GLOBAL HEALTH DIPLOMACY

The Role of CSOs

Building CSO Capacity Workshop, Kampala

Francis Omaswa, ACHEST, 19.09.18

PRESENTATION

- Context
- Definitions and Origin of Health Diplomacy & Global Health Diplomacy
- Approaches and Key Actors in GHD
- Illustrative examples in GHD
- Linking local, regional and global
- CSOs and GHD: FENSA,
- CSOs and SDGs
- CSO Skills for GHD

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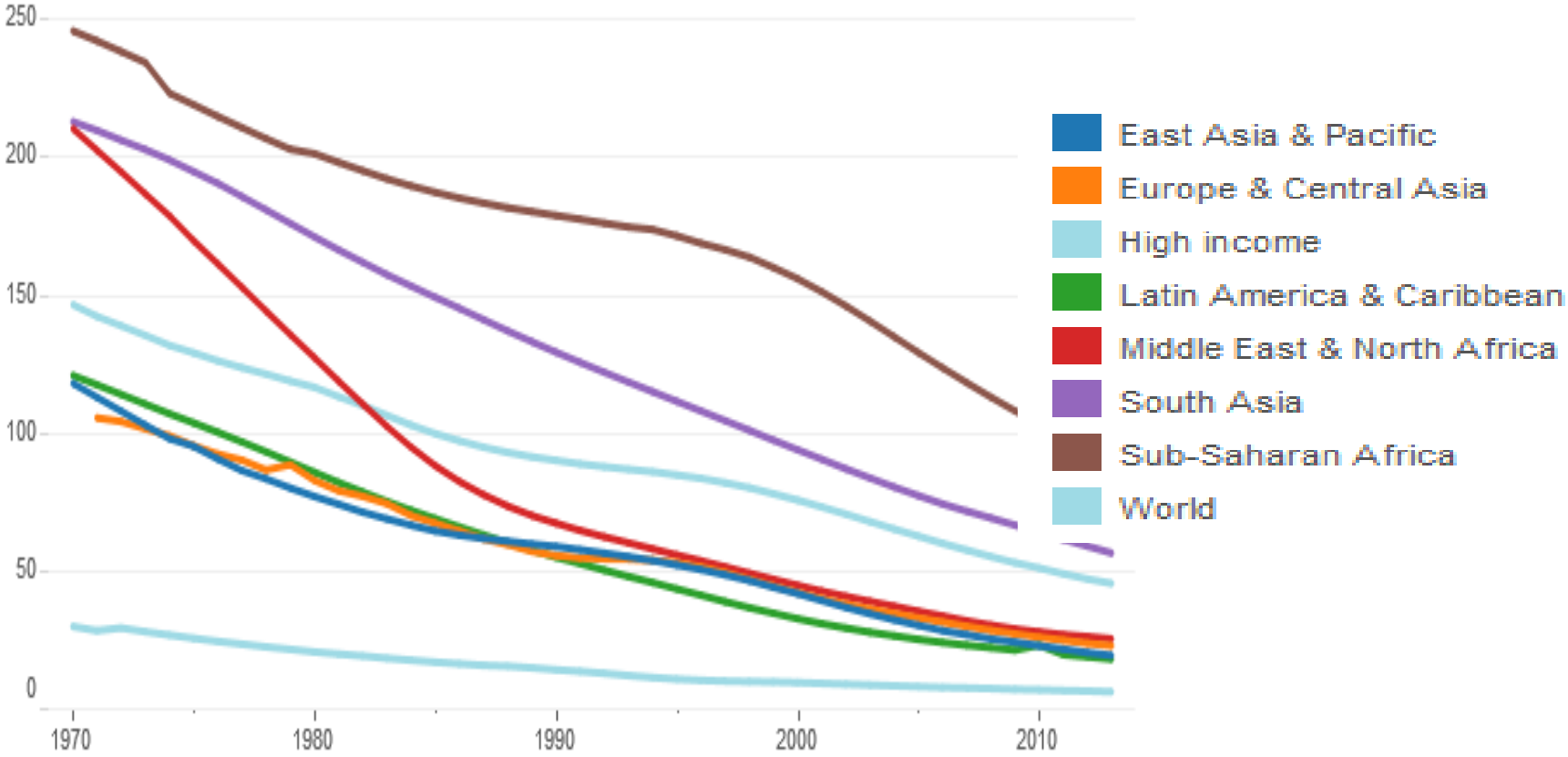
Child mortality rate per 1000 live births from 1960 to 2012 by region



