Volume IX, No. 1 & 2
Spring & Fall 2019 Issue

Global Health Governance

The Scholarly Journal For The New Health Security Paradigm

www.ghgj.org

GLOBAL HEALTH GOVERNANCE

THE SCHOLARLY JOURNAL FOR THE NEW HEALTH SECURITY PARADIGM
PEER REVIEWED, OPEN ACCESS JOURNAL

ISSN 1939-2389

GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

PUBLISHER
THE SCHOOL OF DIPLOMACY AND INTERNATIONAL RELATIONS,
SETON HALL UNIVERSITY

GLOBAL HEALTH GOVERNANCE

GLOBAL
HEALTH GOVERNANCE

VOLUME IX, NO. 1 & 2
2019 SPRING & FALL COMBINED ISSUE

TABLE OF CONTENTS

JAPAN'S HEALTH DIPLOMACY: PROJECTING SOFT POWER IN THE ERA OF GLOBAL HEALTH

Hisashi Kato, Tim K. Mackey, and Yee K. Heng

Few scholars have studied the use of "Global Health Diplomacy" by the Japanese Government, a unique form of diplomacy that relies on the use of "soft power" and "smart power" but also one that is undergoing changes based on current geopolitical developments in Japan and the Asia-pacific region. This article will provide a review of the literature based on a multilingual document review on Japanese global health diplomacy by examining how health diplomacy has been used by the Japanese government in furtherance of broader foreign policy and diplomatic goals in the international fora. This article will also discuss the limitations of Japan's nascent health diplomacy strategy and possible challenges in the near-future; specifically, the possible revision of Article 9 of its Constitution.

INTRODUCTION

One of the most frequently made criticisms towards Japanese foreign aid policies is that Japan is a large funder of international development initiatives but doesn't provide direct support beyond finances and technical assistance. However, through the establishment of the Official Development Assistance (ODA) charter and judicial justifications on the usage of Self Defense Force (SDF) for non-coercive means such as Peace Keeping Operations (PKO) and ODA in 1992, Japan has undergone changes in its foreign assistance policies, which have further accelerated from the beginning of the second administration of Prime Minister Shinzo Abe since 2012.

In his inaugural address, Prime Minister Abe made the remark that Japanese diplomacy should be the "diplomacy that takes a panoramic perspective of the world map"[1] Moreover, in terms of legal justifications for making Japan capable of active commitments, the Abe administration has made historical changes from the past. In his keynote address in Shangri-La dialogue in 2014, Prime Minister Abe made the following remark specifically highlighting that Japan should be a "proactive contributor to peace"

> "Imagine now that civilians or NGO workers there, powerless to defend themselves, came under sudden attack by armed elements. Under the approach that the Japanese government has taken to date, Japan's Self-Defense Forces are unable to go rescue these civilians enduring the attack. Is this an appropriate response into the future? My government is thinking hard about it, and a close consultation is underway within the ruling coalition parties. It is precisely because Japan is a country that depends a great deal on the peace and stability of the international community that Japan wishes to work even more proactively for world peace, and wishes to raise the banner of "Proactive Contributor to Peace." [2]

In response, in 2015, the Diet passed a law that allows the SDF to carry weapons to assist allies and/or to protect Japanese civilians during PKO operations. Hence, Japanese diplomacy is now in a phase of historical transition. Prime Minister Abe went further to claim that in terms of global health (a multidisciplinary field originating from international health that includes disciplines of public health, public policy, international relations, economics, and security), Japan has what it takes to make contributions for the well-being of others. In the article he published in the medical journal *the Lancet*, he made the following illustrative statement:

> "Japan's strategy on global health diplomacy corresponds to the changing strategic environment. The 21st century calls for major challenges of the international community, in addition to the leadership of 20th-century-style power politics. This dynamism is described as the age of smart power. Japan has capacity and determination to undertake this new form of leadership."[3]

This statement by Prime Minister Abe highlights the need for and importance of academic research in the field of Japanese global health diplomacy (GHD). This article is the first scholarly paper regarding Japanese health diplomacy that examines multilingual source documents and literature while using Joseph Nye's frameworks of soft and smart power. In this article, we analyze the current position of Japanese diplomacy and how foreign policy actions are being made, presented, and implemented with a specific focus on the sub-field of health diplomacy. This is accomplished by conducting a literature review and primary document policy analysis in both Japanese and English. We use the theoretical framework of "power" by Joseph Nye, to identify, describe and assess the characteristics of Japan's use of "health diplomacy".

TYPES OF DIPLOMATIC POWER AND THE RISE OF HEALTH DIPLOMACY

The evolution of Japanese diplomacy has undergone several dramatic shifts in the post-WWII period, where diplomatic policies were heavily focused on building good relationships with Asian counterparts. In the first phase, Japanese aid assistance began in the 1950s as a means to make reparations for war crimes and other damages committed during WWII. As a second phase, in the 1980s, due to the national economical upward trend, the so-called "Bubble", Japan significantly increased its foreign aid contributions. For example, in the year 1980, the ODA budget of Japan was 351.6 billion yen, but in only 10 years in 1990, it jumped up to 817.5 billion yen.[4] However, since most of the aid was provided in the form of loans (in Japanese Yen) tied to specific projects, it also created significant financial burden on recipient countries due to incurring higher debt load compared to foreign aid that came in the form of grants and aid from other countries.

Importantly, as Japanese diplomacy has evolved, how can it be theoretically conceptualized and what do changing tendencies of foreign aid mean for the identity of Japanese diplomacy? Some works by Joseph Nye help us to answer these questions. Joseph Nye, defined power as: "the ability to influence the behavior of others to get the outcomes one wants."[5] According to Nye, power can be categorized into a few groups; hard power, soft power and smart power. He defined hard power as, "the ability to use the carrots and sticks of economic and military might to make others follow your will,"[6]

indicating that hard power is determined by the use of military or economic incentives and disincentives - although the categorizations of economic incentives has been controversial. Conversely, he defined the term, soft power as, "the ability to get what you want through attraction rather than coercion or payments."[7] In other words, soft power does not rely on military activities but attractiveness of other venues of foreign policy (such as cultural diplomacy and foreign aid), which enables the state's power capabilities.

While soft power and hard power differ significantly from each another, Nye also created the concept of, "Smart Power". He defines smart power as "the ability to combine hard and soft power resources into effective strategies"[8] Here, Nye provides a framework to appropriately address global issues that are complex, multilateral and multi-stakeholder. Hence, winning hearts and minds of people with soft power and at the same time appropriately using hard power capabilities represents an optimal foreign policy strategy.

Nye often refers to Japan as one of the best examples of a country that has effectively used the concept of soft power.[9] Both the uniqueness of Japanese culture can be a resource to attract others, but also the concept of pacifism and a pacifist-centric constitution enacted after WWII have been considered Japanese soft power assets. Additionally, in recent years, the Japanese government has tried to utilize this concept of soft and smart power as one of its core diplomatic strategies and to differentiate its approach from other states. From utilization of Japanese animation characters such as the robot cat Doraemon as an ambassador, to provision of large amounts of aid to disaster affected areas, Japanese diplomacy is ultimately aimed at achieving the full use of its soft and limited hard power capabilities.

GHD is also an important Japanese diplomatic strategy that is based on the concept of effectively utilizing soft and smart power. What makes Japanese GHD unique and worthy of study is the fact that few countries are similarly inhibited in their ability to use their military as a foreign policy tool (as this is specifically restricted per Japan's current post-war Constitution in Article 9). Tokyo instead has to pursue diplomatic goals primarily through peaceful means. Therefore, Japan is an interesting case study because of its constitutional limitations and its peculiarity in its approach to global diplomatic agendas.

However, in order to better understand the specific operation of Japanese health diplomacy, a definition of the concept of "health diplomacy" is first needed. The earliest mentioning of the term in the literature appears in 2008 by Adams and Novotny when they defined GHD as "an emerging field that addresses the dual goals of improving global health and bettering international relations, particularly in conflict areas and in resource-poor environments.[10] Although there is a subsequent review article by Lee et.al.,[11] that attempts to further define the term 'global health diplomacy' by aggregating the definitions of others, in this piece we instead follow the definition formulated by Katz et.al., [12] as arguably this article provides the most precise, holistic, and categorical definition available.

According to GHD categorizations by Katz et.al., there are three different types of GHD; core, multi-stakeholder, and informal GHD.[13] Core GHD has two different aspects; "bilateral treaties and agreements", and "multilateral treaties and agreement." By core health diplomacy, Katz et.al., means the diplomacy which takes places either in the form of negotiation between two formal state parties or, in a forum populated by state actors who govern international institutions, such as World Health Assembly in the World

Health Organization.[14] This form of diplomacy is only practiced by a small numbers of state representatives (i.e. it explicitly does not include non-state actors), and is considered to be the most formal operation of health diplomacy.

Multi-stakeholder GHD, is defined as the diplomacy with partnerships with other agencies not only governmental but also with multilaterals. Good examples of this include the Global Funds to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, Stop TB Partnership, Roll Back Malaria, etc. [15] These organizations include Public Private Partnerships (PPPs) and are becoming a popular governance mechanism in global health.[16] The modern field of GHD tends to include a larger sphere of multi-national governance and rulemaking regimes, such as the G8 summit, and international meetings and conferences on global health, often organized by UN organs and agencies but also including non-state actors. Therefore, multi-stakeholder GHD can be understood as less formal than core GHD, but more official and high-level diplomacy compared to informal GHD.

Lastly, informal GHD is defined as the diplomacy which "encompasses interactions between public health actors working around the world and their counterparts in the field, including host country officials, representatives of multilateral and non-governmental organizations, private enterprises and the public."[17] Informal GHD does not necessitate a government agency or state representative to be an actor. This feature significantly differentiates informal GHD from core and multi-stakeholder GHD in terms of participation of different actors and shared governance. The potential benefit of informal GHD is that, by incorporating diverse perspectives from non-state and non-multilateral actors, the strategy and levels of cooperation for tackling global health problems can potentially be more inclusive. The Bill and Melinda Gates Foundation represents one such example of a private actor, in this case a private philanthropy, emerging as a driving force in global health through large amounts of funding and stakeholder engagement and that may compel channels of informal GHD to open. From the year 1994 to 2010, Gates Foundation has spent over $14 billion for global health.[18]

Hence, it is important to note that GHD takes place not only in the conventional spheres of diplomacy such as state-to-state, and diplomats-to-diplomats negotiations, but in other diverse arenas.

METHODS

To further explore Japanese GHD, we conducted an interdisciplinary literature review and primary document policy analysis specific to the topic of Japanese GHD. For the first phase, we used JSTOR and PubMed to search academic literature on the subject of Japanese health diplomacy. Since this research is about health diplomacy in Japan, for the literature search, we used the keywords "health diplomacy" and "Japan" in the abstract search function for articles published in both English and Japanese language. Based on these search parameters, PubMed and JSTOR returned 3 and 7 results respectively which met the criteria for this study with searches conducted in July 2018 (see Table 1 for summary of extracted articles). An additional fourth article published in a special 2011 *Lancet* series on Japan and global health was not originally captured in our literature review, but was detected in other related web searches and was relevant to the study so was added to our results and is also discussed. In order to complement the limited information available in scholarly articles, in the second phase, we conducted

document extraction and analysis for the purposes of identifying more formal policy documents. In this phase, searches were conducted on the search engine Google and Google Scholar for materials related to the keywords "Japan" and "Health Diplomacy" (国際保健外交 Kokusai-Hoken-Gaikou) in both Japanese and English. This allowed us to access a broader base of information, including official Japanese government documents that are only published in Japanese. We also conducted similar keyword searches on official Japanese government websites including the Ministry of Foreign Affairs (MOFA), Ministry of Defense (MOD), Ministry of Health, Labor and Welfare (MHLW), Cabinet Office (CAO) and Parliamentary Office to obtain official policy and legislative documents.

Table 1: Summary of 11 Articles Retrieved from PubMed, JSTOR and Lancet

Author Name and Year	Title of Article, Content Type, and Language	Included (Y/N)	Subject	Citation
Abe S. (2013)	Japan's strategy for global health diplomacy: why it matters (Comment-English)	Yes	Japan strategy on GHD	Abe S. Japan's strategy for global health diplomacy: why it matters. Lancet 2013;382(9896):915-6
Blouin, C, and Dubé, L. (2010)	Global health diplomacy for obesity prevention: Lessons from tobacco control (Article - English)	No	GHD specifically for obesity prevention	Blouin, C, and Dubé, L. 2010. "Global health diplomacy for obesity prevention: Lessons from tobacco control." *Journal of Public Health Policy* 31 (2): 244-255
Corbett, P, E. (1959)	International Organization (Book chapter-English)	No	How laws influence the relationship among different nations	Corbett, P E. 1959. "International Organization." In *Law in Diplomacy*, 187-250. Princeton University Press.
Dent, C, M. (2002)	Reconciling Multiple Economic Multilateralisms: The Case of Singapore (Article - English)	No	Analysis on Singapore's Foreign Economic Policy (FEP)	Dent, C M. 2002. "Reconciling Multiple Economic Multilateralisms: The Case of Singapore." *Contemporary Southeast Asia* 24 (1): 146-165.
Hinoshita E. (2016)	Industry, Academia and Government Partnership through the Global Health Innovative Technology Fund (GHIT) (Sympoisum – Japanese)	Yes	Global health funding	Hinoshita E. Industry, Academia and Government Partnership through the Global Health Innovative Technology Fund (GHIT). Yakugaku Zasshi 2016;136(2):237-42

Llano et al. (2011)*	Re-invigorating Japan's commitment to global health: challenges and opportunities (Series article – English)	Yes	Global health and foreign policy	Llano R, Kanamori S, Kunii O, Mori R,Takei T, Sakai H, Nakamura Y, Kurokawa K, Hai Y, Chen L, Takemi K and Shibuya K. 2011 " Re-invigorating Japan's commitment to global health: challenges and opportunities." *The Lancet,* 378, 1255-1264
Outterson, K. (2009)	Import Safety Rules and Generic Drug Markets. (Book chapter-English)	No	International framework to fight counterfeit medicines	Outterson, K. 2009. "Import Safety Rules and Generic Drug Markets." In *Import Safety: Regulatory Governance in the Global Economy*, 110-128. University of Pennsylvania Press.
Sakamoto et.al. (2018)	The G7 presidency and universal health coverage, Japan's contribution (Commentary [Lessons from the Field content type] - English)	Yes	GHD at G7 forum	Sakamoto H, Ezoe S,Hara K, Hinoshita E, Sekitani Y, Abe K,Inada H, Kato T,Komada K, Miyakawa M, Yamaya H, Yamamoto N, Abe S K and Shibuya K. 2018. "The G7 presidency and universal health coverage, Japan's contribution." *Bulletin of the World Health Organization* 96: 355-359.
Shen, S. (2004)	SARS Diplomacy" of Beijing and Taipei: Competition Between the Chinese and Non-Chinese Orbits (Article - English)	No	GHD of SARS practiced by China	Shen, S. 2004. "The "SARS Diplomacy" of Beijing and Taipei: Competition Between the Chinese and Non-Chinese Orbits." *Asian Perspective* 28 (1): 45-65.
Shen, S. (2008)	Borrowing the Hong Kong Identity for Chinese Diplomacy: Implications of Margaret Chan's World Health Organization Election Campaign. (Article - English)	No	Chinese diplomatic practices at WHO	Shen, S. 2008. "Borrowing the Hong Kong Identity for Chinese Diplomacy: Implications of Margaret Chan's World Health Organization Election Campaign." *Pacific Affairs* 81 (3): 361-382.
Yanzhong,H. (2010)	Pursuing Health as Foreign Policy: The Case of China (Law Review article - English)	No	Global healyh and foreign policy of China	Yanzhong, H. 2010. "Pursuing Health as Foreign Policy: The Case of China." *International Journal of Global Legal Studies* 17 (1): 105-146

* Article added in addition to the literature review

JAPAN'S HEALTH DIPLOMACY

Literature Review – A Focus on the Soft Power of GHD

As previously mentioned, there were only a few articles that met our criteria as literature focused on Japanese health diplomacy. This is not particularly surprising, given that the same search using the non-jurisdictional focused term "health diplomacy" with no country name garnered only 156 and 139 results in PubMed and JSTOR respectively. The focus of articles published on the broader concept of health diplomacy were primarily on diseases or were country specific (i.e. not about Japan but another country) and were generally non-empirical in nature. Among the 10 articles extracted using the initial keyword search for "Japan" *and* "Health Diplomacy" and the additional article detected in the *Lancet* special series on Japan, we will discuss 4 of the articles most relevant to our purposes. This is because search results extracted from JSTOR were either; (1) focused on the discussion of other countries' GHD activities and not Japan[19]; or (2) articles that mentioned Japan, but were unrelated to the topic of Japanese GHD.[20]

The small number of relevant articles indicates that, although the concept of GHD is arguably incorporated into Japanese foreign policies (as will be discussed later), research on Japanese GHD has not been established. In fact, the current literature on Japanese soft power is focused on other aspects such as "Cool Japan" or smart power policies associated with the operations of the SDF not specific to health.[21] One possible explanation for the small number of articles is that health diplomacy is a relatively nascent field in political science and international relations, with arguably the first conceptualization of the topic in the literature occurring in 2008 by Adams and Novotny in an anthropology journal. Further, tangible policy implementation of GHD principles has only taken place in recent years –particularly starting from the Kan administration since 2010 to 2011.[22] In fact, the 4 articles extracted for discussion in this study were published relatively recently in 2011, 2013, 2016 and 2018.

It is also important to note that the articles published on the subject of Japanese health diplomacy are not empirical, and in fact, in the case of the first article published in the medical journal *the Lancet*, not even written by an academic. This article was non-peer reviewed and was written by Prime Minister Abe in 2013.[23] However, despite not being an analytical piece, it provides significant insight regarding the objectives of Japanese GHD.

In the article, Abe first points out the contributions of Japan in global health and its role as an agenda setter. He argues that, "Japan has played a significant part, for example by leading discussions at the G8 Kyushu-Okinawa Summit in 2000 and by helping to establish the Global Fund." This effort of GHD can be categorized as multi-stakeholder diplomacy according to the definitions by Katz et.al. By collaborating with other states and institutions, Japan has helped to shape the framework of a global health regime that has prioritized combating particular infectious diseases using a public-private partnership model.[24]

Other examples of multi-stakeholder diplomacy, explained in Abe's article include Japan's contributions in leading discussions supporting Universal Health Coverage (UHC) for the post-Millennium Development Goals (MDGs) framework, also known as the United Nations Sustainable Development Goals (SDGs). Abe argues that under the newly introduced Japanese diplomatic strategy called "Strategy on Global Health

Diplomacy", in order to fill gaps of inequities, Japan will contribute by helping to standardize UHC. Moreover, he argues that by utilizing the knowledge and successful experiences of Japan's national health insurance system, Japan is in the position to assist developing countries to create well-functioning medical systems, social welfare, and redistribution schemes by standardizing healthcare delivery focused on UHC principles.

For the implementation of this strategy and its related global health programs, Prime Minister Abe also describes the creation of the Global Health Innovative Technology Fund (GHIT). The fund operates through initial government investments in private pharmaceutical companies for research and development (R&D) of medical technology and new medicines. It envisions encouraging these companies to develop medicines which they normally avoid, because the medicines developed in this program will be used in developing countries, situations where it is unlikely that they would be developed without government subsidy. [25]

The second article on Japanese GHD was published in 2016 by Hinoshita, an article also written by a government official.[26] In this article Hinoshita expands on how the GHIT Fund is structured and details its applications for global health. Specifically, GHIT was founded to address the problem of Neglected Tropical Diseases (NTD), diseases common to some of the poorest and least developed countries.

Due to lack of commercial viability, pharmaceutical companies have difficulties justifying investment in drug discovery and product development for NTD drug candidates. Therefore, Japan has volunteered to actively commit to this problem as a part of its global health diplomacy through technology investment. GHIT functions as a PPPs; as of March 2015, MOFA, MHLW, Astellas Pharma, Eisai, Shionogi, Daiichi-Sankyo, Takeda, Chugai-pharma, and the Gates Foundation have joined this fund to develop medicines, vaccines, and diagnostic methods for NTDs. Along with investments from pharmaceutical companies and the Gates Foundation, a total of 10.5 billion yen have been used for R&D and a total of 7 billion yen have been disbursed to GHIT though the UNDP for the development of distribution pathways in the event new medicines are developed.[27]

The third article was published in 2018 by a group of scholars and government officials documenting Japan's contributions to GHD in the fora of G7 summits. Sakamoto et.al., describe in-detail how the Japanese government and its officials promoted UHC at G7 events and argue that strong leadership in agenda setting in this influential global forum has helped Japan raise awareness to UHC.[28] However, this article merely describes what Japan has done so far on global health in the context of the G7 and did not provide further analysis as to why Japan wants to promote its global health agenda or what is its ultimate goal from a diplomatic standpoint beyond simply promoting UHC.

A fourth and last article authored by Llano et al. in 2011 was published in a special *Lancet* series dedicated to Japan and global health.[29] Authors briefly discussed the origins of Japanese GHD primarily in the context of ODA, including Japan's adoption of human security as a cornerstone of its foreign policy objectives in 1998 (which officially marked the entry of health as a foreign policy goal), coordination with UNICEF and the World Bank, and the establishment of the Japan International Cooperation Agency (JICA). Importantly, the authors conclude that though global health is driven by multistakeholder partnerships (including civil society and other non-state actors), Japan's stance on ODA and Development Assistance for Health (DAH) remains government-centric due primarily to lack of awareness, attention, and fragmentation of efforts from Japanese stakeholders.[30]

Llano et al.'s article also includes an analysis of Japanese DAH based on data from the OECD and Institute for Health Metrics and Evaluation and found that Japan contributed the smallest shared of DAH compared to other OECD countries (Japan's health ODA is only 2% of its total ODA share) and was the only country that experienced a sustained DAH decline since 2000.[31] Hence, the article characterizes Japan as focused on core and multilateral forms of GHD that has primarily been concentrated on global health in Asia but is increasingly shifting towards improving health outcomes in Africa. Finally, authors close with a set of recommendations to reinvigorate Japan's leadership in global health including formation of a global health committee at the highest level of Japan's government, increasing Japan's health ODA, and tapping into the financial resources of non-government actors. [32]

We also note that there were additional articles that discussed Japan's foreign policy stance in the context of global health, but did not explicitly mention global health diplomacy and were not included in our literature review but merit some discussion. A 2007 article in *the Lancet* by Mashiko Koumura, former Vice-President of the Liberal Democratic Party and Minister for Foreign Affairs, describes Japan's help in establishing the Global Fund, fighting infectious diseases, improving maternal child health outcomes, strengthening health systems, and commitment to the MDGs.[33] The 2011 *Lancet* special series on Japan and global health (which included the article by Llano et al.) focused on the post-war evolution of health care in Japan and its growing commitment to global health, with a particular focusing on UHC, health insurance and system design, quality of care, and healthy aging. [34] Many of these articles also discussed aspects of Japan's commitment to global health that could inform Japanese GHD strategy.

Collectively, the four articles specific to Japanese GHD indicate that Japan is making recent proactive commitments for the development of global health, but at least one (Llano et al.) includes some criticism of Japan's global health commitments and overall strategy. However, all articles were written or co-authored by government officials (including the Llano et al. article that had co-authors from both academia and the Japanese government). Hence, the limited existing published literature generally lacks non-government and analytical perspectives on Japanese GHD. Despite these limitations, certain insights can be explored, such as the types of health diplomacy and international stakeholders engaged. Applying the typology of GHD which we introduced in the definition section, this literature can be summarized into certain major global health themes (see Table 2).

It appears based on this table that Japanese GHD actions are taking place primarily in the sphere of state-centric or multilateral health diplomacy. In other words, if we were to apply Katz et.al, definitions of GHD, the majority of Japanese GHD actions would be categorized as focused on multi-stakeholder diplomacy.

Overall, the literature on Japanese GHD provides a general description and singular viewpoint on its practice (Abe), focuses on global health diplomacy in the context of Japanese ODA and UHC (Llano et al.), and is limited to the description of a specific programs or forums of GHD -GHIT (Hinoshita) and fora of the G7 (Sakamoto et.al.) Hence, a complete picture of what Japan contributes to global health through diplomatic approaches remains relatively narrow and understudied. For this reason we found it necessary to extend our research beyond the literature to primary documents to better understand the practice of Japanese GHD.

Table 2: Summary of Major GHD Themes in Literature

Global Health Issue	Types of GHD	Stakeholders
Agenda Setting	Core and Multi-Stakeholder	Japanese Government, G8 (7) states, UN Member states, MDGs, SDGs fora
Universal Health Coverage	Core and Multi-Stakeholder	Japanese Government, WHO, SGDs fora
Global Health Innovative Technology Fund (GHIT)	Informal	Japanese Government, Gates Foundation Pharmaceutical Companies,
Japanese ODA	Core and Multi-Stakeholder	Japanese Government, G8 states, WHO, World Bank, MDGs, Bilateral arrangements,

Document Review – The Importance of ODA, Soft Power, and UHC

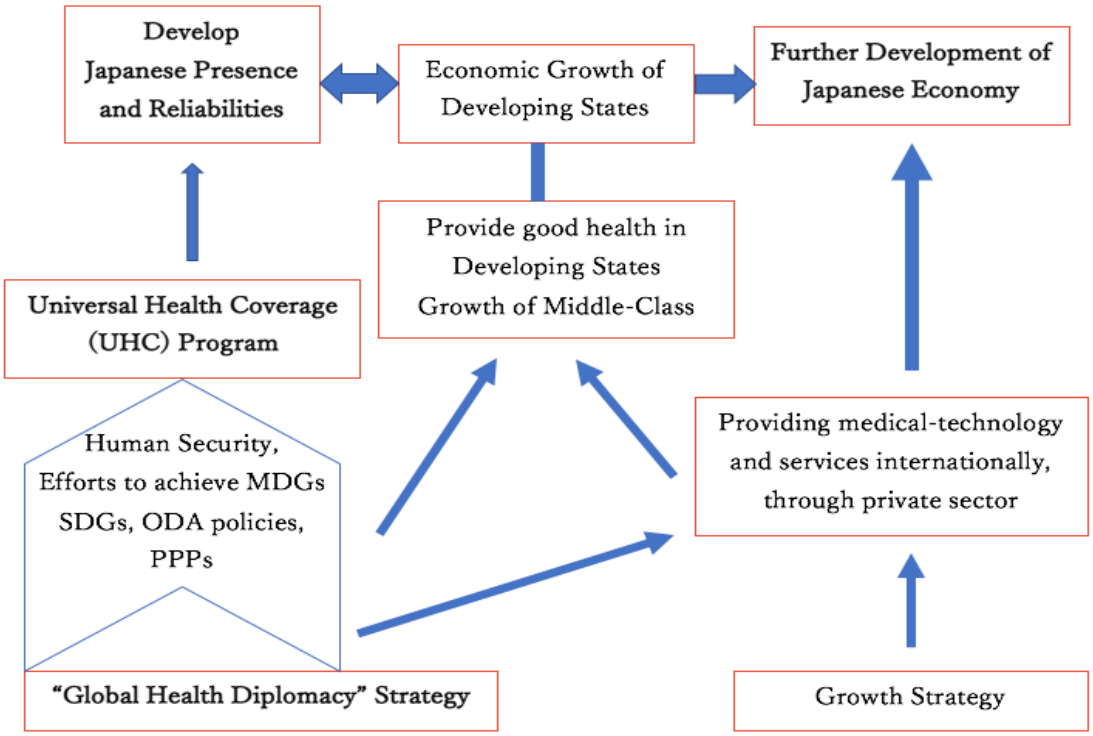
During our review of primary documents from government, nongovernment, and other sources, we reviewed information that provided a more specific view of the practice of health diplomacy by the Japanese government. Figure 1 is a translated chart by the Ministry of Foreign Affairs used to explain the positioning of GHD as a diplomatic strategy[35]. This figure is very informative because it makes clear that the ultimate goal of Japan's "Global Health Diplomacy Strategy" is driven and reinforced by various internationally accepted concepts and practices such as human security, MDGs and SDGs, as well as economic growth and development. In the "Basic Design for Peace and Health"[36] written based on the renewed 2015 "Development Cooperation Charter"[37], it is stated that Japan will make "efforts to address health issues by fully mobilizing Japan's experience and expertise"[38]

According to Sasaki and Llano et al., ODAs are positioned as a critical element of Japanese diplomacy. Sasaki argues that while the primary goal of ODA is to contribute to the development of the recipient, it can also benefit the national interests of Japan.[39] Likewise, Figure 1 indicates that ultimate goal of Japan's GHD strategy is to promote the presence and reliability of Japan in international society, and to further develop and advance the Japanese economy. In other words, Japan is making contributions to global health through various methods including ODAs, PPPs, and financial contributions to international organization as a function of its own national interests.

To be clear, this does not mean that Japan is simply making global health contributions solely for national benefit. Rather, Japan is strategically using global health as a tool to promote its soft power capabilities, together with its economic might and resources. In terms of soft power, recipients' perception matters more than sender's intention. As long as a recipient is convinced that Japanese global health contributions are favorable, ODA can be viewed as a success for Japan. This is also reinforced by Llano et al.'s observation that Japan is responsive to specific requests from recipient countries versus general and unspecified funding. However, it may be too early to assess the effects of how GHD has contributed to the development of soft power because perceptions from

other countries is not something that changes quickly or is easily measurable, though, as a soft power strategy, it appears it is having effects.

Figure 1: Overview of Japanese GHD Strategy (translated)



Singh argues, in the pre-1990s era ASEAN countries were skeptical of Japan taking an active role in Asia because of fear from its actions during WWII. However, by seeing Japan playing a vital role in countries such as Cambodia, while also providing needed financial and technical assistance through ODA programs, they began to have a more favorable attitude towards Japan.[40] Singh's piece unfortunately does not have any data to back up this claim, but survey data shows evidence of Japan being perceived positively from ASEAN countries through its activities in ODAs. According to data from Ipsos Marketing, 84% of ASEAN countries responders answered to the question "Japan's cooperation on development of Southeast Asian countries (e.g. ODA) is helpful" as either very or somewhat helpful.[41]

At the same time, surveys have also engaged on the question of Japan's approach on pacifism: 81% of ASEAN responders either value a lot or little regarding viewing Japan as a peace-loving nation.[42] Also, in a different survey, the marketing consulting firm Ipsos asked the question to ASEAN countries responders of whether they think Japan is a warlike countries or not, with only an average of 4% answering affirmatively that Japan is warlike.[43] These surveys show that Japan's active engagement with ASEAN through ODAs and financial assistance has altered the perspectives of ASEAN countries from negative perceptions of the past to a view of a more trustworthy counterpart that helps the development of ASEAN members.

Additionally, published literature on Japan's GHD efforts mentioned UHC as a critical pillar. By further analyzing more recent government documents, we can update our understandings of the impact of UHC on Japan's global health stance and strategy. This starts with the 2016 Tokyo International Conference on African Development VI (TICAD VI) held in Nairobi, Kenya, Japan announced a new framework for implementing UHC called "UHC for Africa", with the World Bank, Global Fund, and African Development Bank (AfDB).[44] The "UHC for Africa" program was aimed not only at establishing robust health care coverage but also establishing good economic and state structures that are sustainable in the long-term. Additionally, although this program argues that UHC should be considered as a good investment target because of moral and social reasons, it also argues a separate economic reasoning reflected in the following quote:

> "However, UHC is also a good investment. Prevention of malnutrition and ill health is likely to have enormous benefits in terms of longer and more productive lives, higher earnings, and averted health care costs. Effectively meeting demand for family planning will accelerate the fertility transition, which in turn will result in higher rates of economic growth and more rapid poverty reduction." [45]

The dual health and economic benefits of UHC have been promoted by international organizations such as the WHO as a mechanism for poverty alleviation. For example, according to Thirumurthy et.al., the provisioning of Antiretroviral Treatment (ART) for HIV/AIDS in a region in Kenya helped AIDS patient to recover and as a result, patients could work longer hours, generate income growth and consequently this contributed to poverty reduction.[46] This example shows that promoting UHC can bring economic benefit to developing countries that can also benefit donors. In short, people in recipient countries can have their health maximized and poverty minimized and are likely to be thankful to the contributions of donors. By using the framework of Nye, favorable attitudes from others can be a source of power. Therefore, this Japanese program of promoting UHC can be understood as an example of GHD that is aimed for the growth of soft power.

