



Check against delivery!

Speech of Ambassador Martin Dahinden

Challenges for Regional Health Cooperation in Global Health Governance

Third High-Level Symposium on Global Health Diplomacy
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Ladies and Gentlemen,

I am honoured to welcome you to the Third Symposium on Global Health Diplomacy of the Graduate Institute.

This programme of health diplomacy, which is still young, is based on many years of experience of the former Institut de Hautes Etudes Internationales (HEI) and the Institut Universitaire d'Etudes du Développement (IUED), which have now merged to form the Graduate Institute of International and Development Studies (IHEID).

From a foreign-policy perspective as well as a health perspective we can certainly take pride in how much the institute has strengthened the role of Geneva as an international centre of competence for global health issues. As a centre of academic excellence with a focus on health, IHEID without a doubt enhances Switzerland's contribution to the international expertise and competence on global health.

As was the case for many of my generation, I first became aware of the relevance of health for people in developing countries through Albert Schweitzer's work as a physician and missionary in Lambarene, Gabon. While I was working in Africa two decades ago, I made the long journey to the place where he had worked and where he is now buried. His working room was still there, and I found someone to open it for me. His microscope, the old-fashioned medical instruments, his glasses, his books but also some scores of Bach's beautiful music were there as if he had just left the room. At the same time it was also striking how much dust – physically and symbolically – had settled on the place.

Albert Schweitzer's paternalistic approach towards Africans would not fit into today's world, even if we assume that development cooperation is still guided by ethical principles and personal commitment. Today the Medical Research Unit of the Albert Schweitzer Hospital has become part of global health through its membership in the European and Developing Countries Clinical Trials Partnership (EDCTP), an organisation promoting capacity building for African medical doctors in clinical research focussed on poverty-related diseases.

In our days international health governance is facing major challenges in view of globalisation, the increased transfer of international health risks and the challenge of health inequalities worldwide.

Before examining some of those aspects more closely, I would like to look back at the roots of health diplomacy.

Health Diplomacy and Politics

International health diplomacy began in 1851, when European states gathered for the first International Sanitary Conference to discuss cooperation on cholera, the plague and yellow fever. Disease control became a topic of diplomatic discussion in the wake of the cholera epidemics that swept through Europe in the first half of the 19th century. National policies not only failed to prevent the spread of the disease but also created discontent amongst merchants: a quarantine would hurt their shipping interests. Indeed, it was primarily economic interests that led governments to gather for the first International Sanitary Conference – the primacy of shipping interests over public-health concerns was no secret. Each delegation had sent one physician and one diplomat, and the only common ground between them was their total ignorance of the cause (aetiology) of the three diseases or how they spread. But even if a medical consensus had been found, diplomats had strict instructions from their governments on how to vote on quarantine. Thus, the conference participants came to the conclusion that it was humanly impossible to fight cholera, especially through quarantine measures.

The destabilizing impact of commercial and political interests on multilateral health governance did not end with the 1851 conference. More than one and one-half centuries later, multilateral health diplomacy, in particular within the UN system, still suffers from strong politicisation.

For example, Dr Suwardjono Surjaningrat, the president of the 38th World Health Assembly, recommended in his opening speech in May 1985 that because of the "unique technical and social mandate of our Organization, we should strive hard to avoid the spending of the precious time of the Assembly on extraneous political issues which perhaps are best

discussed elsewhere”. The president’s recommendation was not followed: amongst the political issues that were discussed for several hours was a resolution on “Health conditions of the Arab population in the occupied Arab territories, including Palestine” (WHA38.15). Resolutions of this kind are recurrent in all World Health Assemblies.

The creation of the World Health Organization (WHO) on 7 April 1947 as the specialised UN agency for global health issues ushered in a new era in global health governance. For the very first time an international organisation had as its overall objective to strive for “the attainment by all peoples of the highest possible level of health”. With 192 member states, both its mandate and its legitimacy are unquestioned. Nevertheless, the WHO is often bogged down by North-South disagreements on a multitude of issues ranging from public health to human rights, cultural diversity and so on.

The politicisation of the technical work of the WHO is often considered the major compromiser of the organisation’s effectiveness. The long road to approbation of the “Global Strategy for Public Health, Innovation and Intellectual Property” (GSPA) during the last WHA this past May is a good example of the politicisation of the negotiating process. It took more than six years to achieve consensus and bridge the gaps between opposing interests amongst member states on access to medicine and intellectual property. Member countries have not yet found a workable balance between giving incentives to the private sector to invest in drug development and still paying adequate attention to the immediate health needs and needs for health innovation of low- and middle-income countries.

