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The Future of Global Health Diplomacy: Collaborating Across Borders

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ABSTRACT

Global health diplomacy (GHD) is rapidly evolving as globalization, transnational threats, and complex political landscapes reshape the intersections of health and international relations. This paper examines the historical evolution, core concepts, and institutional roles within global health diplomacy, emphasizing the shift from state-centric negotiations to multi-actor, multi-level engagements. It highlights the growing involvement of non-state actors, public-private partnerships, and regional organizations in shaping global health policies. Through case studies and analysis of bilateral and multilateral agreements, it examines successes and persistent challenges, such as health inequities, vaccine nationalism, and governance fragmentation. The COVID-19 pandemic exemplified both the power and the limitations of GHD, underscoring the need for stronger frameworks that balance knowledge, ethics, political interests, and equity. This paper argues that future global health diplomacy must prioritize inclusive collaboration, institutional reforms, and a redefinition of health security to meet emerging threats and ensure sustainable health equity across all nations.

Keywords: Global Health Diplomacy, Health Governance, Public-Private Partnerships, Multilateral Agreements, Health Equity, International Relations.

INTRODUCTION

Public health matters at all levels of government. A nation's health affects its international relations and trade with other countries; an epidemic anywhere threatens people everywhere. In 1996, world leaders realized that solace was futile; they made bold commitments to fight for good health in the 21st century as one means to forge a better world. Launching new partnerships with civil society, individuals, as well as countries, took action. Thus began 5 years of unprecedented networking between health and non-health sectors at the global level. Events led to the adoption of a Framework for Action nourishing global cooperation and more equitable relations, draft resolutions sent to Health Ministers, and a side-event during the 55th World Health Assembly. The momentum stalled; action resulted in passable compromises, much desired but varied little in their capability. Meanwhile, the burden of disease and associated economic costs continued to rise. Nations with a stake in collective action responded by proposing a Convention on Global Health. The document's first drafts aimed to make universal access the norm and render as unacceptable grave health inequities afflicting populations. Tensions between developed and developing nations predestined these efforts, the outcome would look markedly different from what was intended. Across the whole of humanity, workers and their unions remained steadfast supporters of universal access, while identified as charter members of an economically deprived planet. The ultimate challenge facing any emerging Global Health Club was a matter of defining delegable authority and effective representation within it [1, 2].

Historical Context of Health Diplomacy

Resistant to globalization, diplomacy remained largely state-centric and territorial. However, the late 20th century saw changes in diplomatic practices that became contested and transformed. Sub-state diplomacy began linking communities across borders, with non-state actors acting as diplomats through

transnational advocacy. As cross-border issues merged with domestic concerns, states increasingly viewed them as relevant to their interests. For trade, finance, and global movement of people, international organizations and non-state actors could define problems and suggest policies, but were often sidelined in agenda setting. State actors dominated the ACT's orbit, creating weak long-term international responses. In matters like bioterrorism, political coordination efforts aimed to regain lost diplomatic authority. Health diplomacy has been traditionally state-centric, existing primarily as a prerogative of state actors. Non-state actors' participation is often shaped by the frameworks established by states or intergovernmental organizations. Global health governance has emerged as a response to changes from globalization as well as the transboundary impacts of health issues. Essentially, health diplomacy is the political response of states to govern health in a rapidly evolving landscape of globalization and interdependence. The rise of multi-level and multi-actor networks complicates health diplomacy, introducing various levers that states must navigate due to increased non-state initiatives and networking. This evolution of health diplomacy has reshaped how states engage with health issues and the types of responses they formulate [3, 4].

Key Concepts in Health Diplomacy

In global health diplomacy, interventions are made to set agendas and negotiate interests, allowing member states and civil society a collective voice in multilateral processes. Initially, these interventions aimed to create governance mechanisms that persisted beyond established power differentials, focusing on who could negotiate with whom. Normative discussions ranged from early debates surrounding the WHO's creation to the definitions of health following the Alma-Ata declaration. However, no robust analytical framework has yet been introduced in educational contexts. Traditional international relations concepts might offer differentiation and analytical rigor and help in predicting future developments in global health diplomacy. The recognition of international organizations as influential actors in international relations has enhanced their role in politics, with the WHO playing a vital part. The WHO's importance partly stems from its inclusive nature; its constitution expects it to engage nations and their civil societies to create extensive norms and standards. This engagement reveals the diplomatic dimension. WHO's technical negotiations cover areas from the application of scientific knowledge to ethics and human rights. For instance, discussions on COVID-19 vaccinations encompass scientific aspects as well as equity and liberty concerns. The WHO also plays a crucial role in establishing governance frameworks after political negotiations create power differentials. These outcomes often become codified governance mechanisms, akin to the trade and currency regimes of the WTO and IMF, and the WHO's regulations serve as formal rules for member states. Health diplomacy differs in its logic; it's based on knowledge systems and norms rather than on power dynamics. Its strength lies in the non-coercive ability to persuade, motivate, and guide international actors about health's significance for human progress, prosperity, and stability [5, 6].

