEC) is a regional economic forum established in 1989. It comprises 21 Member States[5] and has a permanent secretariat hosted in Singapore.

APEC's primary mission is to promote economic growth in the region through trade and investment liberalization, business facilitation and economic cooperation and integration. Health, however, has an expanding place on APEC's agenda at policy and technical cooperation levels. Its structural reform policy supports, for example, safeguarding health and safety as part of upholding the public interest. More specifically, it addresses health through several institutional mechanisms, such as the Health Working Group, which meets twice a year, and the Health Policy Dialogue and the High-level Meeting on Health and the Economy, both occurring annually.

Starting from an initial focus on communicable disease sparked by the severe acute respiratory syndrome and avian influenza epidemics, APEC's health agenda gradually expanded to cover NCDs and health through the life-course, and the strengthening of health systems in general. The adoption of the Healthy Asia Pacific 2020 Initiative (4) in 2014 was a particular achievement in this direction; in addition, the recommendations of the 2015 High-level Meeting underscored areas such as health innovations, NCDs, mental health, blood safety, and the safety and quality of medical products and services.

APEC's health focus includes addressing health hazards as impediments to trade, security and economies. The 2015 APEC Leaders' Declaration (5) adopted in Cebu, Philippines reinforces this direction, particularly highlighting the importance of health systems in promoting the development of human capital and inclusive growth and addressing the fiscal and economic impacts of ill health.

Another important feature is the high-level political commitment made by APEC leaders in areas closely related to health in recent years (5), such as the environment, food security, connectivity, equity, urbanization and the green supply chain. Finally, there is a clear emphasis on cross-sectoral and multistakeholder engagement for health through mechanisms and tools such as the focus on innovation and intersectoral and cross-border collaboration, as enshrined in Healthy Asia Pacific 2020, the annual High-level Meeting on Health and the Economy and, most recently, the guidelines of engagement with the private sector discussed by the Health Working Group (6). These features and developments may have prominent roles in promoting health diplomacy and governance for health in APEC and beyond.

BRICS

Although not strictly within the Eurasian domain, BRICS has a strong foundation in the region, which is reinforced by its growing ties with other organizations active in the region such as the Shanghai Cooperation Organization (SCO) and the Eurasian Economic Union (see below) (7). In addition, BRICS focuses on structured bilateral and multilateral approaches to development cooperation, rather than development aid in its traditional sense, as well as supporting the south-to-south dimension and technology transfers to empower developing countries (8), which are relevant in the regional context.

BRICS plays a multifaceted role in regional and global health. First, its internal mechanisms have reflected health objectives; they have been signified by the BRICS summits, starting from the third, hosted by China in 2011, and were further fostered by the annual meetings of the BRICS health ministers, starting the same year. Given the standing of BRICS in the world scene, the objectives and strategies backed by these bodies gain substantial relevance in international health.

Further, the member countries have shown global leadership in several priority areas of public health, such as NCDs, TB, maternal and child care, road safety, medicines and the social determinants of health; some of these have explicit implications in global and Eurasian contexts. For example, the first global ministerial conferences hosted by the Russian Federation – on road safety in 2009 and NCDs in 2011 – not only boosted global awareness and commitment in these key areas through subsequent United Nations resolutions (9,10) and WHO strategies, but also promoted action specifically in eastern Europe and central Asia through the 10-country project on road safety embracing the Russian Federation and Turkey, and the establishment of the Russian Federation-funded WHO centre of excellence on NCDs in Moscow, which provides extensive technical assistance to countries in the Commonwealth of Independent States (CIS) (11,12). The Russian Federation also provided substantial resources for malaria control and elimination and paediatric care, particularly focusing on eastern Europe and central Asia and some developing countries. In addition, BRICS recently accrued a wealth of experience in UHC and low-cost medicines and vaccines on which LMICs can draw (13).

Recent developments revealed new trends and mechanisms that would support the health dimension of the bloc's work. BRICS' New Development Bank was launched in 2015 to support infrastructure projects and sustainable development; although not distinctly in the Bank's investment portfolio, support to health objectives would nevertheless be possible due to the multisectoral nature of health and its cross-cutting role in development. Indeed, the Bank's first loan package (14), announced in spring 2016, focused on renewable energy projects, a core aspect of the environment and health domain. Further, the 2015 meeting of BRICS health ministers held in Moscow, Russian Federation signalled support to relatively new forms of cooperation, such as BRICS research consortia and working groups (15); these would link the knowledge and capacities in priority areas across the bloc and potentially beyond.

Overall, BRICS' role in the health agenda has risen in recent years. It attracted considerable attention as a new force able to bolster international health cooperation, and some authors even described it as potentially constituting "a paradigm shift in global health" (16). Given BRICS' significant influence and interconnections in the region, this role becomes evident in the Eurasian context.

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[5] The APEC Member States are: Australia, Brunei Darussalam, Canada, Chile, China, Chinese Taipei, China, Indonesia, Japan, Malaysia, Mexico, New Zealand, Papua New Guinea, Peru, Philippines, the Republic of Korea, the Russian Federation, Singapore, Thailand, the United States of America and Viet Nam.

CIS

The CIS is a regional organization formed during the dissolution of the USSR in 1991. It consists of nine members (Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan and Uzbekistan) and two associate members (Turkmenistan and Ukraine). The Council of the Heads of State and the Council of Heads of Government are the key decision-making bodies of the CIS, and it has a permanent Executive Committee located in Minsk, Belarus. Cooperation at legislative level is driven by the CIS Inter-parliamentary Assembly in St Petersburg, Russian Federation. The Health Cooperation Council and the Inter-parliamentary Assembly are the main CIS bodies with particular relevance to health.

The Council of Heads of Government established the Health Cooperation Council in 1992, among other bodies covering different areas of social and economic policy. It comprises ministers of health and chief sanitary doctors, and has met nearly 30 times. So far, CIS decision-making bodies have approved about 15 intergovernmental agreements and decisions on health proposed by the Health Cooperation Council; the topics addressed include HIV/AIDS, diabetes, falsified medicines, epidemiological control and the provision of medical care within the CIS *(17)*.

The Health Cooperation Council is expanding its cooperation with WHO, particularly through the Regional Office for Europe. Meeting in June 2016, the Council requested WHO for the first time to:

- introduce the key outcomes of the most recent World Health Assembly, to promote awareness and implementation of the Health Assembly's resolutions in the CIS; and
- describe WHO's expanding capacity in the CIS in two strategic areas: primary health care and NCD prevention and control.

Further, the Council agreed, also for the first time, to establish a network of leading national health institutions to prepare and promote a coordinated CIS stand on key issues in public health, including in WHO's governing bodies. These developments clearly show the Council's willingness to better synergize its work with the international health agenda, thus also creating a space and potential for valuable contributions to health diplomacy and governance in the Region.

The Inter-parliamentary Assembly was established in 1992. Its overarching mission is the making of laws and the alignment of national laws in the CIS. In particular, the Assembly offers guidance to the CIS governing bodies and national parliaments, adopts model laws for the parliaments to consider, and adopts recommendations on the compliance of national legislation with inter-CIS instruments.

Model laws are the Assembly's most relevant instrument to consider in relation to its mandate on health and broader social policy *(18)*. These are legal instruments based on international, mainly European standards; they are adjusted to the CIS context and, after adoption by the Assembly, recommended to national parliaments as matrices for localization. The Assembly adopted a number of model laws on health and closely related areas, such as reproductive health and rights, medical rehabilitation, narcotics and psychotropic substances, bioethics, and environmental factors and health. It also adopted various recommendations on social policy, including one on promoting synergy in public health legislation across the CIS.

The process for the development and adoption of model laws and their further utilization in member countries has the potential to enrich and empower health diplomacy within and between countries. If well analysed and utilized, this subregional mechanism could substantially contribute to health diplomacy and governance in the broader context of the WHO European Region. The Inter-parliamentary Assembly and the WHO Regional Office for Europe have been cooperating recently, with Regional Office staff attending the Assembly's plenary sessions and evolving technical cooperation with the Assembly's expert committee on health. Further, a memorandum of understanding (MoU) on more formal and systematic cooperation was under consideration at the time of preparing this publication.

The work of the Health Cooperation Council and Inter-parliamentary Assembly has the potential to make a mutually supportive impact on public health, health diplomacy and international health cooperation in the CIS and possibly beyond. WHO can play a substantial role here by supporting further synergy with the international health agenda in the work of these bodies.

Economic Cooperation Organization

The Economic Cooperation Organization (ECO) is a regional intergovernmental organization established in 1985 as the successor to the Regional Cooperation for Development to promote economic, technical and cultural cooperation among its members *(19)*. Initially founded by the Islamic Republic of Iran, Pakistan and Turkey, it expanded through the accession of seven new countries (Afghanistan, Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) in 1992. The Council of Ministers, at the level of foreign ministers, is ECO's highest decision-making body, supported by the Council of Permanent Representatives and the Regional Planning Council. The Islamic Republic of Iran hosts the General Secretariat of ECO, led by the Secretary-General.

In recent years, ECO has paid growing attention to health. At political level, following the first ECO health ministers' meeting in 2010, the second ministerial meeting was convened on the side-lines of the 2015 World Health Assembly, adopting the Geneva Declaration on Better Health for ECO Region in post-2015 *(20)*, which outlines principles and commitments for health cooperation. The third ministerial meeting, held in 2016, reviewed the draft 10-year ECO action plan for health cooperation, requesting the Secretariat to further develop it for adoption. At technical level, a high-level expert meeting was held in early 2015 in Tehran, Islamic Republic of Iran to reflect upon experience with pursuing the Millennium Development Goals and boost collaboration on post-2015 challenges in a number of areas, such as UHC, emergency preparedness and response, health technologies and medicines, NCDs and strengthening of health systems in the region. In addition, a 2016 comparative report addressed health status across the ECO region, aiming to supply countries with essential analysis and promote policy-making and action nationally and in the region. Further, ECO and FAO recently started a joint project on technical assistance to control transboundary livestock diseases *(21)*.

ECO has also addressed health through cooperation in other areas, such as environment, disaster management, health tourism and climate change *(22–24)*. Finally, most ECO countries are increasingly involved in economic initiatives under the concept of the New Silk Road, largely encompassing the region (further discussed in Chapter 6). This too would affect public health and health cooperation in the region owing to the growing interface between health, economics and trade, particularly taking into account the rising movement of people, goods, capital and services across countries, with cross-border effects on health.

Overall, political momentum and technical capacity to address public health and health cooperation more coherently have grown in the ECO region. Such momentum is assisted by:

- some countries' strong stand in the global arena on key issues such as UHC and the prevention and control of NCDs;
- dialogue with other organizations with overlapping memberships and established patterns of health cooperation, such as the Organization of Islamic Cooperation (OIC) (see below); and
- continued ministerial dialogue in conjunction with the global health debate at the World Health Assembly.

Eurasian Economic Union

The Eurasian Economic Union (EAEU) is an international organization for regional economic integration established by a treaty that entered into force on 1 May 2015. The EAEU's five members are Armenia, Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation. It replaced the Eurasian Customs Union of Belarus, Kazakhstan and the Russian Federation to secure deeper and more comprehensive economic integration in the region. Its governing bodies are the Supreme Economic Council, at the level of heads of state, and the Intergovernmental Council, at the level of heads of government, while the Eurasian Economic Commission, located in Moscow, is its executive and regulatory arm.

The EAEU addresses health in several ways, although its mandate does not directly cover the topic. First, the treaty establishing it contains requirements for establishing a common market for medicines and medical products and common sanitary (including veterinary–sanitary and phytosanitary) regulations *(25)*. Second, the Supreme Economic Council established, in 2015, an EAEU council of heads of national bodies responsible for sanitary–epidemiology welfare and control to strengthen coordination. As another step in this direction, the Eurasian Economic Commission recently established a consultative committee covering a range of social policy matters, including health care.

Further, the Commission recently made important decisions on sanitary control, the nomenclature of medicines and a pharmacopeia committee of the EAEU, the nomenclature and quality, safety and efficiency of medical products, including requirements for technical and clinical testing, and the nomenclature of tobacco products. In addition, harmonization in areas such as taxes, migration, agriculture, technical standards and internal market regulations may affect health positively or otherwise; this requires the vigilance of, and input from, health authorities on proposed measures. For example, the proposed harmonization of taxes on tobacco and alcohol products raised considerable concern in some members' health ministries and experts, in view of the potential harm to public health.

The EAEU represents the first formal attempt at economic integration in the former Soviet Union and thus a new strategic development in the region that can affect public health directly and indirectly. Further, the EAEU's active pursuit of links with other countries and organizations in the region and beyond is likely to enrich the space for regional diplomacy, including for health. Examples include the recent joint high-level meeting with SCO and BRICS, and decisions on establishing free-trade agreements with several countries and fostering cooperation between the EAEU and the New Silk Road Economic Belt *(8,26,27)*.

Organization of the Black Sea Economic Cooperation

The Organization of the Black Sea Economic Cooperation (BSEC) is a regional economic organization that was established in 1992, gaining a full-pledged international legal identity in 1999. It has 12 members and a permanent secretariat in Istanbul, Turkey. Another 12 states, predominantly European, have observer status and a further six, including countries in Asia, have the status of sectoral dialogue partners. Members comprise: Albania, Armenia, Azerbaijan, Bulgaria, Georgia, Greece, the Republic of Moldova, Romania, the Russian Federation, Serbia, Turkey and Ukraine; the dialogue partners include the Islamic Republic of Iran, Japan and the Republic of Korea.

The two principal mechanisms for BSEC's health focus are the Working Group on Health and Pharmaceuticals and the meetings of ministers for health, which are supported by other bodies such as the Committee of Senior Officials and the Council of Ministers of Foreign Affairs. Recent meetings of health ministers – hosted by Greece in 2014, the Republic of Moldova in 2015 and the Russian Federation in 2016 – addressed the establishment of BSEC's network for emergency preparedness and response, further support to strengthen tobacco control and the establishment of cooperation on the quality, effectiveness and safety of medicines. A proposed agreement on cooperation on sanitary protection remains under discussion.

In addition, BSEC's Parliamentary Assembly – its interparliamentary, consultative (although legally independent) body – addressed health in recommendations on cooperation on, for example, public health, child protection, social cohesion and the rights of people with disabilities.

Although health is a relatively new area of activity for BSEC, it has a notable potential for cooperation and synergies on health matters. In the meantime, some overlap of membership with other blocs, such as the EU and EAEU, with their own regulatory systems for health and/or pharmaceuticals, would require careful consideration. Greece and Romania, for example, recently expressed an inability to adhere to the proposed BSEC agreement on cooperation on sanitary protection, citing their membership of the EU. This aspect of health diplomacy and governance may also arise in other organizations and blocs with overlapping membership, particularly in relation to the interface between economic integration and health.

OIC

The OIC, formerly the Organization of the Islamic Conference and established in 1969, is the second largest intergovernmental organization after the United Nations, with a current membership of 57[6] and a permanent secretariat in Jeddah, Saudi Arabia. The Islamic Summit is OIC's supreme authority and its parliamentary arm, the Parliamentary Union of the OIC Member States, was established in 1999 with a permanent seat in Tehran, Islamic Republic of Iran.

Two major mechanisms address health affairs. First, meetings of health ministers, convened in general every two years, review and guide overall cooperation on health policy in OIC. The five meetings convened since 2007 – hosted by Malaysia, the Islamic

Republic of Iran, Kazakhstan, Indonesia and Turkey, respectively – addressed a wide range of issues, including communicable diseases and emergency preparedness and response, NCDs, maternal and newborn health, nutrition, action on poliomyelitis (polio), malaria and TB, and the production, standardization and procurement of pharmaceuticals and vaccines. In 2013, health ministers endorsed the OIC Strategic Health Programme of Action 2014–2023 *(28)* at their fourth meeting.

The second key mechanism for cooperation on health is the Statistical, Economic and Social Research and Training Centre for Islamic Countries, one of OIC's six subsidiary bodies. Located in Ankara, Turkey, the Centre is the prime technical and statistical arm of OIC and acts as the focal point for cooperation on technical activities and projects between the OIC system and the related United Nations agencies. OIC's 2015 health report *(29)*, one in a series of the Centre's reports, was launched at the fifth health ministers' meeting.

OIC works to promote public health as part of its social and economic agenda through its long-term comprehensive health action plan *(28)* and the Centre.

SCO

The SCO is a Eurasian intergovernmental organization established in 2001, with six member states (China, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan and Uzbekistan), six observers (Afghanistan, Belarus, India, the Islamic Republic of Iran, Mongolia and Pakistan, with India and Pakistan planned to become full members in 2017), as well as six dialogue partners (Armenia, Azerbaijan, Cambodia, Nepal, Sri Lanka and Turkey). The Council of Heads of State, which meets annually, is SCO's top decision-making body.

While health is not a core focus area of SCO, attention to health objectives is growing as part of its overall cooperation and dialogue on political, social and security matters. In particular, the second meeting of SCO ministers of health in 2015, hosted by the Russian Federation and in which WHO was invited to participate, focused on matters of health security, with a particular emphasis on falsified medical products. The ministers agreed that broader health reforms should become a priority of social policy in SCO member countries and guarantee public health security. Further, the Ufa Declaration, adopted at the 2015 SCO summit, highlighted the importance of cooperating on public health, responding to sanitary–epidemiological challenges and cooperating in areas closely related to health, such as education, the environment, customs, narcotics control, transport, agriculture and technology. These commitments were largely echoed in the Tashkent Declaration *(30)*, recently adopted by the heads of state of SCO.

SCO's expanding interest in public health and health security demonstrates its potential for promoting health diplomacy and cross-border health in the region.

Other relevant developments

The Council of Europe (CoE), a pan-European organization, has a role in the Eurasian context owing to the membership of some of eastern European countries: Armenia, Azerbaijan, Georgia, the Republic of Moldova, the Russian Federation and Ukraine. Although not in the CoE's core mandate, health is nevertheless reasonably high on its agenda through its major focus on social and human rights. It is embedded in, or affected by, CoE instruments such as the European Social Charter and the convention on human rights and biomedicine *(31,32)*, and other legally binding instruments covering areas such as blood grouping, tissue typing and counterfeiting of medical products. Some other areas are covered by partial agreements, with membership of several countries, such as the European Pharmacopeia and the Pompidou Group on combating abuse and illicit trafficking of drugs *(33,34)*. Interestingly, some agreements are open for accession by non-CoE states, which extends their potential application internationally, including in the Eurasian context. Kazakhstan, for example, ratified several CoE agreements and has observer status to others, including the European Pharmacopeia. Overall, the variety of legal instruments generated and applied, often internationally unique, make the CoE a substantial, although not always sufficiently acknowledged, regional player for health.

Other major undertakings in the Eurasian domain may gain significance for public health. One such development is the New Silk Road concept and initiatives, swiftly earning prominence in the region and beyond. They have so far been examined mostly in political and economic terms. Health may be an important dimension, however, due to the ways and mechanisms in which it is rooted in the agendas for sustainable development and international cooperation. Indeed, the New Silk Road concept and initiatives are essentially at the intersection of trade, economic, transport and infrastructure programmes and policies, and largely embedded in the foreign, development and investment policies of participating countries. The increased flow of people, information, goods and services along the New Silk Road would benefit or affect major public health domains – such as communicable diseases, health security, healthy lifestyles, illegal substances, health and environment, and road safety – and create opportunities for increased trade in health products and technologies, new health-care hubs and medical tourism. Another important factor is the growing significance that prominent organizations operating in the Eurasian space, such as BRICS, SCO and the EAEU, attach to the New Silk Road and to public health. Overall, health could be explored as not only a public good but also a diplomatic tool to connect people, countries, values and benefits along the New Silk Road.

Conclusions

The intersection of national, regional and global health is gaining prominence in international health affairs. Regional organizations, with or without an explicit health mandate, have a unique place in this development, although are not always sufficiently studied and recognized. The following general observations could be drawn from the analysis made in this chapter.

It identifies eight relevant organizations and blocs. Only three of them (the CIS, the EAEU and BSEC) have membership contained within the WHO European Region. The membership of the five others (APEC, BRICS, ECO, OIC and SCO) covers two or more WHO regions, revealing an interesting angle for health diplomacy and international health cooperation from a cross-regional perspective. In addition, BRICS demonstrates the role that a bloc of countries – not a formal organization and not strictly regional – can play in the Eurasian context, as several of the countries are located there. Several of these organizations (APEC, BSEC, the CIS, OIC and the CoE) have parliamentary arms, some of which have their own legal identity.

Although these organizations' core mandates do not include health, they address it through various mechanisms. Most hold regular meetings of health ministers, while others have a health working group of senior officials (APEC) or a coordinating body of national chief sanitary doctors (the EAEU). Some organizations (APEC and OIC) adopted strategic multiyear plans for public health; on top of serving health policy within the organizations, such strategies enrich the intersection of regional and global health and provide valuable input to governance for global health. In some cases, the regional input is supported by global leadership demonstrated by some members in key areas such as health security, UHC, pharmaceuticals, NCDs and the social determinants of health.

The legal instruments and mechanisms used range from the founding treaty of the EAEU, with some articles explicitly touching health, to the legally binding conventions of the CoE and the non-binding model laws of the Inter-parliamentary Assembly of the CIS. Organizations (ECO and OIC) have also published comprehensive, analytical health reports to support policy-making within and between members countries.

Another important factor is the overlapping membership of, and political links between, most organizations. Many hold observer status in one another, and in the United Nations General Assembly; some organizations also established a network of external observers and partners, including on free trade, aimed at outreach and collaboration within and beyond the Eurasian context. Further, BRICS, SCO and the EAEU convened a joint high-level meeting in 2015 and also clearly expressed their support for the new initiative of the Silk Road Economic Belt, encompassing a vast region from China to the Mediterranean. Initial experience shows that parallel membership may have certain impediments: for example, members of economic integration organizations with strict regulatory frameworks, such as the EU and EAEU, may be unable to adhere to overlapping commitments in other organizations. Of special importance is the health impact of economic integration policies, particularly in the EAEU, as some measures (such as the harmonization of taxes, technical standards and internal market regulations) may have positive or negative effects on important health determinants (such as the use of tobacco and alcohol) and broader aspects of cross-border health.

Further, the fact that most regional organizations have their principal mandate in areas outside public health – such as trade, economies, security, development and human rights – creates natural opportunities for the cross-cutting and multisectoral nature of public health to manifest and function. Examples include the CoE's conventions and decisions underpinning health, bioethics and human rights, APEC's annual high-level meetings on health and the economy, and the EAEU's regulations for a common pharmaceutical market. Most of the organizations have taken stands and decisions on matters closely related to health – such as food, transport, migrants and the environment – in many cases propelling health objectives into the scope of the organizations' high-level political summits. The multisectoral and cross-border dimensions of health will play an increasingly prominent role as economic integration on the one hand and large infrastructure and

communication undertakings (such as those linked to the New Silk Road concept and the investment opportunities linked to BRICS' New Development Bank) on the other unfold in sizeable parts of the Eurasian space.

Overall, the cross-cutting and cross-border features of health, and the growing links between health, foreign policy, economies and development, open a unique space in which regional organizations and blocs can promote population health and international health cooperation. This in turn amplifies opportunities for enhanced health diplomacy in multisectoral and multistate settings to protect and promote public health in the face of governments' often competing agendas. It also contributes to governance for global health, a growing governance space in the global health domain.

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6. Turkmenistan: practical experiences in health diplomacy

Bahtygul Karriyeva

Introduction

This chapter presents Turkmenistan's recent experiences in health diplomacy and the conditions that enabled the horizontal coherence of the country's health and foreign policy. Turkmenistan follows a health-in-all-policies approach, maintaining good working relations among a number of sectors outside health. The main features of the country's foreign policy are the principles of positive neutrality and open doors, ensuring global security based on the concepts of security, integrity and indivisibility, and through strategic partnership with United Nations and other international and regional organizations. Turkmenistan is also committed to strengthening cooperation and sustainable development, especially in central Asia. It collaborates with WHO and other United Nations organizations in addressing complex global health challenges through the United Nations system, particularly in advancing the global NCD agenda. Being well placed along the Silk Road, hosting many international forums and having launched a number of international dialogues, Turkmenistan has become a key player in promoting health as an effective diplomatic tool for connecting and engaging the countries along the Silk Road. The country's approach to global health diplomacy reflects the issues that it faces, its understanding of global health challenges and its capability to address them.

For 20 years, Turkmenistan has maintained a status of permanent neutrality: this is the main principle of its foreign policy, which contributes to the strengthening of peace and security in the region and the well-being of the country's population. State social policy focuses on the provision to every citizen of equal opportunities for an adequate standard of living and development. Turkmenistan follows the health-in-all-policies approach

to strengthen health within its foreign policy and development cooperation, without developing any specific strategy or policy paper. The country is making great efforts to strengthen global health through intersectoral national policies and strategies. The factors enabling the coherence of health and foreign policy in the country include high-level political commitment to health, coherence across international settings and the health ministry's active role in global health.

Turkmenistan desires to be more active in regional and international cooperation projects and is preparing to undertake an important mission as a bridge for trade and transit, in line with the construction of the New Silk Road (also discussed in Chapter 5). Greater economic cooperation would also enable long-term stabilization and increased regional cooperation. Launching dialogue on issues at the interface of health, foreign policy, investment, trade and commerce in central Asia will help to advance health diplomacy. This initiative will expand country involvement in global health.

Health policy

The Constitution of Turkmenistan guarantees the core right to health protection, which lies at the heart of national health policy. Recent reforms of the health system led to remarkable advances in the prevention of disease and promotion of healthy lifestyles. The foundation for success was laid in 1995, when the first health strategy was launched. Strengthening primary health care by focusing on family medicine became one of the cornerstones of the health system. Twenty years later, the new health strategy for 2015–2025 (1) was developed, using the principles of the European policy framework, Health 2020 (2), and endorsed by the Government. It prioritizes preventing disease and strengthening health systems to attain long life and the highest level of health at all ages. Turkmenistan's new national health policy reflects both today's health challenges and Health 2020. It was prepared through an extensive process of consultation within the country, with systematic support from the WHO Regional Office for Europe. It focuses on dealing with all of the threats to health across all sectors and developing whole-of-government and whole-of-society responses, improving multisectoral interagency cooperation, creating coherence between ministries and agencies, and improving health management and the overall performance of the health sector.

A national, intersectoral, high-level committee, with representatives from 44 ministries and entities, was established in 2014 to develop a national plan of action. This promoted inclusive participation from all sectors to address the key determinants of health.

Intersectoral governance was recognized as a prerequisite for strengthening health through foreign policy and development cooperation (3). Good collaboration was established with the education, social affairs, sport and environment sectors, and with national NGOs and civil society. The intersectoral mechanisms for health action at national level take the form of coordination committees for programmes addressing various health issues, such as immunization, NCDs, HIV/AIDS and TB. Other structural mechanisms – such as interdepartmental committees, expert committees, scientific establishments consisting of representatives of different government sectors and NGOs – that provide intersectoral collaboration are formed within the framework of the concrete programme or task. Official consultations and intersectoral conferences are held on health issues.

Foreign policy

The foreign policy of Turkmenistan is the logical continuation of the domestic policy. The concept of Turkmenistan's foreign policy for 2017–2023 (4) particularly stresses the importance to the country of stability in the central Asian region and addresses five main areas of international cooperation:

- the protection and strengthening of universal peace and security;
- greater efforts to ensure energy security and fulfil the provisions of United Nations General Assembly resolutions on reliable and sustainable transit of energy resources;
- cooperation in the transport sector on the creation of transport corridors to transform central Asia into a continental transport and transit hub;
- humanitarian affairs and human rights; and
- ecology and environment protection, focusing particularly on the importance of the environmental and water diplomacy of Turkmenistan.

Turkmenistan's foreign policy is based on principles of positive neutrality and open doors, the concept of the integrity and indivisibility of global security, and strategic partnership with United Nations and other international and regional organizations, such as the Organization for Security and Co-operation in Europe, the Non-aligned Movement, the CIS, OIC and ECO.

Positive neutrality is defined as gaining international recognition of the country's independence, agreeing on mutual non-interference in internal affairs and maintaining neutrality in external conflicts. United Nations General Assembly resolution A/RES/50/80 (5) recognizes and supports the permanent neutrality of Turkmenistan, the first such recognition officially made by the United Nations. On 3 June 2015, 193 Member States of the United Nations unanimously confirmed the permanent neutrality of Turkmenistan (6). These two resolutions reflect the international community's recognition of the benefit of neutrality to peace, stability and cooperation in central Asia.

The concept of the integrity and indivisibility of global security recognizes that no single country can achieve security in the absence of security in the region, the continent and the world. Similarly, political and military security will not be long term and fully fledged without economic, energy and food security, preparation for, and management of, environmental and manmade risks, or countering of international terrorism, organized crime, proliferation of weapons of mass destruction and other global challenges (7). From this perspective, one of the most important components of global security is energy security (7).

Based on experience with political and diplomatic peacekeeping under United Nations auspices, Turkmenistan has offered its territory and its good offices for talks between opposing parties. After opening the United Nations Regional Centre for Preventive Diplomacy for Central Asia in 2007, with headquarters in Ashgabat, Turkmenistan expanded opportunities for the development and implementation of structural models of interaction on the basis of universally recognized norms of international law (8). The Centre's mission is to implement the concept of preventive diplomacy through enhanced dialogue, confidence-building measures and genuine partnerships in responding to existing and emerging challenges in central Asia. Its work complements activities within the Istanbul Process, which aims to strengthen security by promoting cooperation among the countries in the so-called Heart of Asia region, including Afghanistan.

The Government of Turkmenistan adopted the policy of open doors to develop and maintain friendly bilateral relations, especially with neighbouring countries in central Asia and around the Caspian Sea. Turkmenistan is expanding cooperation with the four other countries with borders on the Caspian Sea to address issues related to its legal status, the protection and rational use of its water and biological resources, and the prevention and elimination of emergency situations in the area. Turkmenistan also encourages foreign investment and export trade, especially through the development of a transport infrastructure from central Asia southwards, with access to sea terminals in the Indian Ocean *(9)*, and supports projects for transport, trade, infrastructure, connectivity and energy in the country, the region and beyond.

