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International Public Health Diplomacy

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Mary Whelan is the former Irish Permanent Representative to the UN and WHO in Geneva where she chaired the negotiations which led to the establishment of the 2005 International Health Regulations (IHR), as well as former Irish Ambassador to the Netherlands and Austria.

Some years ago I was asked to address the issue of health diplomacy and the extent to which it was a unique construct.[1] At that time, I concluded that 'in its widest sense, foreign policy is the expression of a State's domestic policies as they impact on or are impacted by the external environment. In that sense, governments have always been mindful of the permeability of their borders to disease'. In other words, I argued that health diplomacy was not a new concept. However, over the past decade and more the value of multilateral action was called into question by many even, as the threats facing societies clearly demanded an effective multilateral response in areas as apparently diverse as trade, climate change, migration and health.

This trend is changing as the ineffectiveness of isolationism or 'going it alone' is becoming more apparent. The recently published UK Foreign Policy Review[2] for example, has a section which deals with 'bolstering domestic and international action to address global health risks'. Many States could endorse this approach and indeed many already do.

Health diplomacy is not a new concept in Irish foreign policy. Any consideration of the focus and priorities of Irish Aid, the international development arm of the Department of Foreign Affairs, well illustrates this fact. Of its ten priority areas, five relate to international cooperation on health issues. These are:

- Hunger, where for many years Ireland has played a leading role in international efforts to combat hunger and famine;
- Environment and climate change;
- HIV and AIDS;
- Water and Sanitation - areas intrinsic to policies for eliminating cholera and other water borne illnesses;
- Health per se including strengthening health systems.

This focus informs the work of Irish Aid with its development partners especially in Africa. While the impact of such work can be seen in support for and implementation of pragmatic programmes at the national level, at the multilateral level Ireland has long been a strong advocate and practical supporter of the efforts of the WHO, HIV/AIDS, GAVI and today COVAX, the vehicle established for the provision of COVID vaccines to developing countries. In this context, it might be noted that the government announced additional funding for UNCOVAX as *part of 50 million euro in Irish Aid to global public health this year.*[3]

Furthermore, I do not think that it is stretching a point to suggest that Ireland's work on disarmament is firmly based on a recognition of the devastating consequences for life and bodily integrity

1 Mary Whelan Negotiating the International Health Regulations Global Health Working Paper No.1 (2008) The Graduate Institute Geneva

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/975077/Global_Britain_in_a_Competitive_Age-_the_Integrated_Review_of_Security__Defence__Development_and_Foreign_Policy.pdf p.93

3 Ireland also contribute to the vaccine efforts through the EU, which to date has allocated 850+ million euro to COVAX

of inhumane weapons such as landmines and the existential threat to our planet posed by chemical, biological and nuclear weapons. The role Ireland has and is playing in these areas is effective and well known most particularly with regard to nuclear non-proliferation and other weapons of mass destruction. In addition to work at a political/diplomatic level Ireland also provides financial support to disarmament activities such as demining.

Ireland's engagement with issues relevant to health and wellbeing goes beyond the traditional concerns of foreign policy and can be seen in work on the environment and work on animal and plant health. At the same time there can be a sense in which it is not always easy to discern an overall coherence in our various actions in this regard. Inevitably, silos of excellence can face the danger of work hidden in full view.

The elements of health diplomacy outlined above can and should continue to be strengthened especially with regard to assisting in building capacities in the health systems of developing countries and ensuring equipment and vaccines are available on an equitable international basis.

At the same time, we need to consider the system underpinning international efforts to combat global health threats and how these might be improved.

Present day international cooperation on public health dates back to the mid-19th century when the first of a series of Conferences was held to bring coherence to the different quarantine regulations of various European States. By 1907 an International Office of Public Hygiene was established and in the 1920s a League of Nations Health Organisation was founded.

In the aftermath of the Second World War, the World Health Organisation (WHO) was established as a specialised agency of the United Nations. It took over and expanded the role previously played by other bodies. In its early decades great progress was made in fighting infectious diseases thanks to developments in science, sanitation and economic development. There were easily taken for granted successes such as the eradication of smallpox, the near eradication of polio and the decline in the numbers facing death and disfigurement from diseases such as measles, mumps, diphtheria, leprosy, HIV/AIDS.[4] Even in the area of less well known diseases – such as guinea worm and river blindness - major strides were made.

In 1951 the International Sanitary Regulations were adopted by the World Health Assembly, the policy making forum of the WHO, which focussed on efforts to control six major diseases – cholera, plague, relapsing fever, smallpox, typhoid and yellow fever. By 1969 these were replaced by the first iteration of the International Health Regulations (IHR) again relating to specific, although a reduced number of, named diseases.

