Global Health Diplomacy to Combat Communicable Diseases and to Promote Universal Health Coverage in Achieving the Sustainable Development Goal 3

Yasushi Katsuma

Abstract

The aspiration of the Goal 3 of the Sustainable Development Goals (SDGs) to “ensure healthy lives and promote well-being for all at all ages” is derived from both the “right to health” norm in the field of international human rights and the “health for all (HFA)” goal in the field of international development. The principle of “Leave no one behind” in achieving the SDGs is logically endorsed both by the right to health and the HFA. First, communicable diseases have become perceived as a threat to “human security” in global health, and Japan started to use the concept in global health diplomacy to elevate the level of dialogues. Nevertheless, Ebola Virus Disease and COVID-19, not anticipated when the SDGs were adopted, now urge us to re-visit the needs to reform global health governance. Second, to promote universal health coverage (UHC), international partnership has been strengthened. In 2019, at the G20 Summit, Japan played an important role in promoting the UHC among the twenty members. This led to an expanded international commitment made at UN High-Level Meeting on UHC in the same year. It shows that global health has become an important agenda for diplomacy.

Keywords

Global health diplomacy · Communicable diseases · Universal health coverage · Primary health care · Human security

2.1 Introduction

This chapter focuses on the Goal 3 (SDG 3) of the Sustainable Development Goals (SDGs): “Ensure healthy lives and promote well-being for all at all ages.” First, in the following section, the author discusses that the aspiration of the SDG 3 is derived from both the “right to health” norm in the field of international human rights and the “health for all (HFA)” goal in the field of international development.

The section three explains how communicable diseases have become perceived as a threat to security in global health diplomacy. First, it is reviewed how the concept of security started to be used to discuss not only the state sovereignty, but also various threats to people of international concern. Second, the author discusses how global health issues, particularly communicable diseases, have become perceived as a threat to “human security.” Lastly, it is reviewed how Japan started to use the concept of “human...
security” in global health diplomacy to elevate the level of dialogues.

In section four, the author analyzes two contemporary global health threats that were not anticipated when the United Nations (UN) member states adopted the SDGs: Ebola Virus Disease and COVID-19. It is argued that they have urged us to re-visit the needs to reform global health governance.

Lastly, section five discusses how international partnership has been strengthened to promote universal health coverage (UHC). As a case, the Group of 20 (G20) Summit in 2019 is analyzed to show the role of Japan in promoting the UHC among leading economies. At the end, UN High-Level Meeting (UN HLM) on UHC in 2019 will be presented as a political commitment made by the heads of State and government of UN members.

2.2 “Health for All” as an Internationally Shared Vision

Some of the ideas expressed by the SDG 3 and its targets can be traced back to intergovernmental consensus reached among countries after the World War II. This section discusses that the aspiration of the SDG 3 to “ensure healthy lives and promote well-being for all at all ages” is derived from both the “right to health” norm in the discipline of international human rights and the “health for all (HFA)” goal in the discipline of international development. First, it is reviewed how the “right to health” has been internationally agreed as a legal norm. The “Constitution of the World Health Organization,” an inter-governmental agreement to establish the WHO, was adopted at the International Health Conference held in New York from June to July in 1946. The WHO Constitution, signed by the representatives of 61 States on 22 July in 1946, entered into force on 7 April in 1948. The WHO was established in 1948, as an inter-governmental organization with its own Constitution, as well as its own member States.

At the same time, it is also designated as a specialized agency of the UN, within the terms of article 57 of the “Charter of the United Nations.” With the Agreement between the UN and the WHO, approved at the UN General Assembly in New York on 15 November in 1947 and then by the WHO in Geneva on 10 July in 1948, it is expected that the WHO coordinates their work with the UN.

Realization of the “right to health” is considered as one of the missions of the WHO. In the preamble of the WHO Constitution (1946), it is stated that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” This norm was then brought to the UN. The “Universal Declaration of Human Rights (UDHR),” adopted at the UN General Assembly in 1948, states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services…” in its article 25.