The Role of International Organizations

The experiences of COVID-19, warmly welcomed by the Olympiant 'Hercule Poirot', are significant to health diplomacy, perceived as 'A magnificent success of cooperation', then health protection actively involving at the state level, like other global interests, in international governance, and disappointing others by, for example, "vaccine nationalism". Further complexity involves imperative health development at the state level under the gradual threat of (a) trade and environment linked to health; (b) the megatrend of geopolitics, deglobalization, and economics; and (c) regional governance. A newer focus, therefore, enriches the research agenda of global health diplomacy (GHD), as GHD issues have become ever more costly in recent years and awareness shifts expectantly from 'knowing' to 'doing' it. Deduced from theorized GHD and grounded in public trilateral diplomacy of states, international organizations, and businesses, GHD is defined as state-directed international cooperation engaging an official health bilateral process and the advocacy of health multilateralism for wider development. GHD is concerning issues affecting health and public well-being as an important 'business' of states, which states pursue like other global interests in international governance. On both micro and macro levels, GHD in either bilateral or multilateral diplomacy proactively involves more actors from business and civil sectors in the broader justification and assertion of the recognition and rediscovery of national interests, facilitating an agenda on either governance or safeguarding needs. At a finer level, health interests are problematized first to spotlight 'threats' affecting 'vulnerabilities', prompting clearer formulations on which risks are involved and realizable approaches are ever more imperative. In areas of practice, terms are premised on either soft governance or authoritative engagement as preferences for cooperation are utilized [7, 8].

Bilateral and Multilateral Agreements

A "bilateral" agreement is an understanding between two states, local governments, federal departments, or private industries. Countries that share similar economic, social, or political challenges may enter into a bilateral agreement to reduce those common concerns. Bilateral approaches to action can also be used by an adjacent pair of countries to ameliorate a situation of mutual concern, such as a disease outbreak close to national boundaries. In this instance, actions would be aimed at affecting responses in both countries, and coordinated actions would be put in place at shared border points of entry. Individual nation-states may also enter into bilateral agreements with a UN agency or a non-governmental organization to improve health outcomes, strengthen preparedness, build resilience, or respond to events. On the other hand, "multilateral" agreements can encompass varying numbers of countries or agencies. Multilateral arrangements range from loose networks of countries sharing information to coordinated operational planning and responses, such as the Global Health Security Agenda, which involves bi- and multilateral agreements. The UN, World Bank, International Monetary Fund, and regional Development Banks are examples of multilateral organizations that can help to coordinate both information sharing and resource distribution across nations. Most regional and quasi-governmental agencies, such as the European Union, WHO Regional Offices, and regional UN organizations, have both political and operational mandates similar to those of national agencies. There are also regional disease-specific organizations, such as the Intergovernmental Organization for Health Emergency Preparedness and Response to Combat Transboundary Animal Diseases and the SADC-LGCB Project, that can catalyze joint regional action for public health. Similarly, regional disease or topic-based networks exist to share information and investigator-identified hypotheses. Examples are existing networks of investigators who work on Rift Valley fever, Ebola-HIV co-infections, tuberculosis, and climate change, community health organizations, and numerous other broad or specific topic coalitions [9, 10].

