

The Changing Landscape of Global Health Diplomacy

APRIL 2013

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*A Report of the Global Health
Policy Center*

CSIS

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Introduction

*Katherine E. Bliss*¹

In the fall of 2012 the Center for Strategic and International Studies (CSIS) Global Health Policy Center organized a working group to analyze progress on diplomatic outreach to advance global health during the first four years of the Barack Obama administration. Over three sessions the working group members, who included health policy researchers, former diplomats, and an ex-officio group of current government officials, met to discuss emerging trends related to global health diplomacy and to develop a set of recommendations to enhance U.S. diplomatic outreach on global health for the next four years. Much of the working group's effort focused on the important role played by the secretary of state in raising the visibility of global health challenges on the world stage and on the Department of State's potential to promote greater coherence and integration of U.S. overseas health programs in the next presidential term.

Yet a third important aspect of the project was to examine changes in the ways other countries are deploying their diplomats and foreign assistance expertise in the service of the global health enterprise.² This line of inquiry built on previous CSIS Global Health Policy Center work focused on the role of the emerging economies, particularly the BRICS (Brazil, Russia, India, China, and South Africa), in shaping the global health agenda.³ The working group's mandate was to expand on that earlier work, incorporating analysis of a broader set of actors in order to both shed light on changing practices in the area of global health cooperation and identify opportunities for the United States to enhance its diplomatic engagement with traditional and emerging global health agenda-setters. To provide background analysis to inform the working group's deliberations, CSIS commissioned several papers to inform the working group members about how practices in the area of global health diplomacy are changing and where opportunities for greater U.S. diplomatic coordination with global health partners might lie.

This volume presents those analyses. The studies are loosely grouped around three themes. Two papers identify the ways in which traditional donors and providers of foreign

1. Katherine E. Bliss is senior associate with the CSIS Global Health Policy Center.

2. That paper was published as Katherine E. Bliss, Judyth Twigg, and J. Stephen Morrison, "U.S. Priorities for Global Health Diplomacy," in *Global Health Policy in the Second Obama Term*, ed. J. Stephen Morrison (Washington, DC: CSIS, March 2013). Key recommendations included institutionalizing the secretary of state's leadership role with respect to global health; devising a robust Group of Eight (G8; the highly industrialized nations of Canada, France, Germany, Italy, Japan, Russia, United Kingdom, and the United States) diplomatic strategy; and defining a U.S. diplomatic strategy toward emerging powers.

3. See Katherine E. Bliss, ed. *Key Players in Global Health: How Brazil, Russia, India, China and South Africa Are Influencing the Game* (Washington, DC: CSIS, November 2010).

assistance for global health, namely the European countries and Japan, are refining their approaches in the face of financial challenges. In their examination of the European countries' evolving response to the financial crisis, for example, CSIS Europe program director Heather A. Conley and program coordinator Matthew Melino show that the United Kingdom remains committed to being a significant global health donor and influential policy-maker, while newer actors, such as Ireland and Spain, as well as longtime development leaders, the Netherlands, have had to scale back efforts and reassess goals and priorities. Conley and Melino suggest it is likely Germany will continue to support global health activities but note that there are opportunities for U.S. diplomatic outreach to encourage the German government to engage in more strategic thinking when it comes to long term global health investments. France, they argue, remains committed to remaining a leader in global health, but the François Hollande government faces challenges in calls for budget cuts in 2013.

In discussing Japan's evolving approach to global health diplomacy, CSIS Japan Chair adjunct fellow Ben Self argues that there are multiple opportunities for the United States and Japan to partner on global health, both in the Asia region and within multilateral agendas focused on maternal and child health. CSIS Global Health Policy Center senior associate Katherine Bliss's paper on health diplomacy in the Americas sheds light on Canada's efforts to build its global health muscle and expertise with a focus on "filling gaps" that other, perhaps wealthier, global health funders neglect.

In a second set of analyses focused on Russia and China, two papers examine how these influential but relative newcomers to global health diplomacy use outreach on development to build political and economic influence in key regions. CSIS Russia and Eurasia program senior associate and Virginia Commonwealth University professor Judyth Twigg's analysis shows how Russia is reconfiguring its health diplomacy, with a particular focus on hosting important global meetings on health and building the capacity of Russian bureaucrats to engage in overseas health programming. In this way, her paper sheds light on Russia's strategic goal to be seen as a global leader and donor and the deliberate steps the government is taking to achieve that status. In their analysis of China's diplomatic outreach on health, Peking University Institute of Global Health executive deputy director Lucy Chen and colleagues examine how domestic trends, particularly the government's enormous effort to expand and upgrade health services for the rural population, influence the government's outreach and overseas interests.

A third area of inquiry was the role that emerging powers and middle income countries are playing. CSIS Korea chair research associate Carolyn Marie DuMond and director Victor Cha's analysis of South Korea's health diplomacy demonstrates how the country's "middle power" approach builds on its own recent experience as a recipient of international assistance. In her examination of changing health diplomacy practices in the Americas, Bliss reveals that Brazil and Mexico, and, to a lesser extent, Chile, are developing their own regional and global areas of expertise, with Brazil and Mexico focusing on regional and South-South approaches.

Individually, the papers in this volume offer key insights regarding the background, experience, and politics that shape each country's approach to global health diplomacy. At the same time, they pinpoint clear and specific opportunities for U.S. engagement through existing bilateral and multilateral channels while offering suggestions regarding what topics or themes may be most promising for enhanced diplomatic coordination and action.

Taken together, the papers show that the world of global health diplomacy is quite dynamic at the moment, with new partners setting trends while traditional actors are reconfiguring their views and practices. As the Obama administration moves into a second term, there are numerous opportunities for U.S. diplomats to coordinate on global health goals with middle income countries such as Brazil, Chile, Mexico, and South Korea; to learn more about how Russia and China continue to build their outreach and assistance capacities; and to strengthen existing relationships with Canada, Japan, and Europe to shore up support and innovation in the global commitment to public health.

1 | A Transitional Moment in Global Health Leadership

Europe, the Emerging Economies,
and the Future of Development Assistance

*Heather A. Conley and Matthew Melino*¹

Introduction

Historically, Europe has been both the largest contributor and the largest recipient of international foreign assistance. The United Kingdom, France, and Belgium first initiated development assistance programs in their colonial territories to promote economic development and trade relations. Following the devastation of World War II, Europe was one of the greatest recipients of foreign and reconstruction aid by the United States, symbolized by the delivery of “CARE” (Cooperative for American Remittances to Europe) packages from America to European refugees and the displaced. Because of their experiences as donors and recipients, European states were instrumental in creating new institutions and structures including the Organization for European Economic Cooperation and the Development Assistance Group—today known as the Organization for Economic Cooperation and Development (OECD) and the Development Assistance Committee (DAC). The establishment of these institutions began a rapid expansion of European leadership in development assistance.²

Today, individual European countries such as the United Kingdom, Germany, and France as well as Europe’s collective efforts through the European Union (EU) view official development assistance (ODA) and global health contributions as an increasingly critical foreign policy and soft power tool. European ODA contributions have greatly increased over the past several decades. Global health assistance in particular has increased dramatically, doubling in size between 2001 and 2007, with 17 percent of that increase occurring from 2007 to 2008.^{3,4} At the 2005 Gleneagles Group of Eight (G8)⁵ summit, Canada, France, Germany, Italy, Japan,

1. Heather A. Conley is senior fellow and director of the CSIS Europe Program, where Matthew Melino serves as research assistant and program coordinator.

2. Owen Barder, “Reforming Development Assistance: Lessons from the U.K. Experience,” in *Security by Other Means*, ed. Lael Brainard (Washington, DC: Brookings Institution Press, 2007).

3. “The Global Health Regime,” Council on Foreign Relations, August 21, 2012, <http://www.cfr.org/health-science-and-technology/global-health-regime/p22763>.

4. Gautum Naik, “Gates Urges Support for Global Health Programs,” *Wall Street Journal*, January 25, 2012.

5. Major industrial nations including: Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the United States of America.

the United Kingdom, and the United States pledged to accelerate progress toward achieving the United Nations (UN) Millennium Development Goals (MDGs) by 2015 and committed a total of \$50 billion between 2005 and 2010 to reduce child mortality; improve maternal health; and combat HIV/AIDS, malaria, and other diseases.⁶ At the same time, these countries also reaffirmed the goal of spending 0.7 percent of gross national income (GNI) on ODA.

The recent onset of the global economic crisis in 2008 and the subsequent European sovereign debt crisis in 2010 have resulted in fiscal austerity and growing domestic hostility toward European foreign aid budgets. As a result, European governments have reduced or redirected spending towards domestic projects and export aid, and thus failed to uphold previous aid commitments. This downward trajectory will fundamentally challenge future European ODA leadership and change the development assistance and global health landscape. It is a transitional moment as traditional coordination mechanisms seem out of sync with these evolving trends. New approaches and diplomatic initiatives are needed that emphasize innovation to strengthen international cooperative efforts in an age of austerity and cooperative partnerships with emerging economies. In the short term, strengthening transatlantic development cooperation bilaterally and multilaterally will serve as a reassuring example moving forward.

European Donors

EUROPEAN UNION: STAVING OFF DECLINE IN AMBITION AND ASSISTANCE BUDGETS AS ECONOMIC CHALLENGES MOUNT

As the EU enlarged over the past two decades to twenty-seven members, so too has the EU aid budget and strategy grown more robust. The EU and its member states remain the largest development aid donor in terms of real contributions.⁷ EU member states have strengthened their development partnership between the EU and seventy-nine African, the Caribbean and Pacific nations⁸ and have agreed to boost levels of ODA to 0.56 percent of GNI by 2010 as an intermediary goal to achieving the UN target of 0.7 percent of GNI by 2015.⁹

Despite this distinction, the EU has been profoundly challenged by its heavy debt burden and weak economic growth over the past three years. The EU and its member states have reduced government spending and in turn, development assistance budgets. EU aid to developing countries in 2011 fell €500 million to €53 billion according to the Organization for Economic Cooperation and Development (OECD).¹⁰ The one exception to this trend is the

6. Kaiser Family Foundation, "International AIDS Assistance from Donor Governments: Commitments and Disbursements, 2002–2010," July 18, 2012 <http://facts.kff.org/chart.aspx?ch=946>.

7. "EU Development Aid Drops with Austerity," Euractiv, April 5, 2012, <http://www.euractiv.com/global-europe/eu-development-aid-drops-austeri-news-511983>.

8. European Commission, "The Cotonou Agreement," September 12, 2012, http://ec.europa.eu/europeaid/where/acp/overview/cotonou-agreement/index_en.htm.

9. European Commission, "Development Aid Statistics," September 11, 2012, http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Development_aid_statistics.

10. "EU Development Aid Drops with Austerity," Euractiv, April 5, 2012, <http://www.euractiv.com/global-europe/eu-development-aid-drops-austeri-news-511983>.

United Kingdom. However, its operating and administrative budget for the Department for International Development (DFID) has recently been restricted.

Health has been a particular development assistance priority for Europe with EU member states contributing through bilateral or EU mechanisms. The executive branch of the EU, the European Commission (EC), has been a reliable donor to multilateral organizations that focus on global health. From 2003 to 2011 it contributed approximately €82.5 million, resulting in immunizations for approximately 326 million children and preventing over 5 million future deaths.¹¹ The EC is also an active donor to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Although a consistent donor to the Global Fund since 2008, EC pledges have dropped from a high of approximately \$165 million in 2011 to \$125 million for 2012 and \$135 million for 2013.¹²

The EC and individual EU member states have been and will continue to be increasingly consumed by the politics and institutional challenges related to the deepening sovereign debt crisis. In February 2013 the European Council agreed on a new budget, known as the multiannual financial framework (MFF 2014–2020) that has yet to be approved by the European Parliament. While the MFF calls for €34.4 billion in budget cuts, the amount of EU development aid is to remain unchanged. It is unlikely that the new MFF will adequately replace the amount of ODA that has been reduced from the hardest hit EU donors such as Greece and Spain, with both countries decreasing their bilateral ODA budgets by 40 and 33 percent respectively.¹³ A stagnant budget threatens to jeopardize the EU's commitment to achieve the UN's 0.7 percent GNI target. However, the European Council recommends that 90 percent of external spending be used for ODA. The European Council also agreed to maintain existing levels of funding for the European Development Fund (EDF) at €26.98 billion.¹⁴ The impact of current and future austerity measures and the uncertainty surrounding the European Parliament's approval of the MFF outlay for ODA present a formidable challenge to maintain or increase assistance levels.

UNITED KINGDOM: A RESILIENT LEADER IN GLOBAL ASSISTANCE

The United Kingdom's development assistance program dates back to economic relationships forged under the British empire. The Colonial Development and Welfare Act of 1945 increased official aid to £120 million over ten years to assist colonial governments with the planning of public works, social services, and agriculture.¹⁵ Following the conclusion of World War II and the success of the European Recovery Act, the United Kingdom shifted its development focus toward combining capital and technical assistance to transform

11. GAVI Alliance, "Bill Gates acknowledges EU support for GAVI," January 24, 2012, <http://www.gavi.org/library/news/gavi-features/2012/bill-gates-acknowledges-eu-support-for-gavi/>.

12. The Global Fund to Fight Aids, Tuberculosis and Malaria, "Donors and Contributions," 2013, <http://www.theglobalfund.org/en/donors/statistics/>.

13. European NGO Confederation for Relief and Development, "Aidwatch Report 2012," 2012, 4.

14. European Council "Conclusions (MFF)," February 8, 2013, http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/135344.pdf.

15. Barder, "Reforming Development Assistance."

developing economies.¹⁶ The creation of the Department for International Development (DFID) in 1997 marked another turning point in UK development assistance with the expansion of aid beyond traditional economic assistance and into new areas including poverty reduction.^{17,18}

Today, the United Kingdom is Europe's largest contributor to global health, with London pledging to continue a positive trend in funding both through bilateral and multilateral channels. Between 2010 and 2011 the government increased global health assistance by 14 percent; momentum slowed between 2011 and 2012 with assistance increasing by 2.3 percent.^{19,20} Despite accounting for only 3.6 percent of the world's gross domestic product (GDP), the UK donated \$897 million to HIV/AIDS in 2010, nearly 5.8 percent of total resources. A 2012 pledge of £384 million to the Global Fund made the United Kingdom the fund's third largest donor.²¹ The UK is also one of only two countries to contribute to the GAVI Alliance through direct funding, Advance Market Commitments (AMC), and the International Finance Facility for Immunization (IFFIm), increasing its contributions every year since 2008.²²

In 2010, citing increasing levels of debt, Prime Minister David Cameron's government undertook a comprehensive spending review which mandated cuts of 25 to 40 percent across all government ministries and offices with the exception of the National Health Service (NHS) and DFID. DFID's budget will continue to increase and reach £10.1 billion by 2015 despite a lowered GDP forecast. The United Kingdom remains on track to be the first country in the G8 to meet the UN target of 0.7 percent of GNI to ODA.^{23,24} Andrew Mitchell, former UK secretary of state for international development, supported the budget increase, stating that "the prime minister has made it clear that we will not balance the books on the backs of the poorest people on the planet."²⁵ The United Kingdom's commitment to global health is expected to remain vibrant and its leadership in assistance secure for the foreseeable future.

16. Ibid.

17. UK Department for International Development (DFID), "History," October 23, 2011, <http://www.dfid.gov.uk/about-us/history/>.

18. Howard White, "DFID: The First Four Years," Institute of Development Studies, University of Sussex, April 2001, <http://www.ids.ac.uk/files/DFID4years.pdf>.

19. University of Washington, Institute for Health Metrics and Evaluation, "Financing Global Health 2012: The End of the Golden Age?," 2012, http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2011/FGH_2012_overview_IHME.pdf.

20. University of Washington, Institute for Health Metrics and Evaluation, "Has the Golden Age of Global Health Funding Come to an End?" February 6, 2013, <http://www.healthmetricsandevaluation.org/news-events/news-release/has-golden-age-global-health-funding-come-end>.

21. Mark Tran, "MPs call on UK to set example by increasing Global Fund contribution," *The Guardian*, May 22, 2012, <http://www.guardian.co.uk/global-development/2012/may/22/mps-uk-global-fund-contribution>. "Pledges and Contributions," The Global Fund, 2013, <http://www.theglobalfund.org/en/about/donors/>.

22. "United Kingdom," GAVI Alliance, September 5, 2012, <http://www.gavialliance.org/funding/donor-profiles/united-kingdom/>.

23. "The Comprehensive Spending Review: Sticking to Promises on Aid," Devex, October 21, 2010, <http://www.devex.com/en/news/70427/>.

24. Mark Tran, "UK aid budget takes hit in chancellor's autumn statement," *The Guardian*, December 5, 2012, <http://www.guardian.co.uk/global-development/2012/dec/05/uk-aid-budget-chancellor-autumn-statement>.

25. John Davison, "A conversation with Andrew Mitchell on UK aid reform," Devex, October 19, 2010, <http://www.devex.com/en/news/a-conversation-with-andrew-mitchell-on-uk-aid/70380>.

GERMANY: A SLEEPING ECONOMIC GIANT THAT NEEDS STRATEGIC AWAKENING

Germany's developmental assistance strategy can be directly traced back to U.S. president John Kennedy's "Decade of Development" campaign in 1961, following his administration's establishment of the United States Agency for International Development (USAID). As one of the strongest European economies at the time, as it is today, Germany was viewed as a particularly important partner to Kennedy's vision of engaging other Western states as foreign aid donors. With a strong push from the United States, the German Federal Ministry for Economic Cooperation and Development (BMZ) was established in 1961. As recently as 2011 and after being heavily criticized by the OECD and others for having a cumbersome and inefficient process of aid coordination, the German Development Service (DED), German Technical Cooperation (GTZ), and Capacity Building International (InWent) were merged to create one single entity, the German Agency for International Cooperation (GIZ). GIZ continues to work closely with BMZ to implement an array of German aid programs.²⁶

With a more streamlined delivery mechanism, a growing portion of German ODA has been allocated toward global health initiatives and organizations. Since 2000 German global health aid commitments have more than tripled.²⁷ Germany was Europe's third-largest donor of health assistance funds in 2010, with contributions totaling \$947 million.²⁸ Its priorities include the control of sexually transmittable diseases (STDs), basic health infrastructure, and infectious disease control.²⁹ Germany also maintains partnerships with multilateral institutions, pledging to contribute €1 billion to the Global Fund from 2012–2016, and providing \$58.4 million in direct contributions to the GAVI Alliance in 2012.^{30,31,32}

Germany has not assumed a leadership role at international aid forums, although it has been very vocal regarding the improper use of aid. Following instances of corruption and an estimated \$34 million in fraud, Germany suspended its assistance to the Global Fund in 2011.³³ Despite sizeable donations, Germany must form strategic alliances with engaged states and aid actors such as the United Kingdom and private foundations to pursue a more robust global health campaign that is commensurate with its economic strength and

26. OECD, "Germany: Development Assistance Committee (DAC) Peer Review 2010," 2010, <http://www.oecd.org/development/peerreviews/46439355.pdf>.

27. "Global Health Policymaking in Germany," Global Health Sciences, University of California, San Francisco, December 2010, updated May 2011, <http://globalhealthsciences.ucsf.edu/sites/default/files/content/ghg/e2pi-policymaking-in-germany.pdf>.

28. University of Washington, Institute for Health Metrics and Evaluation, *Financing Global Health 2012: The End of the Golden Age?* February 6, 2013, 37, http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2011/FGH_2012_full_report_medium_resolution_IHME.pdf.

29. "Financing and Policy Making for Global Development in Germany," SEEK Development, April 2012.

30. The Global Fund to Fight AIDS, Tuberculosis and Malaria, "Germany Makes EUR 1 Billion Contribution to the Global Fund," January 24, 2013, http://www.theglobalfund.org/en/mediacenter/newsreleases/2013-01-24_Germany_Makes_EUR_1_Billion_Contribution_to_the_Global_Fund/.

31. "Germany Contributes \$265.6M to Global Fund," Devex, March 8, 2012, <http://www.devex.com/en/news/blogs/germany-contributes-265-6m-to-global-fund>.

32. GAVI Alliance, "Germany," September 5, 2012, <http://www.gavialliance.org/funding/donor-profiles/germany/>.

33. J. Stephen Morrison and Todd Summers, *Righting the Global Fund* (Washington, DC: CSIS, 2012), 1.

leadership responsibilities in and beyond Europe. Although Germany is actively expanding its use of public-private partnerships in development, this mechanism serves as an opportunity to establish and expand new markets for German exports as much as it provides assistance.³⁴ It will be important for this silent partner to become more visible and active in the future.

NORWAY: A GROWING GLOBAL HEALTH LEADER

A non-EU member, Norway has ably demonstrated its leadership in development assistance over the past fifty years. The government promotes a strategy that is heavily based on respect for human rights and poverty reduction. Norway remains one of only five countries in the world to exceed the UN target of 0.7 percent ODA/GNI, and has done so consistently for more than thirty years.³⁵ In 1968 the Norwegian Agency for Development Cooperation (NORAD) was established, and today it administers the majority of development assistance programs. In 2011 NORAD published its most updated strategy outlining its approach toward 2015, which places a new emphasis on expanding development assistance to emerging global challenges, including climate issues. Future funding will most likely remain consistent, as a summary of the 2013 national budget reiterates the Norwegian government's commitment to allocating 1 percent of GNI to ODA. The 2013 aid budget has doubled from 2004 to reach NOK 30.2 billion, including a NOK 650 million increase in global health funding.³⁶

Norwegian ODA and support for global health has increased substantially since 2000, despite recent currency appreciation and a drop in its exports to Europe. In 2006 Norway played a key role in establishing the initiative for Foreign Policy and Global Health, which in 2007 published the Oslo Ministerial Declaration, and called for a stronger focus on health as a foreign policy issue.³⁷ Also in 2007 Prime Minister Jens Stoltenberg launched the Global Campaign for the Health MDGs aimed at accelerating progress toward achieving the health MDGs.³⁸ At the UN in 2009 Prime Minister Stoltenberg renewed Norway's commitment to global health by announcing that Norway would provide NOK 3 billion for global cooperation on women's and children's health in the period up to 2020.³⁹ Norwegian health assistance is primarily delivered through multilateral channels. The government has pledged over \$75.5 million to the Global Fund for 2011, 2012, and 2013, an increase of nearly 22 percent from its commitments in 2010.⁴⁰ A positive trend is also visible in its

34. Heather A. Conley and Uttara Dukkupati, *Leading from Behind in Public-Private Partnerships?* (Washington, DC: CSIS, 2012), 7.

35. OECD, "Norway (2008) DAC Peer Review of Norway—Main Findings and Recommendations," 2008, <http://www.oecd.org/dac/peerreviewsofdacmembers/norway2008dacpeerreviewofnorway-mainfindingsandrecommendations.htm>.

36. Norwegian Ministry of Foreign Affairs, "Norway's Aid Budget Doubled in Nine Years," October 8, 2012, <http://www.regjeringen.no/en/dep/ud/press/news/2012/aidbudget2013.html?id=704094>.

37. "Oslo Ministerial Declaration—Global Health: A Pressing Foreign Policy Issue of Our Time," *The Lancet*, April 2, 2007, http://www.who.int/trade/events/Oslo_Ministerial_Declaration.pdf.

38. Norwegian Ministry of Foreign Affairs, "Global Health in Foreign and Development Policy," February 3, 2012, 11.

39. Ibid.

40. The Global Fund to Fight AIDS, Tuberculosis and Malaria, "Pledges and Contributions," <http://www.theglobalfund.org/en/about/donors/>.

commitments to the GAVI Alliance, where Norway is one of the six original donor countries, and the only donor aside from the United Kingdom that contributes through direct funding, Advance Market Commitments (AMC), and the International Finance Facility for Immunization (IFFIm).

Norway continues to play an outsized role in comparison to its relative size in global health assistance. Unfortunately, coordination mechanisms and private sector partnerships with the United States are lacking. In 2009 only 3 percent of Norwegian aid was channeled through the private sector. The former director general of NORAD, Poul Engberg-Pedersen, wrote in 2009 that it is expensive for Norway to aid individual companies, explaining that “we get more for our money by investing in framework conditions that facilitate investment.”⁴¹

NETHERLANDS: A HARBINGER OF THE FUTURE?

Over the past sixty years, the Netherlands has earned a strong reputation for its commitment to international development. The Dutch Ministry of Foreign Affairs appointed its first minister for development cooperation in 1965, and achieved the 1970 UN General Assembly Resolution of allocating 0.7 percent of GNI/ODA in 1975.^{42,43} A lack of ministerial authority initially hindered the effectiveness of Dutch aid, but as processes became more streamlined and roles for ministers became more defined, the level of efficiency matched its level of generosity. Dutch aid priorities traditionally focus on improving conditions in poor nations across Africa, including Kenya, Mali, and Uganda, among others, with assistance going to security and development, rights for women and girls, and global health. Recently, the Dutch reduced their number of partner countries from fifty-one in the early 2000s to fifteen today.⁴⁴

The Netherlands spent \$675 million on global health in 2009, accounting for 10.6 percent of total Dutch ODA, making it the fourth-largest European government donor in 2010. It prioritizes sexual and reproductive health and rights (SRHR), basic health care, and communicable diseases control.⁴⁵ The 2012 budget, however, included only \$122 million for bilateral cooperation in health, of which \$53 million was used for general health in support of SRHR and HIV/AIDS projects.⁴⁶

A sputtering economy; political fragmentation; and a vocal far-right, xenophobic movement have forced the Netherlands to adjust its development assistance budget and, in the

41. Conley and Dukkipati, *Leading from Behind*, 10.

42. Daniel Bach, “A Brief Summary of Dutch Development Cooperation Policy,” Kapuscinski Lecture Series, April 7, 2011, The Hague, http://sidnl.files.wordpress.com/2011/04/kapuscinski_programme_final1.pdf.

43. OECD, “The Netherlands: Development Assistance Committee (DAC) Peer Review 2011,” 2011, <http://www.oecd.org/development/peerreviewsofdacmembers/49011988.pdf>.