World Bank, 2014

African Health Leadership

Nigel Crisp

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Root Causes of African Health Crisis

- Economic growth: high level of poverty
- Population growth: overwhelmed services
- Dependency: in communities
- Dependency on outsiders loss of “Can do” attitude, low Ownership
- Governance: Tolerance of the unacceptable, weak demand, challenging work environment

DOES ANY ONE CARE? Quality Gap.

- "When I fall sick I just remain like that … like an animal."
- We are resigned to death which is simply shrugged off: " his/her day has come", " God has called him/her“ (UPPAS 2000)
- Quality gap: Access to care by all; All deaths accounted for

Decent work, inclusive economic growth, UHC

Health as a cost disease and a drag on the economy → *Health as a multiplier for inclusive economic growth*

Baumol (1967)

- Growth in health sector employment without increase in productivity could constrain economic growth (data from USA)

Hartwig (2008 and 2011)

- Confirmation of Baumol hypothesis (data from OECD countries)

Arcand et al., World Bank (*In press*, 2016)

- larger dataset; data from low-, middle- and high-income countries
- **establishes positive and significant growth inducing effect of health sector employment; multiplier effect on other economic sectors**
- magnitude of effect greater than in other recognized growth sectors

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MESSAGE 1

UNTIL AND UNLESS IN EACH AND EVERY COUNTY, THERE IS S CRTICAL MASS OF INDIVIDUALS AND INSTITUTIONS THAT WORK WITH THEIR RESPECTIVE GOVERNMENTS AS BOTH SUPPORT AND ACCOUNTABILITY AGENTS, IT WILL NOT BE POSSIBLE TO CREATE AND SUSTAIN ENABLING ENVIRONMENT TO QUALITY IMPROVEMENTS.

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Origins and History of GHD

- Part of Colonization and Military
- Religious missionaries
- Tropical Medicine and Hygiene
- International Health
- Global Health
- Planetary Health

WHO Definition

- Global Health Diplomacy (GHD) is the practice by which governments and non-state actors attempt to coordinate global policy solutions to improve global health.
- It brings together several disciplines including: public health, international affairs, management, law, economics, trade policy
- To build capacity among Member States to support the necessary collective action to take advantage of opportunities and mitigate t risks for health

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Other Definitions of GHD

- “a political change activity that meets the dual goals of improving global health while maintaining and strengthening international relations abroad, particularly in conflict areas and resource-poor environments” Novotny and Adams (2007)
- “multi-level, multi-actor negotiation processes that shape and manage the global policy environment for health” Kickbusch et al. (2007)49
- “winning hearts and minds of people in poor countries by exporting medical care, expertise and personnel to help those who need it most” Fauci (2007)
- “the cultivation of trust and negotiation of mutual benefit in the context of global health goals” Bond (2008)50
- “Health Diplomacy is the chosen method of interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems and securing the right to health for vulnerable populations.”

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DIPLOMACY IN PRACTICE

- "Diplomacy refers to both specific methods for reaching compromise and consensus, as well as a system of organization for representation, communication, and the negotiating process. It entails relationship building at different levels and with different actors."
- To build capacity among Member States to support the necessary collective action to take advantage of opportunities and mitigate the risks for health

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GHD SPACES

- Trade and Health (GAT).
- Foreign policy. Exporting health resources in foreign relations. Soft power
- Global Public goods
- Global Health Security
- Global Health governance
- Global Health Financing
- Social Justice, Equity Space

