Responding to COVID-19: A Resurgence of Global Health Diplomacy

Respondiendo a la covid-19: Un resurgimiento de la diplomacia en salud global

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Abstract:
This article highlights the relevance of joint work of the health diplomacy and the science diplomacy in responding to COVID-19 pandemic ithrough actors such as NGOs, business circles, research centers, universities, cities and other actors, underscoring the need for cooperation at all levels.

Resumen:
En este artículo, se destaca la relevancia del trabajo conjunto de la diplomacia en salud y la diplomacia científica para enfrentar la pandemia de covid-19, a través de los actores como ONG, comunidades empresariales, centros de investigación, universidades, ciudades, entre otros, lo que subraya la necesidad de la cooperación a todos los niveles.

Key Words:
Health diplomacy, COVID-19, pandemic, international cooperation, scientific cooperation, leadership, WHO.

Palabras clave:
Diplomacia en salud global, covid-19, pandemia, cooperación internacional, diplomacia científica, liderazgo, OMS.

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A resurgence of global health diplomacy in times of COVID-19

The second pandemic of the 21st century has radically changed the global health mindset, disrupting the usual pathways of international health relations. It has also changed the way health diplomacy is practiced, who is involved and how it can generate sustainable and equitable outcomes. The world is still grappling with the political reality that, despite the now one-year experience with a highly infectious virus worldwide, national selfishness and geopolitical games continue to overshadow public health considerations and global solidarity continues to be undermined by nationalism.

Initially, many countries responded to the pandemic with uncoordinated crisis diplomacy in the face of an unknown health threat. Normally after the declaration of a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO), countries around the world would have worked together to address the threat under its auspices, but the focus on national responses across the world and the geopolitical standoff between the United States and China did not allow for this to happen. Indeed, throughout 2020, we witnessed the increasing decoupling of global health, which has created complex problems for global health diplomacy. For example, the United States refused to accept agreements that included mentions of support of the WHO and initially insisted on calling COVID-19 "the China virus disease" in key political resolutions.

Countries competed rather than cooperated in the early months of the pandemic, either by not adhering to the International Health Regulations (IHR) and closing borders or by attempting to garner political good will from the geopolitical standoff. China was severely criticized for its lack of transparency; the United States for its lack of cooperation. In response, China, for example, moved to help address the lack of personal protective equipment such as facemasks in many countries. This "mask diplomacy" was carefully targeted and raised questions of political allegiance, for example when it sent masks to the heavily affected Italy, an European Union Member State and one of the European end points of the Chinese Belt and Road Initiative. Mask diplomacy is now being overtaken by a flurry of vaccine diplomacy as the politics of global vaccine distribution escalate.

To avoid and counteract such developments in the future, the President of the European Council has suggested a Global Pandemic Treaty.[1] This would be only the second international treaty in global health, after the Framework Convention on Tobacco Control. It would be considered the political complement to the International Health Regulations. Pre-negotiations to explore such a treaty began in early 2021.

How global health diplomacy is challenged

The classical, still valid and often cited concept defines the aim of global health diplomacy (GHD) as capturing "multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health".[2] Over the past 15 years, a very complex, dynamic and diversified political "ecosystem" has emerged, which global health diplomats have

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1 European Council, "Press Release by President Charles Michel on an International Treaty on Pandemics," December 3, 2020, at *https://www.consilium.europa.eu/en/press/press-releases/2020/12/03/press-release-by-president-charles-michel-on-an-international-treaty-on-pandemics/* (date of reference: February 5, 2021).

2 Ilona Kickbusch, Gaudenz Silberschmidt and Paulo Buss, "Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health," in *Bulletin of the World Health Organization*, vol. 85, no. 3, March 2007, 230-232, at *http://dx.doi.org/10.2471/BLT.06.039222* (date of reference: February 5, 2021).

to be able to navigate. On the one hand, GHD has ceased to be the exclusive domain of government representatives, while the contribution of a multitude of non-governmental organizations (NGOs), business circles, knowledge centres, cities and other actors, often referred to as multi-stakeholder diplomacy, now influences its outcome; but on the other, it has remained highly dependent on the willingness of nation-states to cooperate with one another, as the COVID-19 pandemic has clearly shown. GHD depends on a functioning and accepted system of multilateralism, within which it can both enhance and restrain the power of the players involved. The present crisis of multilateralism severely hampers progress in global health.