Good relations with Afghanistan are particularly important. Turkmenistan bases its position on the strong belief that the situation in Afghanistan can be resolved only through peaceful political means and on the basis of a broad, all-inclusive national dialogue by advancing such confidence-building measures as infrastructure projects and trade *(8)*. The most important components of the support for the Afghan people are humanitarian aid and assistance in training qualified national personnel for work in various segments of the economy and social sector, including health.

Experience with global health and health diplomacy

The country's approach to global health diplomacy reflects the issues that it faces, its understanding of global health challenges and its ability to address them. Turkmenistan is very active in the areas of the global health agenda traditionally accepted as the nexus of foreign policy and global health *(10)*: post-conflict or emergency action and the tackling of challenges to health security. This work included providing humanitarian and medical assistance after earthquakes in Haiti and Nepal, assistance to the Government of Sierra Leone during the Ebola crisis, and assistance to Afghanistan in rebuilding its economy, constructing health-care facilities and procuring medical equipment. Citizens of Afghanistan could receive health care on the border of Turkmenistan free of charge.

Further, Turkmenistan is committed to achieving the goal of national health security and to full implementation of the IHR using existing structures in the country, which requires intersectoral work *(11)*. The country was the first in the WHO European Region to volunteer to conduct an assessment of baseline capacities for global health security. A group of international experts and representatives of ministries (including health and foreign affairs) and stakeholders responsible for surveillance and responses to public health threats, in collaboration with other sectors (such as animal health, tourism and transport), jointly evaluated Turkmenistan's capacity to detect and respond to public health events using a set of criteria for operational capacity and performance in June 2016.

Turkmenistan recently expanded its involvement with global health by helping to solve health problems through WHO governing bodies, regional and international health initiatives, stronger cross-border cooperation and technical cooperation in the health sector with neighbouring countries in central Asia.

Turkmenistan's experience in cross-border collaboration was one of the main factors in the process that resulted in WHO's official certification of the country as free of malaria in 2010 *(11)*. This success was based on the country's strategic approach, which included a strategy for cross-border collaboration, targeted activities conducted jointly with representatives of neighbouring countries (Afghanistan, the Islamic Republic of Iran and Uzbekistan), participation in cross-border meetings on malaria, and the sharing of information and experience with countries and partners.

To help ensure that the 2030 Agenda for Sustainable Development *(12)* addressed health, Turkmenistan hosted two rounds of national consultations on the focus of the post-2015 agenda and how to implement the future global framework, which identified health as a top priority. Turkmenistan actively embarked on the process of nationalizing the SDGs by designing a structured approach with three stages. Stage one comprised 17 days of consultations (one SDG per day) in March 2016, during which the relevant ministers and United Nations agencies led in-depth discussions on the targets and indicators, with those recommended for adoption being defined *(13)*. In September 2016, the Government of Turkmenistan formally adopted the 17 SDGs, 148 targets and 198 indicators, to be implemented over the following 15 years *(14)*.

To support implementation, Turkmenistan held the first global conference on sustainable transport systems, an initiative of the United Nations Secretary-General *(15,16)*. The development of international transport corridors as a basis for regional and interregional cooperation is one of the priorities of Turkmenistan's foreign policy (see above). The conference addressed all modes of transport – road, rail, air and water – as well as transport in urban and rural areas, energy and transport, public transport, countries in special situations, road safety and financing for sustainable transport *(16)*.

Turkmenistan works closely with WHO and other United Nations organizations to address complex global health challenges, especially in advancing the global NCD agenda. In 2013, the country hosted a WHO European ministerial conference that resulted in the Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020 *(17)*. In 2014, Turkmenistan adopted a national strategy to implement the objectives of the Ashgabat Declaration in 2014–2020 and its plan of action. An effective national response requires coordinated multistakeholder engagement for health involving governments and a wide range of other actors. Building on this momentum and in preparation for a third high-level meeting on NCDs in 2018, the country is seizing the opportunity to develop a consolidated model for multisectoral and multistakeholder collaboration that could serve as an example for all other countries.

To support implementation of the Ashgabat Declaration *(17)*, Turkmenistan and the Regional Office developed a project, running from April 2015 to March 2018, that builds on Turkmenistan's commitment to, and leadership in, tobacco control. The aim is to advance the country's tobacco control policies and spearhead an approach to accelerate progress within the WHO European Region *(18)*.

Strengthening the health component of the education of diplomats is one of the important elements of Turkmenistan's practical approach to fulfilling its commitments in global health. The Ministry of Health and Medical Industry organized events in the country on health diplomacy to increase awareness of global health and promote health as one of the main components of foreign policy. The first took place in June 2014, during the first

visit of WHO Director-General Margaret Chan. She met with students of the Institute of International Relations of the Ministry of Foreign Affairs and the Turkmen State Medical University, and gave a lecture on global health and diplomacy.

Late in November 2014, the Ministry of Health and Medical Industry hosted a five-day executive course on health diplomacy in Ashgabat, organized by the global health programme at the Graduate Institute of International and Development Studies in collaboration with the Regional Office. The participants – 38 government officials from Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan – used the perspective of health diplomacy to discuss such important issues as the effects of globalization, the negotiation of the SDGs, the role of international actors in newly independent states, the implications for the Region of WHO's European priorities, and cooperation to combat multidrug-resistant TB (MBR-TB) and NCDs.

Convening informal dialogues that bring together the health, foreign affairs and development sectors is a priority to move towards comprehensive, effective and sustainable forms of policy coherence among these sectors *(1)*. In July 2015, on the 20th anniversary of the national health programme, the Ministry of Health and Medical Industry held an international health forum, A Vision for a Healthier Future: Building on Our Achievements, in Ashgabat under the auspices of the President of Turkmenistan, Gurbanguly Berdimuhamedow. High-level delegations from all parts of the world attended to discuss progress and visions relating to public health issues of pressing concern. Under the overall banner of achieving effective approaches to improve health across the whole of society, a special session focused on foreign policy and health. Participants discussed different entry points and instruments to allow government authorities to address global health issues and achieve better results in negotiating with international health and non-health organizations. The outcome document noted the necessity to exploit foreign policy for the promotion of health, understanding of global challenges and achievement of better health results in negotiations.

New initiative on health diplomacy: health and the New Silk Road

Turkmenistan aims to become a regional transit hub for central Asia via big projects in the transport sector, including rail lines traversing the Islamic Republic of Iran, Turkmenistan and Kazakhstan, and Turkmenistan, Afghanistan and Tajikistan. These railroads, along with Turkmenistan's position on the eastern shore of the Caspian Sea, will make the country a gateway for imports and exports from central Asia. Critical to its planned railway projects is Turkmenistan's participation in the Transport Corridor Europe–Caucasus–Asia (TRACECA), an international transport programme that includes the EU and 14 countries in eastern Europe, the southern Caucasus and central Asia. TRACECA's involvement in the country's transport system will significantly reduce cargo delivery times compared to those of the traditional route from the ports of eastern and south-eastern Asia to European ports, consolidating Turkmenistan's position as an important regional and continental transit and transport hub. One of the projects under negotiation is the construction of a central Asian multimodal highway, with access to Turkey via the transport corridor in the southern Caucasus.

Further, Turkmenistan's energy and transport policy helps to promote China's concept of a Silk Road Economic Belt *(19)*. Chinese President Xi Jinping proposed jointly building a New Silk Road while visiting central and south-eastern Asia in September and October 2013. The concept suggests five areas for joint action – political coordination, transport relations, trade, finance and cultural relations – taken on the basis of joint consultation, implementation and benefits *(20)*. Accelerating the building of the Road and Belt can help promote the economic prosperity of the countries along them and economic cooperation in the region, strengthen exchanges and mutual learning between different civilizations, and promote world peace and development. The concept also foresees strengthening cooperation among neighbouring countries to share epidemic information, exchange prevention and treatment technologies and use the training of health professionals to improve the capability for jointly addressing public health emergencies. Central Asian countries, including Turkmenistan, supported the concept, as it integrates well with its plans for railway construction *(21)*.

The approaches proposed for implementation of the so-called One Belt/One Road concept include exchanges and cooperation between political parties, parliaments and NGOs, promotion of friendly exchanges between legislative bodies, major political parties and political organizations of countries along the Road and Belt, exchanges and cooperation among cities, joint research work, and the organization of public interest activities concerning education, health care, poverty-reduction, biodiversity and ecological protection *(20)*. Sports exchanges and supporting countries along the Road and Belt in bids to host major international sports events is one of the priorities of public support for implementing the initiative. Turkmenistan is expanding and advancing practical cooperation in this area, as the country will host the 5th Asian Indoor and Martial Arts Games in Ashgabat in September 2017. The public health risks involved in hosting a mass gathering warrant considerable investment in ensuring host communities' preparedness and response capabilities. In addition, such an event can leave a public health legacy: lasting improvements to public health, health services and the environment. To plan and prepare for the Games, Turkmenistan actively collaborates with countries along the Road and Belt to study their experience in organizing major sports events.

Promoting health as an effective diplomatic tool for connecting and engaging the countries along the Silk Road has become a very important direction of Turkmenistan's health diplomacy. The idea of expanding New Silk Road initiatives, from the economic and political dimensions to health, was proposed at the International Health Forum in 2015. A dialogue would explore the usefulness of health as a diplomatic tool for connecting and engaging the countries along the route in another historic period of globalization, to show that the dynamics envisaged to generate economic growth throughout the region, by strengthening cross-border trade and modernizing infrastructure along the New Silk Road, should be matched by the connectivity of, and investment in, health institutions. Cross-border cooperation for health and alignment of health-related policies along the New Silk Road would significantly augment the economic and social benefits of financial and infrastructure investments and enhance people's health and well-being. Options for further dialogue may include the sharing of health information and knowledge, including an education strategy for health professionals, cross-border health security through implementation of the IHR and preparations for mass gatherings, and trade in health products and cross-border services.

Conclusion

As a key country along the Silk Road, Turkmenistan is well placed to start a conversation on the possibilities for creating health benefits for all countries involved. Health is very high on the Government's agenda, and the country is very active in advancing a global health agenda. Turkmenistan follows the principles of equality, justice in international affairs and wide cooperation in the name of progress and development. Turkmenistan's positive neutrality has been instrumental in the country's active role in the region, promoting stability, good neighbourly relations and regional cooperation, especially in energy and transport. The country is also committed to strengthening cooperation and sustainable development, especially in central Asia.

Turkmenistan has great experience with hosting international conferences and forums and launching international dialogues, thus creating frameworks for meaningful interaction. All these factors indicate that the New Silk Road initiative, to launch a dialogue on health as an effective diplomatic tool for connecting and engaging countries, will become a reality in the immediate future.

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7. South-eastern Europe Health Network: intergovernmental cooperation on health contributing to peace-building, economic development and prosperity

Alain Nellen

Introduction[7]

Cross-country cooperation in public health can serve as a useful mechanism to identify and address health challenges shared by countries and regions. WHO argues: "It involves creating, adapting, transferring and sharing knowledge and experiences to improve health – while also making the most of existing resources and capacities" *(1)*.

The South-eastern Europe Health Network (SEEHN), an intergovernmental initiative for cooperation on health in a subregion of the WHO European Region, was established in 2001 to strengthen national health systems and stability and facilitate integration into the EU. This chapter argues that SEEHN's various activities acted as an effective mechanism for post-conflict recovery. Serving as a trust-building platform, SEEHN has brought countries in south-eastern Europe to the same table to pool resources and establish a shared vision by implementing joint regional projects on common health concerns. SEEHN has facilitated long-term partnerships between the member countries and numerous other countries, international organizations and NGOs that have supplied technical and financial

support. Over the years, SEEHN has shifted its methodology towards promoting health as an integral part of economic development through a whole-of-government and whole-of-society approach. While SEEHN has proved to have huge potential to be a sustainable initiative with regional ownership, it faces continuing and new internal and external challenges that put it at risk of operational stagnation and undermine its sustainability. Most notably, SEEHN is making greater efforts to ensure continuing political commitment and engage in numerous partnerships.

While SEEHN's primary vision has been to strengthen national health sectors in south-eastern Europe, it has also aimed to foster subregional cross-country cooperation, institutionally strengthen member countries and prepare the region for integration into the EU (2). This chapter therefore has two parts. First, it explores SEEHN's notable strengths and achievements, outlines the evolution of SEEHN's methodological approaches to meet its vision in an ever-changing political, social and economic landscape, and explores the role of regional collaboration and external partners in the process of securing regional reconciliation, peace and stability in south-eastern Europe. Second, the chapter addresses the past and upcoming notable challenges faced by SEEHN as a regional network, providing lessons learned, recommendations and ways forward for policy-makers in global health.

Strengths and achievements of SEEHN

SEEHN's methodology: a reviewing, updating and ratifying process

SEEHN's institutional framework resulted from an extraordinary partnership between the founding member countries, formed under the auspices and strategic guidance of the CoE, the Council of Europe Development Bank and the WHO Regional Office for Europe (Table 7.1) (3,4). One could argue, however, that establishing SEEHN was an achievement in itself. The conflicts in the former Yugoslavia not only destroyed health systems in the region, but also ushered in an era of political instability, tension and mistrust between countries.

Table 7.1. Member countries of SEEHN

Member	Entry date
Albania	2001
Bosnia and Herzegovina	2001
Bulgaria	2001
Croatia[a]	2001
Israel	2011
Montenegro[b]	2006
Republic of Moldova	2002
Romania	2001
Serbia[a]	2006[a]
The former Yugoslav Republic of Macedonia	2001

[a] Croatia left SEEHN in 2016 (5).
[b] Montenegro entered as part of the Federal Republic of Yugoslavia.

SEEHN nevertheless managed to facilitate intergovernmental cooperation by political means, providing leadership in designing its key policy documents and areas of policy-making. The south-eastern Europe health ministers' forum is SEEHN's highest political body. Forums have been held in Dubrovnik, Croatia in 2001, Skopje, the former Yugoslav Republic of Macedonia in 2005, Banja Luka, Bosnia and Herzegovina in 2011, and Chisinau, Republic of Moldova in 2016. At the forum, the SEEHN member countries review, update and ratify their mandate of subregional cooperation in health in the form of a pledge adopted in the presence of external partners (6–8).

As illustrated in Fig. 7.1, SEEHN emphasized the health sector as a post-conflict recovery mechanism (6–10). Over the years, SEEHN has shifted its methodology towards promoting health as an integral part of economic development through a whole-of-government and -society approach and achieving the SDGs to improve health, equity and accountability (11). SEEHN succeeded in putting health on the regional agenda for economic development by incorporating a health pillar with various fields of action into the new south-east Europe 2020 strategy (10), adopted in November 2013 by the region's economic ministers. This was the first time that health had become an integrated pillar of a strategy for economic growth in the region. This inclusion represents a changing view of health: from being a narrow, money-consuming sector, to a contribution to employment and an entry point for governments to pursue their ambitions for fairer, more inclusive and cohesive societies (3). Creech et al. (12) highlight an added benefit of network governance: "those who work in partnerships can better enrich the content of their programs, scale them up, intensify their outreach, and continue to support them".

Fig. 7.1. Evolution of SEEHN's methodology

2001
- Post-conflict recovery and conflict prevention mechanism
- Dubrovnik Pledge (6)

2005
- The nexus between a healthy population and economic development
- Skopje Pledge (7)

2009
- Formal establishment of SEEHN's governance structure for regional cooperation on health
- MoU (9)

2010
- Shift to regional ownership: signing of the Secretariat agreement
- Host-country agreement

2011
- A whole-of-goverment and -society approach to adress the complexity of health issues, particularly in regards to health inequity and NCDs
- Banja Luka Pledge (8)
- Amendments to the MoU (9)

2014-June 2016
- Development of strategic action initiatives under the health pillar of the south-east Europe 2020 strategy (10)
- Achieving the SDGs to improve health, equity and accountability

Regional projects: health as a bridge for peace (2002–2011)

From SEEHN's inception until 2011, it facilitated technical cooperation to design policies and best practices through nine projects addressing public health issues of common concern (Table 7.2). Member countries committed themselves to lead one project by establishing a regional project office for technical cooperation on their chosen topics, cultivating ownership and leadership. This was a vital factor in encouraging them to work together on initiatives led by fellow member countries in order to increase prosperity in countries and cultivate greater cooperation and trust among governments.

Table 7.2. SEEHN regional projects, 2002–2011

Lead country	Project focus	Period	Partners/donors
Albania	Communicable diseases surveillance and control	2002–2008	Belgium, France, Greece, Netherlands, WHO Regional Office for Europe
Bosnia and Herzegovina	Mental health	2002–2008	Belgium, Greece, Hungary, Italy, Slovenia, Sweden, Switzerland, WHO Regional Office for Europe
Bulgaria	Information systems for community health services	2005–2008	Geneva Initiative, Greece, Open Society Institute, Switzerland, WHO Regional Office for Europe
Croatia	Tobacco control	2005–2007	Norway, Slovenia, WHO Regional Office for Europe
Republic of Moldova	Maternal and neonatal health	2007–2010	Norway, WHO Regional Office for Europe
Romania	Blood safety	2004–2011	CoE, Ireland, Slovenia, Switzerland, WHO Regional Office for Europe
Serbia	Community-based care for children with disabilities	2009–2011	Belgium, WHO Regional Office for Europe
Serbia	Food safety and nutrition	2002–2008	Belgium, Greece, Italy, Slovenia, Switzerland, WHO Regional Office for Europe
The former Yugoslav Republic of Macedonia	Public health services	2007–2011	Council of Europe Development Bank, Israel, Slovenia, United Kingdom, WHO Regional Office for Europe

The regional project offices facilitated, coordinated and observed regionally-based technical cooperation by bringing together the professional community and/or experts from all the member countries and specific external partners to share knowledge, assess national health systems' status and help their health ministries in policy-making and reform. One of the most successful regional projects was in the field of mental health, led by Bosnia and Herzegovina *(13)*. Such cooperation brought several added benefits for the region. For instance, it reduces the risk that an individual country would implement counterproductive reforms, and "a regional approach is more effective in raising public awareness and combating stigma, as the process gains in authority and scope" *(13)*.

Moreover, cooperation between the regional professional community and external partners, particularly across the first generation of regional projects (2002–2005), can be linked to features of WHO's concept of health as a bridge for peace *(14)*. The approach integrates the health aspect in building peace during or after a conflict and embraces support to the health-professional community in implementing initiatives for multidimensional policy-making. In the concept, "health personnel from conflicting sides [produce] a joint effort in policy, training and service delivery initiatives" *(14)*. As illustrated in Table 7.3, this argument could also apply to SEEHN regional projects

Table 7.3. Comparison of implementation of WHO's concept of health as a bridge for peace and the methods of SEEHN regional projects

Examples of implementation of WHO concept *(14)*	Methods of SEEHN projects
Health policy: reintegration of demobilized soldiers or minority groups within the national health system	Health equity: core SEEHN objective embodied in all pledges and thus fundamental to all project strategies
Health policy: elaboration of strategic plans for health-system reform, involving all actors in the framework of post-conflict reconstruction	SEEHN: under the auspices of the Stability Pact for South Eastern Europe's initiative for social cohesion, so crucial actors, particularly in health matters (WHO Regional Office for Europe, CoE and the Council of Europe Development Bank) for post-conflict reconstruction were present
Training: joint working groups on technical issues	Cooperation of national expert groups (with the support of external partners) through regional projects to develop, strengthen or reform specific public health policies and legislation
Training: promotion of regular contacts between health professionals of all communities through multiple cross-community technical conferences, workshops and seminars	Training workshops/capacity-building: an essential part of most projects
Training: exchange activities promoting international links among professionals of different groups	Collaboration mechanism in regional projects: development of trust, shared knowledge and shared visions with strong working and learning links to external partners that supported the process

Regional health development centres (2010 to date)

Many of the projects mentioned above succeeded in meeting SEEHN's ambitions. As a result, most regional project offices, with their experts, were transformed into regional health development centres (RHDCs). Others were integrated into existing national institutions in the relevant technical fields. At the time of writing, SEEHN had nine RHDCs, each focusing on a specific public health area of common subregional concern (Fig. 7.2): in Tirana (communicable diseases), Sarajevo (mental health), Sofia (AMR), Zagreb (organ donation and transplant medicine), Chisinau (human resources for health), Podgorica (NCDs), Oradea (blood safety), Belgrade (accreditation and continuous quality improvement of health care) and Skopje (public health services). The RHDCs act as a subnetwork of institutional agents within SEEHN.[8] Each has specific external partners and is led by one SEEHN member country, in collaboration with national counterparts (also called national focal points[9]) in the other member countries.

Moreover, RHDCs are vital agents in ensuring technical subregional cooperation by "supporting planned strategic objectives at the subregional and European Region levels, enhancing the scientific validity of SEEHN's public health work and developing and strengthening the institutional capacity of south-eastern Europe countries, and even beyond" (17). Similar to the projects in 2002–2011, regional collaboration through the RHDCs bring meaningful value to the SEEHN member countries, as each can benefit from the others' specific scientific expertise without having to establish or maintain domestic centres in all technical health areas at the same scientific level. The RHDC on organ donation and transplant medicine in Croatia, for instance, worked closely with the SEEHN member countries to design, implement and constantly update country-specific action plans that serve as independent and sustainable models to foster donation and transplants (see Raley et al. (15) for further information).

Often due to limited managerial and financial capacities, however, not all RHDCs are similarly developed and operationally active. Ideally, the health ministers of SEEHN countries should officially commit to making financial contributions to the RHDCs and revise the current managerial mechanism to ensure their sustainable functioning. The effective functioning of RHDCs is vital for SEEHN to avoid reversal or stagnation of its operational capacity.

External partners

The high political engagement of member countries has been recognized since SEEHN's establishment; SEEHN has therefore not only provided a platform for collaboration, but also enabled member countries to connect to various international organizations, other countries in Europe, NGOs and specific specialized partner institutions (Table 7.4). External partners have had a great incentive for involvement with SEEHN, a collaborative partnership that gives an entry point into the countries in the region, while SEEHN can benefit from the new ideas brought by partners.

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[8] The 2009 memorandum of understanding gives a detailed outline of RHDC functions and key roles, and the criteria for their designation (9).

[9] A national focal point is a professional who serves as liaison officer for SEEHN and is responsible for the coordination of activities within a particular country and across countries (15). National focal points can also be linked to be agents of the theoretical notion of intermediate modularity. Creech et al. (16) argue that this notion "allows different groups to develop partly distinct knowledge and perceptions of the problem at hand, which can then be conveyed across to other groups within the network", and thus strengthens governance to enhance effective problem-solving.

Fig. 7.2. Current political and technical governance structure of SEEHN
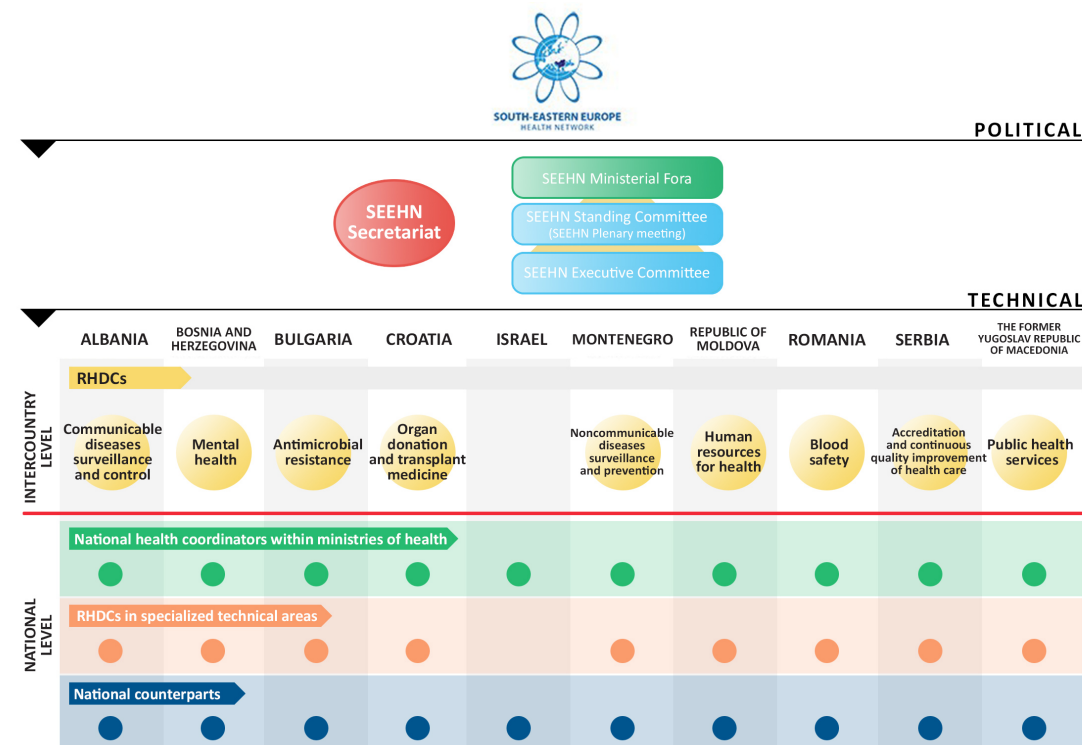
Source: SEEHN *(18).*

Since SEEHN's inception, its partners have provided strong political, technical and/or financial support and shown a cooperative spirit. Through building trust, partners have meaningfully contributed to SEEHN by engaging in long-term collaborations. Partners have supported SEEHN to strengthen regional health policies and implement health projects, and helped establish and support RHDCs according to their financial means and technical expertise. Internationally agreed principles, goals and standards were used to guide many projects, which increased the capacity for policy-making, harmonization and advocacy. Consequently, Maurer & Murko (13) argue: "the transfer of knowledge and expertise as to what to do and how to do it is facilitated, while making it more difficult for a given individual country to ignore the consensus or delay reforms".

The WHO Regional Office for Europe has been SEEHN's key partner from the start, providing political, managerial, technical and financial support in establishing its governance structure, delivering Secretariat capacity and providing operational support for various regional projects. During its evolution, SEEHN has adopted several WHO action plans and frameworks. For instance, the health-in-all-policies approach, the European policy framework Health 2020, the action plan for implementation of the European strategy for the prevention and control of NCDs and the European action plan for strengthening public health capacities and services (19–21) are crucial to SEEHN's current and future operations. For the foreseeable future, the Regional Office will potentially provide technical support to SEEHN to implement the south-east Europe 2020 strategy (10), mobilize resources with other potential partners and help strengthen capacities of the RHDCs (22).

Table 7.4. List of external partners of SEEHN, by year of entry

Partners		Status (entry date)
Name	**Type**	
CoE	Regional organization	Founding partner (2001)
Council of Europe Development Bank	Regional development bank	Founding partner (2001)
WHO Regional Office for Europe	Regional organization, part of United Nations specialized agency	Founding partner (2001)
Belgium, France, Greece, Hungary, Ireland, Italy, the Netherlands, Norway, Slovenia, Sweden, Switzerland and United Kingdom	Countries	Partner countries for differing periods due to the length of projects and initiatives in which they were involved, mostly 2002–2011
International Organization for Migration	International organization	Partner (2005), signatory to MoU in 2013
Northern Dimension Partnership in Public Health and Social Well-being	Policy framework partnership	Signatory to MoU (2007)
European Health Forum Gastein	Regional forum	Signatory to MoU (2012)
EuroHealthNet	Regional network	Signatory to MoU (2012)
International Network of Health Promoting Hospitals and Health Services	Network	Signatory to MoU (2012)
Project Hope	NGO	Signatory to MoU (2012)
Regional Cooperation Council (successor to Stability Pact for South Eastern Europe)	Regional organization	Signatory to MoU (2013)
Studiorum	NGO	Signatory to MoU (2013)
United Nations European Centre for Peace and Development	Research institution	Signatory to MoU (2014)
South East European Network on Workers' Health	Regional network	Signatory to MoU (2014)
European Commission	Regional organization	Observer

Challenges to SEEHN's sustainability and the way forward

Partnerships and complex policy scenarios

During the first post-conflict decade, south-eastern Europe attracted many external partners, particularly countries, to implement the health-related regional projects. Health was seen as a bridge for peace. The partner countries' aid landscape has changed over the years, however, as indicated by fewer resources being available to SEEHN and the designation of other priorities in 2016. As a result, SEEHN partner countries have decreased in recent years to the current total of two: Slovenia and Switzerland. Slovenia mainly provides technical guidance and shares experience by attending SEEHN events (Dr M. Ruseva, acting head of the SEEHN Secretariat and co-opted member of the SEEHN Executive Committee, personal communication, 1 April 2015). Through the Swiss Agency for Development and Cooperation, Switzerland has engaged in multiple partnerships; its contribution to SEEHN is partly due to the Agency's overall development cooperation strategy in different sectors and fields across south-eastern Europe and the Swiss Health Foreign Policy agenda (Ms M. Zaric, Programme Officer for Health at the Agency's office in Bosnia and Herzegovina, personal communication, 21 May 2015) (see also Chapter 1).

SEEHN gradually proceeded to full regional ownership: the Regional Cooperation Council took over the management of SEEHN in 2008, the 2009 MoU *(9)* covered the establishment of the RHDCs and the SEEHN Secretariat, and the host-country agreement on the Secretariat was signed in 2010. SEEHN nevertheless still requires strong links with external partners until member countries have the political and financial resources to ensure sustainable self-ownership. SEEHN's dependence on support from the Regional Office and a limited number of external partners may therefore make it vulnerable to the stagnation of its operational capacity. For instance, according to SEEHN's key policy documents, tackling health inequity is central to its methodological approaches, so enhancing knowledge through partners from the bottom up is vital to establishing comprehensive health strategies. Local actors' engagement can be ensured through RHDCs. In addition, such an approach is crucial for SEEHN to ensure a comprehensive policy-making process by creating a multilevel and multisectoral collaborative platform that can help to meet the goals of the health action plans under the south-east Europe 2020 strategy (10) and to secure health, well-being and prosperity in south-eastern Europe in the framework of the SDGs.