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Key Actors Global

- UN Multilateral Agencies: WHO, UNAIDS, UNICEF, UNDP, UNFPA, UNEP, UN Women
- International Finance Institutions: WB, IMF, WTO
- Government Technical Agencies: USAID, NORAD, SIDA, IDRC, DFID, JICA
- Foundations: BMG, Rockefeller,
- Global Health Initiatives/Partnerships: GFTM, Stop Tb, GAVI, PMNCH, , GHWN
- Contractors and Consulting Firms: MSH, JS, JIEPGHO, PATH
- For Profit Business,: Pharma, Vaccines, Divices, .
- CSOs: PHM, G2H2, Wemos, World Vision International, White Ribbon

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Key Actors Africa Regional

- AUC
- Regional Economic Communities: ECSA HC, WAHO, SADC,
- UN Agencies: WHO Afro, UNICEF, UNAIDS etc
- Financial Institutions: AfDB, WB,
- Professional Associations, Academia
- CSOs: Amref, ACHEST, AMAMA, SIKIKA, APHRH

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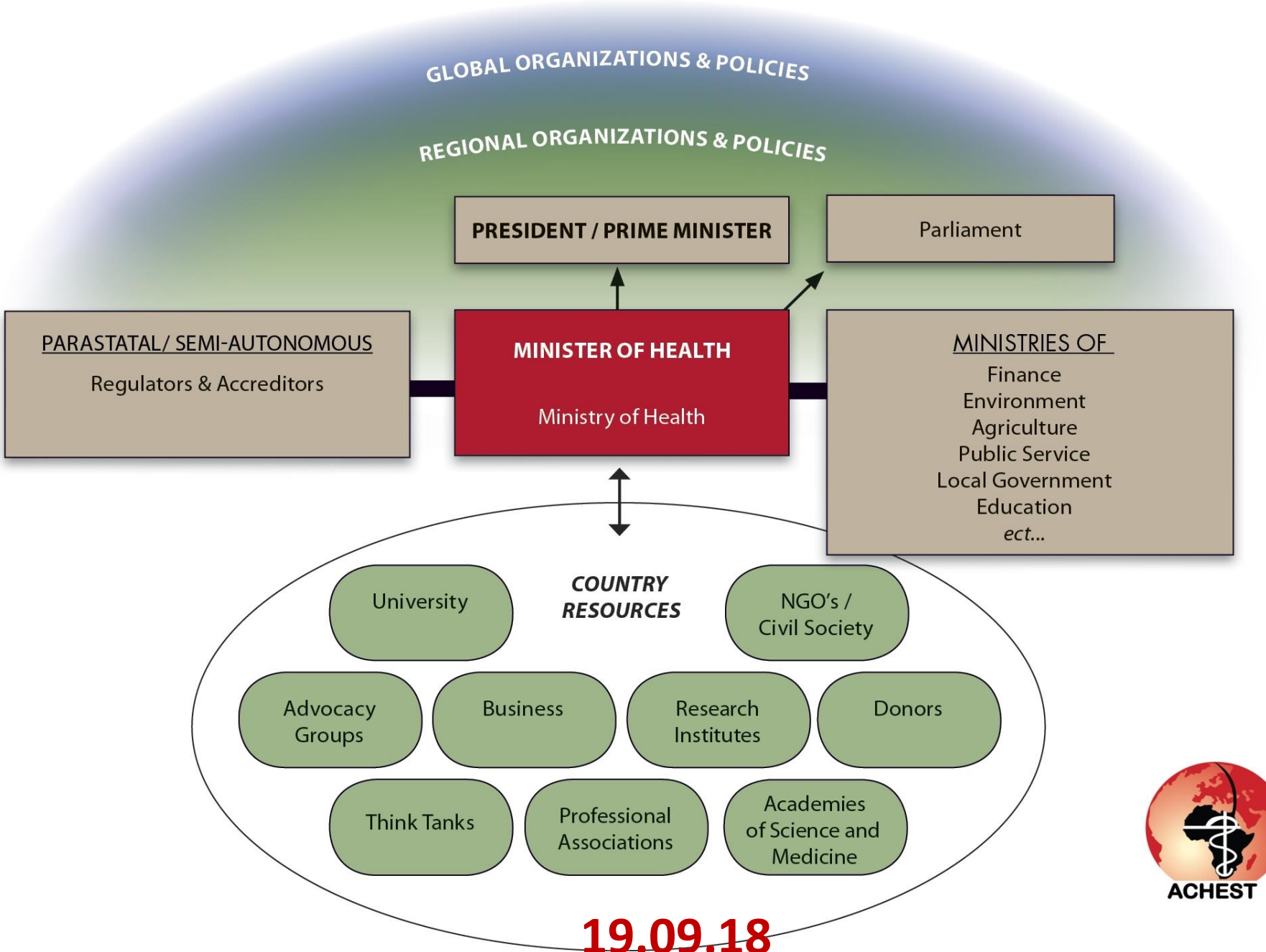
MOH OPERATING ENVIRONMENT