GHD is a manifestation of the increased importance of issue diplomacy, such as health and the environment. It refers first and foremost to negotiation processes within the multilateral system that address collective health-related challenges. At the core of GHD are health issues that transcend national boundaries and require global agreements, instruments and alliances if they are to be tackled successfully and sustainably through joint action. In view of the challenges experienced with the COVID-19 crisis, a consensus is being sought on how to ensure better equity and the provision of global public goods through international agreements. Of course, GHD, as indicated above, covers many other diplomatic processes, such as bilateral health diplomacy as manifested in donor relations.

In addition, GHD has become professionalized in recent years. More and more countries have responded to the growing challenge posed by increased global health risks not only by strengthening the international health departments within their health ministries and establishing health units in their foreign ministries, but also by assigning health attachés to provide public health expertise to their diplomatic missions in key hubs, such as New York and Geneva. Experience suggests that skills in diplomacy and negotiation, applied science and cross-cultural competencies are essential for the tradecraft of health attachés. A country's representation in global health negotiations has proven to be much more effective if a diplomat with public health training is available to work together with the diplomatic generalists of representations abroad or to international organizations.

It can be said that GHD combines the art of diplomacy with the science of public health: at its best, it balances concrete national interests with the collective health concerns of the larger international community;

reduces health inequities; secures human rights; and recognizes that effective international health interventions are ethical and sensitive to historical, political, social, economic, and cultural differences.

Innovative approaches to vaccine diplomacy

The COVID-19 pandemic has led to a significant increase in GHD activities in many different political venues and international organizations, especially through innovative approaches in the field of vaccine diplomacy. Vaccine diplomacy has a long history dating back to the 19th century. For example, in 1801 Dr. Edward Gantt, the chaplain of the U.S. Congress, vaccinated Native American diplomats who were visiting Washington, D.C., and in 1803, the Lewis and Clark Expedition was provided with smallpox vaccines intended for Native Americans living on the western frontier.[3] The great success of GHD combined with science diplomacy was cooperation between the Union of Soviet Socialist Republics (USSR) and the United States during the Cold War on both polio and smallpox eradication, putting aside ideology in the interests of health. So far it has not been possible to fully overcome the geopolitical de-coupling during the COVID-19 pandemic to achieve similar concerted action.

Modern vaccine diplomacy started with the creation of Gavi, the Vaccine Alliance in 2000 after it was recognized in the late 1990s that coverage of the six basic vaccines under the WHO Expanded Programme on Immunization had been stagnating or declining, and that other vaccines, including new, potentially lifesaving ones, were too expensive for developing countries. By 2018, Gavi-funded programs had reached over 700 million children. Many countries gained access to rotavirus and *Haemophilus influenzae* type B vaccines. The Gavi Alliance also facilitated the development of a new *Streptococcus pneumoniae* vaccine.[4]

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[3] Peter J. Hotez, "'Vaccine Diplomacy': Historical Perspectives and Future Directions", in *PLOS Neglected Tropical Diseases*, vol. 8, no. 6, June 26, 2014, e2808, at *https://doi.org/10.1371/journal.pntd.0002808* (date of reference: February 5, 2021).

[4] "Gavi, the Vaccine Alliance", at *https://www.gavi.org/* (date of reference: January 27, 2021).

The COVID-19 crisis revived the field of vaccine diplomacy by re-opening the debate on how to ensure affordable and equitable access to vaccines as a global public good. In the past, the term "vaccine diplomacy" referred to all aspects of global health diplomacy pertaining to the development, manufacture, and delivery of vaccines as global public health goods. Among the key features of vaccine diplomacy are its potential as a humanitarian intervention and its proven role in helping to mediate the cessation of hostilities and ceasefires during vaccination campaigns.

