Navigating the Global Health Terrain: Mapping Global Health Diplomacy

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Articles

NAVIGATING THE GLOBAL HEALTH TERRAIN:
MAPPING GLOBAL HEALTH DIPLOMACY*

David P. Fidler**

ABSTRACT

This article engages in mapping thinking and practice on global health diplomacy. Increased interest in "global health diplomacy" and "health diplomacy" heightens the need for more rigorous descriptive, conceptual, analytical, and practical approaches to these phenomena. This article discusses why more rigor is needed with respect to global health diplomacy, provides a way to describe global health diplomacy that provides a foundation for further analysis, explores conceptual underpinnings of global health diplomacy to deepen the mapping exercise, and offers a simple but flexible analytical template for use in mapping different aspects of global health diplomacy. The article concludes with thoughts on the importance of mapping for helping States, intergovernmental organizations, and non-State actors move

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towards shaping global health diplomacy in ways that contribute to improvements to humanity's health.

**KEYWORDS:** diplomacy, global health, global health diplomacy, global health politics, global health governance, globalization, international relations
I. INTRODUCTION

The profile of health as an issue in global politics has grown significantly in the past 10-15 years. This increased political prominence for health is a new phenomenon for those working in foreign policy and global health in the early 21st century. This development and its novelty have increased interest in what is increasingly called “health diplomacy” or “global health diplomacy.” The different ways people use these terms exhibit diversity, which makes it hard to understand what they mean and whether people are talking about the same thing. Such diversity is to be expected in early stages of attempts to identify and explain significant changes in global affairs.

However, with growing interest in global health diplomacy, the need for more rigorous approaches to this concept is increasingly important. This article engages in mapping thinking and practice on global health diplomacy. The newness of this area means that any mapping exercise has to be iterative because the complexity and fast-moving nature of the topic are not conducive to definitive conclusions. However, this challenge is not different from ones faced in many areas of international relations. In this and other respects, health is not unique in terms of problems and issues that have emerged in global political life.

This article’s approach to mapping global health diplomacy focuses on five tasks. First, I explain why moving beyond rhetoric about global health diplomacy towards more descriptive, conceptual, analytical, and practical rigor is important to those concerned about how States, intergovernmental organizations, and non-State actors deal with health problems in international relations (Part II). Excitement and hope about health’s potentially transformative impact on foreign policies and global politics are important, but, without better frameworks for understanding and harnessing

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1 See, e.g., the series of six articles on global health diplomacy published in PLoS Medicine in 2010: Harley Feldbaum & Joshua Michaud, Health Diplomacy and the Enduring Relevance of Foreign Policy Interests, 7(4) PLOS MED. e1000226 (2010); Kelley Lee et al., Brazil and the Framework Convention on Tobacco Control: Global Health Diplomacy as Soft Power, 7(4) PLOS MED. e1000232 (2010); Lai-Ha Chan et al., China’s Engagement with Global Health Diplomacy: Was SARS a Watershed?, 7(4) PLOS MED. e1000266 (2010); David P. Fidler, Negotiating Equitable Access to Influenza Vaccines: Global Health Diplomacy and the Controversies Surrounding Avian Influenza H5N1 and Pandemic Influenza H1N1, 7(5) PLOS MED. e1000247 (2010); Kerri-Ann Jones, New Complexities and Approaches to Global Health Diplomacy: View from the U.S. Department of State, 7(5) PLOS MED. e1000276 (2010); Sigrun Megedal & Benedikte L. Alveberg, Can Foreign Policy Make a Difference to Health?, 7(5) PLOS MED. e1000274 (2010).

2 This growing interest is reflected in the establishment of the Global Health Diplomacy Network that “brings together researchers and practitioners with the common goal of improving capacity for health diplomacy.” Global Health Diplomacy Network, http://www.ghd-net.org/ (last visited Feb. 27, 2011).
these motivations, the effort to strengthen the voice of health in foreign policy circles and global diplomatic forums will be less effective.

Second, the article develops an approach to describing global health diplomacy (Part III) because, to date, the concept has been used in ways that are not consistent or coherent. Such diversity in thinking about global health diplomacy is neither alarming nor debilitating, but the mapping exercise requires a common descriptive template of the activities being studied. Without such a template, we run the risk of using global health diplomacy as a catch-all term for overlapping but distinct processes, thus diminishing prospects for greater analytical clarity.

Third, the article explores conceptual underpinnings for global health diplomacy by examining theoretical concerns that arise with respect to the practice of diplomacy and the pursuit of health as a policy objective (Part IV). Serious dangers in these contexts exist without some conceptual frameworks to explain what is happening in global health diplomacy. Public health experts unfamiliar with theoretical approaches to understanding diplomacy can exaggerate the importance of health in international relations and minimize the difficulties diplomacy faces in any issue area. Similarly, diplomats unfamiliar with conceptual frameworks elucidating the significance of health might miss opportunities to give health the political traction it deserves.

Fourth, the article presents some analytical ways to break down and chart the complex elements that make up the structure and dynamics of global health diplomacy (Part V). The descriptive and conceptual complexity of these elements make the mapping challenge difficult, and developing a simplified template helps center analysis so that, for any given issue or problem, the key actors, processes, and pressure points can be more readily identified.

Fifth, the article offers some thoughts on how mapping exercises can help move towards efforts to shape global health diplomacy. In everyday life, maps help us identify where we are and, more often, how to get to a selected destination. Any mapping exercise for global health diplomacy cannot forget that the ultimate point of the exercise is to assist policy makers shape policy more effectively for objectives established as normatively important. Moving from mapping to shaping global health diplomacy reveals the difficulties the objective of advancing health globally may confront diplomatically.
II. GETTING REAL: MOVING FROM RHETORIC TO RIGOR WITH RESPECT TO GLOBAL HEALTH DIPLOMACY

The ways in which global health diplomacy and health diplomacy are used are, if you will, all over the map. This diversity reveals the political attractiveness of these terms with respect to purposes that do not synchronize. On one end of the spectrum, linking the words “health” and “diplomacy” produces the possibility of centering international relations on health as the normative engine of political cooperation and progress. Health can, perhaps, transform the nature and practice of foreign policy and diplomacy.

On the other end of the spectrum, linking “health” and “diplomacy” captures the attempt to use health instrumentally to achieve other foreign policy and diplomatic goals not grounded in health thinking or interests. Far from being transformative, health merely becomes another mechanism for a country individually, or countries collectively, to exercise “soft power” or “smart power” to achieve other strategic or tactical interests in global politics.

The existence of such different views on the relationship between health and diplomacy is not surprising, but, without more intellectual and analytical rigor, the concepts of “global health diplomacy” and “health diplomacy” become little more than rhetorical devices employed with equal skill and fervor by people who are not talking about the same things. Getting beyond rhetoric requires more systematic attention to what we mean by global health diplomacy, why we use this concept, and where this idea can take us.

A. What is Global Health Diplomacy?

The spectrum of views about the relationship between health and diplomacy expresses different practical and normative perspectives on health and diplomacy as policy activities. Mapping global health diplomacy
must take account of the two opposing perspectives mentioned above and views that fall in-between because we see, empirically, actors in international relations connecting health and diplomacy in many ways. The normative, transformative energy exhibited by many global health activists co-exists with the cold calculations of the diplomat who seeks, by any means available, to protect, augment, and advance his or her nation’s interests, power, and influence.

The broad scope needed to accommodate the diverse activities undertaken in the realm of global health diplomacy contributes to the rhetorical attractiveness of the term but not to its analytical utility. Thus, global health diplomacy often becomes an interchangeable term for “global health governance” or “global health politics.” Conflating global health politics, diplomacy, and governance produces confusion rather than clarity. These activities overlap, but, in terms of a mapping exercise, analysis needs to distinguish between them to help delineate key characteristics of each one.

As Figure 1 below depicts, the overlapping relationships between politics, diplomacy, and governance in international relations locate diplomacy between politics and governance. In other words, the traditional understanding of diplomacy views it as the process through which States articulate, advance, and defend their national interests in political and economic interactions with other States. When interests converge sufficiently, States utilize diplomacy to craft collective action solutions—governance—on specific problems.