44. OECD, “The Netherlands (2001), Development Co-Operation Review: Main Findings and Recommendations,” 2001, <http://www.oecd.org/dac/peerreviewsofdacmembers/thenetherlands2001developmentco-operationreviewmainfindingsandrecommendations.htm>.

45. “Financing and Policy Making for Global Development in the Netherlands,” SEEK Development, March 2012.

46. Ibid.

process, drop global health as an official priority. In 2009 Dutch ODA fell by 4.5 percent, and although it increased in 2010 to well above the 0.7 percent ODA/GNI Gleneagles goal, new legislation mandates that it drop back to a fixed 0.7 percent of GDP starting in 2012.^{47,48} However, these figures are not immune to change, as a newly elected government must wrestle with reducing government spending. The most recent 2010 Dutch coalition agreement required that ODA be reduced by €958 million beginning in 2012, the leading development official be downgraded from minister to state secretary, and that the definition of what constitutes ODA be broadened.^{49,50}

The Netherlands is an example of emerging political dynamics within Europe that may significantly alter future aid development policies and budgets. As nationalistic and xenophobic political parties take more prominent roles in parliaments, political compromises and forced austerity measures may sacrifice European donor generosity. Public diplomacy strategies for maintaining strong public support for foreign aid will be vital to mitigate the impact of anti-aid political forces.

FRANCE: WHERE DEVELOPMENT ASSISTANCE LEADERSHIP MEETS AUSTERITY

French development assistance is a product of long-standing relations with its former colonies. In 1959 President Charles de Gaulle created the Ministry of Cooperation to facilitate military cooperation with French colonies, primarily in Africa, using active-service military volunteers to carry out their missions.⁵¹ In 1961 the body was rebranded as the Ministry of Cooperation and Development, although the focus still remained on former colonial states.⁵² It was not until Alain Juppé's first term as prime minister in 1995 that this ministry was fully merged with the Ministry of Foreign Affairs. Two years later, Prime Minister Lionel Jospin changed the position title from "minister for cooperation" to "minister for cooperation and Francophone countries" or, alternatively, "minister for cooperation, development, and Francophone countries." In 2010, under François Fillon, the two portfolios were again separated, with separate ministers handling development and Francophone matters.⁵³ This evolution shows the close interface between France's colonial roots and its development agenda, although Paris has since expanded its development programs to English- and Portuguese-speaking Africa as well as the Caribbean Basin.⁵⁴

Stagnant economic growth, increased unemployment and debt, and rising taxes are all causes for concern that France will not be able to sustain its current levels of aid support.

47. Conley and Dukkupati, *Leading from Behind*, 5.

48. AidWatch, "Challenging Self-Interest: Getting EU Aid for the Fight Against Poverty," May 2011.

49. "Netherlands Unveils Top Aid Priorities, Cuts for 2012," Devex, September 21, 2012, https://www.devex.com/en/news/netherlands-unveils-top-aid-priorities-cuts-for/75966?source=ArticleHomepage_Headline.

50. Stephen J. Flanagan, *A Diminishing Transatlantic Partnership?* (Washington, DC: CSIS, 2012).

51. Alain Rouvez, *Disconsolate Empires* (Lanham, MD: University Press of America, 1994), 106.

52. *Ibid.*, 37.

53. "Président de la République," Assemblée Nationale, 2012, <http://www.assemblee-nationale.fr/histoire/gvt5rep.asp>.

54. François Pacquement, "How Development Assistance from France and the United Kingdom Has Evolved: Fifty Years on Decolonisation," *Revue internationale de politique de développement*, March 11, 2010.

Empirically, French ODA has already decreased. France plans to increase its global health and sub-Saharan ODA levels by only €1.12 billion, missing its Gleneagles target level by nearly one-third and raising concerns that President François Hollande will not meet the global health commitments of his predecessor.⁵⁵ The current French global health strategy emphasizes the nation's commitment to fighting communicable diseases such as HIV/AIDS, tuberculosis, and malaria.⁵⁶ Despite dwindling ODA commitments, France remains a strong contributor to multilateral global health organizations, namely the Global Fund and the GAVI Alliance. Since its inception in 2000, France has been the second-largest donor to the Global Fund, contributing a total of €2.91 billion.⁵⁷ The country has maintained a strong link to the Fund as the Friends of the Global Fund Europe are headquartered in Paris and the Fund's former executive director, Michel Kazatchkine, was a French citizen. Without a French executive director to the Global Fund, a lack of a similar location and personnel connection to GAVI and an overall declining global health budget that has resulted in steadily decreasing contributions since 2011, questions are being raised about future levels of funds and current signs are not encouraging. For 2013 France has pledged \$80.7 million, a decrease of over 10 percent from 2012 levels.⁵⁸

As one of the largest European economies and an intellectual and monetary leader of global health initiatives, France represents an important test of the impact of the European sovereign debt crisis. The United Kingdom has placed a *cordon sanitaire* around DFID and the Germans have left their aid funds largely intact although lacking strategic direction, but the French are under increasing pressure to adjust their development assistance budgets as the Hollande government must cut €33 billion from its 2013 budget to meet European debt and deficit targets, while simultaneously implementing numerous campaign pledges to stimulate the French economy as economic growth weakens. Leadership outreach to the highest levels of the French government will be critical during this uncertain political budget environment to shore up resolve for the continuation of French global health leadership and the implementation of its previous commitments.

New Horizons: European Engagement with Emerging Economies (Brazil, Russia, India, China, South Africa)

As European donors reduce their ODA and global health budgets, the emerging economies—Brazil, Russia, India, China, and South Africa, known collectively as the BRICS—are beginning to fill the void and demonstrate a willingness to play a larger role in development assistance and global health. Brazil's development assistance in 2010 totaled \$1.2 billion—an increase of approximately 20.4 percent per year since 2005. India's

55. ONE "France," *The 2012 DATA Report*, 2012, http://one.org.s3.amazonaws.com/pdfs/data_report_2012_en.pdf.

56. Evidence to Policy Initiative, "Global Health Policymaking in France," May 2011.

57. Morrison and Summers, *Righting the Global Fund*, 8.

58. GAVI Alliance, "France," February 8, 2013, <http://www.gavialliance.org/funding/donor-profiles/france/>.

assistance has also increased by around 10.8 percent per year, growing to \$680 million in 2010. From 2004 to 2010 China's aid nearly quadrupled to almost \$4 billion, while Russia's assistance increased substantially before stabilizing at its current level of approximately \$450 million per year.^{59,60} However, it is important to note that BRICS aid will not replace diminished European aid in the near future.

Data suggest that the BRICS indeed have assumed a greater role as donor nations in global health, with each country earmarking a significant percentage of development assistance funds for global health initiatives. It is important to note, however, that as emerging economies, the BRICS still receive development aid from Europe, although European aid toward the BRICS is on the decline. According to OECD statistics, since 2008 European nations have reduced contributions to Brazil by \$27.25 million, to India by \$28.05 million, to China by \$17.03 million, and to South Africa by \$110.91 million.⁶¹ In December 2011 the European Commission recommended nineteen countries "graduate" from aid recipient to a new type of partnership based on their ability to generate enough resources to ensure their own development. The Commission's plan resulted in the discontinuation of bilateral aid to countries such as Brazil, China, and India.⁶² It will end €365 million in direct transfers to India, €170 million to China, and €60 million to Brazil by the implementation of the next MFF in 2014.⁶³

Clearly, Europe and the BRICS are experiencing a transitional moment in development assistance where cooperation patterns are shifting. As the economic and political influence of the BRICS expands and European resources are constrained, a new dynamic and form of cooperation between traditional European donors and emerging BRICS donors must be found. To date, cooperation with the BRICS has been limited due to conflicting philosophies on aid coordination. The BRICS, with the exception of Russia, prefer a South-South model characterized by horizontal cooperation and mutual respect between the donor and the recipient. This model does not impose social, political, or economic conditionality to the aid that is delivered—a requirement that is increasingly used by European donors.

If this hurdle of incompatible philosophies can be overcome, an effective future development model is trilateral assistance cooperation. Combining the regional expertise and domestic experience of the BRICS, coupled with the support and organizational know-how of a European donor to execute a project in a third country, assistance funds could be more efficiently distributed and program implementation made more effective. For example, the Brazilian Ministry of Health and the Brazilian Cooperation Agency (ABC), the Uruguayan Ministry of Public Health (MSP), and the German Agency for International Cooperation

59. Global Health Strategies Initiatives, "Shifting Paradigm: How the BRICS Are Reshaping Global Health," 2012, 6, http://www.ghsinitiatives.org/downloads/ghsi_brics_report.pdf.

60. Sujata Rao, "BRICS: Future Aid Superpowers?" Reuters, March 26, 2012, <http://blogs.reuters.com/globalinvesting/2012/03/26/brics-future-aid-superpowers/>.

61. OECD, "DAC Official and Private Flows."

62. European Commission, "The Multiannual Financial Framework: The Proposals on External Action Instruments," December 7, 2011.

63. Stanley Pignal, "EU to Stop Aid to Fast-Growing Countries," *Financial Times*, December 7, 2011.

(GIZ) are currently engaged in a trilateral initiative to combat HIV/AIDS in Uruguay. The program is designed to strengthen the Uruguayan health system and its response to HIV/AIDS. The initiative combines Uruguay's knowledge of local needs with Brazil's technical expertise and Germany's experience facilitating and monitoring the international cooperation processes. The German government contributes €5 million in funding for the project, which is delivered through the Kreditanstalt für Wiederaufbau (KfW), a government-owned development bank. Results are encouraging, as the project has improved access to HIV/AIDS diagnosis for approximately 353,000 Uruguayan citizens.⁶⁴

Although efforts such as this have been successful, trilateral cooperation initiatives remain underutilized, limiting potential opportunities for cooperation between European and BRIC donor countries.

Transatlantic Donor Assistance Cooperation

Development cooperation between the United States and Europe dates back to the conclusion of World War II with the enactment of the European Recovery Act (the Marshall Plan). Launched by the U.S. government in 1948, the act allocated \$13.3 billion in funds for post-war European recovery efforts. Following the success of the Marshall Plan, the dynamics of U.S.-European donor relations shifted toward donor collaboration and coordination. Over the last several decades, the United States and Europe combined are the largest contributors to international development, now totaling nearly 80 percent of global ODA. In 2010 the EU and its member states contributed €53 billion in assistance and the United States contributed \$30 billion.⁶⁵ The United States and the EU launched a development dialogue in the 1990s to facilitate aid coordination amid an environment of strained donor budgets. Although there was initial optimism regarding this new the EU-U.S. development dialogue, it was largely abandoned.

Searching for EU-U.S. summit deliverables as well as seeking to highlight transatlantic development assistance, the United States and the EU re-launched the development dialogue in November 2009 with an emphasis on food security, climate change, global health, the implementation of the Millennium Development Goals and aid effectiveness (based upon aid effectiveness indicators developed as the follow-on to the Busan international aid effectiveness conference). For climate change and food security, pilot countries, such as Mali, Indonesia, Ethiopia, and Bangladesh, were identified to move the development dialogue from a conversation between Brussels and Washington to more directed conversation and engagement with the recipients. Pilot countries were not selected for global health as it was believed that a sufficient policy dialogue regarding specific country outcomes occurred within existing structures such as GAVI. Additionally, the two sides agreed to hold annual meetings at the ministerial level between the administrator for USAID and the

64. Deutsche Gesellschaft für Internationale Zusammenarbeit, "Regional HIV/AIDS Programme for Latin America and the Caribbean," May 8, 2012.

65. European Commission, "Joint EU-U.S. Statement: EU-US Development Dialogue London," Brussels, June 16, 2011, http://europa.eu/rapid/press-release_MEMO-11-414_en.htm.

EU commissioner for development to enhance transatlantic cooperation and encourage field input and quantifiable outcomes.⁶⁶ The two sides committed to scale up contributions even further in order to achieve the MDGs by 2015. The resumption of this initiative occurred at a time when both the EU and U.S. aid budgets were under increasing political scrutiny.

The EU-U.S. development dialogue has evolved and matured and is considered to be a more effective dialogue than its previous incarnation. In 2011 a joint EU-U.S. task force on health experts was created to identify areas of cooperation between the EU's policy on global health and the U.S. global health initiative. The task force currently prioritizes strengthening health systems in partner countries in the developing world, while also exploring future joint EU-U.S. efforts in global health-related initiatives.⁶⁷ Specific projects will target developing countries struggling to achieve the MDGs, with a particular emphasis on sub-Saharan Africa, and least developed countries (LDCs) in other regions.⁶⁸ Some American officials note that the global health component of the EU-U.S. dialogue is not as robust as the other three elements, as health is not considered a European development "core competency" as is food security or climate change issues. The global health component seeks to raise cross-cutting issues as well as become a place of exchanging "best practice" information. Also, as European development agencies tend to shy away from incorporating the private sector in public-private aid partnerships and the United States embraces a variety of corporate and foundation alliance mechanisms, there is less transatlantic discussion about engaging increasingly important private development aid partners.

Bilaterally, the United States has also forged strong partnerships with individual European nations, most notably the United Kingdom. In May 2011 UK prime minister David Cameron and U.S. president Barack Obama made a joint commitment to improve the lives of nearly 1.2 billion of the world's poorest citizens by accelerating progress toward the Millennium Development Goals.⁶⁹ The two leaders agreed that over the next five years, the two nations would work together to prevent stunting and child mortality in 17 million undernourished children by improving access to vitamin supplements and to save the lives of at least 50,000 women during pregnancy and childbirth by training more midwives in developing countries.⁷⁰

Strong U.S.-UK leadership is also a driving force behind the success of many multi-lateral organizations. At a June 2011 replenishment conference for the GAVI Alliance, the United States and the United Kingdom joined forces to secure commitments that exceeded the GAVI Alliance's \$3.7 billion request by \$500 million. These funds will allow GAVI to

66. European Commission, "EU Commissioner Piebalgs in Washington to Relaunch the Development Dialogue with the USA and to Attend the World Bank Development Committee Meeting," Brussels, April 23, 2010, http://europa.eu/rapid/press-release_MEMO-11-414_en.htm.

67. European Commission, "Joint EU-US Statement: EU-US Development Dialogue London," Brussels, June 16, 2011, http://europa.eu/rapid/press-release_MEMO-11-414_en.htm.

68. Ibid.

69. Department for International Development, "US and UK Join up on Global Development," May 25, 2011, <http://www.dfid.gov.uk/news/latest-news/2011/us-and-uk-agree-joint-partnership-for-development/>.

70. Ibid.

immunize more than 250 million children in the world's poorest countries by 2015, preventing more than 4 million premature deaths.⁷¹ Furthermore, from 2001 to 2011 EU and U.S. contributions combined totaled nearly 53 percent of all of GAVI's funds. The United States contributed approximately \$737 million, representing approximately 14 percent of total contributions, and the EU and its member states contributed approximately 39 percent of contributions during that same period.⁷²

Despite ongoing leadership from the EU and the United States, challenges will persist. Fiscal austerity measures on both sides of the Atlantic will limit future resources. Seamless EU-U.S. coordination must occur during this restrictive budgetary environment or funding priorities and objectives will quickly become misaligned, leading to confusion among recipient countries and potentially lethal gaps in assistance. Although transatlantic donor coordination has greatly improved since 2009, both sides struggle with understanding future trends, seeking greater programmatic flexibility to meet emerging challenges and focusing on societal resilience from the adverse effects of climate change and how this fits into the larger EU-U.S. dialogue.⁷³ Moreover, new assistance innovations such as the growth of public-private partnerships and trilateral cooperation have yet to be fully explored within the EU-U.S. development dialogue.

Time for a Health Diplomacy Strategy

Although the quote has been attributed to Winston Churchill, its origin is unknown: "Gentlemen, we have run out of money. Now is the time to think." International development assistance has by no means "run out of money," but future funding levels and the arrival of new donors will drive a very dynamic period over the next ten years. Now is both the time for traditional European donors to drive innovation and for emerging economies to embrace their new roles as partner donors. By doing so, new strategies will become more effective. Innovative financing mechanisms, civil society organizations, foundations and private sector involvement represent new frontiers to build awareness and sync traditional coordination mechanisms with new trends.

INNOVATIVE FINANCING MECHANISMS

The International Finance Facility for Immunization (IFFIm) is a new funding mechanism embraced by many European donors. It uses long-term pledges from donor governments to sell "vaccine bonds" in capital markets, making large volumes of funds immediately available for programs under the GAVI Alliance umbrella. Since its inception, the program has nearly doubled GAVI's funding for immunization programs. The GAVI Alliance benefits

71. The White House Office of the Press Secretary, "Joint Fact Sheet: The U.S.-UK Partnership for Global Development," March 14, 2012.

72. GAVI Alliance, "Key Figures: Donor Contributions and Pledges," 2013, <http://www.gavialliance.org/funding/donor-contributions-pledges/>.

73. G. William Anderson, "The U.S.-EU High Level Development Dialogue: Building on the Legacy of the Marshall Plan," June 24, 2011, <http://www.gmfus.org/archives/the-u-s-eu-high-level-development-dialogue-building-on-the-legacy-of-the-marshall-plan/>.

from over twenty-three years of participation from the governments of the United Kingdom, France, Italy, Norway, Australia, Spain, the Netherlands, Sweden, and South Africa. To date, IFFIm has raised more than \$3.6 billion.⁷⁴

UNITAID, an international drug-purchasing facility, is another example of an innovative financing mechanism that has successfully promoted global health. Established through the joint leadership of Brazil and France (an excellent example of trilateral cooperation), the program utilizes specific market interventions to improve access to medicines, diagnostics, and preventive items used to combat HIV/AIDS, tuberculosis, and malaria.⁷⁵ According to the UNITAID *Annual Report 2010* report, the practice has achieved a 49-percent price reduction from 2008 to 2010 for pediatric medicines, and over 70,000 children newly living with HIV now have access to quality child-formulated antiretroviral treatment.⁷⁶ UNITAID fills a critical gap in global health financing as it utilizes strategic market intervention to increase the supply of drugs while ensuring that their prices remain low and accessible for developing nations.

CIVIL SOCIETY ORGANIZATIONS

Civil society organizations (CSOs) across Europe play an increasingly important role in driving the global health agenda by serving as a coordinating mechanism between large multilateral organizations and recipients. The success of these organizations has led the GAVI Alliance to commit over \$21 million in 2010 to CSOs in the planning and delivery of immunization services, often reaching “the last 10 to 20 percent of a country’s population.” Due to geographic, socioeconomic, or cultural reasons, these citizens are out of the reach of government services and remain unimmunized.^{77,78}

CSOs also serve as mobilizing forces to create a demand for immunization and other health services by bringing attention to global health issues among domestic constituents, and advocating to policymakers and donors on behalf of civil societies.⁷⁹ On average, European DAC country nongovernmental organizations (NGOs) receive 16 percent of bilateral ODA from national governments to implement specific projects.⁸⁰ In the Netherlands, for example, the CSO platform Partos represents over one hundred member organizations that advocate for development causes to the Dutch Ministry of Foreign Affairs. In this capacity, they also serve as watchdogs, holding governments and international organizations accountable for their commitments.

74. “Overview,” International Finance Facility for Immunisation, 2013, <http://www.iffim.org/about/overview/>.

75. UNITAID, “Why Unitaid Adopts a Market-Based Approach,” 2012, <http://www.unitaid.eu/how/market-approach>.

76. UNITAID, *Annual Report 2010*, World Health Organization, 2011, http://www.unitaid.eu/images/NewWeb/documents/AR10/unitaid_ar2010_web.pdf.

77. GAVI Alliance, “Civil Society Organisation Support,” <http://www.gavialliance.org/support/cso/>.

78. Ibid.

79. Ibid.

80. “Financing and Policy Making in Germany,” SEEK Development, April 2012.

PRIVATE SECTOR

The increased activity of private organizations and foundations has filled an important funding gap left unmet by national governments. In 2010 private-sector funds accounted for over \$336 billion in development aid.⁸¹ The Bill & Melinda Gates Foundation has invested more than \$13 billion in global health since 1994, totaling approximately 5 percent of all funding for global health assistance.⁸² Its contributions have resulted in greater access to medicines, improved disease detection, and growing community participation. The foundation has also been instrumental in helping restore credibility to the Global Fund amid a corruption scandal when the foundation pledged \$750 million in January 2012. The donation, more than double the amount the foundation contributed in the past, will accelerate programs to fight infectious diseases among the poorest populations.⁸³

The United Kingdom is at the forefront of these efforts. In 2008 DFID published a strategy document entitled “The Engine of Development: The Private Sector and Prosperity for People” emphasizing the benefits of private-sector aid.⁸⁴ As part of the restructuring of its development priorities, the Netherlands has also begun to focus more on private-sector involvement.⁸⁵ European donor governments, particularly those undergoing painful austerity measures, should increasingly look to public-private partnerships as a means to achieve their aid goals without worsening their fiscal situation, but this will require American and British guidance and leadership.

POLITICAL LEADERSHIP

Improved coordination mechanisms, greater involvement of CSOs, or financing innovation will never be a substitute for political leadership and the ability to implement a long-term vision or goal. In an era when political paralysis and economic uncertainty dominate, it is increasingly unlikely that leaders will focus on bold global health or big development assistance ideas without substantial engagement. Political will and individual leadership will be tested as budgets continue to decline. Leaders such as Vladimir Putin, who first placed neglected tropical diseases (NTDs) on the G8 agenda in 2006, and Angela Merkel and Gordon Brown, who jointly established the International Health Partnership, were instrumental in galvanizing donors to enhance their commitments to meet the Millennium Development Goals. For his part, former French president Nicolas Sarkozy made the European partnership with Africa a point of focus during France’s presidency of the G8 and the Group of Twenty (G20)⁸⁶ as a way to further progress on the Gleneagles pledge. The perfect

81. OECD, “Development Aid: Private Flows,” April 4, 2012, http://www.oecd-ilibrary.org/development/development-aid-private-flows-2012_aid-pvt-fl-table-2012-1-en.

82. Bill & Melinda Gates Foundation, “Global Health Program Overview,” 2010, <http://www.gatesfoundation.org/global-health/Documents/global-health-program-overview.pdf>.

83. Andrew Jack, “Gates Pledges \$750m to Global Fund,” *Financial Times*, January 26, 2012.

84. Department for International Development, “Private Sector Development Strategy: Prosperity for All: Making Markets Work,” 2008, <http://www.dfid.gov.uk/Documents/publications/Private-Sector-development-strategy.pdf>.

85. Conley and Dukkupati, *Leading from Behind*.

86. A group of finance ministers and central bank governors from 19 countries: Argentina, Australia, Brazil, Canada, China, France, Germany, India, Indonesia, Italy, Japan, the Republic of Korea, Mexico, Russia,

opportunity to initiate a new leadership engagement effort will be the 2013 G8 summit under British chairmanship with concurrent Russian chairmanship of the G20. British development innovation and dynamism along with a more pro-active role by Russia and the other BRICS would serve as a fitting symbol of ODA and global health's transitional moment.

Conclusion

Europe's leadership in promoting development assistance and global health should be recognized and celebrated but not taken for granted. The European Union and its member states have led by example through their bilateral global health policies and through their commitments to multilateral organizations. But Europe's future leadership will be sorely tested as fiscal austerity and economic malaise threaten to hinder further progress. New strategies and partnerships are needed and should include new donors such as the BRICS and other emerging economies to not only enhance efforts but to also fill the gaps where European aid is receding. A new strategy should combine the expertise of regional powers as well as the experience and financial backing of traditional donors. This will ensure aid effectiveness and eliminate excess spending. American leadership, from the level of head of state and government to ministerial-level coordination, will be vital to encourage Europe to embrace new and dynamic strategies.

As a leader in ODA and global health assistance itself, the United States should seize this moment of transition in ODA and global health and transform it. Honest, transparent, and ongoing communication between the United States and European donors about the state of aid budgets and the impact of aid effectiveness will help identify areas of weakness and highlight areas of strength. European donors must embrace the emergence of new donors such as the BRICS and develop new mechanisms of aid delivery, most notably through trilateral cooperation. Europe must also develop new and innovative forms of cooperation with the private sector. Together, Europe and the United States must develop new approaches to sustain public support of global health initiatives in close cooperation with CSOs. If outdated modes of coordination and consultation are to give way to new forms of health diplomacy, the United States, in full cooperation with Europe, must lead the way.

Saudi Arabia, South Africa, Turkey, the United Kingdom, the United States of America and the European Union, which is represented by the President of the European Council and by the Head of the European Central Bank.

2 | Japan's Global Health Diplomacy

Internationalization of Public Health

*Benjamin Self*¹

Introduction

Japan has been a frontrunner in development assistance, and its state-led development model has effectively transformed Asia from a backwater to the pulsing heart of the global economy. Yet Japanese development assistance for health has lagged behind, despite the large sums of money that Japan has put into official development assistance (ODA) and Japan's own enviable record of improving its own healthcare system to achieve longevity and well-being from 1950.² Given the centrality of improving health to poverty alleviation, the enthusiasm among the Japanese for spreading the lessons of their own experience, and the increasing dynamism of transnational, intergovernmental, and public-private partnerships, health diplomacy can become a substantial new tool for Japan in the years to come. This process should certainly be encouraged by Japan's existing and potential partners.

History of Japanese ODA

The roots of Japanese official development assistance (ODA) were reparations for World War II, notably with Asian countries that had been previously European colonies. Japan explicitly sought to build closer ties with newly independent states, such as Burma, as well as to reconstruct regional economic interdependence. Substantial expansion of ODA in the 1970s similarly targeted Southeast Asian countries, aiming to build "heart-to-heart" relations and simultaneously to enhance business relations.³ Later, Japanese economic cooperation with China, launched in 1979, similarly focused on economic infrastructure through the end of the 1990s.⁴ The focus on enhancing the capacity of recipient countries to increase gross national product meant that the place of health in the ODA framework was quite low

1. Benjamin Self is an adjunct fellow with the CSIS Japan Chair.

2. Infant mortality rates were reduced steeply by two-thirds by 1965, and maternal mortality by three-quarters by 1972. Keizo Takemi, "21世紀型パワーポリティクスとわが国のヘルス・ダイプロマシー" [21st Century-type Power Politics and Japan's Health Diplomacy], *Gaiko Forum* 5 (August 2011): 36–47.