Political commitment and efficiency of health diplomacy

Political commitment from member countries' health ministers is crucial for SEEHN's future work and integration into the EU.[10] Given the frequent changes in health ministers and representatives of health ministries that are characteristic of many SEEHN member countries, however, political commitment can shift. Participants in SEEHN's 34th plenary meeting, for example, thought that this constant change undermined SEEHN's operation, as it necessitated a continuing process of building trust and re-establishing commitment in countries, in which independent advisers, such as the Regional Office and the Regional Cooperation Council, played an important role (SEEHN, unpublished information, 2014). WHO Regional Director for Europe Zsuzsanna Jakab started to gather the SEEHN health ministers twice a year in ad hoc meetings and during international events such as the

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[10] Bulgaria and Romania joined the EU in 2007, followed by Croatia in 2013. Albania, Montenegro, Serbia and the former Yugoslav Republic of Macedonia are candidate countries, and Bosnia and Herzegovina is a potential candidate.

World Health Assembly and sessions of the WHO Regional Committee for Europe (Dr M. Ruseva, acting head of the SEEHN Secretariat and co-opted member of the SEEHN Executive Committee, personal communication, 1 April 2015).

Continued political commitment is vital for the future. As the countries in south-eastern Europe are relatively small and have limited resources, they tend to struggle to be influential in European and global health policy-making. Identifying common issues and goals gives them an opportunity to speak as one in international negotiations on health governance. This practice can be directly linked to the term global health diplomacy, which Buss et al. *(23)* describe as the goal to incorporate "multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health". Speaking together, SEEHN member countries can directly influence the landscape of European health policy, as they did in joint statements to the 62nd session of the WHO Regional Committee for Europe that meaningfully contributed to draft resolutions addressing a number of issues *(24,25)*. The lessons learned from engaging in European negotiations on health policy give SEEHN member countries great potential to be influential actors when engaging with one voice in negotiations at the annual World Health Assembly.

Communication, and intersectoral and Secretariat efficiency

The SEEHN website is still far from complete, in terms of having sufficient updated and dynamic content on the activities of SEEHN, RHDCs and external partners within SEEHN (see references). Through improved knowledge-management techniques, however, the website has great potential to be a valuable instrument for digital health diplomacy. Through the website and engagement in social media, SEEHN could inform the health and other governmental sectors, the international community, NGOs, the business sector, academe and the wider public on its daily work. This is particularly important in advocating for the health-in-all-policies approach. The use of new communication technologies has great potential for SEEHN to gain public attention, as well as needed financial, technical and political support.

At the time of writing, SEEHN activities were mainly limited to the health sector, lacking the involvement of other government sectors. As an international network, engagement with foreign ministries is recommended. Although SEEHN organized two comprehensive executive courses on health diplomacy for its member countries in 2012 and 2014, key decision-makers from sectors other than health were not well represented among the participants. This indicates a missed opportunity to advocate health diplomacy across government sectors. For instance, SEEHN co-coordinated the 2014 course with WHO and the Graduate Institute of International and Development Studies, Switzerland with the support of the Swiss Agency for Development and Cooperation. The faculty comprised regional and international experts in global health governance and health diplomacy, and the course introduced and further enhanced participants' skills in intersectoral negotiations by exploring the role of health diplomacy and discussing new tools and technologies for diplomacy *(25)*.

Overall, the incomplete transparency of SEEHN's past and future activities can be understood to result from the transition of the SEEHN Secretariat from the Regional Office to member countries. A lack of human resources limited the Secretariat's managerial, coordinating and administrative support to SEEHN, although employing eight additional staff members during the first half of 2016 addressed this issue. Focusing on administrative support and the promotion and coordination of activities is fundamental for sustainable functioning and the achievement of SEEHN's ultimate goal: to become self-supporting.

Conclusion

SEEHN's evolution can be argued to be a success story of the past with an uncertain future. SEEHN is subjected to continuing and new internal and external challenges that carry the risk of operational stagnation, thereby undermining its sustainability. Although SEEHN has an innovative governance structure with great potential, this potential is untapped, as the RHDCs are not equally developed and/or active, often due to limited managerial and financial capacities. SEEHN should therefore review the operational, managerial and financial capacity mechanisms for RHDCs. Owing to the frequent change in health ministers and ministries in member countries, external partners such as the WHO Regional Office for Europe play a vital role in the continuing process to ensure political commitment. Further, the SEEHN Secretariat needs to be an effective and permanent administrative and coordinating body. A functioning Secretariat must focus on more efficient knowledge-management, particularly in enhancing the promotion and transparency of SEEHN activities. Accordingly, advocacy to intersectoral partners, particularly to secure the involvement of foreign ministries, is recommended. An efficient Secretariat and a sophisticated and active communication strategy would help to ensure that SEEHN gains multilevel, multisectoral and public attention that might lead to the financial, technical and political support needed for a sustainable capacity for subregional cooperation. This is particularly important to address complex health policy scenarios, such as meeting the goals of the south-east Europe 2020 strategy *(10)* and securing health, well-being and prosperity in south-eastern Europe in the framework of the SDGs.

Finally, the rationale for establishing SEEHN as a network for cross-country cooperation has proved to have added benefits. First, a network approach highlights trust-building and vision-sharing by identifying common health challenges to address and international health governance trends to follow. Given the political landscape in 2001, this cooperation contributed to reconciliation, peace and stability in south-eastern Europe. Second, collective action to strengthen health systems by merging resources and knowledge can be more efficient than individual action, thus contributing to a strong partnership among all stakeholders. Third, cross-country cooperation can serve as a tool for collective stances in international negotiations on health governance, making individual countries more vocal and powerful. This can be of a particular benefit for small countries with shared interests and/or limited resources.

Update

In 2017, important developments took place to strengthen SEEHN. Its health ministers signed the new far-reaching Chisinau Pledge of cooperation at their meeting in the Republic of Moldova in April. The nine countries of SEEHN agreed to:

- increase public financing for health, despite economic hardship;
- coordinate efforts to improve people's health through universal health coverage, whole-of-government and whole-of-society approaches, and tackling health inequalities – all in order to achieve the health-related goals and targets of the 2030 Agenda for Sustainable Development;
- build a cross-border mechanism for a coordinated response to health emergencies; and

- establish a subregional health workforce observatory to promote and monitor the cross-border mobility of health-care workers, harmonize their qualifications and prevent the emigration of young specialists to more affluent regions to ensure a sufficient number of health workers in south-eastern Europe to cover the health needs of an ageing population.

In addition, ministers appointed staff to improve day-to-day management and revised the regulation of the governing bodies and expert groups to improve the operation of SEEHN.

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8. Central Asian countries: ensuring a polio-free Europe

Maksut K. Kulzhanov

Health diplomacy is an important component of countries' work in the 21st century to improve population health and reduce inequities in health. In the current globalized and interconnected world, interaction between a numbers of players is greatly needed to solve public health issues. Health extends beyond purely technical issues to become an important element of foreign policy and overall global policy, so health workers and policy-makers need to use the right arguments and skills to advocate and reach a result-oriented consensus. This is usually not easy, as diplomats, not public health experts, conduct negotiation processes. Today, global health diplomacy has three important aspects:

- to reach compromise and consensus in multilateral negotiations on issues related to health, in the face of other interests, values and principles;
- to use health for foreign policy goals, including security, and vice versa; and
- to use health as a bridge to peace in crises.

All these should be matched to different traditions, cultures and approaches in countries, to understand the vision for health in the 21st century.

A good example to demonstrate health diplomacy at work is the outbreak of (polio) in 2010 in central Asia.

Sustaining the Region's polio-free status is one of the primary goals of the European vaccine action plan 2015–2020 *(1)*. In June 2002, all 53 Member States of the WHO European Region were certified free of endemic transmission of wild poliovirus. Since then, the Region has experienced at least two importations of the virus. The polio outbreak, which started in 2010 in Tajikistan and spread to three other countries, led to over 400 clinical cases.

The Government of Tajikistan reported a sharp increase in cases of acute flaccid paralysis (AFP), the most common sign of polio, in April 2010. WHO sent a team of international experts to Tajikistan on 16 April 2010 to investigate the suspected outbreak and provide technical support to the Government, in partnership with UNICEF and the Centers for Disease Control and Prevention, United States of America. Genetic sequencing determined that the wild poliovirus type 1 found in Tajikistan was most closely related to viral strains previously identified in Uttar Pradesh, India.

Throughout 2010, Tajikistan reported 457 laboratory-confirmed cases of wild poliovirus type 1, including 29 deaths. The outbreak spread to neighbouring countries; in 2010, laboratory testing confirmed 14 cases in the Russian Federation, three in Turkmenistan and one in Kazakhstan. Immunization activities to respond to the outbreak in the Region delivered more than 45 million doses of monovalent type 1 oral polio vaccine (OPV) and trivalent OPV. The Russian Federation reported the last confirmed case in the Region, with a date of onset of 25 September 2010 *(2)*.

The Ministry of Health of Kazakhstan formed a polio preparedness task force jointly with WHO and UNICEF on 26 April 2010. On 17 May, the Ministry decided to conduct one round of supplementary immunization activity (SIA), targeting 1 820 341 children aged 0–6 years, and a social mobilization campaign targeting the general population, especially parents of children under 6. WHO and UNICEF supported the Ministry in its planning and implementation. In addition, UNICEF was requested to support the social mobilization activities before the SIA through such means as developing and producing information, education and communication materials for the target groups in the population.

The Government of Uzbekistan at the highest level recognized the collective risk to central and eastern Asia posed by the outbreak. Representatives of WHO and UNICEF met with Mr Adkham Ikramov, Minister of Health, to underline the importance of conducting a series of three mass immunization campaigns and to offer assistance in vaccine procurement, operational planning, logistical issues, and communication and social mobilization.

Uzbekistan decided to conduct two rounds of SIAs for its 2.8 million children aged under 5 years and a subnational campaign focusing on the areas bordering Tajikistan and Afghanistan. UNICEF ordered an initial supply of 3.3 million doses of OPV and the vaccine arrived on 2 May 2010.

WHO worked closely with the governments of Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan to prevent the possible spread of the outbreak in eastern central Asia. With the active participation of its partners, WHO provided technical and field support throughout the outbreak. Countries held national immunization days (NIDs): two rounds each in Kazakhstan, Kyrgyzstan and the Russian Federation, three rounds in Turkmenistan, five in Uzbekistan and six in Tajikistan. The six countries also agreed to synchronize rounds of SIAs in spring 2011.

Moreover, WHO played the role of a bridge in health diplomacy between countries, creating consensus in the subregion and ensuring cooperation among countries with different political arrangements and a history of relations that were not always friendly.

With support from UNICEF and WHO, the governments of central Asian countries started to develop a communication strategy. Conducting national immunization campaigns required large-scale mobilization of human resources and logistical arrangements that were most likely also needed for other planned public health activities in the countries. The overall objective was to provide communication and social mobilization to contain the transmission of wild poliovirus in central Asia and protect all children under 5 years from infection by raising immunity levels through high-quality SIAs and strengthening routine immunization.

The key communication challenge was to provide convincing reasons to families, journalists and even members of the medical community for suddenly conducting national polio immunization campaigns in addition to the routine immunization schedule for children. The key interventions concentrated on advocacy, outreach to the mass media and social mobilization. The lessons learned from the communication response to polio could be used to strengthen routine immunization or other public health interventions and health diplomacy in countries.

According to a series of studies conducted in the subregion, 70% of the population gets information through television. Television therefore needed to be extensively used through editorial leverage and placing of public service announcements. Health ministries needed regularly to share promotional materials, press releases and campaign information with the print media, especially those at local level to reach families in rural areas.

Advocacy concentrated on preparing a communication note for cabinets of ministers, members of parliament, oblast and district governors and community leaders to get full and cross-sector buy-in at all levels. Outreach to the mass media was important. The health infrastructure, going down to district level, and media organizations can mobilize regional media to carry information, news or human interest stories related to immunization campaigns.

Social mobilization was needed to support the health ministry in mobilizing the education ministry to provide information to parents of kindergarten and pre-school children. Since pre-school coverage was reportedly close to 17%, however, other strategies were used to mobilize older children as channels of interactive communication with their families.

No less important for communication interventions were the standardized messages that the health ministry could use to ensure that the right messages went out to communities during the NIDs. The aim was to give correct and helpful information to families without spreading rumours or creating panic. The communication working group adapted these messages for use in information, education and communication materials, and communication training.

The European Regional Certification Commission for Poliomyelitis Eradication *(3)* held its 24th meeting in January 2011 in St Petersburg, Russian Federation to review the epidemiological situation in the countries affected by the polio outbreak (Kazakhstan, the Russian Federation, Tajikistan and Turkmenistan) and to assess the response measures taken to interrupt further transmission in the WHO European Region. The Commission reviewed the evidence on the current situation in six Member States (Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, Turkmenistan and Uzbekistan) to determine whether the European Region would keep its status as polio-free.

The Commission noted that Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan had made a strong and adequate response to the extremely large outbreak, although the current success, achieved through SIAs, was fragile. The central Asian countries (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) and the Russian Federation needed to ensure that all necessary measures were planned and implemented to improve coverage rates for routine immunization with polio vaccine and to strengthen surveillance for AFP. The Commission commended Kazakhstan and the Russian Federation for their

timely detection of wild poliovirus importation and immediate response measures, and advised them to conduct additional SIAs in the affected regions in accordance with WHO recommendations.

The Regional Certification Commission called for more transparency and cooperation by national authorities in reporting and investigating AFP cases. The failure of one or several countries to share specimens with the polio regional reference laboratory in Moscow, Russian Federation for confirmation and virus differentiation could jeopardize the certification status of the entire Region. WHO and health ministries would continue to work with the relevant authorities to resume and/or systematize the shipment of samples in the near future *(4)*.

In conclusion, the Regional Certification Commission acknowledged that a large outbreak of wild poliovirus type 1 from northern India had occurred in Tajikistan, with further spread to neighbouring and distant countries. From the evidence presented, the Commission commended countries' actions, including the allocation of large numbers of staff and amounts of money to stop further poliovirus transmission.

After further reports from the six countries, the Regional Certification Commission determined that the European Region remained polio-free *(3)*. All six Member States pledged their readiness to provide the necessary evidence and details for review by the Commission.

Monitoring and review process

WHO documented good practices and lessons learned from the outbreak and used them for training. After the outbreak showed the need for heightened preparedness, sub- and interregional polio outbreak simulation exercises (POSEs) were conducted in:

- Bosnia and Herzegovina in 2011 for representatives of Bosnia and Herzegovina, Montenegro and Serbia;
- Ukraine in 2013 for representatives of Armenia, Azerbaijan, Georgia and Ukraine, an observer from the Russian Federation, and experts from European polio reference laboratories;
- Romania in 2015 for representatives of Czechia, Hungary, the Republic of Moldova, Romania and Slovakia;
- Kazakhstan in 2015 for representatives of Kyrgyzstan, the Russian Federation and China and Mongolia (in the WHO Western Pacific Region); and
- Kazakhstan in 2016 for representatives of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

A national POSE was conducted in the United Kingdom in February 2013.

A POSE *(5)* is a two-day table-top exercise designed to help Member States critically review and update their national plans for responding to the detection of imported wild polioviruses and vaccine-derived polioviruses, including use of the IHR *(6)*. A POSE addresses communication, coordination and collaboration at international and national levels and exposes any weaknesses in arrangements for polio preparedness and response. Each proposes a specific scenario, starting with detection of a suspected polio case and progressing to cross-border transmission. Participants are asked to simulate the implementation of country preparedness plans to contain the outbreak. A POSE concludes with a post-event scenario some 25 weeks after the last case was reported.

In addition, POSEs are attended by observers from WHO headquarters, country offices and partner agencies. By facilitating hands-on practice, POSEs:

- emphasize the importance of communications as the key element of any response;
- point to the need for crisis communications plans;
- provide an opportunity to review national plans from a new perspective using a novel methodology; and
- highlight the importance of liaising across borders/countries and building partnership as part of outbreak response preparedness.

The WHO Regional Office for Europe planned to conduct further regional and interregional POSE exercises *(7)*.

Lessons learned from the outbreak and future steps

The 2010 outbreak provided a good example of successful management in central Asian countries, demonstrating the need for open mutual collaboration between countries and international organizations, with WHO coordinating the channelling of information between countries and the determination of all stakeholders to get the situation under control.

This is a good demonstration of using the principles of health diplomacy in the field. Global health diplomacy brings together the disciplines of public health, international affairs, management, law and economics, and focuses on negotiations that shape and manage the global policy environment for health. The relationship between health, foreign policy and trade is at the cutting edge of global health diplomacy. Its main goals are to support the development of a more systematic and proactive approach to identifying and understanding key current and future changes that affect global public health, and build Member States' capacity to support the necessary collective action to take advantage of opportunities and mitigate risks to health *(8)*.

Countries remain core actors that must reorient their health and regional policies to align their national interests with the diplomatic, epidemiological and ethical realities in central Asia. This alignment involves governments adjusting to globalization by overcoming fragmented policy competencies in national governance systems *(9)*. This in turn requires additional efforts to develop health diplomacy at regional level. Countries need to be brought together to discuss common problems and common action to prevent disease and improve health, and even to develop transregional documents setting out agreements on preparedness to respond to health risks and threats at regional level.

Polio does not respect borders and, since the 2010 outbreak in Tajikistan, with which Uzbekistan and other central Asian countries share a long border, these countries are at risk of importing and transferring poliovirus. While the European Region was certified as polio-free in 2002, poliovirus still circulates in many countries globally. Children need to be protected immediately; every child under 5 years in the world should be immunized against polio, even if he or she has had routine immunization. Vaccinating all children aged 0–5 years through rapidly conducted polio immunization campaigns will raise the immunity level of all children and keep them safe from polio.

At its 30th meeting in May–June 2016, the Regional Certification Commission *(3)* said that outbreak preparedness and significant improvements in surveillance and immunization coverage remained essential to ensure that poliovirus cannot make a comeback in the European Region. The Commission's conclusions echoed the assessment of the global emergency committee under the IHR regarding the international spread of poliovirus, which declared in August 2016 that the spread of poliovirus continued to constitute a public health emergency of international concern *(10)*. In May 2016, it had reviewed the status of all countries that had been affected by wild poliovirus or circulating vaccine-derived polioviruses and concluded that all possible measures were still needed to support the final phases of polio eradication.

Stressing the need for continued vigilance, Professor David Salisbury, Chair of the Regional Certification Commission, said: "All countries remain at risk to varying degrees and must take appropriate action" *(3)*. The five-member Commission called for urgent measures to reverse declines in vaccination coverage and surveillance quality in some countries, to prevent re-establishment of transmission in the event of an importation or emergence of vaccine-derived strains, and for all Member States to conduct POSEs.

In 2013, the World Health Assembly endorsed a comprehensive polio eradication and endgame strategic plan for 2013–2018 *(11)* to guide an intensified global effort to complete the eradication of all polioviruses and certify the remaining WHO regions polio-free by the end of 2018. The plan's major objectives include the phased withdrawal of OPV, starting with type-2-containing OPV. By early 2014, important progress had been achieved against all four of the plan's objectives.

Seventeen countries in the European Region are switching to bivalent OPV: Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, the Republic of Moldova, the Russian Federation, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan. Belarus and Poland will move to a schedule using only inactivated polio vaccine. All central Asian countries agreed to participate in the switch from OPV *(7)*, which can be seen as demonstrating readiness to contribute to a sustainable solution to polio in the European Region.

In all these situations, health diplomacy should have an important place. The 2010 polio outbreak could be used as a case in a training course on how the principle of health diplomacy could influence outbreak management. This could be a good way to develop practical skills among health policy-makers.

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9. Eastern Europe: a health diplomacy perspective on the HIV/AIDS crisis

Michel Kazatchkine

The worldwide mobilization against HIV/AIDS of the last 30 years has generated historic achievements in global health. Scientific advances have rapidly been translated into large-scale prevention and treatment programmes in almost all settings. Today, over 18 million people have access to antiretroviral therapy in LMICs across the globe. That figure was less than 1 million just 15 years ago. The number of new infections and AIDS-related deaths has decreased by 35–40% in the last 15 years *(1)*. Prevention services in antenatal settings have led to the reduction of the rate of transmission of HIV from mother to child to below 2–5% *(2)*.

Fifteen years after the first-ever special session of the United Nations General Assembly was devoted to a particular health condition, HIV/AIDS, the world committed to ending AIDS as a public health threat as part of the 2030 Agenda for Sustainable Development *(3)*.

Against these remarkable achievements, signs remain that simultaneously threaten and highlight the fragility of the AIDS response. Nearly 2 million people are newly infected with HIV every year, despite prevention efforts. A large proportion of infected people remain undiagnosed and three out of five HIV-positive people are not on treatment. Progress remains highly unequal across the world, and specific groups of people – including young girls in Africa, men who have sex with men and people who inject drugs – remain highly affected by HIV precisely because they are harder to reach with prevention, treatment and care services. In addition, political commitment to investing in the AIDS response is declining globally. Activism is weakening. International funding for AIDS is decreasing.

The world is at a crossroads in the unfolding history of the epidemic. If prevention and treatment are not intensified and fast-tracked, the numbers of people becoming infected with HIV will increase and the death toll, currently at 1.5 million people a year, could start to rise again.

In this context, the epidemic in eastern Europe and central Asia is of particular concern. This chapter depicts the main features of the HIV/AIDS epidemic in eastern Europe and central Asia and presents short case studies of health diplomacy addressing the epidemic in the region.

Eastern Europe and central Asia: an epidemic still expanding

Eastern Europe and central Asia comprise the only region of the world still experiencing an expanding HIV epidemic. The number of new cases reported annually has increased by as much as 57% in the last five years *(4)*.

Over 1.5 million people are living with HIV in the region, which comprises 12 countries in the eastern half of the WHO European Region: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. Together, the Russian Federation and Ukraine account for 90% of HIV cases in this region.

In the Russian Federation (population: 146 million), 836 000 people are officially registered as living with HIV *(5)*. Estimates based on mathematical modelling, however, suggest that the number is 1.1–1.4 million and that overall prevalence is close to 1%. The health authorities of Yekaterinburg, the fourth-largest city in the Russian Federation, recently announced that one in every 50 people in the city is infected with HIV *(6)*. In 2015, 100 000 new cases were reported in the country.

In Ukraine (population: 45 million), 220 000 people are estimated to be living with HIV *(4)*. The number of new cases in 2015 was 13 000 *(7)*. Nevertheless, the epidemic has slowly started to reverse: the number of new diagnoses was slightly lower in 2015 than in previous years.

Across the region, unsafe drug injection has driven the epidemic, accounting for over 70% of all cumulated HIV cases. In the last few years, heterosexual transmission has become an increasing component in the epidemic's growth. New infections in women occur among the sexual partners of people who inject drugs, and as the result of a generalized epidemic in some areas of high prevalence.

Access to antiretroviral treatment remains low in the region, at 21% of the estimated number of people living with HIV *(1)*. Care for people living with HIV is the task of specialized regional AIDS centres, following a vertical and provider-centred model of health-service delivery.

HIV prevention is far from being sufficiently accessible, except for programmes to prevent vertical transmission. As discussed below, access to harm reduction for people who inject drugs remains very limited in the region.

Finally, the region also reports one of the highest prevalence rates of co-infection with TB and MDR-TB in the world. The prevalence of HIV and TB co-infection has steadily increased in the last 10 years: 12% of new TB cases now occur among HIV-positive people *(8)*. The prevalence of co-infection with hepatitis C is also high, reaching over 70% among HIV-positive people who inject drugs, while access to hepatitis treatment remains very limited.

Challenging societal context for key affected populations

From the early days of the epidemic, HIV/AIDS has exposed the weaknesses and dysfunctions of societies across the world. The epidemic in eastern Europe and central Asia is no exception: stigma and discrimination are high and add to the structural, cultural, societal and political obstacles to the AIDS response.

The epidemic in the region follows a so-called concentrated pattern, meaning that HIV disproportionately affects specific groups in the population. These groups are highly stigmatized (men having sex with men), often marginalized, and either illegal (sex workers) or criminalized (people who inject drugs). Stigma, criminalization and marginalization mean that people in these vulnerable groups are hard to reach, hindered in accessing prevention messages and hesitant in seeking services from the public system due to fears of possibly facing discrimination in health settings and/or collusion between professionals in the health sector and police.

Stigmatization and criminalization also explain why data on the prevalence and incidence of HIV among vulnerable populations remain very limited. This limitation in turn is an obstacle to the design of prevention strategies.

Available surveys indicate an HIV prevalence of 6–9% among men having sex with men in the region. A recent study in Moscow, Russian Federation showed an HIV prevalence of 15.6% among men having sex with men, with only 25% of the HIV-positive men having been previously aware of their infection *(9)*. Requirements for HIV testing enforced by some employers are among the factors linked to being unaware of one's HIV infection, underlining the negative impact of stigma on access to treatment and care. The dual stigma of homosexuality and HIV and the fear of breaches in confidentiality impede access to health care for men having sex with men. These key affected populations distrust the public system, while dedicated NGO and peer-led counselling are rare across the region and are now confronted with decreasing funding from international sources.

The prevalence of HIV among sex workers is estimated to be around 10%, and 20 times higher among female sex workers who also inject drugs. A report based on community-led research among sex workers in 16 countries of the region documented their daily experience of extortion, fines and violence by police and clients *(10)*. The report also tells how police routinely use the possession of condoms as so-called evidence of crime and confiscate or destroy syringes. It cites evidence from the region documenting how poor policing practices are causally associated with a lower capacity for risk-reduction, poor access to services and increased exposure to HIV. It further describes the fear that sex workers' drug use or work may be reported to police or child welfare authorities discourages them from seeking services and entering the care system.

The prevalence of HIV among people who inject drugs exceeds 20% in the region and may reach 50–70% in some highly affected settings *(4)*. The epidemic among people who inject drugs began in the second half of the 1990s after the dissolution of the USSR, when unemployment, poverty and crime increased dramatically in the Russian Federation and other eastern countries. New drug markets opened up at that time, leading to the increased availability of, and demand for, drugs. In the early 2000s, HIV/AIDS and drug-related health issues emerged as pressing social and public health challenges.

Drug policies and legislation are based on the enforcement of prohibition law across the region. Policing and law enforcement focus on users, who constantly fear arrest and incarceration. As a consequence, users go underground and inject drugs in unsafe and unhygienic conditions or in a rush.

Harm-reduction and health diplomacy

WHO, the United Nations Office on Drugs and Crime and the Joint United Nations Programme on HIV/AIDS (UNAIDS) jointly recommended a package of harm-reduction interventions to reduce the risk of acquiring HIV, hepatitis or TB and improve treatment and care for people who inject drugs *(11)*. Needle–syringe programmes, opioid substitution therapy and antiretroviral therapy are the most critical elements of the package. Compelling evidence indicates that the provision of clean injecting material and opioid substitution therapy reduces the sharing of injecting equipment and averts HIV infections. In combination with antiretroviral treatment, these interventions reduce HIV transmission, decrease mortality, promote the initiation of, and compliance with, antiretroviral treatment, reduce drug dependency in the long term, reduce crime and public disorder, and improve the quality of life *(12)*. In addition, there is strong evidence that supervised injection sites, distribution of naloxone and programmes for medical heroin prescription should be relevant additions to the list of interventions recommended by the United Nations.

Despite the evidence of its effectiveness and the increasing international acceptance of harm-reduction as an evidence-based strategy for minimizing the health risks associated with injecting drug use, resistance and opposition to harm-reduction persist among health and drug-control authorities in the Russian Federation and a number of other countries in eastern Europe and central Asia. A number of social networks and parts of the political leadership in the region argue that needle-exchange programmes enhance drug use, despite evidence to the contrary. Harm-reduction has become a highly polarizing issue in the region and demonstrates the tension between politics and scientific evidence.

The Russian Federation stands strongly against harm-reduction, arguing that its implementation would implicitly legitimize illicit drug use, and opposes opioid substitution therapy on the grounds that, as methadone acts as an agonist of opioid receptors, its use as a medicine would substitute one opioid addiction for another.

In the last 10 years, the Russian Federation has expressed opposition to harm-reduction in all regional and international forums, including the annual meetings of the Commission on Narcotics and Drugs and the United Nations General Assembly's special session on drugs and its High-level Meeting on Ending AIDS (the last two held in 2016). Moreover, it banned opioid substitution therapy within days in Crimea following the temporary occupation of Crimea. This decision resulted in the deaths of at least 10% of the people previously treated with methadone.

In contrast, Ukraine has implemented large-scale peer outreach and needle-exchange programmes for people who use drugs, as well as opioid substitution therapy, for over 10 years. The country has witnessed a sharp decrease in the number of new HIV infections among people who inject drugs in recent years.

Harm-reduction interventions, including needle-exchange programmes and opioid substitution therapy, are also in place in Armenia, Belarus, Georgia, Kyrgyzstan, the Republic of Moldova and Tajikistan. Kazakhstan recently included harm-reduction in its national strategy against AIDS, after years of pilot-testing. Throughout the region, however, such programmes remain far too insufficient in scale and are fraught with a combination of divided opinion in the medical profession and coverage by social media, and scepticism or opposition in parliaments. Most of the programmes have been initiated through financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria. International funding is decreasing across the region, however, as most of the countries are designated as middle-income countries according to the World Bank's classification.

In earlier days, governments in western Europe, confronted with the HIV epidemic among people who inject drugs, also met significant resistance to harm-reduction from citizens. The introduction of harm-reduction as part of national health strategies was a political decision based on the scientific evidence and pragmatism. Pragmatism eventually convinced the people of Switzerland to approve new approaches to drug policies in a referendum.

Drug policies, harm-reduction, opioid substitution therapy and the populations most at risk continue to be central to the dialogue between the United Nations, experts from the field, health authorities and governments in the region. In 2008, the then United Nations Secretary-General Ban Ki-moon said *(13)*:

> In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us.

Lessons for global health diplomacy

Several lessons can be drawn for global health diplomacy as one seeks a better understanding of the context, the facts, the players and the arguments. First, some governments' objections to harm-reduction illustrate how policy can be disconnected from evidence and consequently how difficult the dialogue between science and policy-making can often prove to be. Second, the responsibility for policy solutions to health-related issues often lies with ministries that are unrelated to health; in eastern Europe and central Asia, this primarily means ministries of the interior. Third, when a policy decision (to support harm-reduction or not) is to be made, it is essential to establish an evaluation mechanism at the same time to follow up and accumulate evidence that can be used to confirm or reorient the policy. The role of science and evidence should not stop at informing a decision, but continue with the evaluation of its consequences.

While health diplomacy on harm-reduction has achieved only a few small steps towards more evidence-informed policies, other initiatives at the intersect of health and politics in the region have generated more results and hope. These include initiatives for access to health for migrants in central Asia and those populations situated in the conflict areas of eastern Ukraine.