In the background to growing international cooperation and coordination on infectious diseases there was an awareness of the strong possibility of a repetition of the great flu pandemic of the early 20th century; there was a view that such an event could emerge in east Asia. While work was ongoing for some years on updating the IHR, partly to deal with this threat, it took the outbreak of SARs in 2003 to inject greater urgency to the matter. SARS created panic and severe economic disruption. Interna-

4 Faced with the HIV/AIDs epidemic existing structures did not deal adequately with the situation. Hence in 1994 UNAIDS was formed as the main advocate for comprehensive and coordinated action on the pandemic.

tional suspicion and lack of transparency did not facilitate the international response. Yet while the economic cost in terms of disruption to trade and travel were very significant, the death toll was less than a thousand. So SARs was not the 'once in a century event' that was long anticipated in the public health. That still lay in the future. However, SARs did point up the need to prepare for it with a greater sense of urgency.

It was against this background that the negotiations on the revision of the IHR took place in 2004/5. I was asked by the then DG of WHO, Dr Lee Jong-wook, if I would chair the working group negotiating the new Regulations. Over the following months I chaired three negotiating sessions and on 23 May 2005 the World Health Assembly adopted an agreed text. These regulations, which are legally binding on 196 States, provide the overarching legal framework that defines States Parties obligations in responding to public health emergencies of international concern. They therefore form the basis to the work of the WHO in the fight against COVID.

The IHR (2005) differ significantly from its predecessors for while its purpose is, 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade' it does not limit itself to specific diseases as in the past. It also covers 'health risks, irrespective of their origin or source' – in other words the impact of a biological, chemical or radiological event is covered by the regulations provided that such an event constitutes a Public Health Emergency of International Concern (PHEIC). The IHR set out the circumstances in which a PHEIC should be declared, the obligations of States Parties to provide information on a likely event in an expeditious manner, the protection of the human rights of persons and the obligations of States to develop certain minimum core public health capacities.

The major issues in the negotiations were:

- The balance between the prerogatives of States Parties and the role of the WHO. The Regulations had to give to an international entity that was reasonably free from political interference, the key role in determining a public health emergency. This entity had to be the Director General (DG) of the WHO. governments were concerned that there should be adequate consultative mechanisms in place to ensure that this authority was exercised with prudence, and after taking the broadest available advice. And so while the DG, in Article 12 of the IHR, is given the responsibility to declare whether an event constitutes a PHEIC, s/he is required to consult with the relevant State Party and, if the latter does not agree s/he should consult with an Emergency Committee of Experts. I would argue that the responsibility of the DG is absolute, but with lots of built-in consultative bumps – and hence potential delays.
- The need for balance between effective, science based measures to protect public health and avoiding unnecessary restrictions on international traffic was a central concern.
- The scope and definition of a PHEIC proved a difficult issue. Here a major issue was the need for the regulations to refer to both naturally occurring diseases and the deliberate or accidental release of a chemical, biological or radio nuclear agents. This was achieved by agreeing a definition to cover all eventualities.[5]

5 An event determined to (1) constitute a public health risk to other states through the international spread of disease and (2) to potentially require a coordinated international response.

- Federal and confederal States had particular problems. Each such State was unique in its structure and yet the regulations had to cover all. Yet central governments were expected to assume obligations for which they did not have domestic competence.
- Given the very wide powers which government could assume, for example, power to quarantine travellers, insist on medical examinations etc., there was support across the board for the inclusion of a strong reference to the need for the application of the IHR to take account of human rights issues. This was achieved in Article 3 of the IHR.[6]
- A central concern of developing countries related to core capacity to implement the Regulations. States were assuming significant obligations without a balancing commitment to assist them in developing the requisite capacities. Unfortunately, developing countries did not get much more than best efforts.
- Some negotiating partners wanted provisions to allow for sources of information on potential outbreaks of diseases other than those provided by governments. This was eventually agreed.
- Some States wanted to be in a position to introduce additional measures beyond the scope of the IHR. Others were cautious and saw this as a potential Trojan horse. This too was resolved.

The negotiations were a lesson in the difficulties inherent in health negotiations. Some delegations were headed by public health professionals, this had some advantages in that they knew what they were talking about but disadvantages in that they did not always have working contacts outside their own neighbourhoods. Large States and in particular the United States and China, to some extent, were trying to coordinate the input from multiple agencies with varying agendas. Many States were suspicious that negotiating partners would use health concerns to limit travel or trade without just cause.

The negotiations achieved what they did – which represented the limit of the possible in 2005 - because at the end of the day the outcome was in everyone's interest. The negotiations had strong political elements but they were not politicised. I would also note that 16 years ago China was not as assertive actor on the world stage as it was to become.

A feature of commentary on the current crisis relates to the WHO and the reform of same. Some of this is valid and goes beyond the topic of the pandemic response but, I fear, some is based on deflection from failures at the national level.

When the scale of the current crisis began to emerge the blame game started in earnest. President Trump decided that the problem lay with China and the WHO. The US withdrew from the latter and its focus on a possible non-naturally occurring source for COVID is unlikely to have facilitated Chinese cooperation with efforts to identify the origin of the outbreak. It has also ensured that the calls for a reform of the WHO became an automatic response to the pandemic.