3. Peng Er Lam, ed., *Japan's Relations with Southeast Asia: The Fukuda Doctrine and Beyond* (London: Routledge, 2012).

4. Hideo Sato, "Japan's China Perceptions and its Policies in the Alliance with the United States," Stanford University Asia-Pacific Research Center Working Paper, September 1998.

in the early stages. Even where ODA was health related, it tended to focus on physical infrastructure, such as hospital buildings.

ODA was in this era under the purview of the Ministry of Foreign Affairs (MOFA), with implementation by the Japan International Cooperation Agency (JICA) in cases of grant aid, or the Overseas Economic Cooperation Fund in cases of yen loans. The basic mission for ODA was principally diplomatic, and secondarily economic, with input from the Ministry of International Trade and Industry (MITI) and its overseas staff in the Japan External Trade Organization (JETRO). Bureaucratic stovepipes separating the Ministry of Health and Welfare from the process prevented any of Japan's domestic public health expertise from supporting the formation of ODA policy.

Japan became a major donor after the revaluation of the yen at the Plaza Accords in 1985, and emerged as the world's number one donor in terms of gross disbursements in 1989. This brought intense scrutiny of Japanese ODA practices, with criticism from other donors as well as domestic civil society and even some recipient countries.

One point that nongovernmental organization (NGO) critics raised was that Japan ignored the environmental consequences of projects it funded, as had been a problem for World Bank and other international projects. Often in relation to this concern the rights of ethnic minorities were seen as receiving insufficient consideration. Another complaint, especially from other donor governments, was that ODA was excessively tied to Japanese corporate interests. This assertion that aid was an extension of "Japan, Inc." was particularly troublesome in the context of serious trade friction between Japan and the United States. The rapid expansion of ODA had in part been a response to accusations of free riding by Japan, which maintained a limit of one percent of gross domestic product (GDP) on defense spending. Strategic aid was meant to be part of Japan's contribution to the West during the Cold War, and to the New World Order after. If Japan's ODA was a component of a strategy for regional economic domination, it was a threat to the hegemony of the United States rather than a buttress.

At the same time, at the beginning of the 1990s, signs of doubt emerged about Japanese support for China's economic modernization. Following the Tiananmen massacre, public opinion in Japan turned against the People's Republic of China (PRC) regime. China's military modernization, including nuclear weapons, concerned many Japanese who had believed that economic growth would moderate the belligerence of Chinese foreign policy.⁵

These concerns led to the establishment of the ODA charter in 1992. Japan would factor several new conditions into its aid decisions: balancing environment with development; avoiding aid to countries engaged in military conflict, or that carried out excessive military build-up or engaged in the production of weapons of mass destruction (WMD) and

5. Benjamin Self, *The Dragon's Shadow: The Rise of China and Japan's New Nationalism* (Washington, DC: Henry L. Stimson Center, 2006).

ballistic missiles; and expecting some progress on issues of democratization, market economics, and respect for human rights.

Over the course of the 1990s, during which Japan remained the largest donor in the world and provided a total of approximately US\$112 billion to developing countries,⁶ Japanese ODA underwent a gradual process of change, becoming increasingly professionalized and separated from the economic interests of Japanese corporations. The Overseas Economic Cooperation Fund (OECF) was the lending arm of Japanese ODA, which made up the bulk of Japanese assistance.⁷ Its staff was very small, so it relied heavily on support from the Foreign Ministry, which actually negotiated loans, as well as the Finance Ministry and Ministry of International Trade and Industry. JICA staff, who handled grants and technical cooperation, were drawn from a mix of development and diplomatic backgrounds, but Japanese dispatched as experts to the developing world were a wide mixture of people drawn from across the public and semi-public sectors in Japan. Retired police officers might serve as advisers to developing country justice ministries, while university information technology (IT) specialists might help modernize computer systems. The process of building a pool of appropriate field staff for development assistance was necessarily gradual, in part because many of the Japanese with experience in the developing world were staff of trading companies.

While Japanese ODA retained many of its distinctive characteristics, at the same time the Japanese development community underwent a process of socialization into the mainstream of the OECD donor culture. Partially this arose from direct pressure on Japan to conform to the norms of the international donor community, through diplomatic channels as well as in international organizations and the NGO sector. Learning also took place via professional and human interaction at the individual level. For example, the repeated hosting of the Tokyo International Conferences on African Development (TICAD) in 1993, 1998, 2003, and 2008 has brought a much deeper appreciation of diverse perspectives and interests involved in the complex picture of development in sub-Saharan Africa. The initial TICAD in 1993 was an effort to assert some Japanese leadership in transferring some of the dynamism of East Asia to Africa. By TICAD IV in 2008 there had been a substantial shift in Japanese aid priorities to Africa (aside from Afghanistan and Iraq, aid to Asia had dwindled to a small share). Prime Minister Fukuda Yasuo was able to commit to a doubling of Japanese aid and foreign direct investment to Africa (the latter supported by a US\$2.5 billion fund established by the government).

By the beginning of the new millennium, Japanese ODA was no longer generating controversy in the world outside, but had begun to come under greater attack domestically. Fiscal pressures—Japan's government spending dwarfed its revenues—intensified the aid fatigue that arose in Japan, as elsewhere in the advanced industrial nations, in the face of

6. Derived from OECD Statistics at <http://stats.oecd.org>, official development assistance net disbursements at current prices, 1990–1999.

7. The OECF was merged with the Japan Export-Import Bank in 1999 to create the Japan Bank for International Cooperation (JBIC). The ODA yen loan functions of JBIC were transferred to JICA in 2008.

corruption and the ineffectiveness of previous efforts. This combination has seen aid disbursements decline substantially, with Japan dropping from first in the world to fifth place over the course of the decade. Yet the shift appears greater than its impact on the ground, in part because Japan's ODA rose and fell against a contrasting backdrop of ODA from other OECD members. Simply put, as a late entrant into development assistance, Japan seems to be on a delayed cycle of enthusiasm and disillusionment. Luckily for the developing world, Japan surged forward at the very moment that aid fatigue was eroding the spending of the United States and Europe. As Japan encountered its own aid fatigue at the end of the 1990s, the United States and others were galvanized to pick up the burden again.

Since the onset of aid fatigue there have been substantial efforts to counter the decline in Japanese public support for ODA, first by the appointment of the charismatic and popular Ogata Sadako as head of JICA in 2003. This led to the creation of "New JICA" in 2008 with the inclusion of the yen loan functions of JBIC under JICA's umbrella. After the Great East Japan Earthquake in 2011, early fears that Japan would turn inward and drastically reduce ODA as a result of the enormous expense of coping with the triple disaster have proven false. If anything, the international response to the crisis served to remind the Japanese that they are indeed a valued member of global society and the benefits of remaining engaged are far greater than the costs.⁸

Development Assistance for Health

As noted above, for most of its fifty-year history Japan's ODA was primarily focused on economic infrastructure, with health receiving a very small share of project funding. The share of health in total development assistance was found by a recent survey to be only about 2 percent.⁹ Various factors ought to drive this percentage much higher. Health has achieved a significantly higher priority in Japanese ODA in recent years, due to a confluence of several trends. First, Japan's Asia-focused economic development schemes have largely succeeded in raising its neighbors to middle-income status. Second, the international community in general (and the United States in particular) has increased its focus on health as the fundamental basis of social and economic development. Third, pandemic and epidemic diseases have made direct contact with the Japanese people, who had previously viewed many of these diseases as distant and irrelevant. Fourth, the success of the domestic health care system in Japan has strengthened the conviction among development professionals and the general public that Japan has valuable lessons to offer the world, particularly in gerontology. Finally, the increased dynamism of public-private partnerships offers a means for leading Japanese corporations and NGOs to play a larger role in global health.

8. Remarks by Tanaka Akihiko, the new president of Japan International Cooperation Agency (JICA) at CSIS, Washington, D.C., July 23, 2012.

9. Rayden Llano et al., "Re-invigorating Japan's commitment to global health: challenges and opportunities," *The Lancet* 378 (2011): 1255–1264.

NEXT ON THE AGENDA

Asia has been the main recipient of ODA from Japan, so the success of Asian economies has taken some of the wind out of the sails of the Japanese public's enthusiasm for supporting international economic development. Notably, China was the largest recipient of Japanese aid, but when China attained enormous foreign exchange reserves and began providing aid to other countries many in Japan felt it was no longer appropriate to give money to the Chinese. Furthermore, the lack of appreciation from China for the assistance and continuing negative attitudes about Japan prevalent among the Chinese people were significant in undermining the popularity of ODA. As mentioned, this has led to substantial cuts in allocations for ODA in the overall government budget-making process. At the same time, however, it has also freed up room in the ODA budget itself for health-related allocations.

SOCIAL LEARNING ABOUT HEALTH

One important turning point for Japanese development assistance for health was the year 2000. This watershed year witnessed the G-8 Kyushu-Okinawa summit, the establishment of the Global Fund, and the UN Millennium Declaration. The Millennium Development Goals (MDGs) brought a special degree of attention to health as the foundation of both quality of life as well as economic development, with three of the eight goals aimed at improving maternal health, improving child health, and ending HIV/AIDS. Japanese leaders and officials did play a role in establishing the international agenda for development assistance, but the global enthusiasm for ameliorating extreme poverty and improving quality of life for millions resonated back to Japan through the mass media and the emerging nongovernmental sector.

NO ISLAND NATION IS AN ISLAND

Although Japanese typically express sympathy for the victims of disease in the developing world, there has also been some distance in the relationship between domestic health and global health. For one, as an island country with a strong tradition of in-group versus out-group discrimination, Japanese saw the health problems of foreign countries as largely irrelevant to them personally. This detachment connects to lingering cultural tendencies to view disease as quasi-spiritual pollution. Furthermore, the stigma associated with HIV/AIDS in the West was also prevalent in Japan, although the bulk of Japanese infected were actually hemophiliacs who contracted the disease through tainted blood-clotting products.

Several transnational public health incidents have helped to break down the detachment with which the Japanese traditionally viewed international health. The spread of a particularly dangerous strain of *Escherichia coli*, *E. coli* HO157, in the mid-1990s, began to make the Japanese aware that their isolation was breaking down. The severe acute respiratory syndrome (SARS) outbreak at the end of 2002 into the summer of 2003, although it caused no infections in Japan, was a shock because it revealed the potential for rapid expansion of deadly new pathogens. This was followed closely by the emergence of Avian

Influenza H5N1, a highly pathogenic form of the disease. These diseases fostered a new willingness to combat threats to public health on a collaborative basis.

PROUD OF JAPAN'S TOP-NOTCH HEALTH STATISTICS

Postwar Japan defined itself through economic reconstruction. The miracle economy of the rapid growth period enabled Japan to catch up to the West and emerge as the world's second-largest economy at the end of the Cold War. Yet the subsequent stagnation of Japan, and the rapid growth of China in the same period, has left Japan trailing its neighbor in both dynamism and overall scale. By the end of 2010 China had overtaken Japan, undermining a central component of national identity. Since their sense of what it meant to be Japanese had been formed around the sheer size of its economy and the productivity of its industry, the Japanese people have been reflecting on what about their nation they can take pride in now that the glory of their industrialization has faded.

One obvious answer to the question of what makes Japan special has been health. Japan leads the world in longevity, and demonstrates remarkable quality of life across a range of indices despite spending a relatively modest 8 percent or so of gross domestic product on health care. If the Japanese model of economic development has lost its sheen, there is no doubt that a Japanese model of health care should retain its appeal. Already Japanese health care attracts foreign patients, with wealthy Chinese traveling overseas to obtain superior treatment. While there is excellent care available at hospitals all over the world, Japan can take pride in the health care system that it has developed since the 1950s.

Japan's effective, low-cost health care is a source of comparative advantage in the twenty-first-century struggle against transnational challenges. Japanese strategists consider the effective response to these common transnational threats as very highly significant, if not as much so as coping with traditional security threats. Demonstrating capacity to meet them is a vital component of Japan's soft power.¹⁰

Dynamic Partnerships

The prospects for a greater Japanese role in global health depend not only on the government but also on the private sector. While traditionally the private sector role in ODA was through trading companies and aid contractors that sought to absorb some of the revenue stream, now there is emerging a new model of cooperation in which the companies can galvanize a more effective overall response to challenges in health. One notable example is the case of Sumitomo Chemical's bed nets.

In the fight against malaria, no other tool has proven nearly as effective as bed nets. Insecticide-treated nets are better than untreated nets (or nets that require application of insecticide by users), and most effective of all are nets pretreated with a special long-lasting insecticide, known as LLINs. A technology for producing LLINs was developed by

10. Takemi, "21st Century-type Power Politics."

Sumitomo Chemical, which provided the technology free of charge to a Tanzanian enterprise, and subsequently cooperated in the production of nets in Tanzania and elsewhere, in order to reduce the impact of malaria. The active collaboration between the government of Japan, including the Foreign Ministry and of course JICA, along with a private Japanese company, produced results far greater than could have been achieved by either working alone. This success then leveraged further collaboration between the United States and Japanese governments, where the U.S. Agency for International Development (USAID) helped to print and distribute malaria education materials developed by the Japanese.

Japan's International Cooperation in Health

Since joining the United Nations (UN) in 1956, Japan has placed a special priority on its role in multilateral organizations. Japanese enthusiasm for the UN system emerges in part from domestic politics and the legacy of the disaster of World War II's Pacific war, as the UN promised an alternative to the competitive international power politics that many Japanese believed had brought about the war and threatened to do so again during the Cold War. During an era of intense political division domestically that reflected the confrontations of world politics, the UN represented the ultimate source of legitimacy.

In line with its economic growth, Japan became a major supporter of the World Health Organization (WHO). It has been noted that the bulk of Japanese payments are based on assessments rather than voluntary contribution, somewhat muting Japan's agenda-setting power.¹¹ Even so, the large scale of Japanese spending for WHO has made a substantial impact on the premier global organization for health. Japan is also a top contributor to UNICEF, the largest donor to the UN Development Program (UNDP) and the United Nations Population Fund (UNFPA), and a major supporter of the Global Fund. In fact, Japan channels a substantial majority of its total development assistance for health through multilateral organizations.¹² Counter to this positive, though, is the relatively small presence of Japanese staff in these organizations.¹³

It is notable that Japan's multilateralism has mainly been within the UN framework. While there are exceptions—some Group of Eight (G8) initiatives and the Asian Development Bank—these serve mainly to prove the rule: the UN is easiest for Japan to support. Japan has been relatively low profile within Asia-Pacific Economic Cooperation (APEC) despite a close overlap of priorities such as response to outbreaks of potentially epidemic diseases and treatment of noncommunicable disease on the agenda of the APEC Health Working Group. One workshop on strengthening health systems as a means of supporting human security was actually convened by Taiwan, rather than Japan.

Bilateral and minilateral cooperation with other donors (with the exception of the United States, discussed in detail below) has been minimal. Even the increase in coopera-

11. Llano et al., "Re-invigorating Japan's Commitment to Global Health."

12. Ibid.

13. Ibid.; Takemi, "21st Century-type Power Politics."

tion with neighboring countries in relation to influenza has been predominantly carried out by way of comprehensive global or regional multilateral structures such as WHO or the Asian Development Bank. Although the issue of public health and the importance of health in development (especially the three health-related Millennium Development Goals) were raised at the fifth trilateral summit among Japan, the PRC, and the Republic of Korea (ROK) in May 2012, they were mentioned in passing in the context of a wide range of issues where agreement was noncontroversial. There was no initiative beyond discussion among the health ministers.

On a bilateral basis, the Japan-China relationship is extensively developed and is no doubt the broadest and deepest of Japan's relations with the so-called BRICs (Brazil, Russia, India, and China) that represent the large economies outside the Organization for Economic Cooperation and Development (OECD). Nonetheless, coordination on health is minimal. The Japanese have been worried about the safety of Chinese products, especially foodstuffs, following an incident of poisoned dumplings exported from China to Japan in 2008. Similarly, the potential for the emergence of communicable disease from China—particularly southern China—has been a matter of concern related mainly to Japanese public health. There has been little discussion of global health and no coordination of policies in this domain.

Japan's relations with Russia have been dogged by the legacy of World War II, in the final days of which the Soviet Union attacked Japan in Manchuria and the Kurile Islands, seizing the latter and occupying them to this day. This issue has prevented the conclusion of a peace treaty and has generally hindered bilateral cooperation. Health has not emerged as an issue of bilateral discussion.

As for India, the emergence of India as a major international actor since the 1990s has been somewhat controversial because of the nuclear issue. The 1998 nuclear tests, and subsequent declaration of its status as a nuclear weapons state, made India exceedingly unpopular in Japan. At the same time, India is a democracy and espouses liberal values of freedom and respect for human rights, while sharing with Japan a deep concern about the rise of China and its People's Liberation Army (PLA) military modernization. Over the past few years the Japanese have reluctantly overcome their anger and outrage over India's nuclear weapons, and have launched a substantial partnership between Tokyo and Delhi. This has as yet not approached health issues outside of the context of bilateral aid from Japan to India.

Finally, Brazil is a special case, having been a major destination for Japanese emigration. There are more people of Japanese descent in Brazil than in any other country outside Japan. This has been the basis of substantial flows of workers from Brazil to Japan, under the presumption that they would somehow be better able to operate within the Japanese system than foreigners with no Japanese ancestry. There are also a number of prominent Brazilian-Japanese, including in the field of politics. The two sides have engaged in policy dialogue and proposed coordination in multilateral forums on global issues including climate change, disarmament, and proliferation, as well as UN reform, but thus far there has been no substantial discussion of health.

U.S.-Japan Coordination of Health Assistance

In contrast to the lack of policy dialogue on health—to say nothing of actual policy coordination—in the context of Japan’s relations with its neighbors and emerging economies, the degree of collaboration in the U.S.-Japan partnership has achieved a remarkable standard.

The United States and Japan have sought to enhance their ODA cooperation since the early 1990s. The global partnership agreement of 1992, signed by President George H. W. Bush and Prime Minister Miyazawa Kiichi, singled out cooperation to support the developing world as an important element of the plan of action for promoting world peace and prosperity. Furthermore, the agreement specifically identified support for the children’s vaccine initiative as a focus of cooperation.¹⁴

Shortly afterward the United States, now under the leadership of President Bill Clinton, sought to widen the area of cooperation with Japan and put into broader context the trade disputes that were plaguing the bilateral relationship. In July 1993 the two governments announced the U.S.-Japan Common Agenda for Cooperation in Global Perspective, which included promoting health and human development as one of its four pillars. This framework for cooperation included specific focus on infectious diseases such as HIV and polio, as well as efforts for family planning and maternal and child health.

DIFFERENT SYSTEMS, DIFFERENT PHILOSOPHIES

Japan and the United States have sought to enhance cooperation and coordination while retaining their own preferences for development assistance in general and development assistance for health in particular. Japan has emphasized provision of materials and, to a lesser extent, capacity building in terms of training health care workers and upgrading health facilities. In contrast, the United States has been keen on identifying best practices, expanding proven interventions, and rigorous monitoring and evaluation.

Nonetheless there has been a degree of convergence between the two, particularly in terms of the big picture. Neither is positive about general budget support to developing country governments, especially in health care, although there is some pressure from European donors to adopt this approach.

In the G8 Kyushu-Okinawa summit in 2000 the two managed to come together in support of the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The U.S. Agency for International Development (USAID) has had a long-standing close relationship with JICA in global health, and the two established a global health partnership in 2002. They coordinate at the headquarters level regarding global level policy issues and have initiated in-country coordination in three pilot countries (Bangladesh, Ghana, and

14. The Tokyo Declaration on the U.S.-Japan Global Partnership, January 9, 1992, http://tcc.export.gov/Trade_Agreements/All_Trade_Agreements/exp_005589.asp.

Senegal). Each has signed joint statements on country-level collaboration. High-level consultation meetings will determine the next phase of the global health partnership.

Global health is a sector where the United States and Japan are frequently in synch on policies and programming. Their commonality of purpose has become even more marked recently with the launch of Japan's new global health policy, remarkably congruent with the global health initiative (GHI), and its corresponding new model EMBRACE (Ensure Mothers and Babies Regular Access to Care), which focuses on the strengthening of health systems and making more effective preventive and clinical interventions for maternal and newborn survival at both the community and facility level. EMBRACE is targeted on accelerating progress toward Millennium Development Goals (MDGs) 4 and 5, and aims to save more than 12 million lives by scaling up proven interventions in maternal and child health care. The new policy also affirms the importance of Japan's continued support for MDG 6, and assistance directed at HIV/AIDS, tuberculosis (TB) and malaria control by both multi-lateral and bilateral health assistance.

Japan's global health policy for 2011–2015 was produced by the Foreign Ministry, with close consultation with stakeholders inside and outside of Japan. The report itself notes the valuable contributions made by UNAIDS, UNFPA, UNICEF, WHO, the World Bank, the Global Fund, the GAVI Alliance, and NGOs such as International Planned Parenthood Foundation, as well as academics.¹⁵ Typically for a Japanese government report it does not identify authors, but Dr. Kanamori Sayako was the MOFA point person for global health matters and no doubt contributed enormously. Dr. Shibuya Kenji, chair of the Department of Global Health Policy at the University of Tokyo School of Medicine, has served as an adviser to the Foreign Ministry on these issues and was also a key player in developing the new policy framework. As Dr. Shibuya had previously served at WHO, the integration of global perspectives into Japanese policy formulation in health can be said to have reached a new level.¹⁶

Both the United States and Japan have joined a number of global health partnerships, including such initiatives as Harmonization for Health in Africa (HHA) and the GAVI Alliance. Japan has joined the recently launched Child Survival Call to Action.

Aside from intergovernmental cooperation there have also been innovations in trans-national public-private partnerships. One new cooperative effort between JICA and the Gates Foundation on polio eradication established a yen loan from JICA to the government of Pakistan, which will be repaid by the Gates Foundation provided satisfactory progress is achieved. This offers an exciting new model of collaboration.

One long-standing obstacle to cooperation on the ground has been a difference in structure and decision-making authority. USAID devolves authority to field offices to promote adaptability and responsiveness, but JICA has always required consultations in Tokyo

15. Government of Japan, "Japan's Global Health Policy, 2011–2015," http://www.mofa.go.jp/policy/oda/mdg/pdfs/hea_pol_ful_en.pdf.

16. Personal e-mail communication, Ministry of Foreign Affairs official, July 12, 2012.

before the central office can provide guidance to the field.¹⁷ The old system that separated yen loans from grant aid and technical cooperation further complicated policymaking; even now the separation of bilateral ODA under JICA from multilateral ODA still under MOFA causes some confusion in policy formulation.

Avenues for Further U.S.-Japan Cooperation

Maintaining close relations with the United States is the main pillar of Japanese diplomacy, and with the return of the Liberal Democratic Party in late 2012 there is renewed emphasis on the U.S.-Japan alliance. While the focus is on economic revival first and foremost, and national security concerns have risen higher in the concerns of Tokyo in the context of threats from North Korea and China, Japanese are nonetheless still positive about making international contributions in “soft” areas such as health, development, and environmental protection. Furthermore, Japan is more receptive than ever to American priorities, which gives the United States an opportunity to inspire greater contributions from Japan.

SHARE JAPAN’S EXPERIENCE WITH THE WORLD

Enthusiasm for developing Japan’s untapped potential in global health is high.¹⁸ For example, the success of Japanese efforts in drastically reducing maternal and infant mortality over the course of the 1950s and 1960s offers important lessons for achieving those same goals in the developing world today.¹⁹ Yet there are relatively few formal efforts to capture and validate those lessons. Japan’s universal health care model has produced the world’s best health statistics (in disability adjusted life-years), but there has been relatively little analysis of what elements can be usefully duplicated elsewhere. Mining the Japanese experience ought to pay dividends for both developing countries and emerging economies.

ENHANCE JAPAN’S EXPERTISE AND HUMAN CAPITAL

Kyoto University Graduate School of Medicine established a School of Public Health in 2000, prior to which training of public health specialists had been under the National Institute of Public Health, an element of the Ministry of Health and Welfare (now Ministry of Health, Welfare and Labor, or MHWL). The ministry reorganized the National Institute of Public Health in 2002, adding some components from the National Institute for Infectious Disease, but the mission of the revamped organization is still limited to the promotion of public health inside Japan. Its Department of International Health and Collaboration has only seven members.²⁰ Medical schools in Japan frequently have departments of public health but only a handful are actively involved in studying and teaching about international or global health.²¹ This gap has prompted some to call for a greater effort to link Japan’s

17. Personal correspondence, retired senior USAID official.

18. Llano et al., “Re-invigorating Japan’s Commitment to Global Health.”

19. Takemi, “21st Century-type Power Politics.”

20. Government of Japan, National Institute of Public Health, “Department of International Health and Collaboration,” http://www.niph.go.jp/soshiki/11kokusai/index_en.html.

21. Llano et al., “Re-invigorating Japan’s Commitment to Global Health.”

domestic success to its international contributions, to develop health expertise and human capital in the Japanese development community, to foster career paths for Japanese in global health, and to break down barriers both within government and between government policymakers and outside experts.²²

SHIFT FROM TOP-DOWN TO ALL-INCLUSIVE HEALTH

Including a wider range of participants in the formulation of health development policy is already the basic paradigm of JICA. A JICA technical cooperation project on parasite control in Thailand determined that even the schoolchildren receiving instruction and screenings should be considered as health partners, not passive objects of medical care. The traditional model of public health in Japan, which combined the doctor-patient and mandarin-subject hierarchical structures of authority, needs to be replaced with an open and inclusive system.