More recently, in 2017, Japan pledged $2.9 billion to countries pursuing UHC.[47] In December 2017, Japan co-hosted the UHC Forum 2017 with the World Bank, WHO, and UNICEF to discuss concrete methods of UHC implementation and issued the "Tokyo declaration on Universal Health Coverage". [48] Another example of specific GHD commitments by Japan is the EMBRACE Program that focused on maternal child health (See Case Study in Text Box 1). It still too early to determine the effects of UHC on Japanese soft power capabilities, but the strong presence and leadership of Japan in international UHC initiatives and declarations is likely to have some tangible impact on global health and Japan's position in the international development aid community.

Hence, information from Japan's own GHD strategy document and survey results indicate that global health is one of Japan's soft power tactics, particularly in the context of promoting UHC.

Text Box 1: Case Study of EMBRACE

In 2010, under the Kan administration, Japan announced "Japan's Global Health Policy 2011-2015." This agenda was implemented to engage on issues formally made part of the MDGs; specifically, child mortality, maternal health and combatting HIV/AIDS, TB, and malaria. The EMBRACE program stands for the abbreviation "Ensure Mothers and Babies Regular Access to Care" and was specifically developed to contribute to MDG targets 4 and 5. The EMBRACE program focused on providing antennal care packages (including antenatal care visits, tetanus immunization, and Vitamin A supplementation) to local communities. Japan also announced work on establishing emergency care facilities and providing assistance to promote healthy post-natal care.

Today, EMBRACE is integrated as Japan's broader UHC strategy. The EMBRACE program can be viewed as an attempt by the Kan administration to show that Japan was shifting from simply providing financial assistance to a more hands on approach and direct involvement in designing programs and interventions in global health specific to the MDGs and broader support of UHC.

THE FUTURE OF JAPAN'S GHD?

Current approaches for Japanese global health programs that reflect its health diplomacy stance are based on soft power strategies. However, changes in the historical role of the SDF and potential changes to Japan's constitution may lead to a rise in the combination of both hard and soft power in future Japanese global health diplomacy approaches. We outline these developments below.

FUTURE ROLE OF SDF IN GHD

In Japan's non-global health agenda, there has already been cases in which the SDF were deployed with the aims of increasing soft and smart power presence. Heng analyzes the cases of Japanese smart power strategies via the deployment of SDF with a number of case studies.[49] In Iraq, the SDF undertook 3 levels of assistance programs. The first level was to provide food, water and medicines as emergency assistance. On the second level, the SDF worked to improve basic infrastructures, like repairing roads, creating facilities for healthy water, and improving sanitation. Finally, on the third level, Japan helped build power plants to develop critical infrastructure in post-war Iraq. Although the projects were driven by the SDF, arguably a hard power/military force, according to surveys, local Iraqis indicated favorable attitudes towards the Japanese SDF. The reason is because the SDF were deployed in an assistance capacity, rather than in a coercion or threat mode, and Japanese popular cultural representation, such as anime, were utilized in tandem with developmental assistance.[50]

Other case studies also illustrate Japan's use of SDF to promote its diplomatic agendas. In March 2009, Japanese SDF vessels were deployed to Somalia for anti-piracy programs.[51] More notably, Japan has been active in making commitments on disaster

relief; 2013 Super Typhoon Haiyan's assistance in the Philippine [52], earthquake assistances on 2008 in Sichuan, 2010 in Haiti, 2015 in Nepal, and other cases. Additionally, when Japan experienced its own natural disaster in the Tohoku earthquake and resulting tsunamis and nuclear disaster in 2011, the SDF was utilized for joint operations and assistance with the US military.[53]

These case studies indicate that the Japanese government is attempting to use the SDF as a part of its smart power capabilities. However, currently the SDF has a limited scope of operation in the field of global health. Though Japan takes part in the US-led Pacific Partnership program which provides medical assistance to developing countries, compared to other countries such as the United States and China, Japan lacks the capacity to fully deploy the SDF in global health functions as a part of more systematic approaches to utilizing smart power tactics.

For example, the United States has specific hard power capabilities for providing health assistance, the USNS Mercy and USNS Comfort. These are Navy ships that function as fully equipped hospitals with 1000 beds and 1200 physicians, nurses, corpsman, technicians, and support staff.[54] Notable use of these "grey hull" maritime forms of health diplomacy include the USNS Mercy's deployment and provisioning of assistance during the Haiyan Typhoon in 2013 and USNS Comfort's deployment during the Haiti earthquake. While the Japanese SDF could only provide basics such as water, food, and medicines, these ships functioned as fully equipped hospitals that could provide more complex health assistance, particularly in the context of countries that have undergone severe disruption to their public health systems and local hospital infrastructure.

At the end of WWII, Japan had a total of 30 hospital ships but since then, Japan no longer operates any. However, with the experiences of Tohoku Earthquake in 2011, the Japanese government has begun to reassess the necessity of hospital ships and therefore hosted a research and study group to discuss whether it should re-introduce them for disaster relief use.[55] According to estimates by the study group, the cost of building a new medical ship is 140billion to 350 billion yen and annual operating cost was estimated between 9 to 25 billion yen. The cost is by far the biggest barrier of operating a medical humanitarian ship. However, as an alternative to making a new medical ship, a proposal was made to use preexisting private and or SDF ships and repurpose them into a medical humanitarian vessel in order to mitigate budgetary issues.[56]

As of today, the Japanese government has not yet introduced a medical ship. However, if one is introduced, by taking advantages of smart power capabilities it will play, Japan may be able to utilize it as a possible instrument for global health diplomacy and further extend its approaches in exercising smart power as the US and China have done with their own medical ship humanitarian assets.

CONSTITUTIONAL REVISION: ARTICLE 9

Current debate in the domestic political agenda regarding Japan's re-militarization has the potential to have a lasting impact on its current and future GHD strategy. Specifically, Prime Minister Abe has advocated for amending Article 9 of Japan's current constitution (that came into effect in 1947), in which the country renounced war as a sovereign right and also agreed to not maintain a military force. In July 2014, the first step to expanding Japan's military and defense capabilities came through a reinterpretation of SDF powers

allowing defense of allies in case of war, though stopped short of an actual amendment to the constitution. However, Prime Minister Abe continues to advocate for amending Article 9, including possible clarification of the SDF's legal status, purpose and character.[57] Though public support of an amendment process remains an uphill climb (a recent survey conducted by Kyodo News found that 54% of respondents oppose the amendment), if the Japanese constitution Article 9 is revised, it could represent a significant hindrance to perceptions about Japanese soft and smart power capabilities, including Japanese GHD.[58] We explain this rationale below.

First, revising Article 9, as is currently subject to intense domestic political debate in Japan, to allow the SDF to actively engage in kinetic operations overseas could inflict fear of re-militarization among international stakeholders, which could also undermine decades of international aid flows to recipient countries in the form of development assistance for health or other forms of ODA. This could effectively erode Japan's image as a state committed to soft power approaches to foreign policy challenges. This may especially be the case for neighboring Asian countries, who were heavily affected by the atrocities committed by imperial Japan during the WWII and who may fear the re-emergence of a military aggressive Japan.

Heng points out that, even though China is trying to promote soft power, because its political institutions are autocratic, this limits the capabilities of its soft power.[59] The same logic could also be applied to Japan. If Japan re-militarizes with a constitutional revision or further "reinterpretation" of Article 9, other countries could perceive that Japan is giving up its long-standing position as a peace-loving democratic nation and returning to the aggressive and autocratic state of the past. Since perceptions by others are one of the most important elements in the soft and smart power, if Japan is no-longer considered attractive due to perceptions about perceived re-militarization, Japanese soft and smart power could be diminished.

Second, if Article 9 undergoes changes, Tokyo will likely shift national spending from foreign assistance budgets to increase its military capabilities. Japan may lose certain incentives to make contributions to global health because they do not need to rely on soft power but instead seek to shift to hard power capabilities, which will increase the country's security presence and influence in the region.

At the very least, by engaging in constitutional reform, perceptions towards Japan from other countries will change. The short and long-term impact of these changes on hard fought efforts to establish a persona of soft and smart power and its effect on Japan's GHD strategy will be difficult to assess.

CONCLUSION

In this article, we analyzed how the Japanese government has attempted to achieve its soft and smart power goals by making contributions to the development of global health through diplomatic strategies.

As Prime Minister Abe argued in his article in *the Lancet*, Japanese experiences of rebuilding its national health insurance system provides lessons for broader global health goals of UHC that have produced formidable population health and development results post-war. In the year 1947, the average life expectancy of a Japanese woman was 53.96 years and for men it was 50.6 years.[60] However, based on data from 2016, that number

has experienced a dramatic increase to 87.14 years and 80.98 years form women and men respectively, equating to Japanese life expectancy the highest in the world.[61]

In only about 70 years, Japan has succeeded in stabilizing the health of its nation dramatically. We argue that the value of Japan as a longevity country can also form the basis for greater soft power capability. This demographic trend is often framed as the "Aging society" and carries with it negative connotations. Though for countries who are currently struggling with low average life expectancy due to high disease burden, inadequate health coverage, or weak health institutions, the Japanese model and its translation to other countries could represent a viable form of health diplomacy coupled with capacity building.

Despite these opportunities of GHD translation to other countries, the current Japanese administration is standing at the cross roads of a historical policy change that could change the image and landscape of Japan's position in the foreign policy hierarchy for decades to come. At the very minimum, the Abe administration should carefully consider how domestic policy changes may impact its strategic position on global health and health diplomacy as a critical instrument of Japan's legacy of adept use of soft and smart power. Ideally that decision will be driven not only by national interests, but also shared goals of advancing population health, economic growth that relates to good health outcomes, and security that can only exist with the rise of "healthy" nations.

Hisashi Kato *is a PhD student at the University of Tokyo Graduate School of Public Policy. Initial version of this piece was written during his study abroad to University of California, San Diego -School of Global Policy and Strategy.*

Tim K. Mackey *is an Associate Professor of Anesthesiology and Infectious Diseases and Global Public Health at University of California, San Diego - School of Medicine and the Director of the Global Health Policy Institute. He has also completed an Executive Course in Global Health Diplomacy at the Graduate Institute, Geneva and worked as a consultant for the World Health Organization and several other organizations. His work focuses on global health policy, governance, and technology.*

Yee K. Heng *is Professor at the Graduate School of Public Policy, University of Tokyo. His work on Japan's foreign and security policy includes peer-reviewed articles in The Pacific Review; International Relations of the Asia-Pacific; and Journal of Strategic Studies, amongst others.*

[1] Prime Minister's Office. 2013. "Policy Speech by Prime Minister Shinzo Abe to the 183rd Session of the Diet." 1 28. Accessed 4 16, 2018. https://japan.kantei.go.jp/96_abe/statement/201301/28syosin_e.html.
[2] MOFA. 2014. "The 13th IISS Asian Security Summit -The Shangri-La Dialogue-Keynote Address." 5 30. Accessed 4 16, 2018. http://www.mofa.go.jp/fp/nsp/page4e_000086.html.
[3] Abe, S. 2013. "Japan's strategy for global health diplomacy: why it matters." *The Lancet* 382 (9896): 915-916.
[4] MOFA. 2018. *ODA Budget*. 4 3. Accessed 8 2, 2018. https://www.mofa.go.jp/mofaj/gaiko/oda/shiryo/yosan.html.

[5] Nye, J. 2004. "*Soft Power The Means to Success in World Politics."*
[6] Nye, J. 2003. "Propaganda Isn't the Way: Soft Power." *International Herald Tribune,* January 10, 2003. Accessed 10 26, 2018. https://www.belfercenter.org/publication/propaganda-isnt-way-soft-power
[7] Ibid., Nye 2004. P.X
[8] Nye,J. 2011. "*The Future of Power: Its Changing Nature and Use in the Twenty-First Century."*
[9] Nye,J. 2005. "Soft Power Matter in Asia." *The Japan Times.* 12 5. Accessed 4 13, 2018. https://www.belfercenter.org/publication/soft-power-matters-asia.
[10] Adams, V, Novotny, TE and Leslie,H. 2008. "Global Health Diplomacy." *Medical Anthropology* 27 (4): 315-323.
[11] Lee, K, and Smith, R. 2011. "What is 'Global Health Diplomacy'? A Conceptual Review." *Global Health Governance* 5 (1).
[12] Katz, R, Kornblet, S, Arnold, G,Lief, E and Fischer, J E. 2011."Defining Health Diplomacy: Changing Demands in the Era of Globalization"*The Milbank Quarterly* 89 (3): 503-523.
[13] Ibid., p506
[14] Ibid., pp506-507
[15] Ibid., pp508-509
[16] Clinton, C, and Sridhar, D. 2017. "*Governing Global Health"* Oxford University Press.
[17] Ibid., p510
[18] Ibid., pp510-511
[19] Yanzhong, H. 2010. "Pursuing Health as Foreign Policy: The Case of China." *International Journal of Global Legal Studies* 17 (1): 105-146
Shen, S. 2004. "The "SARS Diplomacy" of Beijing and Taipei: Competition Between the Chinese and Non-Chinese Orbits." *Asian Perspective* 28 (1): 45-65.
[20] Blouin, C, and Dubé, L. 2010. "Global health diplomacy for obesity prevention: Lessons from tobacco control." *Journal of Public Health Policy* 31 (2): 244-255.
Shen, S. 2008. "Borrowing the Hong Kong Identity for Chinese Diplomacy: Implications of Margaret Chans World Health Organization Election Campaign." *Pacific Affairs* 81 (3): 361-382.
Outterson, K. 2009. "Import Safety Rules and Generic Drug Markets." In *Import Safety: Regulatory Governance in the Global Economy* , 110-128. University of Pennsylvania Press.
Dent, C M. 2002. "Reconciling Multiple Economic Multilateralisms: The Case of Singapore." *Contemporary Southeast Asia* 24 (1): 146-165.
Corbett, P E. 1959. "International Organization." In *Law in Diplomacy*, 187-250. Princeton University Press.
[21] Heng, Y K. 2014. "Beyond kawaii pop culture: Japan's normative soft power as a global trouble-shooter." *The Pacific Review* Vol. 27 (No. 2): 169-192.
Heng, Y K. 2010. "Mirror, mirror on the wall, who is the softest of them all? Evaluating Japanese and Chinese strategies in the 'soft' power competition era."*International Relations of Asia-Pacific* Vol.10: 275-304.
Heng, Y K. 2015. "Smart Power and Japan's Self-Defence Forces." *Journal of Strategic Studies* Vol. 38 (No.3): 282-308.
Berger, T. 2010. "Japan in Asia: a hard case for soft power." *Orbis* Vol.54 (No.4).
[22] MOFA. 2010. "Japan's Global Health Policy 2011-2015." *MOFA.* 9. Accessed 7 30, 2018. https://www.mofa.go.jp/policy/oda/mdg/pdfs/hea_pol_ful_en.pdf.
[23] Ibid., Abe, 2013
[24] Ibid., p915
[25] Ibid., p916
[26] Hinoshita, E. 2016."Industry, Academia and Government Partnership through the Global Health Innovative Technology Fund (GHIT)." *Yakugakuzasshi* 136 (2): 237-242.
[27] Ibid., p241
[28] Sakamoto, H, Ezoe, S, Hara, K, Hinoshita, E, Sekitani, Y, Abe, K,Inada, H, Kato, T,Komada, K, Miyakawa, M, Yamaya, H, Yamamoto, N, Abe, S K and Shibuya, K. 2018. "The G7 presidency and universal health coverage, Japan's contribution." *Bulletin of the World Health Organization* 96: 355-359.
[29] Llano, R, Kanamori, S, Kunii, O, Mori, R, Takei, T, Sasaki, H, Nakamura, Y, Kurokawa, K, Hai, Y, Chen, L, Takemi, K and Shibuya, K. 2011. "Re-invigorating Japan's commitment to global health: challenges and opportunities" *The Lancet,* 378, 1255-1264
[30] Ibid.,p1258

[31] Ibid., p1258-1259
[32] Ibid.,p p2160-1263
[33] Komura, M."Global health and Japan's foreign policy" *The Lancet*, 370,1983-1985
[34] The Lancet. 2011. "Japan: Universal Health Care at 50 Years" 8 30. Accessed 5 28, 2019. https://www.thelancet.com/series/japan
[35] Original chart is available at https://www.mofa.go.jp/mofaj/gaiko/oda/bunya/health/pdfs/ghd_03.pdf in Japanese. This chart is being simplified and translated in English by the author.
[36] MOFA. 2015. "Basic Design for Peace and Health (Global Health Cooperation)." *MOFA*. 9 11. Accessed 8 2, 2018. https://www.mofa.go.jp/mofaj/files/000110234.pdf.
[37] MOFA. 2015. "Development Cooperation Charter." *MOFA*. 2 10. Accessed 8 2, 2018. https://www.mofa.go.jp/mofaj/gaiko/oda/files/000067701.pdf.
[38] Ibid., MOFA. "Basic Design for Peace and Health"
[39] Sasaki, K. 2014. "Gaikoryoku Kyoka to Sekkyokuteki Heiwashugi." *Rippo to Chosa* (349): 58-63.
[40] Singh, B. 2002. "ASEAN's Perceptions Of Japan: Changes and Continuity." *Asian Survey* (University of California Press) 42 (2): 276-296.
[41] Ipsos Marketing. 2016."Japan-ASEAN Relations: Public Survey on Japan among ASEAM Citizens."*Ipsos Marketing*.
[42] Ibid., p40
[43] Ipsos Hong Kong. 2014."ASEAN Study."*Ipsos Hong Kong*.
[44] MOFA. 2016. "Prime Minister Abe attends high level event on Universal Health Coverage in Africa." 8 27. Accessed 4 15, 2018. http://www.mofa.go.jp/afr/af2/page4e_000494.html.
[45] The World Bank. 2016. "Universal Health Coverage (UHC) in Africa: a framework fo action: Main report." P3. 8 24. Accessed 4 16, 2018. http://documents.worldbank.org/curated/en/735071472096342073/Main-report.
[46] Thirumuthy, H, Graff Zivin, J and Goldstein, M. 2008. "The Economic Impact of AIDS Treatment Labor Supply in Western Kenya." *The Journal of Human Resources* XLIII: 511-552.
[47] Kyodo,2017 "Japan pledges $2.9 billion to support countries pursuing universal health coverage" 12 14. Accessed 10 26, 2018. https://www.japantimes.co.jp/news/2017/12/14/national/science-health/japan-pledges-2-9-billion-support-countries-pursuing-universal-health-coverage/#.W9JX1qeZN24
[48] MOFA. 2017. "Prime Minister Abe's speech at the side event to the 72nd UN General Assembly on UHC." 9 18. Accessed 4 16, 2018. http://www.mofa.go.jp/ic/ghp/page4e_000672.html.
[49] Ibid., Heng. 2015
[50] Ibid., pp.293-294
[51] Ibid., p.288
[52] Ibid., p302
[53] JICA. 2017. "Disaster Relief and JICA Striving to make Difference." *JICA*.
[54] Mercy, USNS. 2018. "USNS Mercy Steaming to Assist." Accessed 8 2, 2018. http://www.mercy.navy.mil/index.html.
[55] Cabinet Office. 2014. "Saigaiji Tamokutekisen ni kansuru cyousa kento houkokusho." *Japanese Cabinet Office*. 3. Accessed 8 2, 2018. http://www.bousai.go.jp/jishin/sonota/pdf/h24tamokutekisen_houkokusyo.pdf.
[56] Ibid., pp.75-76
[57] Kyodo News. 2019. "Poll shows 54% oppose revision of Japan's pacifist Constitution under Abe's watch." *Japantimes.co.jp*. Accessed 6 2, 2019. https://www.mhlw.go.jp/toukei/saikin/hw/life/life16/dl/life16-15.pdf
[58] Ibid.
[59] Ibid., Heng 2010 p300
[60] MHLW. 2016. "Seido no Gaiyo Oyobi Kisotokei." *Ministry of Health, Labour and Welfare*. Accessed 8 2, 2018. https://www.mhlw.go.jp/wp/hakusyo/kousei/16-2/kousei-data/siryou/sh0100.html.
[61] MHLW. 2017. "Heisei 28nen Kani Seimeihyo no Gaiyo." *Ministry of Health, Labour and Welfare*. 9 27. Accessed 8 2, 2018. https://www.mhlw.go.jp/toukei/saikin/hw/life/life16/dl/life16-15.pdf

WHY DOES GLOBAL HEALTH MATTER TO DIPLOMACY? GLOBAL HEALTH AS A SECURITY AND ECONOMIC CHALLENGE AND AS AN OPPORTUNITY FOR WORLD LEADERS, WITH A SPECIAL FOCUS ON THE G7 ISE-SHIMA SUMMIT

Kotono Hara and Satoshi Ezoe

Why does global health matter to diplomacy as an agenda of world leaders while those leaders are facing other competing agendas? To respond to this question, the authors, who engaged in the preparatory and follow-up process of the global health agenda at the G7 Ise-Shima Summit, analyze the reasons why and how global health became a priority agenda of G7 Leaders, using the Ise-Shima Summit as a case. With regard to why, the authors discuss that global health became a center of global attention, being strongly linked with pressing security and economic challenges, as well as the attainment of sustainable development towards 2030 , and that the G7 and its Presidency in 2016 had a comparative advantage to demonstrate a prescription on global health for the international community based on their rich expertise and experiences in the field. Then, with regard to how, the authors discuss the unique approach to global health taken at the G7 Ise-Shima Summit and the measures that successfully solidified the status of health as a priority agenda of world leaders, which led to upgrading global health to leaders' agendas at subsequent major international occasions.

INTRODUCTION

This article aims to answer the question why global health matters to diplomacy as an agenda of world leaders while those leaders are facing other competing agendas, such as downside risks to the global economy, terrorism and a record-high number of refugees.

In order to promote the recognition of health as an agenda of world leaders, it is also necessary to show how global health itself is now related to pressing challenges for diplomacy, and at the same time to what extent and in what ways health can be a viable tool to address those challenges in today's globalized world. Historically, the conventional purpose of diplomacy is to protect a territory from external threats and to ensure economic prosperity. However, as former UN Secretaries-General have pointed out, in the context of the continuous progress of global integration and interconnection, no country can solve all the challenges that it faces on its own. Now, the major functions of diplomacy in the 21st century include the promotion of development assistance to developing countries and the protection of human dignity, in addition to the realization of security and the creation of economic prosperity. Against the backdrop of this transition of diplomatic objectives, health has become more and more internationally highlighted as an important agenda of world leaders[1]. This trend has been well reflected in the expansion of the G7 Summit agenda, which was originally established to recover economy after the oil crisis in the 1970s, then expanded to more diversified economic

issues as well as the East-West political confrontation in the 1980s, globalization after the end of the Cold War in the 1990s and now covers wider global challenges, including global health, in the 21st century.

To respond to the question at the opening, the authors, who engaged in the preparatory process of the global health agenda at the G7 Ise-Shima Summit, firstly analyze the reasons why global health was elevated to be one of the G7 Leaders' priority agendas at the Ise-Shima Summit. We will look at the external situations by which global health had become the center of global attention, being strongly linked with pressing the security and economic challenges, as well as the attainment of sustainable development leading up to 2016, and the internal conditions where the G7 and its Presidency in 2016 had a comparative advantage to demonstrate a prescription for global health to the international community based on their rich expertise and experiences in the field.

Based on analysis on those reasons, the authors will also discuss the measures taken at G7 Ise-Shima Summit to actually make global health a priority agenda of world leaders. They will do so by consolidating the outcome of the health agenda at the G7 Ise-Shima Summit into a unique approach that solidified the status of health as a priority agenda of world leaders not only at the G7 but also at other major international occasions.

1. Why did the G7 Ise-Shima Summit make health a priority agenda for leaders?

1.1. Increased sense of urgency in addressing global health from the security perspective

Firstly, we will look at the recent trend that public health emergencies are growing to become threats equivalent to conflicts and natural disasters, as well as the trend that those health emergencies are increasingly being triggered or exacerbated by conflicts and disasters.

Public health emergencies, especially pandemics, have negative impacts on the lives and livelihoods of human beings that are as severe as the impacts of wars and conflicts. In fact, not many threats claim human lives on a scale equivalent to pandemics. According to some estimates, while armed conflicts resulted in an average of 1 to 1.5 million deaths per year in the 20th century, the same scale of annual deaths are brought by AIDS or tuberculosis, which each claimed the lives of 1.5 million people in 2013[2]. During the 1918 Spanish flu pandemic, as many as 100 million people died - up to 5 percent of the world's population. According to an estimate by the Bill & Melinda Gates Foundation, if a similar outbreak to the Spanish Flu were to happen today, the death toll could reach 360 million, despite the availability of vaccines as well as modern antiviral and antibacterial drugs[3].

Most recently, the 2014 Ebola outbreak in several West African countries proved that infectious diseases know no borders and that an outbreak in one country threatens the security of other countries. The disease first emerged in Guinea and Sierra Leone, it then spread to several other African countries, as well as to the US and Europe. The total number of deaths from the outbreak amounted to about 11,300, with a likelihood of death at about 40 percent[4]. In September 2014, the UN Security Council adopted a resolution to position the Ebola outbreak in the affected countries as "a threat to the peace and

security of the international community (UNSCR 2177)." From this perspective, preventing, preparing for and responding to pandemics should be regarded not only as a health issue but also as indispensable actions for the security of every nation and the entire world[5].

Moreover, health-related morbidity and deaths risks are further exacerbated by direct combat- or disaster-related effects[6]. Conflicts and disasters damage and disrupt health systems and infrastructures, reduce the capacity of and access to health services, and deteriorate the capacity to respond to severe infectious diseases, and thereby threaten individual and collective health. For example, post-conflict countries such as Angola and Congo are facing outbreaks of serious infectious diseases[7]; and polio, which had once been eradicated, is now re-emerging in Syria[8]. The most severely affected people under such circumstances tend to be the most vulnerable, including women, children and refugees. Under such situations, the Munich Security Conference took up health for the first time as one of its agendas at its side event entitled "Health Security Roundtable Munich: Healthcare under Attack." The discussion at the event confirmed that strengthening health systems, particularly in fragile states, is necessary, highlighting the relationship between wars/conflicts and health status[9].

1.2. Pressing needs to work collectively on global health from an economic perspective

We now review that both the persistence and expansion of communicable diseases and the emergence of non-communicable diseases (NCDs) are calling for collective global actions from an economic perspective.

With regard to health expenses, some 800 million people are spending out of pocket on health at least 10 percent of their household budget, and nearly 100 million people are being pushed into extreme poverty each year due to heath care costs[10]. In addition, outbreaks of epidemic and pandemic disease can result in extreme negative economic impacts. For example, the World Bank has estimated that the three countries most severely affected by the 2014 Ebola outbreak in West Africa lost at least USD 2.2 billion in forgone economic growth in 2015 as a result of the epidemic[11]. Today, human/animal contact is increasing due to a growing population and expanded animal husbandry to feed more people. At the same time, person-to-person interaction is also expanding through vitalized trade and human mobility. These trends have enhanced the risk of outbreaks of communicable disease and their accompanied economic impacts[12]. Moreover, undue fear of an infectious disease can spread even faster than the disease itself in the present world whose furthest corners are now closely connected by global media and social network services. Such spread of fear can alter public behaviors or policy decisions, and thereby paralyze an economy. Expected economic losses from potential pandemics could amount to around USD 60 billion per year[13].

In the context of such intentional and unintentional responses to a pandemic, it is not enough for a government to think only about its own country and its own people while attempting to safeguard its security and economy from the impacts of pandemics. This recognition is now widely shared not only by health experts but also by diplomats as matters relating to the free flow of goods and people[14]. For example, the SARS outbreak of 2003 enhanced a shared recognition that specific international rules are necessary to address such matters. This recognition eventually pushed health into the diplomatic

sphere in 2005, leading to the inclusion of Article 2 of WHO's International Health Regulations (IHR) that reads "to prevent, protect against, control and provide a public health response to the international public health risks and avoid unnecessary interference with international traffic and trade", adopted in 2005[15]. However, an improved framework of actions, building upon the lessons learned from the Ebola outbreak, is still necessary.

The economic impacts of Antimicrobial Resistance (AMR) have also gradually been recognized as an emerging economic threat. According to the Review on AMR that was commissioned by the UK Prime Minister in 2014 and whose final report was issued in 2016, even as existing antimicrobials are becoming less effective over time, the development of new antimicrobials is falling behind. If this state of affairs continues, it is anticipated that the challenges of AMR will claim a life every three seconds, resulting in the death of 10 million people in total, and bring an economic loss of 100 trillion USD by 2050.

Lastly but not least, with the increasing aging of the population, the composition of total disease burden will shift from acute to chronic and from communicable to non-communicable. Such a shift will require longer periods of daily care for chronically ill patients, which will result in the further expansion of public expenses in health care[16]. In fact, the increasing incidence of NCDs, mental illness and dementia all over the world has expanded the negative impact on the economic well-being individuals and nations, and it is expected to continue to increase. For example, NCDs and mental illness were major causes of morbidity and death in 2012, and 40 percent of the people who died from NCDs and mental illnesses were younger than 70 years old[17]. About 44.4 million people were affected by dementia in 2013 and this number is expected to increase by three-fold to 135.5 million by 2050[18].

1.3. More attention to positive security and economic impacts related to health

On the other hand, the promotion of health and the improvement of health outcomes yield many great positive security and economic impacts.

In order to respond to security issues such as terrorism and conflict, it is necessary not only to invest in enhancing national defense but also in addressing the root causes of those issues and ensuring 'human security', a concept that is promoted by Japan and now officially recognized at the UN, and consists of 'freedom from fear' and 'freedom from want.' Investing in health system strengthening towards attaining UHC is deemed to play a crucial role for ensuring security at the national, community and individual level, as it is the forefront of responding to infectious diseases NCDs[19], and also reducing or covering the medical costs borne by individuals in doing so. Therefore, UHC is conducive to ensuring human security, by contributing to both 'freedom of fear' and 'freedom of want.' UHC can also enhance the resilience of a community through fostering its cohesiveness. The process of achieving UHC is linked to wider challenges of peace and democracy, such as restructuring entrenched governance, realizing rights while addressing marginalization and exclusion, and equitably redistributing opportunities. Therefore, it enables the people in a community to enjoy healthier lives with dignity in times of calm, and mitigates shocks to the community in times of emergency[20].

Health is a driving force for promoting economic growth with significant returns on investment (ROIs). From the macro-economic perspective, a one dollar investment in health can yield up to ten dollars of economic growth[21]. Another study shows that 24 percent of the full-income growth in low and middle income countries, comprising growth in GDP and the value of the peoples' additional life years from 2000 to 2011, was a result of improved health[22]. Moreover, investment in prevention and preparedness are much cheaper than the cost of *post hoc* responses to epidemic outbreaks, which bring many negative economic impacts as mentioned above. For example, in the wake of the Ebola outbreak in West Africa, it is estimated that prior investment in health systems could have mitigated the impacts at only one third of the cost[23]. Also from the micro-economic perspective, good health is indispensable for reducing poverty and promoting personal well-being. For example, UHC can reduce the proportion of out-of-pocket expenses on health of total household expenses, enabling families to invest in more productive areas such as education.

1.4. Responsibility to implement health-related global goals under the new paradigm for sustainable future

In 2015, the UN General Assembly adopted 2030 Agenda for Sustainable Development which includes 17 so-called "Sustainable Development Goals" (SDGs), while attaching importance to universal implementation and global partnership as well as a people-centered approach, which corresponds to the concept of human security. Goal 3 of the SDGs is exclusively focused on health with its overarching commitment not only to realizing healthy lives both physically and mentally but also promoting well-being for all ages, as the afore-mentioned negative and positive health impacts. More specifically, the goal expanded its scope from infectious diseases and child and maternal health upheld in the previous Millennium Development Goals (MDGs) to include NCDs, taking into consideration demographic and epidemiological changes[24].