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EXAMPLES IN GHD

- Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Paris Declaration on Aid Effectiveness
- Stop TB Partnership
- Polio immunization in Nigeria

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People and CSOs in Health for All

- Original principles 1978 reaffirmed in 2008:
- "The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries."
- "The people have a right and duty to participate individually and collectively in the planning and implementation of their health care."
- "Primary health care is essential health care… made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development…"

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CSO ROLES IN GHD

- Traditionally, CSOs have played a supplementary role where government institutions have been weak or failed or nonexistent
- gaps in funding and resources,
- neglected issues or constituencies require advocacy.
- Perhaps most visibly, CSOs are accepted as playing a critical watchdog role

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FENSA ENTRY POINT FOR CSOs

Private sector (§10)	• Commercial enterprises, that is to say, businesses that are intended to make a profit for their owners; • Entities that represent, or are governed or controlled by, private sector entities, including international business associations.	
Nongovernmental organizations (§9)	• Nonprofit entities that operate independently of governments, free from concerns which are primarily of a private, commercial or profit-making nature.	WHO will determine through its due diligence if a non-State actor is subject to the influence of private sector entities (through financing, participation in decision-making or otherwise) to the extent that the non-State actor has to be considered itself a private sector entity (§13).
Philanthropic foundations (§11)	• Nonprofit entities whose assets are provided by donors and whose income is spent on socially useful purposes, clearly independent from any private sector entity in their governance and decision-making.	
Academic institutions (§12)	• Entities engaged in the pursuit and dissemination of knowledge through research, education and training, including think tanks that are policy-oriented institutions, as long as they primarily perform research.	

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Principles (§5)	• Demonstrate a clear benefit to public health; • Conform with WHO's Constitution, mandate and general program of work; • Respect the intergovernmental nature of WHO and the decision-making authority of Member States as established in the WHO's Constitution; • Support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO's work; • Protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards, including information gathering, preparation for, elaboration of and the decision on the normative text; • Not compromise WHO's integrity, independence, credibility and reputation; • Be effectively managed, including by, where possible avoiding conflict of interest and other forms of risks to WHO; • Be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect.
Benefits (§6)	• Contribution of non-State actors to the work of WHO; • Influence that WHO can have on non-State actors to enhance their impact on global public health or to influence the social, economic and environmental determinants of health; • Influence that WHO can have on non-State actors' compliance with WHO's policies, norms and standards; • Additional resources non-State actors can contribute to WHO's work; • Wider dissemination of and adherence by non-State actors to WHO's policies, norms and standards.
Risks (§7)	• Conflicts of interest; • Undue or improper influence exercised by a non-State actor on WHO's work, especially in, but not limited to, policies, norms and standard setting, including information gathering, preparation for, elaboration of and the decision on the normative text; • Negative impact on WHO's integrity, independence, credibility and reputation; and public health mandate; • Engagement being primarily used to serve the interests of the non-State actor concerned with limited or no benefits for WHO and public health; • Engagement conferring an endorsement of the non-State actor's name, brand, product, views or activity; • Whitewashing of a non-State actor's image through an engagement with WHO; • Competitive advantage for a non-State actor.

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CSO MANDATE IN GHD

- CSOs have played the biggest roles in initiating, formulating and implementing formal rules in GHG.
- Given the intergovernmental nature of the instruments reviewed, CSOs perhaps understandably have not been given formal authority to make and enforce policy decisions.