INTERNATIONALIZE

The steps above would certainly be necessary to enhance Japan's contributions, but they do so in isolation from the international community rather than by deepening Japan's already successful engagement with the United States and global institutional partners, such as WHO. To better leverage the relationships and skills already present in the world beyond Japan, its human capital development needs to be thoroughly internationalized.

- Japanese involved in global health policy need to be dispatched for study at schools of public health that conduct cutting edge research and programs.
- JICA should send observers to learn best practices at international NGOs and develop relationships with potential partners.
- Japanese experts should share their experience and clinical findings with a wide audience at international conferences and in global publications.

The knowledge built up in Japan over the past few decades of how to improve the overall health of its society—and insights being developed today on coping with an aging population that faces an increasing burden of non-communicable disease—must be pooled with the wisdom of the rest of the world, rich and poor, to advance the cause of global health.

22. Ibid.; and Takemi, "21st Century-type Power Politics."

3 | Russia, the United States, and Global Health

Russia Ascends

*Judyth Twigg*¹

Beginning in 1955, and continuing throughout the Cold War period, the Soviet government expended considerable financial and human resources on assistance to the developing world, primarily as a tool of political influence and diplomacy. It spent US\$1 billion on economic, military, and development aid in 1961, a figure that swelled to US\$26 billion annually by 1986. In the health field, thousands of physicians were trained in Soviet medical schools, Russian doctors were stationed overseas, and Soviet expertise and leadership were instrumental in several key global public health success stories—most visibly, the smallpox eradication campaign of the 1960s and 1970s.

With the Soviet collapse in the early 1990s, things changed. Through the first turbulent post-transition decade, there was neither the resource base nor the political will to engage in any form of overseas development assistance. Between 1990 and 2004 Russia was an aid recipient rather than an aid donor, the beneficiary of over US\$20 billion in Western largesse. Since about 2005, however, as revenue from sales of oil and natural gas replenished state coffers and invigorated the country's self-image as a resurgent great power, interest in development leadership has been revived. Russia no longer receives any official bilateral aid, and though some Russian nongovernmental organizations (NGOs) still receive support from abroad, that mechanism appears to be coming to an end with the September 2012 eviction of the U.S. Agency for International Development (USAID) and the voluntary departure of most other national (and some multilateral) aid agencies. For the last six or seven years, Russia has been deliberately pursuing an identity as an international development leader and donor, with growing financial commitments and institutional capacities to match. Global health has figured prominently in this new evolution, as an instrument to improve Russia's reputation and, simultaneously, to demonstrate its emerging resources and abilities. As a relatively noncontroversial issue with demonstrable public good, health leadership provides a straightforward path toward Russian re-emergence on the list of the world's great powers. And although some of Russia's health-related approaches and practices have earned it a reputation for occasional inefficiency and obstinacy, an awareness of

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the country's post-Soviet institutional legacy and political-economic context can pave the way toward effective and fruitful international collaboration.

Current Health Leadership

Russia's first watershed moment in global health leadership was its presidency of the Group of Eight (G8) in the summer of 2006. Here it placed infectious disease control and prevention firmly on the G8 agenda for the first time, along with monitoring of the health commitments of G8 member states. In preparation for that event, Russia also began to plan its own strategic vision and priorities for foreign aid, culminating in the 2007 publication of a concept paper, "Russia's Participation in International Development Assistance." That Foreign Ministry document, with its thematic focus on health, education, and energy security, was accompanied by an action plan that was never approved. As a result, though the 2007 concept has provided a rough set of principles or guidelines, centered around classic elements of "soft power"—ensure stability in neighboring states, maintain a positive image abroad, reduce global poverty—it has not served practically to coordinate momentum behind Russia's health leadership, nor has it launched a coherent institutional framework or champion to implement Russia's global health efforts.

Russia is the only G8 member without a statutory or regulatory framework for development assistance. There is no legislative provision for a dedicated foreign aid budget. Russia's universities have no courses of study to train professionals in the practice. The government agencies engaged in the process—Ministry of Finance with jurisdiction over the funds, Foreign Affairs the diplomacy, Health and Social Development the substantive expertise—bicker over bureaucratic control of policy and resources. Several attempts to establish a federal agency to consolidate and oversee aid activity have sputtered. RosCooperation was formed in 2008 as an interministerial commission with limited staff and influence; it initially went nowhere. The much-ballyhooed Russian Agency for International Development (known as both RusAID and RAID) was set to launch in January of 2012 but was then postponed until after the spring 2012 presidential elections. Currently, RAID—under the Ministry of Finance—is on hold (it was rumored to have been a pet project of now-departed finance minister Alexei Kudrin), and the stated intent is to move forward instead with RosCooperation as the umbrella for all bilateral development assistance, spearheaded by the Ministry of Foreign Affairs. RosCooperation, also known as Rossotrudnichestvo, the Federal Agency for the Commonwealth of Independent States, Compatriots Living Abroad, and International Cultural Cooperation, has now picked up the official mantle of the old Soviet-era language and cultural centers located in Russian embassies around the world. Currently there are fifty-nine such centers globally (compared to nearly nine hundred analogous centers run by China), with the mandate to promote the use of the Russian language, including support of Russian-language media abroad; operation of Russian language courses for potential labor migrants to Russia; promotion of Russian science and culture abroad, including establishing affiliates of Russian museums and live broadcasts of premiers of Russian theater and film productions; increasing contact

with foreign youth, with an eye toward upping the number of foreigners studying at Russian universities; and providing continuing educational opportunities (perhaps online courses) in countries with large numbers of graduates of Russian universities.

Whether the Ministry of Finance will agree to provide the necessary funding for this agency, however, is an open question, as is whether the language/culture and development assistance missions can practically coexist, and whether any dedicated Russian development agency can coordinate on-the-ground practice with higher-level policy priorities, fill key posts in a scarce human resource environment, and build the necessary bureaucratic clout to succeed in Russia's cutthroat political environment. For now, the institutional mechanisms for bilateral development and health assistance remain a work very much in progress.

A handful of fledgling bilateral health assistance efforts have made it off the ground, all focused in Russia's immediate neighborhood. In 2011–2012, for example, Russia provided 9.3 million doses of polio vaccine to Armenia, Belarus, Kyrgyzstan, and Uzbekistan, along with 14 units of laboratory equipment for polio diagnosis and 340 units of cold chain equipment for vaccine delivery (it is not clear what coverage of need this represents). Yet it would be a mistake to identify Russia's global health activity narrowly as bilateral development assistance, traditionally defined. Russia's efforts to assume the mantle of "global health leader" have instead evolved in recent years through a series of funding streams and hosting of key international events, as well as a process of capacity building, that very appropriately and explicitly recognize its limited ability to support traditional country-to-country health projects.

Funding

The vast majority of Russian financing for all development assistance (including health) in the post-Soviet period has been through multilateral channels, including the United Nations (UN) system, the World Bank Group, and several major global initiatives and special-purpose funds. Simply channeling money through established multilateral mechanisms permits Russia to claim increasing impact without having to fret over project preparation, monitoring and evaluation, procurement and financial management support, environmental and social safeguards, and other standard elements of project supervision for which Russia lacks capacity. Amounts have increased from around US\$100 million in 2004 to over US\$500 million in 2011 and 2012 (with a spike to US\$785 million in 2009 to mitigate the impact of the financial crisis in Kyrgyzstan). Of these amounts, more has been spent on global health—about 25 percent of the total (US\$80–130 million annually)—than on any other single sector.

In a move carrying considerable symbolic importance, Russia decided in 2006 to reimburse all of the monies that had been disbursed for projects on its soil by the Global Fund to Fight AIDS, Tuberculosis and Malaria. This move was clearly precipitated by a desire not to carry the mantle of "aid recipient" into Russia's 2006 presidency of the G8. Since then

Russia has become a donor to the Global Fund (US\$100 million net, with a continued promise of US\$20 million annually through 2013). Russia has also pledged US\$80 million to the Advance Market Commitments for pneumococcal vaccine for 2010–2018 (disbursing US\$18 million so far), and has delivered US\$24 million to the Global Polio Eradication Initiative. Through the Muskoka Initiative on Maternal, Newborn, and Child Health, Russia has committed US\$75 million through 2015 (US\$22.5 million disbursed to date), with specific focus on two projects: strengthening human resources capacity for malaria control and elimination, and improving the quality of pediatric care in first-referral hospitals, both in select countries in Central Asia and Africa. And through the World Bank Booster Program for Malaria Control in Zambia and Mozambique and the World Health Organization (WHO) Global Malaria Program, Russia contributed US\$19 million from 2008–2010 to strengthen malaria control in Africa and the Middle East; this effort has continued with a 2011–2014 project through which Russian specialists have been involved in training 45 health workers from African countries and 150 from former Soviet states (with a US\$4.5 million Russian financial contribution). Other smaller contributions have also been made to the UN International Children’s Emergency Fund (UNICEF), UN Population Fund, and UN Program on HIV/AIDS (UNAIDS). In absolute terms, Russia gives more to health multilaterals than any other BRICS (Brazil, Russia, India, China, and South Africa) country, but its totals fall far short of most of its G8 counterparts.

Hosting

Russia seems determined to achieve global health prominence through the hosting of key high-profile international conferences and discussion forums. The selection of issue areas through which to pursue this strategy clearly flows from Russia’s domestic health agenda: to spotlight reversal of prior intransigence (HIV/AIDS, where the government in 2005–2006 made a remarkable transition from ignoring its own epidemic to funding significant levels of treatment); to highlight areas of steady progress (maternal and child health, where post-Soviet Russia has made great strides in reducing infant mortality and voluntary abortion); and to call attention to its own most pressing challenges (noncommunicable disease [NCD] and injury, which drive Russia’s alarmingly high middle-aged male mortality, as well as maternal health issues that may be suppressing birth and fertility rates). To a limited extent, Russia’s shaping of these meetings is also helping to guide overall global health priorities. In partnership with UNAIDS and the Global Fund, the Russian government has convened (and largely funded) the Eastern Europe and Central Asia AIDS Conference three times—in 2006, 2008, and 2009, with over 2,500 participants from fifty countries—and continues to chair the Commonwealth of Independent States Council on HIV/AIDS. In April 2011 Russia hosted the First Global Ministerial Conference on Healthy Lifestyles and Non-Communicable Diseases, with both then–Prime Minister Vladimir Putin and WHO’s Director-General Margaret Chan attending. (At that meeting, Russia pledged US\$36 million to support global NCD control efforts.) In October 2011, in partnership with UNAIDS and the World Bank, Moscow convened the first High-Level International Forum dedicated to achieving Millennium Development Goal 6 (to combat

HIV/AIDS, tuberculosis, and malaria) in Eastern Europe and Central Asia; more than one thousand government and NGO representatives from fifty donor and partner countries attended. That same month, Russia hosted a parallel and similarly prominent international conference titled “Ways to Reduce Infant Mortality: The Russian Experience,” focused on Millennium Development Goals 5 (improve maternal health) and 6 (reduce infant mortality).

Capacity Building

Several of the world’s major donor agencies, most notably the World Bank, the United Nations Development Program (UNDP), and USAID, launched programs over the last decade aimed at developing Russia’s institutional capacity for overseas development assistance. Collective self-interest drives these efforts; as Russia emerges into the community of donors, there is shared desire to ensure that it does so effectively and responsibly.

USAID’s activities in this area began in 2007 with a series of seminars and exchange visits to present best practices in areas including management, budgeting, and disaster assistance. A March 2010 USAID workshop in Budapest also included representatives from new development aid agencies in Turkey, Hungary, the Czech Republic, and Slovakia, with a focus specifically on the challenges new donors face in the startup phase. Russia-specific sessions in early 2010 and mid-2011 dealt specifically with USAID contracting procedures, and included not only government officials but also representatives from Russia’s nongovernmental and private sectors. In parallel with these “classroom” trainings, USAID has also sponsored a series of trilateral health projects designed as “learning-by-doing” exercises for Russians in the field. These programs sent Russian medical professionals to Botswana, Ethiopia, Namibia, Tanzania, and Uzbekistan to help develop laboratory services and treatment, care, and surveillance for HIV, tuberculosis (TB), and other infectious diseases, with particular success around the development of rabies vaccine production capacity in Ethiopia.

The World Bank, whose efforts are ongoing (in contrast to USAID), has followed a similar path: conferences and training, in parallel with third-party sponsorship of “traditional” health projects. The World Bank organized a May 2008 symposium with the Russian Ministry of Finance in Moscow on development assistance statistics and reporting systems, followed in subsequent years with international events on partnerships in development finance, development assistance communications strategies, monitoring and evaluation, and related topics. Many of these sessions have been financed through a 2009–2011 Russia as a Donor Initiative trust fund backed by the UK Department for International Development (DfID) with DfID. Having scratched bilateral aid to Moscow altogether in 2010, DfID was clearly hoping through this mechanism to boost Russia’s capacity to stand on its own. Illustrating the World Bank’s unique convening power, these events have been attended by key Russian stakeholders across the board—Finance, Foreign Affairs, Education and Science, academia, the media, think tanks—as well as representatives spanning the donor community. And through the World Bank’s Malaria Control Booster Program, Russian

technical specialists have gained hands-on experience training almost two hundred health workers, distributing bed nets, and carrying out an insecticide spraying campaign in Zambia and Mozambique.

Motivations

Russia's primary *regional* health interest is self-interested and threat-based: both media and government habitually trumpet the risk of infectious disease imported via migrant labor, primarily from Central Asia. (This attitude persists despite a convincing body of evidence that migrant workers are much more likely to contract HIV or TB in Russia and carry it home, rather than the other way around.) As a result, regional health efforts have focused squarely on infectious disease, with a major emphasis on strengthening surveillance and diagnostic capacity. Most urgently, in 2010 a polio outbreak in Tajikistan spread to southern Russia, costing Russia its WHO polio-free certification. Russia responded immediately with increased efforts around surveillance, immunization campaigns, technical assistance, and advocacy. HIV/AIDS programs headed by Russia in the former Soviet region include vaccine and microbicide research, IEC (information, education, and communication), the development of individual country strategies for HIV/AIDS, and treatment. Neglected tropical diseases (NTDs) have also received some focus, with programs on surveillance, diagnosis, and prevention of leishmaniasis, schistosomiasis, and blinding trachoma in neighboring Commonwealth of Independent States (CIS) states (as well as some African countries).

Russian motivations for assuming the mantle of *global* health leadership certainly relate, in part, to the kinds of self-interest demonstrated in the priority area, Central Asia: protection of its own citizens from cross-border transmission of infectious disease, as well as promotion of stability for its neighbors—both for political and security reasons, and also to prevent erosion of economic capacity among current and potential trading partners. Russia's global health priorities have also, in part, mirrored its recognition and desire to address some of its own more pressing health challenges—rates of adult male mortality unprecedented for a peacetime society, resulting largely from high prevalence of tobacco consumption and binge alcohol drinking—and also to build on some of its more impressive post-Soviet health achievements, such as reductions in abortion and infant mortality.

Channels

In the short- to medium-term, Russia will most likely continue to engage on global health through multilateral channels. Its hosting of the G8 in 2014 will provide another opportunity to keep health issues at the top of that agenda—an effort that seems plausible, given Russia's determination to keep its 2006 health commitments (80 percent compliance through 2011, compared with 68.5 percent for the G8 countries overall). Russia will also host both the BRICS summit and the Group of Twenty (G20) in 2013. Thus far, the G20 has been relatively inert on health issues, though the Seoul meeting in 2010 noted the links

between education, health, gender, and skills development. Russia may use the 2013 G20 meeting as an opportunity to call attention to the impact of noncommunicable disease and injury on the global workforce, but given the immediacy of alternate issues on the G20 agenda, it is equally likely that health issues will be deferred to the G8 the following year. And, given Russia's own struggles with NCDs—and attention it may want to call to slight recent upticks in its own indicators in this area—it seems plausible that Russia will use its next presidency to add NCDs to infectious disease as part of the G8 health agenda.

For several years, Russia was less energetic about using the BRICS forum to promote global health issues than it had been with the G8. In 2011, however, BRICS leaders began to make health commitments, and in July of 2011 the BRICS health ministers met in Beijing, where they discussed a wide range of issues. Moscow's leadership on noncommunicable disease, and its hosting of the high-level ministerial on NCDs just three months earlier, placed that issue high on the 2011 BRICS health agenda. The health ministers met once again on the sidelines of the New Delhi BRICS session in May 2012, and in New Delhi in January of 2013 they adopted the "Delhi Communiqué," promising greater collaboration in ensuring access to public health services and in implementing affordable, equitable, and sustainable solutions to emerging health threats. Russia is ensuring that NCDs continue to play a central role in those conversations, along with collaboration on strengthening pharmaceutical sectors and promoting access to affordable medicines.

Russia has lobbied to get HIV/AIDS on the agenda of both the Shanghai Cooperation Organization and the Eurasian Economic Community. U.S. and Russian health leaders have met and signed key agreements recently on the sidelines of Asia-Pacific Economic Cooperation (APEC) meetings, and Russia has been one of the driving forces behind APEC's Health Working Group and its focus on management of NCDs throughout the life course (with St. Petersburg hosting a meeting on this topic in June 2012). These efforts illustrate Russia's recent determination to elevate health issues through virtually every available multilateral mechanism.

Russian private sector activity on global health has thus far been limited to piecemeal "social advertising" projects, intended largely to polish the tarnished image of wealthy oligarchs. A few major companies are beginning to assess and respond to the local needs of neighbors, particularly in Central Asia, but the lack of a coherent government global health strategy is a serious obstacle. Under President Vladimir Putin, business is reluctant to undertake serious initiatives (or expend serious resources) without a clear political signal encouraging them to do so, and so far, that signal is murky or absent.

One of the clearest paths for international health engagement with Russia, however, is through Russia's rapidly growing pharmaceutical industry. Current Russian research and manufacturing capacity is limited. Raw materials are almost entirely imported. Most of the approximately six hundred drug manufacturing plants in the country have not been upgraded since they were first built during the Soviet era, and only about fifty meet international Good Manufacturing Practice (GMP) standards. But in 2011, as part of an overall

health care development program, Putin launched a US\$4 billion strategy to resurrect the industry. Dubbed Pharma-2020, the plan calls for 50 percent of medicines sold in the country to be produced locally by that year (up from the current 22 percent), for 60 percent of that production to be innovative rather than generic, and for Russia's global market presence to expand to 3 to 5 percent over that same time period (Russia currently owns about 0.5 percent of the world market). About 160 facilities are to be retooled to GMP standards, and ten new biomedical research and development centers are to be created (with a focus on Skolkovo, the much-heralded new innovation center outside Moscow), all with the goal of boosting exports to US\$100 million annually.

This aggressive import substitution strategy has sent an unambiguous signal to an international pharmaceutical industry with a clear stake in this enormous market (US\$17 billion in 2010): locate manufacturing and research and development (R&D) facilities inside Russia, or else it will suddenly become very difficult to sell your products within Russian borders. In response to these pressures, since 2010 over a dozen major global drug companies have announced plans to extend or build research facilities and production plants in Russia, with total committed investment volume well over a billion dollars. But significant impediments seem likely to retard the implementation of Pharma-2020, including corruption and a business and R&D environment not conducive to innovation. As Russia accedes to the World Trade Organization (WTO), there are significant concerns about lack of uniform quality standards for drugs and protection of intellectual property. Unless WTO membership brings about tangible changes in behavior, international pharmaceutical firms may hesitate to develop and produce innovative drugs on Russian soil for fear of intellectual property "leakage," and Russian researchers with new products they would like to patent will leave the country to do so. Western companies, lured by the potential of Russia's consumer market, are now clearly anxious to find safe and efficient ways to navigate through the Russian health landscape.

What Does This Mean for the United States and U.S.-Russia Health Cooperation?

The recent deterioration in U.S.-Russian relations has been widely interpreted largely around President Vladimir Putin's assault on, and U.S. continued support for, democracy and free media. The tit-for-tat chain looks, on the surface, straightforward: the United States proposes and passes the Magnitsky Bill (a law preventing travel to and banking in the United States to Russian officials labeled as responsible for human rights violations) and generally supports Russian NGOs active in election and media monitoring (viewed by the Russian government as directly culpable in a series of public demonstrations against Putin's regime). Russia subsequently evicts USAID, bans American adoption of Russian orphans, withdraws from the Nunn-Lugar Cooperative Threat Reduction Program, and threatens its own NGOs receiving international support with the label of "foreign agent" and with a newly expansive definition of treason; the U.S. responds with withdrawal from the civil society working group of the U.S.-Russia Bilateral Presidential Commission. In

other words, following this causal chain, the USAID situation is directly related to the larger bilateral conflict over human rights, free media, and democracy in Russia.

A broader lens, however, also views the USAID expulsion, as well as parallel moves toward UNICEF and Nunn-Lugar, in light of Russia's strong desire to be accepted as a resurgent great power. Russia does not want to be seen as a poor country or recipient of aid. It does not want, in any way, to be put in the same category as Africa. If Russia is once again a great power, with all that entails for great-power responsibility for international development assistance and leadership in an area like global health, then the new policy toward USAID becomes quite understandable—as do comments from Foreign Minister Sergey Lavrov and others in Russia that they would very much like to sustain and cultivate multiple avenues of health collaboration with the United States, minus USAID involvement.

Within this perspective, there were many within USAID who wondered why it took Russia so long to throw them out, and many more who argued that the United States should have left unilaterally years earlier. The perceived value of health engagement at USAID had already been on the wane, with the State Department increasingly favoring broader and more direct democracy and governance initiatives over more functional endeavors. Why should U.S. taxpayer dollars, particularly in the current fiscal and political environment, support programs related to Russian health when Russia clearly has ample financial resources of its own?

U.S.-Russia health engagement does not depend on USAID and certainly does not end with USAID's exit. Since 2009 the U.S. government has tried to subsume health collaboration activities under the umbrella of the U.S.-Russia Bilateral Presidential Commission (BPC). The last of the BPC's working groups to hold an initial meeting (in September 2010), the Health Working Group got off to a sluggish start, but it has built some momentum over the last two years. It began with three established priority areas—maternal and child health (MCH), promotion of healthy lifestyles, and infectious disease control and prevention—and later added a fourth, global health. Currently, virtually all government-led collaborative activity is subsumed under the BPC umbrella, and the Obama administration has made it clear that it expects all of the groups to generate activity that could plausibly lead to tangible results. Health, under the formal auspices of the U.S. Department of Health and Human Services and the Russian Ministry of Health, has done so: bilateral agreements to cooperate in the global fight against polio (2011) and malaria (2012), joint meetings on tuberculosis control (some hosted by Partners in Health) and on ensuring the quality and safety of pharmaceutical products (hosted by the U.S. Pharmacopeia Convention), and conferences on tobacco control and MCH. The U.S. Centers for Disease Control and Prevention and the National Institutes of Health have each signed collaboration agreements with their Russian counterparts, the latter already spawning a major joint forum in Moscow on medical research (November 2011) that linked over 150 scientists and private corporations, as well as a joint research competition on HIV/AIDS prevention that awarded its initial thirteen grants in June 2012.

In tandem with government-to-government links, a USAID-funded Civil Society Partnership Program (CSPP) brings together NGOs and private citizens, featuring health as one of its eleven functional working groups. The Russian government has explicitly encouraged this program to continue through public remarks by the Russian embassy's deputy chief of mission (at the November 2012 annual CSPP conference in Washington, right as the Magnitsky Bill was passing the U.S. House of Representatives). The civil society forum is intended to nurture and highlight the substantial amount of citizen-to-citizen health activity that has already taken place: Text4Baby, an ingenious public-private partnership launching simultaneously in the United States and Russia to provide information and education to new mothers via text message; the American International Health Alliance, which has linked over 100 health institutions in the United States and the former Soviet Union since 1992 via community-based "twinning" arrangements; the Eurasian Medical Education Program, an ongoing exchange providing training to Russian physicians in the areas of cardiovascular disease and diabetes management and prevention; the Campaign for Tobacco-Free Kids, which has effectively lobbied for policy change through collaboration with its Russian counterparts; Rotary International and its sponsorship of countless visiting Russian health delegations and assistance programs; and literally hundreds of other small- to medium-scale health projects connecting individual institutions, communities, academics, and practitioners.

Sadly, this flurry of energetic and potentially productive collaborative activity sparks suspicion and resentment in some Russian quarters. Most of the efforts currently in place still take the form of knowledge and technology transfer to Russia. Russia, however, desperately wants to shed the image of constant crisis, of a country in need of help. Both the United States and Russia increasingly and overtly insist that the proper labor for their joint health work is no longer "assistance" but instead "partnership." But this is political ground requiring extraordinary levels of finesse and sensitivity. Russia has transferred scientific and technical knowledge to international partners in a limited number of areas: effective management of asphyxia in newborns, genetics research related to substance dependency, and HIV/AIDS prevention and treatment among drug users beyond standard practices of harm reduction and/or substitution therapy (which are limited by Russian government policy). But on the whole, the vast majority of expertise and experience still resides on the Western side. Russia's health sector has an unworkable definition of modernization (just build new buildings and buy new equipment). It is reluctant to ask new questions and adopt new ways of thinking. The central tension is therefore clear: how to find balance between the political imperative to treat Russia as an equal, and the stark reality that although it may be flush with resources, Russia still stands to learn much from the rest of the world.

This dilemma is exacerbated by multiple frustrations U.S. experts have reported in dealing with their Russian counterparts: the need for Russian colleagues constantly to tune into political signals from the Kremlin, and to be guarded during periods when cooperation is less favorably viewed; logistical challenges, including ever-changing reporting and registration requirements and increasing interaction with Russian security personnel; and

the politicization and (sometimes) corruption of medical research and practice. Perhaps most exasperating is the seemingly inexplicable resistance to adopt internationally recognized best practice in many areas, including DOTS for tuberculosis, and harm reduction and substitution therapy for injection drug users.

But it is important to recognize that Russia has plenty of smart, talented professionals whose work has evolved logically within their country's unique political and economic history. A solid understanding of Russia's incentive structure and institutional matrix renders international partners less likely simply to label Russia as irrational or unreasonable, and more likely to look for ways to evolve through that context and find common ground.