Case Studies in Health Diplomacy

Global health diplomacy (GHD) emerged as a concept at the intersection of public health, political science, and international relations, with the aims of "better health for the poor", "prevention of transnational pandemics", and "a way to exert soft power". Since GHD gained momentum in 2000, several notable studies have been published. Key questions relate to identifying (non-state) actors who practice GHD, flagging successful GHD practices, exploring how developing countries exert GHD, and discovering how diplomatic practices in other fields could be applied to GHD. While this literature is mostly prescriptive, recent studies have called for a systematic appreciation of GHD. Differentiated globalisation, accompanied by a growing health-development nexus, has arguably made global health governance more plural, leaving many regional or subregional actors and policy regimes in want of serious scholarly attention. This paper responds to the call from this new wave of scholarly inquiry and asks how non-state agents (e.g., networks or NGOs) engage in GHD at the regional level. It specifically focuses on Asia and ASEAN's attempts to address the H1N1 pandemic through the Comprehensive Health and Development Social Plan during 2005-2008. The paper emphasises the importance of the region in which health diplomacy takes place. GHD strives to solve global health adversities, but health diplomacy might pursue normative goals under a different agenda due to the impact of local context. In Asia, thus far, most nGHEs seem to desire a change in interaction among states to devise improved governance frameworks. The Asia Health Diplomacy Programme is designed for that purpose. ASEAN has played a functional role in a broad coalition for health equity, but retained difficulties in decision-making, politic protection, and implementation in a context of mutual sensitivity. Hence, regional health diplomacy has encountered alternatively deeper discussions on norms lost to a set of non-formulas and more constraining treaties. It should be noticed that the normative ingredients of regional health diplomacy or an effort for ameliorating ground arrangements call upon different modes of deliberation that seem conducive to maintaining reciprocal meetings [11, 12].

Challenges In Global Health Diplomacy

The intensification of globalization and the widening gap between the 'haves' and 'have-nots' in health pose significant challenges for global health diplomacy. The uneven spread of infectious disease risk and varying national responses are major future health security risks that complicate global public health equity. The rise of chronic non-communicable diseases (NCDs) in lower-income countries and the focus on health systems resilience raise critical questions about the rules of engagement to ensure good intentions do not worsen inequities. While understanding the supply side of global health is improving, there is a pressing need to study the demand side. The differences in the interpretation of global health governance between recipients and providers highlight the need for action to avoid competency traps

dominant within the UN system. A comprehensive, coordinated approach connected to broader political and governance discussions is essential, including structural reforms of the WHO and enhancing the UNGA's role. Health diplomacy, perceived as a soft power, may evolve as chronic structural inequities and nationalism-related health risks become more pronounced. The governance of health may intersect more with core UN functions, leading to significant implications for territorial conflicts. Health diplomacy will continue to evolve amid uncertainties, but TICAD487 must create channels for the voices of recipient states to avoid repeating the G20's track record in global health concerning Africa [13, 14].

The Impact of Politics on Health Diplomacy

The COVID-19 pandemic has highlighted the importance of global health diplomacy, a term that encompasses various public health-related issues, scientific and legal instruments, and long-standing negotiations. Recently, governments and multilateral institutions have increasingly used this term to express commitments to collaborative strategies aimed at promoting healthier populations and controlling pandemics. Leaders of the WHO and global health advocates have redefined health as a bridge to peace, shifting focus towards improving health policies, investments, and technologies. The pandemic intensified discussions on global health architecture, making health diplomacy a priority. The health crisis prompted heightened diplomatic efforts, with the WHO adopting an active role in post-pandemic reconstruction by forming committees and addressing heads of state. The pandemic response brought global health diplomacy into the spotlight at international organizations, facilitating crisis diplomacy for a coordinated response involving non-pharmaceutical measures, data sharing, equitable vaccine access, and necessary reforms. This unique health diplomacy culminated in a special UN General Assembly session dedicated to health, despite geopolitical tensions between the East and West. WHO led coordinated efforts to promote a united response to this significant global health emergency, standing as a testament to the vital role of diplomacy in safeguarding human health [15, 16].

Emerging Global Health Threats

Global health is inextricably entwined with international affairs, and the perceptions and actions of world leaders set the tenor for the framing of health issues in multilateral venues. In this multi-actor arena, public health has long had a tough time competing with the shinier attractions of security, trade, and foreign relations, as well as more recent actors and threats such as terrorism, climate change, and the environmental crisis. Yet, with the globalization of trade and the transnational nature of several global disease threats, health issues have risen to the top of the international agenda with notable consequences and reforms. Whether the urgency of health is maintained in the international arena remains to be seen, but with the presence of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), severe acute respiratory syndrome (SARS), avian flu and, more recently, swine flu on the cusp of a pandemic order, it is clear that health is a foremost concern and a global asymmetric threat. Within the wider context of complex globalization forces and a shifting global landscape of power, there are significant implications for all actors involved in global health diplomacy. Given the growing uncertainty and unpredictability of 21st-century global health problems, containment on narrow biomedicine-oriented terms is becoming increasingly difficult [14]. Subsequently, there is a growing role for scholarship of GHD research and teaching targeted at building the capacities to contribute effectively in this multifaceted, ever-expanding space. Global health encompasses the multitude of issues that transcend national boundaries – social, economic, biomedical, political, environmental, migratory, security, and technological – to determine the health and human security of people in both rich and poor countries. The rise of non-communicable diseases in both resource-rich and resource-poor nations typifies the transnational nature of global health determinants [17, 18].