The Global Health Agenda

As the health system has become more global, new players besides the WHO have altered its shape. Over the past decades, the range of actors involved in agenda setting has become more diverse, with the public sector and multilateral agencies losing influence, while the voices of the corporate sector, foundations, civil society and pressure groups have gained clout.

If we understand the term “global health agenda” to mean the issues that a set of principal organisations involved in global health are paying attention to at a given time, we can conclude that particularly private organisations have, both formally and informally, gained greater power and influence over the global agenda. Private foundations, new partnerships and civil society all play an important role in global governance and setting health agendas.

Today the principal organisations involved in global health are providing significant resources such as funding, scientific expertise and information to health questions of cross-national concern.

Private funding, once fairly insignificant, now accounts for nearly one-quarter of all development assistance for health (DAH). The Bill & Melinda Gates Foundation, for example, has, as the dominant player in that sector, disbursements equal to more than half the expenditure of the WHO.

The roll-out of crucial health programmes in developing countries would not be possible without private funding. But depending on such institutions also bears risks. Private philanthropies are not accountable to the public, and their decisions may not be in line with the most urgent (or long-term) needs of recipient countries. If their programmes are ineffective, if resources decline, or if interest diminishes, recipient countries dependent on such funds may be left in the lurch.

“Development assistance for health” is driven by a variety of factors. Some health issues, such as HIV/AIDS, get a disproportionate amount of attention, whilst others, such as non-communicable diseases or injuries, do not receive the kind of consideration they would if the global health agenda was driven mainly by the burden and distribution of mortality and morbidity.

However, money alone does not explain the weight of a bilateral donor or foundation in the policy-making and agenda-setting process. Amongst the bilateral donors, those most influential in shaping the agenda are the agencies with strong in-house technical expertise (such as USAID, CIDA in Canada, DFID in the UK, GTZ in Germany or SIDA in Sweden) that usually collaborate with external technical advisors. Such influential media include medical journals and media outlets.

Research groups and actors with a voice in the agenda-setting process include the Global Forum for Health Research (supported by Switzerland through the SDC), the Harvard School of Public Health and the London School of Hygiene & Tropical Medicine.

Let me mention at this point that Switzerland has also contributed to setting the agenda, for example in the fight against malaria through successful programmes of Swiss partner agencies. The malaria interventions developed in Tanzania by the Swiss Tropical Institute in collaboration with Tanzanian partners have led to setting international standards in malaria control.

In addition to its normative role, the WHO also places issues on the agenda through the World Health Reports and can take the lead in such instances as the current H1N1 flu pandemic. The WHO has co-sponsored research programmes – HRP in the field of sexual and reproductive health, and TDR for tropical diseases – that are influential in helping to define the agenda. Switzerland, through the SDC, is a donor to both of these programmes.

I want to point out just 3 *global health issues* that are important priorities for the SDC, as well as being of eminent relevance for international cooperation, and are to be addressed at the regional and the global levels.

Population dynamics are closely linked to *migration, climate change and the economic crisis*. Whilst we must not revert to 1970s-style enforced population control, population growth needs to be addressed by giving all people access to rights- and choice-based family planning and general health services.

Population growth not only drives international migration, it also aggravates current climate change threats, which, in turn, have an adverse effect on human health. Climate change is one of the most inequitable health risks of our time, and developing countries are disproportionately affected and at the same time less able to rely on social protection by their governments. Not to mention the fact that they have contributed least to global warming.

The global economic crisis is another global threat caused by the richest countries but whose consequences are primarily borne by the poorest. Hunger and malnutrition are spreading rapidly. At the household level, spending on food will be given priority over health care. Investing in affordable and accessible health services for the poorest to achieve the long-term goals of poverty reduction and population health is more important than ever.

Issues become priorities through a process of dialogue and lobbying amongst like-minded partners. However, it is not only individual agencies, institutions or countries that can drive the agenda; networks and platforms that bring together such stakeholder groups as policy makers, scientists and experts, interest groups and private industry are increasingly taking their place. Examples include the G8/G20 and the European Commission, which will be looked at in some detail during this symposium.

I am sure you would join me in welcoming the increased significance that health has found on an international level over the past years, to the point of being recognised today as a crucial factor for development and stability.