Functionally, diplomacy (1) forces actors in international relations to formulate and articulate their interests from the hurly-burly of domestic and international politics; and (2) provides the means to translate and sustain common interests into and through governance strategies and mechanisms. Governance settles politics and diplomacy into agreed patterns, providing for more consistency, transparency, and predictability in how actors handle problems diplomatically and politically.
Diplomacy serves the same functions in global health. Global health politics involve many actors and issues, and the interaction of actors and the handling of issues do not necessarily involve diplomatic activity. For example, commentators often remark that globalization has forced many health issues historically handled domestically into the world of diplomacy. While communicable disease issues have long been the subject of diplomatic activity, recent developments find more non-communicable health concerns and diseases (e.g., road traffic injuries, tobacco, and chronic diseases) becoming the focus of diplomatic attention. This diplomatization of non-communicable disease and health problems has, functionally, forced actors to formulate their interests, articulate and advance them, and determine what to do, if anything, if interests converge on the need to address such problems collectively.\(^7\)

The boundaries between politics, diplomacy, and governance are not, of course, stark and fixed as Figure 1 statically depicts. Some areas of international relations have more politics than diplomacy because the nature of the problem in question does not spill across national boundaries sufficiently to activate diplomatic resources. For example, historically

\(^7\) A good example of the diplomatization of non-communicable disease problems involves the decision by the United Nations (UN) General Assembly to hold a high-level meeting on non-communicable diseases in September 2011, which triggered pre-meeting diplomacy on the subject matter and possible outcomes of the meeting. On this process, see General Assembly of the UN, High-Level Meeting on Non-Communicable Diseases, http://www.un.org/en/ga/president/65/issues/ncdiseases.shtml (last visited Feb. 27, 2011).
States engaged in more diplomacy on trade issues than on health issues. Health was a subject of politics, but it did not for many decades, as trade did, stimulate much diplomacy outside limited contexts associated with trade and economic activities (e.g., the spread of communicable diseases).  

Some areas of global affairs experience more diplomacy than governance because of the lack of converging interests or the absence of effective mechanisms for collective action. An example of this pattern comes from efforts to counter terrorism. Tremendous diplomatic activity occurs on the threat of terrorism. However, this intense diplomacy has produced governance mechanisms, such as threat-specific counter-terrorism treaties, that have proved insufficient to deal with the changing nature of the terrorist danger, leading to efforts to change how States engage in collective action on terrorism.

Some areas of international politics have more governance than other areas, meaning that patterns of politics and diplomacy are grooved more deeply in the interactions of actors. Compare, for example, the broad, comprehensive, and centralized system of governance for international trade housed in the World Trade Organization (WTO) with the fragmented, often shallow, and incomplete nature of governance addressing global health problems.

Connecting politics, diplomacy, and governance in this fashion reflects their mutual relationships. Politics continues simultaneously with diplomacy and governance, and diplomacy continues to support governance mechanisms once established. What is important analytically is the need to distinguish the three activities and not to use one label—global health diplomacy—when referring to all three or when discussing global health politics or global health governance.

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8 International health diplomacy began in the mid-19th century because of concerns about the negative trade impact of the imposition of national quarantine measures. The long series of international sanitary conferences and conventions that followed were as much about trade as they were about protecting population health. On the early decades of health diplomacy, see David P. Fidler, The Globalization of Public Health: The First 100 Years of International Health Diplomacy, 79(9) BULL. WORLD HEALTH ORG. 842 (2001).


10 A significant shift from the treaty-based approach occurred when, after the terrorist attacks of 9/11, the UN Security Council adopted decisions binding on UN member States under Article 25 of the UN Charter on addressing the terrorist threat. See, e.g., S.C. Res. 1373, U.N. Doc. S/RES/1373 (Sept. 28, 2001).

B. Why Global Health Diplomacy?

As noted above, the rhetorical appeal of global health diplomacy indicates that this concept has significant normative appeal and reach. The increasing use of the concept also reveals an appreciation in many communities, ranging from Machiavellian diplomats to global health idealists, of changes in international relations that focus more political attention on health issues. The answer to why we refer to global health diplomacy more frequently today has, therefore, empirical as well as normative features. Mapping global health diplomacy must accommodate these empirical and normative features when analyzing why global health diplomacy has become more prominent.

Focusing on these empirical and normative aspects of global health diplomacy helps illuminate critical characteristics of this burgeoning area of concern. On the normative side, arguments that global health diplomacy promises great things for not only global health but global politics more broadly might strike historians of diplomacy as odd and, perhaps, ill-informed. The reader will no doubt be familiar with traditional skepticism about diplomacy. What is a diplomat? A person sent abroad to lie for his or her country. The nature of diplomacy, and the techniques diplomats refined to navigate the dangerous shoals of international politics, have long been the source of cynicism. On the one hand, diplomacy was critical for States and their interactions, as evidenced by international legal protections for diplomatic immunities and privileges. On the other hand, diplomacy has long been considered subservient to national interests and power, limiting what diplomats could actually achieve. In this view, diplomacy represents something of a Sisyphean effort—commanded but futile in the long run with respect to more ambitious goals.

Activists for global health sometimes embrace global health diplomacy without perhaps pausing to consider why, through much of the history of the modern international system, diplomacy has not been held in high regard, particularly with respect to effecting and sustaining significant normative change in international relations. Thinkers who sought to devise better worlds often avoided trying to fix diplomacy and focused on either the underlying politics of international relations or the governance mechanisms needed for building peace and prosperity among States and peoples.

For example, many normative projects concerning international relations have focused on changing fundamentally the politics of international relations. These projects sought to create political conditions

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that would lessen the frequency and severity with which national interests diverged and conflicted. Thus, we have seen advocacy for such ideas as “peace through trade” (economic interdependence) and “the democratic peace” (ideological likemindedness). Similarly, Marxism posited that revolutions by and dictatorships of the proletariat within countries would transform world politics. These ideas attempt to transform the politics that inform diplomacy and governance; they do not view diplomacy as transformative in any way.

Similarly, projects with a governance focus looked to construct mechanisms and institutions that would authoritatively determine policy directions and settle disputes between States. These mechanisms include proposals favoring world government, promoting more and better intergovernmental organizations, and international courts with binding, compulsory jurisdiction. These proposals assumed that politics and diplomacy were necessary but insufficient without strong governance processes to keep them anchored. Again, these perspectives on reform did not see diplomacy as transformative because they concentrated on governance mechanisms that would lock diplomacy into better, more peaceful patterns of State behavior.

Those in global health excited about global health diplomacy might actually have normative agendas that do not directly engage diplomacy as opposed to politics and governance. In terms of politics, global health activists might actually want national and international politics to center more on health than other normative agendas (e.g., security, power, and economic wealth). If more States and their peoples believed health was politically important, then the nature of diplomacy and governance on health would be transformed for the good of humanity’s dignity and well-being. This political project is not about diplomacy as a distinct process fulfilling specific functions in international relations. The project is about transforming the significance of health as a national and international political issue. If achieved, the processes of diplomacy and governance would work better because the political transformation would create more convergence of interests on policies that promote and protect health.

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13 These ideas have most closely been associated with liberal theories on international relations. See, e.g., Tim Dunne, Liberalism, in THE GLOBALIZATION OF WORLD POLITICS: AN INTRODUCTION TO INTERNATIONAL RELATIONS 162 (John Baylis & Steve Smith eds., 2nd ed. 2001).


In terms of governance, calls for a stronger World Health Organization (WHO), more institutional commitment to health in the WTO, or new treaties on specific health problems (e.g., calls for treaties on alcohol, obesity, research and development on neglected diseases, or social determinants of health) are calls for specific governance mechanisms not proposals to change the nature and practice of diplomacy. Achieving governance reforms will, if successful, affect what diplomacy does, thus potentially avoiding the age-old problem of how to change the nature of diplomacy before making normative progress in international relations.