The Role of Non-State Actors

Health and development are inevitably political, and political actors will shape the resources devoted to health, the objectives of health policy, and how policies will be put in place. The rules governing the political game are consequently as important for health and development as the magnitude of resources committed. There has always been a political element to health, and health diplomacy is not new. Political relationships associated with globalisation in the 20th century have altered health and development trends. Political decisions relating to these relationships shape health decision-making. Globalisation is increasingly multi-actor in character, with states, intergovernmental organisations, non-government organisations, and other 'non-state actors' interacting in a networked architecture of authority that influences health. The evolving dynamics of this multi-actor landscape raise questions about the agency and capacity of non-state actors to shape health and development trends. Political dimensions in other health and development decisions are much broader, encompassing policy domains where 'non-state'

entities create rules governing surveillance of non-state health risks such as epidemics and bioterrorism. Advocacy coalitions may also exist, composed of a mix of health actors from both state and non-state entities. Health diplomacy has come to differ deeply in form, style, and trajectories between totalitarian regimes, liberal democracies, and developing democracies. The politics and questions regarding policy decisions, negotiation, authority dynamics, and accountability also differ. These distinctions have yet to find attention in the public health diplomacy and global health diplomacy literature on 'emerging states' [19, 20].

Public-Private Partnerships in Health

Global Public-Private Partnerships for Health (GPPPs) facilitate diverse player participation in health policy decisions. This text outlines the governance functions in public health security, viewed as a common-pool resource. It discusses the nature and evolution of health GPPPs, their stakeholders, and products, emphasizing the need for redesigning these partnerships to enhance international health security. Public health security aims to reduce the public's vulnerability to significant health events and requires diverse decision-making involving not just public sectors but multiple players. Since the 1990s, there's been a heightened focus on minimizing vulnerabilities to health events, leading to the formation of initiatives like the STOP TB initiative and the Global Fund for AIDS, TB, and Malaria. These partnerships operate as collaborative governance mechanisms that allocate tasks among diverse players and enhance fund distribution, research, and medical supply logistics. They also facilitate international aid and enforce commitments from governments. However, criticisms exist regarding the dominance of financially powerful entities in negotiations and decision-making outside accountable systems. This necessitates a redesign of GPPPs towards better social adaptation, particularly in developing nations. Sustainable health promotion requires long-term cooperation among public entities, private organizations, and nonprofits. It involves three GPPP categories: global product-based partnerships across intergovernmental organizations, partnerships focused on medical supply chain efficiency, and the weakest partner addressing social inequality and health access. The latter should embrace an open-ended structure characterized by deliberative democracy [21, 22].

The Importance of Cultural Competence

As our world has become increasingly mobile, perceptions of health and disease have become more transnational. Globalization and migration have transformed localities into meeting spots of cultures, customs, languages, and beliefs that can encourage both health and disease. Therefore, as disease pathways have widened into transnational ones, so must health pathways be conceptualized and organized into new cross-cultural responses. However, cultural diversity can complicate health care delivery. Cultural competence, defined as the ability of healthcare providers to understand and respond effectively to the cultural and linguistic needs brought by the patient to the healthcare encounter, is desirable for the patient and clinician alike. Improved patient and family satisfaction measures, quality of care, and health outcomes are expected as relationship-building and trust arise from cultural competence. Multiple barriers were cited, with language and mixed messages prevailing. Though the methodology possessed limitations, the satisfaction measures signal the earnestness of the issue and illuminate a path of hope for clinicians wishing to address their patients' cultural and contextual needs. Developing awareness of barriers cultural groups may face when interacting with the healthcare system is the first step in cultural competence. The next step is to reach out to specific communities to understand their cultural beliefs in conjunction with their health beliefs. Traditionally, formal training on cultural competence either takes the form of a lecture or an interactive workshop. The lectures are often designed to drive home what is often asserted as generalizable facts about a population. In recent years, however, another type of training has begun to emerge. Objective-structured clinical exams are widely used in medical education to test and provide training for students in examination techniques, ability to speak to patients, and ability to interact with other healthcare providers [23, 24].