But to effectively face the imminent challenges, we also need to improve governance and policy coordination at every level, increase the synergy of the various programmes and initiatives, and establish better coherence and transparency amongst the different actors.

I can't pretend to know what an improved coordination of global health governance would look like. Unlike many of the experts present at this symposium, I am not a health specialist. But based on our experience as a development agency, I would rather focus on *improving existing platforms* and coordination mechanisms – especially on country and regional levels – than on creating altogether new structures.

When questioned on the background of the current economic crisis, the editor in chief of the *Lancet* raised some provocative questions with respect to global health issues, such as whether the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) should merge with the Joint UN Programme on HIV/AIDS (UNAIDS), whether the Global Fund should extend its concern beyond those three core diseases or whether the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Gates Foundation could be brought more into the mainstream of global health governance.

I do not have the answers to these questions, but at the Swiss Agency for Development and Cooperation we are committed to contributing to improvements in health governance.

Switzerland and Global Health – Swiss Health Foreign Policy

Smaller donor countries like Switzerland have to act in like-minded groups to be heard. This is how the Swiss delegation contributes to the policy dialogue during the World Health Assembly, or SDC representatives get their point across in the governing bodies of such institutions as UNICEF, UNFPA, UNDP, UNAIDS and GFATM.

The *Swiss Foreign Policy Report 2009* states an important principle which reflects Switzerland's role in reforming global health governance from a development perspective:

“The growing number of global challenges and the fact that multilateral organisations have limited capacities to deal with them is increasing the pressure for reform. For Switzerland it is important to ensure that law takes priority over power in international relations, and that the interests of the less powerful nations are given due consideration in the universal legal instruments.”

The inequities regarding the global health situation remain alarming and can only be addressed by strong partner countries and with the support of efficient and integrated

international cooperation efforts. To make the Swiss contribution relevant, different Swiss stakeholders need to join forces.

Swiss involvement in global health has made important strides in establishing common ground on the health foreign policy objectives of different departments of the Swiss public administration beyond the Federal Department of Foreign Affairs and the SDC. This offers an instrument for developing a holistic and coherent health policy approach on a national level.

One of the key areas of *Swiss health foreign policy* aims to strengthen the Swiss contribution to the Millennium Development Goals (MDGs). Of particular relevance to the field of development cooperation are the health foreign policy goals to “improve the efficiency of multilateral players in the fields of health, development cooperation and humanitarian aid” and “to make appropriate contributions to eliminating the three significant poverty-related diseases – AIDS, tuberculosis and malaria (MDG 6) – paying particular attention to gender issues.”

This is in line with the Swiss Federal Council's *Message on the Continuation of Technical Cooperation and Financial Aid for Developing Countries*, the messages for the development cooperation with countries in the South and in Eastern Europe and with Humanitarian Aid, establishing health as a key sector for Swiss contributions towards poverty reduction as part of the MDGs.

Filling the Gap on Regional Cooperation and Governance

Ladies and Gentlemen,

One of the essential questions in reaching the MDGs is how to make the greatest number of people benefit from good prevention and health services. Whilst we were seeing some encouraging progress on the three health-related MDGs starting in the early 1990s, it is now certain, unfortunately, that in a number of countries these MDGs won't be reached by 2015. Current gaps mainly involve access to health services: approximately 1 billion people lack access to health services, and billions more have inadequate access.

Historically, national governments have taken the lead in safeguarding population health, with very little cross-border cooperation. Yet as the crossing of national borders has become more common, government control has weakened, and the global effects of individual countries' actions have intensified. Because health threats are increasingly likely to span multiple countries and regions, national and even bilateral action is no longer sufficient. In many instances, only a pooling of regional or global resources can ensure that population

health is adequately addressed. Regional alliances and cooperation are needed more than ever before.

Experience shows that for all the improvement in global health governance, there is a deficit in health governance on a regional level, which also needs to be addressed. We are finally at the point where global policies are being implemented regionally and actual health outcomes can be assessed. It's at this critical juncture that Switzerland has contributed to change and will continue to do so.

Let me illustrate how we can strengthen health governance on a local level and, thus, increase the impact of global policies.

We all know that *water* is a basic determinant of health. Drinking water should always be clean and free of contaminants to ensure proper health and wellness. The WHO as the global benchmark authority in the domain of health determines the basic quality standards for drinking water and sanitation systems. But this alone does not ensure an effective and coordinated implementation at country levels.