This governance-centered approach has to address the question how States get from the present state of affairs to stronger governance mechanisms without transforming either the nature of the politics or the dynamics of diplomacy. Typically, the response to this question recognizes the need to change the nature of politics rather than reform the nature of diplomacy. In the case of health, we can get a stronger WHO by making global health more politically important to States and their peoples. Diplomacy simply functions as the pass-through process for normative changes happening in the political and the governance realms. Under this perspective, talking of global health diplomacy as a transformative process does not make sense.

On the empirical side, observations that health has become a more important issue for States, intergovernmental organizations, and non-State actors in international relations reflect changes in how health problems affect other political interests. Empirically, as analysis of health commitments made by the member countries of the Group of 8 (G8) and the Asia-Pacific Economic Cooperation Forum (APEC) illustrates, health features diplomatically more today than perhaps at any other point in the history of international relations. This evidence does not mean, however, that the nature of international politics, diplomacy, and governance has

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16 See, e.g., Gaudenz Silberschmidt et al., Creating a Committee C of the World Health Assembly, 371(9623) THE LANCET 1483 (2008).
18 See, e.g., Don Zeigler, USA: Alcohol Control Movement Follows FCTC Lead, 16(4) TOBACCO CONTROL 4, 4 (2007).
changed. Instead, health problems stimulate or put at risk existing interests by posing threats or creating challenges and opportunities. Thus, the rapid spread of potentially virulent communicable diseases becomes a threat to national security and the economic well-being of a State. Similarly, health-based initiatives offer ways for a State to increase its influence internationally or block the spread of a rival power’s influence.

How health gets configured into existing interests and advanced vis-à-vis other actors in global politics is the very stuff of diplomacy, traditionally understood. Global health diplomacy becomes important, but not because “health” suddenly trumps other interests States and non-State actors pursue in international relations. In terms of analyzing international relations, we can explore whether the health issue constitutes an independent, dependent, or intervening variable in explaining State behavior. What kind of variable the health issue represents might tell us important things about how health considerations affect diplomacy on the problem in question. With this understanding, we might be able to predict how similar or other health issues will play out in diplomatic contexts, and then test those predictions against empirical outcomes. Global health diplomacy examined through the empirical approach might perhaps be more interesting because diplomacy does not simply function as a pass-through process between the transformation of health as a political issue and the construction of improved or new governance mechanisms.

We do not have to reconcile the normative and empirical aspects of the rise of global health diplomacy in order to grasp the need to focus more rigorously on this phenomenon. Any mapping exercise has to be sensitive to the range of perspectives brought to bear on global health and global politics. The sheer breadth of things that directly and indirectly affect health nationally and internationally also counsels for a mapping approach that is broad and inclusive rather than narrow and exclusive. In Part IV, this article returns to why global health diplomacy is important across the range of normative and empirical perspectives when it examines conceptual underpinnings for such diplomacy.

III. GETTING STARTED: DESCRIBING GLOBAL HEALTH DIPLOMACY

The need for more rigor in thinking about global health diplomacy identified in Part II requires, to begin, some attention to describing the

23 For analysis on how different countries use health to advance their national interests, see Ctr. for Strategies & Int’l Studies, Key Players in Global Health: How Brazil, Russia, India, China, and South Africa Are Influencing the Game – A Report of the CSIS Global Health Policy Center (Katherine E. Bliss ed., 2010) [hereinafter Key Players in Global Health].
characteristics of this phenomenon. This task mandates breaking global health diplomacy into its component parts and looking at key trends in each part. With a basic descriptive framework in place, the article turns to theoretical considerations that connect to the framework and its parts.

A. From Globalization of Public Health to Global Health Diplomacy

This article draws on the latest phase of my involvement as an international legal consultant for WHO in efforts to understand the significant changes affecting global health over the past 10-15 years. The emergence of intense interest in global health diplomacy during this time period, as opposed to earlier, makes sense when I reflect on the progression of the analyses WHO has undertaken with respect to global health politics, governance, and diplomacy. At first, the focus was on the impacts globalization was having on health nationally and globally. These efforts attempted to understand how globalization was or was not transforming the environment in which national and international politics on population health occurred. Then, interest turned to addressing challenges presented by the emergence of “global health governance,” including the related exploration of ways to understand the governance relationship between trade and health and to improve the production of global public goods for health. Next, the focus was on foreign policy and global health, which again drew attention back into the realm of politics in order to understand how States addressed global health in formulating their respective foreign policies. Only then did this WHO analytical process turn its attention specifically to global health diplomacy.

This analytical process replicated the traditional policy and normative gravitations toward politics (globalization and public health) and governance (global health governance) described in Part II, without pausing in between to consider the processes of diplomacy. Of course, the emphasis

24 See, e.g., the special theme issue on globalization in 79(9) BULL. WORLD HEALTH ORG. 802-905 (2001).
28 See, e.g., David P. Fidler & Nick Drager, Health and Foreign Policy, 89(4) BULL. WORLD HEALTH ORG. 687 (2006) (noting increased foreign policy importance of global health and announcing a special theme issue of the BULLETIN on foreign policy and global health for March 2007); and the special theme issue on global health and foreign policy in 85(3) BULL. WORLD HEALTH ORG. 161-244 (2007).
on globalization, then global health governance, and then foreign policy and global health implicated diplomacy, but, interestingly, the analyses of these topics did not single out global health diplomacy as a special area of concentration until later.

More recently, attention at WHO and elsewhere has turned more directly towards studying global health diplomacy as a distinct phenomenon. This turn not only includes the specific topic of global health diplomacy but has also increased scrutiny on the related concern of the relationship between health and foreign policy. In the progression of global health analysis, we have arrived at the point where understanding the specific functions of diplomacy in global health have become important to the ability to shape global health politics and governance. Describing the characteristics of global health diplomacy draws directly on conclusions reached and arguments made in the earlier literatures on globalization and governance.


Describing global health diplomacy requires breaking the concept into its three component parts—global, health, and diplomacy—and analyzing each part to understand its importance in the overall phenomenon. These parts provide centers of gravity for mapping purposes because we can develop profiles for each part and connect the parts together analytically. As outlined below, mapping global health diplomacy involves identifying players, problems, processes, and principles. See Figure 2 below. As with any description, the one developed in this article has flaws, but the objective is to construct an approach that provides a foundation for deeper, more sophisticated conceptual and analytical work.

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31 See, e.g., UN General Assembly, Global Health and Foreign Policy: Strategic Opportunities and Challenges – Note by the Secretary-General, U.N. Doc. A/64/365 (Sept. 23, 2009); David P. Fidler, Health in Foreign Policy: An Analytical Overview, 15(3) CANADIAN FOREIGN POL’Y 11 (2009).
1. Global. — In global health diplomacy, what does “global” mean? The same question arose in analyses on global health governance, and “global” was not used in that context merely to impart geographical meaning or scope to governance challenges. Instead, experts often distinguished international governance from global governance according to the actors involved.\footnote{See, e.g., Richard Dodgson et al., \textit{Global Health Governance: A Conceptual Review} (Discussion Paper No. 1, Feb. 2002), http://whqlibdoc.who.int/publications/2002/a85727_eng.pdf (last visited Feb. 27, 2011).} International governance referred to mechanisms that involved only States. The issues WHO addresses have global scope, but WHO, as an intergovernmental organization, has functioned historically as a State-centric example of international governance. Global governance describes governance efforts that include not only States but also non-State actors. Thus, when States and WHO work closely with non-governmental organizations (NGOs) on addressing health challenges, such as HIV/AIDS, forms of global governance have emerged (e.g., the Global Fund to Fight
AIDS, Tuberculosis, and Malaria\textsuperscript{33} that differ in structure and dynamics from traditional international governance mechanisms.

Global health diplomacy concerns diplomatic activity, which typically (but not exclusively) involves formal or informal negotiations, on health issues that involves States, intergovernmental organizations, and non-State actors. In short, mapping global health diplomacy involves identifying the players implicated in any given context. What States are involved, which intergovernmental organizations have a role, and what non-State actors have stakes in the issue and try to participate in influencing the outcome? Identifying the players is not necessarily a difficult task because implicated or engaged States, intergovernmental organizations, and non-State actors can usually be readily identified.