Along with this expansion in scope, concrete actions to be taken in order to achieve this goal cover not only specific efforts to respond infectious diseases but also strengthening health systems and promoting UHC[25]. UHC, Target 3.8 of the SDGs, is a particularly important element as exemplary of the SDGs' over-arching principle of "no one left behind." Therefore, the implementation of the health-related SDGs, including UHC, is now one of the important agendas of world leaders. The Ise-Shima Summit was held amid the international expectation to steadily implement the health-related SGDs as the first G7 Summit held after the adoption of this 2030 Agenda.

1.5. Making most of the comparative advantage of the G7 and its 2016 Presidency in global health

The G7 has a comparative advantage in taking up the most pressing global agendas, while other international fora have difficulties in doing so due to their broader or more diverse membership; and in showing and expanding a prescription to address those agendas to the wider international community. To this end, a G7 Presidency itself needs to have a certain level of expertise and experiences conducive to leading the G7's interests and building a consensus on such a prescription.

Infectious diseases were discussed for the first time at the Kyushu-Okinawa Summit in 2000, and then health systems strengthening was highlighted in a comprehensive manner at the Hokkaido-Toyako Summit in 2008. Between and after those two Summits, global health had been a relatively regular part of the agenda. Therefore, the G7 had a solid foundation on which to make global health priority agenda for world leaders. On the other hand, the UN General Assembly has been adopting resolutions on global health every year since 2008, but it has not been an agenda that world leaders directly discuss and intervene in, and the G20, the premier international forum for economic cooperation, had not taken up the health agenda until 2016.

Japan, holder of the G7 Presidency in 2016, also had experience taking up global health, including at the leaders' level, from the security and economic perspectives and UHC as the solution of those perspectives.

Japan stipulated its "National Security Strategy" in December 2013, which aims at contributing more to peace, stability and prosperity in the international community under the policy of proactive contribution to peace, based on the principles of international cooperation. The Strategy commits to strengthening cooperation toward global challenges based on universal values, such as freedom, democracy and human rights, as one of the strategic security approaches that Japan should take, and then sets concrete actions in response to development and humanitarian issues, including health, that could hinder peace and stability in the international community[26]. Japan has also contributed to manifesting the health agenda as a part of its diplomatic policy in "Japan's Strategy on Global Health Diplomacy" announced in 2013[27], together with declarations of Japan's political resolve to do so as expressed by Prime Minister Abe in The Lancet in 2013 and 2015[28].

Therefore, Japan had an intention to contribute to health as security and diplomatic policy a little earlier than the Global Health Security Agenda (GHSA) led by the US since 2014, which pursues a multilateral and multi-sectoral approach to strengthening both the global capacity and nations' capacities to prevent, detect, and respond to human and animal infectious disease threats (Global Health Security Agenda, 2014). Moreover, the Government of Japan developed its "Basic Design for Peace and Health" as a guideline for health challenges in September, 2015 as a part of its efforts for proactive contribution to peace.[29,30]

Japan also achieved universal health coverage (UHC) as early as the 1960s through the adoption of its "Universal Health Insurance System", which has since served as the foundation of its economic growth, and has maintained it over the last 50 years. Japan also has cutting-edge medical technologies and rich experiences responding to natural disasters and an aging society.

2. How did the G7 Ise-Shima Summit make health a priority agenda for G7 leaders?

We have seen the external situations and internal conditions that helped global health become a leaders' priority agenda. Now, we would like to discuss how the G7 Ise-Shima Summit was able to place health in the unprecedented position of a priority agenda of the G7 Leaders?

With about 10% of the G7 Leaders' Declaration dedicated to health, it is clear that global health became a priority agenda at the G7 Ise-Shima Summit[31]. In summary, the health agenda at the Ise-Shima Summit consisted of the following three pillars: (i) reinforcing the Global Health Architecture to strengthen responses to public health emergencies, (ii) strengthening health systems with a view to attaining UHC and enhancing preparedness for emergencies, and (iii) addressing AMR, together with innovation and R&D as a cross-cutting issue. A comprehensive package of actions to materialize the commitments in the Leaders' Declaration was also announced as the Annex "G7 Ise-Shima Vision for Global Health", which covered the aforementioned pillars[32]. As summarized in Table 1, the G7 Summits prior to the Ise-Shima Summit had constantly dealt with health, but not as comprehensively as the latter. The leaders also agreed on seven annexes on global health in the previous summits but focused rather on specific areas of global health such as infectious diseases at Saint Petersburg summit in 2006 and at Sea Island Summit in 2004, maternal and child health at Muskoka Summit in 2010 and AMR at Schloss Elmau Summit in 2015. While the Hokkaido-Toyako Summit welcomed a quite comprehensive document on global health, it comprised only the experts' recommendations to the leaders, not the leaders' commitments.

Table 1: Global Health in the previous G7/G8 Summits

Summit	Major elements of the Leaders' Declaration/Chair's Summary	Annex
G7 Summit 2015 in Schloss Elmau (June 7-8, 2015)	✔**Strengthening health systems*** ✔**Ebola**: WHO's International Health Regulations (IHR)/Global Health Security Agenda (GHSA), reform and strengthening of the WHO's capacity, development of a Pandemic Emergency Facility by the World Bank ✔**Antimicrobial Resistances** (the annex) ✔**Neglected Tropical Diseases (NTDs)**: NTD-related research, investment in the prevention and control of NTDs, the GAVI Alliance, the Global Fund to fight AIDS, Tuberculosis and Malaria, ending of preventable child deaths and improving maternal health	**Joint Efforts to Combat Antimicrobial Resistance (AMR)**
G7 Summit 2014 in Brussels (June 4-5, 2014)	✔**Maternal, newborn and child health*** ✔**Infectious diseases*:** the GAVI Alliance, the Global Fund to fight AIDS, Tuberculosis and Malaria, the GHSA/the WHO's IHR, development of a Global Action Plan on antimicrobial resistance	

G8 Summit 2013 in Lough Erne (June 17-18, 2013)	None	
G8 Summit 2012 in Camp David (May 18-19, 2012)	None	
G8 Summit 2011 in Deauville (May 25-26, 2011)	✔**Infectious diseases***: the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, polio eradiation, facilitation of the affordable generic medicines, ✔**Improving maternal health and reduction of child mortality***	
G8 Summit 2010 in Muskoka (June 25-26, 2010)	✔**Maternal and child health***: significant reduction of the number of maternal, newborn and under five child deaths, endorsement/launch of the Muskoka Initiative, strengthening of country-led national health systems in developing countries, training of medical personnel, stronger health innovation networks in Africa and other regions ✔**Infectious diseases***: the Global Fund to Fight AIDS, TB and Malaria, polio eradication, the control or elimination of high-burden NTDs	**The G8 Muskoka Initiative: Maternal, Newborn and Under-Five Child Health**
G8 Summit 2009 in L'Aquila (July 8-10, 2009)	✔**Strengthening health systems*:** health workforce improvements, information and health financing systems ✔**Building a global consensus on maternal, newborn and child health*** ✔**Infectious Diseases*:** universal access to HIV/AIDS prevention, treatment, care and support, combat against TB and Malaria, addressing of the spread of NTDs, polio eradication	
G8 Summit 2008 in Hokkaido-Toyako (July 7-9, 2008)	✔**Ensuring disease-specific and health systems approaches as mutually reinforcing** ✔**Health system strengthening***: comprehensive approaches to address the strengthening of health systems, quantitative and qualitative improvement of the health workforce, achievement of the MDGs on child mortality and maternal health	**Toyako Framework for Action on Global Health - Report of the G8 Health Experts Group**

	✔**Infectious diseases***: fulfilling of the past commitments on malaria, polio eradication, commitments to NTDs	
G8 Summit 2007 in Heiligendamm (June 6-8, 2007)	✔**Improvement of health systems***: strengthening of health systems, sustainable and equitable financing of health systems, human resource capacity within the health sector ✔**Infectious diseases*:** fight against HIV/AIDS, malaria and tuberculosis (the Global Fund)	
G8 Summit 2006 in Saint Petersburg (July 15-17, 2006)	✔**Infectious diseases***: enhancement of international capacities to monitor and response to outbreaks, preparation for a possible human influenza pandemic, fight against HIV/AIDS, tuberculosis and malaria (the Global Fund), polio eradication, strengthening of health care systems in developing countries, research and development of new drugs and vaccines	**Fight Against Infectious Diseases**
G8 Summit 2005 in Gleneagles (July 6-8, 2005)	✔**Delivering free basic health care for all** ✔**Providing as close as possible to universal access to treatment for AIDS** ✔**Africa:** investment in health systems, significant reduction of HIV infections, polio eradication, scaling up of actions against malaria	
G8 Summit 2004 in Sea Island (July 8-10, 2004)	✔**Endorsing and establishing a Global HIV Vaccine Enterprise** (the annex) ✔**Polio eradication** (the annex)	**G8 Action to Endorse and Establish a Global HIV Vaccine Enterprise** **G8 Commitment to Help Stop Polio Forever**
G8 Summit 2003 in Evian (June 1-3, 2003)	✔**Infectious diseases*** (the annex): the Global Fund to Fight AIDS, Tuberculosis and Malaria, research on diseases mostly affecting developing countries, polio eradication, international co-operation against new epidemics such as SARS ✔**Access to health care*** (the annex)	**Health: A G8 Action Plan**

G8 Summit 2002 in Kananaskis (June 26-27, 2002)	✔**Infectious diseases in Africa***: combat against Malaria, Tuberculosis and HIV/AIDS, polio eradication	
G8 Summit 2001 in Genoa (July 20-22, 2001)	✔**Launch of a new Global Fund to fight HIV/AIDS, malaria and tuberculosis** ✔**Strong national health systems** ✔**Strong and effective intellectual property rights protection as a necessary incentive for research and development of life-saving drugs**	
G8 Summit 2000 in Kyushu-Okinawa (July 21-23, 2000)	✔**Infectious diseases***: mobilization of additional resources, development of equitable and effective health systems, innovative partnership, cooperation in basic research and development, a quantum leap in the fight against infectious diseases (HIV/AIDS,TB ,malaria), a conference in Japan to deliver agreement on a new strategy to harness our commitments	

Note: Sub-titles with * are added by the authors for categorization.

This seems to be because the Ise-Shima Summit took a unique approach, hereinafter referred to as the "Ise-Shima Approach to Global Health" that is presented in Chart 1 and consists of the following five elements that made the most of health features as diplomatic challenges and tools.

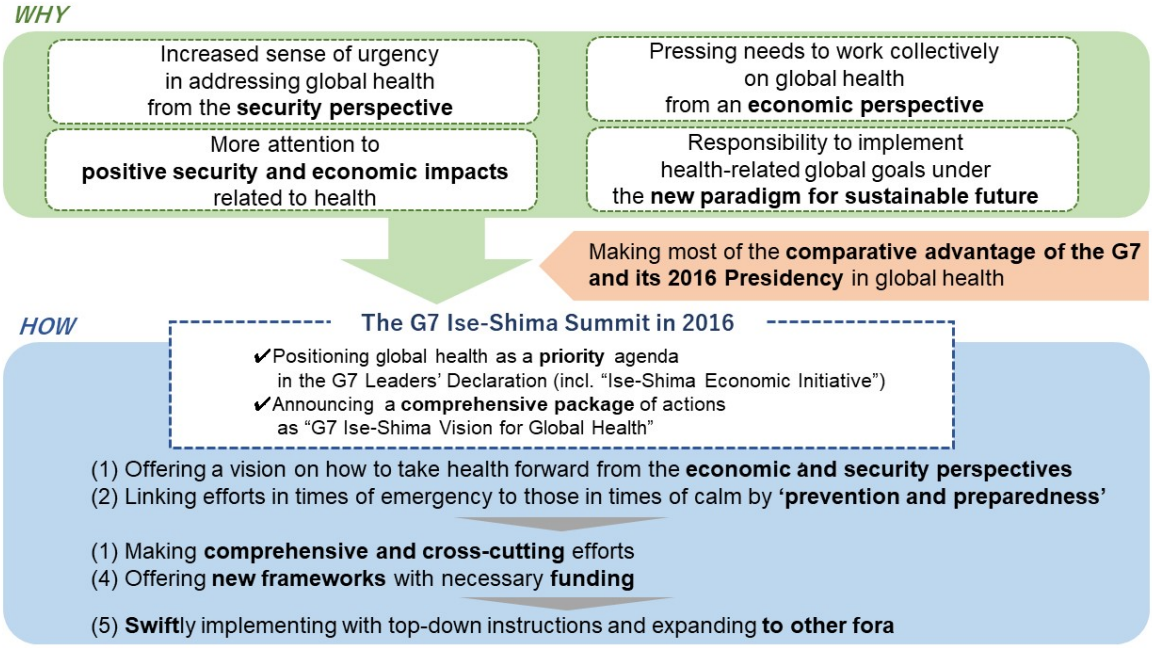
2.1. Offering a vision on how to take health forward from the economic and security perspectives

At the very beginning of the health section in the Leaders' Declaration, the G7 Leaders articulated that "health is the foundation of peace and prosperity" for an individual and a nation. While many other G7 Summits had consistently addressed health as a development issue, the Ise-Shima Summit gave a vision and future direction to health that would enable it to positively affect and contribute to security and the economy.

As a part of this effort, taking into consideration the positive and negative economic issues discussed in the previous sections, health-related commitments were included in the "Ise-Shima Economic Initiative," a policy package to improve the foundations for long-term economic growth, as well as to respond to current economic challenges such as downside risks and uncertainty. The Summit also shed light on active aging for the first time in order to turn the economic challenges brought on by aging into economic opportunities. Moreover, as the first Summit to be held after the adoption of the SDGs at the UN General Assembly in September, 2015, the Ise-Shima Summit was fully committed to implementing the health-related SDGs, and especially to attaining Goal 3.8 on UHC for the first time in the history of G7/G8 Summits, as a comprehensive

framework that underpins all of those Goals[33].

Chart 1: The Ise-Shima Approach to Global Health



2.2. Linking efforts in times of emergency to those in times of calm by the key phrase 'prevention and preparedness'

The Ise-Shima Summit linked efforts in times of emergency to those in times of calm by the key phrase 'prevention and preparedness,' where both of them had been dealt either separately or selectively in past G7 Summits, and positioned the various health-related efforts under both circumstances as not mutually exclusive but rather mutually reinforcing. More concretely, fostering health-related human resources, improving medical facilities, appliances and goods, and elaborating health fiscal systems with a view to attaining UHC were recognized as leading to preventing against and preparing for future health emergencies.

Historically, mid-to-long-term challenges such as strengthening health systems and thereby attaining UHC had been relegated to a position of lower priority during times of health emergencies. However, the concept of 'prevention and preparedness' brought about a consensus to continue working on those challenges under all circumstances whatsoever. This consensus was underlined by the roles and impacts of UHC in both security and the economy as mentioned above. Also from the perspective of preparedness, strengthening the implementation of WHO's IHR, including through the GHSA, was reaffirmed as the follow-up of the Elmau Summit in 2015.

2.3. Making comprehensive and cross-cutting efforts

Furthermore, the Japanese Presidency proactively took a comprehensive and cross-cutting approach that is usually only possible under the initiative of Leaders, as Ministers only have their respective policy scopes.

Firstly, the G7, which takes pride in its sophisticated technology, discussed innovation as a cross-cutting issue, including such topics as innovation and R&D to address diseases that need attention but are not market-driven, such as neglected tropical diseases and AMR, acceleration of testing, manufacturing and distribution of medical products for public health emergencies, and innovation and R&D for active ageing.

Moreover, the G7 set forth multi-sectoral approaches, such as highlighting the health-human- itarian nexus in response to health emergencies, promoting a 'One Health' approach to AMR that covers agricultural and livestock industries, and improving nutrition for maternal and child health. It also committed to pursue multi-sectoral approaches to active ageing in order to reach the highest attainable level of well-being, from health care and long-term care to health promotion, welfare, employment, pension, housing, and urban/transportation planning, with due consideration to gender specific aspects. From a procedural perspective, as inputs to the Leaders' discussions and/or follow-ups to their instructions, the greatest number of G7 ministerial meetings took up health issues in the history of G7/G8, starting from the Foreign Ministers' Meeting to the STI, Agricultural and ICT Ministerial Meetings before the Summit, and then intensively at the Health Ministers Meeting after the Summit.

2.4. Offering new frameworks with necessary funding

The Ise-Shima Summit not only delivered a high-level political message but also offered new frameworks with necessary financial resources to realize that message. Firstly, the G7 requested and supported WHO reform—especially the clarification of its chains of command and the establishment of an Emergency Response Programme—and reflected upon WHO's lack of capacity to adequately respond to the emergency of the Ebola outbreak. Moreover, as the Ebola outbreak also revealed the necessity of swift fundraising, the G7 backed the launch of the Pandemic Emergency Facility (PEF) of World Bank, an emergency funding mechanism complementary to the Contingency Fund for Emergencies (CEF) of WHO. WHO emergency reform and the creation of CEF were envisioned and initiated before the Ise-Shima Summit but the G7's strong commitment with financial contributions expedited and strengthened the processes. As for the PEF, the idea was initiated by the World Bank leadership but the actual launch was ensured by the engagement of the G7 and its Presidency. For example, Japan led the coordination and dialogue between World Bank and WHO in crystalizing the technical details of epidemiological and actuarial conditions, and the design of the PEF in relation to the CEF so that they would have complementary roles. Japan also urged the parties so that the PEF could be launched in time for the Ise-Shima Summit given its urgency.

While humanitarian agencies such as OCHA have played a significant role in cases of natural disasters such as earthquakes, they lack the expertise to respond to unknown infectious diseases, and coordination with WHO, which has rich expertise, was not

sufficient in the Ebola outbreak. Therefore, the G7 Leaders also requested the formalization of a Standard Operating Procedure (SOP) for Health Emergencies, to enhance health and humanitarian system-wide coordination among WHO and other relevant UN partners, under the UN Secretary-General. In the case of the SOP, Japan facilitated the multiagency dialogue among OCHA, WHO and World Bank that culminated in the launch of "Level 3 (L3) Activation Procedures for Infectious Disease Events" by the Inter-Agency Standing Committee in December 2016[34]. This is a result of the commitment and support from the G7 Presidency, including an informal stakeholder conference hosted by Japan in April 2016 which was attended by the UN Secretary General's representative and the heads of OCHA and WHO, who agreed to the principle that WHO should continue to take a lead but under the inter-agency mechanism led by the Secretary General. This was followed by further elaborated commitment and support at the G7 Kobe Health Ministers' Meeting and its outcome[35].

As for UHC, in advance of assuming the G7 Presidency, Prime Minister Abe had already emphasized the need to bring together expertise and resources from donor countries, the international organizations including WHO, the Global Fund and World Bank, and the private sector to establish and promote an international alliance to support developing countries to achieve stronger health systems towards the ultimate goal of achieving UHC, at the event entitled "the Path towards Universal Health Coverage: Promotion of Equitable Global Health and Human Security in the post-2015 Development Era" held during the 70th UN General Assembly Meeting in 2015 (Ministry of Foreign Affairs, 2015). Based on this call, Japan took initiative as the G7 Presidency in leading the International Health Partnership (IHP+) to enhance collaboration among donor agencies, has expanded its scope to include UHC, and officially launched "IHP+ for UHC2030" as an international framework to coordinate catalysts and leverage efforts of relevant stakeholders and various initiatives such as the new policy framework "UHC in Africa."

To bring those frameworks into function, the government of Japan announced its decision to financially contribute up to USD 1.1 billion to health-related international agencies in advance of the Summit. For emergency responses, Prime Minister Abe announced a contribution of USD 50 million to WHO's Health Emergencies Programme, of which Japan had already disbursed half as of the end of 2016. In addition, Japan has contributed approximately USD 10.8 million to the CEF, meaning that Japan had become its largest donor as of the end 2016, and Prime Minister Abe also announced a contribution of USD 50 million to the PEF earlier than any other country. With the G7's financial commitments and their encouragement to the international community as stated in the Leaders' Declaration, the 5th replenishment of the Global Fund successfully achieved a total pledge of USD 12.9 billion in September. At the "UHC Forum 2017" to be explained below, Prime Minister Abe announced that Japan would commit US$ 2.9 billion for health, nutrition and water and sanitation in support of countries pursuing UHC.

2.5. Swiftly implementing with top-down instructions and expanding to other fora

It is also only leaders who can swiftly implement those commitments that encompass a wide-range of scopes beyond health, with strong leadership.

As for strengthening responses to public health emergencies, WHO reforms are now underway, with the newly established WHO Health Emergencies Programme, as well as concrete reform and supplementary budget plans that were approved at the World Health Assembly in May 2016, shortly after the Summit.

The emergency funding mechanisms, especially the PEF, are now fully operationalized. Moreover, the SOP for Health Emergencies was eventually agreed at the Inter-Agency Standing Committee (IASC) in December 2016 as a Level 3 activation procedure, and also welcomed in a UN General Assembly Resolution in December 2016. Progress was also made towards offering concrete assistance – including assistance with the development of national plans and completion of WHO Joint External Evaluations – to 76 countries and regions to build core capacities to implement the IHR. Moreover, consideration was given to including preparedness for, responses to and recovery from pandemics in policy commitments of the International Development Association (IDA) during its IDA18 replenishment meeting in December 2016.

Concerning the attainment of UHC with strong health systems and better preparedness, the IHP+ Steering Committee in June 2016 decided to adopt and launch "IHP+ for UHC2030" as a UHC platform. A new framework for "UHC in Africa" to serve as reference for achieving UHC and health system strengthening in African countries was launched in August, 2016 at the Sixth Tokyo International Conference on African Development (TICAD VI), proposing a set of actions in five areas in the UHC process; namely, financing, services, equity, preparedness and governance. In partnership with WHO, World Bank, UNICEF and the aforementioned new platform IHP+ for UHC2030, Japan co-hosted the "UHC Forum 2017" to stimulate global- and country-level progress towards UHC, which included the participation of the UN Secretary-General, the heads of WHO and UNICEF, the Prime Minister, Health Minister and Finance Minister of Japan and high level representatives of many other countries. Building on the "G7 Ise-Shima Vision for Global Health" and other major initiatives, the Forum highlighted the power of UHC as mentioned above and committed to strong inter-sectoral collaboration. Furthermore, a forum on promoting healthy and active ageing was held in Kobe, Japan, on the sidelines of the G7 Kobe Health Minister's Meeting in September 2016 with a view toward sharing best practices and research to foster healthy longevity in societies.

The Ise-Shima Summit also paved a way forward for serious discussions on health at the G20 Summit, the premier international forum on economic cooperation, by sending the message that health-related issues have inextricable positive and negative impacts on the economy. The G20 Summit started to shed light on health at the Hangzhou Summit in September 2016, firstly with a focus on the strengthening of response to AMR, the economic impacts of which are particularly concerning, then the 71st UNGA in September did so by organizing the High-level Meeting on AMR in order to further accelerate political commitments. Then, the G20 Hamburg Summit in July 2017 placed particular importance on building a consensus among G20 members to work on and promote cooperation for the three pillars of the health agenda at the Ise-Shima Summit, even with the change of leadership in many G7 countries. As Japan holds the G20 Presidency in 2019, the G20's actions on health are expected to be further materialized under its Presidency.

CONCLUSION

The G7 Ise-Shima Summit was held amid the international expectation for world leaders to address security and economic challenges that are more strongly linked with global health in the face of the Ebola outbreaks and the emergence of NCDs, and to swiftly implement the health-related global goals as the first G7 Summit held after the adoption of Agenda 2030 for Sustainable Development. The G7 Summit and its Presidency in 2016, Japan, had a comparative advantage to respond to such expectation, building on their expertise and experiences of delivering viable solutions with concrete actions to the international community. The G7 Leaders shed light on global health from the aspects of both security and the economy; highlighted the novel concept of "prevention and preparedness" which effectively linked efforts in times of emergency to those in times of calm; offered comprehensive and cross-cutting commitments backed by new frameworks and necessary funding: and swiftly translated those commitments into actions and expanded them to the international community. The "Ise-Shima Approach to Global Health" consolidated by the authors in this article and comprised of the above-mentioned five elements will continue to help global health remain as the Leaders' priority agenda in future international occasions.

Kotono Hara *is government official at the Ministry of Foreign Affairs (MOFA) of Japan, having previously been in charge of the health and other development agendas for the G7 Ise-Shima Summit and then worked on the 2030 Agenda for Sustainable Development. She holds a PhD from University of Osaka (2011), an MPhil from University of Cambridge (2008) and an MBA from Université de Paris I (2003).*

Satoshi Ezoe *was previously the first appointed Senior Coordinator for Global Health at the Ministry of Health, Labour and Welfare (MHLW) of Japan, where he coordinated the health agenda for Japan's G7 presidency in 2016. He is currently Counsellor of the Permanent Mission of Japan to the United Nations in New York covering Global Health. He is a medical doctor with a PhD and holds an MPH and an MPA from Harvard University.*

*This article was written as authors' personal capacities.

---

[1] Kickbusch, I. (2011). Global Health Diplomacy: how foreign policy can influence health. *BMJ*, 342:d3154.
[2] Health Alliance International. (n.d.). *Using Public Health Solutions to End War*. Retrieved August 7, 2017, from https://healthallianceinternational.org/advocacy/war-and-public-health/
[3] Bill & Melinda Gates Foundation. (2016). Preparing for pandemics: how systems, planning and research can protect the world in the next outbreak? *The New York Times*, Retrieved from https://paidpost.nytimes.com/gates-foundation/preparing-for-pandemics.html
[4] World Health Organization. (March 30, 2016). Ebola Situation Report. Retrived August 11, 2017 from http://apps.who.int/ebola/current-situation/ebola-situation-report-30-march-2016
[5] Sands, P., Mundaca-Shah, C., & Dzau, V. J. (2016). The Neglected Dimention of Global Security: A Framework for Countering Infectious-Disease Crises. *The New England Journal of Medicines*, 1-7.

[6] Falk, J. (November 20, 2015). The health impacts of war and armed conflict. Retrived August 9, 2017 from MedAct: https://www.medact.org/2015/blogs/the-health-impacts-of-war-and-armed-conflict/
[7] Rushton, S., Lillywhite, L., & Devkota, B. (2015). Conflict, disaster, and health security. *Lancet*, 94-96.
[8] Munich Security Conference. (2016). Health Security Roundtable Munich: Healthcare under Attack. *Munich Security Conference*. Munich Security Conference.
[9] Munich Security Conference. (2016). Health Security Roundtable Munich: Healthcare under Attack. *Munich Security Conference*. Munich Security Conference.
[10] World Bank. (2017). *Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development*.
[11] World Bank. (April 6, 2016). *Briefing: Ebola Response Fact Sheet*. Retrieved August 11, 2017, from http://www.worldbank.org/en/topic/health/brief/world-bank-group-ebola-fact-sheet
[12] Kickbusch, I. (2012). Twenty-first Century Health Diplomacy: A New Relationship Between Foreign Policy and Health. In I. Kickbusch, & T. Novotny, *Twenty-first Century Health Diplomacy:* (pp. 1-40). World Scientific.
[13] Sands, P., Mundaca-Shah, C., & Dzau, V. J. (2016). The Neglected Dimention of Global Security: A Framework for Countering Infectious-Disease Crises. *The New England Journal of Medicines*, 1-7.
[14] Ibid.
[15] Ibid.
[16] Reich, M. R., Ikegami, N., Shibuya, K., & Takemi, K. (2011). The Lancet Special Series on Japan: Universal Health Care at 50 years. *Lancet* (378), 24.
[17] World Health Organization. (February 2017). *Fact Sheet: Cancer*. Retrieved August 5, 2017, from http://www.who.int/mediacentre/factsheets/fs297/en/
[18] Yach, D., Nishtar, S., & Kalache, A. (2015). The effects of non-communicable diseases and population ageing on health security. *Lancet*, 1891-1892.
[19] Rob Yates, Dhillon, R. S., & Rannan-Eliya, R. (2015). Universal health coverage and global health security. *Lancet*, 1897-1899.
[20] Sidibe, M. (2016). Universal Health coverage: political courage to leave no one left behind. *Lancet*, 355-356.
[21] Summers, L. H. (2015). Economists declaration on universal health coverage. *Lancet*, 1-2.
[22] Jamison, D. T., Summers, L. H., & Yamey, G. (2013). Global health 2035: a world converging within a generation. *Lancet*, 1898-1955.
[23] Summers, L. H. (2015). Economists declaration on universal health coverage. *Lancet*, 1-2.
[24] Reich, M. R., Ikegami, N., Shibuya, K., & Takemi, K. (2011). The Lancet Special Series on Japan: Universal Health Care at 50 years. *Lancet* (378), 24.
[25] Reich, M. R., Ikegami, N., Shibuya, K., & Takemi, K. (2011). The Lancet Special Series on Japan: Universal Health Care at 50 years. *Lancet* (378), 24.
[26] National Security Council of Japan. (December 17, 2013). *National Security Strategy of Japan*. Retrieved August 5, 2017, from Cabinet Secretariat: http://www.cas.go.jp/jp/siryou/131217anzenhoshou/nss-e.pdf
[27] Ministry of Foreign Affairs. (September 2015). Statement by Mr. Shinzo Abe Prime Minister of Japan at the side-event "the Path towards Universal Health Coverage: Promotion of Equitable Global Health and Human Security in the post-2015 Development Era". Retrived August 3, 2017 from Ministry of Foreign Affairs: http://www.mofa.go.jp/files/000102317.pdf
[28] Abe, S. (2015). Japan's vision for a peaceful and healthier world. *Lancet*, 2367-2369.
[29] Headquarters for Healthcare Policy of Japan. (September 11, 2015). *Basic Design for Peace and Health*. Retrieved August 7, 2017, from http://www.mofa.go.jp/ic/ghp/page22e_000761.html
[30] Horton, R. (2016). Offline: Japans daring gamble in an age of apprehension. *Lancet*, 13.
[31] Government of Japan. (May 27, 2016). *G7 Ise-Shima Vision for Global Health*. Retrieved August 17, 2017, from Ministry of Foreign Affairs: http://www.mofa.go.jp/files/000160273.pdf
[32] Government of Japan. (May 27, 2016). *G7 Ise-Shima Vision for Global Health*. Retrieved August 17, 2017, from Ministry of Foreign Affairs: http://www.mofa.go.jp/files/000160273.pdf
[33] Lancet. (2016). Universal Health Coverage - looking to the future. *Lancet vol.388*, 2837.
[34] Inter-Agency Standing Committee. (2016). *Level 3 (L3) Activation Procedures for Infectious Disease Events* (Reference document). Retrived April 5, 2019, from https://interagencystandingcommittee.org/principals/documents-public/final-iasc-system-wide-level-3-l3-activation-procedures-infectious
[35] Shiozaki, Y., Philpott, J., Touraine, M., Gröhe, H. G., Beatrice, L., Hunt, J., Andriukaitis, P. V. (September 16, 2016). G7 Health Ministers Kobe Communiqué. *Lancet*.

THE JIGSAW PUZZLE OF GLOBAL HEALTH SECURITY

Raad Fadaak

This paper traces the uneven and recent history of 'global health security' (GHS) as a conceptual space that emerged in the 1990s, and questions how it is undergoing transformation today. It argues that GHS has shifted - from at one time exclusively referring to revisions occurring to international public health norms (the International Health Regulations), to now marking a complex arena where multiple actors debate and re-consider what counts as both 'preparedness' and measurable health systems strengthening 'action'. This shift is explored here in three ways: (1) by focusing on early landmarks of conceptual change occurring in the idea of 'global health security' across the 2000s; (2) by evincing these changes through a case-study on the Global Health Security Agenda (GHSA); and (3) by highlighting some of the effects that this change introduces in thinking about—and acting on behalf of—GHS. These changes that have taken place over the last decade have far-reaching effects on both global health policy and project development.