Consequently, essential questions have been overlooked and especially why governments were so ill prepared for a pandemic which was expected to occur. Why were there no stockpiles of essential equipment, why did it take so long to act, why did it take so long to establish effective quarantine and tracing regimes?

6 Article 3 states that the regulations should be implemented with full respect for the dignity, human rights, and fundamental freedom of persons.

This is not to say that the WHO could not have acted more expeditiously. But it is a fact that whatever the legal position, there is no means of enforcing the cooperation of large powerful States. It is clear from considering the reports of the recommendations of the Emergency Committee of the WHO in January 2020, that a speedier response would have been justified.[7]

The WHO has to learn lessons from the crisis. Already the WHO, using the review mechanism of the IHR, has established a Review Committee to look at ways to improve the International Health Regulations. It is working at a brisk pace and issued an interim report in January. Among the issues identified is the need for a better monitoring system to ensure compliance by states; the idea of a peer review mechanism for government actions in implementing the IHR, along the lines of that used in the UN Human Rights Council has been floated. The Committee is also looking at notification and verification procedures and whether, for example, an intermediate alert system is needed before moving on to a declaration of a PHEIC. Another issue is the need for greater transparency around the composition of the Emergency Committee which advises the Director General some of whose members may be considered too close to their governments. The final report of the Review Committee and its recommendations will merit very serious consideration.

The work of the Review Committee was complemented by the work of an Independent Panel also established by the Director General of the WHO, to address the failures of the organisation's COVID response and how these might be addressed. The resulting Sirleaf/Clark Report makes a number of far-ranging proposals including proposals for a new pandemic framework agreement, changes to the tenure of the Director General and a greater focus on the role for government leaders in addressing global health issues. Despite the positive response to this report that there will be difficulties in maintaining the requisite level of political engagement over the long term which this issue requires.

I have focussed on the IHR but every negotiation in the WHO is political. During the negotiations of the Framework Tobacco Convention it was clear that while there was very significant support for the agreement, there were powerful lobbies on the other side. These ranged from tobacco producing States with strong related industries to, for example, States where the tobacco lobby were significant political donors.[8]

Beyond the COVID pandemic there have been ongoing discussions on the reform of the WHO some of this has related to the relationship between field offices and headquarters in Geneva and some work has been carried out in this area. Other issues, long highlighted, relate to the ever growing agenda of the organisation and the need to refocus on basics. The budget has been a long standing problem. Much of the funding for WHO activities comes from donor States and other actors. For many years this has led to criticism that the activities of the organisation may be over-influenced by donors. Some of these problems are also addressed in the Sirleaf/Clark report.

A strengthened Irish health diplomacy would consider how it can contribute to the discussions at the WHO on reform at the multilateral level and strengthening compliance at the national level. But multilateral efforts to strengthen the international health regime must also consider how we operate

7 Statements at the second meeting of the IHR (2005) emergency committee dated 30/1 noted that at its first meeting the Emergency Committee expressed divergent views on whether the event constituted a PHEIC or not

8 As far back as 2010 the European Council conclusions requested Member States to gradually move away from earmarked WHO funding towards funding its general budget.]

regionally and in our neighbourhood. To illustrate this point one only has to consider our strongest cultural, social and trade links. We know that last summer we seem to have imported a more virulent form of the COVID virus from Spain and over Christmas we imported a further mutation from the UK. So while thinking global we need to act local. Global coordination is vital but regional is existential.

At a multilateral level, the **EU** could be accused, at times, of over promising and underperforming. We say that the EU and its Member States are the largest aid donors and contributors globally to international development programmes and multilateral institutions. But there is a fundamental problem with the manner in which the EU engages with multilateral institutions. Its relationship with the secretariats may be positive, even exemplary. But in negotiations we can be so coordinated that we appear rigid and inflexible. In a public diplomacy sense we simply gain so much less than we give. This limits the influence of the EU.

Effective communications, both internally within the Union and externally with other international actors, have not characterised the response to the current crisis. This is not an insurmountable problem. The present crisis has also shown that the debate on 'strategic autonomy' may need to be broadened to include health and related areas.

And finally to the neighbourhood and perhaps the most important forum for effective action. The COVID-19 crisis has highlighted the problems of our **all island aspirations** and piecemeal level of health cooperation. We need better structures at the all-island level and perhaps also with the UK that produce more effective responses to common pandemic threats.

To return to my opening comments I would ask **what should health diplomacy look like**? **Well it should build on the excellent work already carried out including by Irish Aid. In addition, it should have an all island or even islands approach, a regional or EU level and a global approach based on the WHO**. It would focus on adding value and achieving results and would be rooted in domestic policy entities. It should be realistic. Billions will be poured into this area in the coming year. We need to define our niche contribution.

Consideration could be given to establishing a focal entity to deal with Ireland's international efforts in the health arena, recognising this covers many areas of government. This would take account of the fact that we have a track record on which to build.

We need to more systematically engage with the global architecture for delivery of health outcomes including the WHO.

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