2. Health. — The “health” in global health diplomacy draws attention to problems that involve the protection or promotion of human health. These problems can arise in one of three forms. First, the problem itself constitutes a direct threat to human health, such as the rapid spread of a virulent virus. Second, the problem can involve indirect threats to health, such as deterioration in social determinants of health (e.g., poverty). Third, the problem can be one unrelated to health but which stimulates a health-related response. An example is the attempt by U.S. and allied forces to defeat Islamist insurgency forces in Afghanistan by winning the hearts and minds of the Afghan population through provision of, among other things, health goods and services.\textsuperscript{34} The objective—defeating an insurgency—is not a health-specific or health-driven objective but is a geopolitical one, but strategies and tactics to achieve this objective involve health-related initiatives that fall within the scope of foreign policy and diplomacy.

3. Diplomacy. — The “diplomacy” in global health diplomacy refers to processes in which States, intergovernmental organizations, and non-State actors interact in articulating, advocating for, and defending their interests on health-related problems. In this description, diplomacy is not an end in itself; it is only a means to an end. The end is, however, determined through the clash, competition, or convergence of the players’ interests. As such, these processes (1) force the players to identify, express, defend, and build support for their preferences in how to address problems, and (2) provide the venues for translating shared preferences, however achieved, into collective action. In these processes, the participants attempt to attract support or deflect opposing arguments by appealing to various legal or moral rules and norms associated with the issues in question as a way to


ground their negotiating positions and underlying interests in principles considered legitimate. Mapping global health diplomacy requires identifying the (1) processes in which States and non-State actors interactively engage in articulation, advocacy, and defense of their respective interests on health-related challenges; and (2) principles of international law, morality, and politics that inform such national interests and negotiating positions.

C. Players, Problems, Processes, and Principles: Key Trends in Global Health Diplomacy

1. Common Trends. — The component parts of a description of global health diplomacy share four important trends that a mapping exercise should capture. Looking across the players, problems, processes, and principles that make up global health diplomacy, we can identify *quantity, diversity, velocity, and instability* issues in each one.

In quantitative terms, we simply have more players, problems, processes, and principles implicated today than in previous eras. In terms of players, the increased involvement of NGOs and other civil society actors provides one illustration of the growth in the number of actors trying to influence global health. To the traditional communicable disease concerns have been added many more problems, ranging from neglected tropical diseases, non-communicable diseases, and deteriorating social determinants of health, such as poverty, education, and gender relations. Players address these and other problems through multiplying processes, many of which deliberately avoid classical forms and venues of diplomatic activity, as evidenced by the increased use of “public-private partnerships.” The number of normative concepts, ideas, and rules has also increased, reflecting the creation of new global health governance mechanisms and health’s higher political profile across more areas of foreign policy. The proliferation of players, problems, processes, and principles is part of what makes global health diplomacy difficult to contain descriptively and analytically.

35 WORLD HEALTH ORGANIZATION, WHO REPORT ON NEGLECTED TROPICAL DISEASES 2010: WORKING TO OVERCOME THE GLOBAL IMPACT OF NEGLECTED TROPICAL DISEASES (2010).
The second common trend, diversity, is closely related to the quantity trend. As noted above, States increasingly have to deal with non-State actors in global health, but mapping global health diplomacy must acknowledge that diversity in States, intergovernmental organizations, and non-State actors has increased. Great powers and failing States are engaged on global health concerns. The traditional philanthropic mainstays of international health, such as the Rockefeller Foundation, have been joined by a bewildering variety of large and small foundations, NGOs, issue entrepreneurs, and celebrities in advancing global health causes. Global health problems addressed diplomatically have become more diverse, ranging from pandemic infectious diseases (e.g., HIV/AIDS, influenza), to the sale of unsafe, counterfeit drugs, to the "brain drain" crisis involving health personnel emigrating from low-income countries. The venues for diplomacy also reveal an unprecedented diversity, involving processes from the august chamber of the United Nations (UN) Security Council to the private offices of Bill Gates in Seattle, Washington. Normatively, global health has become more diverse as actors widened the ways in which they look at, articulate, and advance their interests, appealing to not only the traditional humanitarian ideals associated with health but also principles grounded in national and global security.

All components of global health diplomacy also share the characteristic of increasing velocity—global health has become an incredibly fast-moving area. States, intergovernmental organizations, and non-State actors must react to developments more quickly because of the speed of events. Health problems of all kinds have taken on urgency never before experienced in the long history of international health activities. The overlapping, often competing venues for diplomatic activity give global health diplomacy a more frenetic pace than prevailed when WHO was the unrivaled center of international health diplomacy. The speed of events, and its impact on players, problems, and processes, also affects how diplomatic activities reflect different normative concepts and international legal rules.

The increased quantity, diversity, and velocity contribute to the fourth common factor—instability. The pecking order among the players of global health has been upset and destabilized by, among other things, the rise of

40 World Health Assembly [WHA], WHO Global Code of Practice on the International Recruitment of Health Personnel, WHA63.16 (May 21, 2010).
powerful non-State actors, none more so than the Bill and Melinda Gates Foundation. Health problems also exhibit instability through changing patterns of, among other things, antimicrobial resistance, emergence and re-emergence, product consumption, environmental degradation, poverty alleviation, and sustainability in national governance and health care capacities. Diplomatic processes are likewise unstable with new initiatives frequently appearing, attempts to shift issues among different forums often occurring, and interest divergence stalling diplomatic progress on important health challenges. Normative instability has also been present, exemplified by tensions over the “securitization” of global health problems and continued difficulties with long-standing norms, such as the human right to health. These four common trends mean that the global health terrain is populated with more and different players, problems, processes, and principles and is prone to rapid, destabilizing changes. Mapping such shifting terrain is difficult because it contains a diplomatic density and complexity that reflects global health’s new political importance and the fragmentation of efforts to exploit this new importance.

2. Key Trends with the Players. — In addition to the common trends, each component has other key trends that deserve mention. In terms of the players in global health diplomacy, two trends are important to note. First, the great powers, particularly the United States, have re-engaged in global health in significant ways in the post-Cold War period. International health constituted a marginal, neglected area in the foreign policies of the big powers during the Cold War, but, across many agendas and for diverse reasons, these powers have realized the need to focus more on global health concerns, as seen in the G8’s emergence as one of the most important diplomatic venues for global health. The re-engagement of the great powers has produced mixed results for global health diplomacy. On the one

44 From 1999 through 2009, the Gates Foundation spent approximately $10.6 billion on global health. See INSTITUTE FOR HEALTH METRICS AND EVALUATION, FINANCING GLOBAL HEALTH 2010: DEVELOPMENT ASSISTANCE AND COUNTRY SPENDING IN UNCERTAINTY 24 (2010).
46 On forum shifting in foreign policies and global health, see Fidler, supra note 31, at 201-21.
47 Shridar, supra note 45, at 466 (noting problems with linking global health with security concepts).
hand, great power involvement has raised the political significance of
global health problems generally and in some areas, such as HIV/AIDS,
has produced more financial resources for global health. On the other hand,
the great powers have a degree of independence in their actions that allows
them to have disproportionate influence in diplomatic processes of all kinds,
including those addressing global health.

Second, the power now wielded in global health by the Gates
Foundation represents an epochal change in terms of the players in global
health. Experts in global health have raised concerns about the influence
the Gates Foundation possesses, influence directly related to the huge
sums of money the Foundation commits to global health endeavors. The
non-governmental status of the Gates Foundation, and the financial
resources it has, gives it the ability to maneuver in global health diplomacy
largely on its own terms. As explored more below, such freedom of action
on the part of non-State actors creates significant problems for global
health diplomacy’s relationship with governance activities.