As an outcome of the efforts to codify the UDHR into legally binding human rights treaties, the “International Covenant on Economic, Social and Cultural Rights (ICESCR)” was adopted at the UN General Assembly in 1966. It entered

2.2.1 The Right to Health

In this sub-section, it is reviewed how the “right to health” has been internationally agreed as a legal norm. The “Constitution of the World Health Organization,” an inter-governmental agreement to establish the WHO, was adopted at the International Health Conference held in New York from June to July in 1946. The WHO Constitution, signed by the representatives of 61 States on 22 July in 1946, entered into force on 7 April in 1948. The WHO was established in 1948, as an inter-governmental organization with its own Constitution, as well as its own member States.

At the same time, it is also designated as a specialized agency of the UN, within the terms of article 57 of the “Charter of the United Nations.” With the Agreement between the UN and the WHO, approved at the UN General Assembly in New York on 15 November in 1947 and then by the WHO in Geneva on 10 July in 1948, it is expected that the WHO coordinates their work with the UN.

Realization of the “right to health” is considered as one of the missions of the WHO. In the preamble of the WHO Constitution (1946), it is stated that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” This norm was then brought to the UN. The “Universal Declaration of Human Rights (UDHR),” adopted at the UN General Assembly in 1948, states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services…” in its article 25.

As an outcome of the efforts to codify the UDHR into legally binding human rights treaties, the “International Covenant on Economic, Social and Cultural Rights (ICESCR)” was adopted at the UN General Assembly in 1966. It entered
into force on 3 January in 1976, in accordance with its article 27. The article 12 of the ICESCR states that “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” As of January 2022, there are 171 States parties to the ICESCR. It shows that the right to health is explicitly accepted as a legally binding norm by many countries.

In April 2002, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health was established by then Commission on Human Rights (E/CN.4/RES/2002/31). After the Human Rights Council was established in 2006, replacing the Commission, the mandate of the Special Rapporteur was extended in 2007, and most recently renewed in 2019 (A/HRC/RES/42/16).

The mandate of the Special Rapporteur was established to
1. Gather, request, receive and exchange information,
2. Foster dialogue on possible cooperation with relevant actors, including the WHO and the UN,
3. Report on the realization of the right to health throughout the world, and
4. Address specific cases of alleged violations of the right to health.

The Special Rapporteur on the right to physical and mental health have been engaging in dialogues with the WHO for the purpose of expressing their common understanding on the right to health (UN High Commissioner for Human Rights and WHO 2008). The signatory States of the ICESCR have the obligation to take appropriate measures towards the full realization of the right to health to the maximum of their available resources in their countries. However, there is a recognition that the right to health can be hampered by a lack of domestic resources. This reference to “resource availability” leads to the needs of many low-income countries to seek development assistance from high-income countries.

At the 30th World Health Assembly (WHA) convened by the WHO Secretariat in 1977, the WHO member States agreed on a vision that all the people of the world should attain a level of health that will permit them to lead a socially and economically productive life by the year 2000. This international development goal is known as “health for all by the year 2000.” The WHO serves as an inter-governmental organization to promote multilateral cooperation for health development, providing technical assistance to low-income member States. At the same time, high-income countries are expected to provide bilateral development assistance for health, not only technical assistance but also grant aid, to low-income countries, for the purpose of achieving the HFA globally by 2000.

The right to health is a human rights norm, in which people are treated as the rights-holder and the States as the duty-bearer. The emphasis is put on the obligation of each State to take appropriate measures to realize the right to health for everyone in the country. On the other hand, the HFA is a development goal that encourages international cooperation for health, so that low-income countries suffering from resource scarcity can receive development assistance from inter-governmental organizations and high-income countries. In this context, this inter-disciplinary nexus of human rights and international development is significant, as health financing is indispensable for progressive realization of the right to health.

To achieve the HFA by 2000, particularly among low-income countries, a strategic focus was chosen within the health sector. In 1978, an international conference was held in Alma-Ata, where the “Declaration of Alma-Ata on Primary Health Care” was adopted. This declaration was a call for the implementation of a comprehensive strategy of primary health care (PHC) as an essential component of the health system in all countries. The aim of PHC is to provide accessible and affordable health services to the population, focusing on prevention and promotion of health, care for illness and injury, and management of chronic diseases. The Alma-Ata declaration emphasized the need for a collaborative approach involving various stakeholders, including governments, health professionals, civil society, and the private sector. It highlighted the importance of equitable access to health services, particularly in rural and underserved areas, and the role of health education in promoting healthy lifestyles.