In the face of a truly global pandemic, its nature has changed as it becomes clearer that individual countries or regions cannot be protected unless the global threat is addressed. Therefore, the term is mainly used today to express the use of COVID-19 vaccines for geopolitical intent to boost soft power or to work together to ensure collective access to vaccines. Examples of such diplomacy are, on the one hand, competition between India and China and their respective vaccines, which are being made available to neighbors and geopolitical allies,[5] and on the other, attempts to negotiate access to a global public good.

Health diplomacy meets science diplomacy

While countries were grappling to come to terms with diplomatic responses to a global health crisis of unprecedented impact on health, economics, and social life, a strong new diplomatic dynamic emerged—driven by the WHO—between a wide range of stakeholders to find vaccines, therapeutics and diagnostics to counteract the pandemic. It became clear early on that it would take an intensified global health diplomacy effort to find common ground in the development, production, purchasing and distribution of COVID-19 vaccines that bore the promise of being able to defeat the virus. A result of this was the creation of the Access to COVID-19 Tools (ACT) Accelerator in 2020, an important global collaboration to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines, achieved in record time. The initiative brings together gov-

[5] Kim Beng Phar and Clementine Bizot, "The Jury Is Still Out on Beijing's 'Vaccine Diplomacy'", in *The Diplomat*, January 20, 2021, at *https://thediplomat.com/2021/01/the-jury-is-still-out-on-beijings-vaccine-diplomacy/* (date of reference: February 5, 2021).

ernments, scientists, businesses, civil society, and philanthropists and global health organizations (the Bill & Melinda Gates Foundation, CEPI, FIND, Gavi, The Global Fund, Unitaid, Wellcome Trust, the WHO, and the World Bank) to speed up an end to the pandemic.

COVAX is the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator. The COVAX Facility—co-led by Gavi (The Vaccine Alliance), CEPI (The Coalition for Epidemic Preparedness Innovations) and WHO—is a global risk-sharing mechanism for pooled procurement and equitable distribution of eventual COVID-19 vaccines. It has been termed the largest, most encompassing and challenging international agreement since the Paris Agreement on Climate Change. The speed with which this was established has no precedent in global health. Yet there have been bumps on the road as the unimaginable happened: the first vaccine became available at the end of 2020 and a whole range of other vaccine candidates from all around the world followed suit.

Key leaders agree that the only truly global solution to this pandemic will be to ensure that people everywhere will get access to COVID-19 vaccines once they are available, regardless of their wealth. But here, too, global vaccine diplomacy has come up against vaccine nationalism, with certain countries attempting to ensure large contingents of vaccine for its own population. Now vaccine diplomacy has also come to include negotiations between companies and countries (depending on how the vaccines are produced and who owns the patents) on procurement and pricing. One key initial problem was that the United States, after having announced it would leave the WHO, also decided not to join COVAX and embarked on a vaccine shopping spree that left most of the world behind. The new Biden administration has now agreed to join COVAX, which has caught up on organizations and funding and is on track to deliver at least 2 billion doses by the end of 2021, including at least 1.3 billion doses to 92 lower income economies to vaccinate their most vulnerable population groups.

Building on the experiences of decades of crisis-based health diplomacy

Crisis-based health diplomacy has many historical precedents, beginning with 19th-century cholera pandemics. "Modern" health crisis diplomacy

emerged in the early 2000s, when the HIV epidemic, a global cross-border health threat, was placed on the agenda of the U.N. General Assembly and Security Council, notably in the Declaration of Commitment on HIV/AIDS "Global Crisis–Global Action," adopted on June 27, 2001 at the special session of the General Assembly on HIV/AIDS.[6] Multilateral cooperation and diplomacy have further helped in responding effectively to tuberculosis and malaria, and have paved the way for large-scale vaccination campaigns in fragile settings. Over the past 20 years, outbreaks of avian influenza, severe acute respiratory syndrome (SARS-CoV), Middle East respiratory syndrome (MERS-CoV), Ebola and COVID-19 have posed further challenges to the international multilateral order, international organizations and crisis diplomacy in general.