3. Key Trends with the Problems. — The increase in the number and
kind of global health problems finding their way onto diplomatic agendas
better reflects the broad, comprehensive definitions of health contained, for
example, in the preamble of the WHO Constitution. As the quantity and
diversity of problems addressed by global health diplomacy has increased,
interdependencies have also importantly been revealed. For example,
increasing access to antiretrovirals in countries with poor or collapsing
health care systems brings needed attention to the imperative for
comprehensive health system reforms. The crowding of the global health
diplomacy space with more and more problems forces the players to
prioritize what problems get what level of political attention and financial
resources. How global health problems get prioritized does not necessarily
follow epidemiological evidence of the burden of disease or humanitarian
norms traditionally associated with public health because the problems
have ceased to be just health concerns, the players are no longer just public

51 See, e.g., David McCoy et al., The Bill & Melinda Gates Foundation’s Grant-Making
Programme for Global Health, 373(9675) THE LANCET 1645 (2009); Robert E. Black et al.,
Accelerating the Health Impact of the Gates Foundation, 373(9675) THE LANCET 1584 (2009);
Donald G. McNeil Jr., Gates Calls for a Final Push to Eradicate Polio, N.Y. TIMES, Jan. 31, 2011,
(reporting criticisms of Gates’ support for eradication of polio).
52 WHO CONSTITUTION, pmbl. (defining health as the “complete state of physical, mental and
social well-being and not just the absence of disease or infirmity”).
53 See, e.g., Stephanie M. Topp et al., Strengthening Health Systems at Facility Level: Feasibility
of Integrating Antiretroviral Therapy into Primary Health Care Services in Lusaka, Zambia, 5(7)
PLOS ONE e11522 (2010) (noting arguments that efforts to increase access to antiretrovirals have
“weakened the national health system[,] and the continued separation of ART clinics from other
primary health departments raises questions relating to sustainability of HIV care and treatment,
distribution of human resources, access and equity of care, space and infrastructure availability,
continuum and quality of care, and stigma.”).
health advocates, the processes are often highly political in nature, and competition exists over how issues get framed normatively and politically.

4. Key Trends with Processes. — The unprecedented proliferation of diplomatic initiatives on global health is remarkable and worrying. The proliferation is remarkable because never before has global health had such prominence in international relations. It is worrying because the proliferation has radically changed political interest formation with respect to health issues, particularly among States, and has fragmented or, in some contexts, displaced traditional diplomatic and governance strategies used for global health. A trend for the future will be the extent to which this proliferation results in more epidemiologically sound interest formation and articulation by States and non-State actors, more efficient diplomatic activities, and more effective governance to sustain appropriate public health strategies. In short, how well does global health diplomacy fulfill its basic functions against the background of epidemiological evidence on the global burden of diseases?

5. Key Trends with the Principles. — In terms of principles, three trends have been apparent. First, efforts have been made to broaden the normative foundation for global health beyond the traditional emphasis on the importance of health to human dignity. This broadening has involved connecting global health activities to State interests in national security, national economic power and well-being, and the effectiveness of development policies. Second, coalitions of actors have attempted to rejuvenate long-standing normative principles, particularly the right to health, by clarifying substantive content and advocating for more implementation of these norms in policymaking and legal processes, including national courts. Third, States, intergovernmental organizations, and non-State actors have created new rules affecting global health through adoption of new binding international agreements (e.g., WHO Framework

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54 Margaret Chan et al., Foreign Policy and Global Public Health: Working Towards Common Goals, 86(7) BULL. WORLD HEALTH ORG. 498, 498 (2008) ("Pandemics, emerging diseases and bioterrorism are readily understood as direct threats to national and global security. But health issues are also important in other core functions of foreign policy, such as pursuing economic growth, fostering development, and supporting human rights and human dignity.").


56 See Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/4/28 (Jan. 17, 2007) (noting that “numerous reports have explored how the right to health can be operationalized. Law cases, literature and courses on health and human rights are increasingly common”).

Convention on Tobacco Control, 57 International Health Regulations (2005)58 or non-binding arrangements (e.g., International Finance Facility for Immunization) or strategies (e.g., Millennium Development Goals).

IV. GETTING CONCEPTUAL: THEORETICAL CONSIDERATIONS FOR MAPPING GLOBAL HEALTH DIPLOMACY

Describing global health diplomacy in terms of the players, problems, processes, and principles provides a starting point, if for no other reason that it allows analysts to make lists of what actors are engaged with which problems in what diplomatic venues under what normative influences. Those lists can be compared across players, problems, processes, and principles to identify patterns that may be worth further exploration. To some extent, experts are engaging in this type of analysis because they have identified where, for example, the Gates Foundation is active and where it is not. This descriptive mapping also highlights how the United States engages in intense global health diplomacy in areas related to its security interests, but shows less interest in non-communicable disease problems.

Descriptive mapping is, however, largely an exercise of looking at what is happening on the surface. The patterns and insights generated by breaking global health diplomacy into the interactions of players, problems, processes, and principles still lack conceptual depth. Mapping should aim to illuminate not only what is happening but also why it might be happening. Addressing conceptual issues is perhaps even more important in an area such as global health diplomacy because it involves interaction between communities that often have different world views about health and global politics. The conceptual level is often where the optimism of global health advocates about the potential of global health diplomacy is at odds with the merciless pragmatism of foreign policy makers.

As commentators have noted, little theoretical work has been done in terms of health as an issue in international relations. 59 Historically, international relations theorists have showed little interest in health, and health scholars and practitioners have not been engaged with the debates raging in the world of international relations theory. Although this situation of mutual neglect is changing, 60 this mapping exercise does not have a

deep theoretical literature on which to draw in thinking about conceptual aspects of global health diplomacy.

A. Why Diplomacy?

The origins and basic functions of diplomacy are anchored in what international relations experts call the condition of anarchy that characterizes international politics. In this context, anarchy means that the units of the system do not recognize any common, superior authority. Politics within a State is hierarchical because the citizens of the State recognize such an authority. The actors in the international political system do not. In this condition of anarchy, the dominant actors, States, developed means of interacting, and the mechanism of diplomacy emerged as a key instrument for political interactions in anarchy.

The discipline of international relations has developed many theories that explain the impact of the condition of anarchy on States, intergovernmental organizations, and non-State actors. All theories recognize the process of diplomacy as important in making international relations function, but the theories do not agree on the nature of diplomacy and its potential in international politics. In fact, for most major theories, diplomacy is not a central theoretical concern in their attempts to make empirical or normative sense of anarchical politics.

For this article's purposes, the different theoretical approaches to international relations tend to emphasize the severe limitations of the process of diplomacy. For realists and institutionalists, diplomacy is an merely instrument in the pursuit by States of power, survival, and self-interest, but engaging in diplomacy, per se, does not have any independent effect on the way States formulate their national interests. Further, neither of these theories considers non-State actors relevant to analysis of international relations.

By contrast, liberal theory focuses on the importance of non-State actors, but the real action for liberalism comes through non-State actors facilitating the bottom-up development of economic interdependence between peoples and the spread of democratic politics within States in the international system. The proliferation of economically interdependent democracies transforms international politics and diplomacy from the bottom-up, but the transformation does not come about through strategies

61 On realism, see generally Scott Burchill, Realism and Neo-Realism, in THEORIES OF INTERNATIONAL RELATIONS 70-103 (Scott Burchill eds., 2d ed, 2001).
63 See Dunne, supra note 13, at 162-181.
focused on using traditional diplomatic techniques or changing the nature of diplomacy.

Of the leading international relations theories, only social constructivism appears to give theoretical significance to the process of diplomacy itself. 64 Constructivism argues, to paraphrase Wendt, that anarchy is what State and non-State actors make of it.65 The very process of interactions through diplomatic and non-diplomatic venues can affect how States and non-State actors formulate their political preferences and interests. In this perspective, diplomatic processes become more than mechanical conduits for articulating and defending pre-determined interests; they become means by which States and non-State actors intersubjectively construct and express their ideas, interests, and identities. In short, diplomatic processes become the substance of politics and governance.

Of these major theories, excitement about the possibilities for global health diplomacy resonates best with social constructivism. Constructivism posits that the diplomatic process itself can heighten the commitment of States and non-State actors to the protection and promotion of human health. In other words, engaging in global health diplomacy can help transform interests and attitudes in ways that make health more politically important. The power of the idea of health helps re-make the condition of anarchy.