INTRODUCTION

This paper traces the uneven and recent history of 'global health security' (GHS) as a conceptual space that emerged in the 1990s, and questions how it is undergoing transformation today – after the 2014 West African Ebola crisis and the announcement of a number of major political initiatives. By outlining a broad arc of conceptual debate surrounding GHS, this paper looks both at enduring continuities and surprising ruptures in the way this idea appears now. It is argued that GHS has shifted - from at one time exclusively referring to revisions occurring to international public health norms, to now marking a complex arena where multiple actors debate and re-consider what counts as both 'preparedness' and measurable health systems strengthening 'action'. The shift in emphasis that has taken place over the last decade has far-reaching effects on global health policy and project development, thus warranting further attention and elaboration.

This shift is explored here in three ways: (1) by focusing on early landmarks of conceptual changes occurring in the idea of 'global health security' across the 2000s; (2) by evincing these changes through a case-study on the Global Health Security Agenda (GHSA); and (3) by highlighting some of the effects that this change introduces in thinking about—and acting on behalf of—GHS. By charting the recent past of GHS, it is hoped the conceptual and practical stakes of the present moment will be clarified.

The initiatives, programs, and policies that adopt the language of 'global health security' today are nearly too numerous to count—each sitting as a piece of a health-security 'jigsaw puzzle'. Although it is widely recognized—and often critiqued—by experts working in the field that GHS is nebulous, defying stable definition or singular meaning, few authors have explored how the concept itself has recently undergone a transformation from a policy/legal framework into a platform for 'acting' in the name of global health. The aim of this paper is not to reveal the bigger picture that emerges once the smaller puzzle pieces are juxtaposed or re-assembled, but to suggest that the new and shifting

pieces that make up the GHS landscape present the possibility of drawing altogether new pictures. The coordinates for global health security have changed, with new pieces fitting together in ways unexpected or unimagined.

The history and the origins of the idea of global health security have been explored in-depth, and at length by others [1,2,3,4,5]; this article does not intend to supersede these studies. Instead, it argues that the making and remaking of GHS introduces new possibilities for designing and executing GHS projects, and as a consequence, constitutes a new manner of thinking about today's global health governance problems. GHS as an idea today evokes a complex history of high-level political urgencies, international legal reforms, and public health emergencies. The idea at once points to an imagined world resilient to the resurgence and increased spread of infectious diseases, alongside a timeline that juxtaposes the global health blunders of Ebola, the 'politicization' of influenza or Zika, the neglect of public health systems, and ongoing debates over vaccine research and development. Although there is no doubt that an earlier legal/normative understanding of GHS persists, the idea today clearly envelops and evokes a much wider collection of problems and issues than simply referring to the major transformations happening in the world of global health governance at the end of the 1990s[i].

Following major events both political and pathogenic, GHS has become an increasingly active domain in global health. But this is not because the field is "new" –the idea was first articulated nearly 25 years ago. However, following the tragic Ebola outbreak in West Africa in 2014, the issue has fundamentally transformed. It has taken on a pressing imminence, importance, and sense of novelty, gaining significant attention and investment by a broad collection of both national and international (or "global") actors. If the fiasco of Ebola provided the rallying cry, the renewed relevance and importance of GHS has been a major rallying point. Dr. Peter Piot, the original "discoverer" of the Ebola virus in its first known outbreak in the 1970s, once went as far as to declare that GHS was "created" in 2014. There are many reasons to disagree with Piot, but his statement illustrates the aura of newness and importance surrounding GHS in recent discussions.

A palpable sense of excitement for global health security drives a continued influx of novel actors and stakeholders to support and engage with the idea. Such excitement no doubt produces its own kind of infectiousness, but the idea is also facing a significant moment of precarity in an uncertain political climate. In both instances, the fundamental stakes of GHS as a priority cannot be grasped without a critical attunement to the recent history of this idea. A closer look is thus warranted that highlights these subtle changes, in hopes of better understanding just how the idea of global health security seen today at once responds to— and produces—a changed world.

A BRIEF HISTORY OF GHS, PART I: GLOBAL THREAT: GLOBAL RESPONSE

Beginning in the early 1990s, a new manner of articulating the threat posed by pathogens, infectious diseases, and epidemics took shape. A story now told many times over, 'global health security' (GHS) emerged at this moment as a novel problem-space and governance challenge in response to new 'global' circulations and intensifications of

[i] See Fidler, D. P. (2005) From international sanitary conventions to global health security: the new International Health Regulations. *Chinese Journal of International Law*, *4*(2), 325–392.

infectious disease[ii]. Further marked through the 2000s by major epidemic events, 'global health security' appeared both as a manner of identifying major reforms to global health priorities and regulations, and as a normative device orienting the expectations of nation-states to health governance problems[6].

Relying on the concept of 'emerging infectious diseases', in the early 1990s the World Health Organization (WHO) and public health experts argued there was a "global crisis…[looming] over humanity"[iii,7]. It was at this moment that the WHO and others positioned the "spread of communicable diseases [as] a transnational issue"—a new "global threat…[requiring] a coordinated, global response"[8]. The form such a 'global response' took in this decade between 1995-2005 occurred primarily at the level of policy and regulatory norms, as the WHO overhauled its principal legal instrument: the International Health Regulations (IHRs). The tumultuous decade-long process of this revision has been analyzed carefully by many others.[9,10,11,12] For the purposes of this article, it is more important to point to the widespread recognition that the ideas that underwrote the new IHRs represented a distinct rupture at the level of international relations and global health governance. For some, this moment marked the "death of the traditional…approach to international infectious disease control."[13] For others, it was the birthplace of a new 'regime' of global public health—what is commonly today called global health security.[14,15,16] In either case, at the turn of the century 'health security' became a principal formation situating an 'emerging global agenda' for public health, one that would challenge "traditional conceptions of the citizen, the state, and international relations"[17]. In doing so, the usage and understanding of GHS during this time became tightly coupled with the process of revising the IHRs—a platform to discuss and articulate new legal requirements and responsibilities of states to a 'global' space, brimming with infectious diseases that paid no mind to the political constraints of diplomatic agreements or national borders.

With the publication of these revised IHRs in 2005, GHS became formally attached to the burgeoning domain of 'global health' and surfaced as a conceptual problematic in its own right. Along with the SARS outbreak in 2003 and the avian influenza anxieties of the following years, global health security – at least as it was embodied in the new IHRs – resonated with the WHO and its member states who shared deep concerns in developing the means and technologies to control the global circulation of infectious diseases[iv]. The coupling of prominent attention to these epidemic events, and the major changes underwriting the new IHRs, GHS became emblematic of the calls for a 'global response' to infectious diseases, a conceptual, legal, and governance approach categorically different from the international frameworks that came before it.

Nevertheless, despite both high-profile outbreak events and significant legislative attention at national and global levels, the new IHRs failed to transform into material and practical commitments to public health capacity building and preparedness, with a large majority of WHO Member States either asking for compliance deadline extensions, or failing to report to the WHO at all[v]. Although it is important to ask why these regulations

[ii] See Elbe, 2010; Fidler, 2005

[iii] For a thorough history and analysis of the idea of 'emerging infectious diseases', see King 2002 and Lakoff 2010.

[iv] Davies et al. (2015) call this the period of "norm cascade" of the Regulations, utilizing the political theory of norm development and diffusion.

[v] See e.g. Davies et al., 2015 and Fischer and Katz, 2013

failed to generate tangible commitments, as has been done elsewhere, it is equally important to recognize that the 'shortfalls' in compliance to these new norms were now articulated as GHS issues or challenges. In other words, it was only against this new backdrop of 'global health security' that one could situate expectations of state behavior and responsibility, and recognize or identify a 'shortfall' in compliance to the norms set out in the IHRs. In this way, it was really in the latter part of the 2000s, when the deadlines for IHR compliance were coming to pass, that a certain legal/normative component of GHS became crystallized and recognizable.

This period of the early 2000s witnessed a great number of important convergences between early GHS projects: the WHO IHR revisions (1995-2005); the signing of the G8 Global Partnership Against the Spread of Weapons and Materials of Mass Destruction (2002); and the related formation of the Global Health Security Initiative (2001). As a result of these initiatives, as well as the epidemic events that flickered across the 2000s and the 2001 American anthrax incidents, GHS quickly became something more than simply a call to revise and adhere to the IHRs. As Fidler and Gostin (2008) have detailed, GHS came to describe a broad set of programs aimed at prioritizing the strengthening of immediate alert, response, and preparedness for disease outbreaks, attacks from biological/chemical weapons, and other natural incidents. Intersecting with a post-Cold War commitment to 'threat reduction' and non-proliferation, health security was later to be prioritized as a legitimate international security concern[18].

Much has been written about this productive nexus of 'health' and 'security', although perhaps less attention has been paid to how the broader intersections of health-security and international norms like the IHRs have informed specific projects and programs across governmental and non-governmental organizations. In any case, as it became clear from the formative moments in the early 2000s, GHS as a conceptual and practical field would reshape possibilities for thinking and acting on global/public health, not only through its 'securitization', but by reframing the responsibilities and demands presented by the 'global', and the type of 'humanity' that constituted it [19,20,21]

A good many scholars have treated 'global health security' today much as if it has remained a static issue since this tumultuous period; as if the same problems, players, and projects that came together in the early 2000s still persist. While there have been continuities in both thinking about and programming for health security issues in the United States and further abroad, this article suggests that there has been a substantive conceptual discontinuity separating this early legal/normative formation of global health security that originated the early 2000s and the global health security seen today following Ebola and Zika. These conceptual and practical discontinuities are non-trivial, changing both the kinds of projects made possible under the umbrella of GHS, but also enabling strategic and often surprising re-articulations of these issues across global health sectors.

Clearly the IHR revisions and the obligations they imparted to nation-states were only the beginning of a much larger project. As has become acutely obvious in the years after the West African Ebola outbreak, beyond legally-binding Regulations in the form of the IHRs, global health security encompasses a great many debates, discussions, and projects that cross both scalar and diplomatic domains [vi]. The idea has greatly expanded

[vi] See e.g. Heymann et al., 2015

the reach of its interpretive policy communities, becoming a preeminent forum to discuss and debate the aspirations to a better state of global health and health system resilience. More recently, it has become a cornerstone of the WHO's focus on 'universal healthcare' under its new Director General, Dr. Tedros Ghebreyesus.

Since the later part of the 2000s, global health security has not only fundamentally re-situated the responsibilities for individual nation-states to address public health emergencies, but has significantly altered the possibilities of designing political initiatives to tackle 'global' vulnerabilities to emerging infectious diseases. In the words of GHS proponents, the issue has resituated the "reciprocal obligation[s] between all nations"[vii]. Regardless of its many meanings, GHS has changed how preparedness projects and international norms are constituted and connected with one another—but also what kinds of governance effects they will have, and what kinds of policies, projects, and possibilities they carry with them[viii]. As an extension of this, GHS has become a decisive site to debate and discuss the category of the 'global' both as a threat and as a mode of response, an issue dealt with further in the following sections.

If, as argued here, global health security originated primarily in an international legal space—i.e., as a project to establish and promote country adherence to new international norms—today it has transformed into a concept that far exceeds its legal or normative origins. What effects are then introduced when GHS as an idea or problematic expands beyond the space of international law and transforms into a multiplicity of global health projects, ranging from country assessments, national action plans, service delivery, capacity-building, or research and development?

A BRIEF HISTORY OF GHS, PART II: THE RISE AND FALL (AND RISE, AGAIN) OF GHS

To tell the story of global health security as the slow unfolding of an inevitability is to betray its rather precarious recent history, one rife with contestation and debate. Global health security did not emerge—nor does it persist—as a unified package of projects, imaginaries, or visions about the future of global health governance. Nor was it clear to early GHS architects, such as the WHO's David Heymann, that the idea would endure as worth debating after the revised IHRs had been adopted in 2005. The epidemic events across the 2000s, Ebola, and recent GHS projects such as the Global Health Security Agenda have, in many ways, smoothed over this rather uneven history of the idea, changing not only the terms of the debate on GHS, but the manner by which its history is remembered[ix]. Recent political events, which exceed the scope of this review, have again cast the idea into doubt, drawing further attention to the precarity of the domain.

[vii] Quote pulled from the Statement In Support of Extending the GHSA Beyond 2019, available online at https://www.nti.org/documents/2202/In_Support_of_GHSA_Extension_GHC_GHSAC_PSRT_NextGen_July_18_2017.pdf

[viii] It is important to reiterate that the differences here made between the 'legal/normative' dimensions and the project-oriented understandings of GHS are neither incommensurable, nor are they absolute. See e.g. Nading, 2015; Hinchliffe et al., 2013; Mykhalovskiy and Weir, 2006; Rushton and Youde, 2015.

[ix] To some, the very suggestion that the phrase "global health security" did not appear in any major publications before 2001, and very rarely before 2007, is hardly believable. Indeed, this article is an attempt to consolidate important accounts of the very recent history of this phrase and the ideas that underwrite it. Such accounts reveal that what falls under the aegis of GHS today is substantively different than the idea circulating at the turn of the century predominantly within the WHO and between Ministers of Health working with the Global Health Security Initiative.

In a comprehensive paper published in 2015 by The Lancet, a super-group of global health experts offered their reflections on the concept during the twilight of the Ebola epidemic, arguing that "out of [the] human calamity has come renewed attention to global health security—its definition, meaning, and the practical implications for programmes and policy"[22]. Alongside deep criticisms of the WHO's leadership and performance record, they note that global health security has been renewed as a platform that encompasses issues as diverse as migrant health, pharmaceutical governance, and universal healthcare. However, according to most of these analysts, the core of the idea — the 'protection of the health of people and societies worldwide' from infectious diseases and other health threats, has remained the same since the mid-1990s[x]. As the Lancet paper argued, "the moment for global public health systems development is now", a statement that suggested the concept of GHS would embrace a renewed initiative for recovery and repair following the havoc caused by Ebola (Heymann et al., 2015: 1890). Broadly speaking, global health security was *the* "lesson learned" from the West African crisis, with health system strengthening, surveillance technologies, epidemic preparedness efforts, and now health sector recovery established as the preeminent means by which global and country health experts work to operationalize the tenets of the concept[xi].

But the story is not so simple, and writing about GHS as a new "regime" of global health—as has become fashionable—is misleading (Hoffman, 2010; Lakoff, 2010; Davies et al., 2015). As noted, there is no doubt the concept has greatly enlarged its catchment, moving to encompass a large subset of global health initiatives. However, it has been—and is still—met with deep criticism and ambivalence from both academics and public health experts alike, seen as greatly "distorting" the global health agenda through its conflation of the politics of security with the activities of public health (Stevenson and Moran, 2015; Rushton, 2011; Lachenal, 2014; Aldis, 2008). Within this contested space, one could say the concept has taken on the life of a fable as much as a regime: "Once upon a time," writes the Lancet supergroup, "global health security was an innovative idea that produced a strategy resulting in historic changes in global health politics, governance, and law. After the Ebola outbreak, the novelty is gone, WHO is discredited, the changes have proved inadequate, and the strategy is in shambles"[23]. Yet, from these "shambles", Heymann and his influential coauthors have imagined a transformation in the "political, institutional, and legal pillars" of the strategy — a strategy they nevertheless suggest "has never been more uncertain"[24]. Whether the GHS initiatives underway today prove to be the means for this transformation remains to be seen. In this case, it appears that these proposed global health projects are at least as precarious as the humanity they intend to protect.

With the Ebola crisis in West Africa erupting only months after the United States launched its Global Health Security Agenda, global health security was no longer exclusively about the 'prophecy' of the inevitable next pandemic, but the one occurring under our noses [xii]. The concept quickly re-emerged during the Ebola outbreak, appearing as a discussion point throughout global health, policy, and academic communities. The

[x] See Frieden and Weber, 2014; Weir, 2015

[xi] For governance considerations of GHS after Ebola, see the Spring 2016 issue of *Global Health Governance*, available online at http://blogs.shu.edu/ghg/2016/04/25/ebola-implications-for-global-health-governance-toc/, accessed 18 July 2016.

[xii] See Caduff, 2015

epidemic itself was absorbed into the broadest levels of policy discourse, placed neatly within a narrative timeline of 'emerging disease events' following after SARS, the influenza anxieties of the 2000s, and more recently Middle East Respiratory Syndrome (MERS). With disease emergence now seen no longer as possibility but inevitability, Ebola changed the parameters of the conversation. A windfall to the concept and its related initiatives, there is no doubt the West African crisis brought both immense attention and financial resources to the table, highlighting the tragic stakes of fragile country, regional, and global health systems. 'Global health security' readily gave voice both to the frustrations of a world met unprepared, and the urgent demands to take action to prevent such crises from happening again.

Publishing a list of 'ten essential reforms before the next pandemic', a joint Harvard/London School of Hygiene and Tropical Medicine report argued that "the Ebola outbreak is a stark reminder of the fragility of health security in an interdependent world, and of the importance of building a more robust global system to protect all people from such risks."[25] In the post-Ebola scramble, major global health institutions and WHO Member States are committing to setting actionable targets and aligning priorities to combat the ever-present, global emerging disease threat. Central in this effort is the recasting of public health emergencies as humanitarian events, requiring pooled funds, expanded public health workforces, and reformed response platforms.

Seen as 'health security' events, these epidemics—with Ebola proving to be the most momentous and corroboratory—have all been decisive in transforming the contested concept of GHS into a prominent arena by which key actors have articulated reforms for global health policies, initiatives, and governance. With a second outbreak of Ebola in the Democratic Republic of the Congo (DRC) in as many years, we have seen how some of these new platforms—such as the World Bank's new Pandemic Emergency Financing Facility and the WHO's Health Emergencies Programme—have changed the landscape of global epidemic responses. In the words of Davies et al. (2015), it is in this way that GHS has become "the most high-profile, and arguably the most successful, example of sustained political engagement along foreign, security, and health policy communities" (2). Although Heymann's retelling of a checkered history of the idea does not coincide with Davies' depiction, both seem to address the tensions of the present moment in global health security: a domain stressed politically, but increasingly important and prominent to the global health space. There is no doubt that the idea has surged with interest, financing, and commitment since the tragic events in Liberia, Guinea, and Sierra Leone, even if the US Government has not been consistent in its support of the idea.

Nobody felt the post-Ebola windfall for GHS as strongly as Dr. Thomas Frieden, then-director of the US Centers for Disease Control and Prevention (CDC), and an early advocate for GHS as a political priority. As he argued in 2015 at a Public Health 'Grand Rounds' event held at the CDC Headquarters in Atlanta, "global health security is the next big thing in public health."[26] With around $1.77 billion in funding given to his organization as a result of Ebola in 2015, his argument seemed valid[xiii]. Frieden's statement, like Piot's quoted earlier, gives the impression that GHS is a novel framework, which as we have seen is not entirely correct. Quoted earlier, the former WHO Director

[xiii] Note that of this $1.77 billion, $567 million USD was dedicated to the domestic US response to Ebola cases. For a detailed breakdown of GHS funding in 2017, please see Boddie, Watson, and Sell (2016): http://online.liebertpub.com/doi/abs/10.1089/hs.2016.0063.

General Hiroshi Nakajima was vocal back in the late 1990s in arguing that 'global disease threats' would fundamentally change foreign policy and 'global health issues' (Nakajima 1997). Almost eighteen years later, the policy language has not changed significantly.

But perhaps Frieden was speaking about a different kind of global health security. He was most certainly speaking to a world changed and enraged by Ebola, unable to rely on the WHO's leadership or stewardship of global health security[27]. It is this transformation in meaning that gives GHS the feeling of something 'big', or of something both oddly 'new' and somehow timeless—a puzzle whose pieces rearrange themselves just as quickly as they seem to interlock.

FROM 'NORMS' TO 'FORMS': THE GHSA

In order to exaggerate and highlight some of these transformative effects, it will help to analyze one particular initiative as a case-study in the changes happening to global health security. For our purposes here, there are no better initiatives than the Global Health Security Agenda (GHSA). The GHSA has been exemplary as it happens to be one of the most prominent and visible programs in the contemporary GHS landscape, putting into relief some of the broad conceptual questions raised thus far. As a case-study in health diplomacy and GHS politics, the GHSA brings forward some of these subtle shifts in GHS as an idea, illustrating that the concept today is just as important for the various formations of experts and programs it precipitates as the legal norms it attempts to strengthen.

One might point out, however, that GHSA originated precisely as an initiative to combat stagnation in country preparedness and capacity building. In early 2014, partially as a response to the recognition of a 'shortfall' of IHR country compliance, the United States White House formally launched the initiative, designed to mobilize both 'political will' and resources for health emergency preparedness and response. The Agenda promoted a three-pronged strategic focus that has now nearly become mantra—'Prevent, Detect, Respond'—and offered a strong push to "elevate political attention…to IHR core capacities and other GHS frameworks."[28] Designed as a five-year multisectorial initiative, its intention was to bring together diverse technical and political platforms under a strategic framework for securing human and animal health at global scale.

The deft hybridization of both pre-existing and novel targets and indicators drove its twin horses of multilateral global health diplomacy and international 'capacity-building'. The GHSA was, in short, an effort to build both a global culture of accountability alongside a series of interoperable, capacious health systems—ones capable of preventing or mitigating the impact and spread of infectious diseases, dangerous pathogens, and attacks from biological weapons[29]. In the words of its architects—Frieden chief among them—it had the vision of a "world safe and secure from global health threats posed by infectious diseases", achieved by strong individual country preparedness, but additionally in the interconnection of health systems at a 'global' level[30]. As its advocates argued at its launch, it "gathers, elevates, and shines a bright light on a series of deeply important issues that do not necessarily receive the attention or the international collaborative effort they require."[31]

Although it was one of the few major initiatives launched during the Ebola outbreak rather than proffered as a response to it, the GHSA has become one of the highest-visibility programs aimed at translating global health security from a set of legal

requirements into specific, actionable global health projects. At a launch event hosted by the Center for Strategic and International Studies (CSIS) in February 2014, Laura Holgate of the US National Security Council brought this changed approach to the foreground, noting that during the formulation of the GHSA: "we [the designers of the GHSA] really challenged ourselves to define in concrete terms - what does 'global health security' really mean…how will we know when we get there, and how do we measure our steps along the way?"[xiv]

Clearly the GHSA was, from the outset, just as interested in developing the steps and actions necessary to adhere to international norms as it was in articulating or 'enforcing' the norms themselves. There is no doubt this was a departure from the former understandings or uses of 'global health security' as an idea: no longer merely as an index of dramatic legal/normative changes at the level of international health politics, nor merely a curious meeting of public health and security worlds[32,33,34] Instead, there has been a subtle shift to reconfigure such norms into intermediary mechanisms and targets by which countries might act both 'in their own interest' and for the 'global' commons. The mechanism of this translation under the GHSA has been the adoption of broad technical set-pieces, an umbrella of 11 "Action Packages" that allow countries to voluntarily contribute expertise, programming, and specific commitments over the five-year duration of the initiative[xv]. In this case, a technical 'development' platform has attempted to transform global health security into discrete mechanisms and guidance for country and private sector 'action' rather than a collective problem of inaction.

The 'technicization' of GHS under the Agenda has, for some, produced mixed results. There has been worry that these targets occlude as much as they reveal the bigger problems and challenges of global health security today—mistaking the puzzle pieces for its bigger picture. Thus, an initiative that was intended to break open "silos" has in many cases, replaced them with 'packages'—technical blinders that keep actors and participating countries focused on discrete indicators rather than coordinated 'horizontal' systems strengthening efforts. As GHSA stakeholders shift the terms of debate and discussion, pushing to broaden and "unsilo" the initiative with new mechanisms or instigators of action, it is worth pointing out that the very problem of designing and instigating 'action' itself reveals something important: that along with the GHSA, certain forms of necessary GHS action have been put on the table, and that these actions are becoming largely constitutive of how global health experts understand GHS today. One can see this similarly in the newly fashioned IHR Monitoring and Evaluation Framework, which prioritizes not only transparent external country assessments with the Joint External Evaluation tool, but developing National Action Plans to address weaknesses and gaps in country capacities. To understand and agree upon what exactly 'action' means in this context has been a continued challenge, one addressed in the section below.

The GHSA is thus helpful—but by no means unique—in focusing attention on how the search for 'meaningful action' can also highlight changes happening at the level of international relations and health governance. The Agenda helps situate how GHS has fundamentally changed its conceptual foundations, expanding into a platform to develop and elaborate technical programs and projects for countries and non-governmental partners engaged in health systems strengthening and capacity-building. Branded as a

[xiv] https://www.youtube.com/watch?v=9pFjSDdRtDk, accessed 10 July 2016.
[xv] Details on the Action Packages can be found online at https://ghsagenda.org/packages.html, accessed 18 July 2016

'multi-partner initiative', the GHSA—both as a policy set-piece and as a technical platform—sits as a reminder of the consequences of 'unpreparedness' and as a way imagined to finally do something about it. It has been perhaps the most concrete initiative integrating and extending these principles and commitments, transforming such engagements from legal norms and policy-dialogues into policy-projects.

With the GHSA and the various other initiatives leveraging GHS today, there is much more at stake than either the WHO's efforts to revise the IHRs or to reform its responses to public health emergencies. It is with the GHSA and the myriad of other post-Ebola initiatives that GHS is becoming not only a new manner of articulating the possibilities and responsibilities of global health actors, but an altogether different manner of acting upon and framing global health problems. That is, under GHS today, the form global action can take has significantly changed. Here, the GHSA helps us mark a pivotal moment not only in the emergence of new conceptual debates about the position of public/global health norms, but further in a transformation of global health security from a primarily discursive security framework into a concrete problem-area requiring the elaboration of material, technical, and human infrastructures and technologies.[xvi]

To summarize: where global health security once stipulated what should be done at the level of international legal and regulatory reform, it later came to term as a way to talk about what had not been done in the wake of the new country requirements of the IHRs. Today it predominately appears as a form of asking what can be done to craft a future better prepared for epidemic events and other public health emergencies. None of these senses or uses of GHS are exclusive, and they do and will continue to coexist in all areas of discussing this critical issue. But a conceptual shift has no doubt occurred; one subtle but significant, changing the manner which global health actors might imagine their roles in, and capacity to act on behalf of, this global project[xvii].

COMMITTED TO 'ACTION'

The United States Centers for Disease Control and Prevention (CDC), a leading technical coordinator under the United States' waning commitment to the GHSA, has likewise been at the forefront of translating GHS from 'commitment to action'. Managing over 36 organizations in over 26 countries, it has overseen a great number of GHS technical programs facilitating public health capacity building efforts. Beginning in February 2016, the CDC began publishing GHSA "Action Stories" on its website, presenting short vignettes that "illustrate the day-to-day work being done by CDC and its country partners to implement the GHSA across the globe"[xviii]. Like the prominent tale of the Nigerian polio facility quickly repurposed to control an unexpected Ebola outbreak, the CDC's GHSA Stories give us glimpse into the curious mélange of infrastructures and technologies that

[xvi] See Harman (2016) for a critical appraisal arguing that Ebola revealed that "norms alone are not enough to deliver global health security" (15). Her essay exemplifies this shift in understanding GHS as something much more than simply normative or legal reform.

[xvii] This does not mean to suggest that GHS is extra-legal or irrelevant to the law, per say. In fact, many lawyers working in this area would argue the law is applicable to all aspects of global health security, including the packages outlined by the GHSA. Instead, the argument that the *law should apply itself to GHS problems* suggests a subtle, but important change in perspective: that GHS itself is not *legal in essence*. That is, GHS itself does not describe purely the legal processes and components of international regulatory reforms or enforcement.

[xviii] http://www.cdc.gov/globalhealth/security/stories/default.htm, accessed 15 July 2016.

today represent 'global health security', admixtures of a recent history reconfigured to control the urgencies of the present[xix,xx].

As argued here, this elaboration of global health security as something more than purely a normative, legal "commitment" has put into question the basic parameters for thinking about, and acting upon global health. Transparent assessments under the Joint External Evaluation tool are seen as necessary, but insufficient without follow-up National Action Plans. But even before (or if) GHS "commitments" actually turn into measurable or quantifiable GHS "actions"—something significant has happened to the way that health-security problems are posed at a global level. The demands made for accelerated implementation, resource mobilization, and tangible outputs have produced changes to the conceptual frameworks for thinking about the intersections of risk, disease, vulnerability, and the global responsibilities to these categories.

RETHINKING THE 'GLOBAL' IN GHS

One consequence of these changes has been a recalibration of how the 'global' ought to be thought or legislated, as GHS debates once again re-situate who will be responsible for global disease issues, as well as what kinds of interventions, practices, and possibilities they demand from individual countries. By changing the parameters of what constitutes and how one thinks about global health security, another shift has consequently taken place – a shift in how to act on behalf of the 'global' and the 'national' which these projects aim to at once protect and police. Thus, in addition to asking how these diverse technical and political initiatives are changing the principles of disease management and control, it should also be asked how the GHS constitutes the 'global' not only as a domain of public health protection, intervention, or governance, but also as a project-space—one that requires not only "commitments" at a formal level, but concrete and coordinated forms of management and technical programming.

Even after its disruption in 2016, GHS as an idea still appears both as a vestige of a transformative moment in global health thinking and as a horizon of global health promises and aspirations. Organizations both governmental and non-governmental speak about the concept in many senses, yet woven into these visions is a new understanding of the 'global' in global health—as a distinct sphere to be protected by the collective work of GHS stakeholders acting in 'globalized concert'. As noted above, plenty of scholarship and commentary has focused on unpacking and critically examining 'health' and 'security' in GHS, but very few pieces have taken a close look at what kind of 'global' this concept invokes.

Global health security has been and is still one of the preeminent sites to witness and document the processes and debates that reshape the possibilities for thinking and acting 'globally'. Biological threats have posed a unique challenge to ideas of governance at least since the problem of 'emerging infectious diseases' took off in the 1990s (King 2002). Since at least this period, arguments have suggested that there is a "need to move

[xix] One might also wonder whether telling stories about global health security itself constitutes a form of 'action'. Certainly advocacy, here in the form of narrative publicity, has become a critical component in the work of a number of health security stakeholders.

[xx] For the Nigerian polio facility repurposed during Ebola, please see http://www.cdc.gov/globalhealth/security/stories/nigeria-prepared-for-outbreaks.html; Vaz et al. 2016; and Shuaib et al. 2015.

beyond traditional national and international strategies and to globalize governance…[by developing] strategies tailored to the globalized nature of biosecurity threats" [35] Such pressure to respond 'globally' to the 'global' has only increased after Ebola and its attendant fallout.

A commissioned assessment of the WHO's response efforts during the Ebola crisis stressed the importance of such a 'new governance world', one that imparts new collective responsibilities — articulated under a novel concept of "shared sovereignty" (World Health Organization, 2015: 10). The report notes that while "health is considered the sovereign responsibility of countries, the means to fulfill this responsibility are increasingly global" (ibid.). As the editors of the Lancet likewise commented in a special issue devoted to the topic of GHS, "to reach a fuller and richer understanding of health security, governments [and others]…might also argue that each of us has an affiliation to the larger world we inhabit—a global identity that demands global solutions through cooperation between nations" [36] Across these discussions, there is an obvious and tight coupling between health-security and the 'global'—presented as both a challenge to governance and the means for finding ways to presumed betterment.

It is clear that what is meant by 'global' in these contexts is fundamentally different than the 'global' imagined in the late 1990s and early 2000s when public health was first 'globalizing'[xxi]. Rather than simply marking a 'world-encompassing' or 'trans-boundary' space, the 'global' here appears both as a form of political identification (i.e., a "global identity") and as a domain of responsible state action (i.e., a "means to fulfill responsibilities" through "global solutions"). Further, where the WHO was once seen as a summative institution to coordinate, manage, and oversee 'global health security' through its process of revising the IHRs, today's GHS debates upset this dynamic. GHS has instead become a domain of global health action that is preeminently 'multisectoral'—involving multilateral, bilateral, national, non-governmental, and private sector 'players'—in terms of its scope, design, and responsibility. It is worth recognizing that non-state actors are no longer auxiliary agents to GHS—mere 'sources of information' for the WHO, for instance—but instead have become its principal executors.