The SARS-CoV epidemic that affected over 25 countries in 2003 served as a wake-up call for the international system. In its wake, revisions to the International Health Regulations (IHR) were negotiated by WHO Member States and finally endorsed in 2005 as an international legally binding framework by the World Health Assembly. In adopting the revised IHR, Member States committed to reporting to the WHO any disease outbreaks that had the potential to become global public health threats.

Within less than 10 years, health diplomacy was confronted with the failure of countries and international agencies to respond effectively to the first outbreak of ebola, which began in West Africa in early 2014. Here, too, lack of coordination between the affected countries was a defining factor when taking decisions with economic and political implications. Bilateral and multilateral efforts were undertaken to support countries in their fight against the epidemic in Africa and to prevent it from escalating into a global pandemic. The U.N. Secretary-General appointed a Special Envoy on Ebola, while ad hoc ambassadors were designated by a number of countries and the European Union to conduct the crisis diplomacy required. The U.N. Security Council adopted resolution 2177 (2014) on the Ebola outbreak[7] and its impact in Africa and beyond.

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6 United Nations Human Rights, "Declaration of Commitment on HIV/AIDS", at *https://www.ohchr.org/EN/ProfessionalInterest/Pages/CommitmentOnHIVAIDS.aspx* (date of reference: February 5, 2021).

7 United Nations Security Council, "Resolution 2177 (2014)", S/RES/2177 (2014), September 18, 2014, at *http://unscr.com/files/2014/02177.pdf* (date of reference: February 5, 2021).

Instruments negotiated in the face of the global health crisis

Crisis diplomacy covers issues as diverse as multilateral and bilateral aid, border closures, the pooling of scientific information, and the design and development of medicines and vaccines. Once the Ebola outbreak was over, health diplomats called for a reinforcement of the IHR, the creation of a contingency fund and the establishment of a global health emergency workforce (World Health Assembly resolutions A68/22, A68/24, A68/26 and A68/27).[8] A WHO Health Emergencies Programme was established in 2016 at the request of the World Health Assembly. In terms of health crisis management, the most important lessons learned from the Ebola epidemic were the need for countries to fulfil their obligations under the IHR effectively and the urgent necessity of empowering the WHO to monitor implementation of the IHR and promote health-related data transparency.

The recent COVID-19 crisis has made it clear that these lessons were not fully heeded. It has also illustrated that the world is endangered if the instruments negotiated at the global level between countries are not implemented at the national level. Fifteen years after the negotiation of the IHR, many countries are still far from having established the structures required and now find themselves up against new challenges as COVID-19 rages. The proposal for a Global Pandemic Treaty is therefore both timely and necessary.

Outbreaks of SARS-CoV, AH1N1 influenza, Ebola, MERS-CoV and Zika, along with the growing problem of antimicrobial resistance, have made the production, financing and availability of adequate and effective vaccines an even more sensitive political issue. Geopolitical and national interests have hampered negotiations on vaccination. A "securitization" of the public health agenda made itself felt in these negotiations, as did lobbying by health and pharmaceutical industries, while increasing insistence on national sovereignty has slowed down global talks. Notably, during the long process of the WHO-convened Intergovernmental Meeting on Pandemic

[8] World Health Organization, "WHA68: Main Documents", May 26, 2015, at *https://apps.who.int/gb/e/e_wha68.html* (date of reference: February 5, 2021).

Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits (2007-2010), Member States failed to come to an understanding for years because they could not agree on the assets to be provided to developing countries.