Specific areas of U.S.-Russia health collaboration most likely to bear fruit are those where there is a credible claim to be solving common problems together, and where political controversy promises to be minimal. Healthy lifestyles—including obesity, tobacco and alcohol control, and diabetes and hypertension detection and management—are an obvious priority. Maternal and child health programs are always viewed favorably. Who can argue with saving mothers and babies, especially given Russia's two-decade population decline? Academic medical and public health research is another important area, particularly given recent Russian government programs that reward its young scientists for engagement with the international community (until recently, the Russian Academy of Sciences determinedly frowned on publication in non-Russian journals). Several other key areas hold great promise, but have not yet risen to the top of the bilateral health agenda: joint work on health data and information systems, extending into electronic medical records and comparative effectiveness research; institution building for Russian professional medical societies that can serve as independent mechanisms for policy advocacy and fund-raising; cross-translation of English- and Russian-language medical literature; and common challenges related to immigrant health and labor market development.

The Way Forward

There is currently substantial momentum driving Russia's global health engagement. Despite budget pressures borne of the global financial crisis and volatility in oil and gas prices, Russia continues to channel its money—and increasingly, its expertise—into the global health enterprise. It has begun to contribute importantly to the setting of the global health agenda, particularly for noncommunicable disease. It is taking appropriately careful and deliberate steps toward emergence into the community of donors. With Putin and Russia under the global spotlight with the BRICS and G20 in 2013, Winter Olympics and G8 in 2014, and even the World Cup in 2018, Russia is clearly looking to health as a key area where it can demonstrate its positive contribution to world affairs.

But Russia has not yet entered or conceptually bought into some of the most important regimes of international best medical and public health practice. This is, by far, the most important thing that is lost with the departure from Moscow of USAID and other donors,

and with the Russian government's rejection of the idea that Russia can and should receive help from others. Unless Russia can be lured into these regimes under the mantle of "partnership," its own health issues will (at best) be resolved much less effectively than could have been the case, and its emergence onto the global health scene could result in contribution to, rather than solution of, key international health challenges.

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4 | Health Care Reform in China

Approaches That Will Shape China's Global Health Agenda

*Lucy Chen, Xu Ji, and Jennifer Fang*¹

Background

Under the One-China principle, China began South-South collaborations in the 1950s. These relationships continue to be guided by the “Eight Principles” set forth in 1964, including equality, sovereignty, and self-reliance.² In 2006 these principles were reaffirmed under China's Africa Policy, which reiterated sincerity, equality, mutual benefit, close coordination, and learning from each other as core values.³

Since the 1990s China's global presence has grown dramatically. Such growth has occurred across multiple spheres, attracting great attention from the United States and other development partners that have traditionally dominated international aid. Attention has focused on China's nontraditional approaches, including the policy of no-conditionality,⁴ and packaging together grants, concessional loans, commercial investment, and trade-related financing.⁵ Although not formally considered as part of its foreign assistance program, debt cancellation to African states alone amounts to US\$10 billion or more, and effectively turns loans into grants.⁶

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2. Premier Zhou Enlai, “Eight Principles for China's Aid to Third World Countries,” January 1964. The principles are equality and mutual benefit, respect sovereignty and never attach conditions, provide interest-free or low-interest loans, help recipient countries develop independence and self-reliance, build projects that require little investment and can be accomplished quickly, provide quality equipment and material at market prices, ensure effective technical assistance, and pay experts according to local standards.

3. Chinese Ministry of Foreign Affairs, “China's Africa Policy,” January 2006, <http://www.fmprc.gov.cn/eng/zxxx/t230615.htm>. Summarized in Kerry Brown and Zhang Chun, “China in Africa—Preparing for the Next Forum for China Africa Cooperation,” June 2009, <http://www.chathamhouse.org/publications/papers/view/109090>.

4. LI Xiaoyun, “China's Foreign Aid and Aid to Africa: Overview,” <http://www.oecd.org/dataoecd/27/7/40378067.pdf>.

5. Centre for Chinese Studies, Stellenbosch University, *China's Interest and Activity in Africa's Construction and Infrastructure Sectors*, <http://www.dfid.gov.uk/Documents/publications/chinese-investment-africa-full.pdf>.

6. N. Woods, “Whose Aid? Whose Influence? China, Emerging Donors, and the Silent Revolution in Development Assistance,” *International Affairs* 84 (2008): 6.

Economic and commercial goals are a part of the South-South collaboration agenda, which is directed by the Ministry of Commerce. Energy sources and raw materials are needed for the support of China's continued economic growth. In addition, because Chinese businesses are seeking global opportunities, they are encouraged to participate in the government's South-South program. At the same time, diplomacy and global influence are also factors as China seeks opportunities to promote its own key values (such as sovereignty) abroad and through international and United Nations (UN) agencies.

Health Care Reform in China: Approaches That May Shape the Global Agenda

China's expansion of South-South collaborations in health will be firmly grounded in its own successful development and programmatic models. The most impressive initiative under way is the large-scale health care reforms, which aim to achieve universal coverage by 2020.⁷ The reforms are instructive in understanding how China addresses challenges in its own health sector, as this view will shape approaches to investments and activities abroad. In addition, the experiences in dealing with such challenges are likely to influence China's global health agenda.

China has a three-tiered health care system managed differently for rural and urban areas, where municipal, provincial, and district hospitals and community health centers are the main health care providers in urban areas. In rural areas, on the other hand, these are replaced by county and township hospitals and village health clinics. The majority of health care facilities to date are state-owned.⁸

THE NEED FOR HEALTH REFORM

The current health reforms are driven by the unintended consequences of government policies undertaken in the 1980s that led to various problems that emerged in the 1990s. These included growing disparities between urban and rural health status, lack of access and affordability of health care, and an inability to respond to nationwide epidemics. As the central government decreased its health care expenditures, the burden to fund health services was hoisted on the provincial and local governments. This directly increased disparities between wealthy and poorer provinces. The government maintained tight control on health care service prices charged by public hospitals while also giving them permission to earn profits from drugs and technology. Thus, public hospitals became inherently for-profit businesses. This further contributed to health inequities, as health care costs were unaffordable by the majority of the Chinese population, while a small proportion of the rich had access to world-class medical care. The Chinese government also

7. Communist Party of China Central Committee, State Council, *Opinions of the Communist Party of China Central Committee and the State Council on Deepening the Health Care System Reform* (Beijing: Government of the People's Republic of China, 2009).

8. Q. Meng et al., "Mobility of primary health care workers in China," *Human Resources for Health* 7 (2009): 24.

decentralized its public health system, significantly reducing public health funding for local programs. In order for local public health services to gain revenue, authority was given to inspect businesses such as hotels and restaurants. As a result, public health authorities no longer focused on public health efforts, diverting their attention to higher profit activities instead. The decision that had the most impact on the rural health of the Chinese population was the dismantlement of communes to privatize the agricultural economy. Approximately 900 million Chinese rural residents were left without any medical insurance. The previously employed barefoot doctors were no longer subsidized by communes for their primary health care practices, and many switched to technical services or selling drugs.⁹

INTERNALLY DRIVEN PROCESS WITH BROAD CONSULTATION

The health sector reform process in China was internally driven and managed—in sharp contrast to health reforms in some low-income countries that were a response to external international policies. By the late 1990s it was widely recognized and acknowledged that health care was inaccessible and unaffordable for many people, particularly in rural China. The solutions, however, were far from clear. The national health care reforms announced in 2009 were the result of deliberate planning, reflection, and broad consultation that occurred between 2006 and 2009, among the Chinese government, stakeholders, interest groups, and academia. The international community was also invited to provide ideas, comments, and to share experiences. However, it was clear that a solution with “Chinese characteristics” would need to be developed. Just prior to the release of the national health care reform plan, the draft was published online for public comments—and tens of thousands of responses were received. Even though the reforms are relatively recent, this signals China’s capacity to recognize problems, to mobilize open debate on technical issues, and to conduct wide consultation among stakeholders, including the public.

SEEKING INTERNATIONAL SUPPORT AND COOPERATION

China’s health reform received wide recognition and support from the international community as it was introduced and progress was described at the annual World Health Assembly as well as in many other bilateral discussions. Information exchange platforms currently exist with countries that have already undergone or are in the process of undertaking health reforms, including Germany, France, the United Kingdom, and the United States. Germany and France have undertaken reforms in the management and internal organization of public hospitals, also a focus area of China’s health reforms, which so far, has met with many challenges. The European Union (EU) financed a project to strengthen urban health insurance, similar to the social health insurance models in Germany. France established a counterpart relationship in which public hospitals in China and France were matched to encourage technical collaboration and exchange. The

9. D. Blumenthal and W. Hsiao, “Privatization and Its Discontents: The Evolving Chinese Health Care System,” *New England Journal of Medicine* 353 (September 2005): 1165–1170.

United Kingdom has introduced measures to significantly increase the efficiency of its public health system, including the establishment of the National Institute for Health and Clinical Excellence (NICE). The Chinese Ministry of Health has signed a collaborative agreement with UK NICE to pilot clinical pathways for public hospitals across China. Major collaboration is also taking place with the United States, especially in the areas of HIV/AIDS, chronic diseases, and folate supplementation for pregnant women. The United States has a highly established disease control and prevention system in place, the implementation of which China has begun to study. More recently the July 2011 the BRICS (Brazil, Russia, India, China, and South Africa) health ministers meeting was held in Beijing with the theme of “Global Health—Access to Medicine,” where ministers pledged to work together to implement health reforms and share the successes and challenges of experiences. This collaboration is especially valuable as the BRICS nations face similar challenges in health, and any successful solutions will have the potential to become a model for implementation in another country. Support from the international community is also available in the form of financial aid, training and technical support, research, information dissemination, and sharing of past experiences. Similarly, China can also share its health reform experiences, challenges, and solutions with other countries. China’s approach to health care has been directly influenced by such international collaborations.¹⁰

PRIMARY HEALTH CARE APPROACH

China’s approach to health care reform is grounded in the revitalization of its primary health care system that was successful in the 1970s. This approach encompasses overall well-being, health worker professionalism, universal insurance coverage, and preventive medicine. Similar to the concept of traditional medicine, primary health care emphasizes a holistic approach to well-being, with the patient at the center of health care. It also emphasizes human resource capacity and a professionally trained workforce, working under the three-tiered health care network. This is similar to the movement in the 1980s when the “barefoot doctors” were systematically retrained and licensed. In addition, the approach aims for universal coverage (defined as covering 90 percent of the population) under the rural health insurance program, and coverage of essential services and medicines.

The emphasis on preventive medicine has long been a hallmark of the Chinese health care system, and remains so under the national health care reform, in which population mobilization for health and self-care are key components. In China, patriotic health campaigns have been successful in mobilizing the population around the community public health agenda. While these campaigns may be unique to China, the strategy is pragmatic and based on the concept of cost-effectiveness. Scarce resources are focused on preventive health care that is in demand by the population and can have a large positive health impact. The campaigns emphasize the responsibility of the individual and his/her role within the community. At the same time, they are supported by the preventive

10. Key informant interviews conducted in June and July 2012.

medicine systems at province, county, and township levels, which are responsible for disease control and detection, environment, food safety, and hygiene and sanitation, among others.

China's regions vary greatly in terms of economics, social and cultural factors, human resources, and population density. It is recognized, therefore, that sustainability requires adaptation to local conditions. Between 2006 and 2009 a key part of the deliberations during health care reforms was the piloting of models to systematically test promising programs or models on a small scale before nationwide implementation. These models were carefully designed under central policy guidance and monitoring. However, implementation was decentralized, and local governments adapted the models to the needs and conditions at local levels. This approach remains a cornerstone of the implementation plan after the announcement of health care reforms. It is best exemplified in the pilot reforms of public hospitals, in which the overall principles were established by the central level, and pilots were implemented in each region for adaptation to local levels.

PUBLIC FUNDING AND INFRASTRUCTURE

Health reforms in China are taking place under continued high economic growth, reported to be 9.2 percent in 2011, with an annual gross domestic product (GDP) growth under the twelfth five-year plan projected at 7.5 percent.¹¹ Thus, health care reforms have followed a similar path, in which the government initiated a major influx of funding, infrastructure, and capital investments to address gaps and deficiencies. Total health expenditures have increased from 3.5 percent of GDP in 1995 to 5.0 percent of GDP in 2010.¹² In absolute terms, this represents a ten-fold per capita increase from US\$21 to US\$220. The government's contribution to total health expenditure has increased from a low of 36 percent between 2001 and 2003, to 54 percent in 2010, with billions of dollars devoted to the construction or renovation of thousands of rural facilities at county and township levels, and urban community health centers. More than US\$2 billion was invested nationwide in rural health infrastructure and equipment between 2003 and 2007, which marked the start of the reconstruction of the primary care system.¹³ Between 2009 and 2011 some 2200 county hospitals and 33,000 urban and rural primary care facilities were built or renovated.¹⁴ Government investments in the three-year implementation plan from 2009 and 2011 were reported to have reached 1.13 trillion Yuan (US\$174 billion, at 6.5 Yuan per US\$).

11. People's Republic of China, "Report on the Work of the Government, Wen Jiabao, Premier of the State Council," delivered at the Fifth Session of the Eleventh National People's Congress on March 5, 2012.

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INTRODUCING NONGOVERNMENT FUNDS (SHEHUI ZIBEN) IN HEALTH SERVICE DEVELOPMENT

The official document issued by the State Council¹⁵ at the end of 2010, and a series of implementation policies by the Ministry of Health since April 2012^{16,17,18} have been part of the health reform agenda specifically designed to implement hospital reform. The call for nongovernment funds to invest in hospitals is intended to increase medical and health services funding, expand service provisions, meet the demands of the entire population for a variety of services, encourage competition, and improve efficiency and quality. The private sector is given the equal policy for investment and management of hospitals and other medical institutions; equally important is the recognition that public funding alone cannot meet the increasing expenses of a nation's health sector demand.

INVESTING IN HEALTH SYSTEMS AND SUPPORTING INSTITUTIONS

The reform targets four systems for strengthening: public health, service delivery, medical security, and pharmaceuticals. The reform is based on a systems approach starting with “broad coverage at low levels”—that is, first putting systems and institutions into place and then systematically expanding their quality. Between 2003 and 2007 the government's revamped insurance program for rural residents expanded coverage from 21.0 to 93.0 percent, with 80 percent of the annual premiums paid by central and local governments. By 2011 more than 1.28 billion people were covered by health insurance. Funding levels increased once the structure and framework was established. Inpatient reimbursement rates reached 64.6 percent under the programs covering urban employees and government workers, and 47.2 percent for the rural and urban resident programs.

SYSTEMATIC CAPACITY BUILDING

At the same time, there is a concerted effort to develop strong and capable public institutions, and invest in human resources for increasing capacity to innovate and adapt. This has allowed China to take advantage of international innovations with adaptations to the unique Chinese context. Such investments have taken the form of long-term human resource investments through technical training institutions for human resource professionals, as well as building institutional capacity for leadership through fellowship programs, and increasing the capacity of research institutions. Capacity building and communication have been supported through systematic twinning between health facilities, research institutions, and individuals.

15. Communist Party of China Central Committee, State Council, “The guideline on further encouraging and guiding social capital into the development of medical institutions,” November 26, 2010.

16. People's Republic of China, Ministry of Health, “The notice on the operational nature of medical institutions established by social capital,” April 13, 2010.

17. People's Republic of China, Ministry of Health, “The notice on the levels of hospital established by social capital,” May 17, 2012.

18. People's Republic of China, Ministry of Health, “The notice on regional health planning and medical facilities planning to promote the development of non-public medical institutions,” July 11, 2012.

Evolving Challenges

The health reforms were driven by inequities in health care access between rural and urban areas, low quality primary care, rising health care costs, and risks of medical impoverishment.¹⁹ Between 2009 and 2011 the reforms focused on expansion of health insurance and social safety net, access to essential medicines, reconstruction of the primary care system, equal access to public health services, and changes in the organization and financing of public hospitals on a pilot basis.²⁰ The plan sets forth the role of the government in ensuring access to basic services, medicines, and public health for the population. Monitoring and evaluation systems are being put into place to ensure that the plan is on track, problems could be identified, and policy adjustments made where needed. A few challenges still exist.

RELATIVELY LOW FUNDING LEVELS PER CAPITA

While the investments in health care reform have been large on aggregate, such investments continue to be relatively low on a per capita basis, when divided by 1.3 billion people. For example, over the next four years, inpatient benefits will increase under the rural and urban residents' programs. Though substantial, the increase is still minimal, whereby annual premiums are targeted to reach a minimum of 360 Yuan (US\$57) per person by 2015, from about US\$32 in 2010. The government provided a per capita subsidy of 25 Yuan (US\$4) for the basic public health service package composed of individual prevention and health education services. The subsidy is expected to increase to 40 Yuan (US\$6.3) by 2015, and it is anticipated that the variety of basic services offered will also be expanded.

PUBLIC HOSPITAL REFORM

Although health reforms have already been under way for several years, public hospital reforms have only recently begun. This is due to many challenges faced and problems encountered during the process, leading to a significantly slower progress. Hospital reforms not only need internal restructuring, retraining of health care personnel, coordination of relevant sectors, and the governance structure defining roles and responsibilities at various levels of government, but also the implementation of a new financial system. All these challenges have been more or less encountered and solved by countries where such reforms have already taken place, such as Germany and the United Kingdom; this has opened up space for valuable experience sharing and learning opportunities.

HARMONIZATION

The reforms face challenges due to the interaction between several factors: acceptance by the public, economics, and evolving knowledge. At the same time international cooperation

19. Y. Liu et al., "China's health system performance," *The Lancet* 372, no. 9653 (2008): 1914–1923.

20. Communist Party of China Central Committee, State Council, *Implementation Plan for the Recent Priorities of the Health Care System Reform (2009–2011)* (Beijing: Government of the People's Republic of China, 2009).

in sharing experiences, practices, and lessons learned generates new perspectives. Even though knowledge may not be applicable, it can serve as a mediator to eventually support consensus building for reform implementation. For example, after reviewing the list of essential medicines compiled by the World Health Organization (WHO), China sought to introduce a similar list on its own, consisting of 307 different drugs. However, due to low implementation rates and the difficulties for local government to cover the lost profits to the hospitals that would otherwise be made on medicines, China's implementation of a list of essential medicines will require adjustment—similar to all of the other reform policies under way.

HEALTH REFORMS AND ECONOMICS

The slow implementation of health reforms is also due to a lack of a clear economic growth direction of the country. Similar to the challenges met by the proposed economic reforms, health reforms are also difficult to achieve because of growing governmental control of health care resources.

MANAGING PUBLIC-PRIVATE PARTNERSHIPS

The new agenda of introducing nongovernment funds into hospital development and management can lead to the immediate challenge of management capacity of the Ministry of Health. Until now, the management of private institutions is often through entry permission and service items permissions. The public and private sectors co-existence in a national health system requires a stronger management capacity beyond policy frameworks. Countries where the governments' capacity in contractual agreements and performance monitoring are strong, for instance, Australia, both the public and private sectors can deliver more efficient, effective, and quality services.

Evolution of China's Foreign Policy and Evolving Relationships with International Institutions

The mode of China's cooperation with the international community has been evolving along with its economy. China first emerged into the global health field since taking over membership in the United Nations system from the Republic of China in the 1970s. During this period, China was mainly on the receiving end of support from the international community, most often expressed in the form of financial aid used to improve living conditions for the vast population, including in the areas of environmental health and water sanitation. Following China's economic reform of the 1970s and a rapidly strengthening economy, direct financial support began to decrease, making way for support in the area of policy development instead. Now, as the second largest economy in the world, China's international cooperation is mainly focused on specific projects (such as those on HIV/AIDS), which can often directly influence China's domestic health policies and strategies, as well as approaches to public health and health reforms.

AFRICA

The government of China has been sending medical teams to Africa since the 1960s. At present, forty-two medical teams are deployed to forty-one African countries.²¹ Grants amounting to more than US\$37.5 million have provided for thirty malaria prevention treatment centers and drugs.²² In this year's Forum on China-Africa Cooperation (FOCAC) meetings, China is also committed to providing further support to hospitals it has built in Africa, including upgrading hospital and laboratory equipment. It has also confirmed the government's commitment to continue to send medical teams, medicines, and materials, and to improve health facilities and train staff. In addition, it commits to technical exchanges in infectious disease prevention and treatment, research and application in traditional medicines, and exchanging experiences in the management of public health emergencies.²³ Cooperation in the areas of maternal and child health, health system development, training of health care personnel, and communicable diseases including HIV/AIDS, malaria, and tuberculosis (TB) will also increase. A new area of collaboration is the "Brightness Africa" campaign, which will provide free surgeries to treat cataracts.²⁴

GLOBAL FUND

China started actively collaborating with the Global Fund in 2003, giving and receiving aid, eventually becoming the country to receive the largest funding. At the same time as receiving, China donated US\$20 million, pledging to increase contributions in 2012 and 2013. In 2011 the Global Fund froze its disbursement to China due to concerns of funding misuse and the lack of involvement of community groups. This led to debate about whether or not China should be a further recipient of funding, as some critics believed it was now fully capable of financing its health projects. The grant freeze was lifted several months later; however, all grants for the year of 2012 were suspended. China responded by pledging to match domestic grants to make up for the promised Global Fund contributions to treat HIV/AIDS, receiving commendation from the UN Programme on HIV/AIDS (UNAIDS) and WHO.^{25,26,27} Collaboration with the Global Fund in the areas of disease control, treatment, prevention, and management of HIV/AIDS, TB, and malaria has had an important

21. Ministry of Health, "China, Africa," Department of International Cooperation, September, 2009; also see *China Daily*, November 6, 2009.

22. African Center for Economic Transition, "Looking East: Policy brief on engaging China for African Policy Makers," October 2009.

23. In addition, the policy emphasizes cooperation in human resources development and education, including training, student exchange, and cooperation between Chinese and African educational and academic institutions; science and technology cooperation, including applied research, technological development and transfer, and demonstration programs; exchange and cooperation in civil service system building, public administration reform, and training of government personnel; training and technological assistance in disaster reduction and relief, response to requests for humanitarian aid, and exchanges between the Red Cross Society of China and African counterparts.

24. Ministry of Foreign Affairs, "The Fifth Ministerial Conference of the Forum on China-Africa Cooperation Beijing Action Plan (2013–2015)," July 22, 2012.

25. Sharon La Franiere, "AIDS Fund Frozen for China in Grant Dispute," *New York Times*, May 20, 2011.

26. The Global Fund to Fight AIDS, Tuberculosis and Malaria, "The Global Fund's Donor Governments," <http://www.theglobalfund.org/en/donors/list/>.

27. UNAIDS, "UNAIDS applauds China's Decision to fill its HIV resources gap," December 1, 2011, <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/december/20111201pschina>.

impact on China's communicable disease control and prevention. Not only did the programs reach the largest number of patients, but they also involved nongovernmental organizations and encouraged participation of the general public. This was made available by the creation of community support groups, such as those for HIV/AIDS.²⁸ Thus, the projects created innovations in service delivery and modes of cooperation that were important models.

DOMESTIC POLICIES

Domestic policies for international aid need to be modified to effectively harness harmonization. The domestic health sector is responsible for providing technical assistance issues to recipient countries, but the majority of the fund for international aid in health has been managed and implemented by the main implementation agency. China has not yet developed its own global health strategy despite calls to do so from the research communities. On the implementation level, it is widely recognized that China needs a global health strategy to direct China's future role in the global health field. China can make significant contributions through helping developing countries attain higher standards of living and better health status of their populations.²⁹

REGIONAL POLICIES

In recognition that diseases do not respect international borders, China has increased its health cooperation with neighboring countries in order to better prevent and manage infectious diseases. China's regional policies focus on strengthening relationships with neighboring countries in the Asia-Pacific region. China first started a health-related partnership with the Association of Southeast Asian Nations (ASEAN) in 2003, eventually implementing health collaborations such as China-ASEAN (10+1); China-Japan-Korea (CJK); ASEAN-China, Japan and Korea (10+3); the Asia-Pacific Economic Cooperation (APEC); the Greater Mekong Sub-region (GMS), the Shanghai Cooperation Organization (SCO) and the Central Asia Regional Economic Cooperation (CAREC). China is an active participant in these partnerships, including launching communicable disease prevention and control programs, and developing regional health frameworks. Programs in training and human resources for health also exist. All these programs have made significant contributions to increasing the well-being of the regional population and, at the same time, to building stronger relationships between and among governments.

UNITED STATES

The United States has a highly developed disease control and prevention system, as well as its robust Food and Drug Administration (FDA) system. China developing better national

28. World Health Organization, "WHO-China Country Cooperation Strategy 2008–2013," May 2008, http://www.wpro.who.int/china/china_ccs_2008_2013_en.pdf.

29. 《转变思维模式—金砖国家如何改变全球卫生与发展》，全球卫生占率行动组织, Shifting Paradigm: How the BRICS are Re-shaping Global Health and Development (Global Health Strategies initiative, 2012, http://www.ghsinitiatives.org/downloads/ghsi_brics_report.pdf).

disease prevention and food and drug regulation programs and strategies. Current collaborations with the United States include sharing knowledge on emerging infectious diseases, with a strategy framework covering years from 2011 to 2015 and focusing on timely reporting, response, and management. The second phase of the cooperation will focus on public health research of emerging infectious diseases. Another major U.S.-China collaboration is the Global AIDS Program (GAP), which supports countries in the areas of HIV/AIDS prevention, treatment, and increasing the quality of life of HIV/AIDS patients through providing financial aid. China also works to benefit from lessons learned by the United States in managing various lifestyle-inflicted chronic diseases as they are becoming more and more common among large portions of the Chinese population due to rapidly changing lifestyles.