In this way, GHS is not only a key site to examine the debates, discussions, and differences introduced into the world of public health governance and policy, but a critical arena to examine the emergence of a specific understanding of the 'global' as an epistemic, infrastructural, and ethical challenge—one that exceeds the capacities of individual, sovereign nation-states to address or manage. The earlier understandings of GHS relied on an 'internationalism' that was about sharing techniques and developing guidelines for national action through the development of new inter-national 'norms' of disease control—i.e., the revised IHRs. Today's debates are different precisely in that, to paraphrase the human rights scholar Samuel Moyn[37], they "introduce the global forum itself a scene of intervention or reform", as a site of collective state/non-state action and problematization.

As Davies et al.[38] argue, the legitimacy of the new norms and responsibilities imposed on states through the IHRs and GHS are, for the most part, no longer critically debated. Rather, state responsibilities have become primarily about developing the "material capacity to carry out the actions required of them, through having the surveillance, detection, and communication structures that are essential to fulfilling their

[xxi] See Fidler, 1997

obligations". We have seen already that the question of addressing and overcoming "material challenges to compliance" has been central to the discussions happening as the GHSA has progressed, and new outbreaks of Zika and Ebola have emerged. Even after a disruptive 2016 presidential election, we are still seeing a "proliferation of global health security organizations, new instruments of foreign policy" alongside various "flexible partnerships" of private and public institutions[39]. Although there are vastly different conversations happening at each of these junctures, the problem of 'global action' currently runs through each of them. Thinking through the lens of global health security at this critical moment, it is important to ask how, and by what means, the global must be defended—and what kinds of responsibilities, possibilities, and challenges are inspired by this particular vision of the 'globe' at the heart of global health security today.

A "JIGSAW PUZZLE" OF HEALTH SECURITY FRAMEWORKS

The persistence and endurance of GHS as an orienting device for public health attention has thus transformed this concept from a very specific legal-normative project within the WHO into an 'amorphous' collection of interests, projects, and visions for how best to prepare a world threatened by public health emergencies. While many lament this lack of singular definition, suggesting the concept finds "widespread but inconsistent use"[40], for others, this interpretive flexibility has been a central reason for its longevity and expansion across private, public, and non-profit sectors. In this way, GHS works as what sociologist of science Susan Leigh Star[41,42] once called 'boundary objects'—"arrangements that allow different groups to work together without consensus"[43]. Most importantly, these boundary objects provide various expert communities both interpretive flexibility and a common language of deliberation, giving rise to ideas like 'shared sovereignty', novel forms of 'globalism', and an elaborate manner of rethinking health security 'actions'. Whether expounding criticism for the imprecision of the concept, or celebrating its ability to solicit contributions from sectors normally left outside the negotiating table, many recognize 'global health security' as something to work "toward and with", to again use Star's words[44]. All this is to say that GHS clearly does not hover untethered to the world, an abstract concept debated in the airless halls of the WHO or the UN and inconsequential to the rest of those working in global health. As the concept pushes outward with a focus on 'action' in the form of tangible deliverables and 'work products', we are clearly on the cusp of seeing exactly what GHS might do to the world it is so intent on preparing and protecting.

None of this should suggest a coherent, consistent collection of actors or actions in this domain. Health-security as a nexus still invites an uneasy, tenuous convergence of experts who often work perpendicular to one another. Organizations and actors lose interest, while others remain uninterested in the idea, worrying about the connotations or consequences of 'security' remaining part of a global health program. And, of course for those who do take up the issue, the puzzle pieces multiply briskly: the WHO has been actively and rapidly reforming its mandate and organizational structure in response to criticisms leveled at it for its lackluster response to the Ebola crisis; the UN has produced a number of framework documents aimed at addressing global vulnerabilities to disasters, including biological threats[xxii]; the World Bank recently launched and deployed

[xxii] e.g. the Sendai Framework for Disaster Risk Reduction 2015-2030

its Pandemic Emergency Financing Facility for the first time in the DRC; the Coalition for Epidemic Preparedness Innovations (CEPI) has been actively engaged with catalyzing research and development for vaccines; the U.S. National Academy of Medicine put together its "Global Health Risk Framework for the Future", an initiative providing recommendations for revising the architecture of global health in the wake of Ebola (see Sendai Framework). The list multiplies; these represent just a few of many political initiatives—national, bilaterial, and multilaterial—that address biological risks as the target of global health policy and programming.

Once again, to look for a larger 'global health security' picture emerging from all of these puzzle pieces seems not only Sisyphean, but misguided. More important is the task of depicting a changing GHS topography; a new terrain of problems, challenges, and proposed solutions that change the way we think about the world and global public health's role in its safeguarding. It is for this reason that attention should remain not only on the emergent diseases and on the threats they pose, but on emergent institutions, partnerships, policies, and potentials that make up the changing landscape of global health security today. Global health security continues to shift the terms of debate, of dialogue, of *how* and *what* one can do to act on global biological risks and threats. On those terms, it has fundamentally changed the world it has sought to protect.

Raad Fadaak *recently obtained his PhD from McGill University in Medical Anthropology. For his dissertation research, he worked for the Seattle-based NGO PATH as a Special Projects Officer with their Global Health Security Partnership. His dissertation focused on global health security, health policy, global governance, public health preparedness, and health systems development. Raad now works with University of Calgary's School of Public Policy on Antimicrobial Resistance and health systems quality improvement. He continues to explore health security issues through hands-on project management and development, research, teaching, and publication of analyses and commentaries.*

[1] Weir, L. (2012). A Genealogy of Global Health Security. *International Political Sociology*, *6*(3), 322–325.
[2] Weir, L. (2015). Inventing Global Health Security, 1994-2005. In S. Rushton & J. R. Youde (Eds.), *Routledge handbook of global health security* (pp. 18–31). Milton Park, Abingdon, Oxon; New York, NY: Routledge, Taylor and Francis. Retrieved from http://public.eblib.com/choice/publicfullrecord.aspx?p=1761961
[3] Rushton, S., & Youde, J. R. (Eds.). (2015). *Routledge handbook of global health security*. Milton Park, Abingdon, Oxon; New York, NY: Routledge, Taylor and Francis. Retrieved from http://public.eblib.com/choice/publicfullrecord.aspx?p=1761961
[4] Kamradt-Scott, A. (2015). Managing global health security : the World Health Organization and disease outbreak control. Retrieved from http://www.palgraveconnect.com/doifinder/10.1057/9781137520166
[5] Davies, S. E., Kamradt-Scott, A., & Rushton, S. (2015). *Disease diplomacy: international norms and global health security*. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=882676
[6] ibid
[7] Nakajima, H. (1997). Global disease threats and foreign policy. *Brown J. World Aff.*, *4*, 319.
[8] World Health Organization. (1995). *Communicable Disease Prevention and Control: New, Emerging, and Re-Emerging Infectious Diseases* (Provisional Agenda Item 19 No. A48/15). Geneva, Switzerland:

World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/177496/1/WHA48_15_eng.pdf
[9] Kamradt-Scott, A. (2015). Managing global health security : the World Health Organization and disease outbreak control. Retrieved from http://www.palgraveconnect.com/doifinder/10.1057/9781137520166
[10] Fidler & Gostin, L. O. (2006). The new International Health Regulations: an historic development for international law and public health. *The Journal of Law, Medicine & Ethics*, *34*(1), 85–94.
[11] Davies, S. E., Kamradt-Scott, A., & Rushton, S. (2015). *Disease diplomacy: international norms and global health security*. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db
[12] Katz, R., & Fischer, J. (2010). The Revised International Health Regulations: A Framework for Global Pandemic Response. *Global Health Governance*, *3*(2), 1–18.
[13] Fidler, D.P. (2005). From international sanitary conventions to global health security: the new International Health Regulations. Chinese Journal of International Law, 4(2), 325–392.
[14] World Health Organization. (2007). *A Safer Future: Global Public Health Security in the 21st Century* (World Health Report). Geneva, Switzerland.
[15] Weir, L. (2012). A Genealogy of Global Health Security. *International Political Sociology*, *6*(3), 322–325.
[16] Lakoff, A. (2010). Two Regimes of Global Health. *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, *1*(1), 59–79. https://doi.org/10.1353/hum.2010.0001
[17] Fidler, D. P. (1997). The Globalization of Public Health: Emerging Infectious Diseases and International Relations. *Indiana Journal of Global Legal Studies*, *5*(1), 11–51.
[18] Koblentz, G. D. (2010). Biosecurity Reconsidered: Calibrating Biological Threats and Responses. *International Security*, *34*(4), 96–132. https://doi.org/10.1162/isec.2010.34.4.96
[19] Collier, S., & Lakoff, A. (Eds.). (2008). *Biosecurity Interventions: Global Health and Security in Question*. New York: Columbia University Press.
[20] Lakoff, A. (2010). Two Regimes of Global Health. *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, *1*(1), 59–79. https://doi.org/10.1353/hum.2010.0001
[21] Rees, T. (2014). Humanity/Plan; or, on the "Stateless" Today (also Being an Anthropology of Global Health). *Cultural Anthropology*, *29*(3), 457–478. https://doi.org/10.14506/ca29.3.02
[22] Heymann, D. L., Chen, L., Takemi, K., Fidler, D. P., Tappero, J. W., Thomas, M. J., ... & Kalache, A. (2015). Global health security: the wider lessons from the west African Ebola virus disease epidemic. *The Lancet*, 385(9980), 1884-1901.
[23] ibid
[24] Heymann, D. L., Chen, L., Takemi, K., Fidler, D. P., Tappero, J. W., Thomas, M. J., ... & Kalache, A. (2015). Global health security: the wider lessons from the west African Ebola virus disease epidemic. *The Lancet*, 385(9980), 1884-1901.
[25] Moon, S., Sridhar, D., Pate, M. A., Jha, A. K., Clinton, C., Delaunay, S., ... Piot, P. (2015). Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola. *The Lancet (Online First)*. https://doi.org/10.1016/S0140-6736(15)00946-0
[26] Frieden, T. (2015, September). *Public Health Grand Rounds: Shifts in Global Health Security: Lessons From Ebola*. Atlanta, GA. Retrieved from http://www.cdc.gov/cdcgrandrounds/archives/2015/september292015.htm
[27] Harman, S. (2016). Norms won't save you: Ebola and the norm of global health security, *X*(1), 11–16.
[28] US Government. (2014). Accelerating Progress on the Global Health Security Agenda. Department of Health and Human Services. Retrieved from http://www.globalhealth.gov/global-health-topics/global-health-security/GHS%20and%20Post%20Launch.pdf
[29] US Government. (2014). Global Health Security - Vision and Overarching Target. Department of Health and Human Services. Retrieved from http://www.globalhealth.gov/global-health-topics/global-health-security/GHS%20and%20Post%20Launch.pdf
[30] ibid
[31] Inglesby, T., & Fischer, J. E. (2014). Moving ahead on the global health security agenda. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science*, *12*(2), 63–65.
[32] Fidler, D.P. (2005). From international sanitary conventions to global health security: the new International Health Regulations. Chinese Journal of International Law, 4(2), 325–392.

[33] Fidler, D.P. & Gostin, L. O. (2006). The new International Health Regulations: an historic development for international law and public health. *The Journal of Law, Medicine & Ethics*, *34*(1), 85–94.
[34] Elbe, S. (2010). *Security and Global Health*. Cambridge: Polity.
[35] Fidler, D.P. & Gostin, L. O. (2006). The new International Health Regulations: an historic development for international law and public health. *The Journal of Law, Medicine & Ethics*, *34*(1), 85–94.
[36] Horton, R., & Das, P. (2015). Global health security now. *The Lancet*, *385*(9980), 1805–1806.
[37] Moyn, S. (2010). *The last utopia: human rights in history*. Cambridge, Mass.: Belknap Press of Harvard University Press. Retrieved from http://site.ebrary.com/id/10428845
[38] Davies, S. E., Kamradt-Scott, A., & Rushton, S. (2015). *Disease diplomacy: international norms and global health security*. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=882676
[39] Calain, P., & Sa'Da, C. A. (2015). Coincident polio and Ebola crises expose similar fault lines in the current global health regime. *Conflict and Health*, *9*(1), 1–7.
[40] Aldis, W. (2008). Health security as a public health concept: a critical analysis. *Health Policy and Planning*, *23*(6), 369–375.
[41] Star, S. L. (2010). This is not a boundary object: Reflections on the origin of a concept. *Science, Technology & Human Values*, *35*(5), 601–617.
[42] Star, S. L., & Griesemer, J. R. (1989). Institutional ecology,translations' and boundary objects: Amateurs and professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. *Social Studies of Science*, *19*(3), 387–420.
[43] Star, S. L. (2010). This is not a boundary object: Reflections on the origin of a concept. *Science, Technology & Human Values*, *35*(5), 601–617.
[44] ibid

DELAYED RESPONSES: REACTIVITY IN INTERNATIONAL RESPONSES TO THE EBOLA AND ZIKA CRISES

Aliya Allen-Valley and Mark Daku

This piece explores international responses to the 2013-2016 Ebola and 2016 Zika Virus outbreaks. It argues that international responses were heavily reactive in nature as they occurred long after the initial outbreaks and were characterized by a slow scale up of response efforts and difficulties securing funds. These reactive responses are relative to the rise of securitization within global health governance, where responses to an outbreak are scaled up when a virus is perceived to pose a threat to the state, rather than when the outbreak initially occurs. While the Ebola and Zika outbreaks were very different, the similarly reactive nature of the responses to each epidemic illustrates the limitations of using a securitization-based framework for epidemic response.

INTRODUCTION

Criticisms of the international community's ability to respond to global health crises are common and often warranted. The backlash that the World Health Organization (WHO) faced due to its response to the Ebola outbreak in West Africa in 2013 is one such example. The WHO's slow response and their hesitancy to declare this crisis a Public Health Emergency of International Concern (PHEIC) until August 2014 was heavily derided. In 2016, when the Zika outbreak hit, it appeared as if not much had changed.

Herein we analyze the securitization of Global Health Governance (GHG), specifically in relation to the Ebola and Zika Virus epidemics. We argue that securitization, or the practice of responding to an outbreak when it poses a threat to the state rather than when it initially occurs, has encouraged global actors to respond reactively in the wake of a crisis. Securitization created the conditions for a terrifyingly slow scale up of response efforts in the wake of the Ebola outbreak, and a difficulty in securing funds to properly respond to the Zika Virus in a timely matter. We argue that while securitization has created a nature of reactivity in global health responses, it does not tell the whole story, as the ways in which a disease is conceptualized, specifically concerning its assumed impact, and the community at risk, have contributed greatly to constraining effective responses. It is this interaction of securitization, perceptions of affected populations, and the scale of the outbreak that have contributed to the reactive environment of GHG.

Our approach to this argument is three-pronged. First, we define and outline securitization as it relates to GHG, providing a framework and applying it to the cases of the Ebola epidemic and the Zika epidemic, respectively. Second, we outline the history and scale of each outbreak, and demonstrate how securitization ultimately hindered global responses in each instance. Finally, we discuss the importance of addressing the question of 'who matters?' in GHG. Ultimately, while securitization can be used to increase financial aid and attention to endemic areas during a crisis, it has also contributed to reactivity, and has limited international responses.

Ebola and Zika Virus differ greatly in their scale, their vectors, and their impact. Despite these differences, securitization of both epidemics occurred, and the global health community failed to respond effectively until a perceived threat to Western home-states was assumed. This should be of great concern to those involved with global health governance, as the logic of securitization creates the conditions for slow, reactive responses to legitimate global health issues. It is precisely this logic that must be challenged if GHG is to be improved.

SECURITIZATION

Global health refers to "an area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide".[1] The development of global health marked a transition from international health, which focused upon the ways in which information and practices of experts from the industrialized world could be shared and taught to those in developing countries.[2] Global health is differentiated from international health in that it aims to be a more multidisciplinary and all-inclusive approach to the health-care needs of different groups, communities, and people across the world. While global health emphasizes equity and inclusion, it is not free from other influences. In particular, global health practices and governance have been significantly influenced by the theory of securitization.

Securitization refers to an expanded focus on the protection of the 'nation-state', such that military security is no longer the only concern.[3] Wæver argues that securitized issues are created when " a securitizing actor designates a threat to a specified referent object and declares an existential threat implying a right to use extraordinary means to fence it off." [4] However, it does not truly become a security issue until it is accepted by the relevant audience, specifically when this audience accepts that this issue belongs in the realm of security, and "grants the actor a right to violate rules that otherwise would bind."[5]

Drawing on Wæver's definition, Kelle divides the securitization process into three categories: "a securitization actor, a referent object to be securitized, and an audience that accepts (or rejects) the securitizing move".[6] In other words, an issue must not only be *identified* as a security threat, but it also must be *accepted* as a security threat in order for exceptions to prevailing rules to be acceptable.

These three elements are easily identifiable in the global response to both the Ebola and Zika epidemics. In both cases, the securitization actors have been political representatives in rich donor states (e.g. the United States) and international organizations (e.g. the WHO), that have greatly influenced and coordinated global response efforts, and that have emphasized securitization in response to the international spread of each disease. Further, in each case, Ebola and Zika respectively represented referent objects that the international community felt it necessary to protect themselves from. However, despite these similarities in securitization phases, the manner in which each of these viruses have been presented to and received by the audience (both globally and domestically) has influenced the manner in which the international community responded to each epidemic.

In the case of Ebola, this meant a strikingly slow scale up of response efforts. In the case of Zika virus, this led to difficulties securing funds for the crisis. In other words, the Ebola epidemic was recognized and accepted as a referent object to be securitized by the receiving audience when a perceived potential risk of infection was assumed in Western

states. Contrarily, Zika virus was rejected as a referent object, as it was perceived to be mild and discriminant. Nonetheless, in both cases, the response of the international community was abysmally slow, and widely criticized.

Horton and Das assert that "thanks to Ebola, global health security is now a priority, not only for ministers of health but also for heads of state".[7] However, this 'increased security' has also created an environment in which health issues have become framed as "threats to existence" that are commonly addressed only in situations in which the threat is of concern to dominant actors within the international community .[8] Global health security has created "a tendency to focus on containment rather than prevention", and a narrow focus upon the perception of security risks within the international community.[9] Thus, it can be argued that securitization frames disease as a war, where the troops and ammunition (the response) is determined primarily by how threatened the most powerful players feel by the disease. In the case of the Ebola epidemic, response was not evoked among Westerners at first, due its containment in West Africa. Alarm was only raised in the international community once the vulnerability of state borders was demonstrated by the declaration of Ebola as a PHEIC, and by the case of Thomas Duncan, a Liberian man who travelled to the United States and died from the virus therein. In the wake of the Zika crisis, few Americans felt threatened due to its lack of severity and the fact that it primarily affects marginalized communities, both globally and domestically. Securitization creates a reactive environment in which powerful states and actors do not respond to global health threats that are impacting other 'far-away' regions until they feel there is a serious risk at home.

Despite these shortcomings, the logic of securitization can also bring attention to issues of health inequity and global suffering and can increase aid and funding to the countries and regions most affected by epidemics. Nonetheless, securitization has created a global health environment in which the international response to crises is heavily reactive in nature. In this sense, securitization can be said to create a dichotomy between affected areas, and those that have not been impacted by a disease. This is emphasized by Benton, who argues that "security paradigms of public health are premised not only on thinking of diseases as global threats that transgress national borders, but of certain places (and their residents) as posing inherent threats to others".[10] Disease, people, and place become conflated, and the perception of Ebola as dangerous, (particularly after the virus began to spread to the United States and Europe) led to a barring of endemic areas, the closing of borders, and the cancellation of flights, all in an effort to protect individuals in the Global North. Due to this conflation, it is not enough to only examine the disease being spread, but also who is at risk, and how historical and contemporary ideologies of different areas and diseases may impact perceptions of security and international responses.

The securitization of diseases must therefore be analyzed not only in relation to its ability to raise global alarm and bring attention to the impact of epidemics in endemic areas, but also with regard to the ways in which it legitimizes slow responses and ignorance to global health crises when they are endemic to areas far away from the developed world. Simply, securitization is premised not only on the security of certain states, but also upon the security of certain people.

In this sense, securitization does not end at national borders, but also can be seen in the differential responses to disease domestically. This logic of securitization, which tends towards the protection of certain communities in certain places will be discussed

with respect to the Ebola Virus Disease (EVD) and the Zika virus epidemics to assess how securitization has impeded the ability of the international community to respond effectively to global health crises.

THE SECURITIZATION OF EBOLA: AN ALARMED AUDIENCE

Many differences can be noted between the 2013-2016 encounter with EVD and its previous outbreaks in 1976 and 1995. Primarily, while previous encounters with the disease remained generally contained in the rural areas of Zaire and Uganda, the outbreak in 2013 permeated country borders, and proved a threat to the international community, leading to its declaration as a PHEIC in August 2014. In addition, while the world was scientifically unprepared for previous encounters with the disease[11], the creation of safety tools in the years since, such as HAZMAT suits, biotechnological advancements, and cellphones have helped to protect those on the frontlines battling the disease. However, despite these differences, the mishandling of the 2013-2016 Ebola crisis by the international community was unfortunately familiar.

At time of writing, the most recent major encounter with Ebola began in December 2013, when a small boy died in Guinea from an unidentified disease. The young boy exhibited symptoms such as fever, nausea, and bloody diarrhea, and soon after his death many other people in this area experienced similar symptoms. Quickly, the disease spread to other countries in the vicinity, but it was not until March 23rd, 2014, that the WHO was able to declare this outbreak was indeed Ebola.

Despite the nearly 40 years separating the first encounter with EVD with the latest, the ability of the international community to respond to EVD in an efficient and effective manner has been hindered by reactive responses, enabled by the logic of securitization. This was demonstrated primarily by the disappointing response of the WHO and the international community at large to the outbreak in West Africa. Despite cries for help on the ground from Medécins Sans Frontières (MSF) and political leaders in the hardest hit countries, Sierra Leone, Guinea, and Liberia, the WHO did not declare Ebola a PHEIC until August: eight months after the first case in December 2013; and approximately 1,799 reported cases and 961 reported deaths later.[12]

I. Entry of the Securitization Actor: Too Little, Too Late

It was not until September 2014 that securitization actors began to pay close attention to the virus that had been killing and infecting thousands of people in parts of West Africa for months. On September 16th, President Obama sent 3,000 military personnel to West Africa in order to respond to the epidemic. He also called for a contribution of $750 Million to the response effort.[13] However, by October, the perceived threat of Ebola to the international community was amplified by the case of Thomas Duncan, a Liberian who died from Ebola in the United States. The infection of a Spanish nurse in Europe further intensified fears in the West. These encounters increased concerns amongst securitization actors in the United States and Europe, leading to closed borders, widespread panic, and a new perception that Ebola was no longer contained to West Africa, and that individuals in the Global North were potentially at risk.

On October 25th, President Obama stated that "We can beat this disease. But we have to stay vigilant. We have to work together at every level … and we have to keep

leading the global response, because the best way to stop this disease, the best way to keep Americans safe, is to stop it at its source – in West Africa".[14]

II. Containing the Referent Object

The increased response to Ebola after this realization revolved heavily around the objective of containing the epidemic, the referent object, "over there"; and of protecting those in the developed world who now felt at risk of infection. Despite the scale and impact of the epidemic in West Africa previously, Ebola had received little attention in popular Western media, leading to little action from securitization actors in the Global North. It was only once Ebola became a perceived threat to Westerners that it received increased attention. On September 17th 2014, military personnel from the United States Army arrived on the ground in Liberia.[15] Almost simultaneously, British military personnel entered Sierra Leone in order to respond to EVD, and both armies constructed Ebola treatment centers on the ground.[16] Undoubtedly, this increased attention and fear increased awareness of the situation in West Africa, and was accompanied by a shift in focus away from the epidemic in West Africa toward "the enemy within". [17] Phelan notes that 'border closures', 'border screenings', and 'quarantine and isolation' were all measures considered by securitizing actors in the United States to guard themselves from any further spread of the epidemic domestically. In October 2014, "27 Members of Congress … wrote President Obama requesting that the State Department impose a travel ban (including visa suspension) for citizens of Liberia, Sierra Leone, and Guinea until the end of the outbreak"[18]. While President Obama acknowledged that these proposals for protectionist practices could exacerbate the issue[19], the proposition itself reflects the fear among the American public and some securitization actors. The proposition also marks an attempt to securitize the referent object.

Attempts to isolate and quarantine infected and potentially exposed people [20] were also practiced widely during the Ebola epidemic. While many states implemented these practices, New York and New Jersey implemented "mandatory 21-day quarantines for health care workers returning from countries with intense EVD transmission"[21]. Although these practices were implemented to protect the American public at large from the spread of the virus, it also villainized and ostracized courageous HCWs who worked on the ground aiding those in need in endemic areas, and West Africans who may be travelling to the United States. These practices also bolstered the hysteria felt throughout the general public.

III. Acceptance by the Receiving Audience

Russell argues that the surge of hysteria that pulsated through the general public concerning EVD occurred in waves stages of alarm.[22] We argue that each of these stages contributed to the eventual acceptance of the securitizing move proposed by international actors among the panicked receiving audience.

The first alarm raised by the American public involved the return of Dr. Kent Brantly to Emory University Hospital on August 2, 2014. Brantly, a clinician who was infected with EVD in Liberia while treating patients, was isolated and received immediate care upon his return. It was this event which gave the virus an "American face", leading to increased media coverage about the dangers of the virus, and garnering further

attention among the receiving audience.[23] The arrival of Dr. Brantly seemingly localized the disease, demonstrating that it was no longer viable to think of it as a disease of "over there" – the receiving audience now had to accept the possibility, however slight, that this was a disease that could affect Americans.

This fear was amplified following what can be seen as the second alarm: when Ebola was declared to be a PHEIC on August 8, 2014.[24] While the declaration occurred months after the first case in Guinea, it marks the moment when global health actors officially recognized the increased risk of infection beyond West African borders. Dr. Margaret Chan, the Director General of the WHO, made the announcement following the recognition that EVD was a threat that required "a coordinated international response to stop and reverse [its] international spread"[25] This recognition occurred much later than it should have, given it was similar to calls made by MSF's director of operations Dr. Bart Janssens months prior, who called on "the WHO, the affected countries and their neighboring countries [to] deploy the resources necessary for an epidemic of this scale".

Yi Dionne and Seay propose that the homogenous view of Africa held widely by those outside the region was demonstrated throughout the crisis, as "Americans who are used to referring to 'Africa' as one entity will mistake just how big of a threat EVD is, who might have been exposed to it, and the likelihood of infection".[26] This point was well demonstrated by the third alarm: the infamous case of Thomas Duncan, which solidified the perception that it was possible for Ebola to place Americans at a high risk of infection. While the case of Dr. Brantly gave Ebola an American face, the case of Thomas Duncan led to the assumption that individuals from affected areas were placing the state at risk. Taken together, these alarms and assumptions heightened the hysteria among the American public concerning the spread of the virus.

The small risk of EVD for Americans was enough to spark global panic, as states in the West began to securitize and prepare for the perceived arrival of EVD within their national borders. Misconceptions and misinformation surrounding the disease also began to permeate popular imaginations through social media, as it was thought that the disease was airborne, that if you survived Ebola you could still pass it on to others, and that bringing Ebola patients to the United States would only leave Americans at risk.[27] It was also during this time that Ebola responses in endemic areas were scaled up tremendously. Treatment units increased, emergency response teams were sent out to affected areas in larger numbers, and unsafe burials were targeted.[28] However, in the months leading up to this response, thousands of lives were lost, politicians in endemic areas were asking the international community for help, and health systems in affected countries continued to crumble under the weight of the outbreak. After all the panic created regarding national safety within developed countries, only seven cases of Ebola were reported in the West, with only one resulting death. This should be contrasted with the "28,639 confirmed, probable, or suspected Ebola cases and the 11,316 deaths reported to WHO" that occurred in West Africa.[29]

The Consequences of Delayed Panic

Securitization and fear of the spread of EVD eventually led to more resources on the ground in endemic areas and increased financial aid from international organizations and securitization actors in Western countries. It also increased fears about the spread of the disease in the West and led to restrictions placed on the deployment of HCWs from other

countries such as the United States. While the work of local HCWs and international actors such as MSF in affected states cannot be undermined, it is also important to outline their restrictions. Many health care systems in affected areas were under-resourced before Ebola struck. They were heavily dependent on foreign aid for funding[30], leaving them in need of significant aid in the wake of the crisis. Throughout the EVD outbreak, many of these health systems and economies were even further derailed. Before Ebola was designated a PHEIC, MSF sounded the alarm, calling the crisis "out of control".[31] The organization also released a statement asking for international aid, proclaiming that "it has reached the limits of what its teams can do", and began working to raise awareness of the severity of the epidemic in the global arena.[32] In Liberia, President Sirleaf had declared a national state of emergency before the declaration of Ebola as a PHEIC, and asked the Centers for Disease Control and Prevention (CDC) and the WHO for further assistance in battling the crisis.[33] The CDC reports that once they became involved in the crisis, "surveillance, contact tracing, diagnostic testing, community engagement and ownership, infection prevention and control … and vaccine evaluation all improved steadily".[34] It is not difficult to make the case that an earlier response to the crisis would have led to significantly different results. The failure of the international community to respond effectively to the Ebola epidemic is a direct result of the reactive logic of securitization.

THE SECURITIZATION OF ZIKA: A LACK OF CONCERN

On February 1st, 2016, the WHO declared the Zika virus a PHEIC due to its relationship to increased cases of microcephaly in affected areas, a rare condition where babies are "born with a small head or the head stops growing after birth".[35] Zika represented the fifth declaration of a PHEIC, following Ebola, smallpox, swine flu, and polio. Although the experience with Zika differed greatly from that of Ebola, it serves as an example of how the reactivity led by securitization shapes international responses to global health crises.

While Ebola caught the attention of the global community after the realization that it could permeate the borders of countries in the Global North, Zika was viewed with a general lack of concern, due to the belief that the effects of the virus were relatively mild. Despite its status as a PHEIC, and the subsequent declaration that the virus was a long-term concern, the international community struggled to respond quickly to the Zika epidemic.

Discovered in 1947, Zika virus is a mosquito-borne disease whose symptoms generally include sore joints, fatigue, fever, and chills. However, four in five people with Zika are asymptomatic.[36] The profile of the disease is much different than that of Ebola, and contributed to a different perception of risk on behalf of the public. While Ebola carries a high mortality rate (50% on average)[37], Zika resulted in no reported deaths or hospitalizations in the period from 1960-1980, leading to the general assumption that the virus was relatively mild in nature.[38] Resultantly, while fears of Ebola sparked significant, though delayed, attention, such that "public opinion polls found 39-52% of Americans – depending on the date of the poll – thought there would be a large EVD outbreak in the United States"[39], the Lancet reported that 77% of the American public was not concerned about the Zika virus at all.[40]

Nonetheless, Zika began to receive greater attention in the media following the finding that infection with the virus was correlated with microcephaly, as well as with

Guillain-Barré syndrome. Incidences of microcephaly increased 20-fold in the period from 2014 to 2015, and pregnant women were thus called to be extremely cautious as to avoid infection with the virus, often by avoiding unnecessary travel to endemic areas, as "Zika virus [had] the potential to rapidly spread across Latin America and the Caribbean"[41].

I. Entry of the Securitization Actor: Response to a Mild Threat

On July 29th, 2016, CNN reported that the Zika virus had permeated American borders after four cases transmitted by local mosquitoes were found in Florida.[42] In response, the Florida Department of Health and the CDC issued warnings to those in affected areas, informing pregnant women, and men with pregnant sex partners, to protect themselves from spread of the disease.[43] President Obama announced that "we all have to remain vigilant when it comes to combating the spread of diseases like Zika", calling for the rapid development of a vaccine, increased access to testing for pregnant women, and the assurance that affected communities were well equipped with the resources necessary to respond to the virus.[44] However, while the presence of Zika in the United States led domestic health departments to inform the public about how to protect themselves from the disease, it did not lead to significant increases in response efforts.