Migration in central Asia

Central Asia faces a major intraregional migration flow. It is also part of one of the largest corridors for labour migration in the world, with hundreds of thousands of seasonal and longer-term migrant workers moving from central Asian countries to the Russian Federation each year *(14)*. Central Asian countries face some of the highest burdens of MDR-TB in the world and growing HIV epidemics *(7,8)*. Regional health diplomacy is becoming critically important for central Asian countries to improve cross-border collaboration to ensure migrants' rights to health as an effective measure of disease control (see also Chapters 5 and 6).

Migrants, whether they leave central Asian countries for work for several months or are longer-term residents in a host country, have only limited access to the public health-care system and hence to HIV and TB services. In the last few years, Kazakhstan has changed its policies, now ensuring access to TB treatment for all registered migrants in the country, at least until patients have negative sputum smears. Although these are progressive policies, many problems remain, including the conditions under which patients returning to their countries of origin have to complete their treatment, as well as the lack of access to care of the many people who work illegally. Many seasonal workers fall in the latter category.

The Russian Federation has policies of screening and requiring health insurance for registered migrants prior to entry to its territory. It allows access to care for legal migrants at the sites where they have registered for work. Many people, however, work outside the registration system for short periods.

Migration is clearly recognized as a risk factor for TB and MDR-TB *(15)*. It also makes people more vulnerable to HIV. Over 60% of the people who were detected as HIV-positive in the last three years in Armenia have gone to the Russian Federation for work at some point.

At the crossroads of public health and economic interests, health diplomacy aims to increase the awareness of political and economic leaders, and mobilize health and political decision-makers to ensure coordinated responses and avoid the spread of disease through migration corridors.

Kazakhstan plays an important leadership role in health diplomacy in central Asia on the issue of cross-border health. Under the auspices of the Kazakh Ministry of Health, and with the support of the United States Agency for International Development and the Global Fund, bilateral agreements are being negotiated between Kazakhstan and neighbouring Kyrgyzstan and Tajikistan to ensure access to care and treatment for migrant workers and the proper communication of information to patients when they return to their home countries *(16)*.

The United Nations facilitates these negotiations, which should have an important and positive impact on health and human rights, particularly if they include access to care for migrants working illegally. At present, a diagnosis of TB, MDR-TB or HIV infection too often means deportation. If successful, current and future regional efforts at health diplomacy would therefore strengthen national and regional security, improve the region's international image and, most important, contribute to better health for all.

Eastern Ukraine

Access to medicines for HIV and drug-resistant TB in eastern Ukraine has been a concern from the early days of the conflict in the area. In November 2014, the risks of the emergence of polio and of insufficient blood safety were brought to the attention of the international community and WHO. As the United Nations Secretary-General's Special Envoy on HIV/AIDS in Eastern Europe and Central Asia, I expressed concern about the risk of an abrupt interruption in the availability of antiretroviral AIDS medicines for thousands of patients in the Donbas in June 2015 *(17)*.

Even prior to the conflict, Donetsk and Luhansk were among the regions in Ukraine and Europe that had witnessed the highest incidence and prevalence of HIV infections and drug-resistant TB. Before the conflict, most of the antiretroviral AIDS medicines had been funded by the Ukrainian Ministry of Health. Medicines for drug-resistant TB were funded by the Global Fund and channelled to Donetsk and Luhansk through a Ukrainian NGO that is the principal recipient of a Global Fund grant.

The central authorities, however, discontinued the funding for medicines in both the Donetsk and Luhansk territories at the end of 2014. The clinics in Donetsk and Luhansk used existing stocks to treat patients until July 2015, when the interruption of supply was recognized as an urgent public health threat that needed to be addressed.

In the summer of 2015, intense health diplomacy efforts – involving the de facto authorities in the Donetsk and Luhansk regions, the Ukrainian Government, the European Commission, the United Nations and the Global Fund – resulted in an emergency humanitarian solution in the form of an emergency grant of US$ 3.6 million from the Global Fund to UNICEF, covering the needs for antiretroviral medicines and laboratory reagents in both territories for one year. The Global Fund grant consolidated funding for the procurement of drug-resistant TB medicines to the Ukrainian NGO recipient until the end of 2017. Thus, health diplomacy secured a solution for over 10 000 HIV patients on antiretroviral treatment in the Donetsk and Luhansk regions and about 500 cases per year of people living with MDR-and pre-extremely drug-resistant TB.

Uncertainties, however, continue to persist beyond the summer of 2017 for an estimated 12 000 patients in these regions. The situation also remains critical with regard to access to TB and MDR-TB treatment in the penitentiary system in Donetsk, as the Médecins Sans Frontières programme left at the demand of the new authorities. The area may soon face the risk of another acute treatment interruption and a subsequent regional public health crisis.

Health diplomacy continues to be actively deployed to find solutions to these public health problems. It first consisted of alerting and informing the de facto authorities in Donetsk and Luhansk regions, the Ukrainian Government and the international community of the seriousness and urgency of the situation. It then facilitated the search for possible funding sources to finance emergency support to these regions, which ultimately brought together the Global Fund, UNICEF, WHO, UNAIDS, the Ukrainian Government and Ukrainian nongovernmental partners to set up the mechanism that enables the needs for drug supply to be met for 2017.

Finally, these efforts now also address the Ukrainian Government and the foreign affairs ministries of the Russian Federation, France and Germany (the so-called Normandy

format) to try to put the issue of the funding of expensive medicines for TB and HIV on the agenda of the negotiations in Minsk, Belarus on the future status of the Donetsk and Luhansk regions within Ukraine *(18,19)*.

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10. Russian Federation: multistakeholder collaboration for road safety

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Introduction

Road safety is one of the global public health challenges that cannot be addressed by health-care professionals' decisions alone, but require a multistakeholder approach. Moreover, health diplomacy cannot always be reduced to the diplomatic efforts of health authorities and organizations. Sometimes the activities of other governmental structures, such as the ministry of internal affairs, serve the cause of health. As long measures for reducing road accidents count as primary prevention, the political promotion of such measures should be viewed as health diplomacy. This chapter shows how the efforts of non-health ministries improve the health sector's positions and represent the health diplomacy approach.

The problem of road safety is probably as old as transportation systems, but the enormous growth of the vehicle-to-population ratio in the beginning of the 21st century, followed by the dramatic increase of car accidents with human losses, brought the question to the fore of the agenda of the United Nations. WHO's 2004 report on preventing road traffic injuries *(1)* directed countries' attention to the issue and advised action. This was the start of high-level diplomatic collaboration for road safety. Action by countries preceded this process, however, and included internal actions for road safety and efforts to place the issue on the international agenda.

Action in the USSR (1970–1990)

In Soviet times, road safety was considered a problem for the Ministry of Internal Affairs. In the middle of the 1970s, when the problem of road safety first came to notice, a governmental commission was established, chaired by the Ministry. It created a network of regulations, guidelines and institutions for road safety, including some facilities focused on health care. As nearly half of the drivers in the USSR were professional operators, these institutions focused on creating a basis for psychophysiological tests and functioning. The network also included some international information exchange, mostly with eastern countries but also with the United States of America. Up to the 1990s, the system worked effectively, although road use was growing.

In this period, road traffic crashes were not considered a problem of the health sector, so health diplomacy efforts were restricted to creating the general standards for medical care for injuries. Health professionals did this job themselves, and the work was coordinated by the health ministry's chief specialists, who were the directors of leading institutions for trauma and emergency care. These institutions acted as a contact point through which health-care institutions exchanged data, shared experience at international level and, in collaboration with ministry officials, developed national standards for clinical care.

Achieving federal recognition (1990–2005)

During the 1990s, the former system was largely deconstructed, and problems with road safety emerged. The vehicle-to-population ratio rose from 5.5 per 1000 people in 1970 to 132.4 per 1000 in 2000, and the number of crashes followed suit *(2)*. Between 1997 and 2003, the ministries of health, internal affairs and transport developed numerous programmes to prevent road accidents but, owing to the lack of centralized financing and sufficient collaboration among stakeholders, the situation worsened, with deaths rising to 28.7 per 100 000 population *(2)*.

The Ministry of Internal Affairs, analysing the problem, understood that the situation required a multidisciplinary approach involving specialists and authorities from the police, health care, construction and the automobile industry, as well as federal funding and general assistance from the regions and republics of the Russian Federation. Securing these conditions required the problem of road safety to be raised at a higher level of government administration, with the subsequent creation of a national document. To attract attention, actions were taken inside the country and in the global arena to increase the number and scope of information sources about road safety that were aimed at the highest levels of the national Government.

Internal actions focused mostly on forming a more detailed and conclusive reporting system for road safety. This meant improvements of internal governmental reporting lines and the creation of information resources for civil society, which has political influence through channels other than federal ministries. Collaboration between the ministries of internal affairs and health helped greatly in preparing for diplomatic action, as the latter played a crucial role in gathering health statistics. This work also laid the foundation for the further development of a common vision of road safety.

Diplomatic actions were the most interesting part of this levelling-up of road safety. They pursued a number of goals: to involve the influential Ministry of Foreign Affairs in collaboration for road safety, to create a supragovernmental basis for action, and to involve various international organizations and NGOs in road safety projects in the Russian Federation. The crucial element of this diplomatic effort was the collaboration of the ministries of internal affairs and foreign affairs to make a significant Russian contribution to the first two United Nations General Assembly resolutions on road safety in 2003 and 2004 *(3,4)*.

Their adoption had two main consequences. First, they drew the attention of top governmental echelons, leading to the session of the national Council Presidium in 2005 that directly sanctioned the Governmental Commission on Road Safety. Second, the 2004 resolution *(4)* invited WHO to become a coordinator for road safety issues within the United Nations system. This decision greatly increased the involvement of the health sector in road safety; traditionally, WHO's mandate in the country limited its scope of governmental counterparts to the Ministry of Health.

Federal programmes for road safety and the Moscow ministerial conference

Owing to the growing number of road accidents, some comprehensive programmes were designed between 2003 and 2006 *(5)*. Though quite limited, their effect (a 4.6% reduction in fatal automobile accidents), alongside growing road traffic, prompted the federal Government to create the first federal programme on road safety for 2006–2012.

To create the programme, a common vision of road safety had to be established. The Ministry of Health and WHO took the initiative, issuing a number of statements that the Ministry of Internal Affairs accepted completely. They first agreed that road safety is a problem of public health, having a direct impact on the population. Next, the two ministries revised the definitions of injury and death following road crashes, leading to the generation of statistics comparable with those of other countries. Finally, both agreed on a mechanism for future cooperation: the Ministry of Internal Affairs, as a traditional coordinator of road safety, would continue in this role during the federal programme, while the Ministry of Health, assisted by WHO, would coordinate the integration of global experience into the national road safety agenda.

Integration of national road safety programmes with the global experience began in 2010 when a four-year pilot project for road safety was launched in two territories in the western part of the Russian Federation by a consortium of international partners – including WHO, John Hopkins University and the Global Road Safety Partnership – with the ministries of internal affairs and health *(6)*. Bloomberg Philanthropies provided financial support. As part of the global Road Safety in Ten Countries Project, it addressed three risk factors by improving road safety legislation and its enforcement, and changing road users' behaviour through social marketing campaigns. An important and novel part of the

project was a monitoring and evaluation tool that allowed the use of direct indicators of users' behaviour and state statistics from the ministries of internal affairs and health. The project's interventions included a package of general measures addressing the three main risk factors, intended to increase the use of seatbelts and child restraints and decrease the number of drivers exceeding the speed limit.

The results of the programme included changed road users' behaviour and improved intersectoral collaboration. The main challenges were the insufficient involvement of the health sector, and the limited number of risk factors for crashes and injuries addressed (for example, drink–driving was not included). This led to the subsequent inclusion of a number of the first programme's provisions into the newly developed federal programme on road safety for 2013–2020.

Both federal programmes had mixed budgets – with federal, regional and extrabudgetary allocations – amounting to about US$ 1.5 billion for 2006–2012 and US$ 1 billion for 2012–2020. Nearly half-and-half funding by federal and regional budgets proved to be an effective way to actively involve regional governments in implementing the federal programme. This even encouraged some regions to create their own subprogrammes, making an additional contribution to the federal programme's results. On the other hand, many regions that could not afford co-funding were prevented from joining the federal programme.

The growing integration of the national and global contexts, which culminated in the First Global Ministerial Conference on Road Safety held in Moscow in 2009, helped to further the development of the topic in the Russian Federation. The Conference adopted the Moscow Declaration, which invited the United Nations General Assembly to declare a Decade of Action for Road Safety 2011–2020.

Today, collaboration between the ministries of health and internal affairs continues. They agree that road safety is a public health problem at federal and regional levels. Now the task is to preserve the balance of power created and ensure leadership in this field by WHO and the Ministry of Health.

Issues and challenges

Every year, the new budget gives life to numerous federal and regional subprogrammes for road safety, making it almost impossible to mention them all. This chapter mentions the most challenging projects to show a variety of aspects of road safety.

Network of emergency medical response

The country has a particular road profile, with long roads running through almost uninhabited regions with a scarce medical network, including on-road ambulance stations, and an extensive use of aeromedical units. This required the creation of a medical network that can effectively assign sufficient numbers of ambulances, choose the best hospitals and identify the ways to get to them.

By 2006, the network had begun its work. The logistical scheme includes: three levels of health-care facilities (from a minimally equipped level III to a highly specialized level I) organized to fully cover all critical zones of road accidents; a trauma assessment tool; and a navigation system that directs the ambulance, either a road vehicle or a helicopter, to an appropriate trauma centre by the shortest way. This required fruitful multistakeholder

teamwork among health-care facilities managed by different ministries (such as the ministries of health and emergency situations), operators of the satellite communication system and regional governments. This result was achieved because the provisions for such a network were issued by the Governmental Commission for Road Safety.

Tightening control over drink–driving

Drink–driving is a major risk factor contributing to injuries, including from road crashes, in the Russian Federation. The Ministry of Internal Affairs took significant measures to strengthen the legislation on drink–driving and its enforcement, and to decrease the availability of alcohol products in the shops, depending on the time of day and age of customers. The current legislation on drink–driving has a blood–alcohol concentration (BAC) below 0.016 mg/L, which is equivalent to 0.03 g/dl, for the general population, without special levels for novice drivers. The international recommendation is for a BAC not higher than 0.05 g/dl for the general population and 0.02 g/dl for novice drivers. Still, the general BAC level is lower than those in many European countries, and enforcing the law is the major challenge. The latest survey in the WHO European Region shows a significant decrease in alcohol-attributable deaths in the Russian Federation, confirming the effectiveness of multisectoral measures *(2)*; these results correlate to the data from road traffic police on road crash injuries and deaths related to drink–driving.

Measures against drivers using drugs

Although a substantial number of road accidents result directly from drug use, screening measures are limited for several reasons. First, a very wide list of modern drugs is used to address clinical disorders, greatly complicating the education of police and health-care personnel. Second, so far, no quick, sweeping tests have been available that show when drivers are under the influence of drugs and that can effectively be used by police at road posts. Third, the law in this area is poorly elaborated, forming the same legislative pressure on drink- and drug-using drivers. In this situation, one global health problem interacts with another, and combating drug abuse was considered the primary aim.

Improving safe pedestrian behaviour

Although drivers are legally accountable for most crashes involving pedestrians, unsafe behaviour by pedestrians, particularly children and young adults, accounts for many injuries. Significant efforts were made to improve the road infrastructure, ensuring lower driving speed in urban areas, and to improve road safety legislation and its enforcement. Preventive activities also included mass media and social marketing campaigns, special training sessions in driving schools and enforcement actions aimed at the safety of child pedestrians.

The Ministry of Internal Affairs implements special actions, mostly in summer, when the number of accidents involving child pedestrians is especially high. Continuous education for safe road behaviour, carried out from kindergarten to the end of school, is intended to teach young people the responsibility of pedestrians to observe traffic regulations.

Expansion of use of non-motorized vehicles

The use of non-motorized vehicles, especially bicycles, can dramatically reduce the incidence of road accidents in cities, but WHO reports estimate that cyclists have high risks of injury and death. Thus, encouraging bicycle use requires a considerable number of cyclists and a city environment that is safe for them.

Action to promote cycling has not been launched at national level but has begun in big cities. Despite huge numbers of cycle lanes and a bicycle-sharing system in Moscow parks

and streets, cycle paths had no specified legal status until 2015. Now, a new regional law requires a special driving regime for these lanes, giving special priority to cyclists, although it is too soon to evaluate the effect of this measure.

Evaluation of programme results

There can be substantial controversy over evaluating results, even within a single programme. While some measures – such as the use of seatbelts and child restraints, or drink–driving restrictions – are considered undoubtedly to have independent results, statistical sources mostly provide health-care data on mortality, morbidity and injury severity.

Two types of difficulties result in a preference for surrogate endpoints. The first is associated with differences in classifications of the severity of road injuries used by different clinics and ministries. Developing new universal standards for clinical care that are coherent with statistical definitions of the Ministry of Internal Affairs is expected to solve this problem.

The second problem occurs mostly at regional level, where statistics include those involving drivers from other regions and crashes on federal roadways. This leads regional governments to switch reported endpoints to more personalized trial data from local scientific investigations. A new reporting system, with far more detailed data, will be implemented to solve this problem.

Conclusion

Health diplomacy to prevent injuries and deaths from road crashes in the Russian Federation helped to increase the effectiveness of road safety measures. It has developed through cooperation within government and at global level. These two lines of work are effective in themselves, but also complement each other's political efforts. In the Russian Federation, health diplomacy supported the considerable involvement of non-health sectors, showing once again the invaluable role of interstakeholder cooperation on such complex problems.

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11. WHO: health in climate-change negotiations

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Introduction

The climate system is unequivocally warming, and many of the observed changes since the 1950s are unprecedented over periods of decades to millennia. Human activities have contributed to changing the climate, and this change is much more rapid and dangerous than previously thought. Throughout the 21st century and beyond, governments and societies' near- and longer-term choices on reducing greenhouse gas (GHG) emissions (mitigation) and preparing for and managing the current and projected consequences of a changing climate (adaptation) will affect population health and well-being. This chapter briefly describes the health aspects of climate agreements, the current situation and next steps.

Health diplomacy aspects in climate agreements

The United Nations Framework Convention on Climate Change is a legally binding multilateral environmental instrument, and associated discussions are held within the international rules of diplomacy. Member States that ratified the Convention are the Parties to it, while other entities (such as United Nations agencies and NGOs) are

observers. Only representatives of Member States to the Convention or its bodies can propose text or negotiations dealing with health. The main representatives from countries to the Convention come from environment ministries, although ministries of foreign affairs, financing and interior have had a stronger presence in recent years. Countries normally negotiate their positions individually or as a group, such as the EU. Health ministers and ministries do not normally represent their governments at the negotiation table. To promote health in climate-change negotiations, health ministries, or civil society or interest groups, therefore need to lobby their countries' representatives to the Convention or work indirectly through observer organizations such as WHO.

At the 1999, 2004 and 2010 sessions of the WHO Regional Committee for Europe and in the 2008 World Health Assembly, representatives of health ministries agreed on increased action on climate change and health. To highlight the health consequences of climate change, WHO called for action on the issue on World Health Day, 7 April 2008. In 2010, WHO established an informal group called the Friends of Public Health, composed of volunteers from national delegations and other participating organizations, to participate in open and non-binding discussions on health within the negotiations on implementing the United Nations Framework Convention on Climate Change.

United Nations Framework Convention on Climate Change

The Convention was adopted at the United Nations Conference on Environment and Development (the Earth Summit) in Rio de Janeiro, Brazil in 1992 *(1)*. All Member States in the WHO European Region and the EU ratified the Convention. The Parties to the Convention agreed to protect the climate system for the benefit of present and future generations of humankind, on the basis of equity and in accordance with their common but differentiated responsibilities and capabilities.

The Convention mentions health in two important articles *(1)*: Article 1 notes that climate change has adverse effects on human health and Article 4.8 asks Parties to consider public health in "their relevant social, economic and environmental policies and actions" for mitigation and adaptation and "employ appropriate methods, for example impact assessments, formulated and determined nationally".

Under the Convention, the Nairobi work programme on impacts, vulnerability and adaptation to climate change, established in December 2005, facilitates and catalyses the development and dissemination of information and knowledge that would inform and support adaptation policies and practices. In August 2016, the programme launched a call in the area of impacts on human health. This was the second formal call for case studies on health since the Convention was adopted; the first, in 2003, was on tools and methods and the second focused on examples of best practice. Thirty WHO Member States in Europe submitted the information (the 28 EU countries, Serbia and the former Yugoslav Republic of Macedonia). Results were discussed during the Conference of the Parties in Marrakesh, Morocco in November 2016. Submissions by Parties would be summarized in a synthesis report in 2017 and submitted for further action to the next Conference of the Parties, in Bonn, Germany in November 2017.

Parties to the Convention report on progress every five years through national communications that take account of action at national level to reduce GHG emissions and to adapt. Considering that most of the representatives to the Framework Convention are not health professionals, WHO has started to develop national country profiles. These began in the WHO European Region and are now developed globally. The climate and health country profiles *(2)* provide relevant and reliable country-specific information about the current and future effects of climate change on human health, the opportunities for health co-benefits from climate-mitigation actions and current policy responses from countries. They aim to empower health ministers and other decision-makers to engage, advocate and act for health in national preparations for the negotiations and reporting mechanisms of the United Nations Framework Convention on Climate Change. In addition, they form the basis for longer-term priorities, research, and implementation and monitoring of health and climate activities. As the promotion of the country profiles has started only recently, their impact on the implementation of, and reporting on, multilateral climate agreements has not yet been evaluated.

The Paris Agreement

The Paris Agreement *(3)*, reached in December 2015, reflects a changing landscape in international climate policy by focusing on implementation to:

> … strengthen the global response to the threat of climate change, in the context of sustainable development and efforts to eradicate poverty, including by holding the increase in the global average temperature to well below 2 °C above pre-industrial levels and pursuing efforts to limit the temperature increase to 1.5 °C above pre-industrial levels, recognizing that this would significantly reduce the risks and impacts of climate change.

Its preamble acknowledges "that Parties should, when taking action to address climate change, respect, promote and consider … the right to health" *(3)*.

Nationally determined contributions

The main instrument in the Agreement is the so-called nationally determined contributions, which spell out amounts of GHG reductions by country, or groups of countries, such as the EU. The Agreement establishes binding commitments by all Parties to prepare, communicate and maintain nationally determined contributions and to pursue domestic measures to achieve them, as well as measure and report them. The threshold for entry into force of the Paris Agreement was achieved on 5 October 2016 and the Agreement entered into force on 4 November. After its ratification, countries are asked to report every five years.

Climate scenarios show that for the likelihood of limiting the increase in global mean temperature to 2 °C, global GHG emissions would need to be lowered by 40–70% (compared with 2010) by mid-century *(4,5)*. To pursue the full decarbonization pathways will require significant stronger efforts than those so far announced *(5)*. WHO European Member States have committed to making a 43% reduction in GHG emissions by 2030, compared to 1990. Reductions primarily target the sectors mentioned in the Agreement: power, transportation, buildings and industry.

Before the Conference of the Parties in Paris in December 2015, 189 Parties submitted their intended nationally determined contributions, covering about 99% of all emissions.

Most of these build on Convention reporting guidelines, which require Parties to inventory emissions and removals from five mandatory sectors: energy; industrial processes and product use; agriculture; land use, land-use change and forestry; and waste. While the Convention asks Parties to consider the health effects of mitigation measures, reporting on these is not mandatory.

Of the 189 submissions, 124 intended nationally determined contributions mention health, mainly in relation to adaptation to climate change *(6)*. Fifty-two European Member States made such submissions, but only 10 of the countries (19% – Armenia, Belarus, Georgia, Israel, Kyrgyzstan, Monaco, the Republic of Moldova, Serbia, Tajikistan and Turkmenistan) refer to health in the adaptation section.

The Republic of Moldova had the most detailed consideration of needs and responses for health adaptation. The submission by the EU, a Party to the Convention, focused on mitigation only in key economic sectors, which explains the relatively low representation of health in the intended contributions submitted.
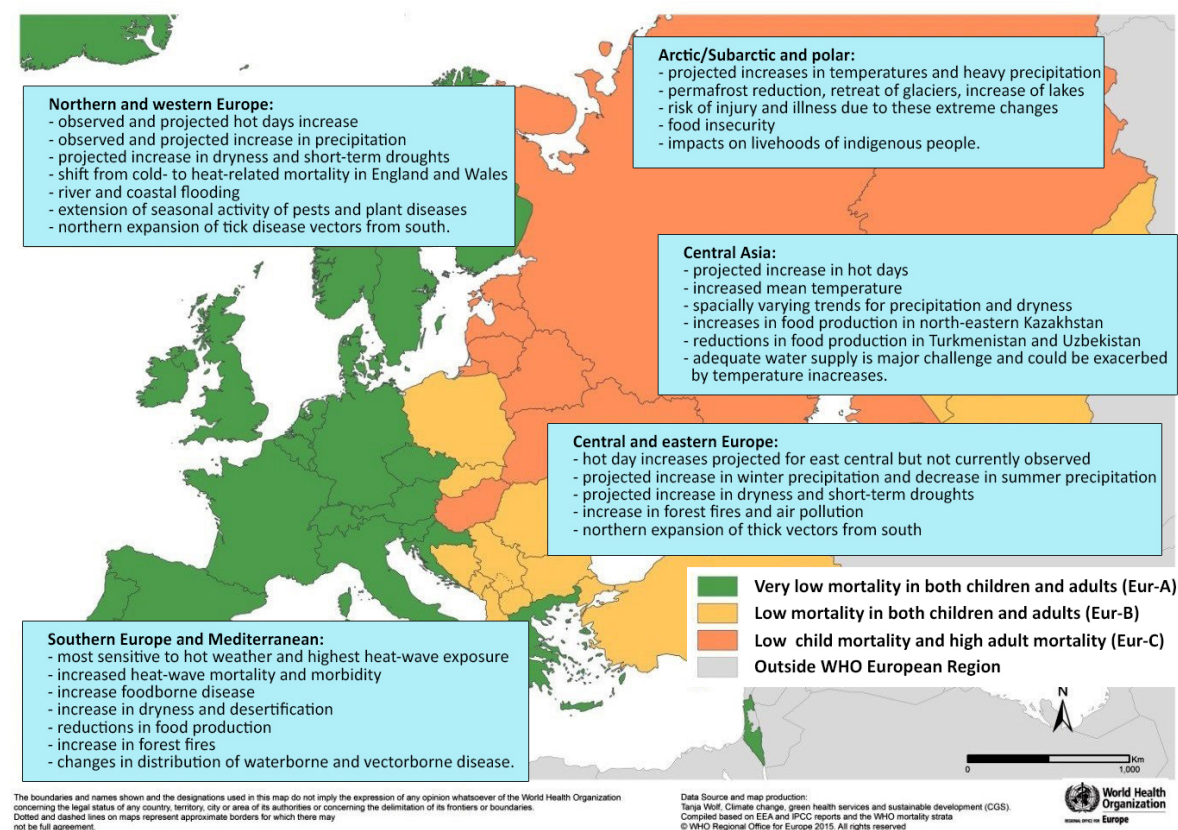
Adaptation

The Paris Agreement *(3)* also calls on countries for significantly stronger adaptation efforts – through cooperating at regional level, enhancing adaptive capacity, strengthening resilience, reducing vulnerabilities and increasing the understanding and implementation of adaptation actions – to contribute to sustainable development and ensure an adequate adaptation response. National adaptation plans should be based on assessments of effects and vulnerabilities related to climate change, taking account of vulnerable people and places, and include monitoring, evaluation and learning systems. The Paris Agreement also significantly enhances the Warsaw International Mechanism on Loss and Damage. In 2013, the Conference of the Parties under the Convention established the Warsaw International Mechanism for Loss and Damage associated with Climate Change Impacts *(7)* to address loss and damage associated with the effects of climate change, including extreme and slow-onset events, in developing countries that are particularly vulnerable to adverse effects.

Fig. 11.1 shows the projected risks, identified vulnerabilities and projected health effects of climate change, by the number of countries that reported findings *(8)*. These important assessments provided evidence for the development of national adaptation strategies and regular national communications to the Convention, and/or served to attract government attention to the prevention of specific risks, such as heatwaves or emerging infectious diseases.

European countries are at different stages of preparing, developing and implementing adaptation strategies or action plans *(9)*. Of the 53 Member States in the WHO European Region, 32 have developed multisectoral national assessments of climate-change vulnerability, impact and adaptation. Twenty-four have developed multisectoral national adaptation plans or strategies, 22 of which address human health among their priorities (Fig. 11.2) *(10)*. The inclusion of health depends on the magnitude and nature of the observed health effects, the assessment of current and future vulnerability, the capacity to adapt and the willingness to act. In the WHO European Region, most health-adaptation interventions to date have focused on improving current public health functions to better

Fig. 11.1. Climate-change exposures relevant to human health in the WHO European Region

Source: adapted from van Oldenborgh et al. *(8)*.

manage adverse health outcomes from climate variability, such as enhancing surveillance and monitoring programmes, improving disaster risk-management and facilitating coordination between health and other sectors to deal with shifts in the incidence and geographic range of diseases. So far, long-term strategies or short-term planning in the health sector rarely takes account of climate information. Ten European Member States developed health-specific national or subnational adaptation plans *(10)*. The inclusion of health-specific actions in the adaptation plans is important to attract national and international financing and identify areas of priority action in government allocation of funds. Significant further support is needed to strengthen health in the development of national adaptation plans, the promotion of their approval by the whole of the government and the evaluation of their effectiveness over time.