Indonesia, for example, was reluctant to share viral sequences. A compromise was eventually reached whereby pharmaceutical manufacturers were no longer permitted to access data on and samples of circulating viral strains for the development of influenza vaccines unless they committed to benefit-sharing arrangements, including the provision of a certain percentage of influenza vaccines at heavily discounted prices. Other benefits included such measures as technology transfers and improved access to diagnostic reagents and influenza test kits—resources that many lowincome countries had previously been struggling to obtain. All these GHD issues will come to the fore again in the various aspects of the pandemic response, especially as regards scientific cooperation and data sharing. For example, advances in gene sequencing have allowed scientists to trace and monitor the COVID-19 pandemic faster than any previous outbreak. The next frontier of pandemic cooperation will be a multilateral consensus on meaningful (health) data governance.[9]

Global health diplomacy in the face of vaccine nationalism

Now that vaccines are available, the COVID-19 pandemic has abruptly reraised the question of how they will reach everyone who needs to be vaccinated. Political and global leaders have called for COVID-19 vaccines to be treated as a global public good that should be available to all.[10] Nevertheless, rich countries have rushed to place advance orders to ensure vaccine

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9 Rohinton P. Medhora, "We Need a New Era of International Data Diplomacy", in Centre for International Governance Innovation, January 18, 2021, at *https://www.cigionline.org/articles/we-need-new-era-international-data-diplomacy* (date of reference: February 5, 2021).

10 UNAIDS, "Uniting behind a People's Vaccine against COVID-19", May 14, 2020, at *https://www.unaids.org/en/resources/presscentre/featurestories/2020/may/20200514_covid19-vaccine-open-letter* (date of reference: February 5, 2021).

access for their citizens, since it is expected that supply will be limited. This raises important questions concerning vaccine access for people in developing countries, particularly in middleincome countries that are not eligible for support from the Gavi Alliance or other international aid mechanisms.

What we have seen—as geopolitical power has shifted and scientific excellence has been developed in countries like India and China—, is that countries such as these are setting high goals for the vaccination of their population. India has embarked on the world's largest vaccination drive using indigenous vaccines and aims to vaccinate 300 million people by August 2021, but already the drive has been hampered by logistical and technical difficulties and fears over vaccine safety.

At present, the task of fostering effective global cooperation and deciding who should be given priority access to vaccines (WHO has developed guidelines on this) has been pushed aside by the current disarray of multilateral health governance and the nationalistic, free-market-driven, competitive approaches taken by some countries. On the upside, there are several vaccine diplomacy initiatives that point in the right direction. The alliance between several European Union countries for the pooled, advance purchase of vaccines, for example, requires the pharmaceutical companies with which the European Union contracts to make a portion of vaccine supplies available to low-income countries. The COVAX Facility allows participating countries to pool their resources so that they can back the development of a larger number of candidate vaccines than any single country could do on its own. If a vaccine is successful, doses will be distributed equitably through the COVAX Facility as they become available between self-financing countries (there are currently 75), which will pay for their own doses, and developing countries (currently 90) that would otherwise be unable to afford the vaccine. This approach is now moving forward also with Chinese and Russian vaccines in different parts of the world.

The increasing politicization of global health

Global Health Diplomacy in times of COVID-19 underlines the increasing politicization of global health. In 2007, a group of foreign ministers from seven countries highlighted the interface between foreign policy and global health and agreed "to make impact on health a point of departure and

a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies, and to engage in a dialogue on how to deal with policy options from this perspective".[11]

More than 10 years later, the interface between global health and foreign policy has become increasingly dynamic, with both positive and negative implications for health. Global health is now integral to the foreign policy agendas of many countries, notably in relation to economic and social development, security, humanitarian affairs, social justice and human rights, and global crisis management. The number of multilateral health negotiations, instruments, organizations and venues has increased significantly. Health is now part and parcel of global negotiations on food, climate, energy and water, and is discussed at major global and regional summits. This is largely due to the adoption of the Sustainable Development Goals (SDGs) in September 2015[12] and the inclusion of health in the deliberations of both the G7 and the G20.

These developments have highlighted that GHD, like all diplomacy, is always political. Global health professionals are wary of what they consider the politicization of global health, but it is an illusion to think it can be avoided. The increasing involvement of political leaders and actors in health matters can indeed work in two directions: it can be the decisive factor in rallying political support for global health or it can undermine global health if narrow geopolitical or ideological agendas prevail. Both types of effect were observed during the COVID-19 pandemic. The erosion of shared norms can also lead to very difficult negotiations and disagreement on other areas of national policy. For example, a liberal versus a restrictive position on immigration or on women's rights often has a strong impact on health negotiations at the global level and makes it difficult to reach consensus.