II. Containing the Referent Object

Given the presence of Zika in the United States, President Obama stated that it was pivotal that Congress provide emergency funding to control the disease. However, the low risk perception associated with the Zika Virus among securitization actors in Congress led to slow responses from the international community to securitize the threat. This was exemplified by the fact that the U.S. Congress went on summer recess without approving Obama's plea for $1.9 Billion (USD) for an emergency Zika response, which was aimed to improve vaccine research and development, conduct mosquito surveillance, educate health providers, improve health services, and help Zika-affected countries better control transmission.[45] Although Congress eventually approved Obama's request for the Zika emergency response fund , it was "not expected to reach states and localities for several more months because of the federal government's budgeting process".[46] Regardless of its status as a PHEIC, Congress demonstrated a lack of urgency in their response to Zika. Securitization constrained Congress' response, as the lack of the perceived risk of Zika led to difficulty securing funds to combat the disease, even after it arrived in the Global North. These funding difficulties also occurred on an international scale, as the WHO only received $14.4 million (USD) from donors after outlining the need for approximately $122 million in its Zika Response plan for July 2016 – December 2017.[47]

The lack of concern with Zika took on another dimension as well, highlighted by the 2016 Summer Olympic Games in Rio de Janeiro. As Brazil had been framed as a center of the epidemic, the advice given to travelers was to avoid mosquitos, have safe sex, utilize repellent, stay air conditioned, and avoid areas with poor water and sanitation".[48] The Lancet reports these suggestions, though reasonable given the nature of the virus, "highlight the true nature of Zika: it is a disease of the poor and disenfranchised"[49]. While globally the risk of Zika may be low, there is an elevated risk and burden amongst particular communities in particular parts of the world.

III. Rejection by the Receiving Audience

Global responses to Zika not only demonstrate the perception of the disease as mild, but are also reflective of the discriminant nature of the virus. The lack of alarm raised in media and government consequently led to a lack of concern among the general public, and a rejection of the securitizing move as raised by President Obama. In other words, the perception of Zika as relatively mild influenced the response of the receiving audience. While the slow response of the international community to Ebola was due in part to the containment of the virus in West Africa, responses were scaled up due to the perceived risk of its spread. Responses to Zika were slow due to a lack of concern among the general public, despite the uncertainty surrounding future impacts of the disease.

The discriminatory nature of the Zika virus has allowed many citizens and actors to neglect the disease and treat it with indifference, a deeply troubling approach given that there is still much to be learned about the disease. Risk of infection is perceived as being concentrated in particular groups (the poor, the female, the pregnant), allowing the bulk of the (wealthy, male, powerful) population to continue living their lives unchanged. The Olympic Games were able to continue without fear, quite simply, because "the face of Zika is not seen in the air-conditioned shopping malls of upscale Rio neighborhoods" [50], but is rather most prominent among Othered communities.

While the lack of severity that surrounds perceptions of Zika Virus may prevent overreaction, it also had the effect of stifling any reaction at all. While there is no counterfactual to determine how quickly the response to Zika *should* have been, we argue that given the criticisms of the WHO following its slow response to Ebola, and given the frightening potential long-term impacts of Zika, that had Zika been a less discriminating disease, it would have received a much faster response from the international community. The importance of an adequate and timely response was not lost on the WHO. In their 2016 Strategic Response Plan to the Zika Virus, the WHO acknowledged that "Zika virus and its complications such as microcephaly and Guillain-Barré syndrome represent a new type of public health threat with long-term consequences for families, communities and countries."[51] However, Zika Virus is generally asymptomatic and was concentrated primarily in regions and populations that have historically not had significant access to global power or voice. The speed and extent of the response seems incongruent with the perceived threat level at the time, something which was also evident in the difficulty surrounding attempts to secure funds for research and vaccines for the virus.

To be clear, we are not arguing for the equivalence of Ebola and Zika. The diseases are remarkably different, and responses to them were triggered for different reasons. However, what we do observe is a similar delay in responses from the WHO and other international actors which can be fruitfully explained through the lens of securitization: in this case the disconnect between the acceptance of Zika as a threat, and its actual and potential threat level within the receiving audience.

The November 18th 2016 declaration of the WHO that Zika is no longer a PHEIC, but is rather a long-term issue, raises questions about how the international community will work to address the disease in the future. The general disillusionment of the receiving audience toward the virus will likely make it more difficult to secure funds now that it is considered a long-term issue as opposed to a novel disease requiring an emergency response. While the WHO has claimed that the removal of the PHEIC warning on the virus is not an attempt to downgrade its importance, there is no question that the removal

of the declaration shifts the frame under which the disease is understood by the global community.

DISCUSSION

Security is not the sole issue. Ebola caused thousands of deaths in West Africa for months before the international community scaled up effectively. In the case of Zika, little alarm was raised as the disease was perceived as rather discriminant in who it affected, and mild in its impact. Security is at the heart of this discussion, but it is incumbent on us to ask: security for who?

Who matters? Securitization and reactivity

Examining which actors matter in GHG highlights the typically reactive nature of the endeavor. While both epidemics had been declared as PHEICs by the WHO and the International Health Regulations (IHR), both responses varied and deviated from best practices. Perhaps the reasoning for this has been best explained by Yi Dionne and Seay: "how we think about a place or a people shapes how we respond".[52]

In the case of Ebola, the place shifted, and so too did the response. Ebola received increased attention when domestic cases (e.g. Thomas Duncan) demonstrated that the United States and Europe were also at risk of infection. Ebola became the referent object in need of containment, leading securitization actors to close borders, and to partake in further othering the endemic West African states. While only a handful of individuals were infected with Ebola in the West, the alarm raised among the audience (and the misconceptions spread) incentivized countries and international actors to act to contain the virus "over there".

In the case of Zika, the people affected, and the differing impact of the disease, warranted a different response. Zika's portrayal as a mild virus allowed many securitization actors to turn their backs to the referent object. As Zika is more likely to impact the poor, "not only due to poor living conditions and infrastructure … but also insufficient access to information, and resources for prevention and care", decision-makers hesitated to place response efforts at the top of any political agenda.[54]

The Ebola case highlights delayed response to international epidemics until they are seen as a risk internally; but the case of Zika extends this inequality to the domestic sphere. People living in poverty are "at higher risk of exposure to the mosquitoes that carry Zika virus" [55]. Poverty is often concentrated in certain areas, and happens that "some of the most impoverished urban areas in the United States are also located in the *aedes aegypti* mosquito belt"[56]. As such, securitization of disease, while being examined on a global scale, must also be examined within domestic borders. In terms of responses, who is affected by the disease domestically matters just as much as who is affected globally.

WHO matters: Securitization & International Organizations

The experiences with EVD and Zika demonstrate gaps and deficiencies in the global health system, specifically issues related to the ways in which global health concerns are securitized. Securitization may shed some light on why the WHO's response to Ebola was slow and highly-criticized. The WHO's response efforts to EVD increased once Western

actors deemed it a risk to their national safety, despite calls from organizations such as MSF to respond quickly to Ebola in earlier stages. Attempts to contain or respond to EVD, including the PHEIC declaration, came eight months after the first case of the virus in December 2013, and we only observe real action and a coordinated response after the announcement by WHO Director-General Margaret Chan that signaled the acceptance of EVD as a securitization issue.

The response to Zika was much different. The WHO released a Zika Strategic Response Plan in 2016 calling for coordinated responses across countries to respond to the epidemic, but there was also a recognition that the Zika Virus was not truly a "global" threat. Its connection to the *aedes agypti* mosquito meant that its spread was heavily isolated to particular parts of the world, and the burden of risk was shouldered primarily by "women and couples planning or expecting a child".[57] There was a clear disconnect between the risk of the disease, and the response. For example, while the WHO's Strategic Plan estimated the need for approximately $109 million (USD) to scale up Zika response efforts by July 2016, they had received approximately $50 million (USD) at the time the document was released.[58] This can be understood as a rejection by the receiving audience of this threat, and it meant that response efforts were likely slowed, and definitely underfunded. Precisely *who* was being affected by the disease intersected with high levels of uncertainty around the long-term health impacts of the virus and created the conditions where scale-up efforts were heavily impacted by securitization.

Global health security ultimately involves two separate and distinct groups: "primary beneficiaries from the system"; and other actors who "are bearing the costs".[59] This was demonstrated by the slow responses to the Ebola crisis, which were only effectively scaled up after the recognized threat to the Global North. This widely criticized, inefficient, and ineffective response led many actors to question the relevancy of the WHO (and other organizations). While valid critiques, international organizations will continue to play increasingly important roles in future outbreaks. The failures of Ebola and Zika should be seen as an opportunity to improve GHG, not an excuse to dispose of it.

First, when Zika emerged, it quickly became apparent that the world was fiscally unprepared to confront such an issue. The global effort to fund responses was ultimately underwritten by existing funds for existing diseases. $500 million (USD) was taken from the Ebola virus disease fund, and "several millions [were taken] from other diseases such as influenza and tuberculosis".[60] This approach turns global health into a zero-sum game and suggests the importance of mechanisms such as a dedicated international emergency fund for emerging global health threats.

Second, the WHO's shortcomings are largely traceable to its economic incapacities. Put bluntly, the WHO's budget is "incommensurate with its responsibilities"[61]. In 2011, the organization cut its budget by almost $60 million (USD), which has strained the ability of the WHO to respond effectively in the wake of a crisis.[62] These crises highlight the need for organized, efficient, and effective responses to emerging global health issues, the kinds of responses which are exceptionally difficult to coordinate without a well- funded centralized organization. Due to shortages in funding and a fear of losing access to future funding, the time-horizon of WHO's emergency disease responses tends to be short. The 2015 World Health Assembly (WHA) conclusions echoed this assertion, noting that the WHO "does not have a culture of rapid decision-making and tends to adopt a reactive, rather than proactive, response to emergencies".[63] Access to sustained and guaranteed funding may help facilitate a cultural shift in the WHO, where more appropriate reactions

to emerging diseases can be taken.

Finally, as this article has demonstrated, global health does not only take place at the global level. Threats, inequalities, and opportunities also exist at the domestic level, and one of the larger opportunities involves an increase in domestic global health capacities and spending. While non-Western states incur 56% of the global disease burden, they only account for 2% of global health spending.[64] While many factors may help explain this disparity, global responses without improved domestic preparedness will likely face many barriers. When Ebola hit, many health systems were unprepared to respond to the crisis[65]. Training and investing in resources, including human resources in endemic areas is crucial for the ability to prepare for a crisis. While the work of clinicians, doctors, and governments on the ground cannot be undermined, further preparedness and investment in health care systems is a crucial way to ensure that domestic systems are prepared in the wake of an outbreak.

CONCLUSIONS

This article demonstrates that the prominence of securitization in GHG has ultimately led to slow responses and reactivity in the wake of a crisis from the international community. In the case of Ebola, the suffering of thousands of people in West Africa was not met by widespread response from the international community until the virus posed a perceived threat to the Global North. On the other hand, the response to the Zika Virus from the international community faced difficulties securing funds due to the perception of the disease as mild; despite the fact that there is still much to be learned about its effects. The securitization framework discussed above helps to make sense of this: In both the cases of Ebola and Zika securitization actors, such as the WHO and domestic actors in the developed world were reactive in their responses. As well, in both cases, the referent object that needed to be securitized was the virus itself. The responses of the audience in each case was dramatically different, as in the case of Ebola, the audience accepted the securitizing move. However, alternatively, in the case of Zika, the securitizing move was ultimately rejected.

Despite the different responses of the receiving audience, global responses to both Ebola and Zika suffered greatly from the practice of securitization among the international community. While it is true that this practice led to increased attention to each virus, respectively; it also legitimized the nature of international actors to respond when they felt they were at risk; not when the virus was targeting individuals on a large scale outside of the Global North, or when marginalized communities within the developed world were at risk. In the case of Zika; it almost legitimized the nature of the international community not to respond at all, as many actors did not feel threatened due to the fact that the virus largely impacted subordinated communities and was perceived to be mild.

Taken together, each of these cases has demonstrated that it is not just the spread of the virus that is important to securitization; but also the communities that the virus affects both globally and domestically. The deadly nature of Ebola, coupled with the misinformation spread throughout the media, led the international community to assume that anyone could be at risk of infection once the disease was found in the United States and Europe, and led to a movement to contain the disease in West Africa by all means necessary. Conversely, the perception of Zika as mild and discriminant led to slow

responses and a lack of investment, even after the virus infiltrated American borders. Overall, while the nature and scale of these diseases have been wildly different, each disease has demonstrated the potential dangers of securitization as it is practiced in the international community.

Bill Gates proposes that the issues we have seen in GHG are "not the fault of any single institution – it reflects a global failure".[66] In order to ensure we are protected in the wake of a crisis, serious reformation is needed, concerning not only the WHO, but also domestic public health systems, including the training of HCWs on the ground. As global health works to achieve health equity for all people, it is important that serious changes are made to the system as it stands, so that we are prepared -- and willing -- to proactively aid those in need the next time an outbreak occurs – even if it does so outside of Northern borders.

Aliya Allen-Valley *is currently a Master of Public Health student at the Johns Hopkins Bloomberg School of Public Health. She holds a Bachelor of Arts from McGill University.*

Mark Daku, PhD*, is an Assistant Professor in the Department of Political Science at Texas Christian University.*

Acknowledgements*: The authors would like to acknowledge the financial support of the Montreal Health Equity Research Consortium and the Institute for Health and Social Policy at McGill University.*

---

[1] Patel, Vikram. "Why Mental Health Matters to Global Health". *Transcultural Psychiatry*. 51, no.6 (2014): 777-89.
[2] Ibid.
[3] Kelle, Alexander. "Securitization of International Public Health: Implications for Global Health Governance and the Biological Weapons Prohibition Regime". *Global Governance,* 13 (2007). 217-235.
[4] Ole Waever, "The EU as a Sovereign Actor: Reflections from a Pessimistic Constructivist on Post- sovereign Security Orders," in Morten Kelstrup and Michael Williams, eds., International Relations Theory and the Politics of European Integration: Power, Security and Community (London: Routledge, 2000), p. 251.
[5] Ibid.
[6] Kelle, Alexander. "Securitization of International Public Health: Implications for Global Health Governance and the Biological Weapons Prohibition Regime".
[7] Ventura, DF. "From Ebola to Zika: International Emergencies and the Securitization of Global Health". *Perspectives* (2016). 1-2.
[8] Ibid.
[9] Rushton, Simon. "Global Health Security: Security For Whom? Security From What?". *Political Studies,* 59 (2011). 799-796.
[10] Benton, Adia, "What's the Matter Boss, We Sick? A Meditation on Ebola's Origin Stories", in *Ebola's Messages: Public Health and Medicine in the Twenty-First Century,* 2016, ed. Nicholas G. Evans, Tara C. Smith, and Maimuna S. Majumder (Cambridge: The MIT Press), 85-94.

[11] Garrett, Laurie. "Ebola's Lessons: How the WHO Mishandled the Crisis". *Foreign Affairs* (2015). 80-107.
[12] Henwood, Patricia C. "Ebola in West Africa: From the Frontline", in *Ebola's Messages: Public Health and Medicine in the Twenty-First Century,* 2016, ed. Nicholas G. Evans, Tara C. Smith, and Maimuna S. Majumder (Cambridge: The MIT Press), 15-30.
[13] Garrett, Laurie, "Ebola's Lessons".
[14] The White House. "The Administration's Response to Ebola: President Obama Provides an Update on the U.S.-Led Response to Ebola". Whitehouse.gov. (accessed October 17th, 2016). [15] Garrett, Laurie, "Ebola's Lessons".
[16] Ibid.
[17] Ibid.
[18] Phelan, Alexandra. "The Ebola Sentinel: A Legal Analysis of US Pandemic Preparedness" in *Ebola's Messages: Public Health and Medicine in the Twenty-First Century,* 2016, ed. Nicholas G. Evans, Tara C. Smith, and Maimuna S. Majumder (Cambridge: The MIT Press), 111-126.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Russell, Cristine. "Risk Watch: Media Coverage of Ebola in the Digital Communication Era" in *Ebola's Messages: Public Health and Medicine in the Twenty-First Century,* 2016, ed. Nicholas G. Evans, Tara C. Smith, and Maimuna S. Majumder (Cambridge: The MIT Press), 141-156.
[23] Ibid.
[24] Ibid.
[25] Ibid.
[26]Kim Yi Dionne and Laura Seay. "American Perceptions of Africa During an Ebola Outbreak" in *Ebola's Messages: Public Health and Medicine in the Twenty-First Century,* 2016, ed.
Nicholas G. Evans, Tara C. Smith, and Maimuna S. Majumder (Cambridge: The MIT Press), 95-110.
[27] Almendrala, Anna. "The Most Destructive Myths about Ebola Virus, Debunked". Huffingtonpost.com. (accessed October 20th, 2016).
[28] Garrett, Laurie, "Ebola's Lessons"
[29] Ventura, DF. "From Ebola to Zika".
[30] Benton, Adia. "What's the Matter Boss, We Sick?"
[31] Medecins Sans Frontieres. "Ebola in West Africa: 'The epidemic is out of control'. Msf.ca. (accessed November 2nd, 2016).
[32] Ibid.
[33] Garrett, Laurie. "Ebola's Lessons"
[34] Friednen, Thomas. "Morbidity and Mortality Weekly Report: Foreword". www.cdc.gov. (accessed October 17th, 2016).
[35] The World Health Organization. "Microcephaly: Fact Sheet". www.who.int. (accessed October 23rd, 2016).
[36] The White House. "Our Response to the Zika Virus." www.whitehouse.gov. (accessed November 3rd, 2016).
[37] The World Health Organization. "Ebola Virus Disease: Fact Sheet". www.who.int. accessed December 10th, 2016.
[38] Kindhauser, Mary Kay et. al. "Zika: the origin and spread of a mosquito-borne virus". www.who.int. (accessed October 1st, 2016).
[39] Yi Dionne, Kim, and Laura Seay . "American Perceptions of Africa during an Ebola Outbreak". *Ebola's Message: Public Health and Medicine in the Twenty-First Century*, by Nicholas G. Evans, The MIT Press, 2016, pp. 95–110.
[40] Lawrence Gostin and James G. Hodge Jr. "Zika Virus and Global Health Security". *Lancet*. 16, no. 10 (2016). 1099-1100.
[41] Bogoch et. al. "Anticipating the international spread of Zika Virus from Brazil". *Lancet*. 387(10016): 335-336.
[42] Goldschmidt, Debra. "Florida health officials confirm local Zika transmission". CNN.com. (accessed November 14th, 2016).
[43] Centers for Disease Control and Prevention. "CDC Guidance for Travel and Testing of Pregnant Women and Women of Reproductive Age for Zika Virus Infection Related to the Investigation for Local Mosquito-borne Zika Virus Transmission in Miami-Dade and Broward Counties, Florida". Emergency.cdc.gov.

(accessed November 14th, 2016).
[44] The White House. "Our Response to the Zika Virus". Whitehouse.gov. (accessed November 14th, 2016).
[45] Ibid.
[46] Sun, Lena. "Despite new Zika funds, states might not get any for months". Washingtonpost.com. (accessed November 16th, 2016).
[47] Lawrence Gostin and James G. Hodge Jr. "Zika Virus and Global Health Security". [48] The Lancet Global Health. "The Rights Approach to Zika". *Lancet*. 4 (2016). e427. [49] Ibid.
[50] Ibid.
[51] (2016, October). ZIKA STRATEGIC RESPONSE PLAN QUARTERLY UPDATE. Retrieved June 23, 2019, from https://apps.who.int/iris/bitstream/handle/10665/250626/WHO-ZIKV-SRF-16.4-eng.pdf?sequence=1
[52] Yi Dionne, Kim, and Laura Seay . "American Perceptions of Africa during an Ebola Outbreak." *Ebola's Message: Public Health and Medicine in the Twenty-First Century*, by Nicholas G. Evans, The MIT Press, 2016, pp. 95–110.
[53] Trump, Donald J. (realDonaldTrump) "The U.S. cannot allow EBOLA infected people back. People that go to far away places to help out are great-but must suffer the consequences!" 1 Aug 2014, 9:22 PM. Tweet.
[54] The World Health Organization. "Zika Strategic Response Plan". (2016). 1-50. [55] Patz, Jonathan. "Preventing the Spread of Zika Requires Addressing Poverty". Huffingtonpost.com. (accessed October 15th, 2016).
[56] Ibid.
[57] (2016, October). ZIKA STRATEGIC RESPONSE PLAN QUARTERLY UPDATE. Retrieved June 23, 2019, from https://apps.who.int/iris/bitstream/handle/10665/250626/WHO-ZIKV-SRF-16.4-eng.pdf?sequence=1
[58] (2016, October). Zika Strategic Response Plan Quarterly Update. Retrieved June 23, 2019, from https://apps.who.int/iris/bitstream/handle/10665/250626/WHO-ZIKV-SRF-16.4-eng.pdf?sequence=1
[59] Rushton, Simon. "Global Health Security: Security for Whom?".
[60] The Lancet Infectious Diseases. "Infectious disease emergencies: taking the long-term view". 16 (2016). 1305.
[61] Lawrence O. Gostin and Eric Friedman. "Ebola: A Crisis in Global Health Leadership". *Lancet*. 384. (2014). 1323-1235.
[62] Ibid.
[63] Garrett, Laurie. "Ebola's Lessons".
[64] Schieber et. al. "Financing Global Health: Mission Unaccomplished". *Health Affairs*. 26, no. 4. (2007). 921-934.
[65] Garrett, Laurie. "Ebola's Lessons".
[66] Gates, Bill. "The Next Epidemic: Lessons from Ebola". *The New England Journal of Medicine*. 372, no. 15. (2015). 1381-1384.

THE POLITICS OF GLOBAL POLICY FRAMES: REPRODUCTIVE HEALTH AND DEVELOPMENT IN GHANA

Ebenezer Agyei and Candace Johnson

INTRODUCTION

Until recently, adolescent and youth health have largely been neglected or considered secondary in relation to maternal and child health, a development that has been attributed to the lack of understanding regarding the health and development challenges that confront young people, as well as the fragmented nature of global governance. [1,2,3] In retrospect, it is also widely acknowledged that global commitments to fulfilling the targets set out in the Millennium Development Goals (MDGs) somewhat undermined the capacity of government and other actors to meet the needs of young people.[4] In 2015, the United Nations announced the Sustainable Development Goals (SDGs) – a global policy agenda that established the framework for the consequent development of two adolescent-friendly protocols, namely (1) the updated Global Strategy for Women's, Children's, and Adolescents' Health (hereinafter "The Global Strategy"), and (2) the Global Accelerated Action for the Health of Adolescents (AA-HA!). These global policy instruments largely account for the increased attention given to young people's health. But in what ways has the issue of adolescent and youth health been addressed at global, national, and sub-national levels, and to what extent do global policy frames affect policy development and reproductive health outcomes for young people?

Drawing on two important adolescent-focused programmes in Ghana – the Adolescent Health and Development Programme (ADHD), and the Ghana Adolescent Reproductive Health Programme (GHARH), this article examines the complex dynamics of issue framing to explain why these initiatives produced divergent outcomes. In the context of this study, implementation success is broadly defined to encompass processes and outcomes that positively reflect the values and objectives of an intended policy initiative, a position that is reflected by the GHARH programme. Importantly, the discussion highlights the merits of an integrated ideational policy discourse in the context of ongoing debates about young people's reproductive health. Although this ideational strategy is not without controversies, the discussion stresses the need to understand framing research not only in terms of agenda-setting, but also from a policy implementation perspective. Against this backdrop, it is worth emphasizing that policy implementation in itself is a matter of framing and discursive strategy. Some scholars have suggested that the link between ideas and policy-making outcomes is better illuminated by paying particular attention to institutional conditions and how specific actors affect the policy process with their ideas, as well as the discursive mechanisms by which policy ideas are translated into practice [5,6]. Our analysis is situated within this broader understanding.

The politics of ideas and global discursive processes has attracted attention from scholars over the years[7,8,9,10,11,12]. By looking at the ADHD and GHARH initiatives from an ideational perspective, this article responds to the call for further research concerning the impact of issue framing on vulnerable and marginalized populations[13]. Specifically, it seeks to identify and examine the core policy frames that provide substantive currency to adolescent and youth health and, most importantly, their intersections with the

trajectories of national politics. To better understand the divergent outcomes of the ADHD and GHARH programmes, the discussion is also situated within larger debates in human rights, which we discuss in more detail in a later section.

There is general consensus among scholars that the success or otherwise of a policy frame depends on a number of factors – the power of ideas used to portray the issue, the power resources of the actors, and the character of the political or institutional context, among others[14,15,16]. This article draws on the existing literature with the view to providing a nuanced understanding of the complexities and politics of global frames, and the environmental factors that shape policy initiatives. Ghana merits attention because it has responded quite well to the global call for comprehensive health programming that aligns with the new development agenda, with adolescent health as a centerpiece of the development discourse [17] (WHO 2017). Moreover, Ghana has been a leader in reproductive health and family planning across the West African sub-region over the past decades [18].

METHOD

This article is based on qualitative research conducted in Ghana from January – June 2017. The research draws on primary and secondary materials including global and national health policy documents, published books, journal articles, local newspapers, and other relevant health reports. A series of semi-structured interviews were conducted with individuals centrally involved with the ADHD and GHARH programmes at the national, regional, and district levels. The respondents include officials at the National Population Council (NPC), Ghana Health Service (GHS), Ghana Education Service (GES), and the National Youth Authority (NYA). Interviews were also conducted with leading officials of the Palladium Group (formerly Futures Group Europe), who constitute the primary implementing and oversight body of the GHARH Programme. Lastly, interviews were held with non-governmental organizations (NGOs) such as MAP International and Planned Parenthood Association of Ghana (PPAG), as well as young people aged 10-24 years. Overall, sixty (60) participants were involved in the study, and with permission from respondents, the interviews were audio recorded and later transcribed for analytical purposes. Discourse analysis and process tracing served as the main instruments for data analysis. This article presents only one segment of the data generated through this research effort.

The study area for the research was Sunyani, which is the administrative capital of the Brong Ahafo region.[i] It was selected as the initial site for the research because the GHARH intervention primarily focused on the Brong Ahafo region. The region was selected as the focal point of GHARH intervention due to the high rates of adolescent pregnancy, as well as recognized gaps and demand in sexual reproductive health services among young people across the region[19]. Interviews were also conducted with Palladium

[i] Ghana is comprised of sixteen administrative regions, and Brong Ahafo lies in the middle part of the country. Research suggests that fertility rates are relatively high in the Brong Ahafo region due to low literacy level. As part of efforts to strengthen Ghana's decentralization system and foster equitable development, six new regions were created following a referendum held on December 27, 2018, thus altering the former ten regional administrative boundaries. Following the regional restructuring, the Brong Ahafo region has been divided into three separate regions, namely Brong Ahafo, Bono East, and Ahafo.

and government officials in the Greater Accra region of Ghana, the national capital. Ethical clearance was obtained from the University of Guelph Research Ethics Board (Canada) and the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (Ghana). Due to ethical considerations regarding this study, the specific study locations are confidential. It should, however, be emphasized that all research participants identified in this article explicitly consented to the use of their full name for the purpose of this study.

The remainder of the paper is structured as follows: The first section provides a brief overview of the trajectory of adolescent health within the context of global politics. The second section provides, a contextual overview of the health landscape in Ghana, with particular focus on the policies and programmes that have been adopted over time to deal with the health challenges faced by young people. The third section includes a comparative overview of the ADHD and GHARH initiatives. The fourth section entails a critical analysis of the core frames embedded in the SDGs, the Global Strategy, and the AA-HA! Framework, which provides deep insight into the complexities and analytical tensions surrounding the discursive construction of adolescent health. The remaining three sections of the paper will discuss the opportunities and constraints associated with the GHARH programme, and will provide focused analysis that offers a conceptual understanding of the intricacies of an integrated ideational policy discourse. The conclusion weaves these different strands of discussion together, and integrates these strands with some final thoughts on framing and policy implementation.

HEALTH IN THE GLOBAL CONTEXT: THE CASE FOR ADOLESCENT AND YOUTH HEALTH DEVELOPMENT

It has been widely recognized that young people have received inadequate support in terms of social policies and programme interventions; as a population, they have been neglected or ignored. The WHO[20], reports that adolescents are generally perceived to be healthy due to the low death rates of this age group vis-à-vis child or adult populations. However, this perception has been dispelled in light of new evidence, which suggests that urgent response is required to confront the challenges and health inequities faced by adolescent and youth populations[21].

Although the MDGs delivered tangible progress in terms of meeting global and regional targets, empirical evidence reveals that the benefits were unevenly distributed across the global communit.[22] Further, a wide category of marginalized, disadvantaged, and vulnerable people had been left behind in the development discourse. The realities of the global and domestic environments, therefore, created momentum and set the global stage for policy action on adolescent and youth health. In structural terms, the global policy window for adolescent and youth health opened after the adoption of the SDGs, with its landmark slogan, "leave no one behind." SDG #3 specifically addresses the adolescent and youth population, and identifies the need to ensure and promote healthy lives and well-being for all at all ages.

As a significant departure from earlier global development commitments, adolescents, women and children have been strategically positioned at the forefront of the global development agenda. In line with this reasoning, the Global Strategy (2015)[23] proposes that, "the survival, health and well-being of women, children and adolescents are essential to ending extreme poverty, promoting development and resilience, and

achieving the SDGs" (p. 12). Within this context, the Global Strategy was launched in September 2015 to complement the SDGs in the global effort to improve the health and well-being of young people, a development that resulted in the subsequent adoption of the AA-HA! Framework.

CONTEXTUAL OVERVIEW OF ADOLESCENT AND YOUTH HEALTH IN GHANA

Ghana has demonstrated a significant level of commitment to improving adolescent and youth health over the past few years. Although gaps and challenges remain, the state recognizes the youth as critical assets in the national development agenda. As such, the revised National Population Policy[24] places emphasis on the general welfare and special needs of the youth. Several policies and programs have been established over time to confront the challenges faced by young people. Examples of such policies, programs, and strategies include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), National Population Policy [25], National Health Policy, National Reproductive Health and Service Policy and Standards, National Youth Policy, Ghana Adolescent Reproductive Health Policy, National Gender and Children Policy, National Condom and Lubricant Strategy (2016 – 2020), Ghana Family Planning Costed Implementation Plan (2016 – 2020), ADHD and GHARH programmes, and more recently the Adolescent Health Service Policy and Strategy (an initiative that emerged from the GHARH intervention).

While these policies, programs, and strategies have varied objectives and goals, they share certain commonalities. A significant point of convergence is the goal towards enhancing the general quality of life of young people, which ultimately boils down to effective policy delivery within an institutional context that facilitates their transition towards productive adulthood. As noted in the Adolescent Reproductive Health Policy, comprehensive and effective health programming could help to avert the wasting of the lives of young people[26]. More broadly, these national policies, programs, and strategies harmonize under the understanding and recognition of health as a human rights issue, the advancement of which leads to empowerment, wealth creation, and overall well-being.

THE ADHD AND GHARH PROGRAMMES IN COMPARATIVE PERSPECTIVE

This section provides an overview of the ADHD and GHARH initiatives with attention to the actors and context that informed the implementation of both programs. Ghana is signatory to several global treaties and conventions that recognize the right to health, and this mechanism has been instrumental in pushing young people's reproductive health issues and rights to the forefront of the national policy agenda. The GHARH programme emerged in response to difficulties faced by the ADHD programme and, specifically, its failure to yield the expected health outcomes for young people. The challenges that undermined the ADHD initiative include the lack of information, education, and communication (IEC) materials from the Ghana Health Service (GHS), inadequate regional support for the programme, poor coordination and supervision, minimal orientation for service providers, insufficient funding from the government, among others [27].