Fig. 11.2. Countries that have carried out a vulnerability, impact and adaptation assessment and/or developed national adaptation plans
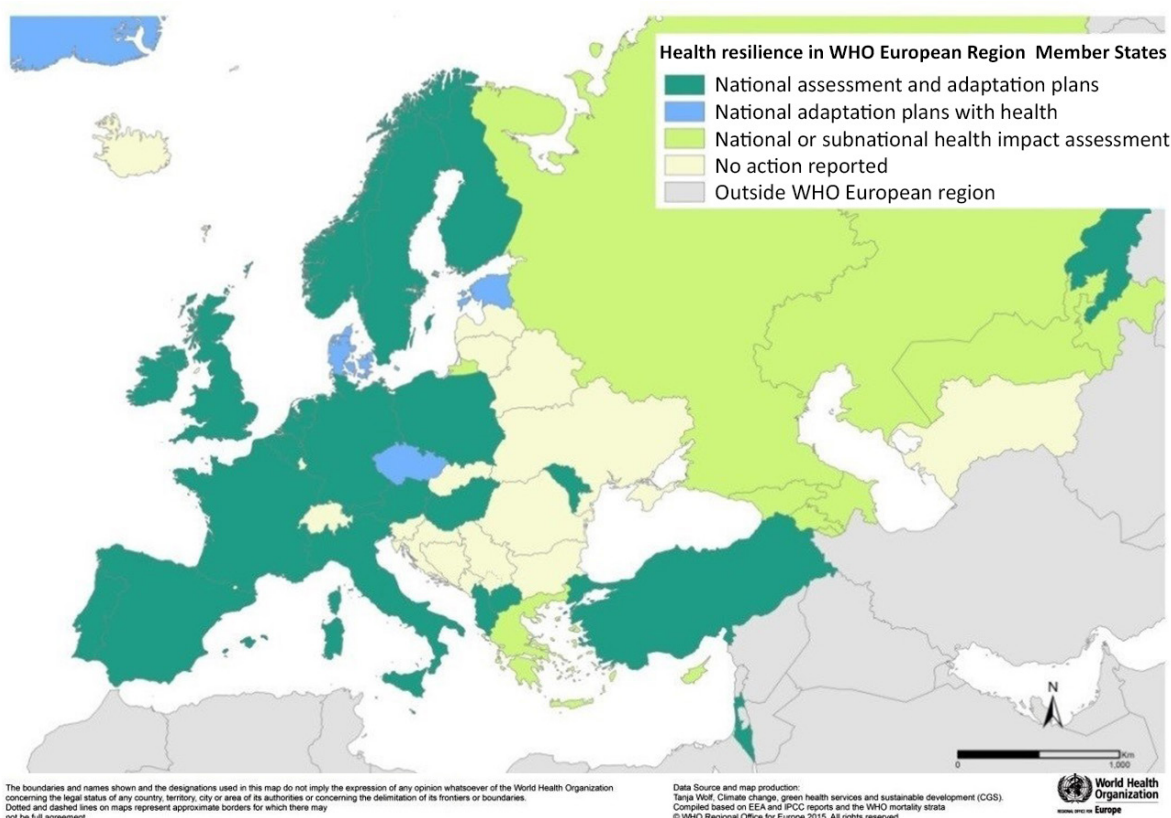
Source: WHO Regional Office for Europe (10).

In April 2013, the EU Member States welcomed an EU strategy on adaptation to climate change *(11)*. Aiming to make Europe more climate-resilient, it focuses on promoting action by Member States, climate-proofing action and better informed decision-making. The development of the strategy was accompanied by a staff working paper from the Directorate-General for Health and Food Safety *(12)* that outlined a range of options to adapt in the health sector and was built on the results of the Climate, Environment and Health Action Plan and Information System project coordinated by the WHO Regional Office for Europe.

The strategy is under revision. A scoreboard to measure indicators of adaptation implementation strategies was proposed for 2017. The European Climate Adaptation Platform (Climate-ADAPT) *(13)* was set up in 2010 to help countries with adaptation measures and continues to be made available and updated. Mainstreaming climate-change health issues into EU environment policies continues, and further efforts will be made to look for political opportunities.

At subregional and subnational levels, pilot projects have been conducted to strengthen health systems to adapt to climate change *(14)*. The largest of such projects, funded by the International Climate Initiative, has been the seven-country initiative on strengthening health systems to adapt to climate change. It provided a firm foundation for future action, giving examples of the priorities, challenges and emerging solutions utilized by the seven countries involved in the project (Table 11.1) *(15)*.

A review of 14 health adaptation projects in LMICs, including six in WHO European Member States (Albania, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan and Uzbekistan), highlighted that multisectoral collaboration was key to success and that *(16)*:

> effective projects had a clear vision of how the adaptation project fit within country development goals and had strong country ownership; focused on the policies and measures that need to be achieved to facilitate a country's vision of what being adapted to climate change would look like; already had capacity in climate change and health or built it before project implementation was initiated …

Table 11.1. Strategic action in seven countries, proposed in their national adaptation plans, grouped according to the WHO European regional framework for action to protect health from climate change

Country	Activity				
	Health in other policies	Strengthen health systems	Raise awareness	Greening health systems	Research, information, data
Albania	Increased coordination between sectors and stakeholders Integration of health into national emergency planning	Development of extreme-weather health action plans Improved management of health problems caused by exposure to pollen, ultraviolet radiation and extreme heat/cold	Education of health professionals Media campaigns	Introduction of energy efficiency and innovative green technology in the health sector	Development and adaptation of environment and health information systems (such as air-quality monitoring) Development of integrated surveillance systems (such as weather, invasive species, diseases and environmental pollution)
Kazakhstan	Strengthening health-sector engagement in emergency planning and developing health-focused cross-sectoral plans	Integration of climate change into health policy Strengthening of environmental health, laboratory and primary health-care services Development of extreme-weather health action plans (such as for floods, mudslides, dust storms and heatwaves) Adequate staffing and resources in priority areas Increasing health infrastructure resilience to extreme weather events	University CV development Media campaigns Health information to other sectors	Introduction of plans for energy efficiency, and waste and water management safety into health systems Resource security during extreme weather events Climate-proofed technologies	Monitoring of air, water, food quality and population nutrition status Research on health and climate change Strengthening of integrated surveillance of climate-sensitive diseases (water- and vectorborne diseases)

Table 11.1 contd

Country	Activity				
	Health in other policies	Strengthen health systems	Raise awareness	Greening health systems	Research, information, data
Kyrgyzstan	Strengthening of health sector's engagement in emergency planning for extreme weather events Development of cross-sectoral plans	Integration of climate change into health policy Strengthening of environmental health, laboratory and primary health-care services Development of early warning and action plans for extreme weather events (such as floods, mudslides, dust storms and heatwaves) Strengthening of NCD prevention (particularly respiratory/cardiovascular diseases and injuries) Adequate staffing and resources in priority areas Increased health infrastructure resilience to extreme weather events	Integration of training on climate change and health into undergraduate and postgraduate programmes Development of communications plans for other sectors and the general public	Energy efficiency, safe waste and clean water in health care Resource security during extreme weather events Technology transfer	Monitoring of air, water, food quality and population nutrition status Research on health and climate change Strengthening of surveillance of climate-sensitive diseases (water- and vectorborne diseases
Russian Federation (northern pilot region)	Promotion of interagency cooperation to develop and strengthen prevention and mitigation efforts Coordination of activities with Ministry of Civil Defence, Emergencies and Disaster Relief, the emergency medical centre, emergency ambulances and fire departments	Strengthening of health services (such as environmental, laboratory, public health and primary health-care services) and equipment supply (in rural areas, for example) Development of extreme weather action plans and early-warning systems (such as for heatwaves) Optimization of NCD prevention (such as encouraging healthy lifestyles) Resource assistance to social isolation units (such as pretrial detention centres, colonies, boarding schools and nursing homes) and children/adolescents	Postgraduate education of the health workforce Training of paramedics, homemakers, police, teachers, veterinary specialists, postal workers, transport workers and pharmacists Education of the general public through the mass media and training on emergency medical aid	–	Improvement of data collection, recording and processing Research on health and climate change Surveillance of climate-sensitive diseases (such as water- and vectorborne diseases)

Table 11.1 contd

Country	Activity				
	Health in other policies	Strengthen health systems	Raise awareness	Greening health systems	Research, information, data
Tajikistan	Measures to improve the legal framework of health-sector action in line with the ratified Convention	Integration of climate change into the national council of health's workplan Improvement of the quality of public health and health-care services (such as wastewater treatment and water-loss minimization) Improvement of regulatory/legal services, logistics support, resource availability and emergency management for hospitals, primary health-care centres and the state epidemiological service Optimization of reproductive health care Strengthening of NCD management (such as respiratory/cardiovascular diseases) Institutional and technical capacity for adaptation issues Development of comprehensive programmes to prevent waterborne diseases Early warning systems for extreme weather	Training of health professionals in the use of geographic information systems, environmental impact assessments, water use and ecosystem conservation Education of the general public about climate change, NCDs, water safety, reproductive health and communicable diseases Involvement of the mass media to aid education delivery	Sustainable health-care systems Training of staff in mitigation activities	Improvement of forecasting, modelling and early-warning systems Development of a research agenda Monitoring of infectious and non-infectious diseases (such as nutritional status in children and young women, waterborne diseases, food security) Development of occupational health guidelines for extreme heat and cold
The former Yugoslav Republic of Macedonia	Establishment of an intersectoral body for effective/efficient use of resources Improvement of coordination between institutions Improvement of urban planning (such as to reduce urban heat-island effects)	Early-warning and management systems for extreme weather conditions (such as heatwaves, air pollution, cold weather, floods and fires) Increased prevention and control of allergic diseases caused by pollen Reduced risk of climate-change-associated communicable diseases (including strengthening the IHR) Health system preparedness (such as for heat- and coldwaves)	Introduction of climate-change-related modules into undergraduate and postgraduate health curricula Regular public education campaigns	Energy-efficiency measures in health institutions	Continuous and regular monitoring of environmental risks (such as heatwaves and air pollution) Promotion of functional sharing of data and information

Table 11.1 contd

Country	Activity				
	Health in other policies	Strengthen health systems	Raise awareness	Greening health systems	Research, information, data
Uzbekistan	Development of national capacities and interagency cooperation	Development of early-warning systems and response plans for extreme weather events Optimization of NCD management (such as by educating health professionals/general public) Refining of national standards of infectious disease management Improvement of national standards for management of climate-change-related NCDs (such as respiratory diseases)	Raising of awareness of medical staff of health effects of climate change (such as air pollution, cardiovascular/respiratory diseases, allergens and nutrition) Education of patients about healthy lifestyles, nutrition and hygiene Use of mass media to disseminate information Training of specialists to work on adverse climate factors	–	Development of a database on health status, depending on meteorological parameters Facilitation of exchange of knowledge of, and experience with, adaptation and mitigation strategies

Source: Menne et al. *(15).*

Financial flows

The Paris Agreement *(3)* highlights that financial flows should be consistent with a pathway towards low GHG emissions and climate-resilient development. It calls upon the developed countries among the Parties to assist developing country Parties to take the lead in mobilizing climate finance from a wide variety of sources and communicate indicative quantitative and qualitative information on how developing Parties are supported every two years. The financial mechanisms that have been established under the Framework Convention also serve the Paris Agreement.

Climate finance refers to financing channelled by national, regional and international entities for projects and programmes for climate-change mitigation and adaptation. They include climate-specific support mechanisms and financial aid for mitigation and adaptation activities to spur and enable the transition towards low-carbon, climate-resilient growth and development through capacity-building. The term has been used in a narrow sense to refer to transfers of public resources from developed to developing countries in light of their obligations under the United Nations Framework Convention on Climate Change *(1)* to provide "new and additional financial resources" and, in a wider sense, to refer to all financial flows relating to climate-change mitigation and adaptation. The report on the global climate finance landscape shows that US$ 391 billion was spent in 2014 on low-carbon and climate-resilient growth *(17)*. East Asia and the Pacific remained

the largest destinations for climate finance, followed by western Europe. The report notes that "public support is significant but totals less than a third of government subsidies for fossil fuel" *(17)*.

Globally, around 3% of the total project financing by development and climate-financing institutions is currently diverted to health-adaptation projects. A recent seminar on early experiences in multisectoral work on climate change and health for international development, organized by the Nordic Development Fund, the World Bank and WHO in Helsinki, Finland in May 2016, concluded that *(18)*:

> More attention needs to be paid to ensuring that existing financing both for climate change and for health is being used in ways that advance the joint agenda. For example, systematically screening projects being delivered with climate financing for their potential health effects (in a light-touch manner) is consistent with commitments in both the original Convention and the recent Paris Agreement, and is a is straightforward way both to avoid investments that can actually harm health and to better document the impact of multisectoral activities on health. Similarly, introducing a simple climate lens in the preparation of health investments can ensure improve the quality of health programming.

Considering the countries in the European Region and their human development, only one (Tajikistan) is part of the group of less developed countries and is thus eligible to receive major donor funding, while only another 15 are eligible for assistance through the United Nations Development Assistance Framework. This means that in 37 countries, financing on health and climate change comes from regular national or regional budgets. A 2014 survey carried out by the WHO Regional Office for Europe confirmed that most climate and health financing is actually provided by pooling funds from regular health ministry budgets for preventive activities related to climate change and health.

Science

The Paris Agreement *(3)* calls upon the best available science on mitigation and adaptation measures. After 1990, the number of published articles on climate change and health (searched by abstract and title in PubMed) grew steeply from 17 in 1991 to peak at 936 in 2016. This reflects the growing interest in this rather complex subject (Fig. 11.3).

Fig. 11.3. Number of articles in PubMed on climate change and health
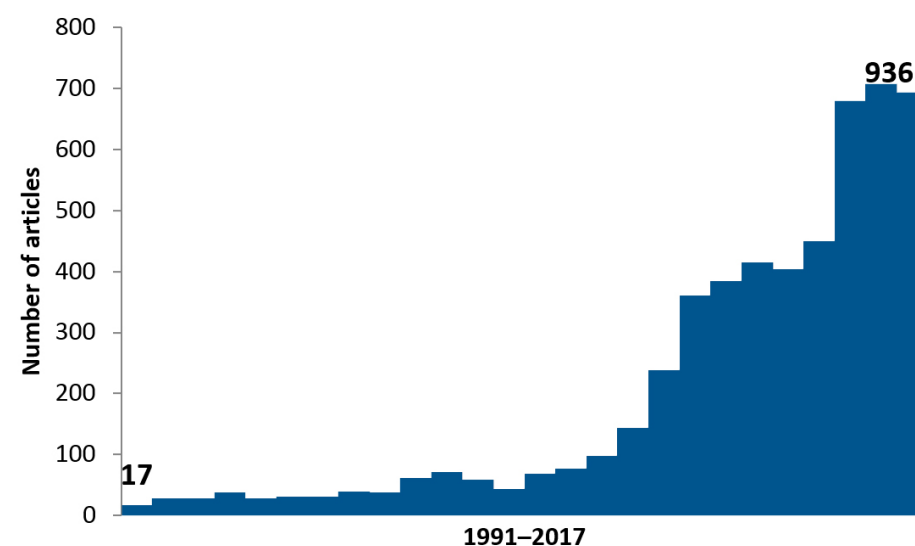
Considerable progress has been made in recent years in building the evidence base, with increasing recognition of the importance of climate variability and climate change for health. Many studies on the effects of weather, climate variability and climate change on health in the European Region are consistent with an increasing level of certainty about known health threats. Exposure to temperature extremes, floods, storms and wildfires affects cardiovascular and respiratory health. Climate- and weather-related health risks from worsening food and water safety and security, poor air quality and ultraviolet radiation exposure, as well as increasing allergic diseases, vector- and rodentborne diseases and other climate-sensitive health outcomes, also warrant attention and policy action to protect human health (19).

The growing number of articles published also leads to a stronger presence of health in the assessments of the Intergovernmental Panel on Climate Change. Its globally approved synthesis reports significantly contribute to advancing action on climate change and health (20–25). The fourth assessment report (26), in 2007, concluded very strongly that: "climate change currently contributes to the global burden of disease and premature deaths. At this early stage the effects are small but are projected to progressively increase in all countries and regions". It also described emerging evidence that "climate change has altered the distribution of some infectious disease vectors, altered the seasonal distribution of some allergenic pollen species, and increased heatwave-related deaths" (26). The fifth assessment report, in 2015, concluded more strongly on the health risks by qualifying some further development, and included for the first time notions on the health effects or benefits of mitigation action, assessed for a variety of productive sectors (27). This is an important step forward towards considering health when taking action to reduce GHG emissions.

In addition, two Lancet commissions examined climate change and health in greater detail (28,29). The central message of the second (28) was: "Tackling climate change could be the greatest global health opportunity of the 21st century". Finally, WHO carried out two global risk assessments. The first concluded that 150 000 deaths from four causes were attributable to climate change in 2000 (30), and the second anticipated around 250 000 such deaths in 2030 (31).

Next steps

Ministerial conferences on environment and health defined the WHO Regional Office for Europe's policy on climate change and health. The statement from the most recent – the 2010 Parma Declaration on Environment and Health (32) – recognized the importance of climate change as a threat to public health in Europe and established six priority objectives. All WHO European Member States and the European Commission declared their commitment to protecting health and well-being, natural resources and ecosystems, and promoting health equity, health security and healthy environments in a changing climate. The European regional framework for action (33), which was welcomed as a blueprint for implementation, has shaped the mandate and areas of contribution of the programme to the environment and health process since 2010. The Working Group on Health in Climate Change, with representatives from 33 countries and five organizations, was established to help support and coordinate the implementation of these objectives in Member States.

Climate variability and change will further affect population health and well-being in Europe. The implementation of the commitment to act in the Parma Declaration (32) is

unfinished in the areas of reduction of GHG emissions, adaptation and health systems' resilience to climate change, financing, awareness-raising, monitoring and accountability. In preparation for the Sixth Ministerial Conference on Environment and Health, to be held in June 2017, Member States identified climate change as a threat to public health in Europe, proposing it as a continuing priority commitment.

The Paris Agreement (3) provides a critical opportunity to advance public health in response to climate change. Further, the United Nations Framework Convention on Climate Change (6) is strongly supported by the 2030 Agenda for Sustainable Development (34), which acknowledges that it "is the primary international, intergovernmental forum for negotiating the global response to climate change" and contains SDGs that specifically address health (SDG 3) and climate change (SDG 13: Take urgent action to combat climate change and its impacts), and goals and targets across many sectors and settings with the ultimate aim of saving the planet and the environment in which people live. As such, it provides specific entry points to support action to protect and promote health– through increasing health resilience to climate risks, improving global health status, prioritizing mitigation actions that benefit health, and pushing for the health sector to become less carbon-intensive and more environment-friendly. Tackling climate change and fostering sustainable development are two mutually reinforcing sides of the same coin; sustainable development cannot be achieved without climate action and a healthy population. Conversely, many of the SDGs address the core drivers of climate change. Today, improved health does not depend on accomplishing SDG 3 only; many others have a significant health dimension. Given the diversity of country contexts, SDG implementation will naturally take different shapes across and within countries (at national, subnational and local levels) and ultimately determine national and local adaptive capacity.

As Member States develop their next nationally determined contributions and/or national communications, more European countries will need to highlight priority sectors for intensified action for adaptation. Ensuring that these priorities include good health and well-being for all at all ages is the responsibility of the whole of government and whole of society at national and subnational levels. A range of actions is proposed to achieve these aims.

Major progress has been made, but many more efforts are needed fully to eradicate a wide range of diseases and address many persisting and emerging health issues. In other words, increasing health and well-being is a means of increasing population adaptation. Additional adaptation measures will be required to tackle specific climate-change risks, such as health effects from extreme weather events.

Overall, this requires considering the inclusion of weather and climate considerations into health programming and action. Further, going beyond a silo approach to health requires strong partnerships with other sectors in society. Understanding and planning for the risks require capacity. Creating this will in turn require considerable investment in the training of health and other professionals. Evidence is necessary, but not always sufficient, if not known beyond a specialized audience. Core capacity to communicate on climate change and health is required.

Achieving national commitments to reduce GHG emissions will need to involve all sectors of society, including the health sector and health systems. Health systems can take a lead in showing the importance of emission reductions for future generations. The health sector can quantify the significant health benefits of mitigation policies and technologies, such as reducing emissions from car exhausts and promoting active transport. Increasing understanding of these benefits, including how they reduce significantly the costs of mitigation, can further motivate action. Hospitals and health systems, particularly in more

industrialized settings, account for around 10% of the gross domestic product and are responsible for 5–15% of carbon emissions, representing a significant carbon footprint *(29,35)*. Energy efficiency, the shift to renewables, and greener procurement and delivery chains can improve services and business continuity, cut carbon emissions and improve the climate resilience of health systems *(36).* In addition, the health sector and its facilities can adopt basic measures to reduce their overall environmental impact through, for example, reducing toxic waste, using safer chemicals and purchasing eco-friendly products. Green policies overall can yield substantial cost savings.

The health sector must lobby for or encourage specific action beneficial to health, such as cities that support and promote healthy lifestyles for the individual and the planet, a strong, predictable and international carbon-pricing mechanism, access to renewable energy, low-carbon healthy energy choices, the empowerment of health professionals to work with other sectors, and investment in climate change and public health research *(29,37)*.

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12. WHO: health diplomacy cooperation with the EU

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Introduction

WHO and the EU share common values and objectives. While the WHO Constitution states that the Organization's objective is the "attainment by all people of the highest possible level of health" *(1)*, Article 2 of the Lisbon Treaty affirms that the EU's aim is to promote "the well-being of all its peoples" *(2)*. Article 168 of the Treaty provides further confirmation, stating that "a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities" *(2)*. Indeed, this latter article set the basis for a concrete and effective health-in-all-policies approach *(3)*.

The partners' mandates vary, however. While WHO has a broad mandate, ranging from strategy development and technical assistance to countries to monitoring of the global health situation and research, the EU has a more restricted one: EU Member States have the main responsibility for health policy and the provision of health care to European citizens.

The European Commission (EC) focuses more on areas where Member States cannot act effectively alone and where cooperative action at community level is indispensable. These include major health threats and issues with a cross-border or international impact, such as pandemics and bioterrorism, as well as those relating to the free movement of goods, services and people. It also includes activities in areas such health technology assessment or strategies to address major risk factors, to be adopted by Member States as appropriate. This mandate has evolved, however. In recent years, owing to the European semester

process *(4)*, the EC has provided non-binding recommendations on the organization, service delivery and financing of health systems. The Expert Group on Health Systems Performance Assessment was set up to compare performance in different countries and share good practices *(5)*.

With this overall political and legal basis, WHO and the EU have developed effective collaboration, interaction and joint work at global, regional and country levels. WHO deals with various EU institutions, such as the EC, the European Parliament and the Council of the European Union. The WHO Representation to the European Union, in Brussels, Belgium plays a facilitating and coordinating role in this collaboration. It closely monitors developments in the EU and ensures WHO input to EU health policies. It also ensures that WHO is aware of the issues discussed and decisions made in the EU institutions, in view of their consequences for the policies of the EU's 28 Member States, which are also Member States of the WHO European Region *(6)*.

Cooperation: institutional developments

Formal cooperation between WHO and the EC started in 1972 and was confirmed by an exchange of letters between the WHO Director-General and the European Communities in 1982. In 1992, a joint statement of intent was signed by the WHO Deputy Director-General and European Commission Directorate-General I (External Relations).

In 2001, WHO, represented by Director-General Gro Harlem Brundtland, and the EC, represented by European Commissioner for Health and Consumer Protection David Byrne, signed and exchanged letters agreeing to strengthen and enlarge the existing collaboration *(7)*. The accompanying memorandum identified the main areas of cooperation, including:

- generating, collecting, processing and disseminating data to inform monitoring processes and policy-making;
- developing methods and tools for monitoring and surveillance;
- strengthening surveillance of, and response to, communicable diseases;
- exchanging information and experience on the health effect of agents in the environment;
- promoting research and technological development;
- mobilizing and coordinating resources for health interventions; and
- seconding staff.

In addition to these areas, the letters established the need to organize annual meetings between high-level officials in WHO and the EC to review the progress of work, exchange information, explore future projects and identify events calling for a cooperative effort. These meetings, called senior officials' meetings, have taken place regularly since 2001, and they maintain and expand the dialogue and synergies between WHO and the EU. The senior officials attending include the WHO Director-General and the Regional Director for Europe, and the European commissioners for health, development, environment, humanitarian assistance and other areas, as required by the priorities discussed.

In 2005, the first memorandum of understanding between the WHO Regional Office for Europe and the newly established European Centre for Disease Prevention and Control

(ECDC) was signed *(8)*. Its aim was to strengthen collaboration on communicable diseases, focusing on the following issues: airborne diseases; vaccine-preventable diseases; sexually transmitted infections and bloodborne viral diseases; food- and waterborne diseases, diseases of environmental origin; AMR and nosocomial infections; and travel health. In addition, to streamline data-reporting mechanisms and avoid duplication and overlaps, it was agreed to integrate reporting systems for communicable diseases to secure effective surveillance in the EU. The parties agreed to establish a joint coordination group to review the goals and monitor progress.

A few years later, in 2010, WHO Regional Director for Europe Zsuzsanna Jakab and European Commissioner for Health and Consumer Policy John Dalli made a joint declaration seeking to strengthen policy dialogue and technical cooperation on public health *(9)*. The declaration focused on issues such as health surveillance, alerts and information and collaboration at country level, and noted the need for an integrated and comprehensive information system covering the entire WHO European Region.

In 2015, the WHO Regional Office for Europe and the EC agreed on the objectives, principles and modalities for cooperation *(10)*, to update the content of the 2010 declaration. This agreement, which was announced at the 2015 session of the WHO Regional Committee for Europe, set the principles for cooperation between 2015 and 2019, and stated that progress should be reviewed annually. Areas of collaboration include health security, research and innovation, NCDs, AMR, health inequalities, emerging health threats, health systems and health information. Box 12.1 shows the key institutional milestones of the WHO–EU partnership.

Box 12.1. Key institutional milestones of the WHO–EU partnership

1972 Start of formal cooperation between the EC and WHO
1982 Exchange of letters between WHO and the European Communities
1992 Joint statement between WHO and the EC
2001 Exchange of letters between WHO and the EC concerning the consolidation and intensification of cooperation *(7)*
2005 First memorandum of understanding between the WHO Regional Office for Europe and ECDC *(8)*
2010 Joint declaration of WHO Regional Office for Europe and the EC to strengthen policy dialogue and technical cooperation on public health *(9)*
2015 Renewed agreement between the EC and the WHO Regional Office for Europe *(10)*

As mentioned above and as agreed in the 2001 exchange of letters *(7)*, high-level officials from the EC and WHO held regular meetings, organized in turn by each. The most recent senior officials' meeting took place in February 2015 and was hosted by the EC. The topics discussed included Ebola virus disease, health security, AMR, cooperation in non-EU countries and access to medicines, and the officials reviewed achievements over the last five years *(11)*.

The cooperation between WHO and the EC has not developed in a linear way. The two have built trust and mutual understanding, with significant improvement and acceleration after the 2010 declaration *(9)*. The dialogue between leaders has intensified since 2014 and ensured coordination and complementarity for public health developments within the partners' different remits.

Policy cooperation

WHO has actively contributed to the development of public health policy in the EU through mechanisms including participation in public consultations, ad hoc meetings with relevant EC units, and seminars and events organized by the European Parliament, stakeholders and think tanks, and WHO.

A weekly WHO newsletter, widely circulated and including a critical overview of major health developments in the EU, has played a major role in recent years *(12)*. For example, WHO participated in the strategic public consultation on Europe 2020 carried out by the EC in November 2014. WHO highlighted the relevance of UHC, the role of prevention policies, and the health-in-all-policies and whole-of-government approaches. In 2015, when the implementation plan of the European consensus on humanitarian aid was discussed, WHO underlined the lessons learned from the response to the Ebola epidemic in Africa and the need to look at the long-term strengthening of health systems as an effective mechanism to respond to future issues. Further, WHO and other United Nations agencies submitted a joint response to the EC public consultation on the relationship between the EU and African, Caribbean and Pacific countries in December 2015, underlining the importance of SDG 3 in the implementation of the 2030 Agenda for Sustainable Development *(6)*.

The EC has actively participated in consultation processes initiated by WHO on important policy documents, such as that for the Health 2020 policy framework *(13)*. With the countries holding the EU Presidency, the EC promotes a mechanism to coordinate the input of the 28 EU Member States and associated countries to WHO governing bodies to facilitate a common position on the public health issues being discussed. Although individual countries may take independent positions on particular topics, this mechanism contributes to consensus-building and often accelerates the approval process.

Country and project collaboration

EU delegations in countries cooperate with WHO country offices in promoting public health policies, and the EC and WHO collaborate on projects requiring technical and financial assistance.[11] These projects involve the Directorate-General for Health and Food Safety and other directorates-general, such as those for climate, development and cooperation or research *(14)*. For example, on behalf of the Directorate-General

for Health and Food Safety, the WHO Representation to the European Union conducted the Research Agenda for Health Economic Evaluation project, which identified priorities for research and produced a synthesis of the health-economic evidence on the 10 main conditions responsible for the highest burden of disease in the EU *(15)*. Its conclusions included recommendations to the EC on how to address the identified knowledge gaps.

Further, WHO and EU institutions discuss and advance the EU public health agenda in a number of public fora, such as the Global Health Policy Forum, jointly organized by three EC directorates-general *(16)*. WHO actively contributes to planning and conducting these meetings, with input coming from the Regional Office and WHO headquarters, according to the issue discussed.

Finally, the Directorate-General for Health and Food Safety is an observer at the annual meetings of the Regional Office, the WHO Executive Board and the World Health Assembly.

Case studies

This overall framework of collaboration has been applied over the years to a number of public health issues. The experience has been positive and productive overall, although different perspectives and vested interests and conflicting strategies have sometimes made collaboration and synergy complex and challenging. Examples can be given of both successful results and difficult subjects, including the cases of the Tobacco Product Directive and *trans* fatty acids, which are illustrated in more detail below.

Tobacco policy in the EU: the Tobacco Product Directive

The submission, discussion and approval of the revision of Directive 2014/40/EU (the Tobacco Products Directive) *(17)* is a clear example of the public health achievements the collaboration between WHO and EU institutions can make and the pressures coming from huge vested interests.

The first EC Tobacco Products Directive (Directive 2001/37/EC), regulating the manufacture, sale and presentation of tobacco products, was approved in 2001. In 2009, under pressure from the public health community and following the entry into force of the WHO Framework Convention on Tobacco Control *(18)* in 2005, the EC initiated the revision of the Directive.