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11 Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand. "Oslo Ministerial Declaration – Global Health: A Pressing Foreign Policy Issue of Our Time", in *The Lancet*, vol. 369, no. 9570, April 21, 2007, 1373, at *https://doi.org/10.1016/S0140-6736(07)60498-X* (date of reference: February 5, 2021).

12 United Nations General Assembly, "Transforming Our World: The 2030 Agenda for Sustainable Development," in William Rosa (ed.), *A New Era in Global Health: Nursing and the United Nations 2030 Agenda for Sustainable Development*, New York, Springer Publishing Company, 2017, 529-567, at *https://doi.org/10.1891/9780826190123.ap02* (date of reference: February 5, 2021).

Recent examples illustrating the politicization of health include negotiations on universal health coverage at the United Nations,[13] endless discussions on the health rights of refugees and migrants, also at United Nations fora,[14] and the compromise achieved for the World Health Assembly resolution on the COVID-19 response.[15] In all these cases, health objectives were diluted because of national political positions.

Geopolitical tensions and health diplomacy

The specific national and geopolitical context has always been important in GHD. During the Cold War between the former Soviet Union and the United States (and their allies), ideological conflict was inseparable from the negotiations conducted at the United Nations and the WHO, especially negotiations concerning the role of the state and the private sector in the provision of health care. Since the 1990s, positions detrimental to the advancement of global health have been closely tied in with the protection of economic interests and industries (for example, tobacco and pharmaceuticals), including patents and intellectual property rights. Almost all Member States use health negotiations to promote their industrial policy or their perceived economic interests, but they rarely do so openly in the context of health organizations, preferring instead to invoke health or humanitarian arguments.[16]

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13 United Nations General Assembly, Political Declaration of the High-Level Meeting on Universal Health Coverage, A/RES/74/2, October 18, 2019, at *https://undocs.org/en/A/RES/74/2* (date of reference: February 5, 2021).

14 United Nations General Assembly, "Intergovernmental Conference to Adopt the Global Compact for Safe, Orderly and Regular Migration. Draft outcome document of the Conference: Note by the President of the General Assembly," A/CONF.231/3, July 30, 2018, at *https://undocs.org/en/A/CONF.231/3* (date of reference: February 5, 2021).

15 Seventy-Third World Health Assembly, "COVID-19 response," WHA73.1, May 19, 2020, at *https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf* (date of reference: February 5, 2021).

16 Marcos Cueto, Theodore M. Brown and Elizabeth Fee, *The World Health Organization: A History*, Cambridge, Cambridge University Press, 2019.

Since early 2020, geopolitical tensions between China and the United States have become a determining factor in global health diplomacy, with wide-ranging implications. These tensions came to a head during the COVID-19 pandemic, when the United States declared its intention to withdraw from the WHO (a decision that was repealed by the new Biden administration). Generally speaking, though, the threat posed by COVID-19 has accelerated multilateralism and cooperation in Europe, despite the closing of borders, protectionist policies and trade restrictions imposed during the early response to the pandemic. The African Union has secured a provisional 270 million COVID-19 vaccine doses from manufacturers for Member States to supplement the COVAX program.

It is clear that, because of shifts in ideology and geopolitical power, the agreements, declarations, positions and approaches adopted through multilateral negotiations in the past can no longer be taken for granted. The constant conflicts on human rights matters are a case in point. Representatives of civil society and communities expect their positions and concerns to be taken into account in formal negotiations. Social media has also encouraged wider debate on and greater public involvement in global affairs, but in some cases, it has contributed to an erosion of trust in the international system or reinforced conspiracy theories about who sets global priorities. This can create considerable difficulties for the technical and evidence-based work of health organizations and for the consensus-oriented approach to global health diplomacy in the governing bodies of the United Nations and the WHO. Social media therefore needs to be factored in as a potentially critical new element in both diplomacy and policy-making as countries and leaders themselves increasingly use these channels.