WHO

China first joined the United Nations system as the People's Republic of China in the 1970s. It was not a vigorous participant during the early stages of its relationship with the WHO, with limited international technical cooperation. Following national economic reforms introduced in the late 1970s, China's cooperation with WHO started evolving to adapt to the changing needs of its massive population. With rapid economic growth, China has become more active in the field of global health not only in terms of financial contributions, but also technical assistance to other member states. The successful eradication of diseases such as schistosomiasis and leprosy has enabled China to share valuable experiences with the international community. In addition, China's growing pharmaceutical industry is also undergoing changes in order to attain recognition by the WHO with the purpose of production of generic drugs for export. As a way to assert the mutually beneficial cooperation between the WHO and China, the first Country Cooperation Strategy (CCS) was signed for the years 2004 to 2008, and the second CCS for 2008 to 2013. A memorandum of understanding was signed in 2004 by the WHO director general and China's Ministry of Health to outline the priority areas of WHO's work in China and to further strengthen collaboration.

Opportunities for Engagement

There are multiple potential collaborations in the area of global health, in which the international community can develop bilateral cooperation, facilitate trilateral action, or support global health indirectly through multilateral agencies and/or regional bodies.

The South-South collaboration is the most important framework for engagements both politically and technically, and it is inclusive of global south and global north partners.

There are several key engagement opportunities:

Pharmaceuticals. It has long been recognized that China's large domestic pharmaceutical industry could play a role in increasing access to quality-ensured generic essential medicines as a part of its South-South collaboration. China has a great capacity to increase the global supply of quality-ensured generic essential medicines because over four hundred companies in China produce active ingredients for the production of HIV, malaria, and TB

medicines. It is opportune that the Chinese State Food and Drug Administration (SFDA) is currently revising its Good Manufacturing Practice (GMP) standards to be in line with WHO standards and strives to become a stringent regulatory authority in the future. The existing U.S. FDA policies could be used to ensure a robust and transparent medicines regulatory system in China, demonstrated via documentation in registration, postregistration, and pharmaco-vigilance.

Support for public-private partnerships (PPP). Support to the government of China in capacity development of managing PPP can accelerate both domestic reforms and the global health engagement. Establishing platforms for Chinese entrepreneurs to meet their American and/or African colleagues can increase the access and supply of global public commodities; strengthening the collaborations between governments and leading think tanks/research institutions can support the capacity building in establishing PPPs.

Trilateral cooperation schemes. Support The recent Forum on China-Africa Cooperation (FOCAC) in Beijing and the announcement of forthcoming support for health initiatives in Africa indicates the consensus of the government of China in the key areas of support. There is a scope for trilateral cooperation. The United States, however, should reference China's approach to the health reform process: closer high-level exchanges in the health sector between and among governments, strengthening of medical and research institutions, scientific and technology exchanges with Chinese institutions, and support business community dialogues between China and the United States, and among African partners. There is a need to critically look at successes and failures in the health sector development of African countries and to engage and mutually support the overall development.

Support for multilateral organizations. There has been an increasing intensity of discussions between China and many multilateral organizations since 2009. China has actively participated in the global health governance initiated by the World Health Organization (WHO), with its specific focus on WHO reform. Active explorations to offer new measures for African health development with WHO has also received great attention in Beijing because it meets China's domestic policy priorities as well. Access to quality medicines in Africa is a WHO prequalification initiative and a work in progress with UNAIDS. Chinese ministries are involved in securing Anti-retroviral therapy (ARV) supply collaborations with China and African regional organizations. These are important initiatives, and the expansion of technical support in these areas from the United States can lead to a greater impact and better outcomes.

5 | South Korea and Global Health Diplomacy

Carolyn Marie DuMond and Victor Cha¹

South Korea holds a unique place in the global health donor community. It is the first country to transition from a recipient of official development assistance (ODA) to becoming an ODA donor, joining the elite ranks of the Organization for Economic Cooperation and Development (OECD) donor community in 2010. South Korea does not currently have a large or long established presence as a donor in global health assistance, especially when compared to other donor countries. The government does, however, have a growing program of ODA with a small, yet increasing, amount committed to global health aid. South Korea's relatively new entry as a global health donor means its aid infrastructure is not yet well developed and that the country has relatively little experience coordinating and cooperating with other donors. Nevertheless, the country is fully committed to expanding its global diplomatic reach and has greatly increased its efforts to engage in the global health community. These new initiatives, both with multilateral institutions and trilateral engagements with the United States, show great potential. South Korea's history and experience as an aid recipient, combined with its commitment to be a leader on the global stage, make it a country uniquely positioned to make impactful contributions to global health diplomacy in the future.

This chapter first looks at South Korea's history and background as a recipient of international aid and its experience transitioning into an ODA donor before turning to an overview of the country's middle power diplomacy, the government's channels for aid, and South Korea's commitment to global health. The following two sections outline South Korea's engagement in Asia and least developed countries (LDCs) and its cooperation with the United States. The final section gives some brief suggestions for enhancing collaboration on global health.

History and Background

South Korea's history as an aid recipient has shaped its current commitment to and involvement with ODA and global health aid. The health projects that were carried out in

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Korea by the international aid community focused primarily on the areas of family health and planning, technical training and health infrastructure construction, and tuberculosis prevention.² Today, the country's global health assistance programs generally tend to focus on these similar issue areas.

South Korea's experience as a recipient of international aid was shaped by the realities of a post-war society, international pressures from the Cold War, and the prevailing public health trends of the day. In the wake of the devastation caused by the Korean War (1950–1953)³ to both the economy and the country overall, South Korea was one of the poorest nations in the world. Consequently, South Korea was one of three main recipients of U.S. development assistance in the 1950s and 1960s.⁴ In the immediate postwar period health projects focused primarily on treating infectious diseases and injuries. However, the majority of aid given to South Korea by the international community was directed to development aid and poverty reduction more generally, rather than being specifically targeted as health aid.

Health aid from the international community, especially from the United States, funded a significant part of the development of family health and medical training in South Korea during the 1950s through the 1970s. As the country's economic growth increased and the government underwent reforms, South Korea began to develop some initial programs for overseas assistance. However, the majority of the assistance South Korea gave at that time was typically directed toward more general economic development aid, sharing Korea's development model, rather than being targeted as global health aid. In 1963 Korea started a development training program which was sponsored by the United Nations. The South Korean government began funding the training program on its own in 1965 and sent its first experts abroad to developing countries in 1967. The majority of Korea's development assistance was funded by the United Nations (UN) through the mid-1970s but as developing countries expressed increased interest in Korea's unique economic development experience, the government slowly expanded its own funding. In 1977 the Ministry of Foreign Affairs and Trade (MOFAT) received a budget of KRW900 million to provide developing countries with equipment and resources. Also in 1977 the Korean Development Institute created the International Development Exchange Program (IDEP), which invited leaders from developing countries to participate in education programs on Korea's development experience.

Nevertheless, even as South Korea developed initial development assistance programs, the country continued to receive aid from a variety of sources abroad. For example, starting in the 1980s, as a part of the government's fourth five-year economic development plan, loans from the International Bank of Reconstruction and Development (IBRD) were used to

2. Na-mi Hwang, "Family Health: ODA Project Model of Development/모자보건 ODA사업모형개발," Korea Institute for Health and Social Affairs, October 2011.

3. The Korean War technically has never ended, but full scale hostilities ceased with an armistice agreement signed on July 27, 1953.

4. In total the Korean government estimates that it received US\$12.7 billion of aid in the postwar period. OECD, "Special Review of the Republic of Korea's Development Co-operation," 2008, 9, <http://www.oecd.org/dac/peerreviewsofdacmembers/42347329.pdf>.

build health centers to reduce the differences in health care across regional areas. The IBRD funds built eighty-nine health centers in rural areas in the first half of the decade.

TRANSITIONING INTO AN ODA DONOR

In 1987 the Korean government established its first ODA institution, the Economic Development Cooperation Fund (EDCF), at the Export-Import Bank of Korea under the Ministry of Strategy and Finance (MSF).⁵ The EDCF was created to provide aid loans to developing countries. Its projects focus on economic development, infrastructure, training, and knowledge exchanges.

On January 14, 1991, the National Assembly enacted the Korea International Cooperation Act. The Korea International Cooperation Agency (KOICA) was established on April 1, 1991, under the Ministry of Foreign Affairs and Trade.⁶ KOICA focuses on giving full scale aid in the form of grants to developing countries. The aid provided by KOICA supports seven different sectors of development assistance: education, health, governance, rural development, information and communication technology, industry and energy, and environment and gender. In the early 1990s KOICA and EDCF gave only approximately US\$100 million of ODA annually.⁷ These two institutions, EDCF and KOICA, have since expanded their contributions to ODA and continue to form the backbone of Korea's ODA infrastructure today. Combined, international aid from KOICA and EDCF accounted for 88 percent, or US\$1.17 billion, of the country's total annual ODA contributions in 2011.⁸

At the same time the Republic of Korea (ROK) government was transitioning from an international aid recipient to a donor, the ROK National Red Cross also began looking outward. The ROK National Red Cross began providing international assistance in the 1990s with support for several developing countries. It increased the range of its international assistance by responding with emergency relief following the 2004 Indian Ocean tsunami, the 2010 earthquake in Haiti, and the 2011 food crisis in Africa. In June 2012 the ROK National Red Cross and the Ministry of Foreign Affairs and Trade signed a memorandum of understanding with the international Red Cross Red Crescent to explore new areas of cooperation in a number of areas, including health.⁹ The agreement focused on pilot development projects in Vietnam and Bangladesh, programs which were to be funded with approximately US\$2.1 million of planned assistance from the South Korean government.

The Korea Foundation for International Healthcare (KOFIH) was established in 2004 by the National Assembly. KOFIH provides healthcare assistance in least developed countries

5. MSF serves as the policymaking authority, while EDCF is the implementing authority.

6. MOFAT is the policymaking authority, while KOICA is the implementing authority.

7. Ministry of Foreign Affairs and Trade, "Millennium Development Goals Project Report: Republic of Korea," http://www.undg.org/archive_docs/8134-Millennium_Development_Goals_Progress_Report_Republic_of_Korea.pdf.

8. OECD, "Korea: Development Assistance Committee (DAC) Peer Review, 2012," December 11, 2012, <http://www.oecd.org/dac/peerreviews/dacmembers/Korea%20CRC%20-%20FINAL%2021%20JAN.pdf>.

9. "Red Cross Red Crescent signs landmark agreement with Republic of Korea government," June 26, 2012, <http://www.ifrc.org/en/news-and-media/press-releases/asia-pacific/korea-republic-of/red-cross-red-crescent-signs-landmark-agreement-with-republic-of-korea-government/>.

(LDCs) and North Korea as well as foreign disaster emergency relief and medical equipment assistance. KOFIH's mission is to meet Korea's growing responsibility in the international community by becoming a "specialized institution in health assistance" providing systemic and professional healthcare assistance to developing nations.¹⁰ KOFIH's health-care assistance in LDCs includes projects related to maternal and child health, primary health care, communicable disease management, and the training of medical engineering technicians, nurses, and doctors.

A second major part of KOFIH's projects is focused on health care assistance to North Korea. While the majority of health care aid which South Korea provides to North Korea is not counted in official ODA,¹¹ it is, nevertheless, an important component of South Korea's health diplomacy. Some of the current projects which KOFIH is carrying out in North Korea include initiatives for the prevention of hepatitis B in children and controlling tuberculosis in Naseon area. KOFIH hosts seminars on North Korean health care development and strategy with participants from the World Health Organization (WHO) and civil society organizations. Assistance given by KOFIH also supports North Korean pharmaceutical factories in the production of basic medicine and medical supplies and provides medicine and medical supplies to Nampo Maternity Hospital.¹²

In January 2010 South Korea joined the OECD's elite donor community, the Development Assistance Committee (DAC). South Korea was the twenty-fourth country to join the DAC and was the first to have transitioned from a recipient country to a donor. While each DAC member has its own unique capacities, expertise, and resources to contribute, membership in the DAC is predicated on the DAC's assessment of the "size of a country's aid program, the existence of appropriate institutions and policies to manage aid, the quality of a country's statistical reporting on ODA efforts, and the country's ability and willingness to implement important DAC recommendations."¹³ Despite South Korea's considerably low proportion and absolute amount of ODA compared to other DAC countries, it has committed to increase its aid to 0.25 percent of gross national income (GNI) by 2015. Furthermore, South Korea's firsthand experience as an aid recipient, its knowledge of the importance and value of using aid effectively, and its relatively recent experience with the development process are some of the key strengths DAC noted on South Korea's admittance. In its 2012 peer review, the DAC noted that South Korea has not only made significant strides as an ODA donor since it first joined but has also been particularly effective in serving as a bridge between DAC members and BRICS (Brazil, Russia, India, China, and South Africa) countries to ensure BRICS's support for the global partnership for effective development and cooperation.

10. Korea Foundation for International Healthcare, "Foundation Overview," <http://www.kofih.org/>.

11. Despite the continued division of the peninsula, Article 3 of the South Korean constitution states, "The territory of the Republic of Korea shall consist of the Korean peninsula and its adjacent islands." Therefore, any aid given to North Korea is not ODA because, according to South Korea's constitution, it is a part of South Korean territory.

12. Korea Foundation for International Healthcare, "Foundation Overview," <http://www.kofih.org/>.

13. Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC), "Joining the Development Assistance Committee (DAC)" <http://www.oecd.org/dac/joiningthedevelopment-assistancecommittee.htm>.

Global Health and South Korea's Middle Power Diplomacy

South Korea's commitment to expand its contributions to global health assistance will remain on a positive trajectory for two reasons. First, South Korea is proud of its economic growth and development. It sees itself as a middle power country that can share the lessons it learned through its transition from poverty to wealth with the world's developing nations. Korea has used its international aid programs, in part, to further the government's goal of promoting its national image of "Global Korea" and become a leader both regionally and globally. Second, as part of "Global Korea," the South Korean government believes that the commitment to more international aid fulfills Korea's responsibilities to provide public goods for the international community more in line with its enhanced global status. On December 9, 2011, KOICA chief Park Dae-won stressed that South Korea, as one of the ten to fifteen largest economies in the world, should at least contribute the average OECD amount to foreign aid.¹⁴ The director of the Ministry of Health and Welfare's International Cooperation Division argues that Korea's plan to advance its international assistance is a chance to increase pride for Koreans and their sense of global citizenship by improving Korea's international prestige.¹⁵ KOFIH sees Korea's growing importance on the global stage as a challenge to significantly scale up South Korea health care assistance to developing countries.

In recent years the Korean government has been expanding its commitment to ODA in general as well as developing plans to scale up its support for global health. Upon joining the OECD's DAC in 2010, South Korea's deputy minister for multilateral and global affairs at the Ministry of Foreign Affairs and Trade pledged that Korea would increase its amount of official development assistance to around 0.25 percent of GNI by 2015.¹⁶ Notwithstanding its relatively low rate of contribution as compared with the size of its GNI, Korea has substantially increased its net ODA expenditures from US\$279 million in 2002 to US\$816 million in 2009, nearly tripling its contributions in less than a decade. This increase is especially impressive given that at the same time Korea has been increasing its net contributions, it has also been working to build up its development aid infrastructure. The country has continued to build on this progress disbursing over US\$1 billion in ODA for the first time in 2010 and achieving an ODA/GNI ratio of 0.12 percent in both 2010 and 2011. In 2012 Korea expanded its ODA net disbursements to US\$1.86 billion, up US\$539 million over the previous year, and reached an ODA/GNI ratio of 0.15 percent.¹⁷

Korea's contributions to health aid have also been increasing. According to OECD data, Korea expanded its bilateral ODA and multilateral concessional flows to health aid from

14. The Korea Economic Daily. "Foreign Aid is a way of coexistence . . . strengthen the capacity of recipient nations," December 9, 2011, <http://www.hankyung.com/news/app/newsview.php?aid=2011120841411>.

15. Kotshigue Shin, "Korea's Official Development Assistance for Maternal & Child Health: Overview and Progress," November 15, 2011, presented at the OECD International Forum on Strengthening MCH Partnerships for Attaining MDGs, Seoul, Korea.

16. OECD-DAC, "DACnews Special Alert, 26 November 2009: OECD Development Assistance Committee (DAC) welcomes Korean membership," <http://www.oecd.org/dac/44149382.html>.

17. Prime Minister's Office, ODA Korea, "Total Net ODA in % GNI," www.odakorea.go.kr/index.jsp.

zero in 2004–2005 to US\$36.7 million in 2006–2007. For the 2008–2009 period Korea further increased its disbursement of health aid to US\$79.1 million, a 116 percent increase over the previous two years.¹⁸ However, in 2011 Korea gave US\$44.65 million in ODA toward health, down somewhat from the previous year's health aid of US\$67.16 million.¹⁹ In the 2011 bilateral health ODA accounted for 9.8 percent of Korea's total bilateral ODA commitments, of which basic health aid was 2.4 percent.²⁰ Health continues to be one of Korea's top thematic priorities for ODA and is one of the three areas where Korea spends most of its ODA money.

INTERNATIONAL DEVELOPMENT DIPLOMACY CAREERS IN SOUTH KOREA

Since South Korea's ODA programs are so new, there currently is not a unified career track for development professionals in South Korea, nor has the profession developed yet into a highly desirable career. While a number of ministries have overseas programs, people interested in pursuing a career as an ODA professional at KOICA must first take an exam specifically for that organization. Individuals with a specific interest in development careers have historically been more involved with the nongovernmental organization (NGO) community because this has had a longer history than the professional careers in government ODA programs. However, as South Korea gains more experience and the general public becomes more aware of the ODA field, interest in a professional development career track should continue to grow. There are a few university programs focused on development and a very small number of organizations offer scholarships for advanced study in this field. However, these are mostly geared toward training students from other countries to work in development in their home countries.²¹ As Korea expands its aid programs to meet its 2015 ODA/GNI goal more development staff will be needed. The 2012 OECD DAC Peer Review found that staffing for development could become a major issue and noted that current development staff are already pressed to manage ever increasing amounts of ODA for increasingly complex projects.²² The Korean government has acknowledged this need and KOICA has committed to hiring an additional 105 staff members and EDCF has committed to doubling its staff by 2015. This increased demand for development staff should also contribute to increased programs and interest for development diplomacy careers.

In spite of South Korea's new entry as an ODA donor, it has a fairly well-established system for sending personnel and volunteers abroad to multilateral aid institutions and to other countries. World Friends Korea (WFK) is South Korea's equivalent to the U.S. Peace Corps. First founded in 2009 by the Korean government, WFK unified three different

18. OECD-DAC, "Aid to Health," Table 1, December 2011, www.oecd.org/dac/stats/health.

19. Korea International Cooperation Agency (KOICA), "KOICA Statistics: Table 19 Aid by Major Purposes in 2011," http://stat.koica.go.kr:8077/komis/jsptemp/ps/stat_index.jsp.

20. OECD Statistics from A to Z, "Table 19: Aid by Major Purposes in 2011," <http://www.oecd.org/statistics>.

21. For example, Korea University offers a Master's degree program in International Development in conjunction with funding from KOICA for students from developing countries.

22. OECD, "Korea: Development Assistance Committee (DAC) Peer Review, 2012," December 11, 2012, <http://www.oecd.org/dac/peerreviewsofdacmembers/Korea%20CRC%20-%20FINAL%2021%20JAN.pdf>.

programs previously run by a variety of other government ministries.²³ It is estimated that WFK will send approximately 20,000 volunteers abroad over the period of 2009–2013. In addition to the volunteers sent aboard, South Korea sends a number of professionals overseas for development work in other countries. These professionals are generally based at field offices near South Korean embassies. South Korea also sends professionals to multilateral aid institutions, especially the UN International Children’s Emergency Fund (UNICEF). The number of development professionals which KOICA has sent abroad each year has dramatically increased to approximately 10,000 from only about 200 per year prior to 2004.

SOUTH KOREA’S CHANNELS FOR PROVIDING HEALTH AID

While KOICA is the primary vehicle for health aid, there are over thirty ODA institutions in Korea. To improve the coordination and effectiveness of the country’s international aid, the ROK government created the Committee for International Development Cooperation (CIDC) in January 2006. The CIDC was created as a part of the Prime Minister’s office with the purpose of analyzing the key policies and plans of South Korea’s ODA. The committee adopted a number of plans including a mid-term ODA strategy and country assistance strategies. The CIDC’s working committees consult with the both ODA policy authorities and implementation authorities. Ministers, representatives from the private sector, and ODA experts are consulted and serve on various levels of the CIDC’s structure. In October 2010 CIDC adopted the Strategic Plan for International Development Cooperation. The strategic plan outlined three core strategies to strengthen Korea’s capacity as a development partner. Its recommendations included “systematically documenting the development contents of successes and failures derived from Korea’s development experience, strengthening ODA implementing capacities, and taking a proactive role in addressing global issues.”²⁴ While the committee’s reports are good initial efforts to undertake long-term ODA planning and to coordinate the various institutions administering policy, it could be more effective at genuinely integrating ODA strategic plans across the government. A better integrated approach and more centralized policy making could help make ODA institutions more effective and efficient at delivering aid.

The Korean military has also been involved with providing international development assistance. The military conducts missions related to postconflict stabilization and reconstruction efforts, including work in public health. For example, the Korean military sent 250 troops to Haiti as a part of the UN peacekeeping operation in March 2010. More notably, in August 2004 the Korean military also sent the Zaytun Division²⁵ of 3,000 troops comprised of Special Forces, engineers, and medical personnel to the northern part of Iraq for peacekeeping operations, reconstruction efforts, and health assistance.

23. The oldest overseas volunteer program was first established in 1989. Korea Overseas Volunteers (KOV) was a part of MOFAT and was managed by KOICA prior to being folded into WFK. World Friends Korea, “Guide to WFK Programs,” <http://www.worldfriendskorea.or.kr/eng/sub/guide/guide01.jsp>.

24. “Future Direction of Korea’s ODA,” http://www.mofat.go.kr/ENG/policy/oda/index.jsp?menu=m_20_110.

25. Zaytun is the Arab word for olive, a symbol of peace.

South Korea has been developing relations and coming to agreements with a variety of multilateral institutions. In recent years South Korea has become much more involved in providing multilateral ODA and, by extension, global health assistance. On September 22, 2009, South Korea signed a framework agreement with UNICEF that established the legal basis for bilateral cooperation and laid a foundation for closer collaboration on the ground, particularly in Africa. South Korea is committed to providing mid- and long-term support for UNICEF's programs. Like its foray into other global donor communities, South Korea is also the first country to transition from a UNICEF program country, which it was until 1994, to a donor and a member of UNICEF's network of national committees. South Korea has held director-general level consultations with UNICEF every year since 2004. Most recently, South Korea and UNICEF held their 9th Annual Policy Consultation Meeting on June 11, 2012.²⁶ South Korea and UNICEF discussed possible cooperation on global health assistance between the International Vaccine Institute (IVI), a Seoul-based international organization, and UNICEF. The meeting also looked at ways to leverage cooperation between governments on multilateral projects through international organizations. Additionally, the ROK is a member of UNICEF's executive board in 2012 and will continue to serve in this capacity in 2013.

Korea is also particularly focusing its efforts on strengthening its partnerships with the United Nations Development Program (UNDP) and the World Food Program (WFP). South Korea officially ended its relationship with the UNDP as a program country in 2009, which had begun in the 1960s. The ROK signed a new strategic partnership agreement to become a UNDP donor and assume an increased role in ending poverty and achieving the UN Millennium Development Goals (MDGs). As the country scales up its ODA activities, these channels should begin to be more highly utilized.

In the near term, however, South Korea is likely to be most active as a donor to overseas work on health through KOICA, the primary institution which provides bilateral grant aid and technical cooperation for the ROK government.

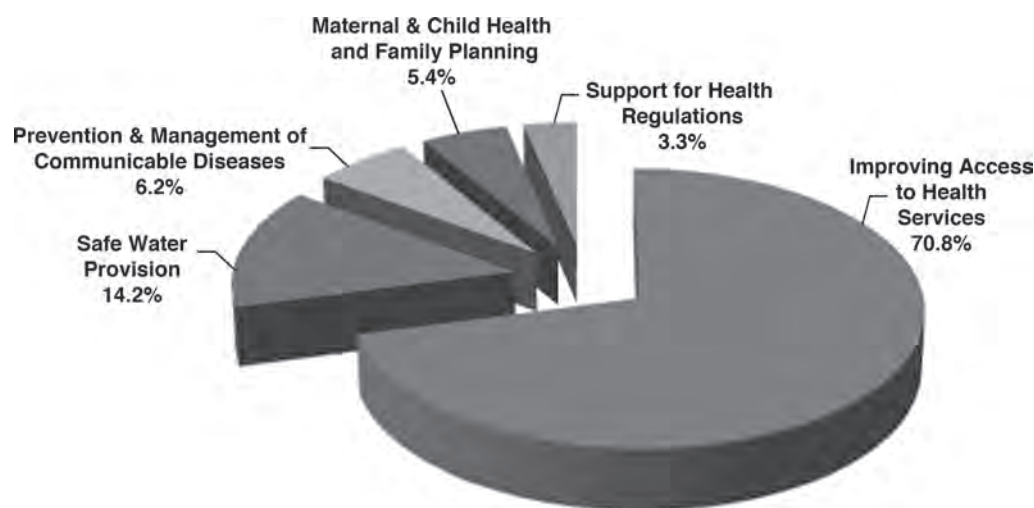
KOICA'S COMMITMENT TO GLOBAL HEALTH

KOICA has outlined its global health assistance strategy for 2011–2015. Its vision is to “contribute to sustainable development through healthy lives of developing countries” by focusing on the target group of women and children to meet the goal of helping developing countries to provide “essential health services to vulnerable people.” The strategy outlined specific strategic objectives for five areas: strengthening of human resources, support for health regulations, improvement of access to health services, improvement of maternal and child health and family planning, and the prevention and strengthening of the management of communicable diseases.²⁷

26. ROK Ministry of Foreign Affairs and Trade, “Outcome of the 9th ROK-UNICEF Annual Policy Consultation Meeting,” June 12, 2012, http://www-dev.kdi.re.kr/kdi_eng/highlights/govern_view.jsp?no=6029&page=37&rowcnt=10.