The process started in February 2009 with an impact assessment, which lasted until July 2012. The proposal was adopted by the College of Commissioners in December 2012 and the ordinary legislative process began in January 2013. The final text of the Directive was agreed in early 2014 and entered into force on 19 May. The revision was considered "the most lobbied dossier in the history of the EU institutions" *(19)*. The tobacco industry giant Philip Morris International employed more than 160 lobbyists *(20)*; during the discussion and approval of the Directive, the tobacco lobbyists undertook huge outreach activity towards members of the European Parliament and other stakeholders, which was not disclosed *(21)*. This happened despite the provisions of Article 5.3 of the Convention *(18)*, which specifies that Parties should take precautionary measures to protect tobacco policies from industry lobbying. This clearly applies also to contacts between the

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[11] The Financial and Administrative Framework Agreement between the European Community and the United Nations was signed in 2003 and applies to all contribution-specific agreements from that date. It aimed to establish a coherent and mutually acceptable financial framework. This agreement underwent negotiations in 2014/2015 and is updated regularly to comply with new financial regulations of the EC and allow continuous cooperation.

tobacco industry, members of the European Parliament and government officials, but its enforcement was not adequate during the Directive discussion. One of the tobacco industry's main objectives was to soften the content of the Directive on issues such as packaging and additives, and to delay the approval of the Directive as much as possible *(22)*. These efforts were partly successful and translated into an approved text that was weaker than initially proposed, although the Directive introduced important measures strengthening tobacco control in the EU.

WHO actively contributed to the approval process by providing evidence, conducting advocacy and supporting the work of the Directive Rapporteur in the European Parliament. WHO engaged with other active stakeholders in public health, such as the European Public Health Alliance *(23)* and the Smoke Free Partnership *(24)*, keeping pressure on the decision-makers and disseminating data and evidence on sensitive issues such as electronic cigarettes or packaging. This active engagement took different forms, including participation in public hearings, discussions with members of the European Parliament and a proactive use of social media. WHO organized a public health seminar at the European Parliament on World No Tobacco Day, 31 May 2013.

Following the adoption of the Directive *(17)*, WHO continued to follow up the development of a number of delegated acts necessary for its full implementation and to address other decisions related to the Framework Convention on Tobacco Control *(18)*. For instance, WHO used scientific and moral arguments to invite the EC not to extend its agreement with Philip Morris International on financial compensation of the tobacco industry for illicit trade *(25)*. This was linked to participation in, and support of, a number of initiatives to encourage Member States to become full Parties to the Convention's Protocol to Eliminate Illicit Trade in Tobacco Products.

Trans fatty acids – a never ending story

Trans fatty acids are defined by Regulation (EU) No. 1169/2011 as "fatty acids with at least one non-conjugated (namely interrupted by at least one methylene group) carbon-carbon double bond in the trans configuration" *(26)*. They can be naturally present in a few food products in small amounts or originate from industry. Consumption of *trans* fatty acids increases the risk of heart disease, and high intake is a risk factor for developing coronary heart disease *(27)*.

WHO recommends that trans fatty acids should account for no more than 1% of the daily energy intake, which is 2.2 g for an adult ingesting 8368 kJ (2000 kcal). The European food and nutrition action plan 2015–2020 underlines the need for policies to reduce *trans* fatty acid content in food in the European Region *(28)*. In September 2015, the Regional Office published a policy brief on eliminating *trans* fatty acids in Europe *(29)* connected to the Action Plan.

WHO has submitted evidence and data and illustrated the need to drastically reduce and possibly eliminate *trans* fatty acids in food on a number of occasions, including meetings at the European Parliament, scientific conferences and working groups. WHO has also participated in dialogues and discussions with decision-makers at a high level. Overall, EU institutions (the European Parliament and the EC) have supported this proposal, although a number of members of Parliament did not facilitate an effective and rapid decision. By the end of 2015 (a year later than scheduled), the EC issued a report to the European Parliament and the Council on *trans* fats in food and their presence in the diet of EU citizens. It presented the options available to policy-makers for limiting consumption of *trans* fatty acids, outlined the consequences of introducing these strategies and concluded

that a legal limit on industrial trans fatty acid content would be the most effective measure in terms of public health, consumer protection and compatibility with the internal market. The report also announced that the EC intended rapidly to launch a public consultation and carry out a full-fledged impact assessment to allow an informed policy decision to be made in the near future *(30)*.

A number of countries have not supported a rapid decision to ban *trans* fatty acids, despite the solid public health evidence on the effects on health that WHO and other stakeholders have presented. This attitude is possibly linked to pressures from some sectors of the food industry, mostly small and medium-sized enterprises. In contrast, a number of multinational food companies have supported the elimination of *trans* fatty acids *(31)*.

Although there is no EU regulation on the *trans* fatty acid content of food, voluntary agreements are in place in countries such as Belgium, Germany, Greece, the Netherlands, Poland and the United Kingdom. Austria, Denmark, Hungary and Latvia have set limits on the concentration of *trans* fatty acids in products for human consumption. Data from Denmark show a decrease in cardiovascular mortality associated with the elimination of *trans* fatty acids from food sold in the country *(32)*.

Informal council meetings of health ministers of EU countries held in April and September 2015 included exchanges of views on *trans* fatty acids. In the April meeting, the majority of health ministers supported the need to reduce industrial *trans* fatty acids in food products *(33)*. In the September meeting, Member States discussed the issue again, but views continued to differ, which prevents the adoption of a common policy. Some Member States favoured the EU establishing legal limits on *trans* fatty acids on food, and others preferred voluntary reformulation of foods *(34)*.

In October 2016, the EC published an inception impact assessment to limit the intake of industrial *trans* fatty acids in the EU, announcing an open consultation and the establishment of an interservice group to carry out a full impact assessment to be completed in 2017 *(35)*.

The example of *trans* fatty acids illustrates the challenges of translating scientific knowledge into public health action, even when the evidence is unequivocal and indicates a huge benefit for public health. The release of data and policy options by WHO exerted pressure at institutional level within the EC and the European Parliament, which helped these institutions to outline a position and the policy options on *trans* fatty acids, but this has not yet been enough to ensure that Member States would decide to ban or drastically limit their use.

Conclusions

The collaboration between WHO and EU institutions has developed through different mechanisms and formal decisions over the years. This helped the partners synergize actions, share evidence and improve the implementation of public health policies in Member States. The partners' different roles in policy development give each an opportunity to strengthen the other to take public health action. A better understanding of the successes and failures of this partnership could help greatly in improving the timeliness and effectiveness of public health policies in Europe and beyond.

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13. Malta: opportunities of a small state in health-governing bodies – personal reflections of a senior official

Ray Busuttil

There is no clear definition of a small state, although the World Bank and the Commonwealth define it as a sovereign state with a population of less than 1.5 million people *(1,2)*, and the WHO Regional Office for Europe as a state with a population of less than 1 million *(3)*. No matter the definition adopted, Malta's population size would still make it a small state. In international relations, a state's power is often attributed to its population and territorial size, economic status and military capacity. According to such criteria, small states have very little power and are deemed incapable of exerting any real influence on world affairs *(4)*.

Having represented Malta in international forums, primarily WHO and the Commonwealth, for the past 25 years, I am more than convinced that small Member States can not only play an important role in the decision-making process, but can also influence its final outcome. Although small states may be regarded as less powerful and have significantly fewer resources at their disposal than larger countries, they make up for this with superior commitment, backed up by a tightly knit, albeit small, network of domestic institutions. This enables them to have more holistic views and thus be better equipped to contribute to the development of sustainable solutions in global or regional policy development and governance. The role played by small Member States in WHO governance structures manifests this.

Looking at the involvement of small Member States in WHO governance structures, one can see substantial activity. For example, representatives of small Member States have always served on the Standing Committee of the WHO Regional Committee for Europe over the past 20 years and have chaired it over two of the past 10 years. At global level, small Member States comprised four of the representatives of the European Region on the WHO Executive Board over the past 20 years, with Iceland (2004–2005) and Malta (2016–2017) serving as the chair.

Malta as a WHO Member State

Malta has been a very active Member State since it joined WHO in 1965. As one of the smallest Member States in the WHO European Region, it has never been deterred by its size and so-called power, or the lack of it. Malta has always put forward representatives who were experienced and technically competent in their fields; over the years, they have made significant contributions to policy development and the governance of WHO.

On a technical level, Malta has been involved in many WHO programmes, often taking an active part in developing policies and initiatives that have had long-lasting effects on the approach to health promotion and disease prevention. I feel very privileged to have been directly and actively involved in these developments as Malta's representative. While detailing the many initiatives in which I was involved is impossible, I think that two merit a special reference.

Malta was a founder member of the Countrywide Integrated Noncommunicable Disease Intervention (CINDI) programme. I was fortunate enough to take over and revive the CINDI Malta initiative, an experience that allowed me to meet many distinguished people in the field of health promotion and disease prevention. This experiential enrichment allowed me to bring back home innovative ideas and experiences of good practice that helped Malta shape the modus operandi of the then newly established Department of Primary Care and Health Promotion. I shared my experiences with my team in the Department, and Malta's involvement was smoothly maintained when the directorship of the CINDI Malta programme passed to my successor, who remained heavily involved in policy and guideline development and ultimately became one of the authors of the CINDI dietary guide *(5)*. Today, the guide forms the basis of dietary and nutritional advice across the health field.

Malta was also very actively involved in WHO's Expanded Programme on Immunization, with regular contributions to the meeting of programme managers. In the early 1990s, the WHO European Region faced the health impact of the dissolution of the USSR. The Region had to deal with not only the rapid expansion of the number of Member States, but also major changes in the disease burden. These changes required adaptation at organizational and operational levels. In those early years of the expanded European Region, the challenges were great and required concerted action in response. To my mind, those were the years in which the work to eliminate measles and rubella and eradicate polio really started. The regional initiative to increase immunization coverage in all Member States raised awareness of the need to do the same at national level. National information campaigns were aimed at the public and health professionals. The antivaccine lobby in Malta is very small and the vast majority of the medical profession was on board. When it was felt that the public and professionals were adequately informed, radical reforms were initiated that resulted in increasing the national basic immunization coverage from 50–60% to over 95% for diphtheria, pertussis, tetanus and polio.

Having the opportunity to be involved in such major international policy issues presents one with a significant challenge that was initially perceived as a threat. Sitting at the same table and discussing with many more senior and experienced people coming from much larger and more powerful Member States, and perhaps even challenging them, was not easy for a young, relatively inexperienced public health director coming from a miniscule Member State. My initial level of confidence was nonexistent, to say the least. In the first

two or three meetings, I can remember just sitting there observing, listening, evaluating and reflecting on what was said by the more experienced and confident people sitting around the table.

One soon realizes, however, that the basic problem is the same in all Member States; what varies is the context in which that problem presents, the extent of the problem and the capacity of the particular Member State to deal with it. Having the right technical knowledge as background, one soon learns how to make the necessary adaptations from one's national context and come up with potential solutions. This is where I feel coming from a small Member State becomes an advantage. The day-to-day reality in small countries is that resources are scarce and officials often wear multiple hats. This provides them with a much broader view of the health scenario than that of their counterparts from larger countries. This allows small Member States to put forward pragmatic proposals for a solution to a particular problem.

Activities in governing bodies and technical work

Having had experience of the way WHO works at technical and operational levels, and as a result of my promotion to the post of Director-General for Health in Malta, my involvement with WHO moved to the political level. Although I had had a taste of the WHO Regional Committee for Europe as a member of Malta's delegation to the 1995 session, the 1999 session was the first I attended as a representative of my country. I have attended every session since then. The type and level of discussion at the Regional Committee are very different to those at technical meetings. Although many of the items under discussion are technical, one can readily sense a political component to each issue. This feeling is even stronger at global level during discussions at the World Health Assembly.

While a representative of a small Member State can relatively easily establish equality with other technical colleagues from much larger Member States, the same cannot be said at the political level. The criteria of population and geographic size, economic strength and military capacity defining the size of a Member State come very much more into play at this level of interstate discussions and negotiations. Moreover, in the 1990s Malta had only been a sovereign state for 30 years or so, and therefore the long-standing mentality of being subordinate to much stronger powers persisted. The urge and desire to establish one's sovereign national identity, however, mitigated this feeling.

I feel that Malta did not take long to establish this identity. As early as 1967, three years after independence, a Maltese initiative was launched at the United Nations General Assembly that eventually culminated in the adoption of the 1982 United Nations Convention on the Law of the Sea. In 1988, a letter from the legal advisor to the then Maltese Prime Minister suggested that "a comprehensive global strategy [was needed] to protect the weather and climate as part of an effort to ensure that our planet remains fit to sustain human life" and proposed that such a strategy "should commence by a United Nations resolution declaring climate to be part of the common heritage of mankind" *(6)*. This letter, entitled "Weather as a world heritage" *(6)*, may be regarded as the first step in a remarkable initiative taken by Malta that brought to the attention of the world

community the urgent need to conserve the climate in the interests of present and future generations of humankind. Similarly, it did not take long for Malta to establish itself in the health sector. Its active participation in WHO governance structures soon resulted in Malta being elected to the WHO Executive Board, which it chaired in 1987/1988.

Malta's active involvement in WHO has accelerated over recent years. In the European Region, Malta was a member of the Standing Committee in 1993–1995 and 2011–2013. The Malta representative chaired the Standing Committee between September 2013 and September 2014 and was elected Executive President of the 2014 session of the Regional Committee. During its membership of the Standing Committee, Malta also chaired the Committee's subgroup on governance and took a leading role in improving transparency in WHO's European governance structures by developing a tool to help select nominees for posts in the governing bodies and elaborating a code of conduct for candidates for election as WHO Regional Director for Europe. Developing such tools and satisfying Member States' many and varied demands and expectations are no easy tasks. Achieving consensus in such matters is equally difficult; it takes a substantial amount of formal and informal consultation, as well as substantial credibility in the negotiator and the negotiating Member State, an attribute that I feel Malta has managed to achieve over the years. In May 2015, Malta was once again elected to the Executive Board and its representative was elected Chairman in the following year. Once again, Malta is leading the selection process for the three candidates to be put forward for the post of WHO Director-General, to be elected by the World Health Assembly in May 2017.

Over the years, more and more Member States appear to show an interest in forming part of WHO governance structures at regional and global levels. There is no magic formula for success; much depends on the number of people nominated by Member States, their qualities and the number of vacancies to be filled on the governing bodies. At regional level, the Regional Committee defined and confirmed the criteria for selection in two resolutions *(7,8)*. From the work done by the Standing Committee subgroup on the priority to be given to these selection criteria, it transpired that the most important were the candidate's ability to coordinate, collaborate and communicate, the degree of commitment shown and the candidate's career profile, with a public health background being considered as the most important. The least favoured criteria were membership of high-level committees and work experience with WHO or any other United Nations or international organization. It is important for Member States, particularly small ones, to keep these priorities in mind when making nominations for membership of WHO governing bodies.

After the political role of the Environment and Health Ministerial Board was established through the Parma Declaration on Environment and Health in March 2010 *(9)*, the 2010 Regional Committee elected Malta to the Board. Malta contributed to clearly defining the Board's role through clarification of its terms of reference and contributed to starting the process of implementing the Parma Declaration.

Having had substantial experience in the various WHO structures, Malta is very sensitive to the great demands on its resources posed by various international organizations and their reporting requirements. It was therefore no surprise that Malta took on with great enthusiasm San Marino's proposal to establish a network of small Member States within the WHO European Region – the small countries initiative *(3)*. The network allows members to pool resources, experience and expertise in intersectoral and intergovernmental collaboration on the formulation of policy statements for presentation at regional forums. The outcome statement of the network meeting held in Andorra in July 2015 served as the

basis for the Minsk Declaration on the Lifestyle Approach in the Context of Health 2020, adopted in October 2015 and later noted by the Regional Committee *(10,11)*. Further, the network established the Small Countries Health Information Network in the context of the WHO European Health Information Initiative, which held its first meeting in Malta in 2016 *(3)*. Malta is once again a front runner in this initiative.

Apart from participating in numerous technical and governance meetings, Malta has also hosted numerous large and small meetings over the years. As early as 1970, only five years after joining WHO, Malta hosted the Regional Committee session. The country also had the honour to host the historic 2012 session, at which the Regional Committee adopted the European health policy framework Health 2020 *(12)* and other key policy documents. Once again, by hosting these meetings, Malta has shown that despite its generally limited resources, it was capable of successfully hosting small and large meetings alike.

Leadership in health

Despite its small size, Malta has always been ready to provide humanitarian support in times of crisis, such as those in Libya and Tunisia in 2012. It served as the transit point for 21 000 foreign workers and expatriates who fled Libya to return to their homelands. The massive influx of people into a small country with very limited resources was a major challenge that Malta managed to overcome. In addition, the country also provided, within its resource limitations, acute hospital care to civilians who were wounded as a result of the fighting and served as a shipping base for medical supplies to be sent to the most affected areas. During this time, there was significant coordination among the various entities locally and collaboration with United Nations agencies, other Member States and NGOs. Apart from the heavy demand on resources to provide logistical, material and technical support, such initiatives required extreme sensitivity to the diplomatic issues that prevailed in such volatile situations. It was important that clear lines of communication and levels of responsibility were defined and strictly followed in all operational areas. Negotiations were constantly going on at political, technical and operational levels, both internally and with national and international stakeholders. It was therefore essential that such negotiations complemented each other, and this could only be achieved through clearly defined and effective lines of communication at all levels.

Because of its geographical position between Africa and Europe, Malta has in recent years received substantial numbers of refugees and migrants arriving by boat from the north African coast. With the Libya crisis, the number of people fleeing the conflict areas rose exponentially and this led to WHO taking up the initiative to more actively address migrant health issues, triggered by an initiative from Italy supported by Malta *(13)*. The subsequent flow of migrants to mainland Europe strengthened the need for such an initiative. Malta's main concern was that the possible large influxes of refugees and migrants would lead to the collapse of its health system. As a small island state, Malta has a reasonably robust health-system infrastructure, but surge capacity is limited, and the relative impact of such an excessive load would surely render the health system unsustainable.

Malta's activity and leadership in health have not been restricted to WHO. Since its independence, Malta has remained a member of the Commonwealth and has always actively participated in meetings of its health ministers. Malta formed part of the

Commonwealth Advisory Committee on Health between 2011 and 2015, chairing it in 2015. During this time, it also took the initiative to introduce reforms in the governance structure to make membership of the Committee more equitable and representative of the various geographical regions. This initiative required substantial diplomatic sensitivity, as the changes would benefit some Member States while others would lose in the frequency and extent of representation. At the last Commonwealth health ministers' meeting, in May 2016, Malta led a discussion on health security and health systems.

Malta has also engaged with a number of partners in the field of health at government and nongovernmental levels. It has been a member of the CoE since 1965 and has continuously contributed to the execution of its values and principles in promoting and safeguarding public health. It took over the CoE presidency in 2017, and held the Presidency of the Council of the European Union at the same time *(14)*, focusing on overweight and obesity, a public health problem that affects most European countries, as its primary health theme. Malta is also addressing issues related to the accessibility and affordability of health care through structured cooperation. These priority issues were chosen after careful internal discussions on what were considered EU priorities with a substantial national interest and negotiations with the other members of the troika (the Netherlands, Malta and Slovakia) to ensure a continuum in the main issues forming part of the Presidency programme. In the context of its Presidency of the Council of the European Union, Malta is hosting a number of high-level meetings, conferences and workshops addressing various public health issues. Apart from its Presidency role of mediating and brokering compromises among the 28 Member States and between the EU institutions, Malta will also broker WHO's involvement in such priority health issues being addressed under the auspices of the EU within the spirit of the joint declaration between the WHO European Region and the EC (see Chapter 12).

Conclusion

In conclusion, although Malta became a sovereign state just over 50 years ago, it has made substantial achievements in international fora and great achievements in the governance structures of WHO. I feel that its success reflects its determination to contribute actively and constructively to global policy developmen, and results from its eagerness to establish a national identity. In these efforts, the country puts aside the many restrictions imposed by its limited resources by ensuring maximum efficiency in their use.

Malta's relative success shows that small Member States can achieve, even alongside much larger Member States with more resources. I feel that the critical factors in success are determination, commitment, technical competence and a realistic ambition to achieve. Malta's achievements show that opportunities within WHO governing bodies and other structures are just as open to small Member States as they are to larger ones.

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14. WHO: health diplomacy in action at country level

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Introduction

Following the establishment of WHO in 1948, the Regional Office for Europe was set up in 1952. Today, the European Region is one of the most diverse and dynamic of WHO's regions. The political and economic upheavals faced by the countries of central and eastern Europe and the newly independent states (NIS) of the former USSR[12] had a serious effect on the social determinants of health. The Regional Office acted rapidly to respond to these challenges.

The Regional Committee approved the Eurohealth programme for intensified cooperation with the countries of central and eastern Europe and NIS in 1990 to develop and scale up activities in the eastern half of the Region. Despite working with a very limited budget, it accomplished much – as the Eurohealth evaluation showed – and the Regional Office channelled its technical work to the target countries through the infrastructure created by the Eurohealth programme. This infrastructure still exists, although it was further developed in the subsequent decade. During these years, the Regional Office, while further strengthening its intercountry mode of working, continued to provide technical support (including policy advice) to Member States, introduced the monitoring of health trends and helped countries to turn the results of normative work into national policies and guidelines. At present, WHO has country offices in 29 European Member States, mainly in central and eastern Europe, south-eastern Europe and the NIS. As a result of

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[12] The NIS are: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

the reform process initiated in 2012 to better prepare WHO to meet today's needs, the country offices constantly evolve to improve their assistance to countries *(1)*.

WHO's roles and ways of working to meet its goals have evolved over the years following the guidance given by Member States through the governing bodies and reaped through WHO reform. In addition, the lessons learned from the Ebola crisis drove the Organization to advance quickly in terms of emergency response and will have a long-lasting impact on how it prepares for, and responds to, emergencies and communicates with its Member States, as well as highlighting the need for stronger country capacities and well functioning health systems.

Supporting countries in resolving their health challenges and strengthening their health systems cannot be achieved only by establishing norms and standards, which are sometimes seen as WHO's main functions. Nevertheless, this work gives an example of global health diplomacy at its best. A strong WHO presence in a country can provide crucial insights into local circumstances, political forecasts and assessments of health needs. These give WHO knowledge of opportunities for change, including close contact with key players and established networks for health, which are key prerequisites for health diplomacy.

The essential resources to address country needs are health advocates in countries, either WHO representatives or staff of WHO country offices, who support countries in their relationships and negotiations with health and non-health stakeholders and other development partners who may not always see the added value of health in a developmental and broader policy agenda. Supporting the health sector in evolving and engaging in multisectoral relationships is one of the key roles for WHO.

Health diplomacy at country level

Health issues, challenges and opportunities in Member States in the WHO European Region vary hugely. The ability to be flexible and responsive in providing support can be the major factor for the success of WHO country offices. They adapt their ways of working according to local needs and aim to strengthen national health capacities. This chapter aims to provide practical, concrete examples of country-level health dialogue from small WHO country offices, with case examples on health diplomacy: the role of the WHO country office in health diplomacy, the context in the NIS, with the Republic of Moldova as case example at national and subregional levels, and the role of WHO and a Member State holding the Presidency of the EU.

Role of the WHO country office in health diplomacy

WHO's comparative advantage at country level includes being seen as a technical and policy expert on health matters, a neutral broker between regional bodies and health-sector stakeholders, and a source of sound, evidence-based guidelines, standards and policies on a range of health issues that help countries to accomplish the goals of their health and development policies. The role of a small country office allows the WHO representative to have a close advisory and supportive relationship with the health ministry, particularly the minister. WHO's core business is health, and it supplies continuous and sustainable support.

WHO utilizes key tools and mechanisms to support the public health agenda in countries. These tools can be legally binding, such as the IHR and the Framework Convention on Tobacco Control (see also chapters 1 and 12) or, in most cases, non-binding frameworks such as the WHO country cooperation strategy (CCS) or commitments made at regional or global level through the governing bodies (the WHO Regional Committee for Europe or the World Health Assembly, respectively).

At country level, the CCS provides a first entry point for negotiation between the country and WHO. The CCS is a longer-term partnership, usually lasting 5–6 years, which defines strategic priorities for both parties. In most countries, the CCS is aligned with the country's health-sector plan, policy or strategy. It is a corporate tool for WHO, powerful in fostering strategic policy dialogue among key stakeholders in countries and positioning health at the centre of work to achieve the 2030 Agenda for Sustainable Development *(2)*. In countries in the WHO European Region, however, the most utilized modality of collaboration is the biennial collaborative agreement (BCA). The BCA is signed by the health minister and the WHO Regional Director for Europe and can serve a similar purpose to that of the CCS, although the timeframe is a maximum of two years. Despite the small size of some of the WHO country offices in the European Region and the limited resources available, effective support from the WHO Regional Office for Europe and other networks, such as the WHO collaborating centres, ensures the flexibility of their operations. The BCA, covering a broad range of topics for health dialogue identified in consultation with the host country, guides the WHO country office on the country's priorities.

Most of WHO's work at country level is related to establishing and leading partnerships, strengthening capacities and providing policy guidance and technical assistance. The means can vary, by using multiple entry points and modalities and in cooperating and negotiating with different partners. Besides the conventional health actors, WHO works more and more with representatives of other sectors whose decisions directly affect health. Recent WHO reform has strengthened the role of country offices in reaching out to, and working with, other sectors and non-health players to represent health interests across different steps of the policy-development cycle. Depending on the need, the WHO country office can be a health advocate itself or support the health and non-health partners in countries to carry out better diplomacy for health, as well as being a platform for health alliances.

Here are a few examples of WHO country offices as health diplomacy actors in three countries on the eastern shore of the Baltic Sea: Estonia, Latvia and Lithuania. They are small, with populations of 1.3 million, 2.6 million and 3.7 million respectively. Despite having high levels of income and development and being members of the EU, health status in these countries lags behind the average for the EU, although they are slowly closing the gap. WHO established a presence in these countries in the early 1990s to support them in reorganizing and even rebuilding their health systems in four ways: convening health policy dialogue, presenting evidence-informed guidance to key government decision-makers, helping to build relationships with other players in non-health sectors, and conducting external and independent programme evaluations, providing policy recommendations and discussing the findings.

First, WHO takes a convening role in health-policy dialogue through facilitation or negotiation between stakeholders from different sectors. This allows representatives to understand the common health issues, see their own role and set a joint vision for health.

WHO country offices do this by building on the technical expertise of colleagues from the Regional Office and WHO headquarters. They organize country missions during which country experts from ministries and agencies engage in roundtable discussions to move the policy agenda forward. For instance, a national policy dialogue was organized at which representatives of the health, food, veterinary and agriculture sectors learned about the status of AMR in Estonia and jointly identified and agreed on the way to address it.

Latvia has shown great commitment to, and considerable progress in, preventing violence, and was one of the first countries in the Region to ban corporal punishment. The BCAs between Latvia and the Regional Office have included violence-prevention as one of the priorities for collaboration since 2006, so a number of activities to strengthen cross-sectoral collaboration on the issue have taken place *(3)*, including:

- the development of national guidelines for reproductive health workers on responding to violence;
- the introduction of capacity-building programmes for participants representing various sectors (social, health, police, justice and municipalities) using WHO's training, educating and advancing collaboration in health on violence and injury prevention (TEACH–VIP) curriculum *(4)*; and
- a survey of adverse childhood experiences among young adults, with a policy dialogue to disseminate and debate the results in 2014 *(5)*.

Second, WHO country offices advocate change and support health decisions by presenting evidence-informed guidance to key government decision-makers. For instance, WHO has been a close and proactive partner of the Ministry of Social Affairs in Estonia in developing a national policy document on nutrition and physical activity. WHO provided a tailored evidence package *(6)* to counteract colliding interests and prepare the health sector for difficult negotiations. Prepared by staff of the Regional Office and the WHO country office in Estonia, the package included epidemiological data on childhood obesity in the country, economic data on price policies, an analysis of the sugar content of sweetened beverages and dairy products, the evidence on potential policy measures and advocacy tips on how to address arguments from the food industry *(6)*.

Third, joint actions under WHO global and regional initiatives provide good entry points to build relationships with players in non-health sectors. As an example, World Health Day 2015 addressed food safety, which opened dialogue and enabled joint communication with the agriculture and food sectors as well as equipping them with new evidence-based materials. The country offices in Estonia and Latvia helped to empower them in their role, which was well regarded and gained media attention in both countries *(7)*.

Fourth, WHO country offices conduct external and independent programmatic evaluations, provide policy recommendations and discuss the findings. For example, WHO assessed the challenges and opportunities for the Estonian health system in securing better NCD outcomes (8). WHO has intensively cooperated with countries on health-financing issues. It commented on the sustainability of health financing in Estonia and provided Latvia with a 10-point proposal for consideration on health-financing policy in the context of the planned introduction of compulsory health insurance in 2012. The main stakeholders of various sectors, including the Latvian Parliament, have discussed the proposal. The WHO Barcelona Office for Health Systems Strengthening, with the support of the European Observatory on Health Systems and Policies, held several meetings with Latvian health ministers and high-level representatives of the finance ministry to discuss the reform proposals and share relevant experiences across Europe, and the country office played a crucial role in bringing the sectors and partners together *(9)*.

As stated above, WHO country offices also work to strengthen national capacities through health diplomacy, including providing training and guidance to enhance health ministries' leadership skills in working with multiple stakeholders for health-policy development.

A WHO country office can serve as an active platform to create alliances for health by supporting the WHO networks that promote health in particular settings, such as cities, hospitals, schools and workplaces; this movement started in the 1990s and the networks provide good entry points for health-related action. For instance, almost 70% of municipalities in Latvia belong to the national network of the WHO Healthy Cities project, which is coordinated by the state Disease Prevention and Control Centre under the Ministry of Health. The networks of healthy cities and health-promoting schools in Latvia expanded rapidly after the crisis in 2009 *(10,11)*.

NIS: the Republic of Moldova

This section discusses the Republic of Moldova as a case example to display health diplomacy at country level and advocacy at subregional level through SEEHN (see also Chapter 7).