2.2.2 “Health for All” Through Primary Health Care

In this sub-section, it is argued that the HFA has been promoted as a development goal, based on the legal norm of the right to health. The right to health is integral part of the economic, social and cultural rights that need to be realized progressively (UN High Commissioner for Human Rights 2008).
Health Care (PHC)” was unanimously adopted. In the wake of these events, at the 32nd WHA in 1979, the Global Strategy for Health for All was launched, in which the PHC was endorsed (WHO 1981).

The concept of the PHC has been redefined repeatedly since 1978, and there are several variants. One of the most recent international consensuses reached by the major intergovernmental organizations is the following:

PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment. (WHO and UNICEF 2018)

After the World War II, the UN and its specialized agencies started supporting many Asian and African countries that had become independent from their colonial rulers. Both in health and education, such support was extended to the tertiary level, either rehabilitating or establishing national hospitals and universities. Therefore, the “Declaration of Alma-Ata on PHC” in 1978 was a paradigm shift of focus from the tertiary to the primary level, ensuring all people to have access to essential health services in their community. Similarly, in education, the “World Declaration on Education for All” was adopted in Jomtien, Thailand in 1990, shifting the focus from tertiary to primary or basic level of education.

The concept of the PHC consists of three synergistic components (WHO 2021):
1. Comprehensive integrated health services that embrace primary care as well as public health goods and functions as central pieces,
2. Multi-sectoral policies and actions to address the upstream and wider determinants of health,
3. Engaging and empowering individuals, families, and communities for increased social participation and enhanced self-care and self-reliance in health.

The original concept of the PHC was challenged in the 1980s. The author of this chapter believes that there were at least three reasons. The first criticism came from within the PHC circle. It was argued that the original PHC was too comprehensive to be achieved in low-income countries. There was a call for “selective PHC” with focus on specific diseases (Walsh and Warren 1979).

Second, high-income countries were more willing to support measurable interventions in low-income countries, such as immunizations. At the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD), the topic of evaluating official development assistance (ODA) started to be put on the agenda since the early 1970s. The high-income countries at the DAC became more interested in measurable health indicators, such as immunization coverages, as the demand for accountability increased in their own society.

Third, some communicable diseases have become threats to high-income countries, too. When the WHO declared global eradication of smallpox in May 1980, there was some sense of optimism. However, after HIV/AIDS was discovered in 1981, and transmitted among people in high-income countries, there was a growing interest in infection prevention and control (IPC), calling for health security.

2.2.3 From the MDGs to the SDGs

The HFA goal was incorporated into a multi-sectoral set of international development goals. This section explains how the HFA vision became integrated into the MDGs, and then into the SDGs.

The MDGs were not part of the “Millennium Declaration” adopted at Millennium Summit of the UN General Assembly in 2000. The MDGs framework was prepared later, as a program of action to carry out the Sect. 2.3 “Development and Poverty Eradication” of the Millennium Declaration. In this context, the MDGs framework was prepared as a composite of the international goals agreed earlier.

The HFA is not expressed explicitly in the Millennium Declaration. The HFA vision is
Table 2.1  Health goals in the MDGs and the SDGs

<table>
<thead>
<tr>
<th>Goals by 2015</th>
<th>MDGs by 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDGs by 2015</td>
<td>Goal 4 (MDG 4): reduce child mortality</td>
</tr>
<tr>
<td></td>
<td>Goal 5 (MDG 5): improved maternal health</td>
</tr>
<tr>
<td></td>
<td>Goal 6 (MDG 6): combat HIV/AIDS, malaria, and other diseases</td>
</tr>
<tr>
<td>SDGs by 2030</td>
<td>Goal 3 (SDG 3): ensure healthy lives and promote well-being for all at all ages</td>
</tr>
</tbody>
</table>

Source: Author

The health goals within the MDGs have been fragmented in the MDGs, as there are three health-related goals, without an overarching vision (see Table 2.1). The MDG 4 can be traced back to the child survival goals committed in the “World Declaration on the Survival, Protection and Development of Children” (A/45/625) adopted at the World Summit for Children held in New York in 1990. Similarly, the MDG 5 can be traced back to the “Programme of Action” (A/CONF.171/13/Rev.1) adopted at the International Conference on Population and Development held in Cairo in 1994.