The challenges for GHD in a divided world are intensifying because—partly as a result of the COVID-19 crisis—it is highly unlikely that the health-related SDGs can be achieved by 2030.[17] Indeed, the main task for the near future is to make up for the development losses caused by the devastating impact of COVID-19 and some of the measures taken to combat the pandemic. Here, too, the impact of vaccine nationalism must be kept in mind:

[17] The Lancet, "Global Health: Time for Radical Change?" in *The Lancet*, vol. 396, no. 10258, October 17, 2020, 1129, at *https://doi.org/10.1016/S0140-6736(20)32131-0* (date of reference: February 5, 2021).

if mainly rich countries vaccinate their populations and poor countries are shut out, the global economy would suffer a loss of $9 trillion, as a study commissioned by the International Chamber of Commerce shows. The economic argument follows the health argument: "No one will be safe until all are safe" and "No economy will be fully recovered unless the other economies are recovered."[18]

The global health diplomacy system

The various responses to COVID-19 have illustrated once again that global health diplomacy is an extensive and complex system composed of many non-health stakeholders, global health institutions, diverse mechanisms, and a very broad range of actors. These elements come together in governance spaces to negotiate, discuss and make decisions on important health-related issues. Of all the global health platforms, the WHO is the most important because of its normative functions and treaty-making powers. Every year its 194 Member States negotiate, discuss and make decisions at the World Health Assembly. Approximately 4000 participants worldwide strive to support the WHO's mandate on achieving the highest attainable standard of physical and mental well-being for all their citizens. Now, in times of COVID-19, all governing bodies meet virtually. This, too, is a major challenge for GHD.

Like other diplomatic practices, the global health diplomacy system comes under stress when the foreign interests of Member States do not align with the interests of their health ministries and the Secretariat's evidence-based recommendations. Health attachés are actors who work on their mission's health-related topics, but they are still diplomats who represent their countries' interests on the international arena. Therefore, their role in bridging the gap between the state's interests and global public health is essential, especially in today's atmosphere, where foreign policy and health are linked more than ever.

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[18] Peter S. Goodman, "If Poor Countries Go Unvaccinated, a Study Says, Rich Ones Will Pay," *The New York Times*, January 23, 2021, at *https://www.nytimes.com/2021/01/23/business/coronavirus-vaccines-global-economy.html* (date of reference: February 5, 2021).

Another critical factor that facilitates global health negotiations is to involve different actors in the negotiation process. Consultation and dialogue with Member States, civil society organizations and the private sector can make an enormous difference in reaching a consensus on proposals and speeding up the process. The involvement of these actors may differ from one institution to another. The WHO regulates these types of relations via the Framework for Engagement with Non-State Actors (FENSA), which governs its relations with civil society and other private actors. Non-state actors can include NGOs, private-sector entities, philanthropic foundations and academic institutions.

Geneva has a strong presence in the global health system due to the comprehensive network of global health institutions and actors located here, including the WHO and other United Nations organizations, such as the World Trade Organization and the International Labour Organization. New York is also an important global health venue and home to the United Nations headquarters, where decisions on the SDGs (more importantly, SDG3 on good health and well-being) are taken. In addition to these venues where high-level summits are organized, G7 and G20 meetings and other major conferences are also important forums for the stakeholders and actors that shape health-related policies. Despite initial opposition to including global health in their deliberations, the COVID-19 pandemic has shown how critical health matters are for the global economy. Meetings of health and finance minters have therefore also gained traction.[19]

Seven aspects of global health diplomacy

There are seven aspects to global health diplomacy, all of which contribute to successful negotiations and promote, support, respond and build favorable health outcomes. In other words, these aspects constitute global health negotiation efforts. All of these aspects have been highly relevant during the COVID-19 pandemic.

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[19] I. Kickbusch, Haik Nikogosian, Mihály Kökény and Michel Kazatchkine, *A Guide to Global Health Diplomacy: Better Health – Improved Global Solidarity – More Equity*, Geneva, Graduate Institute of International and Development Studies, 2021.