Twenty-five years ago the SDC contributed to the creation of the Water and Sanitation Program (WSP) of the World Bank. The WSP is an international partnership of the world's leading development agencies concerned with improving water and sanitation sector policies, practices and capacities to serve the world's poor, helping them get sustainable access to water and sanitation services. The WSP catalyses and capitalises national, regional and global principles to improve water and sanitation services and adapt sector policies to the needs and the context of the individual countries. In the process WSP has become an important and successful instrument for governance of the water sector around the world.

On the global level the small WSP secretariat in Washington, D.C., only consists of a few people, whereas the regional office for East Africa in Kenya or the national office in Dakar, Senegal, boast larger staffs and, therefore, are able to more adequately address the "big questions" on the regional level. These regional offices facilitate local exchange, synthesize it into regional "lessons learnt", which, in turn, can be fed into the global debate with the help and the connections of the global office in Washington.

Another instrument of governance is the Protocol on Water and Health of the UNECE (UN Economic Commission for Europe), signed by Switzerland in 2008. Amongst other things, this protocol sets a framework for the very health-relevant and contentious issue of transboundary water. Many countries have ratified the protocol, which contains binding obligations. The annual meeting of the signatory states is an ideal platform for shaping the regional message, allowing the Central Asian states to speak with a unified voice on their needs or tackle common problems.

The lessons learnt from these examples include:

- 1) There are ways for the poor and often weak countries to strengthen their voice and gain influence at a global level.
- 2) Lessons learnt or technical innovations can flow from the bottom up as easily as from the top down.
- 3) Increased policy coherence, where the weak countries can be influential as well, is attainable.

Global health governance can be facilitated by innovative networks. The SDC supports regional health cooperation, a specific example of which is the South-Eastern Europe (SEE) Health Network. Born out of the Stability Pact, the SEE Health Network is a political forum set up to further cross-border cooperation on health topics ranging from maternal and neonatal health to mental health.

The overall objective of the network is to modernise legislation and bring public health services delivery into line with EU and international standards.

Up to now some major political documents have been signed by the ministers of health of the SEE, such as an agreement on the implementation of the *International Health Regulations*, an agreement on long-term cooperation on mental-health issues in the SEE – ten pilot mental health centres have already been established by the ministries of health – and the ratifications by seven out of the nine countries of the WHO Framework Convention on Tobacco Control.

Why does the SDC support it? On the one hand, we believe that regional cooperation is one important avenue towards political, economic and social stability. Bringing together experts and national authorities from different countries has been one of the strategies pursued by the SDC to reinforce social cohesion and development in the region, themselves key contributors to stability.

It is a well-known fact that health has served as a bridge to peace in this war-torn region, with the SEE Health Network initially dealing with issues of mental health and later expanding into communicable diseases, tobacco control, blood safety etc. On the other hand, we will continue to support the regional health network, because it is clear that through greater cooperation and technical exchanges South-Eastern European countries can help each other significantly in improving their health systems and health outcomes.

Let me share with you the three major lessons learnt by the SDC from this “project of regional health governance”:

- 1) Political cooperation is essential for regional cooperation, and it’s a useful tool in advancing the health agenda and drawing the focus of governments in the region.
- 2) Technical cooperation is important in achieving tangible results of regional cooperation, for example the establishment of a reference laboratory in Romania for South-Eastern European countries, which is proving to be extremely useful in dealing with the current H1N1 flu pandemic.
- 3) A wide network of experts in the South-Eastern European region provides an excellent forum for the exchange of regional experiences, which can then be utilised for country-level health system reforms and during bilateral or multilateral exchanges between countries.

Conclusion

Preventing ill health and combating disease on a local or regional level can have an enormous global impact. Switzerland has good resources and opportunities to assist in finding solutions to the global challenges in the area of health.

Our country’s comparative advantage in this respect is not only based on our knowledge and technical expertise, but also on Switzerland’s and the SDC’s record of pragmatic actions and the experiences and expertise gained on the ground at country level that they bring into the policy dialogue of international institutions and platforms. It is our task to use these advantages consistently, in the interest of vulnerable people living in poverty as well as our own interest.

This symposium offers a unique opportunity for us to learn from each other, to exchange ideas and overcome divides in order to work together for improvements in health governance at the global as well as the local level. I wish you and the organisers fruitful discussions and a lot of success in identifying steps towards improving health governance.

Thank you for your attention.