The MDG 6 became an independent goal, due to an increasing interest in combating communicable diseases and the eventual establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in 2002. The Okinawa Infectious Disease Initiative, launched at the Group of 8 (G8) Summit in Kyushu and Okinawa in 2000, led to strengthened global efforts to combat not only HIV/AIDS, tuberculosis, and malaria, but also polio, parasitic and other neglected tropical diseases. The international dialogues at the 2000 G8 Summit prompted the establishment of the GFATM, as well as corresponding disease-specific programs, which are directly related to the MDG 6.

In the MDG 6, malaria was explicitly mentioned, in addition to HIV/AIDS, showing solidarity with Sub-Saharan African countries suffering from the disease. The Roll Back Malaria (RBM) initiative, launched by the WHO, UNICEF, the United Nations Development Programme (UNDP), and the World Bank in 1998, has been helping strengthen public–private partnerships to reduce malaria episodes in the world, especially in Africa.

The goal of the RBM partnership is to reduce the burden of malaria by forming an alliance of a wide range of partners, including malaria-endemic African countries, inter-governmental organizations, bilateral development agencies, NGOs, foundations and private businesses, organizations of affected communities, and research and academic institutions. In response, in 2000, African heads of State convened an RBM Summit in Abuja to express their personal commitments to kick malaria out of Africa.

At the third Tokyo International Conference on African Development (TICAD) in September 2003, malaria was discussed not only as a threat to African children and women but also as an obstacle to economic development in Africa. It has become clear that the private sector plays an important role in reducing the malaria burden. For example, the Olyset bednet, the first long-lasting insecticidal nets (LLINs) approved by the WHO, was identified as an effective tool to prevent mosquito bites while sleeping at night.

Although the health goals within the MDGs seemed fragmented, without an overarching vision of the HFA, there was an increasing interest in strengthening health systems in low-income countries around the year 2008. This renewed attention to health systems strengthening (HSS) may be explained by four factors.

First, it became clear that MDG 4 (child health) and MDG 5 (maternal health) were not on track to be achieved by 2015, while some tremendous progress was reported in relation to the MDG 6 (HIV/AIDS and malaria), thanks to the GFATM. Although annual deaths among children under five dipped below 10 million in 2006, child mortality rates remained unacceptably high (UN 2008). Similarly, the high risk of dying in pregnancy or childbirth continued unabated in many countries in Sub-Saharan Africa and South Asia. Therefore, it was increasingly...
recognized that the MDG 4 and the MDG 5 could not be achieved without strengthening health systems.

Second, in 2008 when the 30th anniversary of the 1978 “Alma-Ata Declaration” was celebrated, the PHC concept was revisited and reinterpreted at the WHA hosted by the WHO, in which a document titled “Primary Health Care, including Health System Strengthening” was adopted (WHO 2009). The WHO proposed that countries should make health systems and health development decisions guided by four interlinked policy directions: universal coverage, people-centered services, healthy public policies, and leadership (WHO 2008).

Third, eight years after the G8 Summit in Kyushu and Okinawa, in 2008, Japan again hosted the G8 Summit in Toyako, Hokkaido, in which global health was identified as a priority on the agenda. In his speech on global health and Japan’s foreign policy, then Foreign Minister Masahiko Koumura stated that “human security is a concept that is very relevant to cooperation in the twenty-first century. That is to say, it is vitally important that we not only focus on the health of individuals and protect them, but also strive to empower individuals and communities through health system strengthening” (Koumura 2007). At the G8 Summit, there a shift of focus from communicable diseases to the HSS.

Fourth, in 2007, the International Health Partnership (IHP+) was launched. The IHP+ was a partnership of low-income countries, high-income countries and inter-governmental development organizations that signed an IHP+ Global Compact. The IHP+ partners were committed to improve coordination and harmonization within the health sector, by uniting around a single health strategy.