The appeal of constructivism for global health diplomacy is obvious but not without problems. To begin, constructivism does not identify what ideas are good and bad. Thus, constructivism cannot explain why health as an idea has such potent, transformative power through intersubjective experiences provided by diplomacy. Constructivism does not explain why health might succeed in transforming anarchy through diplomatic activities when other ideas, such as trade, the rule of law, democracy, communism, human rights, and environmentalism, have not been able to do so.

Mapping theoretical underpinnings for diplomacy leaves the impression that diplomacy has serious limitations flowing from the difficulties created for politics transpiring in a condition of anarchy. This impression from theory supports the Sisyphean image of diplomacy mentioned earlier—diplomacy is critical as a practical matter but limited in its own political potential.

64 On constructivism, see ALEXANDER WENDT, SOCIAL THEORY OF INTERNATIONAL POLITICS (1999).
B. Why Health?

The second set of theoretical considerations relevant to global health diplomacy concern conceptual issues about health as a political objective. Why should States, intergovernmental organizations, and non-State actors pursue a more robust diplomatic agenda for global health? The conceptual terrain regarding this question is more interesting than the theoretical perspectives on diplomacy reviewed above because the reasons why States, intergovernmental organizations, and non-State actors pursue health have multiplied in the past 10-15 years. Indeed, the expansion in conceptual underpinnings for health connects directly to the increase in the quantity and diversity of players, problems, processes, and principles that constitute global health diplomacy.

Briefly, diplomatic activity on health prior to the end of the Cold War tended to cluster around three objectives: limiting the impact of national health measures on trade, providing health assistance as part of humanitarian aid to developing countries, and advancing the human right to health. The health diplomacy undertaken with respect to these purposes was not coordinated globally, and it did not have a high political profile in international relations.

During the Cold War, the interest of the major trading powers in the burdens national health measures imposed on trade faded because these countries developed better national public health capabilities, which made trade-related communicable diseases less of a threat than in past decades. The health assistance provided to developing countries was humanitarian in nature and was not linked to development strategies pursued during this period. The prevailing trope was “wealth produces health,” so development policies focused on increasing poor countries’ macroeconomic performance. The emergence of international human rights law after World War II supported efforts to advance the right to health, but progress was difficult for many reasons, including ideological controversies over economic,


67 After its establishment in 1948, WHO became heavily involved in helping low-income countries address health problems, and high-income countries often provided health assistance as part of their humanitarian aid to low-income nations. This pattern came to define how experts thought of “international health.”

68 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 (launching the “health for all” initiative grounded in the right to health).
social, and cultural rights and the weak manner in which international law reflected such rights.69

Today’s interest in global health diplomacy reveals a sea change with respect to the perceived political importance of health in global politics. Behind the sea change are linkages made by States, intergovernmental organizations, and non-State actors between health and many important political objectives, including augmenting or protecting a State’s power and influence, strengthening national and international security, protecting national economic well-being, contributing to political and economic development, and the respecting and promoting human dignity.

Thus, we have seen health diplomacy touted as important for the exercise of “soft power” and “smart power” by individual countries, such as the United States,70 China,71 and Brazil,72 in their attempts to maintain or gain influence in strategic regions of the world, such as Africa. Concepts of national and international security now accommodate a broad range of health challenges, including the threat of biological terrorism, the emergence of pandemic influenza, the continued devastation wrought by HIV/AIDS, and access to safe, secure, and affordable food and water. The ability to deal with communicable and non-communicable health threats moving in streams of international trade and travel has become an important feature in protecting national economies from damaging and costly acute shocks or mounting long-term burdens. In terms of development strategies, health has emerged in the priorities of development thinking, as illustrated by the linkage of HIV/AIDS treatment and prevention with development strategies, the many health-related objectives found in the Millennium Development Goals (MDGs), the contributions investments in health can make to macroeconomic growth, and the framing of major non-communicable disease threats as development problems. Human rights activity has also experienced a renaissance concerning the perceived importance of civil and political rights and economic, social, and cultural rights in global health. Finally, the role of health and health services in providing humanitarian assistance has also gained new attention

71 On China, see Charles W. Freeman III & Xiaoqing Lu Boynton, A Bare (But Powerfully Soft) Footprint: China’s Global Health Diplomacy, in KEY PLAYERS IN GLOBAL HEALTH, supra note 23, at 15-23; Yanzhong Huang, Pursuing Health as Foreign Policy: The Case of China, 17(1) IND. J. GLOBAL LEGAL STUD. 105 (2010).
72 On Brazil, see Katherine E. Bliss, Health in All Policies: Brazil’s Approach to Global Health within Foreign Policy and Development Cooperation Initiatives, in KEY PLAYERS IN GLOBAL HEALTH, supra note 23, at 1-14; Lee et al., supra note 1.
in the wake of responses to increasingly frequent natural and man-made disasters.

With health emerging in so many political and foreign policy contexts, the sheer volume of diplomatic activity on health recently witnessed should come as no surprise. This unprecedented development is the source of the proliferation of players, problems, processes, and principles that make up global health diplomacy. Entirely new policy communities, such as those handling security and development strategies, have become engaged in health-related challenges. As a result, health initiatives find their way into diplomatic processes previously devoid of health concerns and experts, such as efforts to control the spread of biological weapons and UN Security Council activities on threats to international peace and security. The wider web of political interests invested in health has helped stimulate the rise of new health problems for diplomatic consideration, such as neglected communicable diseases, global epidemics of non-communicable diseases, the weakening and near collapse of health system capacity in developing countries, and deterioration in the social determinants of health.

Despite the unprecedented transformation of health from a neglected issue to its current global political profile, the appearance of health on so many agendas and its connection to such diverse political purposes produces problems for politics, diplomacy, and governance. Literature on global health governance has raised, for example, the risks of too much health politics and diplomacy occurring without stronger, more coordinated, and better resourced governance mechanisms. These concerns have stimulated desires to craft new “architecture” for global health governance that harnesses the current energy, activity, and pledged money on health problems into more effective policies and mechanisms nationally and globally.

This example brings us back to the relationship between politics, diplomacy, and governance. Global health politics has been transformed with health becoming important to a more diverse range of political purposes than witnessed in previous historical eras. The desire to translate this transformation into better governance for global health echoes the traditional tendency to skip over diplomacy’s intermediating role between politics and governance in international relations in order to focus on improving governance mechanisms. However, the richness, expansiveness, and ambitions of the current conceptual underpinnings for global health run into the warnings international relations theories send us about the limitations of diplomacy in anarchical politics.

73 See, e.g., Shridar, supra note 45, at 462 (arguing that “[i]nstead of examining how the WHO should be reformed, new initiatives are launched that erode the WHO’s authority as the leader in global health.”).
C. Revisiting Anarchy and Diplomacy

Does the promise in the transformation of global health politics founder on the unforgiving rocks of diplomacy’s limits in the context of anarchy? To explore this question requires analyzing whether we can detect in the transformation of global health politics forces at work that also change the nature of anarchy and diplomacy. In other words, are the limits about diplomacy communicated by most international relations theories still as potent in today’s anarchy with respect to global health?

Consensus on answering this question is unlikely to emerge because experts have already fought related battles in other issue areas concerning whether globalization or the rise of non-State actors fundamentally changes the nature of anarchy in international relations. For example, Daniel Drezner analyzes global regulatory regimes in order to test the influence of non-State actors in various diplomatic processes. He concludes that a great power concert is still a necessary and sufficient condition for global regulatory action. In short, the great powers still manage and determine international relations despite the impact of globalization and the increase in the participation of non-State actors. Diplomacy might be more crowded and noisy today, but the power and influence remains where it has always been in the condition of anarchy—with the great powers.

Interestingly, the one “semi-deviant case” in Drezner’s analysis involved global health. Drezner admits that his thesis does not explain well the outcome of the controversy involving the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and access to essential medicines that transpired at the WTO’s Doha Ministerial Meeting in 2001. Drezner analyzes how the coalition of developing countries and global NGOs prevailed diplomatically over the preferences of the United States and other developed countries in the adoption and substance of the Doha Declaration. Drezner’s “semi-deviant case” provides an opening to probe whether anarchy and diplomacy operate differently in global health than in other areas of international relations. If so, then, conceptually, global health diplomacy might have particularly promising characteristics any mapping exercise would have to capture.