- Although the formal authority of CSOs participating in GHG remains limited, the FCTC and IHR (2005) suggest that informal participation can be highly effective.

- Governments are likely to continue to fulfil the formal functions of rule making, but can enhance the policy process by broadening the scope for involvement by CSOs through improved consultation, granting of observer status, and provision of resources to participate in specific functions.

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CSO Institutional Capacity Building Lessons

- Capacity grows up from within; not dropped down.
- Country context critical: political, social, cultural, resource factors. takes time and patience
- Local Institutions to grow capacity exist HRPIs
- Need to support governments and HRPIs simultaneously to grow local:
  - Expand locally driven research, Strengthen management and leadership, Improve sharing of information and strengthen networks, Close implementation gap and improve monitoring and evaluation of performance

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GHLC 1985, 2011:
what matters for good health:

- Political commitment to health as a social goal
- Strong societal values of equity, political participation and community involvement
- High-level investment in primary health care and other community based services
- Widespread education, especially of women Intersectoral linkages for health

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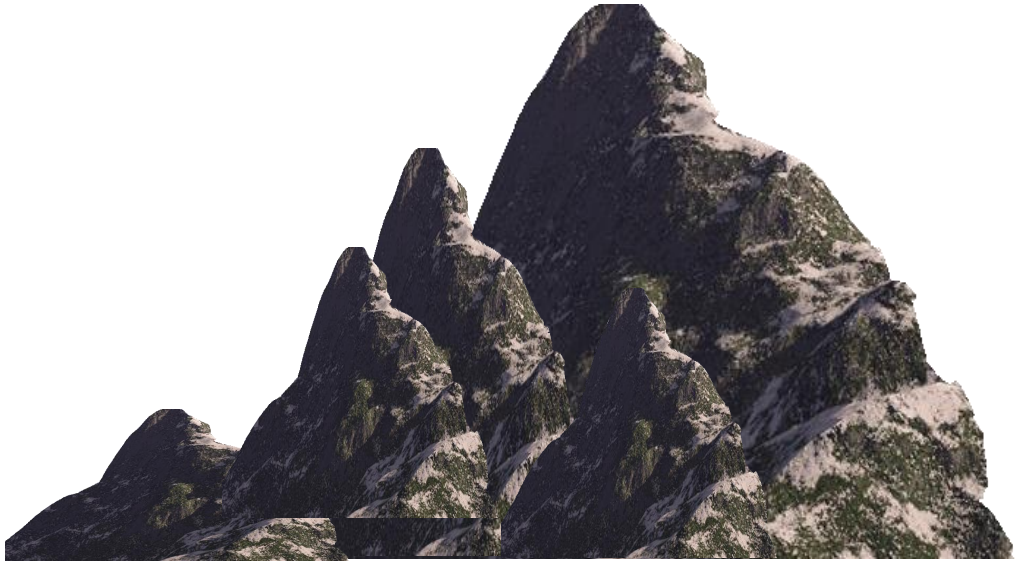
"Triangle that Moves the Mountain"

Knowledge creation



Social mobilization

Political involvement

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CSO Coalitions 10 Countries

- Multistakeholder coordination is critical for progress for RMNCH;
- Strong leadership is critical to structure a successful coalition;
- Incentivizing CSO members is critical to the sustainability of these coalitions;
- Increased funding is required for the implementation of work plan activities, and in some cases, for the running costs of the coalitions. Successful coalitions have in many cases benefited from additional funding from partners;
- Sustained technical support from partners, particularly in making the connection between national efforts and regional and global programmes is required. For instance, many partners noted the need for increased information on how to engage in the Post-2015 global development agenda;
- Exchange between coalitions in different countries is necessary for cross-border learning

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Study on CSOs and SDGs

- It is recommended that all countries take advantage of HPTTs and other CSOs with potential to support cross sectoral implementation of SDGs
- Generating high quality research evidence
- Supporting governments to report SDG implementation annually to the UN forum
- Holding governments accountable.