With an increasing interest in the HSS, on 12 December 2012, the UN resolution on global health and foreign policy (A/RES/67/81) made a recommendation to include the UHC in the discussions on the post-2015 development agenda, that is, the SDGs.

The health goal of the SDGs (SDG 3) “Ensure healthy lives and promote well-being for all at all ages” (see Table 2.1) is an overarching vision that resembles the HFA, overcoming the fragmentation of health goals within the MDGs. In the framework of the SDG 3, there are several Targets (see Table 2.2). The Targets 3.3, 3.8, 3.b and 3.d will be mentioned in the following sections.

2.3 Combating Communicable Diseases for Human Security

This section explains how communicable diseases have become perceived as a threat to “security” in global health diplomacy. First, it is reviewed how the concept of security started to be used to discuss not only the State sovereignty, but also various threats to people. Second, the author discusses how global health issues have become perceived as a threat to “human security.” Lastly, it is reviewed how Japan started to use the concept of “human security” in global health diplomacy to elevate the level of dialogues.

2.3.1 From State Security to Human Security

The scope of the security concept has been expanded in the last two decades. Moving beyond a traditional macro-level focus solely on the States, the concept of security now includes an attention to the micro-level insecurity of individuals and communities (Katsuma 2010). There has been a general agreement on the necessity for a new security paradigm, in which emerging threats to the security of individuals and communities are properly addressed.

It was in the 1990s when the concept of “human security” began to take clearer shape, being reappraised within the UN system. After the end of the Cold War, the UN started to shift its focus from inter-State wars and disputes to other types of intra-State and transnational threats that devastate the lives and livelihoods of people around the world. As part of such efforts, the UNDP published its “Human Development Report 1994,” which had a significant impact on the evolution of the concept of human security,
covering seven domains: economic, food, health, environmental, personal, community, and political (UNDP 1994). This report for the first time made the connection between the concept of human security, and the dual freedoms from fear and want that were originally outlined in the U.S. Secretary of State’s report on the 1945 San Francisco Conference. To translate this concept into practice, the 1994 UNDP report also called for the establishment of a “global human security fund.”

In the 1990s a series of tragedies caused by internal armed conflicts posed serious security threats to vulnerable groups of people within the State. For example, the genocides in Rwanda in 1994 and Bosnia in 1995 graphically illustrated to the world that the traditional concept of security as the protection of national borders was not sufficient for the UN to take responsibility to protect vulnerable people.

The 1997 financial crisis in East Asia provided another example, highlighting the vulnerability of some groups of individuals and communities to the transnational threat beyond their control. Even in some of Asia’s more industrialized countries that had once been

### Table 2.2: Targets within the SDG 3

<table>
<thead>
<tr>
<th>Target 3.1</th>
<th>By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 3.2</td>
<td>By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births</td>
</tr>
<tr>
<td>Target 3.3</td>
<td>By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases</td>
</tr>
<tr>
<td>Target 3.4</td>
<td>By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being</td>
</tr>
<tr>
<td>Target 3.5</td>
<td>Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol</td>
</tr>
<tr>
<td>Target 3.6</td>
<td>By 2020, halve the number of global deaths and injuries from road traffic accidents</td>
</tr>
<tr>
<td>Target 3.7</td>
<td>By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes</td>
</tr>
<tr>
<td>Target 3.8</td>
<td>Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all</td>
</tr>
<tr>
<td>Target 3.9</td>
<td>By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</td>
</tr>
<tr>
<td>Target 3.a</td>
<td>Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate</td>
</tr>
<tr>
<td>Target 3.b</td>
<td>Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all</td>
</tr>
<tr>
<td>Target 3.c</td>
<td>Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States</td>
</tr>
<tr>
<td>Target 3.d</td>
<td>Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks</td>
</tr>
</tbody>
</table>

praised for the “East Asian miracle” by the World Bank (1993), economic growth created the social exclusion of some fragile groups.