What is striking about Drezner’s semi-deviant case is the extent to which global NGOs were able to access the relevant diplomatic processes and directly influence the outcome of anarchical politics. As Drezner acknowledges, State-centric perspectives on the nature of diplomacy in

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74 DANIEL W. DREZNER, ALL POLITICS IS GLOBAL: EXPLAINING INTERNATIONAL REGULATORY REGIMES (2007).
75 Id. at 204.
76 Id. at 176-203.
77 Id. at 177.
anarchy (e.g., realism and institutionalism) cannot explain this episode well. If we turn to the wider context of global health politics, the same theme about the impact of non-State actors appears, especially in connection with the power now wielded in global health by the Gates Foundation. Conceptually, global health politics still occur in a condition of anarchy, but that anarchy seems to have features not witnessed in previous eras of international health that connect to the influence of non-State actors.

In other writings, I have argued that what we see in global health specifically and international relations generally is the emergence of "open-source anarchy." Briefly, this argument posits that the condition of anarchy characterizing all international politics has shifted from an anarchy monopolized by States to one that non-State actors can access, participate in, and influence as never before. Non-State actor engagement in the dynamics of anarchical politics reflects the ability of these actors to wield material power (e.g., through financial resources) and affect the competition of ideas (e.g., through connecting health issues to underlying objectives of political action). This shift affects the nature of diplomacy because it jars the basic functions of diplomacy out of traditional State-centric patterns that have long been the source of cynicism. In addition, diplomacy in open-source anarchy is a broader, more complex phenomenon that blurs or even, in places, obliterates the line between politics and diplomacy and between diplomacy and governance.

The concept of "open-source anarchy" provides one way to make sense of the proliferation of players, problems, processes, and principles in global health diplomacy. Further, this concept might have utility for specific mapping purposes because assessing how open anarchical politics is to non-State actor engagement and influence becomes analytically important for understanding how such politics shapes diplomacy and governance. How "open source" anarchical politics might be will vary across different combinations of players, problems, processes, and principles making up global health diplomacy. Some issues may reflect Drezner's conclusion that the great powers still largely determine what happens, regardless of the number of non-State actors engaged, the quality of their ideas, or the amount of noise they make. Other issues might not follow this pattern, as is clear not only from Drezner's semi-deviant case of the Doha Declaration but also from the acknowledged material power the Gates Foundation possesses in global health politics, diplomacy, and governance.

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Although the idea of open-source anarchy provides one way to make conceptual sense of the intensity and density of diplomatic activity that has developed in global health, such intensity and density are not the same things as progress in global health politics and effective global health governance. As noted earlier, some experts are concerned that global health experiences too much politics and too much diplomacy with sub-optimal collective action emerging from all the uncoordinated activities.

Open-source anarchy generates, however, conceptual and practical obstacles to the objective of producing more effective governance. Most importantly, with non-State actors engaged politically and diplomatically, governance mechanisms might also need to regulate their activities in addition to laying down principles for State behavior. Achieving effective collective action measures to regulate States, especially the great powers, has always proved difficult historically, and this challenge remains as necessary and frustrating as ever. On top of this comes the potential need to control and direct non-State actors, an endeavor fraught with difficulties, particularly given how NGOs fiercely defend their freedom of action and independence from State or intergovernmental control and influence.

The intensity and density of global health diplomacy contains, therefore, serious challenges illuminated by the concept of open-source anarchy. Mapping global health diplomacy should take into account how the nature of anarchy and diplomacy might differ in global health today than in previous historical periods. Mapping exercises could reveal the intensity and density of global health diplomacy on many health problems, but more and more diplomacy is not the ultimate goal.

V. GETTING ANALYTICAL: TEMPLATE FOR MAPPING GLOBAL HEALTH DIPLOMACY

A. Mapping Template

Mapping global health diplomacy requires not only identifying the problems, players, processes, and principles involved but also analyzing the structure and dynamics of how the problems, players, processes, and principles interconnect. The diversity of contemporary global health diplomacy forces us to figure out why one health problem generates different diplomatic activities than another problem. In short, we need the mapping of global health diplomacy to look at problems, players, processes, and principles more systemically in ways that can assist analysis of any given global health challenge.

One way to achieve this systematic perspective is to construct a parsimonious but flexible template to chart what happens in global health diplomacy. Based on the arguments earlier in this article, the template has
to reflect the interactions of the problems, players, processes, and principles with respect to the basic functions of diplomacy. Figure 3 contains an attempt to fit these requirements into a simplified template for mapping global health diplomacy.

The template begins with the first basic function of diplomacy, which is to force actors in international relations to formulate and articulate their interests vis-à-vis a specific international issue or problem. Mapping this function entails defining the global health problem at issue (see Figure 3, far left column entitled “Problem”). Undertaking this task begins the process of identifying the players involved in addressing the problem (see Figure 3, center column entitled “Players”). The mapping exercise might, at various points, continue to add players as the exercise gets deeper into the mapping. The template next requires fleshing out how the players frame the problem in terms of their interests (see Figure 3, second column from the left entitled “Interest Amplification”). The framing of any given problem involves use of various legal or normative principles as players attempt to amplify their self-interests by attaching them to, or explaining them through, normative concepts and objectives, such as security, economic well-being, development, or human dignity.

The template also focuses on the second basic function of diplomacy, which is to provide the means to translate common interests produced through negotiations into collective action or governance. Thus, the template highlights the importance of identifying the processes through which the players negotiate potential collective-action outcomes based on their common interests on the problem at hand (see Figure 3, right hand columns entitled “Negotiating Processes” and “Collective Action”). As described more below, each part of the template contains its own mapping requirements in order to provide detailed examination of the entire case study. The template allows analysis to understand not only each piece of the mapping exercise but also how the elements fit together in explaining episodes in global health diplomacy.
Figure 3: Template for Mapping Global Health Diplomacy

<table>
<thead>
<tr>
<th>FORMATION AND ARTICULATION OF INTERESTS</th>
<th>TRANSLATING COMMON INTERESTS INTO COLLECTIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
<td>Players</td>
</tr>
<tr>
<td>Interest Amplification</td>
<td>Negotiating Processes</td>
</tr>
<tr>
<td>States</td>
<td>Collective Action</td>
</tr>
<tr>
<td>Intergovernmental organizations</td>
<td></td>
</tr>
<tr>
<td>Non-State actors</td>
<td></td>
</tr>
</tbody>
</table>

B. Problem

The template requires detailed information about the global health problem to be described. This step should not present great difficulty given the information typically present about most global health problems. In collecting and sorting this information, the mapping could begin to slot problems into categories based on shared or common characteristics. For example, communicable diseases that pose a direct health threat have different epidemiological profiles than communicable diseases that might only pose an indirect threat to a country. Similarly, non-communicable diseases will share some, but not other, characteristics, and the template can focus analysis by separating out these characteristics. Inadequate or failing health systems might exhibit, as a problem set, consistent features that can be captured in the template. Other problems, such as deteriorating social determinants of health, present their own characteristics. In addition, the description of the problem should include identification of trends affecting it and suggested potential solutions.

C. Interest Amplification

As part of mapping how global health problems get translated into interests, the template draws attention to the processes that engage in "interest amplification." Interest amplification refers to ways in which
global health problems gain political importance, and these ways connect to conceptual reasons why health is a global political concern. This part of the template captures the different principles used by the players to heighten the political importance of the problem and frame their interests in addressing the problem.

For example, a State is more likely to frame a direct threat to its population posed by a virulent, highly transmissible pathogen as a national security and economic threat than by increases in obesity-related diseases in developing countries. A State may consider concern about obesity in developing countries as a potential problem for its trade interests in selling processed foods or a potential opportunity for its pharmaceutical companies to sell treatments for non-communicable diseases in foreign markets. NGOs and intergovernmental organizations also try to frame global health problems in ways that heighten their political importance (e.g., by linking them to development and human rights). How a global health problem gets framed and amplified might also connect to whether it already falls within an existing governance mechanism or strategy that operates according to previously negotiated rules or norms. This part of the template attempts to capture how players frame and amplify self-interests in global health problems, and this aspect recognizes the role non-State actors can play in shaping global health diplomacy.