The ADHD programme was established in 2001 and implemented by GHS, while coordination of the program remained within the ambit of the NPC. The GHARH initiative, on the other hand, is a three-year Department for International Development, DFID,-funded project (£11.3 million UK aid) implemented by the Palladium Group (an international NGO), in partnership with the Government of Ghana (GoG) and other relevant partners (Jan 2014 – March 2017).[ii] Through a multi-sectoral approach, the project was instituted to improve reproductive health and educational outcomes for adolescents and youth in all 27 districts in the Brong Ahafo region, with support from four significant collaborative national agencies –NPC, GHS, GES, and the NYA. Five selected non-governmental organizations (NGOs) were also engaged as implementing partners for the project – Hope for Future Generations (HFFG), Map International, PPAG, Women in Law for Development in Africa (WiLDAF), and Institute of Social Research and Development (ISRAD).

Similar to the ADHD initiative, the GHARH programme aimed at improving national efforts towards the fulfillment of MDG #5 (i.e., improving maternal health), with the ultimate goal of reducing the adolescent pregnancy burden and maternal mortality rates among young people aged 10-24 years. Perhaps the most striking aspect of the GHARH programme is its adaptation to the exigencies of the global policy environment, specifically in relation to the adoption of the SDGs, the Global Strategy, and the AA-HA!, which ultimately served as the overarching framework for policy intervention. Certainly, this 'layering' mechanism effectively demonstrates the dynamic character of Ghana's policy landscape, and also draws attention to the role of ideas in the policy process [28,29,30,31]. As explained by Baumgartner, Jones, and Mortensen[32], new policy images are emotive appeals that hold the potential to attract new participants. Importantly, the broad character of the SDGs relative to the MDGs, as well as emergence of new actors is a key difference in the policy environment that helps to explain the contextual landscape that structured the implementation of the GHARH and ADHD programmes respectively.

To achieve the core objectives of the GHARH programme, Palladium sought to strengthen the capacity of the government and implementing partners in relation to efficient implementation, management, and effective delivery of adolescent sexual and reproductive health programmes. At this point, it should be emphasized that capacity building is a crucial mechanism that highlights the connections between ideas and policy-making outcomes. Drawing insight from Schmidt[33], we will demonstrate in the following sections how the dynamics of "coordinative" and "communicative" discourse translate into what we refer to as the ideational-implementation nexus (p. 310). While the GHARH programme draws on global ideational protocols, it is important to reiterate that it also rests on existing national policies and strategies – an arrangement that illustrates how the success of global policy frames are dictated by national politics and legitimation mechanisms.

[ii] The Department for International Development (DFID) is one of Ghana's key bilateral donors. DFID has supported the nation with millions of dollars in aid towards the goals of eradicating poverty and improving social infrastructure over the past decades.

MAKING THE CASE: FRAMING FOR ADOLESCENT HEALTH

The Sustainable Development Goals (SDGs) are generally agreed to constitute an improvement over their predecessor, the Millennium Development Goals (MDGs) for two main reasons. First, they are more broadly conceived and focused on underlying causes of poverty, disease, and inequality, rather than on specific indicators and their measurement. And second, they are articulated in global terms and not directed exclusively at developing countries. As noted, adolescent health is captured by SDG #3, "Ensure healthy lives and promote well-being for all at all ages." The topic addressed in this paper, reproductive health for adolescents, is also the focus of SDG #5, "Achieve gender equality and empower all women and girls." Each goal identifies a number of problems, some intractable and others more amenable to change, and provides evidence of either progress toward the goal or barriers to its achievement. All goals adopt the language and perspective of human rights, which is to say that they acknowledge universal, global norms and standards to be fundamental to development. However, the goals also try to reconcile this foundation with the need to pay close attention to context and cultural differences. To some extent, this produces frame conflict between the meta-cultural human rights frames and the various action frames for development[34], although the main argument that we are advancing in this paper is that frames should not compete with each other; rather, framing strategies should be integrative and multiple. We also want to emphasize that we understand frames to constitute both cognitive predispositions[35] and political strategies[36].

The first frame that gives shape to global initiatives for adolescent health is human rights. This is evident in the SDGs, as noted above, and also in the Global Strategy and AA-HA! Framework. Regarding progress toward SDG #5, the UN reports that, "Gender inequality persists worldwide, depriving women and girls of their basic rights and opportunities"[iii]. The 2017 progress report for SDG #3 emphasizes that "Preventing unintended pregnancies and reducing adolescent childbearing through universal access to sexual and reproductive health care is crucial to the health and well-being of women, children and adolescents." While the former makes explicit reference to women's rights, the latter suggests the need for universal access to "sexual and reproductive health services," which is itself framed in politically charged, controversial language. Reference to "sexual and reproductive health" represents a discursive shift away from longstanding (and less politically controversial) commitments to maternal and child health (see, for instance, Johnson 2016[37]: 6-10; more on this below). In any case, the 2017 SDG reports for goals #3 and #5 provide consistent evidence of the same universalist, human rights frame. Human rights are embedded in the SDGs as standard commitments to UN sponsored activities. In other words, they are not employed by UN agencies so much as they are fundamental to UN consciousness and therefore serve as a meta-cultural narrative. However, there is also a strategic, action-oriented dimension to the linking of development goals and human rights commitments. The human rights frame signals individuals' rights to a minimum standard of living, dignity, gender justice, and self-determination at the same time that it highlights states' responsibilities to their citizens.

[iii] https://sustainabledevelopment.un.org/sdg5

The WHO's Global Strategy also states that human rights are of paramount importance in achieving health goals. In its updated strategy document, it indicates that:

> *This Global Strategy is much broader, more ambitious and more focused on equity than its predecessor. It is universal and applies to all people (including the marginalized and hard-to-reach), in all places (including crisis situations) and to transnational issues. It focuses on safeguarding women, children and adolescents in humanitarian and fragile settings and upholding their human rights to the highest attainable standard of health, even in the most difficult circumstances*[iv].

Further, the introduction makes clear that, "The updated *Global Strategy* includes adolescents because they are central to everything we want to achieve, and to the overall success of the 2030 Agenda. By helping adolescents to realize their rights to health, well-being, education and full and equal participation in society, we are equipping them to attain their full potential as adults" (p. 5; see also fuller articulation on p. 37). However, this commitment is significantly different from the SDG commitment to human rights. The Global Strategy develops a three-pronged approach to addressing women's, children's, and adolescent health. The approach is structured with three objectives: Survive, Thrive, and Transform. The first element, "Survive" attends primarily to the standard concerns of maternal and neonatal health and survival. The final two – Thrive and Transform – are more clearly focused on adolescents.

The second predominant frame is that of development. In the documents under consideration here, development is conceived in both cultural and economic terms. Regarding the former, attention to cultural specificity is a challenge to the human rights frame, as cultural differences and their practice either contradict human rights guarantees outright, or merely frustrate their realization in practice. Regarding the latter, "sustainable development," refers to both economic growth and the strengthening of financing mechanisms for health care. All three global initiatives, the SDGs, the Global Strategy, and AA-HA!, combine cultural and economic elements in their development frames. The SDGs are the most expansive in their approach to development, and integrate well development and human rights considerations. The SDGs identify the specific underlying causes of inequality and premature death and make these preconditions to development the focus of the global initiative. In other words, the SDGs do not just pay attention to gender inequity, poverty, child marriage, FGM as development-related issues, rather the SDGs are themselves commitments to these socio-cultural phenomena.

The SDGs articulate the goals of reducing poverty, improving health, reducing child and maternal deaths, empowering women, and so on, without justifying them in economic terms. The goals are stated as independent imperatives, intrinsically worthwhile, and not of instrumental value (i.e., worthy of pursuit because they will improve economic performance). Workforce participation and economic growth are included as a separate goal (#8), and not directly connected to all other goals. However, the goal of poverty alleviation is central to the Agenda and is highlighted in the preamble to the 2030 Agenda for Sustainable Development: "The importance of context cannot be overstated: the specific details of each action in different settings will depend on political

[iv] www.wec-globalstrategyreport-200915.pdf , p. 11

environments, power dynamics, economics, religion, social norms and factors affecting health literacy and care-seeking behaviors among women, children and adolescents[v]." In short, the language of development is broadly presented throughout the SDG Knowledge Platform. Interestingly, the Global Strategy and AA-HA! initiatives were developed in response to the SDG agenda, yet both interpret that agenda in different ways.

The SDGs are the most directly concerned with the cultural dimensions of development, namely the contextual factors that contribute to high rates of adolescent pregnancy, domestic violence, FGM, child marriage, and HIV infection. These are acknowledged in both the Global Strategy and the AA-HA! document, although both tend to focus preponderantly on economic rather than cultural dimensions of adolescent health (ill health as the basis for multi-level, multi-sectoral action). For example, concerning cultural factors, the Global Strategy emphasizes that, "the importance of context cannot be overstated: the specific details of each action in different settings will depend on political environments, power dynamics, economics, religion, social norms and factors affecting health literacy and care-seeking behaviors among women, children and adolescents."[38] However, there is consistent and equally forceful reference to the theme of economic development. To this point, the Global Strategy report states, "If countries in demographic transition make the right human capital investments and adopt policies that expand opportunities for young people, their combined demographic dividends could be enormous. In sub-Saharan Africa, for example, they would be at least US$500 billion a year, equal to about one third of the region's current GDP, for as many as 30 years."[39] The entire second chapter of the Global Strategy is dedicated to the theme of investment as one of the primary benefits of improving the health of women, children, and adolescents. This may raise some red flags concerning the existence of neo-liberal predicates, which is to say that the strategy directs itself to adolescent health not as a matter of fulfilment of human rights but as a means of bolstering preparedness of future adults/ productive citizens for participation in the market. Further, the report resolves to, "Identify context-specific needs—including barriers to realizing rights—and promote access to essential goods, services and information. Expand age-appropriate opportunities for socioeconomic and political participation. Ensure that these activities are funded in country plans and budgets" (Global Strategy page 59, point 2).

The Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation – Summary (hereinafter "the AA-HA! document"), is similarly dedicated to economic justifications for development. This document does not make extensive reference to human rights (for brief mention exceptions, see pages 4 and 18). There is an acknowledgment on page 4 that "Adolescents have the fundamental right to health," although this is not cast as a reason for "investing" in adolescent health. Further, the document is not primarily focused on development, although it does describe its purpose as achieving the SDGs (vii) and aligning with Global Strategy commitments. To be sure, the AA-HA! document is an implementation guide rather than a grand visioning strategy. Therefore, it is more oriented toward practice (in the realms of both development and health administration), which is dependent on robust partnerships with constituents (adolescents), communities, government stakeholders and decision makers from different sectors, technical support agencies, and donors.

[v] https://sustainabledevelopment.un.org/post2015/transformingourworld

In the AA-HA! document, the imperative for attention to adolescent health is framed as an investment that brings "a triple dividend" (p. 4, 17, and throughout the document). The health benefits that will accrue from improved attention to adolescent well-being and survival include benefits "for adolescents now… for adolescents' future lives… [and] for the next generation" (4). In addition, the document claims that "investments in adolescent health reduce present and future health costs and enhance social capital" (4). The language of investment is both admirably pragmatic and dubiously instrumental. The language of investment is a sound strategy for convincing governments, political leaders, and policy makers to fund health programs for adolescents. Because revenues and funding sources are limited, it is important to advocate, in whatever language resonates, for the prioritization of vulnerable and often excluded or invisible groups (such as adolescents). However, as Pretice[40] explains, the economic reframing of complex social justice issues often "sidesteps the problem of social inequality" (p. 692). Moreover, "the business case [for childcare or health care] builds an ideological/ conceptual bridge to contemporary wealth production, not to social transformation" (2009: 693). In other words, the case for investing in adolescent health focuses on future economic returns and minimizes the complexities of persistent socio-economic inequalities, endemic poverty, and patriarchy.

The third frame to be considered here is that of adolescent health. While this seems to be a simple descriptive branding of an important policy focus, it is more complex than that. The shift in focus on maternal and child health to adolescent health as a separate but related health domain, is a strategic rhetorical shift, which might or might not possess any potential for change in health outcomes. There is longstanding criticism of the maternal and child health commitments. These criticisms are well explained elsewhere[41,42,43]. Suffice it to say that the focus on maternal health rather than women's health or sexual and reproductive health suggests a pronatalist, conservative bias toward protecting women as mothers. Further, maternal health conveniently tends to ignore the important yet politically divisive issue of abortion[44]. And finally, maternal and child health seem fused in ways that further emphasize the pronatalist bias and thereby marginalize both women and children as independently vulnerable populations.

The focus on adolescents is both much needed and somewhat mystifying. Both the Global Strategy and the AA-HA! document provide compelling justifications for the isolation of adolescents as a group of particular concern. The SDGs speak directly to the need to focus on adolescents as a vulnerable group. For example, SDG #3 mentions the distinct sexual and reproductive health needs of this population, and SDG#5 speaks to the challenges of achieving gender equity and empowerment for girls, whereas SGD#8 emphasizes the labour rights violations and employment needs of adolescents. In the introduction to the Global Strategy, it is stated that, "for the first time, adolescents join women and children at the heart of the Global Strategy. This acknowledges not only the unique health challenges facing young people, but also their pivotal role alongside women and children as key drivers of change in the post-2015 era. By investing in the right policies and programmes for adolescents to realize their potential and their human rights to health, education and full participation in society, we can unleash the vast human potential of this "SDG Generation" to transform our world" (11). Similarly, the AA-HA! document makes clear that, "adolescents are not simply old children or young adults. This deceptively simple observation lies at the heart of the Global Accelerated Action for the

Health of Adolescents (AA-HA!): guidance to support country implementation – which reflects the coming of age of adolescent health within global public health" (foreword, iv).

However, despite the apparent uniqueness of adolescents as a population, there might be more intergroup variation than the updated focus suggests, much of which is still attended to by other global frames. The clearest example of this is the domain (and frame) of maternal health, an area of concern that does not abate in significance under the new frameworks. The SDGs and Global Strategy make abundantly clear that maternal health, related to a wide variety of causes from child marriage to lack of access to medical care, is a major health threat for all women. The AA-HA! document, which is focused exclusively on adolescent health, reveals that the leading cause of death for girls from 15-19 years of age is "maternal conditions" (6), which indicates the precarity of both age and gender. It is possible, given the emphases on maternal health in all three sets of global commitments, that the rhetorical framing of "adolescent health" will necessitate continued attention to the more conventional action frame of "maternal health."

While we have isolated these three frames – human rights, development, and adolescent health – for analytical purposes, the documents and strategies themselves suggest an integrated approach. We endorse this suggestion, but caution that without explicit and careful attention to individual frames and their components, the political and policy implications of integrated initiatives are obscured. We agree with the admonition of the Global Strategy, which declares that:

> *Only a comprehensive human rights-based approach will overcome the varied and complex challenges facing women's, children's and adolescents' health. To succeed, countries and their partners will have to take simultaneous action in nine interconnected and interdependent areas: country leadership; financing for health; health systems resilience; individual potential; community engagement; multisector action; humanitarian and fragile settings; research and innovation; and accountability* (p. 48).

The complexity of this endeavor cannot be overstated. It is enormous, and deserving of increased global resources and attention. It is our intention in this paper to demonstrate this position through the case of adolescent health and multi-level initiatives for adolescent reproductive health in Ghana.

IMPLEMENTING THE GHARH PROGRAMME: FRAMING AND STRATEGIES

Implementation failure or success is contingent on a number of factors, and as suggested by Schmidt[45], it is worth paying attention to the dynamics of the coordinative and communicative discourses. On the one hand, the coordinative discourse speaks to the construction, elaboration, and justification of policy by actors primarily at the center of the policy sphere (i.e., elected officials, civil servants, experts, etc.). On the other, the communicative discourse involves the presentation and legitimation of policy ideas and programs developed in the coordinative discourse to the general public. To better understand the variation in program outcomes – that is, the ADHD and GHARH – we examine the strategies employed by Palladium in advancing their program objectives. It should be noted that although Palladium operated largely as a grant provider, the

organization exercised primary oversight over the implementation of the GHARH programme, while the NPC served as the coordinating unit.

To overcome the key challenges identified in the ADHD programme (i.e., issues of coordination, supervision, advocacy materials etc.), Palladium first sought to coordinate agreement among policy actors in the policy sphere. As such, a key feature of the intervention speaks to the concept of strategic partnership and multi-sectoral implementation. In contrast to the ADHD programme, the GHARH initiative involved a more robust set of policy and implementing actors. Arguably, the emergence of new actors partly contributed to the success of the GHARH intervention. Through sustained engagement with DFID, NPC, GHS, GES, NYA, NGOs, and other relevant stakeholders and implementing partners, a comprehensive strategy was adopted to guide the implementation of the GHARH programme. Of course, the need for concerted action in the context of multi-level governance has gained significant currency in policy and health discourses over the past few years, particularly in response to the complex challenges of modern governance[46,47,48].

In essence, the structural framework adopted for implementation required the need for all key actors to understand the fundamental purpose of the intervention and their specific role both within the policy and implementation streams. As pointed out by the Team Leader, it was important for all the partners to come to a common understanding and agreement prior to the implementation of the GHARH intervention.[vi] By looking at the structural context through the lens of the ideational-implementation nexus, one notices that to ensure effective intervention, implementation in itself had to be understood more broadly in terms of its ideational properties – that is, the institutional values (human rights, development, and adolescent health) that defined Palladium's mandate, and upon which the GHARH programme was predicated. As should be clear by now, the ADHD initiative failed to yield the expected outcomes due to poor understanding of this ideational mechanism. As we discuss in more detail below, the capacity building initiatives undertaken under the GHARH intervention were fashioned to reflect the ideational position adopted at the outset.

The ideational and discursive component of the GHARH initiative is important for two reasons. First, to ensure successful implementation, Palladium had to frame the GHARH programme in ways that not only captured the interest of implementing agencies and partners, but also ensured that the appropriate environment had been created for the various actors to engage the initiative with the requisite knowledge and capacity to deliver on the goals of the programme. Indeed, this was a major failing of the ADHD programme. As we argue, capacity building is an ideational mechanism through which policy ideas are translated into action. Second, capacity building was an ideational strategy intended to link the coordinative and communicative streams. In other words, both the coordinative and communicative discourse helped to legitimate the GHARH programme, and to create a fertile environment for effective policy intervention.

As part of its capacity building strategies, Palladium trained not less than 7,000 people, which includes staff of NPC, GHS, GES, NYA, peer educators, service providers, among others. [vii] Capacity building was aimed towards the need to shift attention away

[vi] Interview with Team Leader of Palladium, Mr. David Logan, Ghana, March 13, 2017
[vii] Interview with Mr. Bashiru Adams (Overall Monitoring and Evaluation Coordinator on the GHARH project), Ghana, May 10, 2017.

from the traditional practice of using general practitioners to handle adolescent health issues (interview with a senior policy official, Accra, 2017). As pointed out by a technical consultant, capacity building was essential because it had been taken-for-granted in many institutions. [viii] Another key aspect of capacity building was that Palladium developed a mobile application for service providers to enhance their interaction with adolescent health resource persons. This strategy was to help bridge the knowledge and service gap between service providers and experts specifically trained in the area of adolescent health, and to help identify the core reproductive and development issues faced by adolescents.

The GHARH intervention, as a rights-based and development initiative, was also embedded with awareness creation, sensitization, and community mobilization. This allowed for information empowerment among the adolescent and youth cohort in the region. It is estimated that not less than 400,000 young people were reached across the region. About 600 school health clubs were also established across the region to provide education and counseling services to young people. Palladium's flagship project in terms of capacity building draws attention to what is popularly referred to as "adolescent health corners". These adolescent-focused health centres were established specifically to expand health service delivery by providing "safe spaces" or adolescent-friendly services for young people in the region. Overall, 54 adolescent health corners were established across the region, with two facilities in each district (this comprises new and refurbished centres). It is worth pointing out that although the ADHD programme championed the concept of health corners, evidence suggests that most of the established corners were fraught with functionality and integrity issues [49]. Arguably, Palladium's reinvention of the health corners can be interpreted as a symbolic effort at shifting the discourse on adolescent pregnancy from the sphere of intentional cause to institutional responsibility.[ix]

Generally, these corners provide counseling services, STI diagnosis, family planning, psychiatric care, antenatal and post-natal care, as well as comprehensive abortion services and referrals for young people. Field visits to two health corners revealed a significant patronization of health services by young people in the region. Overall, it is estimated that about 51,426 young people were reached with sexual reproductive health (SRH) services and information by the GHARH-supported corners[50]. Notably, these corners have been furnished with recreational games such as scrabble, checkers, ludo, and cards that are designed to sustain the interest of young people who visit the health corners. Generally, the field research revealed that some of the young people frequent the health corners merely to play, and this generates opportunities for the health practitioners to educate them, as well as gradually introduce them to the health services offered at the facilities.

Finally, another innovative strategy introduced by Palladium is the television drama series entitled 'You Only Live Once' (YOLO). This educational programme was designed to help young people make sound reproductive health choices, and has been very popular among the youth since its introduction. Perhaps by harnessing the power of the current technological revolution, Palladium was able to engage a broader section of the youth population through interactive media platforms such as Facebook, Twitter, Instagram, and YouTube. Indeed, the drama series was ranked in 2017 as the most

[viii] Interview with Mr. Jacob Larbi, Ghana, Feb. 08, 2017.

[ix] For further detail, see Deborah Stone, *Policy Paradox: The Art of Political Decision Making* (New York: W.W. Norton & Company, Inc, 2012).

influential radio and television program on social media[51]. It is worth emphasizing that while television programmes such as 'YOLO' are not new to the Ghanaian media landscape, YOLO is unique in terms of its packaging as part of a broader interventionist programme and linkage with the adolescent health corners. Overall, an interesting takeaway from these initiatives is that when young people are effectively engaged, they respond positively to health interventions targeted at them.

A DISCURSIVE AGENDA: TOWARDS AN INTEGRATED IDEATIONAL POLICY DISCOURSE

To better understand the dynamics and utility of an integrated ideational policy discourse, which we propose in this article, it would be useful to first situate the discussion within the broader context of debates in human rights. As we argue, a key part of the puzzle that helps to explain why the ADHD programme failed to yield the expected outcomes, and yet has received little attention, speaks to the lack of a unifying global frame and consistent appeal to the human rights norms. It is worth highlighting that the ADHD initiative was developed and implemented within the context of the MDGs.

Today, the language of human rights is often used as strategic leverage to push for political and social goals embedded in principles of social justice, equity, and human dignity[52,53]. Central to the present discussion is the normative advancement of human rights protocols within the context of global development and national health discourses. While the utility of the human rights frame is beyond question, a number of studies suggest that it may not necessarily be an effective ideational instrument in addressing the rising tide of reproductive injustice, inequality, and poor maternal health outcomes [54,55,56,57,58].

Ghana has various resolutions and policies on adolescent health, which are all remarkably inspired by, and grounded in the human rights ideology. Within this context, the outcome of the ADHD programme should be understood as a framing issue, especially given that sexual and reproductive health in itself is defined and largely approached in the Ghanaian context with a rights-based framework, as reflected by Ghana's National Reproductive Health and Service Policy and Standards[59]. If the above ideational premise is flawed, then we argue that the rights-based approach is not enough. Indeed, privileging the human rights frame constrains broader discourses around which policy action can be crystallized. Undoubtedly, the relative success of Palladium in implementing the GHARH programme lies in part on its ability to employ broader strategies that link human rights approaches with other substantive action frames underpinning adolescent health, while recognizing the overarching institutional settings for effective intervention.

While the idea of framing is not without difficulties, Schon and Rein [60] demonstrate the utility of integrative and multiple framing strategies, particularly in the context of program design and implementation. In what they metaphorically describe as "design rationality," the designer (collection of actors) is constantly engaged in a discursive conversation with his or her materials (policy object and external environment), a complex political process that leads to new opportunities or problems, as well as strategies (p. 167). In line with this reasoning, we maintain that an integrated ideational policy discourse provides important reference points for the discursive construction of adolescent health in ways that augment our understandings of health politics in both the global and national spheres.

So, if the language of rights, development, partnership, inclusion, among others, are to translate into meaningful change on the ground, a variegated ideational lens cannot be overemphasized. Rather than privilege the human rights frame over other substantive health ideologies, an integrated ideational policy discourse provides a multidimensional language that allows state and non-state actors to draw on an array of policy tools, options, networks, and resources to produce transformative social change, while appreciating contextual environmental realities and constraints. Of course, a one-size-fits-all ideational platform raises critical and legitimate questions about potential competition between frames. But to assume that every context presents equal or similar socio-political or institutional challenges is unwarranted, if not misleading. Indeed, what one may consider as competing frames in one context could present opportunities in a different venue. It goes without saying that conflicting frames are not immune to resolution[61]. The challenge, then, for policy makers, health programmers, and other stakeholders is to figure out innovative strategies of combining the strengths of the various substantive frames without sacrificing the core values of adolescent health.

Ultimately, the frames that animate the SDGs, Global Strategy, and AA-HA! generate a series of puzzles, yet can be considered complementary, and provide theoretical tools for better understanding of the power of ideas in shaping the trajectory of global and national politics. However, an integrated ideational policy discourse, as we have noted, also requires a critical appreciation of the dialectic value of individual frames.

CONCLUSION

The aim of this article has been to advance understanding on why some policies yield better outcomes and initiatives than others with similar goals. Drawing on Ghana's experience with two significant adolescent reproductive health initiatives (i.e., ADHD and GHARH programmes), we examine why these interventions produced very different outcomes. In contrast to the ADHD initiative, we argue that the advantage of shifts in global thinking about adolescent health, coupled with innovative strategies, helped Palladium structure the GHARH programme in ways that contributed to implementation success. In view of the collaborative nature of the GHARH project, it seems the specific elements and structure of partnership arrangements have implications for policy implementation.

As we have argued, frames hold significant currency in terms of reconstructing policy problems, but could also translate as rhetorical instruments that hold empty promise. Therefore, the need to consider the various dimensions of the policy frame, as well as the nature of the contextual environment, and how they may facilitate or constrain social change cannot be overemphasized. Importantly, the analysis draws our attention to the inextricable link between ideas and policymaking outcomes, and the need to appreciate policy implementation as a matter of framing and discursive strategy.

In the context of institutional constraints and ongoing debates about the complex challenges of adolescent health, we suggest that an integrated ideational policy discourse is relevant for movement towards transformative health service delivery in a lower middle-income country (LMIC) context. Against this backdrop, government ownership and commitment to adolescent health initiatives cannot be overemphasized. We argue that while the ADHD and GHARH programmes offer useful comparative insights into the dynamics of policy framing, it is also the case that such a comparison encourages thinking

beyond agenda setting to include elements of policy implementation, as well as policy sustainability.

Ebenezer Bossman Agyei, PhD, is a graduate of the University of Guelph, with a specialization in public policy and governance. He is a versatile and impact-driven person committed to advocacy, community engagement and initiatives that broadly improve the quality of life in society

Candace Johnson, PhD is a Professor of political science with expertise in gender, human rights, and maternal/ reproductive health policy. Prior to joining the faculty at the University of Guelph in 2003, she held academic positions in the Department of Government at American University in Washington, DC, and in the Department of Community Health Sciences at Brock University in St. Catharine's, Ontario.

---

[1] Dehne, Karl L., and Gabriele Riedner. 2001. "Adolescence - A Dynamic Concept." *Reproductive Health Matters* 9 (17):11-15.
[2] Fatusi, Adesegun O., and Michelle J. Hindin. 2010. "Adolescents and Youth in Developing Countries: Health and Development Issues in Context." *Journal of Adolescence* 33 (4):499-508.
[3] WHO. 2017. Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation. World Health Organization.
[4] UNICEF. 2011. The State of the World's Children. Adolescence: An Age of Opportunity. United Nations Children's Fund.
[5] Campbell, John L. 2002. "Ideas, Politics, and Public Policy." *Annual Review of Sociology* 28:21-38.
[6] Schmidt, Vivien A. 2008. "Discursive Institutionalism: The Explanatory Power of Ideas and Discourse." *Annual Review of Political Science* 11:303-26.
[7] Beland, Daniel, and Robert Henry Cox. 2011. "Ideas and Politics." In *Ideas and Politics in Social Science Research*, edited by Daniel Beland and Robert Henry Cox. New York: Oxford University Press.
[8] Johnson, Candace. 2010. "Framing and the Politics of Public Health: An Examination of Competing Health Narratives in Honduras." *Global Public Health* 5 (1):1-14.
[9] Labonté, Ronald. 2008. "Global Health in Public Policy: Finding the Right Frame?" *Critical Public Health* 18 (4):467-482.
[10] Schon, Donald A., and Martin Rein. 1994. *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books: Hardper Collins Publishers.
[11] Shiffman, Jeremy, and Stephanie Smith. 2007. "Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality." *Lancet* 370:1370-79.
[12] Stone, Deborah. 2012. *Policy Paradox: The Art of Political Decision Making*. New York: W .W. Norton & Company, Inc.
[13] Johnson, Candace. 2010. "Framing and the Politics of Public Health: An Examination of Competing Health Narratives in Honduras." *Global Public Health* 5 (1):1-14.
[14] Schmidt, Vivien A. 2008. "Discursive Institutionalism: The Explanatory Power of Ideas and Discourse." *Annual Review of Political Science* 11:303-26.
[15] Shiffman, Jeremy, and Stephanie Smith. 2007. "Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality." *Lancet* 370:1370-79.
[16] Zahariadis, Nikolaos, and Theofanis Exadaktylos. 2016. "Policies that Succeed and Programs that Fail: Ambiguity, Conflict, and Crisis in Greek Higher Education." *The Policy Studies Journal* 44 (1):59-82.
[17] WHO. 2017. Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation. World Health Organization.
[18] MOH. 2015. Ghana Family Planning Costed Implementation Plan (2016-2020). edited by National Population Council

[19] Smith, E., S. Pereira, and M. Bishop. 2016. Adolescent Sexual and Reproductive Health in Ghana: What Do the Data Tell Us? : Palladium, Ghana.
[20] WHO. 2002. Adolescent Friendly Health Services: An Agenda for Change. World Health Organization.
[21] WHO. 2017. Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation. World Health Organization.
[22] UN. 2015. The Millennium Development Goals Report. United Nations.
[23] Global Strategy. 2015. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). Every Woman Every Child.
[24] National Population Policy. 1994. Accra, Ghana: National Population Council.
[25] Ibid.
[26] National Population Council. 2000. Adolescent Reproductive Health Policy. edited by National Population Council: National Population Council, Republic of Ghana.
[27] GHS. 2017. *Adolescent Health Service Policy and Strategy (2016-2020)*. Accra, Ghana.
[28] Campbell, John L. 2002. "Ideas, Politics, and Public Policy." *Annual Review of Sociology* 28:21-38.
[29] Hacker, Jacob S. 2004. "Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment In the United States." *American Political Science Review* 98 (2):243-260.
[30] Heijden, Jeroen van der. 2011. "Institutional Layering: A Review of the Use of the Concept." *Politics* 31 (1):9-18.
[31] Schmidt, Vivien A. 2008. "Discursive Institutionalism: The Explanatory Power of Ideas and Discourse." *Annual Review of Political Science* 11:303-26.
[32] Baumgartner, Frank R., Bryan D. Jones, and Peter B. Mortensen. 2014. "Punctuated Equilibrium Theory: Explaining Stability and Change in Public Policymaking." In *Theories of the Policy Process*, edited by Paul A. Sabatier and Christopher M. Weible. Boulder: Colorado: Westview Press.
[33] Schmidt, Vivien A. 2008. "Discursive Institutionalism: The Explanatory Power of Ideas and Discourse." *Annual Review of Political Science* 11:303-26.
[34] Schon, Donald A., and Martin Rein. 1994. *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books: Hardper Collins Publishers.
[35] Ibid.
[36] Stone, Deborah. 1989. "Causal Stories and the Formation of policy Agendas." *Political Science Quarterly* 104 (2):281-300.
[37] Johnson, Candace. 2016. *Maternal Transition: A North-South Politics of Pregnancy and Childbirth*. New York: Routledge.
[38] Global Strategy. 2015. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). Every Woman Every Child.
[39] Ibid.
[40] Prentice, Susan. 2009. "The "Investable" Child and the Economic Reframing of Childcare." *signs* 34 (3):687-710.
[41] Johnson, Candace. 2016. *Maternal Transition: A North-South Politics of Pregnancy and Childbirth*. New York: Routledge.
[42] Robinson, Fiona. 2014. "Discourses of Motherhood and Women's Health: Maternal Thinking as Feminist Politics." *Journal of International Political Theory* 10 (1):94-108.
[43] Tiessen, Rebecca. 2015. "'Walking Wombs': Making Sense of the Muskoka Initiative and the Emphasis on Motherhood in Canadian Foreign Policy " *Global Justice: Theory Practice Rhetoric* 8 (1):1-16.
[44] Haussman, Melissa, and Lisa Mills. 2012. "Doing the North American two-steps on a global stage: Canada, its G8 Muskoka Initiative, and Safe Abortion Funding." In *How Ottawa Spends 2012-2013: The Harper Majority, Budget Cuts, and the New Opposition*, edited by G. Bruce Doern and Christopher Stoney, 242-260. Montreal and Kingston: McGill-Queen's University Press.
[45] Schmidt, Vivien A. 2008. "Discursive Institutionalism: The Explanatory Power of Ideas and Discourse." *Annual Review of Political Science* 11:303-26.
[46] Lindquist, Evert. 2006. "Organizing for Policy Implementation: The Emergence and Role of Implementation Units in Policy Design and Oversight." *Journal of Comparative Policy Analysis* 8 (4):311-324.
[47] Rantala, Riikka, Martin Bortz, and Francisco Armada. 2014. "Intersectoral Action: Local Governments Promoting health." *Health Promotion International* 29 (S1).
[48] WHO. 2008. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.