The WHO country office in the Republic of Moldova was established in 1995 in the capital city, Chisinau. The original goal was to provide continuous support to health authorities and partners in improving population health through evidence-based, sustainable public health and health-care interventions, as well as to advise on ensuring the consideration of health in all policies. Over the years, the office has been the focal point for all WHO activities in the Republic of Moldova. Its profile was upgraded in 2011 and it is now led by a WHO representative and is scaling-up its activities to support national policy development. The WHO representative facilitated several high-level visits to the country that enabled increased visibility for its health sector at national and subregional levels: for example, the country held the Presidency of SEEHN. At national level, WHO has reached out through its WHO representative and built a strong, lasting relationship with the Ministry of Health and the minister. To assist the country with its strong reform agenda, high-level dialogue between the WHO Regional Director for Europe and the Prime Minister enabled WHO to help the country place health high on its political agenda.

The Republic of Moldova is modernizing its health sector, which demands almost continuous technical support from WHO. At the same time, the country has improved health outcomes in the areas of immunization and maternal and child health. Infant mortality rates in the Republic of Moldova have fallen by half over the last 15 years, and maternal mortality is following this trend. In 2016, WHO validated the country's elimination of mother-to-child transmission of syphilis, an outstanding achievement that other countries in the Region can follow and that can be used as an example for SEEHN to advocate *(12)*.

EU Presidency to serve as champion for health: the case of Latvia

The Presidency of the Council of the European Union rotates among the EU Member States every six months and the country holding it drives forward the Council's work. The EU Presidency is an opportunity for each Member State, regardless of its size or length of membership, to influence the EU agenda and guide its endeavours. Latvia joined the EU in 2004 and held its first Presidency from 1 January 2015 to 30 June 2015, taking over from Italy and afterward handing over the reins to Luxembourg.

Latvia started preparing for its EU Presidency in early 2014. After dialogue with the WHO representative, the Minister of Health formally requested the WHO Regional Director for

Europe to involve the Regional Office in providing technical support to the ministry in priority areas it had defined.

The Ministry of Health led the overall coordination of health events, with technical support from the Regional Office. The WHO country office in Latvia was at the centre of policy dialogue to ensure direct communication between high-level officials in the country and public health experts.

As a result, two important events were held in Riga in March 2015: a high-level conference on nutrition and physical activity for children and young people in schools, and the 1st Eastern Partnership Ministerial Conference on Tuberculosis and its Multi-drug Resistance. The outcome documents of both had a long-lasting impact on the Baltic states. Slovakia took forward the outcome document on TB and MDR-TB *(13)* in its EU Presidency (July–December 2016) and EU health ministers discussed it during their informal council in October 2016.

Conclusion

WHO plays an important role in health diplomacy at national, regional and global levels. The roles of WHO offices may vary depending on their size, location and characteristics, but WHO clearly aims to involve all possible actors to create better health for all. The means, mechanisms or tools may also vary depending on the country's political context, overall health-policy development and priorities, but this chapter highlights the most widely used health-diplomacy techniques, such as policy dialogues, strategic guidance, strengthening of national capacity on health-policy issues within or beyond the health sector, and participation in important national, regional or global events.

While the strategic direction, guidance and coordination of the work of Member States comes from the WHO Regional Office for Europe, input from its geographically dispersed offices and WHO country offices and collaborating centres, as well as from the vast number of networks, experts and consultants associated with the Regional Office, is used to maximum benefit.

At country level, the WHO country offices act as hubs of health diplomacy; their role is to advocate and support the evolution of a good governance structure for health. This might include a health advisory committee or other mechanism for high-level policy dialogue and intersectoral task forces to support the implementation of overarching national health policies and/or development plans. WHO's work at country level to harmonize support with stakeholders such as development partners is crucial, so the role of WHO representatives is to bring the full strength and voice of health diplomacy to bear to help advance these efforts. A country office should engage all stakeholders that contribute to or influence the health sector so that its support to the country is relevant, appropriate and in line with international norms and standards, evidence-based strategies and plans. Through high-level policy dialogues and consultations with country stakeholders, in theory, the needs and priorities at country level can then inform regional and global priorities *(14)*.

The continuing WHO reform process has demonstrated a need to strengthen overall capacity at country level in not only heads of WHO country offices, but also health advocates in general. Placing more emphasis on the provision of high-quality technical expertise and the necessary financial resources at country level will therefore help to move public health forward.

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15. Udine, Italy: city health diplomacy

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Introduction to a new quasi-concept and paradigm

Three megatrends are colliding: urbanization, an ageing population and climate change. All pose serious challenges to health, but can also offer unique opportunities for improving the sustainability of society at large and enhancing citizens' resilience and well-being. Health must be conceived not just as the absence of disease or infirmity, but rather as physical, mental and emotional (social) well-being *(1,2)*. Through their political leaders and top managers, cities play much bigger roles than they did in the past in addressing the threats and challenges of the megatrends. Nevertheless, a major paradigm shift is necessary, whereby cities may build alliances with all sorts and levels of partners: city health diplomacy. This is an innovative notion, a quasi-concept with no established epistemic community, yet word compounds involving diplomacy are emerging in the recent literature in several fields to indicate the contribution that diplomacy can make. Diplomacy has become so pervasive because all human endeavours now have a global correlate.

For example, public diplomacy is the conduct of international relations by governments through public communications media and dealings with a wide range of nongovernmental entities to influence the politics and actions of other governments. Global health diplomacy *(3)* is multilevel and multi-actor processes that shape and manage the global

policy environment for health in health and non-health forums. Digital diplomacy involves the use of the Internet and new information communication technologies to help achieve diplomatic objectives. Science diplomacy uses scientific and research-based collaborations to address common problems and build constructive international partnerships. Climate diplomacy advocates strategies for decarbonization and energy efficiency, calls for the implementation of policies oriented towards achieving the targets outlined in the Paris Agreement (see Chapter 11) and promotes the cause of environmental sustainability in general. Economic diplomacy promotes the prosperity of local economies internationally by involving not only ministries dealing with the economy and bodies promoting trade and investment promotion, but also chambers of commerce and local authorities. Finally, megadiplomacy involves new coalitions that emerge across the government, business and education sectors.

How can city health diplomacy take place?

First, health is a universal language, a lingua franca that can never divide, but rather facilitates, the establishing of strong bonds. The very word diplomacy through its etymological root of "double" leads straight to concepts such as covenant and compact: binding two subjects on an equal basis.

This chapter discusses the role of city health diplomacy in building alliances for health within a city administration and negotiating with a city's stakeholders, in networking with other cities and in multilevel governance. We discuss in particular the relevant initiatives carried out by Udine (population 100 000; old-age-index (the number of people aged 65 or above per 100 people aged 14 or below): 217) in north-eastern Italy. Udine has achieved a considerable international reputation in city-led health promotion policies in its 21 years of active participation in various WHO networks, most notably the WHO European Healthy Cities Network *(4–6)* and the WHO Global Network for Age-friendly Cities and Communities *(7)*.

City health diplomacy within the city

A vibrant city health diplomacy can be carried out only within a city administration that views the health-in-all-policies approach as a core principle underpinning its overall political and administrative actions. This requires a multi- and intersectoral approach to health policies. Internal city health diplomacy is an excellent antidote to the silo syndrome, so city health diplomacy is just as necessary within the walls of the town hall as in cities' engagement with the outside world.

City health diplomacy enhances the reputation of a municipality at all levels and within its own community. Through it, trust and respect increase upwards, downwards and at peer level. City health diplomacy is therefore crucial in what is becoming a very important issue for promoting solidarity among citizens, ownership of long-term social programmes and positive belonging among citizens: city branding.

A significant part of city health diplomacy has to do also with what we call the middle-out paradigm, borrowing terminology from artificial intelligence research in the 1980s. Traditional top-down approaches do not allow for the full participation of citizens and, in

a time of economic recession, they are financially unsustainable. Further, who is the top in a society that has many levels of authority? Symmetrically, purely bottom-up approaches have their own shortcomings since they might not be healthy at all if appropriate guidance and education are not infused in them, and they are short-lived if not included in a broader framework.

Local authorities therefore need to carry out a new generation of strategies: middle-out approaches. These combine top-down and bottom-up actions in varying proportions by building trustful and respectful alliances. Middle-out initiatives capitalize on the originality and strong motivation (often positively ideological) of grassroots bottom-up actions but place them in a more principled and broader framework, which further empowers citizens and enables local authorities. These approaches are often referred to as social innovation *(8)*, social brokerage or social intermediation, and are based on co-creation. In middle-out strategies, cities do not only support bottom-up suggestions and initiatives, but also act as catalysts, soliciting broader societal engagement, networking social, public and private stakeholders, and profit-making and non-profit-making organizations so that proposals and needs are catered for in a more participatory and hence more empowering and enabling way.

A number of successful middle-out initiatives have been carried out in Udine in the last decade that exemplify health advocacy through city health diplomacy. All go in the direction of building alliances, facilitating networking among local stakeholders and gently nudging their often idiosyncratic vision into a more coordinated, systematic and strategic framework.

1. Move Your Minds (Camminamenti) brings together more than 20 actors, such as the university, the public library and the municipal toy library, and various non-profit-making and profit-making organizations such as the Alzheimer association. All cooperate to offer various activities (such as brain training, music therapy, laughter yoga, mathematics, antiageing games, spine yoga, creative thinking, digital technologies, longevity energetics and handwriting) to combat cognitive decline and the onset of dementia, as well as ageism, solitude and isolation. The activities are carried out in public community centres and are co-created annually by a steering committee including the Healthy Cities Office, the sports, cultural and social services departments, and representatives of the other partners.

2. No Solitude in Udine (No alla Solit'Udine) brings together over 30 voluntary associations that assist older people in their daily activities. Carpenters, plumbers and ironmongers from the retired craftsmen's association offer help with small repairs; other associations offer transportation to do shopping or read the newspaper to people with glaucoma. The municipality coordinates the project through a call centre that collects requests and dispatches them to the associations providing the services. This initiative has built a strong sense of belonging.

3. Many single events are co-created with local stakeholders. For example, readers' night gives public libraries, bookstores, and professional and amateur writers and poets the opportunity to run activities related to reading in various public areas. World Games Day involves over 50 different associations, groups and small enterprises revolving around playing and gaming in all their different facets. Pi Day, which traditionally begins a little before 16:00 on 14 March, brings together associations, individuals and schools to foster mathematics and scientific literacy among the general public. Energy Week involves dozens of enterprises and associations to raise awareness of energy

efficiency and the need to reduce GHG emissions from fossil fuels. The numbers of stakeholders that these events bring together increase every time they are held. All these initiatives indirectly advocate health and well-being, more than if they were the sole focus.

4. Urban gardens are green areas, including former brownfields that have undergone remediation and are assigned to citizens and associations to grow their own vegetables. Associations, rather than individuals, are preferred to boost socialization within the community. Many associations working with disabled people are usually interested in including farming activities in their occupational therapies. Farmers' markets and local markets are related initiatives that promote sustainability and healthy eating habits.

5. Healthy Snacks at School is a project involving all Udine's primary schools to promote healthy eating habits among parents and children, particularly during school breaks. This is a multifaceted programme. Besides providing healthy snacks, it runs educational activities in classes, food and farming laboratories, training sessions for teachers, social events and communication campaigns for increasing the community's awareness on healthy lifestyles. It also engages with profit-making partners (local farm consortiums, supermarket chains and private shops). The project has been evaluated through a 10-year follow-up.

This is just a short list of middle-out initiatives based on building alliances for health. The idea is that much is going on outside the town hall that can easily be boosted and included in a broader strategy for promoting healthy, resilient and sustainable communities.

Networking with other cities

So far, we have analysed mainly city health diplomacy within the city for building alliances for health within the administration and the community. An even stronger case for city health diplomacy, however, occurs in the process of networking with other cities using health as a lingua franca. This is done by signing covenants and through active membership in various EU-funded networks, WHO-inspired networks or even NGOs. Benefits and opportunities are: motivating staff, becoming acquainted with good practices, learning about possible errors and limitations and thus avoiding rebound effects and increasing efficacy, and sharing approaches. The very practice of city health diplomacy is such an example within the WHO Healthy Cities Network *(9)*. The starting point is that cities, rather than viewing themselves as the cities of Europe, should all work towards a Europe of cities. There are many directions along which city health diplomacy is crucial at the level of city-to-city relationships.

Charters, networks and EU projects

Cities can join international and national city networks such as the WHO Healthy Cities Network (for promoting well-being and designing healthy and supportive environments), the European Covenant of Mayors (for promoting energy efficiency and renewable energies), the WHO Global Network on Age-friendly Cities and Communities (for promoting age-friendliness) and Mayors Adapt (for increasing resilience to, and recovery from, disaster).

Cities can commit internationally by signing charters, declarations and covenants that direct their future policies and strategies *(10–19)*. A city can make a significant diplomatic

step towards defining its own branding by hosting the signing of a policy document that advocates its peculiar strategy or policy for health.

To increase their potential as social and economic brokers, cities can also join multisectoral NGOs such as the European Covenant on Demographic Change *(17)*. This association implements the triple-helix paradigm, whereby different statutory stakeholders join forces to pursue a common goal. The spires in the helix comprise: local authorities and public institutions; universities and research centres; and businesses, private institutions, and non-profit-making and profit-making organizations. Health is a very strong economic driver and offers many opportunities for new jobs and enterprises. The so-called silver economy – defined by the EC as the economic opportunities arising from the public and consumer expenditure related to population ageing and the specific needs of people aged over 50 – capitalizes precisely on this.

Cities can also join EU-funded networking projects to develop local action plans and establish local support groups. Udine joined Romanet, on Roma inclusion, with the goal of progressively normalizing informal settlements by accompanying families in improved housing and reducing prejudice, stereotypes and stigma: a paramount example of city health diplomacy. Udine exchanged its experience on active and healthy ageing with Edinburgh (United Kingdom), Brighton and Hove (United Kingdom), Grand Poitiers (France) and Klaipeda (Lithuania) through another project of the European Territorial Cooperation programme. Other EU projects in which Udine was involved concerned enhancing resilience, environmental quality and energy efficiency.

Mayors should be encouraged to become deeply involved in these networks. At the moment this is not widespread, but promoting health is an intersectoral action, and mayors have the greatest intersectoral role.

Evaluation assessments and process monitoring

City health diplomacy can be effective if it engages with hard facts through evaluation processes. Udine engaged in several such exercises: making health profiles of older people, using the 22 indicators of the WHO Healthy Ageing Subnetwork; assessing the eight domains defining an age-friendly city; using the rapid assessment tool; assessing age-friendly environments in Europe; and using the Active Ageing Index for Cities *(20–23)*. Defining easy-to-assess indicators allows one to understand the significance of policy in a comparative way. Excellent frameworks for indicators are available; for example, the WHO publication Measuring the age-friendliness of cities: a guide to using core indicators *(24)* classifies indicators according to four phases in the political implementation process: input, output, outcome and impact. This framework naturally suggests how to disaggregate data to allow health inequities to surface. The lessons learned using these tools are that output or outcome indicators are often more important than impact indicators. One can safely rely on scientific literature for the latter, since they can be measured only in the long term. Output or outcome indicators, on the other hand, measure what is delivered to citizens and therefore have a very high political value. Finally, indexes obtained by weighting different data are not very useful in comparing cities because ultimately the weights depend too much on context.

All these excellent tools are useless, however, if evaluations are not iterated and continuously shared with the public. For this reason, Udine has set up an observatory for the older population and uses geographic information-system health maps to visualize the distribution of various data on the density of various population groups, such as the locations of pharmacies in relation to the distribution of the population aged 65 years and over. Health maps are an innovative tool for monitoring, planning and governance. They

have proved to be very useful for policy-makers and professionals in city health diplomacy negotiations. Moreover, oral health screening of the number of decayed, missing and filled teeth and Significant Caries Index of first-year schoolchildren is implemented to detect health inequities within families *(25).*

In conclusion, quantitative tools are very useful provided data can be disaggregated, but more qualitative data and self-assessments are necessary.

Multilevel networking and governance

The third kind of city health diplomacy operates when planning and promoting health in a cross-cutting way at different levels of government by sharing strategies, methods and data through political networking at multiple levels. Several determinants of health (such as transportation and air quality) are centred on cities, but are not entirely in the hands of local authorities, and depend on regional and national bodies. Cities need to establish more and more alliances with other government tiers at regional, national, European and international levels. Cooperation with the WHO Regions for Health Network can be very useful here.

City health diplomacy is essential in capacity-building and multilevel political governance. A case in point is the initiative Health and Safety NOW (Adesso – Salute e Sicurezza) implemented by the Friuli Venezia Giulia Region and the Udine Healthy Cities Office. It involves 70% of the municipalities of the Region in raising awareness among administrators and top managers on health issues and safety in public buildings. It is also an example of scaling-up local health initiatives after successfully testing their sustainability in the long term *(26)*. At national level, a very effective action in the Italian Healthy Cities Network is the so-called Health Oscar, an annual competition to determine the best practice of the year.

Principles of city health diplomacy

We have outlined the new quasi-concept of city health diplomacy, illustrating the diverse levels and dimensions where it is needed. More pragmatically, we have presented a number of general programmes and concrete initiatives in which city health diplomacy is at work, pointing out the tools that are used. City health diplomacy is a combination in different degrees of some, possibly all, of the lines of action discussed above. Using health as a lingua franca for building alliances is clearly a strong political statement. Health, in the broad WHO definition of overall well-being, rather than in the more restrictive sense of services providing medical care or cure, is a pervasive political concept that can be pursued only by comprehensive long-term policies and programmes rather than temporary projects or initiatives. Further, health inspires moral and ethical value-laden policies because truly healthy societies need to be inclusive, sustainable, equitable, transparent, responsive and caring. In this sense, city health diplomacy is strongly rooted in democracy. Many processes promoted by the WHO Healthy Cities movement *(4)* – such as the whole-of-government, whole-of-society and health-in-all-policies approaches, intersectoral collaboration, citizens' active participation and social inclusion – have great political value, besides health, social and economic benefits.

City health diplomacy is also a means to pursue equity, along with its environmental correlate sustainability, which amounts to equity with respect to future generations. The connection between health and equity is epitomized by The spirit level *(27)* principle: societies can be healthy only if equitable, because even the privileged are worse off in a less equitable society. The recent economic recession multiplied inequities, and disparities are poisoning communities: few spectacular winners are exhibited in the face of numberless losers. Health promotion should aim for initiatives that are as inclusive as possible, regardless of age, ethnic origin, income, gender orientation or ability. City health diplomacy is functional to this end.

City health diplomacy is clearly essential in participatory processes that involve people in the decision-making process of their city (focus groups). Citizens should be put at the centre of not only the service system, but also the decisions that concern them, and city health diplomacy can compensate for the limits and the feeling of marginalization that even the best representative democracy can often entrain.

A basic principle in city health diplomacy is to make the healthy choice the easy choice; otherwise health promotion ends up addressing only health militants. The healthy choice must become also the enjoyable and rewarding choice. In this respect, Udine capitalized on the experience achieved in gaming, being the Italian lead city of the Playful Cities movement. Games are particularly useful in promoting healthy lifestyles and involving older people in activities, especially those for combatting cognitive decline. Evidence shows that people more easily establish relations while playing, because their emotional reactions can compensate for cultural differences or cognitive deficiencies.

Through city health diplomacy, one can more easily advocate change and innovation. Societal health also means energy efficiency and positive action to combat climate change, increase resilience and improve disaster recovery. City health diplomacy can set the stage for addressing current demographic trends – not only the ageing of the population, but also increased numbers of migrants, asylum seekers and marginalized minorities – in a more principled way, because guaranteeing better access to health services is the first step towards integration. In this context, international city networking is crucial for learning best practices and exchanging tried-and-tested models.

Finally, city health diplomacy can operate very effectively within the organization of the local administration, bridging the gulf between its political and executive organs. The health-in-all-policies approach fosters multiple affiliations, in contrast to the silo effect, since it makes the various departments less hierarchical, but not anarchic. Having an intersectoral goal flattens the structure, making it more flexible and dynamic. Further, a population health approach calls for multiple and complementary interventions and strategies across different levels.

Conclusion

In conclusion, health can provide a reliable compass for strong political action, particularly in view of the impressive demographic changes underway in Europe due to the good news of the steady increase in life expectancy and the more difficult issues related to global mobility and migration. Health is a formidable vehicle for action on the urban

scale. It points in the direction of creating cleaner, safer, greener and more age-friendly local environments, appropriate for active and sustainable lifestyles. New jobs and new opportunities can be created if municipalities having health promotion in mind establish partnerships and alliances with the private sector and profit-making organizations. For all these reasons, cities should improve their diplomatic skills in connection to health promotion and fully exploit its potential.

Most severe diseases are related to lifestyles, which can be improved through preventive action. Although prevention is much less expensive than cure, authorities tend to focus on handling emergencies and curing acute cases rather than carrying out strong preventive programmes, as financial resources are scarce. This is not only a matter of physical well-being, since depression and anxiety are serious issues. Only cities can really care for citizens' mental health, so they need to become living laboratories for leading active, meaningful, happy lives, and support and encourage innovation, creative thinking, mindfulness and problem-solving capacities.

City health diplomacy amounts to using health as a medium for sharing, networking and building alliances, fostering participation and commitment, and improving resilience, equity and sustainability in the community. City health diplomacy really means using health to make cities more humane.

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16. Hungary: developing health diplomacy training at a public health faculty – the case of Debrecen

Róza Ádány & Mihály Kökény

Introduction

On the basis of lessons learned from the global health diplomacy courses developed by the Global Health Centre at the Graduate Institute of International and Development Studies, Geneva, Switzerland, the WHO Regional Office for Europe commissioned the Faculty of Public Health of the University of Debrecen, Hungary to organize and host a course on health diplomacy for the countries belonging to SEEHN in 2012. In addition to the general modules, the curriculum of the five days' training reflected the specific regional needs previously identified by the countries concerned.

The positive experiences of this unique enterprise stimulated the largest academic public health institution of Hungary to launch a health diplomacy course for national policy-makers and health policy advisers in the framework of the EU's Social Renewal Operational Programme in 2014. As part of this project, the course organizers produced a handbook entitled Health diplomacy that was published in Hungarian *(1)*. The book is considered useful reading for teachers and students in the Faculty's courses on public health, health policy and health care management. These antecedents helped to insert global health and health diplomacy into the various graduate and postgraduate training curricula delivered by the Faculty to Hungarian and foreign students.

Negotiations for health outcomes that save and improve people's lives on a global scale usually take place in the face of many other interests of international organizations. These developments have brought more diplomats into the health arena and more public health experts into the world of diplomacy.

International talks on health now need to involve the private sector, NGOs, scientists, activists and the mass media, since all these are part and parcel of the negotiating process. This requires a specific set of skills to deal with changing contexts, actors and issues, and has helped to shape the field of health diplomacy. Since 2010, the WHO Regional Office for Europe has collaborated closely with the Global Health Centre in evolving short face-to-face and online health diplomacy courses to satisfy the needs of countries and subregions. Often an academic partner is involved to widen the knowledge base and ensure the contribution of representatives of special disciplines. This has been the case with the Faculty.

Faculty of Public Health of the University of Debrecen

The host institution, the University of Debrecen, was established in 1912 and teaching started in 1914. It has 14 faculties, including traditional ones such as those for the arts, sciences, architecture, agriculture and medicine and three main campuses; the new campus was the site for the health diplomacy courses. The campus itself can be interpreted as a symbolic monument to diplomacy and health: it was built as cavalry barracks at the turn of the 20th century and housed military personnel until after 1990, when the local government donated the site to the University to serve peace and knowledge, instead of war and destruction. Now the campus is the home of the faculties of law, informatics and public health: the last is the only such faculty in Hungary and central and eastern Europe. The Faculty of Public Health was established following a decision of the Hungarian Government on 1 December 2005 by the unification of the School of Public Health and the departments of preventive medicine, family medicine and behavioural sciences of the University of Debrecen.

A 10-year period of development preceded the Faculty's becoming an independent entity of the University of Debrecen. The Faculty has further improved its departmental organization; its structure is shown in Box 16.1 (2).

Box 16.1. Structure the Faculty of Public Health, University of Debrecen

I. Department of Preventive Medicine
   • Division of Biomarker Analysis
   • Division of Biostatistics and Epidemiology
   • Division of Health Promotion
   • Division of Public Health Medicine
II. Department of Family and Occupational Medicine
III. Department of Behavioural Sciences
   • Division of Clinical and Health Psychology
   • Division of Humanities for Health Care
IV. Department of Hospital Hygiene and Infection Control
V. Department of Physiotherapy
VI. Department of Health Systems Management and Quality Management in Health Care
VII. School of Public Health

The Faculty became a unique, internationally recognized and competitive training centre not only in Hungary, but also in the European arena of higher education in public health. In line with the Bologna process, the Faculty has two bachelor's, four master's and six other postgraduate courses, along with one doctoral school in the field of public health and health sciences, offering a rich variety of learning experience. It has also become an internationally recognized workshop of public health research. In recognition of its scientific work in researching Roma health issues, it became the WHO Collaborating Centre on Vulnerability and Health on 9 January 2012.

The first SEEHN course (2012)

SEEHN comprised representatives of the health ministries of its 10 member countries,[13] five partner western European countries and five intergovernmental organizations. It is a government public health network with established long-term partnerships among countries, intergovernmental organizations and NGOs. Since 2001, SEEHN's role has evolved from fostering peace and reconciliation and protecting the most vulnerable populations in south-eastern Europe to a sustained public health partnership that increasingly helps to shape public health agendas in the WHO European Region (2). At the same time, SEEHN has faced numerous challenges at regional and subregional levels that require collaborative efforts to address, including intercountry collaboration within the health sector and between the health and non-health sectors (see Chapter 7 for more details).

In 2011, the WHO Regional Office for Europe started to develop a week-long training course on health diplomacy for SEEHN to bring together staff from health and foreign ministries. Cautious preparations took place in terms of the content. Representatives of the Global Health Centre and the Faculty discussed the modules with SEEHN leaders several times to achieve an educational programme tailored to countries' interests and problems. Some advocated advanced public health training; others wanted approaches to intersectoral work. At the end, consensus formed about focusing on the health diplomacy of the EU, as most SEEHN countries were heading towards EU membership.

As to participants, all 10 SEEHN members sent delegations of 2–3 people. Although the overall objective of the course was to bring together diplomatic and health professionals to explore their common interests, in spite of every effort only civil servants from the ministries of health and public health attended. Hungary sent four observers (including one from the Ministry of Foreign Affairs) and two deputy health ministers (from Montenegro and Serbia) took part as well. The teaching team comprised leading personalities from the Global Health Centre and the Faculty, while guest speakers included a former EU commissioner and the Minister Counsellor of the Delegation of the European Union to the United Nations and other international organizations in Geneva, Switzerland.

At first, SEEHN members objected to holding the course outside the subregion, but finally it was agreed that the Faculty had better facilities in terms of attracting the best speakers, comfortably hosting participants and providing logistical arrangements than any institution within SEEHN.

[13] SEEHN now has nine members (see Chapter 7).

The curriculum for the course was organized into modules with specified objectives. The modules consisted of lectures followed by exercises in working groups. Certain modules were dedicated to improving participants' negotiation skills through simulation exercises. Table 16.1 shows the objectives and topics of the modules.

Table 16.1. Objectives and topics of the modules of the WHO course on health diplomacy for SEEHN countries, 2012

Module	Objective	Topics
1. Understanding the nature of global health diplomacy	To provide an overview of the key characteristics and evolution of health and foreign policy and the synergy between these two domains towards new relationships for global health diplomacy	Multipolar world: global and EU context; changes in health diplomacy; system and methods of diplomacy; global health diplomacy: the new relationship between health and foreign policy
2. Challenges in global health governance	To explore the multilateral landscape of global health, including how various environments and actors affect the way that global health is governed at different levels of governance	How health is becoming global; public health is global health – what does it mean for SEEHN?; the institutional environment: venues of global health diplomacy: focus on WHO
3. The dynamics of global health negotiations	To introduce participants to negotiation skills and to demonstrate key characteristics of global health negotiations through two practical simulation exercises within the EU context and at global level	The institutional environment: the EU's role in global health in health in south-eastern Europe; negotiating within an EU context (simulation exercise); negotiating health: experiences from SEEHN (workshop); multilevel diplomacy: negotiating alcohol policies at various levels of governance (working groups with exercise)
4. Global health strategy: coordination at national and regional levels	To illustrate how countries continue to collaborate at national and regional levels for global health	Good global health begins at home: national global health strategies; health of disadvantaged groups: how to address Roma health across borders: global health diplomacy in action
5. Round up	–	–

During the discussions after the presentations, as well as in the workshops, participants showed that they clearly understood and appreciated the multidimensional and global character of health, but were also enthusiastic about the regional dimensions of health determinants. The most vivid discussion developed in connection with health issues characteristic of south-eastern European countries, especially on health of Roma, the largest ethnic minority accumulated in the region. Survey data from 12 central and eastern European countries clearly show that the Roma population, comprising up to 12% of the population of some of these countries, are significantly less likely to have health insurance than the non-Roma population. The share of Roma people without coverage was almost 30% in Bosnia and Herzegovina, over 40% in Bulgaria and Romania, and 59.7% and 67.7% in the Republic of Moldova and Albania, respectively *(3)*. Throughout the region, Roma people face poverty, poor access to education and high levels of unemployment and social exclusion. All of these might be expected to have adverse effects on their health *(4)*. More than a third of those who are able to access health services report experiencing discrimination *(5)*.

In addition, the participants emphasized the need for competent health diplomats – health attachés –to represent the region and articulate their specific problems in negotiations, and the importance of creating an interface between domestic and foreign policy. Kickbusch & Kökény *(6)* pointed out that there were:

> many health negotiations taking place in different venues … but not many countries can dedicate substantial resources to these negotiation processes. At the recent session of WHO's Executive Board, Member States underlined the importance of good preparation at the national and, increasingly, at the regional level.

The post-1990s economic transformation resulted in rising inequality and poverty, particularly in some countries and regions: inequality tends to be higher and poverty more widespread in the countries of south-eastern Europe *(7)*. Participants in the global health diplomacy course clearly said that developing and launching courses on health diplomacy for national health policy-makers and advisers would be essential.