27. KOICA, “About KOICA: Our Mission,” <http://www.koica.go.kr>.

Figure 5.1 KOICA's Subsectoral Disbursement of Global Health Assistance in 2011



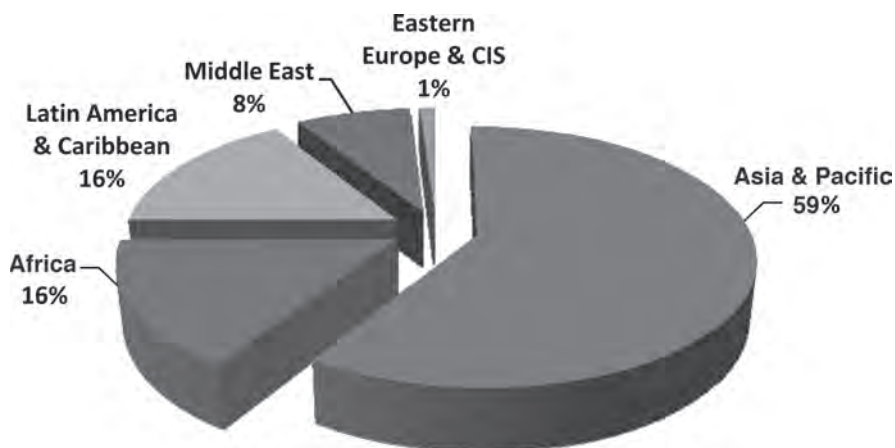
Source: KOICA, "Health Overview," <http://www.koica.go.kr/english/aid/health/index.html>.

Over the time period of 2011–2015, KOICA's objectives for the strengthening of human resources focuses on workforce education in health policies, education for medical experts, and education for basic health workers. In the category of providing support for health regulations, KOICA outlines its objectives as strengthening of health insurance and financial capacity, strengthening of health information systems, and the improvement of health policies. As a part of KOICA's health strategy, the institution plans to address the improvement of access to health services through the improvement of the delivery of essential health programs and the strengthening of primary health programs and health delivery systems. KOICA's objectives for the improvement of maternal and child health and family planning are focused on the improvement of family planning and reproductive health, of pregnancy and labor management, child health, and of maternal and child nutrition. For the prevention and strengthening of the management of communicable diseases, KOICA plans to focus its strategy through 2015 on the prevention and management of neglected tropical diseases, the management of tuberculosis, and the prevention of HIV/AIDS, malaria, and other communicable diseases. See Figure 5.1 for a break out of KOICA's subsectoral disbursement of global health assistance in 2011.

South Korea's Global Health Engagement in Asia and LDCs

While Korea operates under the moniker of global activity, its efforts in international health assistance are in large part regional, yet with demonstrated potential in expanding into other hemispheres. Historically the Asia and Pacific region has been the largest recipient of South Korea's global health assistance. In 2010 KOICA disbursed a total of approximately US\$77.8 million for global health assistance, about 17 percent of the agen-

Figure 5.2 KOICA's Planned Regional Disbursement of ODA Health Assistance to the World in 2011



Source: KOICA, "Performance 2010 & Planned Performance 2011," <http://www.koica.go.kr/english/aid/health/index.html>.

cy's total ODA budget. Asia received 51 percent of the total disbursed health assistance, or approximately US\$39.5 million, divided between the thirty-two countries in which Korea had active ODA programs.

Even though Asia receives the majority of the ROK's ODA for health, South Korea has been engaged as an ODA donor around the world. Latin America and Africa were the second two largest recipients of health funding from South Korea in 2010, receiving US\$14.7 million and US\$10.4 million, respectively. Africa received 15 percent of KOICA's total ODA budget.²⁸ In 2010 the Middle East received US\$7.2 million in South Korean health assistance while Eastern Europe and the Commonwealth of Independent States (CIS) received US\$5.2 million.²⁹

KOICA's planned disbursement for health assistance in 2011 was slightly lower than the previous year, between US\$50.21 million and US\$51.04 million. However, the Asia and Pacific region was still the largest regional recipient of Korean health aid, at US\$29.97 million, or 59 percent of the annual total. Latin America and the Caribbean were to receive 16 percent of planned Korean health aid in 2011, as was Africa. A full list of KOICA's global health projects in 2011 is included in Appendix 5.1.

Of KOICA's total 2011 planned ODA disbursement in Asia, 27.1 percent was designated to go to health assistance. Of the eight sectors of aid, health assistance was set to receive the largest portion of the planned budget.

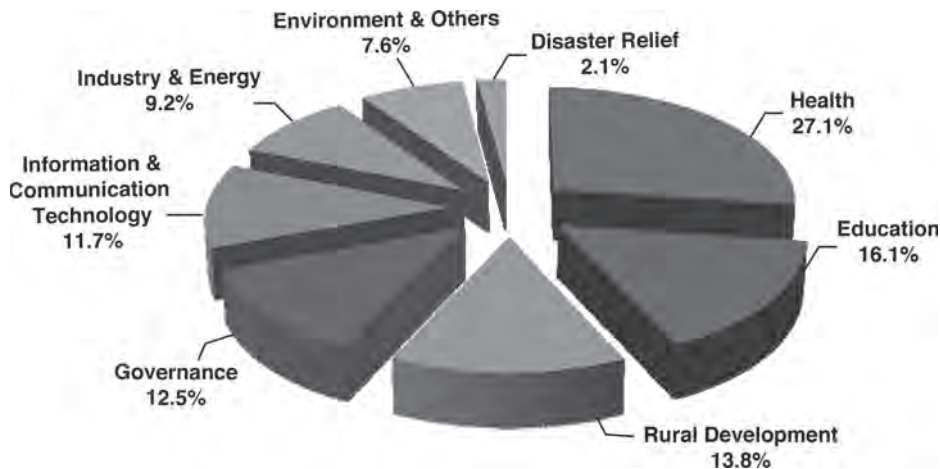
There are a number of factors that influence the distribution of South Korea's development aid. One shaping factor is Korea's high level of tied aid.³⁰ One of the goals of South

28. KOICA, "2010 Annual Report," http://www.koica.go.kr/upload/pr/annual/2010annual_e.pdf.

29. Ibid.

30. Tied aid is defined as aid that is given under the provision that all, or part, of the aid must be used by the recipient country to purchase goods from the donor country.

Figure 5.3 KOICA's Subsectoral Disbursement of ODA in Asia



Source: KOICA, "Asia Overview," <http://www.koica.go.kr/english/countries/asia/index.html>.

Korea's tied aid is to expand its exports and increase resource development. Such aid is typically provided on the condition that South Korean businesses will also benefit. This tendency is institutionalized in the legislation establishing the main pillars of Korea's ODA system that sets out the primary goal of promoting "mutually cooperative relationships" followed secondly by "economic and social development."³¹ Part of the reasoning behind the Seoul Development Consensus, signed by Group of Twenty (G20) leaders at the Seoul Summit in 2010, was that the development agenda should aim to increase demand in developing countries in order to provide "a new growth engine" for the global economy.³²

The global distribution of South Korea's ODA is also largely driven by its commitment to LDCs in line with the UN Millennium Development Goals and much of the international donor system's focus on both Africa and Latin America. South Korea has pledged to increase its ODA to Africa, home to the majority of the world's LDCs. KOICA is committed to doubling its budget for assistance to Africa between 2008 and 2012.

KOICA's engagement with Asia and other LDCs has met with particular success with its health assistance related to parasite control and these projects have brought Korea international recognition. Starting in 1995 through 1999, KOICA carried out a collaborative project with Chinese counterparts. Funding from KOICA supported the Korea-China collaborative NGO project for parasitic disease control in selected areas of China. In 2000–2004, KOICA conducted another Korea-China collaborative project, this time focused on control strategies for helminthiasis, a parasitic worm often spread through contaminated soil or water. The project reduced the infection rate by 50 percent in the targeted areas of Shanghai,

31. OECD-DAC, "Development Co-operation of the Republic of Korea: DAC Special Review," August 2008, <http://www.oecd.org/development/peerreviewsofdacmembers/42347329.pdf>.

32. Ministry of Foreign Affairs and Trade, "2009–2011 Major Diplomatic Achievements," http://www.mofat.go.kr/ENG/ministry/achievements/summary/index.jsp?menu=m_50_50.

Heilongjiang, and Jiangxi provinces, and Nanquing. KOICA's efforts related to parasite control continue today. Some ongoing projects include drinking water supply in East Timor, water supply and sanitation in Lao People's Democratic Republic (PDR), safe water supply systems in Senegal, and drinking water development in Kenya (see Appendix 5.1 for a full list of current projects).

Critiques of South Korea's ODA and Global Health Assistance System

There are a number of critiques that can be offered concerning South Korea's ODA and global health assistance programs. Foremost, despite Korea's increasing involvement as a global donor of ODA, the country's overall ODA accounts for approximately just 0.1 percent of GNI, which is considerably below the OECD average.

Furthermore, the quality of Korean ODA can still be greatly improved upon by increasing levels of bilateral ODA vis-à-vis multilateral ODA, untied aid versus tied aid, budget support versus project financing, and grants versus loans. South Korea also needs to minimize mixing ODA with export promotion and should increase its efforts to consult with civil society in order to raise the quality of its international assistance to the highest levels. In making these improvements, the South Korean government faces the task of scaling up its contributions and activities from a relatively low level with mixed public support and awareness.

One area where outside voices have offered the strongest critique is of South Korea's use of aid loans compared with grants to LDCs. Part of South Korea's emphasis on the use of ODA loans stems from its historical experience as a recipient. South Korea also prefers to give loans to LDCs rather than grants because it believes aid loans can enforce fiscal discipline on recipient countries in a way in which grants cannot. The OECD's DAC has especially pointed out the fact that while South Korea primarily gives grants to upper and lower middle income countries, grants only account for approximately 40 percent of the OAD given to LDCs. Given the fungible nature of both loan and grant aid, the risks of adding unsustainable amounts of debts to LDCs seems to far outweigh the potential fiscal discipline that aid loans might impart. South Korea's global health diplomacy toward LDCs could be greatly improved if it were to increase the amount of aid grants to these vulnerable countries.

U.S.-ROK Relations in Global Health

The United States and South Korea first launched health relations in 1954 by forming a partnership to exchange medical education and research as the ROK underwent its post-war reconstruction. As the South Korean medical system was reconstructed, the U.S. Agency for International Development (USAID) continued to provide South Korea with health assistance focused on family health and planning, technical training, and tuberculosis prevention. Korea graduated from USAID programs in 1980.

On June 24, 2011, the South Korean Ministry of Foreign Affairs and Trade signed a development assistance memorandum of understanding (MOU) with the U.S. Department of State. South Korea is the first country to transition from being a recipient of U.S. aid to being a donor partner with the United States. In a press release the State Department said the understanding was “another milestone of the U.S.-ROK global partnership and recognizes the ROK’s growing emergence as a donor country.”³³ The State Department envisioned the MOU would “enhance policy coordination between both sides to promote the impact and efficiency in aid delivery within mutually agreed priority areas such as global hunger and food security, maternal and children’s health, and climate change” and “puts into place a meaningful partnership to expand the reach of development assistance and help encourage the shift from aid to sustained economic growth and prosperity.”³⁴

At the signing Secretary of State Hillary Clinton commented, “Korea approaches development with a unique credibility, as one of the great success stories of the 20th century, and we were delighted to sign the Development Assistance MOU today and to partner with Korea as it has moved from being an aid recipient to an important donor nation.”³⁵ The two countries committed to cooperate in international aid in a number of areas including global hunger and food security, climate change and environment, disaster response and humanitarian assistance, overseas volunteerism, public-private partnership promotion, aid effectiveness, and health and education.

South Korea and the United States have since collaborated on a number of global health assistance projects. On May 1, 2012, KOICA chief Park Dae-won said that KOICA cooperates with USAID in sub-Saharan Africa to improve health infrastructure.³⁶ KOICA is one of the major health development partners (DP) with the United States in the Ghana health development project for 2012–2017.³⁷ KOICA, in collaboration with the United States and other DPs, jointly reviews and approves the annual program of work for Ghana’s Ministry of Health and helps perform annual program reviews.

KOICA and the United States are also currently developing trilateral projects on maternal and child health in Ethiopia and the Democratic Republic of the Congo. While these trilateral projects are only in the initial stages of development, South Korea has been active in both countries for some time. Active in Ethiopia for several years, South Korea has been greatly expanding its involvement there in recent years. Between 1991 and 2011 South Korea gave a total of US\$35.5 million in ODA grants. In 2011 South Korea gave a total of US\$6.9 million in ODA grants, up significantly from US\$0.4 million in 1991 and US\$0.5

33. U.S. Department of State, “United States and South Korea Sign the U.S.-ROK Development Cooperation,” June 23, 2011,” <http://www.state.gov/r/pa/prs/ps/2011/06/166875.htm>.

34. Ibid.

35. U.S. Department of State, “Remarks With South Korean Foreign Minister Kim Sung-Hwan After Their Meeting,” June 24, 2011, <http://www.state.gov/secretary/rm/2011/06/167072.htm>.

36. Joongang Ilbo, “Nations that wanted money turn to the Korean way of providing experience,” May 1, 2012, http://article.joinsmsn.com/news/article/article.asp?total_id=8044484.

37. “Ghana Global Health Initiative Strategy: 2012-2017,” <http://www.ghi.gov/documents/organization/192502.pdf>.

million in 2001. A portion of the US\$6.9 million in 2011 was given to health aid. One signature health project in 2011 was a maternal and child health/family planning project for which South Korea gave US\$2 million. Another key health project in 2011 was a tuberculosis prevention program for US\$2.8 million. Between 1991 and 2011 South Korea has sent 19 experts and 224 volunteers to Ethiopia.³⁸ In the Democratic Republic of the Congo, South Korea gave a total of US\$4.5 million ODA grants in 2011. Health projects include an immunization project in collaboration with UNICEF that Korea funded with US\$2 million in 2010–2011 and US\$2 million in 2011–2012. Between 1991 and 2011 South Korea has sent a total of US\$11 million in ODA grants, one expert, and two volunteers.³⁹ However, since 2007 South Korea has greatly increased the amount of ODA it gives to the Democratic Republic of the Congo and plans to continue increased support.⁴⁰

The United States and South Korean governments are also in very preliminary stages of discussions for trilateral projects in a number of other countries, including Nepal and the Lao People's Democratic Republic.

These projects have great potential to develop into meaningful and productive collaborations between South Korea, the United States, and the recipient countries. Furthermore, successful collaboration on these initial projects can offer a strong foundation on which to build more cooperation in the future.

In addition to trilateral projects, South Korea recently joined the Steering Committee for Child Survival: A Call to Action.⁴¹ Organized by the United States, Ethiopia, India, and UNICEF, this initiative has three main goals: to mobilize political leadership to end preventable child deaths, to achieve consensus on a global roadmap highlighting innovative and proven strategies to accelerate reductions in child mortality, and to drive sustained collective action and mutual accountability.⁴²

Conclusion: How to Enhance South Korea's Future Collaboration in Global Health

Korea's future as a contributor to the public good of global health in the international community shows both great accomplishments and even greater promise. To realize Korea's potential to its fullest, policymakers would do well to:

Recognize Korea's room for growth. Korea is one of the world's brightest prospects in terms of potential for growth as a global health provider. Starting from a relatively low level of funding and coordination experience as a donor means there is a lot of room for Korea to

38. ODA Korea, "에티오피아 (Ethiopia)," <http://www.odakorea.go.kr/index.jsp>.

39. ODA Korea, "콩고민주공화국 (DR Congo)," <http://www.odakorea.go.kr/index.jsp>.

40. Through 2006 South Korea gave no more than US\$0.3 million to the Democratic Republic of the Congo. Since 2007 it has provided over US\$1.5 million and in 2011 gave US\$4.5 million.

41. "Call to Action: Ending Preventable Child Deaths," last modified June 14, 2012, 45, <http://www.usaid.gov/news-information/news/fact-sheet-call-action-sets-course-end-preventable-child-deaths>.

42. "What is the Child Survival Call to Action?" http://www.apromiserenewed.org/A_Call_to_Action.html.

grow and improve its programs. As Korea embarks on this growth process, deep and close collaboration with countries and institutions that have longer, more extensive experience as global health donors could be incredibly fruitful.

Encourage Korea to develop better structure. Further improvements in the government's aid structure by consolidating the number of aid agencies into a more centralized body for international assistance would allow Korea to better focus its ability to provide high level aid and to more easily coordinate with other countries and multilateral institutions. A single government-wide strategy or policy umbrella could also greatly help KOFIH, KOICA, EDCF, MOFAT, and MSF to better coordinate their various efforts and projects, especially as the country seeks to more than double its ODA contributions by 2015.

Seek a rebalancing of the composition of aid. Korea could do better to increase the amount of untied aid and to strike a better balance between bilateral aid programs and multilateral aid. Especially as global economic growth continues to face significant headwinds and nations around the world struggle with increasing levels of national debt, it will be important for Korea to also work on providing more grants than loans to LDCs. Because LDCs typically have poor or no access to credit markets and large amounts of loans, even aid loans tend to add additional burdens.

Promote a strong partnership with the United States and with international organizations. Korea, by virtue of its deep alliance ties with the United States and its common values, is a very good partner for the United States to contribute to the public goods of global health in the international system. The 2011 MOU lays a mutual foundation of commitment for cooperation and engagement in ODA activities. Both countries should continue efforts to increase the cooperation commitment outlined in the MOU and maintain positive momentum to increase engagement.

Additionally, Seoul's deep engagement with multilateral institutions, both in regional and global contexts, makes it familiar with and conversant on issues, personnel, and procedures related to the provision of health. Continued and increased partnerships with such donors could help Korea to be even more effective and gain greater experience as a high-quality global health donor.

Appendix 5.1

KOICA's 2011 Global Health Projects⁴³

Improvement of Access to Health Services

Project for the Establishment of the Lao-Korea National Children's Hospital in Laos, 2009–2011, US\$3.5 million

Project for the Establishment of a Central General Hospital in Quang Nam Province in Vietnam, 2006–2012, US\$35.0 million

Project for Strengthening Siem Reap Provincial Hospital Services in Cambodia, 2012–2012, US\$3.3 million

Project for Medical Assistance and Vocational Training in Parwan Province, Afghanistan, 2008–2011, US\$39.9 million

Project for Strengthening Vatei Provincial Hospital Services in Cambodia, 2011–2013, US\$3.5 million

Project for the Establishment of the Preah Ang Duong Eye Hospital Referral Center in Cambodia, 2011–2013, US\$5.0 million

Project for Improvement of the National Medico-Surgical Emergency Center in Cameroon, 2010–2012, US\$3.0 million

Project for Capacity Building for Diagnostic Service Improvement of Health Centers in Dar es Salaam, 2008–2011, US\$4.5 million

Project for the Improvement of the Health System in Oruro, Bolivia, 2010–2016, US\$10.0 million

Project for the Improvement of Basic Health in Choco, Colombia, 2009–2011, US\$2.0 million

Project for the Establishment of the Korea-Colombia Rehabilitation Center in Colombia, 2007–2012, US\$11.5 million

Project for Construction of a General Hospital in San Pedro in Paraguay, 2009–2011, US\$ 4.7 million

43. KOICA, "Health Projects in 2011," <http://www.koica.go.kr/english/aid/health/index.html>.

Project for the Establishment of a Dental Clinic at the Universidad Nacional de San Antonio Abad del Cusco, Peru, 2010–2012, US\$ 2.0 million

Project for Strengthening the Comas Maternal-Child Health Center in Peru, 2011–2012, US\$2.0 million

Project for Establishment of a Mobile Clinic in Basra, Iraq, 2010–2011, US\$3.0 million

Project for Strengthening the Primary Health Care in Jenin, Palestine, 2009–2011, US\$3.0 million

Project for Establishment of a Hospital in Lima, Peru, 2011–2013, US\$5.7 million

Improvement of Maternal and Child Health and Family Planning

Project for Home-Based Maternal & Newborn Care Interventions to Accelerate Progress Toward Achieving MDG-4 in Bangladesh, 2010–2013, US\$2.0 million

Project for Routine Immunization Strengthening in the DRC, 2010–2012, US\$2.0 million

Project for Family Planning & Maternal-Child Health Care (2nd) in Arsi, Ethiopia, 2011–2013, US\$2.0 million

Project for Capacity Building for Maternal & Child Health in Guatemala, 2010–2012, US\$1.5 million

Project for Preventing Teenage Pregnancy and Improving Sexual and Reproductive Health Care for Young Women in the Dominican Republic, 2008–2011, US\$1.3 million

Project for the Improvement of the Health Environment for Maternal & Child Health in Huehuetenango in Guatemala, 2011–2015, US\$2.7 million

Prevention and Strengthening of the Management of Communicable Diseases

Project for the Quality Improvement of Medical Care Rendering to Patients with Infectious Diseases, 2009–2011, US\$3.0 million

Project for Improving Public Health and Tuberculosis Control in Cavite, Philippines, 2010–2012, US\$3.0 million

Project for the Development of the Lung Center of the Philippines as the National Referral Center for MDR-TB, 2008–2011, US\$2.9 million

Project for Capacity Building for Communicable Disease Centers in Myanmar, 2011–2014, US\$3.0 million

Project for Waterborne Disease Control in Volta Region in Ghana, 2011–2013, US\$4.0 million

Project for Tuberculosis Prevention & Control in Addis Ababa in Ethiopia, 2011–2013, US\$2.8 million

Project for Fistula Prevention and Management in the Center, North and West Regions of Cote d'Ivoire, 2010–2012, US\$1.7 million

Support for Health Regulations

Project for the Development of Community-Based Health Insurance to Support the National Initiative of the Government of Nepal to Achieve Universal Coverage for Essential Health Care in Nepal, 2010–2011, US\$1.0 million

Project for Strengthening the District Health System in Papua New Guinea, 2010–2013, US\$5.5 million

Project for the Improvement of the Health Environment in Ticaful, Nepal, 2011–2014, US\$5.5 million

Project for Health Insurance Regulation in Vietnam, 2011–2013, US\$0.8 million

Provision of Safe Water

Project for Drinking Water Supply by Desalination Using a Photovoltaic Power Plant in East Timor, 2010–2012, US\$6.0 million

Project for Small Town Water Supply and Sanitation in Xebangfay, Khammouane Province, Laos, 2010–2011, US\$2.0 million

Project for a Multipurpose Rainwater Management System for Climate Change Adaptation in Myanmar, 2010–2012, US\$0.6 million

Project for the Improvement of Water Supply Systems in Senegal, 2010–2012, US\$5.5 million

Project for Drinking Water Development in Awendo in Kenya, 2010–2012, US\$3.0 million

Project for the Improvement of Water Supply Systems in Guarayos, Bolivia, 2010–2012, US\$3.5 million

Project for the Improvement of Water Supply Systems in Huehuetenango, Guatemala, 2011–2013, US\$1.1 million

Project for the Construction of a Grit Chamber in Erbil, Iraq, 2009–2011, US\$3.5 million

6 | Health Diplomacy in the Americas

Relationships in Transition

*Katherine E. Bliss*¹

Introduction

International cooperation on health in the Americas takes a variety of forms. Starting in the early twentieth century, private organizations such as the Rockefeller Foundation supported initiatives related to infectious disease control, as well as water and sanitation. In the 1950s, the U.S. government began to complement such private initiatives through support for a range of population and disease control initiatives in the region. Over recent decades, other donor governments, including Canada, Spain, the Nordic countries, and Japan, have made Latin America and the Caribbean a prime destination for health-related outreach.

With most countries in the region achieving upper middle income country status, many donor governments have moved to phase out or “graduate” overseas health programs, acknowledging the capacity of host governments to shoulder a greater share of the expense of providing health services to their populations. Nevertheless, Bolivia, some of the Central American countries, and, in the Caribbean, Haiti, continue to count on relatively substantial international support.

Even as the number of countries in the Americas receiving foreign assistance for health diminishes, there is nevertheless considerable regional dynamism when it comes to cooperative health activities. Canada, of course, has long been engaged on global health as a donor and provider of technical assistance in the region, as well as sub-Saharan Africa and Asia. But political stability and strong economic performance in several of the Latin American countries over the past twenty years have led some governments to begin offering what they conceptualize as “horizontal” or “South-South” assistance on health to neighbors and others they see as fellow travelers along the development path. During the past two decades Brazil has developed a robust international health outreach program, and in 2011 Mexico launched an international cooperation agency, with health a key area of focus. Like Mexico, Chile aspires to become a more influential development partner and is becoming more engaged as a funder and innovator when it comes to health diplomacy.

The Inter-American system provides a structure for both identifying regional health needs and for channeling program funds. The Inter-American Development Bank (IDB)

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and the Pan American Health Organization (PAHO), the regional arm of the World Health Organization (WHO), are the most significant multilateral partners for health in the region. The Inter-American Bank provides loans as well as technical cooperation to support health projects, while PAHO facilitates the setting of common regional health agendas and offers technical assistance to health ministries.

But other multilateral organizations are important for structuring health assistance emanating from the region, as well. The Group of Eight (G8) has been a focus of Canada's efforts to influence the global agenda when it comes to health. The Organization for Economic Cooperation and Development (OECD) is relevant for member states Canada, Mexico, and Chile, although only Canada reports the quantity and targets of its overseas funding to the OECD's Development Assistance Committee (DAC). The Group of Twenty (G20) engages Argentina, Brazil, and Mexico in discussions about international financial systems and has, in the past few meetings, seen an emerging area of concentration on development concerns. And the Asia-Pacific Economic Cooperation (APEC) provides Canada, the United States, Mexico, Peru, and Chile with opportunities to identify cooperative health projects in collaboration with other partners in the Pacific region.