[49] GHS. 2017. *Adolescent Health Service Policy and Strategy (2016-2020)*. Accra, Ghana.
[50] Palladium. 2016. Building Local Capacity in Ghana's Adolescent Health Sector: Handover Ceremony.
[51] Modern Ghana. 2018. "YOLO Ranked as 2017 Most Influential Radio & TV Program on Social Media." *Modern Ghana*. https://www.modernghana.com/news/836629/yolo-ranked-as-2017-most-influential-radio-tv-program-on-s.html.
[52] Bawa, Sylvia. 2012. "Women's Rights and Culture in Africa: A Dialogue with Global Patriarchal Traditions." *Canadian Journal of Development Studies* 33 (1):90-105.
[53] Johnson, Candace. 2011. "Framing for Change: Social Policy, the State, and the Federación de Mujeres Cubanas." *Cuban Studies* 42:35-51.
[54] Bradshaw, Sarah. 2006. "Is the Rights Focus the Right Focus? Nicaraguan Responses to the Rights Agenda." *Third World Quarterly* 27 (7):1329-1341.
[55] Cornwall, Andrea, and Maxine Molyneux. 2006. "The Politics of Rights - Dilemmas for Feminist Praxis: An Introduction." *Third World Quarterly* 27 (7):1175-1191.
[56] Cornwall, Andrea, and Celestine Nyamu-Musembi. 2004. "Putting the 'Rights-Based Approach' to Development into Perspective." *Third World Quarterly* 25 (8):1415-1437.
[57] Gideon, Jasmine. 2006. "Accessing Economic and Social Rights Under Neoliberalism: Gender and Rights in Chile." *Third World Quarterly* 27 (7):1269-1283.
[58] Johnson, Candace, and Surma Das. 2014. "The Human Rights Framing of Maternal Health: A Strategy for Politicization or a Path to Genuine Empowerment?" In *The Uses and Misuses of Human Rights: A Critical Approach to Advocacy*, edited by George Andreopoulos and Zehra F. Kabasakal Arat. New York: Palgrave Macmillan.
[59] MOH. 2015. Ghana Family Planning Costed Implementation Plan (2016-2020). edited by National Population Council
[60] Schon, Donald A., and Martin Rein. 1994. *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books: Hardper Collins Publishers.
[61] Schon, Donald A., and Martin Rein. 1994. *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books: Hardper Collins Publishers.

INSTITUTIONAL ARRANGEMENTS AND ROLE OF STAKEHOLDERS TO IMPLEMENT THE HEALTH-RELATED SDGS IN PAKISTAN

Saadiya Razzaq

INTRODUCTION

The Sustainable Development Goals (SDGs) encompass social, environmental and economic aspects of development. SDGs are complex and multi-sectoral by nature thus requires efforts from all the stakeholders including, but not limited to government, academia, think tanks, research organizations, civil society organizations, communities, and private sector. However, a very limited literature (almost non-existent) is available on the involvement and role of stakeholders in SDGs implementation; therefore, it is of prime importance to explore the relevance of different actors and identify their existing and potential roles for accelerating the growth on SDGs.

This research aims to explore the national level institutional arrangements (focusing on health-related SDGs) - where and how the progress is happening, which stakeholders are involved in the process, what is the role being played by different stakeholders and what is the status of adaptation of multi-sectoral approach and coordination among different stakeholders in Pakistan. The analysis in the paper will facilitate the better understanding of the institutional framework which is in place or need to be created and the role different stakeholders are playing for accelerating the progress towards health-related SDGs.

HEALTH STATUS AND SYSTEM IN PAKISTAN

Pakistan is the fifth most populated country in the world with 207.7 million population and annual growth rate[1] at 2.4 %. Due to this high population there is a pressure on education, health system and food supply in the country. The relatively high levels[2] of Maternal Mortality Rate (170 per 100000), Infant Mortality Rate (62 per 1000) and Under-5 Mortality Rate (81 per 1000); along with the low nutritional status and disparities in immunization rates in Pakistan are deeply associated with the social status and education of women in the society. In addition; 58% of households are food insecure at the national level. The headcount ratio of multi-dimensional poverty is 38.8% in Pakistan[3] and according to studies almost 4-6 % of population is being pushed into poverty due to catastrophic health expenditures. Whereas out of the total health expenditures 60 % is through out of pocket expenditures[4] and the public health expenditures are less than 1 % of GDP in Pakistan.

Though the public health sector has fairly good infrastructure having three tier (primary, secondary and tertiary) network of basic health units, rural health centers, dispensaries, district and tehsil head quarter hospitals and tertiary care hospitals; almost 75 % of population is seeking care from the private sector – which is mainly unregulated and quite diverse in terms of quality and cost.

METHODOLOGY

This research explores the institutional arrangements for SDGs and contextualizes the stakeholder's role - the extent of their involvement in the SDGs implementation and monitoring and their relations with other stakeholders in this regard.

The qualitative techniques have been used along with quantitative tool to collect the information on relevant stakeholders. The qualitative methods, with their narrative and observatory approach, are widely being used in health care setting[5] as they are more penetrative than the quantitative data. The following methods were used to collect the information: (1) desk review of literature, (2) key informant interviews with relevant stakeholders, (3) consultative meetings with health-related stakeholders, and (4) quantitative survey through emails.

A comprehensive literature review and desk research was conducted for initial listing of the stakeholders; (i) Websites of government institutes/departments, international donors, policy research institutes and universities were explored (to understand the nature of their work regarding health), and (ii) literature on the mapping techniques and role of stakeholders has been reviewed. The stakeholders were identified based on the variables like type of organization, location, geographical boundaries of work and type of work. After identification, stakeholders were categorized in the following for further analysis: government agencies/ departments, international donors/ development partners, policy makers (parliamentarians), commercial private for-profit entities (service providers), non-profit (NGOs, CSOs, foundations), policy research institutes, think tanks (public and private), universities/ academia, media and community.

The 24 key informant interviewees were conducted with the representatives of different organizations as showed in table 1:

Table 1: No. of Key Informant Interviews

Organizations	No. of Interviews
Government ministries and departments	8
Parliamentarian	1
Think Tanks	5
Academia	4
NGOs/ CSOs	3
Development Partners	2
Regulatory Body	1
Total	24

Two stakeholder's consultations were conducted, one in Islamabad and one in Karachi. The participants (34 in Karachi and 39 in Islamabad) represented government, development partners, donors, think tanks, academia, INGOs/ local NGOs/ CSOs and media.

NATIONAL-LEVEL INSTITUTIONAL ARRANGEMENTS FOR SDGS

A SDGs Secretariat has been established in National Assembly as well as the provincial secretariats in their respective provinces have been established to work on SDGs related activities. Prime Minister's SDGs Program (PMSDGP 2016-18) with an allocation up to Rs.136 billion has been launched. The details of the roles and responsibilities by different departments/ bodies and structures within the federal and provincial levels have shown in Table 2.

Parliamentary Task forces: The federal parliamentary Task Force on SDGs is being headed by State Minister. Similarly, the provincial parliamentary task forces have been established in provinces of Punjab and Sindh whereas the Balochistan and KP provinces are still lagging behind. The Provincial Parliamentary Task Forces on SDGs are responsible[6] for providing the policy and strategic guidance for the implementation and localization of SDGs; to make sure the process of SDGs is inclusive and consultative; to review and evaluate the progress of implementation; and to ensure availability and commitment of resources.

Table 2: Roles and Responsibilities for SDGs

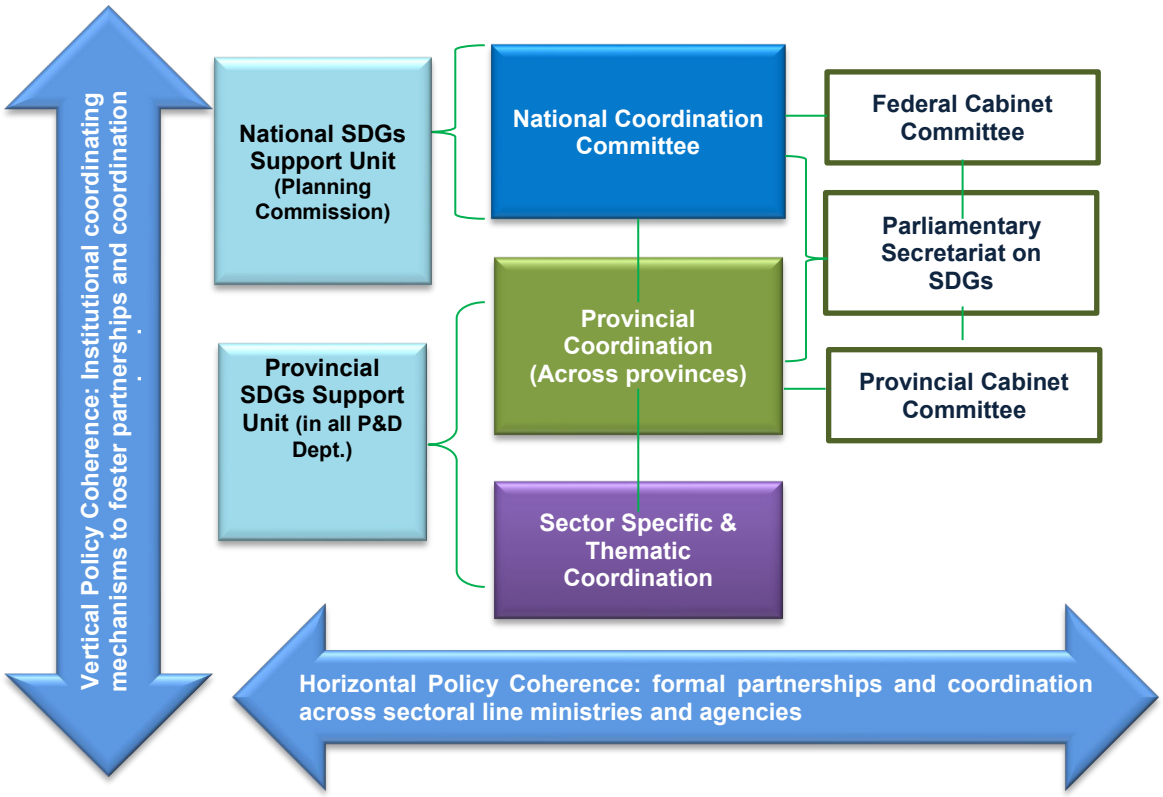
Activity	Key Responsible Agency
Strategic Coordination and Supervision	MoPDR
Aligning SDGs to National Development Framework	MoPDR in collaboration with UNDP
Technical Assistance for Coordinating, Reporting and Monitoring	UNDP
Help in evidence based legislation* Facilitate regular vertical coordination between the federal parliament and provincial assemblies, and enable horizontal coordination and knowledge sharing	SDGs Secretariat, National Assembly Provincial Secretariats, established at Pakistan Institute of Parliamentary Services**
Designing of collaborative work plan based on priority SDG targets***	SDGs Secretariat
Increasing Awareness on SDGs at all levels	MoPDR
Mapping SDGs to the National Development Framework	MoPDR
Development of Indicators and Data collection	MoPDR and Pakistan Bureau of Statistics
Identification and Prioritization of projects for Implementation	SDGs Secretariat
Financing the Priority Projects	Ministry of Finance, Provincial Governments
Monitoring and Evaluation (Progress Review)	MoPDR
Consolidation of Report	MoPDR – 4 provincial SDGs Units will report to the federal SDGs Unit
Dissemination of the Report	MoPDR

*First anniversary of Parliamentary SDGs secretariat observed. APP https://www.app.com.pk/first-anniversary-of-parliamentary-sdgs-secretariat-observed/
**Butt, Salma. (2017, July 25). Missing a Chance to Share Experiences. Dawn. Retrieved from https://tribune.com.pk/story/1465722/missing-chance-share-experiences/
*** National Assembly of Pakistan retrieved from http://www.na.gov.pk/en/pressrelease_detail.php?id=1821

SDGs Units: For the overall strategic coordination and supervision, the SDGs unit has been established in Ministry of Planning, Development and Reform (MoPDR) on cost-sharing bases with United Nations Development Program (UNDP). At the provincial level the similar setups have been established (Balochistan is in the process of establishing the SDGs units). Figure 1 shows the coordination mechanism adopted by SDGs Unit at federal level.

SDGs have been aligned with 7 pillars of Vision 2025 (strategic document by Govt. of Pakistan) and according to the Planning Commission "the government has internalized Sustainable Development Goals (SDGs) as National Goals and this is a major policy shift". MAPS – Mainstreaming, Acceleration Policy Support is the approach for SDGs in Pakistan. Moreover, to apply the multi-sectoral approach the 17 goals have been put under four clusters (1) Social, (2) Economic (3) Environment and (4) Governance. All the ministries have nominated their focal persons to collaborate with SDGs Unit. Integrated sector plans are also on the agenda. A study on private sector is underway to explore the efficient and effective ways to engage the private sector in SDGs implementation process. In addition to that, PC had also organized a summit on SDGs by inviting all the district (135) heads in Islamabad to create awareness about integration of SDGs into the local planning and budgeting. Similar kind of orientations for govt. officials have been conducted by provincial governments in their respective divisions/ districts.

Figure 1: Institutional Coordination Mechanism



Source: Presentation given by Project Director, SDGs Unit, Planning Commission, at Stakeholders Consultation on Health-related SDGs, Islamabad, July 13 2017

Planning Commission (PC) will also be compiling the data from provinces and reporting on SDGs at the national level. This reporting mechanism has also aimed at enhancing the coordination and cooperation among provinces and federal institutions.

A National Committee on SDGs at the federal SDGs Unit is in process to involve all the relevant stakeholders including development partners, donors, academia, think tanks, the civil society, NGOs, private sector etc. For oversight and coordination the inter-ministerial (federal and provincial representation) coordination committee and provincial coordination committees are being established. - Sind province has also notified the Provincial Technical Committee for SDGs which is responsible for review and propose work plan for SDGs implementation; provide guidance; facilitate and coordinate with stakeholders; monitor the implementation of projects; and coordinate with federal SDGs unit regarding the implementation of SDGs in the province.

The Government of Punjab through SDGs Unit is in process of developing the district SDGs plans for 2 districts as a pilot project which will be reflected in ADP (annual Development Plan) of Punjab. These district plans will be focused on under privileged districts and thematic areas to be focused are health, education, culture, and WASH etc. Sindh Sustainable Development Strategy has been prepared to align the provincial initiatives with SDGs, and identifying the key performance indicators and financing gap for SDGs. Sindh SDGs support unit is in process of establishing a Core Group (consisting of all the relevant stakeholders) for developing a framework based on cluster approach. Provincial consultation and orientation workshops have also been conducted in the both the provinces. KP province has aligned it's all health programs with SDGs[a]. Unfortunately, the awareness about SDGs is only among top officials of health department, KP and junior staff need to be oriented on the subject.

The Federal Ministry of National Health Services Regulations and Coordination (MoNHSRC) is responsible for the regulation, oversight, and coordination between the provinces and is the lead Ministry for Health SDGs. In 2016 the National Health Vision 2016-2025 has been developed and is aligned fully with SDGs with the aim to attain the SDGs through resilient and responsive health system. MoNHSRC, has established SDGs cell at the ministry to coordinate all the efforts on health-related SDGs. The provincial health departments have also established the SDGs cells and these are linked with federal cell whereas all these cells are also linked with SDGs Units at PC and P&D departments in their respective provinces.

Regarding monitoring and evaluation, Health Planning, Systems Strengthening and Information Analysis Unit (HPSIU) at the federal MoNHSRC have been established whereas Health and Population Think Tank at health services academy under MoNHSRC is established with the mandate to provide guidance and orientation to the Ministry about the current health issues. MoNHSRC has also formed a National Oversight Committee, focusing on improving the inter provincial coordination and communication, a well as an Inter-ministerial forum has been formed and key performance indicators (KPIs) are being defined.

To improve the quality of care and regulate the private health sector Healthcare Commissions have been established in Sindh, Punjab and KP. The Commissions will

[a] The LHW, EPI, MNCH and nutrition programs has been integrated under MNCH with the aim of reducing MMR

provide licenses and registration of hospitals in private and government sectors to improve the quality of health care delivery.

Availability of credible data is heart of effective monitoring of SDGs; in this regard Planning Commission in collaboration with UNDP and Pakistan Bureau of Statistics (PBS) has conducted an extensive exercise to review the availability of data on SDGs from various sources and timelines. Almost 50 % of data is available for SDGs monitoring rest required different levels of efforts to collect data. Surveys like Pakistan Social and Living Standards Measurement Survey (PSLM), Pakistan Demographic and Health Survey (PDHS), Multiple Indicator Cluster Survey (MICS) and other questionnaires have been reviewed to align them with SDGs indicators. Regarding health-related indicators, data for 23 will be covered through household surveys, for 6 through institutional data and for 2 indicators the data will be available through macro level data sets. Even though the efforts are underway the data availability will be a challenge for Pakistan. A National framework for SDGs[7] has also been developed by planning commission of Pakistan and the SDGs indicators have been prioritized. Health is under priority number 1.

ROLE OF STAKEHOLDERS

Think Tanks

Pakistan has a limited number of think tanks working on health issues. The policy relevant health research in Pakistan consists of medical, public health and health policies/systems research. Think tanks are involved in the policy making process with the varying degree. Employees/ members of these organizations are part of different committees, bodies and policy making forums on behalf on their organizations as well on individual basis as experts. For example, Executive Director, Sustainable Development Policy Institute (SDPI) by virtue of being present on Prime Ministers Economic Advisory Council and also in National Advisory Committee of Planning Commission of Pakistan and different other high-level forums, is playing a catalyst role in transition towards sustainable development. Whereas the Managing Director of Social Policy and Development Center (SPDC) is member of provincial core committee and is actively involved at the provincial level planning. Heartfile is also deeply involved in government policy process and part of many committees and boards. Through heartfile platform, Pakistan was first amongst the Asian countries who have developed national action plan on Non-communicable Diseases. Policy recommendations given by Leadership for Environment and Development (LEAD) have been incorporated in the policies of government particularly in Sindh and Punjab for environment and water sectors.

However, it is difficult to relate a particular policy with the recommendations of a single organization due to the other compounding factors which contribute towards development of policy or any amendment in policies. Nonetheless, it is important that think tanks are involved in policy making process to a larger extent.

Think tanks involvement with CSOs and other grass root level organizations is a bit limited and depends on the relevant projects. Whereas Thinktanks have established formal and informal collaborations with several national, regional and international/ global organizations including academia, other think tanks and networks/ bodies and platforms.

All the think tanks are well aware of the importance of multi-sectoral approach for accelerating the growth on SDGs though the multi-sectoral approach being adopted is with the varying degrees. However, think tanks have showed their concerns on multi-sectoral approach being adopted by the government regarding processes, engagement with the relevant stakeholders and the coordination among different ministries/ departments.

While most of the think tanks are based either in federal or provincial capitals; one of the important challenges is the lack of finances for research that is being faced by all the think tanks. This issue compelled them to sought out the alternative sources of funding which has impact on the design and mandate of the think tanks (as now they are not only conducting the research but also involved in advocacy, training capacity building and project management activities).

Academia

In Pakistan there are around 44 public health institutes and more than 100 medical universities[b]. The public health institutes are conducting research on public health issues as well as the medical universities with portfolio of more than medical education (like Aga Khan University) conduct research on a wide range of issues of health, including public health, maternal and neonatal health and non-communicable diseases.

Some of the academic organizations are providing inputs for policy formulation and research which is being considered for policy debate (Health Services Academy – under the MNHSRC) but it is difficult to say that how much is actually become part of the policy as there are a lot of other factors involved in policy formulation including the political agenda. HSA is also hosting the Health and Population Think Tank. In addition to that the faculty members of different public health institutes are member of committees and forums to develop the policy.

The teaching programs at these institutes, are aligned with SDGs and courses and modules on SDGs related topic are being added to the curricula (for example Health Services Academy and Alshifa School of Public Health). Public health institutes are also collaborating with other national and international organizations in terms of research and academic activities.

However, the multi-sectoral approach is limited to the research only and with a varying degree across institutes.

NGOs/CSOs

A huge number of Civil Society Organization (CSOs) and Community Based Organizations (CBOs) exist in Pakistan with deep penetration in far-flung areas thus making the Civil Society a major stakeholder. A large number of NGOs are still unregistered in Pakistan; therefore, it is difficult to assess the number and scale[c] (however government's efforts to register all the NGOs are now underway).

[b] Source: http://www.pnc.org.pk/PNC_Recognized_Institutes.htm, http://nchpakistan.gov.pk/Colleges.html, http://www.pmdc.org.pk/AboutUs/RecognizedMedicalDentalColleges/tabid/109/Default.aspx

[c] As per SPDC report[c] 2002 the total number of NGOs were 45000 and out of which 2700 were working on health issues. According to the PCP[c] around 100000-150000 NGOs/ CSOs are working in Pakistan which means there was at least one NGO for every 2,000 people. A statement issued by the Ministry of Social Welfare and Special Education in 2010, shows that almost 100,000 CSOs and CBOs are operating in

Currently government is working with many CSOs through public-private partnerships particularly in the education and health sector at federal and provincial levels to enhance the effectiveness of services delivery. Peoples Primary Healthcare Initiative (PPHI) is one of the examples of public private partnership under which basic health units are being managed by the NGOs.

The organizational capacity varies a lot from well-defined structures to just a single person headed organization[8] and CSOs are mainly dependent of donor money. NGOs have played an important role in promoting universal health in Pakistan, the focused areas include physical and financial access to health services, availability of health care providers and quality of care whereas social determinants of health got a limited attention[9]. Most of the NGOs are involved in service delivery along with other activities like training and capacity building, awareness raising, advocacy/policy outreach, monitoring and evaluation, data Collection and research & policy formulation. Out of total expenditures of private hospitals almost 6 % is by the hospitals owned by NGOs 18 % by the hospitals owned by trusts[10].

During the study, very few organizations were able to relate their work with SDGs however Shirkat Gah come up as a best case which has been part of the High Level Political Forum (HLPF) on Sustainable Development held in 2017. Shirkat Gah has conducted SDGs indicators' review from a gender and sexual & reproductive health rights perspective. They are also working on localizing the SDGs indicators. Similarly, the multi-sectoral approach is not being adopted by these NGOs/ CSOs largely except by Shirkat Gah.

The major challenges include the lack of funding, lack of coordination among different NGOs working in the same geographical area and of capacity of human resources.

Development Partners

In Pakistan the UN agencies, multilateral and bilateral development partners[d] are working in health sector. These development partners are spending through government as a budgetary support as well as through local and internal NGOs and they are also managing the programs by themselves. The working style and nature of work varies from donor to donor,; some of the donors are more inclined to implementation whereas some are more focused on policy guidance/suggestion, research, and advocacy.

WHO is providing the policy guidelines and working closely with the MoNHSRC by supporting government in capacity building, information sharing, exchange of experiences and some technical assistance to the government. UNICEF has done policy research in partnership with Universities and specialized research centers. For example, UNIECF in collaboration with a German University is conducting survey on child labour

Pakistan out of which 60,000 to 70,000 are registered. Whereas, a mapping exercise conducted by the Pakistan Centre for Philanthropy (PCP) showed that at least 80 % of registered organizations were inactive in 2010 (USAID 2015). According to Economic Survey 2009 around 206 public private service organizations and 600 NGOs are engaged in health services provision, research and advocacy.[c]

[d] In health sector some of the important donors include but not limited to, USAid (USA), DfID/UKAid (UK), AusAid (Australia), GIZ (Germany), World Bank, Asian Development Bank, Norway, Canada, JICA (Japan). Whereas the UN agencies working in Pakistan include, UNDP, WHO, UNICEF, UNFPA, UN Women. UNDP is involved in overall SDGs while others are working on health-related issues and gender is a cross cutting issue taken care by UN Women.

in Pakistan. UNFPA is supporting research institutions and academia i.e. National Institute of Population Studies, Pakistan Institute of Development Economics, to build their capacity in research techniques and analysis. Moreover, Provincial youth policies and population policies are the successful interventions achieved with support of UNFPA technical assistance. Recently, Government of Sindh has passed Sindh child marriage restraint act 2013 due to the strong advocacy efforts by UNFPA.

WHO is adopting the multi-sectoral approach for achieving SDGs, therefore, has created links of health sector with other SDGs such as poverty, gender, water and sanitation, etc., other UN agencies have also adopted multi-sectoral approach for example UNICEF has adopted multidisciplinary strategies in Early Childhood Development (ECD) and adolescents' health whereas, UNFPA is collaborating with WHO and UNICEF for SDGs attainment.

Non-availability of data on number of indicators and slow process of SDGs' localization were mentioned as some of the key challenges by development partners.

Media

In Pakistan, a lot of print and electronic media does exist. It ranges from local/ district level newspapers to provincial and national newspapers; Radio channels at national and city level including AM and FM bands and a lot of TV channels which are on rise since last decade or so. Currently there are around 97 TV channels[e] are operating majority (51) are entertainment channels followed by news channels (35).

Unfortunately, the SDGs or health is not the priority area for the media in Pakistan. Whereas as per rule by PEMRA (Pakistan Electronic Media Regulation Authority) TV channels have to spend 2 % of the air time on social issues but it is not been practiced. As per code of conduct by PEMRA, TV channels do not broadcast the ads on tobacco and if they have to show a scene of smoking during a drama/ program they include the health warning.

CONCLUSIONS AND RECOMMENDATIONS

Government though has put in place the institutional mechanisms to implement the SDGs but still the pace of work is slow. Furthermore, coordination among different ministries and departments and with federal and provincial entities needs to be enhanced to work in an effective manner. There is a need of repositioning local government as the SDGs focal tier, and to give the responsibilities to the district government as well. The financial allocation for health-related SDGs also needs to be increased to improve the health outcomes.

Prioritization and localization of SDGs is in process however the implementation is on a slower pace. At this stage of implementation, it is quite difficult t state that what is working and what is not. It will take some time to assess the impact of the current policies and programs. Nevertheless, it is important to consider that business as usual and the strategies developed to achieve the MDGs will not going to work. The key lessons learned from the MDGs include the enhancing the focus on (i) availability of quality and timely

[e] Pakistan Electronic Media Regulatory Authority

data; (ii) strong M&E systems and (iii) adaptation of multisectoral and multi-stakeholder approaches, if the goal is to achieve the SDGs.

In this regard the role of policy research institutions (PRIs) needs to be enhanced. Think tanks and academia are involved in policy process with a varying degree across institutions but an integrated plan by the government to involve all the relevant stakeholders is missing. In addition to that the capacity at the policy research institutes in terms of research and adopting multisectoral approach needs to be improved to provide evidence for policy making. Further, the involvement of private sector and media is need of time. Platforms and networks are necessary to avoid duplication of efforts and more collaboration among stakeholders.

A lot of data is missing for monitoring of SDGs and the involvement of PRI and NGOs will be helpful in this regard. At the same time the existing data which is not being reported needs to be analyzed and published. The availability of disaggregated data is another important factor for progress on SDGs. Setting up standard data protocols and developing coordination mechanisms between Federal and Provincial Statistical Bureaus is required. In addition to that data ecosystem for SDGs including coordination, monitoring, reporting, capacity building, and effective use of integrated statistical frameworks for advancing sustainable development needs to be developed. Here the Pakistan Bureau of Statistics needs to assume the leadership role.

Saadiya Razzaq *is currently working as Technical Advisor, Sustainable Health Financing, at Clinton Health Access Initiative (CHAI), Malawi. She is a seasoned development professional having more than 16 years' experience implementing social sector development programmes with a major focus on health sector, managing large project design and implementation teams, and collaborating with governments, donors, and development agencies. Ms. Razzaq is a recognized health financing specialist with expertise in health economics, collating evidence for policy reforms, strategic planning, and health system strengthening. She has been extensively consulted on several health financing assignments. She has been engaged in monitoring and evaluation studies/ activities as well as for promoting the availability of timely and quality data for SDGs.*

Ms. Razzaq has worked with UN agencies, bilateral donors, government and Think Tanks (international and national) on key positions (as full-time employee and consultant). She has been extensively published on health-related SDGs and presented her work on numerous national and international conferences/ meetings.

Acknowledgement*: The author acknowledges the support by Sustainable Development Policy Institute (SDPI), Pakistan and the team - Kashmala Choudhry, Nabila Kanwal and Rabia Tabassum for conducting the research with the funding from IDRC, Canada.*

[1] Government of Pakistan. (2017) Ministry of Statistics. Press Release on Provisional Summary Results of 6th Population and Housing Census – 2017. Retrieved from http://www.pbs.gov.pk/sites/default/files/Population_Census_2017_Results_0.pdf
[2] Government of Pakistan (2017) Pakistan Economic Survey 2016-2017 Retrieved from http://www.finance.gov.pk/survey/chapters_17/11-Health.pdf
[3]UNDP Pakistan (20 June 2016). Pakistan's new poverty index reveals that 4 out of 10 Pakistanis live in multidimensional poverty. Retrieved from http://www.pk.undp.org/content/pakistan/en/home/presscenter/pressreleases/2016/06/20/pakistan-s-new-poverty-index-reveals-that-4-out-of-10-pakistanis-live-in-multidimensional-poverty.html
[4] Government of Pakistan, Pakistan Bureau of Statistics (2016) Pakistan National Health Accounts 2013-14
[5] Mays N, Pope C. (1996) Rigour in qualitative research. In: Mays N, Pope C, editors. Qualitative research in health care. London: BMJ Books
[6] Government of Sindh, ToRs of task force on SDGs
[7] Planning Commission. (March 2018). Summary for the National Economic Council (NEC): Sustainable Development Goals (SDGS) National Framework. Minitry of Planning, Development & Reform. Retrieved from https://www.sdgpakistan.pk/uploads/pub/National_SDGs_Framework_-_NEC_20182.pdf
[8] USAID (2015) The 2015 CSO Sustainability Index for Pakistan
[9] Shaikh, B. T. (2008). Understanding social determinants of health seeking behaviours, providing a rational framework for health policy and systems development. J Oak Med Assoc, 58(1), 33-6
[10] Government of Pakistan, Pakistan Bureau of Statistics (2016) Pakistan National Health Accounts 2013-14

GLOBAL
HEALTH GOVERNANCE

A publication of the Center for Global Health Studies,
The School of Diplomacy and International Relations, Seton Hall University