Effects of the 2012 course: second health diplomacy training event and national courses (2014)

Among the repercussions of this pioneering project, it was interesting to note that, following the course, SEEHN countries started to participate more actively as a group by making joint statements in the discussions of the WHO governing body in the European Region, the WHO Regional Committee for Europe. SEEHN countries also lobbied for a second health diplomacy course, which took place in Chisinau, Republic of Moldova at the end of 2014. This time, over 30 participants, not only from health ministries, attended. Diplomats, economic and health experts gathered to understand and further expand their knowledge about how to make human health and well-being a high priority on already crowded political agendas. The role of health diplomacy was discussed in the context of countries' size and geopolitical location, exploring new technologies for diplomacy and

the prospects for strengthening intercountry collaboration through SEEHN as part of the regional process of development cooperation.

The courses in Debrecen and Chisinau gave the participants skills and knowledge to be able to advocate health and well-being, taking home the following messages as new health diplomats *(2).*

- Public health and health goals cannot be reached by health systems alone and are thus not the sole responsibility of health systems. They concern the whole of society and all sectors, especially in efforts to prevent rather than cure, and should therefore be shared across government and civil society.
- Small states face numerous challenges, but their size does not make them unimportant or uninfluential. Regional collaboration can be a great opportunity to identify common priorities and joint action, making a difference at regional and global levels.
- SEEHN has great potential to speak with a common voice, influence regional health priorities and participate in global health negotiations.
- The opportunities presented to the region with the south-east Europe 2020 strategy *(8)* and the advantage of SEEHN's regional coordination role within this process offer an exemplary learning experience and an excellent chance to practise health diplomacy.

The success of SEEHN courses inspired Hungary and the Republic of Moldova to organize national courses on health diplomacy with the support of the Global Health Centre and WHO Regional Office for Europe.

In the framework of the EU Social Renewal Operational Programme, the Hungarian course took place in 2014 on the premises of the Faculty, with broad cross-sectoral participation recruited from four different ministries covering eight sectors, major universities (including medical students), the hospital association and the local governments of two large cities. The following main topics were introduced:

- introduction to global health diplomacy
- how health becomes globalized
- scenes of health diplomacy (OECD, the United Nations, WHO)
- place and role of Hungary in global processes
- diplomacy and sectoral diplomacy at diplomatic missions
- health diplomacy in EU decision-making
- case studies of the role of sectoral ministries in global health diplomacy negotiations
- duties of health attachés at embassies
- the concept of global health in international law
- health diplomacy advocating Roma inclusion.

To make the event more comprehensive, the faculty members prepared a handbook for the course in Hungarian *(1)*. The staff of the Faculty use this publication widely in preparing teaching materials, and it is offered to students on courses on public health, health management and health policy. According to the feedback received from course participants, they find the handbook useful in their work.

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17. Capacity-building in global health diplomacy in Europe: experiences, challenges and lessons learned

Michaela Told

The SDGs set an ambitious and transformative agenda, calling for collective action for people, the planet and prosperity. The 17 SDGs are characterized by their universality and interdependence, challenging the north–south divide and recognizing the complexity of finding integrated solutions *(1)*. The SDGs are unique in not only their bandwidth, but also the way they were drawn up, which involved the largest consultation in the history of the United Nations with an open working group, a series of global and national conversations and an online public survey *(2)*. They not only represent a framework of engagement, but also reflect the changing nature of diplomacy.

Global challenges – such as global warming, cybersecurity, trade agreements, migration and disease outbreaks – require new mechanisms for problem-solving and collective action by many different actors *(3)*. Diplomats engage in multistakeholder diplomacy not only to address increasing interdependencies and resolve complex global problems through the SDGs, but also to respond to crises, which have become the norm rather than the exception. Diplomatic action is no longer limited to bi- and multilateral negotiations conducted by professional diplomats. It now includes a variety of non-state actors and the use of new technology and social media, and is closely interlinked with netpolitik *(4,5)*: using the Internet for diplomatic purposes, often to address so-called softer issues. National interests remain at the centre but soft-power issues, such as legitimacy, identity, values and public perception, have gained importance.

This changing diplomatic context also applies to global health: protecting the health of one's country remains the primary interest of ministries of health, but this can no longer be achieved in isolation from other ministries, other countries and other non-state actors.

A single country cannot resolve the intertwined and complex issues of health, so collective transborder action is needed with the participation of government actors (at all levels), international organizations and NGOs, the private sector, public–private partnerships, philanthropists, academics and celebrities. In an interdependent world, strengthening the national health system also strengthens the global health system *(5)*. The biggest challenge in this context, however, is to nurture leaders with a "strategic vision, technical knowledge, political skills, and ethical orientation to lead the complex processes of policy formulation and implementation" *(5)*.

Innovation in building capacity for global health diplomacy

Since its inception in 2008, the Global Health Centre at the Graduate Institute of International and Development Studies in Geneva, Switzerland, has pioneered executive courses on global health diplomacy in Europe and beyond. More than 1500 mid- and senior-level professionals have been trained to date. In addition, the Centre understands the participants' needs as adult learners who tackle complex problems, make decisions and participate in negotiations, and have a high degree of self-reflection and discretion to act independently *(6)*. This has led to the following six pillars that characterize the Global Health Centre's approach to building capacity in global health diplomacy.

The Centre's **strategic location in Geneva**, the global health capital, allows participants to follow negotiations first hand and regularly to interact with health diplomats and other health actors based in the city. This provides a competitive advantage in designing executive courses, whether they are held in Geneva, in Europe or elsewhere.

Framing global health issues politically, in health and non-health fora, influences, for example, the understanding among actors and the overall diplomatic process. The Centre's approach concentrates on not only creating this awareness of framing, but also on contextualizing health issues within governance, focusing on decision-making and other political processes.

An **interdisciplinary faculty** bridges theory and practice. The faculty comprises academics and practitioners from different disciplines and backgrounds. Participants, even with a wealth of professional experience, appreciate the opportunity to embed their experience in a theoretical framework and reflect on their work in new ways. Seasoned practitioners on the faculty translate and complement academic thinking into the realities of diplomatic processes.

Small working groups and simulation exercises are integral parts of the executive courses. This allows for transformative learning; the participants can test actions and reactions on interventions that they would not dare to apply in their daily work. This requires the careful selection of participants, who learn through hands-on training and **practising their skills**. The executive courses provide a protected space for this, and an extensive reflection process is crucial to improve the skill set.

A special attempt is made in all courses to ensure the participation of representatives from different backgrounds and a variety of career levels. Such a mix facilitates mutual learning between faculty and participants but also **peer learning**, which is one of the most appreciated features of the Centre's executive courses.

The executive courses are based on long-term engagement and a **partnership model** in which courses are planned jointly by the Centre and its partners. This enables course content to be adapted to the realities of the host country and ensures a sense of joint ownership among the partners.

The executive courses offered by the Global Health Centre are usually organized around a system of complementary modules and are delivered mostly face to face. While this remains the most effective mode of teaching, especially to transfer practical skills, the Centre has extended its reach by offering online courses and hybrid learning initiatives. An extensive reading list is available to all participants, providing them with a compendium of relevant academic literature and other resource materials, including case studies, policy documents, working papers or studies from internationally renowned experts. The Global Health Centre is responsible for developing the curriculum with the partner organization and host country, changing the thematic focus according to the context of the course.

Challenges and benefits of training in global health diplomacy

Each course organized with the involvement of the Global Health Centre has unique features. The Centre does not take a one-size-fits-all approach, but develops tailor-made curricula using examples from the most recent negotiations. This is a key to success and ensures the relevance of the courses. Course design takes account of the particular political context and health priorities of each host country or region. A secretary of state, alumna of the autumn 2015 executive course in global health diplomacy for EU Member States, with a thematic focus on migration, said that the course was very useful. As migration was a hot topic, it was good to devote a day to it, and it helped her to understand collaboration among Member States. The exercise at the end of the day helped her to realize what questions she needed to raise and how she needed to prepare for a discussion of the topic.

This approach may result in a more intense preparatory phase, but makes the courses highly relevant for their participants. Nevertheless, the success of the courses also depends fundamentally on the appropriate selection of participants. Careful consideration has to be given to this, using the criteria mentioned above.

Learning has to be transformative, critical and reflective. It has to encourage participants to find solutions to complex problems and discover new entry points for action. These characteristics are crucial in adult learning, enabling theory to be applied to practice and practice to theory. This dynamic relationship brings added value to the executive courses and allows each participant to grow in his or her career path. One participant, working in the international affairs department of a ministry of health, reflected on his role as chairperson after a negotiation simulation on World Health Assembly resolution WHA69.9 on ending inappropriate promotion of foods for infants and young children *(7)*. Although he had chaired many meetings before, only after this roleplay did he realize that chairing a debate is so different from chairing a negotiation. The former requires trying to provoke different views and perspectives, but the latter requires finding a way to reconcile them. He recognized that these different tasks require different skills.

Individual growth is part of the game, but the executive courses are expected to benefit not only individual participants, but also the organizations or institutions that they

represent, encouraging organizational and systems learning. The Centre depends on all alumni to transfer knowledge, act as multipliers and become mentors for others. It supports initiatives in this regard, trying to reach out to a wider public audience through its platform function with policy dialogues held in Geneva, but also through recently initiated one-hour moderated webinar sessions. A network of global health diplomats is created through dedicated social media platforms and the relationships established among the participants. Participating in an intensive course builds social relations, even if participants later represent different viewpoints in a negotiation.

Executive courses generate several benefits, but nevertheless have various inherent challenges, such as translating learning from the course into practice. Sufficiently practical course content can minimize this challenge, but real change necessitates a change of mindset and implies organizational transformation. The latter can only be achieved if new knowledge is transferred and applied across an organization and if different levels of government or various departments understand their mutual dependence and the interlinkages of health issues. Policy coherence is a must, and the notion that global health begins at home is a simple reality. Creating such coherence is often a long process and may need a champion to drive it forward. Many gaps along this path have to be bridged: information gaps between ministries or between different stakeholders; capacity gaps across different sectors; funding gaps to support global health initiatives; administrative gaps in the organizational setup; and policy gaps occurring due to lack of appropriate or enabling strategies and policies (8). Bridging these gaps requires coordination, leadership and capacity-building initiatives applied horizontally and vertically. Training the right people is not an end but a means to achieve this wider organizational outreach and objectives.

Global health diplomacy – specific skills in demand

Global health diplomacy comes into play at the interface of health and foreign policy where two different professional worlds meet, each with its specific technical expertise, mindsets, values, language and interests. Common ground needs to be defined to move forward effectively; actors need to learn to speak with one voice and position their country successfully on the international stage. Kickbusch (9) highlighted four fundamental pathways in which foreign policy can affect health and vice versa, even though borders remain fluid and are context-specific: : the four pathways of interaction are defined as foreign policy detrimentally affecting health and health being used as instrument, as integral to or as a specific goal of a country's foreign policy. This analytical framework is a useful tool to secure a better understanding of how countries position themselves diplomatically.

Nevertheless, global health diplomacy involves additional complexities because by definition it requires consideration of the interaction of health with sectors and government ministries that go well beyond the traditional focus of foreign policy, including trade, agriculture, environment, development and security. Common ground

needs to be found across these fields as well, and only a few European countries (for example, France, Germany, Norway, Sweden, Switzerland and the United Kingdom) and the EU have developed explicit global health strategies to facilitate this interaction and create policy coherence at national level. These strategies are helpful only if they are implemented jointly by the ministries of health and of foreign affairs; in addition, they vary in purpose, strategic approach and priorities. Health professionals and diplomats must therefore understand these interwoven relationships and engage together in the policy-making process. Ruckert et al. (10) define global health diplomacy as "the practices by which governments and non-state actors attempt to coordinate and orchestrate global policy solutions to improve global health". Global health diplomacy understood in this way entails the following five dimensions: negotiating for health in the face of other interests, negotiating governance, improving relationships through health, creating alliances for health outcomes and contributing to peace and security (11).

Analytical skills facilitate an understanding of the impact of one sector on the other and the recognition of the approaches taken by different countries. The analysis must also include a mapping of the political and economic context, the multiple ways in which health is politicized and the stakeholders involved, which necessarily includes an analysis of the dynamics of power and the manifold interests of various actors (12). These analytical skills can be developed if the theoretical framework is provided, a space for reflection created and experiences shared, including lessons learned.

An understanding of political, organizational and decision-making processes needs to complement the situational and contextual analysis: governance indeed matters. Diplomatic action can only be successful if these processes and the related governance mechanisms are understood. Decision-making in one organization may affect another. Political alliances and venues are increasingly important for health decisions; the set of instruments available and the applicable legal regimes, including the rules of procedure, will determine the range of possible diplomatic action. The composition of governing bodies and their negotiation settings have to be analysed to secure a better understanding of the dynamics of negotiation. Health is a political choice and global health diplomacy is a political process that attempts to reconcile different interests. The provision of global public goods for health is a collective goal that needs conscious decisions at national, regional and global levels and requires action by the whole of government and society (13).

Creating a protected space

Demands on health professionals and diplomats seeking to navigate this global health landscape are high. They need diverse skills that go far beyond the technical realms in which either of these professional groups is primarily trained. At global level, the 2010 United Nations General Assembly resolution A/RES/64/108 on global health and foreign policy (14) recognized the need "to increase capacity for training of diplomats and health officials ... on global health and foreign policy".

At regional level, the WHO Regional Office for Europe was the first to take up global health diplomacy in its work and address the interface of health and foreign policy (15). At the 2010 session of the WHO Regional Committee for Europe, the first held

with Dr Zsuzsanna Jakab as WHO Regional Director for Europe, a technical briefing on global health and health diplomacy and resolution EUR/RC60/R6 on health in foreign policy and development cooperation created momentum for training in health diplomacy *(16,17)*. The resolution not only referred to United Nations General Assembly resolutions A/RES/63/33 *(18)* and A/RES/64/108 *(14)*, but also specifically asked the Regional Director to "contribute to strengthening the capacity of diplomats and health officials in global health diplomacy and develop training standards and open-source information, education and training resources for this purpose" *(17)*. Five years after the Regional Committee's adoption of resolution EUR/RC60/R6 and as part of the agenda of Health 2020 *(19)*, the WHO Regional Office for Europe organized a high-level technical briefing in Berlin, Germany on strengthening health in foreign policy and development cooperation *(20)*. This led to the Regional Office publishing a brief on how the health and foreign policy sectors could work together to implement Health 2020 *(21)*.

These decisions not only recognized the crucial interface of health and foreign policy, but also highlighted the benefits that health professionals and diplomats would gain from capacity-building measures. The Regional Director has responded to these calls for action from the beginning of her mandate in 2010, well before the Sixty-sixth World Health Assembly adopted WHO's Twelfth General Programme of Work 2014–2019 in 2013, recognizing the need for building governance capacity and specifying that *(22)*:

> health diplomacy training, already mandatory for WHO representatives, will be rolled out across other parts of the Organization. Training should include the use of tools from disciplines such as international relations and political science to enable better analysis of complex systems and stakeholder mapping.

By the time the Twelfth General Programme of Work was adopted, the Global Health Centre, commissioned by the Department of Country Cooperation and Collaboration with the United Nations System at WHO headquarters, had already developed a tailor-made online health diplomacy course and trained around 150 heads and deputy heads of WHO offices in countries, areas and territories, as well as members of the Country Support Unit Network, in global health diplomacy. In parallel, the WHO Regional Office for Europe had implemented and supported several face-to-face executive courses on global health diplomacy. In cooperation with the Global Health Centre, the University of Debrecen, Hungary held the first in 2012 for SEEHN (see Chapter 16). Then followed executive courses in global health diplomacy in Turkey (in 2012), the Republic of Moldova (2013 and 2014), Turkmenistan (2014), Hungary (2014) *(23)*, the Russian Federation (2015), Malta (2015) and Cyprus (2016). These courses covered the whole WHO European Region, reaching from the EU to central Asia, and were mostly supported by the host countries' health ministries. For example, the Parliamentary Secretary for Health supported the course in Malta, and the Ministry of Health and SEEHN were involved in organizing the 2014 course in the Republic of Moldova. The executive courses held in Geneva also regularly welcome other European participants delegated from the Regional Office, and the executive course in Turkey included participants from countries in the WHO Regional Office for the Eastern Mediterranean.

Overall, more than 350 representatives of ministries of health and of foreign affairs, the WHO Regional Office for Europe and other health organizations were trained in global health diplomacy in the Region during the period 2012–2016. The Regional Office continues this outreach and commitment, and annually holds at least one such training course for European Member States. Training in global health diplomacy not only responds to complex political challenges and helps to strengthen Europe's role in an interconnected world ,but is also "at the core of the obligation to work towards the attainment by all peoples of the highest possible level of health" *(15)*.

Conclusions

The current European political context includes factors such as the aftermath of the Ebola virus disease outbreak in west Africa, economic uncertainty, the migration crisis, the rise of nationalist movements and a fragmented influence of Europe. Global health diplomacy has to respond to these challenges. This requires, for example, analytical skills, an understanding of the interfaces between different levels and structures of governance, an awareness of the impact of other sectors on health, a coherent, coordinated and shared approach to health issues by many actors, and sound negotiation skills.

Training in global health diplomacy attempts to respond to all these needs. It increases participants' knowledge and skills, but can also contribute to organizational learning and helps participants and faculty members to better understand the realities of the contexts in which global health diplomacy is carried out. Well conducted global health diplomacy can result in better health security and population health for each and all of the countries involved, improved relations between states, and increased commitment of a wide range of actors to joint work and agreements that are deemed to be fair, and support the pursuit of the SDGs, which increases health equity *(8)*. Global health diplomacy can and should trigger collective action and foster the creation of global public goods for health. With its strong commitment to protecting and promoting everyone's right to enjoy the highest attainable standard of physical and mental health and its emphasis on the value of solidarity towards equitable and universal coverage of high-quality health services, Europe has a particular role to play to ensure the achievement of global public goods for health

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18. Europe: challenges in health diplomacy

Ilona Kickbusch & Mihály Kökény

Health diplomacy beyond WHO

European countries will continue to be challenged to engage in health diplomacy to prepare for and respond to a broad spectrum of health issues at national, cross-border, European and global levels. The contributions to this book illustrate how intersectoral and how political health diplomacy has become *(1)*. The venues of health diplomacy have outgrown the framework of WHO governance settings: they highlight the need for WHO to find its role in these new constellations and for countries to better prepare themselves for the new spaces of negotiation *(2)*.

The diversity of health diplomacy reflected in this book is stunning. For example, case studies explore why and how AMR was put on the United Nations agenda, how cooperation between WHO and the EU has progressed, how political clubs such as the G7 can contribute to moving health challenges forward and gaining consensus, how cities conduct health diplomacy, how cross-border health initiatives can help a country emerge from international isolation, and how regional health networks deal with a difficult legacy of conflict and ethnic division.

Just as the entry of global and regional health issues into a much more political arena can bring benefits, it can also make health cooperation across borders more volatile. For example, as some countries challenge the commitment to multilateralism, this can affect support for multilateral health organizations and joint programmes. As transatlantic ties

weaken, health cooperation can be damaged, including in matters of health security. It is difficult to say at this stage how much protectionist trends or ideological divides in Europe will influence health negatively. Nevertheless, two questions stand out for the practice of health diplomacy over the next few years.

- Will European countries maintain their foreign aid budgets and support to global health organizations and initiatives in the face of nationalism?
- Can such a diverse group of countries as those in the WHO European Region reach consensus on divisive issues such as sexual and reproductive health and rights, migrant health or WHO funding?

As the contributions to this book indicate, many political partnerships in different parts of the diverse European Region now also deal with health matters. This includes new organizations as well as new initiatives, such as the New Silk Road. A look back over the last three years of global health diplomacy identifies two issues deserving special mention because of their relevance to health cooperation between European countries: health security and migration. In particular, health security has opened up new opportunities for WHO and European countries to take on global leadership roles in health diplomacy in bodies such as the G7 and G20, at the United Nations and in the EU. Issues of migration have been more divisive and challenging.

The health-security challenge

Owing to the Ebola crisis in 2014 and 2015, the health-security agenda has dominated health diplomacy globally and in many European countries. At national and regional levels, countries in Europe became aware that their mechanisms for crisis-response were not sufficient and new forms of cooperation between sectors were required. As the need to manage the intersections between health, foreign affairs, security and development came to the fore in many countries, increased numbers of global health focal points were appointed in ministries other than health. New mechanisms for crisis preparedness and response were created within the EC to strengthen cooperation between Member States and with partner countries. The global level saw a new approach to cooperation through the GHSA (see Chapter 2), which has strong European participation and was ably steered in its first phase by Finland. The GHSA is an excellent example of successful alliance-building to ensure better health outcomes for all. In addition, the annual Munich Security Conference, which brings together foreign and defence ministers from around the world, now regularly includes a debate and reporting on health-security matters, addressing health as a contribution to ensuring peace and security as well as the responsibilities of the security sector during outbreaks and emergencies.

The last few years have seen health diplomacy gain ground in high-level political bodies under leadership from Europe: the G7 in 2015 under the German Presidency had a strong health focus, including health security, UHC, AMR and neglected tropical diseases. This prominent place for health was reinforced through the G7 agenda in 2016 in Japan and gained continuity (again in Europe) with the Italian Presidency, which prioritized matters of health and women's empowerment.

In 2017, the German G20 Presidency for the first time invited WHO and the World Bank to a meeting of G20 health minsters and worked closely with the two to prepare for the meeting. Its focus lies in a continuation of the G7 agenda: AMR, UHC and health security. G20 responsibilities led to a very high number of global health meetings being organized in Germany. With many difficult and contentious issues on the agenda of the G20 overall, the health meetings offer a diplomatic opportunity to improve relationships between the G20 countries in an area of common concern. Such high-level political events, as the contribution in this book on the G7 illustrates, not only put health ministries in contact with other ministries, but also open avenues to make their case with decision-makers in the centre of power, in this case the heads of government.

The migrant and refugee challenge

The migrant and refugee challenge also underscores the increasing intersections of health with many different sectors and the increasing need for health diplomacy. Here in particular the challenge is to negotiate for health in the face of other strong interests. A sound base in public health evidence is essential for health diplomacy in relation to such a highly politically charged issue, which often generates prejudice or unfounded fears of great health risks.

The WHO European Region was at the forefront in addressing the public health emergencies that have arisen owing to the high number of migrants, refugees and asylum seekers entering Europe, especially linked to the conflict in the Syrian Arab Republic. Member States such as Italy, Malta and Turkey strongly engaged in the health diplomacy required to ensure collaborative action between countries on refugee and migrant health, to promote a common response and to avoid uncoordinated, single-country solutions. Member States came together to adopt a strategy and action plan for refugee and migrant health for the WHO European Region in 2016 *(3)*.

Since refugee and migrant populations are primarily rights-holders under international human-rights law, the goal of health diplomacy in this area remains to protect and improve their health within a framework of humanity and solidarity and without prejudice to the effectiveness of health care provided to the host population. Health diplomacy contributes to achieving a coherent and consolidated national and international response to protect lives and provide for the health needs of refugee and migrant populations in the countries of transit and destination and with the countries of origin. Every country involved in the migration process must meet its international obligations. As a significant number of European countries cannot or do not want to cope with refugees and migrants, the challenge for health diplomacy is immense.

As many of the health, social and economic challenges associated with migration result from global inequity, action that focuses solely on host countries will be less effective than integrated global, interregional and cross-border approaches, many of which are subject to complex negotiations. This also applies to the situation of refugees from war-torn countries who live in large camps, where the interface with humanitarian diplomacy and peace-building is of prime importance. Working beyond governments, with the many voluntary organizations involved and, of course, the migrants and refugees themselves,

is another intersectoral challenge of health diplomacy. In this respect, WHO has to work closely with other members of the United Nations family and NGOs, such as Doctors Without Borders or Migrant Help, in the spirit of its recently adopted framework of engagement with non-state actors *(4)*.

Increased need for health diplomacy

The year 2017 has brought more uncertainties than previous years. As the need to ensure cross-border cooperation in health mounts in relation to many issues – not only those described above, but also others, such as the environment – so does the need for health diplomacy. Bilateral and multilateral health agreements need to be negotiated and the health effects of other negotiations – such as those on trade, migration or economic policies – need to be taken into account. For example, there will be significant health diplomacy in relation to Brexit, including negotiating the health rights of EU citizens in the United Kingdom and vice versa.

The pressure on European countries will increase should the United States of America want to reduce its financial commitments to global health initiatives and its political commitments to multilateral health organizations such as WHO. European health diplomacy will be challenged to argue for the United States continuing its contributions and to increase European countries' own responsibilities. A major upcoming negotiation in relation to global health governance is the increase in the assessed contributions to WHO, a proposal made by a European Member State and supported by other key countries in the Region. The extent to which antiglobalization trends will lead to a setback globally, including in health cooperation, is unknown. That is why having a political body such as the G20 – which includes many of the new actors in global health, such as China – express support for global health initiatives and organizations becomes critical.

In view of the priorities laid out above, it would also be important for the EC to revisit the EU global health policy it defined in 2010 *(5)*, as well as the conclusions of the Council of the European Union on global health adopted in the same year *(6)*. The EU's role in funding health research and supporting cross-border research cooperation further highlights the complementarities of health and science diplomacy, which should be strengthened, as the ninth EU framework programme for research and innovation is negotiated. The issues of access to, and pricing of, medicines are also gaining importance for European countries in relation to, for example, cancer drugs and hepatitis C treatment.

Additional health diplomacy challenges need to be addressed in other parts of the Region. These include central Asian countries' continuing efforts to roll back polio, the gap in vaccination in Ukraine and the fragility of the response to AIDS in the eastern half of the Region.

Strengthening health diplomacy in the European Region

Health-security issues and the migration challenge have gained relevance and led to the interface of health with many different sectors. This development has also shown, however, that the health ministries and their international departments in many countries are still not as strong as they should be and that their links to other sectors remain difficult to establish and maintain. Often the links to the development and the humanitarian sector are also weak. Very few countries have global health focal points in their ministries of foreign affairs and even fewer give their global health negotiators from the health ministries the status of ambassadors. Only a minority of countries in the Region has mechanisms such as those in Switzerland described in Chapter 1.

While interest and training in health diplomacy have increased in the Region through such means as the courses supported by the WHO Regional Office for Europe, building capacities in this area is still not a priority in many countries, which continue to learn by doing. The exceptions are the courses in health diplomacy conducted on behalf of the Regional Office by the Global Health Centre of the Graduate Institute for International and Development Studies in Geneva, Switzerland (see Chapter 16). Hungary has started to teach health diplomacy at the Faculty of Public Health of the University of Debrecen. Heads of WHO country offices were trained through an online course supported by WHO headquarters.

More investments are needed in this area, especially given the high turnover of country representatives in WHO governing bodies. Serving on WHO committees and boards has become more complex, and the people representing the interest of both their countries and the Region need to be better prepared. The absence of appropriate capacities can lead to difficulties in understanding the workings of international organizations such as WHO and to a lack of understanding of the larger political environment in which health negotiations take place.

As already indicated, much health diplomacy will take place at domestic level between sectors in order to contribute to global responsibilities and commitments. For instance, addressing AMR as a priority requires intersectoral actions between health, agriculture, science and education in fighting this threat. NGOs and businesses (the pharmaceutical industry) need to be the part of such cooperation, in which diplomacy must conciliate diverging interests, illustrating that health diplomacy is conducted not only between states but between a wide range of actors at different levels of governance. Here, WHO country offices can play an important supportive role for countries.

The same applies to environmental challenges. Environmental health has been a top issue for the Regional Office since 1989. The European environment and health process *(7)* has resulted in five successful ministerial conferences, the 1999 Protocol on Water and Health to the Convention on the Protection and Use of Transboundary Watercourses and International Lakes, and the 2004 Children's Environment and Health Action Plan for Europe. These are hallmarks not only of progress, but also the productive diplomacy that countries engaged in around this process. The Sixth Ministerial Conference on Environment and Health, to be held in June 2017 in Ostrava, Czechia, will challenge European health ministers to forcefully represent health interests in view of the profound effects of climate change on health.

Health diplomacy and the SDGs

In a region facing considerable unpredictability, international health collaboration and development may remain a solid reference point for delivering fair social outcomes under the 2030 Agenda for Sustainable Development and WHO European health policy

framework, Health 2020 *(8,9)*. Chapter 4 explains how active Sweden was in positioning health during the SDG negotiations through opening up new channels for health-related aid for low-income countries. The 2030 Agenda for Sustainable Development imposes the need for a more systematic and coordinated approach at home in planning national health policies, as well as the national strategies of donor countries for global health. Health has to be presented not as a sectoral issue, but as an overarching area that builds bridges to key determinants of health, such as education and water. Health diplomacy can help mediate this approach.

In the SDG era, the challenges for health diplomacy in WHO include reinterpreting its constitutional role: how to act as "the directing and coordinating authority on international health work" *(10)*. Dilemmas for WHO include many sensitive issues of funding, governance and priority-setting that it has tackled in the reform process of recent years. The renewal of WHO, however, in terms of continuous pressure to adjust to a fluid and quickly changing global environment, will continue for years to come *(11)*.

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Health diplomacy has been a key mechanism of international action since health was recognized as a critical transborder issue in the 19th century. It has gained new relevance through global processes such as climate change, pandemics and the unsustainable consumption patterns of modern societies. Today it is central to global health governance and integral to foreign policy in many countries.

In the WHO European Region, health diplomacy takes place in WHO governing bodies, key regional organizations and other organizations that have a global reach. It is also a feature in national settings, when countries formulate positions for negotiations and need to reach consensus between different interests and stakeholders. In 2010, the WHO Regional Committee for Europe, in resolution EUR/RC60/R6 on health in foreign policy and development cooperation, requested the WHO Regional Director for Europe to help to strengthen the capacity of diplomats and health officials in global health diplomacy.

This book presents 17 case studies on health diplomacy that illustrate recent developments in the Region. The examples given range from negotiating for health in the Paris Agreement on climate change and the pursuit of the Sustainable Development Goals to placing antimicrobial resistance on the global agenda and showing the relevance of city health diplomacy. A diversity of approaches emerges, and less well known experiences from south-eastern Europe, central Asian countries and the Russian Federation are reviewed. Experience with integrated health diplomacy in Malta and Switzerland show how cooperation with foreign policy led to progress for health, and Germany's activities in the Group of 7 and Group of 20 show how European countries can advance global health. Chapters also highlight the work of WHO country offices from a diplomacy perspective and the collaboration between WHO and the European Union. A discussion of future challenges for health diplomacy concludes this unique compilation.