Haiti has long been a significant target of regional outreach on health, and since the January 2010 earthquake Canada, Mexico, Chile, and Brazil all played strong roles in health-related reconstruction efforts. Beyond Haiti, Brazil has identified Lusophone African countries, as well as former Portuguese colony East Timor, as areas of focus, while Mexico concentrates its efforts within the Caribbean and its own Mesoamerican region. Chile's overall foreign policy focus is South America, but the government also engages on global health issues through its role as a founding member of UNITAID, which facilitates the provision of funds gleaned from airfare taxes for work on HIV/AIDS, malaria, and tuberculosis.

As regional government-to-government relations on health transform, the interactions between the United States and regional partners are also in flux. The U.S. Agency for International Development (USAID) is scaling back some of its health programs within its overall development assistance model, but there are new, collaborative efforts coming online. The U.S. Centers for Disease Control and Prevention (CDC) established a global disease detection center in Guatemala in 2006 and continues to support field epidemiology training programs (FETP) in several countries. Since the 1980s the U.S. Navy has maintained a laboratory in Peru to carry out investigations regarding regional disease patterns in collaboration with regional research partners. In 2011 it elevated the facilities in Lima and the Amazonian city of Iquitos from a "detachment" of the Naval Medical Research Center in Bethesda, Maryland, to a more independent "research unit," which maintains investigative partnerships with scientific institutions around the region and is staffed by U.S. and Peruvian personnel. The relationship with Brazil, where the United States still supports some work on HIV/AIDS, has also transitioned to include joint trilateral outreach on infectious diseases and health system strengthening in Central America and sub-Saharan Africa.

Considering the long history of engagement on health between the United States and countries in the Americas, as well as the present dynamism regarding donor activities for health in the region, there are significant opportunities for the United States to strengthen cooperation with longtime donor partners, such as Canada, while working through information exchanges and trilateral cooperation schemes to help build the capacity of the region's emerging donors, including Brazil, Mexico, and Chile, to advance shared global health goals.

Canada: Strengthening Its Contribution to the Global Health Agenda

Canada has carried out overseas work on health for several decades. While the government's early support for development activities was channeled through the United Nations (UN), in 1959 the Department of Trade and Commerce set up a bureau to address in a more direct fashion the needs of developing countries. In 1960 the Department of Foreign Affairs and International Trade (DFAIT) assumed responsibility for those efforts, which were carried out through its office of External Affairs. By 1968 the Canadian International Development Agency (CIDA) had been launched to coordinate and execute Canada's overseas development activities. Today, the majority of Canada's overseas work on health continues to be carried out by CIDA, although DFAIT plays a role in developing strategy and in linking Canada's aid outreach to its foreign policy. Aware that the total monetary value of its global health assistance is lower than that of other funders, Canada supports what it views as neglected countries or topics and seeks to fill "gaps" within the broader global health agenda.² Working as an international development professional is seen as a desirable career track in Canada, and Canadian universities offer courses on development and global health issues. It is not uncommon for Canadians with domestic expertise to seek to share that experience abroad through work for CIDA or one of its nongovernmental organization (NGO) partners.³ As Canada's Health Minister Leona Aglukkaq noted in an address to the 63rd World Health Assembly in 2010, "Canada recognizes that there are many global health issues that need to be addressed. We recognize that we live in a global community and that we are interdependent; we need to work together to find solutions and we need to work together to help each other."⁴

In 2010 the overall total of Canadian overseas development assistance (ODA) was US\$5.2 billion, up 30 percent from a reported US\$4 billion in 2009. According to the OECD's DAC, roughly 29 percent of that goes to education, health, and population programs.⁵ This increase followed a 2007 DAC peer review in which it was recommended Canada enhance the

2. CSIS interview with Canadian International Development Agency (CIDA) official, Ottawa, Canada, December 2010.

3. Ibid.

4. Health Canada, "Canada Plays Key Role in Strengthening Global Health," May 18, 2010, http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2010/2010_81-eng.php.

5. Organization for Economic Cooperation and Development (OECD), "Canada," <http://www.oecd.org/dac/aidstatistics/44284003.gif>

coherence of its development approaches if its performance were to “match its ambition to become a leading player in the donor community.”⁶ The DAC report also found Canada’s aid efforts to be too dispersed to be optimally effective, and in response to the recommendations Canada has sought to concentrate its aid among a specific set of nine strategic partners, including Bangladesh, Bolivia, Ethiopia, Ghana, Honduras, Mali, Mozambique, Senegal, and Tanzania, along with Afghanistan, Haiti, and Sudan. In 2010 the year of the devastating earthquake, Haiti was the top recipient of Canadian aid, receiving US\$289 million.⁷

Its presidency of the G8 in 2010 offered Canada an opportunity to bolster its global health leadership, and at the meeting the Harper government advanced the Muskoka initiative, seeking to reinvigorate a focus on global maternal and child health issues at the summit.⁸ Canada itself committed CAN\$1.1 billion in new money between 2010 and 2015, beyond the CAN\$1.75 billion already in the pipeline. The work, which CIDA leads, addresses three key issues, primarily through work in sub-Saharan Africa: strengthening health systems; reducing the burden of diseases that are the major killers of mothers and children; and improving nutrition through enhanced infant and child feeding practices. CIDA also runs the Africa Health Systems Initiative (AHSI), having committed CAN\$450 million over the period from 2006 to 2016 to AHSI. This effort focuses on “providing support to train, equip and deploy health workers to make health care more accessible for the most vulnerable.”⁹

The year 2010 saw the launch of two additional processes that have laid the groundwork for strengthening Canada’s global health outreach. That spring University of Toronto researchers John Kirton, James Orbinski, and Jenilee Guebert prepared a report called “The Case for a Global Health Strategy for Canada” for the strategic policy branch in the International Affairs Directorate of Health Canada. In it they articulated several reasons for Canada to step up its efforts in the global health arena: improved health “within and outside Canada”; improved “efficiency of various actors and activities operating in global health”; and mobilizing and concentrating “scarce human and monetary resources.”¹⁰ Later that year the Canadian Council of Academies initiated a review process to articulate a recommended strategy for Canada’s engagement as a global health leader. In 2011 the council released *Canadians Making a Difference: The Expert Panel on Canada’s Strategic Role in Global Health*. The panel identified three issues which it argued should guide Canadian global health efforts in the future: equity, effectiveness, and engagement. While noting Canada’s strength in indigenous and circumpolar research, population and public health

6. OECD Development Assistance Committee, “Canada (2007): DAC Peer Review: Main Findings and Recommendations,” <http://www.oecd.org/dac/peerreviewsofdacmembers/39515510.pdf>.

7. Ibid.

8. CIDA, “Maternal, Newborn and Child Health,” http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/FRA-127113657_MH7.

9. CIDA, “Africa Health Systems Initiative,” <http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/JUD-824143542-PTE>.

10. John Kirton, James Orbinski and Jenilee Guebert, “The Case for a Global Health Strategy for Canada,” submitted March 31, 2010, prepared for the strategic policy branch in the International Affairs Directorate of Health Canada,” www.g8.utoronto.ca/scholar/globalhealthstrategy.pdf.

issues, and community-oriented primary care, the expert group also identified several barriers to greater Canadian influence in global health: no unifying vision for global health in Canada; poor coordination among global health actors; resource constraints; and limited “avenues to mobilize interest in global health.”¹¹

While CIDA executes the majority of Canada’s overseas health efforts, domestic agencies also play a role. Health Canada manages the government’s relationship with the World Health Organization (WHO), and another domestic agency, the Public Health Agency of Canada (PHAC), takes the lead on health security issues. The PHAC places some personnel overseas and second staff to Canada’s embassy in China to ensure product safety and to coordinate with China on international disease control regimes.¹² Health Canada and the PHAC jointly maintain an agreement with China regarding professional scientific exchanges as well as cooperation on health issues of interest to both countries, such as chronic diseases as well as pandemic preparedness.¹³ Similarly, Health Canada and Brazil’s Ministry of Health have a memorandum of understanding on health cooperation in Africa, as well as Latin America and the Caribbean.¹⁴ Multilateral engagement in the Americas is also important to Canada, which is active within PAHO policy discussions on indigenous health and telemedicine, issues with which the government believes its domestic agencies have special expertise.

The long, shared border between the United States and Canada, and the two countries’ membership in many of the same multilateral organizations, such as the G8 and APEC, make U.S.-Canadian collaboration on health a logical step. Existing bilateral agreements between the United States and Canada on such issues as indigenous health and product safety can offer platforms for intensified collaboration.¹⁵ Beyond sharing experiences regarding their existing health cooperation with other countries, the United States and Canada can collaborate in strengthening regional and international outreach to Haiti and can cooperate with newer regional donors, such as Mexico, Brazil, and Chile, to strengthen and enhance their own outreach efforts.

11. Canadian Academy of Health Sciences/Académie canadienne des sciences de la santé, *Canadians Making a Difference: The Expert Panel on Canada’s Strategic Role in Global Health*, 2011, ix.

12. CSIS interview with Public Health Agency of Canada (PHAC) official, Ottawa, Canada, December 2010.

13. Health Canada, “Plan of Action on Cooperation Between the Department of Health of Canada, the Public Health Agency of Canada, and the Ministry of Health of the People’s Republic of China in the Field of Health for the Period 2011–2014,” <http://www.hc-sc.gc.ca/ahc-asc/intactiv/agree-accord/chin-coop-eng.php>.

14. Health Canada, “Memorandum of Understanding between the Department of Health of Canada and the Ministry of Health of the Federative Republic of Brazil on Health Sector Collaboration,” <http://www.hc-sc.gc.ca/ahc-asc/intactiv/agree-accord/br-mou-pe-eng.php>.

15. Health Canada, “Memorandum of Understanding on Indigenous Health between the Department of Health and Human Services of the United States of America and the Department of Health of Canada for the Period 2007–2012,” <http://www.hc-sc.gc.ca/ahc-asc/intactiv/agree-accord/us-eu-mou-eng.php>; Health Canada, “Memorandum of Understanding between the Food and Drug Administration, Department of Health and Human Services of the United States of America and the Health Products and Food Branch—Health Canada—of Canada regarding Sharing and Exchange of Information about Therapeutic Products,” <http://www.hc-sc.gc.ca/ahc-asc/intactiv/agree-accord/us-eu-sharing-diffusion-eng.php>.

Brazil: Focus on Regional Institutions and Lusophone Africa

Over the last decade the Brazilian government has made a concerted effort to raise its profile within the global health space, forging ties on health with Latin American neighbors and Lusophone countries in Africa, as well as East Timor, on issues ranging from HIV/AIDS programming and promoting universal health care coverage to facilitating the establishment of national institutes of public health. The government's motivation arises out of a belief that health is a human right, as well as a sense of South-South solidarity: Brazil sees its overseas health connections as integral to a broader goal of strengthening relationships among countries within the global south to challenge what it views as the concentration of influence among the northern powers.¹⁶ Brazil articulates its support for health programs in Latin America, Africa, and Asia as an aspect of bilateral and horizontal, as opposed to vertical, cooperation.¹⁷ Through its outreach efforts the government of Brazil emphasizes its partnership with other countries moving along the development path. To underscore its commitment to integrating health into a wide range of its international relationships, Brazil's foreign minister signed the Oslo Declaration regarding health and foreign policy in 2007.¹⁸

Brazil's philosophical and practical approaches to international engagement on health and development stem from the nation's experience as the recipient of donor support in the 1950s, when the government established a National Commission for Technical Assistance to manage funds received from donor countries. In the early 1960s Brazil then began responding to requests from neighboring countries to offer technical assistance on health issues.¹⁹ Currently Brazil's global health efforts are managed through two federal agencies: the Agência Brasileira de Cooperação (ABC), which is under the Ministry of Foreign Affairs, and the Ministry of Health. The ABC was founded in 1987 and disburses funds on a range of development topics. In 2010 16 percent of the ABC's overall budget of US\$30 million supported health initiatives.²⁰ Brazil also allocates funding for international work on health to the Ministry of Health, a domestic agency that frequently sends personnel to the ABC for projects. In 2007 the Ministry of Health's budget for overseas work was US\$27 million.²¹ Within Brazil there is not yet a widely recognized career track in global health or development; rather, the ABC and Ministry of Health

16. Katherine E. Bliss, *Health Diplomacy of Foreign Governments* (Washington, DC: CSIS, May 2011).

17. Katherine E. Bliss, Paulo Buss, and Felix Rosenberg, *New Approaches to Global Health Cooperation: Perspectives from Brazil* (Washington, DC: CSIS, September 2012), 3.

18. Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, "Oslo Ministerial Declaration—global health: a pressing foreign policy issue of our time," *The Lancet*, April 2, 2007, http://www.who.int/trade/events/Oslo_Ministerial_Declaration.pdf.

19. Lídia Cabral and Julia Weinstock, "Brazilian Technical Cooperation for Development: Drivers, Mechanics, and Future Prospects," Overseas Development Institute, September 6, 2010, 3, <http://www.odi.org.uk/resources/download/5002.pdf>.

20. Marco Farani, "South-South Cooperation," *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 6.

21. Cabral and Weinstock, "Brazilian Technical Cooperation," 11.

frequently depend on personnel with domestic health expertise to carry out international work.²²

Brazil's global health priorities are HIV/AIDS, universal health care, the establishment of national institutes of public health, and a commitment to ensuring that trade or commercial concerns do not trump health in policy deliberations. In general, Brazil seeks to share its domestic experience providing health care and developing research on health with its development partners. Following a decision in the late 1990s to begin offering anti-retroviral medications to all HIV-infected Brazilians who needed them, the Brazilian AIDS program received widespread acclaim from international observers, including UNAIDS and the Bill & Melinda Gates Foundation, and began receiving requests from international organizations for assistance in establishing similar programs.²³ Brazil also seeks to share lessons learned from its experience in the late 1980s and 1990s implementing the Sistema Único de Saúde (SUS), which was created following the military dictatorship to ensure all Brazilians have access to health care. Ongoing challenges in providing equitable access to health services to the most vulnerable sectors have led to calls by civil society groups to reform the SUS, and Brazil shares its experience responding to such internal pressures with neighbors, such as Peru, as well as South Africa. Helping other countries establish national institutes of public health to facilitate research on issues of domestic concern is a third priority area for Brazil. Here again Brazil seeks to share its own experience strengthening scientific research and teaching capacity through the Fundação Oswaldo Cruz (Fiocruz), which was established as the nation's preeminent health research facility in 1900. In Latin America, Brazil has taken the lead on promoting cooperative work on health through the Unión de Naciones Suramericanas (UNASUR), providing start-up funds for the organization's Rio de Janeiro-based health group.²⁴

In the multilateral arena, Brazil has engaged most actively with WHO and the Global Fund. Its voluntary contributions to WHO are often used to support the work of Brazilian technical experts abroad, but Brazilian diplomats also played a pivotal role in shepherding the WHO negotiations on the Framework Convention on Tobacco Control (FCTC) to a successful conclusion in the early 2000s. Some observers credit Brazil's willingness to stand up to its own domestic tobacco lobby and support the FCTC as providing an inspiring model for other countries to emulate in signing the treaty.²⁵ Brazil has been both recipient and donor to the Global Fund to Fight AIDS, Tuberculosis and Malaria, although the government declined to contribute in the recent 2010 replenishment, preferring to instead offer developing countries assistance in preparing grant proposals. As the part of the leadership

22. "A pareceria entre o Itamaraty e o Ministério da Saúde," *Via ABC: Publicação de Agência Brasileira de Cooperação*, March 2007, 2.

23. Shawn Smallman, *The AIDS Pandemic in Latin America* (Chapel Hill: University of North Carolina Press, 2006).

24. Katherine E. Bliss, "Health in All Policies: Brazil's Approach to Global Health within Foreign Policy and Development Cooperation Initiatives," in *Key Players in Global Health: How Brazil, China, India, Russia, and South Africa Are Influencing the Game*, ed. Katherine E. Bliss (Washington, DC: CSIS, November 2010), 1–14.

25. Kelly Lee, Luiz Carlos Chagas, and Thomas E. Novotny, "Brazil and the Framework Convention on Tobacco Control: Global Health Diplomacy as Soft Power," *PLoS Medicine* 7 (2010): 1–4, <http://www.plos-medicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000232>.

of the UN stabilization mission in Haiti, Brazil has been actively engaged in peace and stabilization efforts since the early 2000s, with a recent emphasis on post-2010 earthquake reconstruction efforts.

To build its experience in the area of global health outreach, the Brazilian government has increasingly engaged in trilateral cooperation schemes. Beyond its collaboration with India and South Africa through IBSA, and its work in Haiti with France and Cuba, Brazil has joined the United States in establishing trilateral health programs in El Salvador, Mozambique, Angola, and São Tomé and Príncipe, with each external partner building on existing bilateral relationships to develop a program of cooperative action in the host country. Retrospective assessments about trilateral cooperation schemes suggest that the model has potential for enhancing shared action on the global health agenda, even as it is important for all three parties to be realistic—and very specific—about goals and expectations.²⁶

The United States and Brazil have a long history of collaboration on health, including through the National Institutes of Health (NIH) grants to academic institutions as well as cooperation in regional immunization efforts. Presently the bilateral relationship on health is structured through the U.S.-Brazil Working Group on Health, which falls under the U.S.-Brazil Joint Commission on Science and Technology. This group facilitates cooperation on such issues as chronic diseases, epidemiological investigation, and immunizations, yet U.S. agencies, such as NIH, the U.S. Centers for Disease Control and Prevention, and USAID develop their own relationships with Brazil vis-à-vis trilateral cooperation efforts. Given this somewhat ad hoc approach, it may make sense to develop a more strategic and “whole-of-government” vision for how U.S.-Brazilian bilateral, multilateral, and trilateral relations on health should unfold.

Mexico: Bridging Relations between North and South

Mexico is relatively new to the circle of global health donors, having established an agency for international cooperation under its Secretaría de Relaciones Exteriores (ministry of foreign affairs) relatively recently, in September of 2011. The Agencia Mexicana de Cooperación Internacional de Desarrollo (AMEXCID) consolidates Mexico’s South-South cooperation efforts and focuses program outreach in Latin America and the Caribbean. Health is a substantial focus, along with environment and energy issues.²⁷ Health programming makes up about 15 percent of the work so far, with emphasis on technical assistance and the promotion of courses either in Mexico or offered by Mexican personnel. As with Canada, Haiti has been a focus of the Mexican government’s outreach efforts—and in 2011 the

26. Katherine E. Bliss, Paulo Buss, and Felix Rosenberg, *New Approaches to Global Health Cooperation: Perspectives from Brazil* (Washington, DC: CSIS, September 2012).

27. Secretaría de Relaciones Exteriores. Agencia Mexicana de Cooperación Internacional para el Desarrollo (AMEXCID), *Informe Annual de Cooperación Internacional para el Desarrollo*, 2011, 6.

Mexican government reported having spent more than US\$20 million in Haiti.²⁸ One signature effort has been the US\$150 million Mesoamerican Health Initiative (Salud Mesoamerica 2015), which is a private-public partnership involving the Inter-American Development Bank, the Carlos Slim Foundation, the Government of Spain, and the Bill & Melinda Gates Foundation, along with the Mexican and Central American country health ministries, as organizing partners.²⁹ Mexico has played a leading role in setting the initiative's agenda and sharing lessons learned from its own experience addressing disparities in health outcomes within its borders.

In many ways, the government of Mexico sees its engagement in global health work as a funder and provider of technical assistance as a natural outgrowth of the country's own experience as an ongoing recipient of international support. As such, it articulates its role as one of a "natural bridge of interlocation between countries in different states of development, such as its interaction with countries in the North and South and through triangular cooperation initiatives."³⁰

In its first year of operation the AMEXCID reported having carried out 161 projects. Of these, 126 were bilateral, 23 were regional, and 12 were triangular in nature. According to AMEXCID, 12 to 15 percent of the projects were in the health sector. Mexico has a formal relationship for technical cooperation with Brazil that includes discussion about themes related to public health and water.³¹ With Costa Rica in 2011 Mexico addressed mental health and child psychiatry issues.³² In the Caribbean, Mexican health professionals, through AMEXCID, offered courses on HIV/AIDS and social programs; in Jamaica in February of 2011, for example, thirty-two professionals of thirteen Caribbean Anglophone nations were trained by Mexican professionals on health issues.³³ Multilateral engagement is important to Mexico, which reported that in 2012 the government has carried out three projects with WHO. Mexico also pays special attention to the Organization of American States (OAS), where Mexican diplomats have actively participated in the effort to reform and improve Inter-American coordination and transparency with respect to development initiatives.³⁴

Domestic agencies play a modest but growing role in Mexico's global health outreach. Mexico's Instituto Nacional de Salud Pública (INSP) has launched a program on global health to "strengthen teaching on the topic, but also to strengthen issues such as research, and links, including technical cooperation."³⁵ The INSP also offers a Certificate in Global Health with the goal of "developing high level professionals capable of analyzing, directing

28. Ibid., 4.

29. Inter-American Development Bank, "Mesoamerican Health Initiative 2015," <http://www.iadb.org/en/news/news-releases/2010-06-14/salud-mesoamerica-2015-initiative-launched-idb,7317.html>. See also "President Calderón Launches Mesoamerica Health Initiative 2015," Banderas News, <http://www.banderasnews.com/1006/hb-mesoamerica2015.htm>.

30. Secretaría de Relaciones Exteriores. Agencia Mexicana de Cooperación Internacional para el Desarrollo (AMEXCID), *Informe Annual de Cooperación Internacional para el Desarrollo*, 2011,

31. Ibid., 9.

32. Ibid., 10.

33. Ibid.

34. Ibid., 23.

35. Secretaría de Salud. Instituto Nacional de Salud Pública. "Bienvenida," <http://www.saludglobalinsp.mx/>.

and responding to the public health challenges, especially those in the region of the Americas and in the sub-region of Mesoamerica.”³⁶

In 2000 the United States and Mexico established the Border Health Commission, based in El Paso, Texas, to strengthen leadership on health issues of mutual interest on both sides of the border. In May of 2012 U.S. Health and Human Services secretary Kathleen Sibelius and Mexico’s minister of health Salomón Chertorivksi signed a declaration on strengthening U.S.-Mexican bilateral cooperation on health, including food safety and communication regarding public health events of mutual concern.³⁷ Mexico and the United States could use their shared experience working on border health issues to undertake trilateral projects in the Mesoamerican region, where both countries’ development agencies are active, or through APEC, to which both belong. One important issue to consider is that Mexico’s engagement on global health challenges developed over the period between 2000 and 2012, while Mexico’s presidency was held by the Partido de Acción Nacional (PAN). With the Partido de la Revolución Institucional (PRI) back in power under President Enrique Peña Nieto, who assumed office in December 2012, it will be important to see how Peña Nieto, his secretary of health, Mercedes Juan López, and the new head of AMEXCID, Juan Manuel Valle Pereña, envision Mexico’s ongoing contribution to the regional and global health agendas.

Chile: A Gradual Approach to Global Health Engagement

Over the past decade Chile has been slowly gathering interest in becoming more engaged internationally on health. At present, its focus is on its regional relationships, which it cultivates through the Comunidad Andina de Naciones (CAN) and UNASUR. However, Chile is slowly seeking to build its capacity for more global engagement through offering courses on health diplomacy and arranging for information exchanges with countries that have already become involved in donor activities.

Latin America is Chile’s area of foreign policy focus.³⁸ As a founding member of UNITAID, Chile also supports the effort to generate funds from taxes on air ticket sales to purchase drugs for HIV/AIDS, malaria, and tuberculosis, allowing it to extend its health diplomacy activities beyond the Latin America region. In 2009 the Chilean ambassador in Kenya and permanent representative in Geneva participated in a workshop in Africa to examine health projects being sponsored by UNITAID.³⁹ In May 2012 Chile’s Academia Diplomática de Chile Andres Bello hosted a workshop on “Seminario Salud Global: Perspectivas en la

36. Mexico. Secretaría de Salud. Instituto Nacional de Salud Pública. “Bienvenida Salud Global,” <http://www.insp.mx/centros/sistemas-de-salud/servicios/diplomado-en-salud-global/bienvenida.html>.

37. U.S. Department of Health and Human Services, “United States and Mexico make efforts to strengthen U.S.-Mexican bi-national health,” May 22, 2012, <http://www.hhs.gov/news/press/2012pres/05/20120522a.html>.

38. Ministerio de Salud. Oficina de Cooperación y Asuntos Internacionales del Ministerio de Salud de Chile, “Prioridades de la Política Exterior,” <http://www.ocai.cl/polext2.htm>.

39. Ministerio de Relaciones Exteriores, “Chile participa en encuentro sobre proyectos de salud desarrollados en África,” October 26, 2009, http://www.minrel.gob.cl/prontus_minrel/site/artic/20091029/pags/20091029104304.php.

Diplomacia, experiencias desde Canadá, Brasil y México,” in which academics shared perspectives on country experiences at the intersection of health and foreign policy.”⁴⁰

In the past the United States and Chile have cooperated on health through the U.S.-Chile Free Trade Agreement (FTA), which has offered opportunities for collaborative work on environmental health through the FTA’s environmental cooperation subagreement. Chile’s foreign policy focus is South America, where, for the most part, the United States has begun scaling back health programs within its development assistance efforts. Recently, however, the U.S. Food and Drug Administration signed a cooperative agreement with Chile’s Public Health Institute to facilitate information exchanges on drug surveillance. Given Chile’s deliberately gradual approach to global health engagement, the United States could engage Chilean officials in discussions regarding how each government approaches global health diplomacy, inviting participation by other emerging actors in the region, including Mexico and Brazil.

Conclusion

With a long history of relationships related to public health in the Americas, as well as the emergence of new health leaders, institutions, and practices, regional diplomacy on health is in a state of transition. The United States has numerous existing bilateral agreements and multilateral engagements that offer opportunities for reinforcing health cooperation with Canada while charting new collaborations with middle income countries developing their own global health funding and outreach expertise.

40. Ministerio de Relaciones Exteriores. “Seminario Salud Global: Perspectivas en la Diplomacia, experiencias desde Canadá, Brasil y México,” May 17, 2012, http://www.minrel.gob.cl/prontus_minrel/site/artic/20120524/pags/20120524105120.php.



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