- Negotiations to promote health and well-being over other interests—this was only partially successful.
- Establishment of new governance mechanisms in support of health and well-being. This has been one of the major successes with the establishment of the ACT-A[20] and COVAX initiatives, for example.
- Creation of alliances in support of health and well-being outcomes. Countries have formed alliances to promote WHO reform in the face of the pandemic. For instance, France and Germany initiated the Alliance of Multilateralism and supported WHO efforts during the COVID-19 crisis. The countries of the African Union have come together for vaccine purchasing.
- Building and management of donor and stakeholder relations. Negotiating funding for the global pandemic response has been one of the greatest challenges for the WHO, but also for the many new initiatives such as COVAX. A high-level G20/European Union conference is planned to address these difficulties.
- Responding to public health crises. A number of commissions are assessing how well the WHO responded to the COVID-19 crisis. They will make reform suggestions in their reports, which will then be negotiated by Member States.
- Improvement of relations between countries through health and well-being. The use of vaccine diplomacy to create good relations (or dependencies) has come to the fore, but there are many forms of support, for example by sharing and exchanging scientific information.
- Contributing to peace and security. A systemic approach to addressing COVID-19 challenges in war zones and for refugees and migrants has yet to be developed. Jordan was one of the first countries to start COVID-19 vaccinations for refugees. [21]

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[20] Born of a joint push by Gates, the Wellcome Trust and CEPI that included the WHO, Gavi, GF, European and other governments at the time. Its governance and the transparency of its decision-making are not exemplary.

[21] I. Kickbusch, H. Nikogosian, M. Kökény, and M. Kazatchkine, *op. cit.*

The future of global health diplomacy

As the pandemic continues to rage, it is worth asking what global health diplomacy will look like in the aftermath of COVID-19. It is difficult to predict what the focus of GHD will be in the coming years; whether we will have the courage to create a new, strictly monitored and accountable global pandemic treaty to complement the current, fragile International Health Regulations,[22] which have proven insufficient in critical times, or whether countries will negotiate formal requirements for vaccine passports. It is likely that "in the face of a clash between two conflicting trends—growing international interdependence on the one hand and counties moving toward a policy of isolationism on the other—, diplomats will become the protagonists of a new brand of globalization".[23] Much of this development will take place in a new mix of face-to-face and virtual meetings and the use of social media for diplomatic purposes.

As regards GHD venues, the main focus of health negotiations remains the World Health Organization. However, it is important not to underestimate the health-related function of other emerging global political settings such as the United Nations, the Group of 7 (G7), the Group of 20 (G20) and regional organizations, which will take on greater relevance due to the impact of the pandemic.

Experience with the COVID-19 response[24] has shown that the WHO needs to be given substantive powers to fulfil its mission "as the directing and co-ordinating authority on international health work",[25] as enshrined in its Con-

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22 World Health Organization. "International Health Regulations (2005) Third Edition", at *http://www.who.int/ihr/publications/9789241580496/en/* (date of reference: February 5, 2021).

23 Michael Brodsky, "Diplomacy after the Coronavirus", *The Jerusalem Post*, April 4, 2020, at *https://www.jpost.com/opinion/diplomacy-after-the-coronavirus-623586* (date of reference: February 5, 2021).

24 The Independent Panel for Pandemic Preparedness & Response, "Second Report on Progress for the WHO Executive Board", January 2021.

25 Constitution of the World Health Organization, article 2 (a), in WHO, *Basic Documents: Forty-ninth edition*, Geneva, WHO, 2020, p. 2, at *http://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf* (date of reference: February 5, 2021).

stitution (1948). To this end, its mandate needs to be further strengthened to protect and promote global public health, particularly through the prevention, detection and response to future outbreaks.[26] In light of all these developments, it would be advisable to revisit the goals, mechanisms and tools of GHD at all levels of governance on a regular basis.

[26] Richard Alderslade, Mihaly Kokeny and Agis Tsouros. "The Health of the Public: What Has Gone Wrong?", in *South Eastern European Journal of Public Health*, vol. XV, December 7, 2020, at *https://doi.org/10.4119/seejph-3996* (date of reference: February 5, 2021).