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Local, Regional Global Links

- HASP Theory of Change
- Regional Networks mutual learning and support : Ashgovnet, THINK SDGs
- Global Networks Mutual learning and support: G2H2, PHM, WHA Process ongoing

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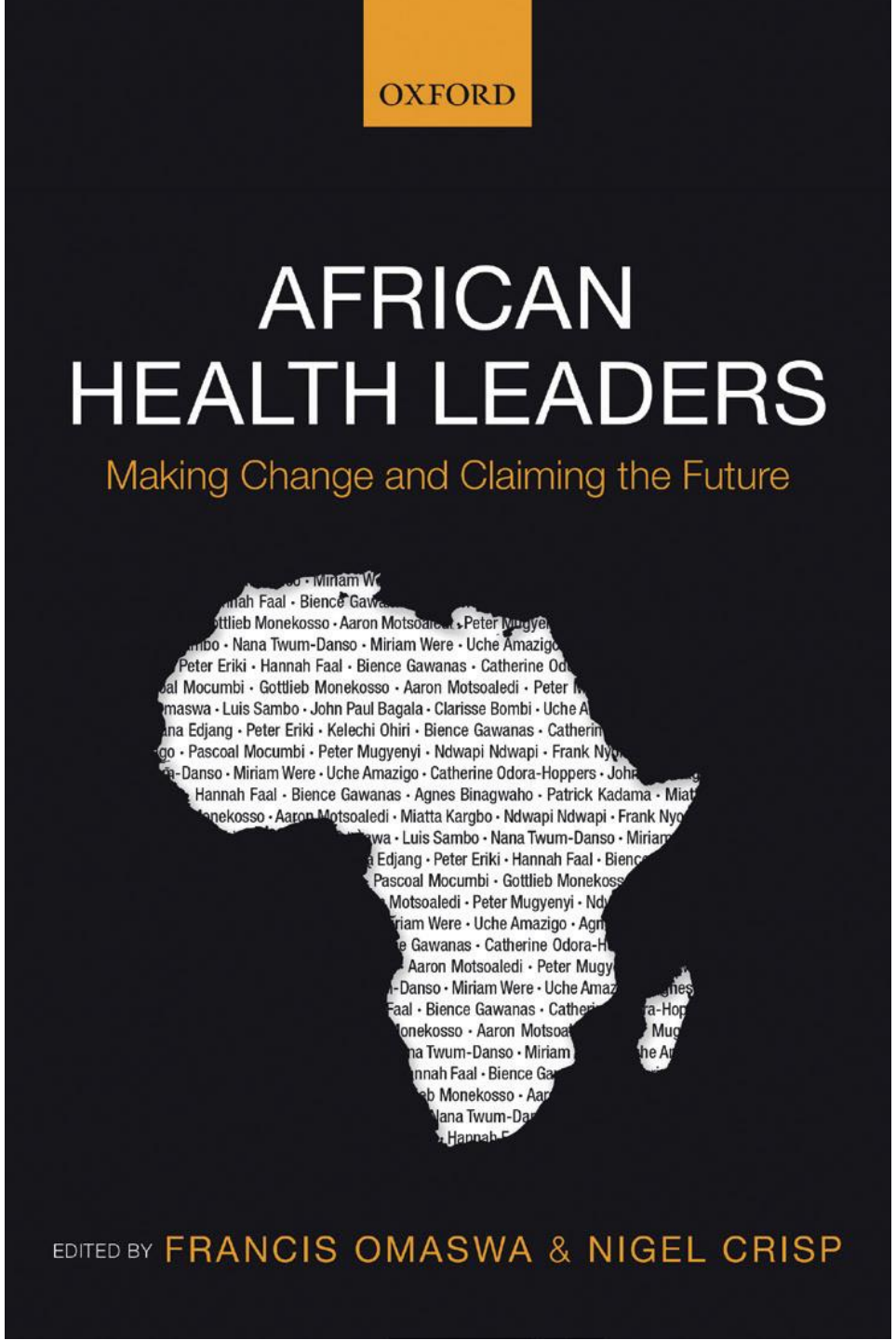

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MESSAGE 2

- **Leadership Needed**
- If not by us; then by whom?
- If not now; then when?
- If not here; then where?
- One by one & collectively
- **This is Africa, what do you expect?**

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THANK YOU!