D. Players

The template next requires mapping to identify the players that become diplomatically engaged in a global health problem. Identifying the global health problem at issue and the manner in which the problem is framed will involve recognition of the various players engaged in the issue. The objective with the “Players” column is to continue the process of pinpointing what players have, or might have, key roles as various diplomatic processes negotiate common interests and potential forms of collective action. In keeping with the transformed nature of global health, the players identified at this step in the template could be States, intergovernmental organizations, or non-State actors. What players are not engaged might be as important to note as what players are. This part of the template also seeks information on what position the players are taking on the issue in question. This information might or might not correlate with the interest amplification process mapped in the previous step (e.g., a key player, such as a great power, has not taken any position but will be a major factor in any negotiations or governance efforts). Mapping different individual global health problems might reveal patterns in player participation in different categories of problems, allowing the mapping
strategy to build up common patterns in global health diplomacy that cut across certain issue areas.

**E. Negotiating Processes**

The next aspect of the template requires analysis of the venues in which the players engage in negotiations about the problem, their different or converging self-interests, and potential collective action responses. Given the nature of contemporary global health diplomacy, the venues for negotiations could be diverse in kind (formal or informal), frequency (*ad hoc* or institutionalized), or scope (multinational, regional, or bilateral). The template might also reveal that players have yet to begin negotiations on collective action, which might mean that the global health problem remains in the interest formulation and articulation stage.

The template also requires identifying efforts by players to shift global health problems from one negotiating forum to a different one (e.g., shifting negotiations about intellectual property rights from TRIPS to bilateral and regional free trade agreements). Tracking the specific progress (or lack thereof) of the negotiating processes is also important for mapping this aspect of global health diplomacy. Analysis of this part of the template should also identify negotiating catalysts—ideas, players, proposals, or capabilities that facilitated progress in the negotiations—and negotiating spoilers—players, positions, and developments that prevented agreement on collective action or made progress more difficult. Finally, negotiations might reach agreement on collective action but through negotiating processes that did not, at the end of the day, gain traction from health-specific arguments.

**F. Collective Action**

Finally, the template seeks information on whether the negotiating processes produced any collective action, and, if so, what kind. The collective action could come in many forms, including revision of an existing intergovernmental mechanism, establishment of a new treaty or governance initiative, adoption of authoritative policy decisions, or issuance of a non-binding political declaration. The mapping could also usefully assess the effectiveness of the collective action produced, particularly with respect to perceived problems or weaknesses with what the players generated in the negotiating processes.
VI. GETTING PRACTICAL: FROM MAPPING TO SHAPING GLOBAL HEALTH DIPLOMACY

To be sure, this proposed template is simple, but it can, if rigorously applied, generate insights that will help experts understand global health diplomacy in the different contexts of global health better. Not only will this simple, or some other more advanced, template generate empirical knowledge about specific episodes of global health diplomacy but it will also allow those participating in global health diplomacy to identify challenges before they arise and to devise more systematic, rather than ad hoc, approaches to global health problems.

WHO's interest in global health diplomacy connects to its desire to anticipate diplomatic challenges emerging out of global changes that affect health and work to shape policy responses as effectively as possible. The desire to shape global health diplomacy requires more sophisticated mapping of the potential diplomatic activities needed to address key areas of global change that experts identify as being relevant to the future of global health.

Many of these anticipated global changes connect to past and present diplomatic experiences with similar, if not exactly the same, issues (e.g., demographics, economic development, trade, security, environment, and technology developments). Many of these areas of coming global change, particularly with respect to the broad range of social determinants of health, are not really new and have been the subjects of decades of diplomatic activity without much effective collective action to show for all the effort. Knowing in more conceptual, descriptive, and analytical detail why previous diplomatic efforts on health-related problems did not succeed could prove useful to future diplomatic activities on global health.

Knowledge gained from mapping global health diplomacy might not, however, provide a basis for optimism about future diplomatic efforts with respect to certain global health problems. Mapping exercises might confirm the limitations on what global health diplomacy can achieve. These limitations are often obscured by normative rhetoric about global health diplomacy, which frequently asserts that nations are interdependent in terms of health, a state of affairs which should generate reciprocal interests in crafting effective governance mechanisms. Technically, interdependence means mutual dependence, which tends to create common interests among States concerning the problem in question. Despite global health rhetoric, not all global health problems exhibit interdependent characteristics, and
this reality is particularly true with respect to non-communicable diseases and health harms.  

Many communicable and non-communicable health problems actually reflect differing levels of interconnectedness rather than interdependence, and interconnectedness is a weaker foundation for the formation of common interests and generation of effective diplomatic action. Although political and economic connections and interactions between the United States and India are increasing, neither national health nor economic prosperity in the United States depends on whether India controls obesity-related diseases, and vice versa. Neither security nor the protection of human rights in the European Union depends on whether countries in sub-Saharan Africa control diseases driven by tropical climatic conditions or local water or air pollution because these disease threats pose no real danger to populations in the European Union.

Historically, diplomatic activity on non-communicable diseases and health harms has been more robust with respect to broadly experienced negative externalities emanating from degradation of a common environmental resource, such as a river, lake, air, or the ozone layer. The common degradation creates contexts of interdependence because disease risks are transmitted to those materially reliant on the environmental resource. This dynamic helps explain why States have engaged in diplomatic activity on these types of problems from the late 19th century to the present day.

Outside the common resource context, diplomatic activity on non-communicable health threats has mainly occurred with respect to: (1) occupational health and safety standards (e.g., in the International Labour Organization); and (2) transboundary movement of products demonstrably harmful to health (e.g., hazardous wastes, pesticides, chemicals, and tobacco). Diplomatic activity on these issues has tended to be difficult, and has often produced weak collective action outcomes, because these issues reflect more economic and political interconnectedness than health interdependence between States and peoples. Emerging non-communicable disease areas, such as obesity prevention and control, mental health policies, and injuries from road traffic accidents, exhibit even weaker interconnectedness, which creates challenges for shaping global health diplomacy in these areas.

Mapping global health diplomacy can help identify patterns of interdependence, interconnectedness, and other characteristics that influence prospects for diplomatic success or failure with respect to different global health problems. Knowing these patterns will be critical to

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80 For more on the difference between interconnectedness and interdependence in global health, see Fidler, supra note 31, at 17-19.
devising strategies to shape global health diplomacy in ways to increase the likelihood of diplomatic success. This knowledge will include understanding both the potential and the limitations of diplomatic activity and will help develop increasing levels of skill at maximizing the potential and minimizing the limitations of global health diplomacy.

VII. CONCLUSION

The intensifying interest in global health diplomacy reflects awareness that one of the great challenges in this realm of international relations is to make diplomacy work more productively for human health around the world. Health diplomacy of various sorts has been around for many decades, but recent changes in global politics have highlighted the necessity to understand and more skillfully operate within the new diplomatic realities. This article analyzed these new realities by pushing for more descriptive, conceptual, analytical, and practical rigor in thinking about and practicing global health diplomacy. Embarking on strategies to map and shape global health diplomacy can facilitate achieving this needed rigor.

The twin tasks of mapping and shaping global health diplomacy mirror the time-honored public health responsibilities of surveillance and intervention. Surveillance of disease conditions and trends in societies maps the health of nations, providing the information needed for public health authorities to design and implement appropriate interventions to reduce morbidity and mortality and improve human well-being and dignity. Mapping and shaping global health diplomacy likewise produces actionable intelligence that those engaged in addressing global health problems can use to their advantage by, where possible, integrating health objectives more powerfully into the life of the global society.

Producing and exploiting this advantage becomes even more important in the context of open-source anarchy, which complicates diplomatic endeavors and fragments possibilities for more coordinated, comprehensive global governance solutions. This fragmentation simply heightens the importance of global health diplomacy itself because, in the absence of effective collective action, the processes of global health diplomacy increasingly become a surrogate form of politics and governance for humanity’s health.
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