Technology and Health Diplomacy

The importance of global health diplomacy has been highlighted during the COVID-19 pandemic, which has brought diplomacy into focus within international organizations and political gatherings. Initial negotiations for a collective response faced delays due to geopolitics, nationalism, and weak institutions. However, efforts have progressed toward creating more transparent and participatory governance frameworks. Many countries, particularly developing ones, lack experience in international negotiations for global health funding, new organizations, or the pandemic accord. These governance systems remain uncertain and dynamic. While negotiations for the pandemic accord are ongoing within the WHO, they also involve G20 discussions and other collaborative structures. Concurrently, developing countries are

experiencing unprecedented digital transformations, driven by numerous private sector actors. Governments face challenges in governing rapid technological changes that can disrupt economies and societies while enhancing human welfare and mitigating the digital divide. The public sector often struggles against the agility and resources of private entities, making it difficult to keep pace with technological advancements. Global health security is increasingly reliant on cyberspace for biosurveillance, travel mapping, rapid diagnostic testing, and disease control. The urgent need to govern cyberspace for global public goods is hampered by inadequate international governance capacity and readiness [25, 26].

Funding and Resource Allocation

Many health-related issues are cross-border issues that cannot be addressed by one country alone. Exceptions to this are very few and are largely seen more as health protection strategies. This chapter will focus on collaborative approaches involving countries coming together to deal with a common health issue that threatens the populations proactively or reactively. Briefly speaking, health diplomacy is defined as "how governments seek to advance their interests in, through, and for global health", approaches to promote awareness, inclusion, and analysis of health as a dimension in international relations. Diplomacy is done through multilaterals, or immensely powerful bilaterals. Multilaterals are considered the most appropriate actors for global health diplomacy, including the WHO and the Global Alliance for Vaccines and Immunizations, as they are seen as encompassing a rights-based ethic. The bilaterals, however, can be demons of global health diplomacy, because of their enormous influence on a country's population health due to their financial power and their power to set agendas and prioritize health issues. Global health 'governance' as a legitimate response to the inadequacies of the traditional diplomatic approach over the past decades to the worst health problems in the world is a huge push towards some preferable identification and building of alternative practices. The most radical outcomes of these global health community investments are an increase in positive pressures for drastic reworkings of the existing standard directionality of health diplomacy inputs, which favor the high-income countries. If such pressures are not heeded, and the healthcare priorities of the currently wealthy countries continue to remain the focus of interventions, then the majority of the world will continue on a flight path towards a more diseased, impoverished future [27, 28].

Ethical Considerations in Health Diplomacy

Health diplomacy generally assumes that states will dominate the process. Relatedly, health governance has been framed, in large part, as a matter of intergovernmental treaties, agreements, and institutions. A cohort of non-state actors, including health organizations, civil society, and the private sector, has become increasingly involved in health diplomacy, and this has raised new questions about the relative power, effectiveness, and legitimacy of diverse, state-versus non-state approaches. If international public health governance settings lack legitimacy, and if solutions are deemed ineffectual or untenable, this can breed a general discontent that can manifest itself in the rise of populism, protectionism, health nationalism, and a general unwillingness to play by the rules. Conversely, governance settings based on normative approaches to health diplomacy can also provoke similar reactions, where actors deem treaties and agreements a violation of their freedoms, and their interpretation and application as overly intrusive, inequitable, or problematic. Of newer concern is how health diplomacy might shape and be shaped by contestation in the global order. Should international public health governance be framed as an arena of a 'G2?' or a 'G0?' given the dominant role of only a select few states and a general absence of coordination of international actions on a set of globally agreed priorities? Should much or more of it be delegated to the private sector? Will non-state actors disrupt or peaceably cooperate and coexist with an emerging and existing landscape of institutions? And will illness, (re)emerging diseases, threats (real or perceived), and other drivers continue to galvanize efforts to coordinate health diplomacy? [29, 30].

CONCLUSION

The future of global health diplomacy lies in its ability to foster inclusive, flexible, and responsive international cooperation frameworks. As globalization continues to intertwine national destinies, health can no longer be managed within isolated borders. Success in global health diplomacy will depend on acknowledging and integrating diverse actors—from states and international organizations to civil society, academic institutions, and the private sector. Building resilience against emerging threats such as pandemics, climate change, and non-communicable diseases demands a shift from transactional diplomacy to transformative partnerships rooted in equity, knowledge-sharing, and mutual accountability. The COVID-19 pandemic provided a profound lesson: health must be treated not merely as a technical issue but as a core element of global security and human development. To truly collaborate across borders,

future diplomatic efforts must reframe health as a universal right, ensuring that no community, regardless of wealth or geography, is left behind.

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