The above series of events in the 1990s provided justification for expanding the scope of security to include both internal and transnational threats to individuals and communities. Furthermore, in this decade, the terrorist attacks in the United States of America (U.S.A.) on 11 September 2001, are often seen as a turning point in how the concept of security is defined.

In addition, the severe acute respiratory syndrome (SARS) outbreak in 2003 also shook the world, putting communicable diseases at the forefront of the human security agenda. Now, among others, avian, swine, pandemic influenza, and new corona virus diseases, as well as climate change, are identified as transnational threats.

A second influential report was published in 2003 by the Commission on Human Security, co-chaired by Sadako Ogata and Amartya Sen. This report, which was presented to the then UN Secretary-General Kofi Annan on 1 May 2003, laid out a definition for human security. The refined definition of human security in this report advocates protecting individuals’ and communities’ freedom from fear, freedom from want, and freedom to live in dignity (Commission on Human Security 2003).

To ensure human security for all, first, it is argued that no one should have to fear pervasive physical violence, whether it is violence by other States, violence by some groups within their own State, or violence carried out in their own communities or families.

At the same time, it is acknowledged that for many people, their most significant daily fears are not necessarily related to physical violence; instead, they worry about how to feed their families, how to keep their families healthy, and how to ensure that their children receive the education necessary to survive and flourish in today’s world. These are among the sources of insecurity that a human security framework also attempts to address.

Finally, the Commission’s report emphasizes the importance of allowing people to live in dignity. In other words, the causes of insecurity go beyond physical needs to include psycho-social needs. Through the process of empowerment, individuals and communities are expected to enhance their own resilience to cope with current and future threats, rather than being dependent solely on external actors taking care of them.

### 2.3.2 Communicable Diseases as a Human Security Threat

The 2003 Commission report identifies 10 immediate areas requiring concerted global action, including the provision of basic health services. In many low-income countries, including those in Sub-Saharan Africa, basic life-saving prevention and treatment are not readily available to large segments of the population, leading to unacceptable rates of preventable death, particularly among children under five and pregnant women.

Health has become a shared global challenge. First, the proliferation of information allows us to see the suffering of people in many African and other low-income countries. This has instilled in many of us a moral determination to respond to this challenge for humanity. Second, it has become increasingly clear that the health of one community now has serious implications for that of other communities around the world. For example, the outbreak of SARS in 2003 offers a vivid illustration of the way, in which communicable diseases can travel rapidly, ignoring national borders and socio-economic differences. As SARS traveled across Asia and across the Pacific Ocean to North America, we were reminded that health threats to people on the other side of the world are our business, not only for moral reasons but also because they have the potential to affect us physically.

Health threats can also have significant economic impacts, particularly the spread of HIV/AIDS, malaria, and other infectious diseases. The impact of HIV/AIDS on development is attributable to its ability to undermine three main determinants of economic growth, namely, physical, human, and social capital.
At the same time, the antiretroviral (ARV) treatment that can extend the lives of HIV-infected people is often prohibitively expensive, so that few developing countries are able to provide these life-saving drugs to this vulnerable group without external assistance. Once people living with HIV start taking ARV drugs, they must continue doing so for the rest of their lives. If they lose their access to these drugs, not only does it mean certain death for them, but it also means the emergence of drug-resistant strains of HIV, which in turn leads to a collective cost for the rest of the world in terms of research and development in search of new drugs.

In translating the concept of human security into practice, the health sector offers a very useful entry point for several reasons. First, low-income countries are more willing to accept health-related development assistance from high-income countries because it is less likely to be politicized. Second, diseases and severe malnutrition are such challenges that one can readily understand at an emotional level, making it easier to rally people in high-income countries to support health initiatives for humanity. Third, the inter-connectedness between health and many other human security challenges, such as education, are relatively clear. Finally, the SARS outbreak of 2003 and other emerging infectious diseases have provided stark illustrations of the fact that communicable diseases do not stop at national borders and have raised people’s awareness that good health in one country depends on good health in other countries. In this context, in its World Health Report 2007, the WHO used the term “global public health security” to draw attention to emerging threats to the collective health of populations living across national boundaries (WHO 2007).

Beyond serving as an entry point, a strong international commitment to adopting a human security approach to dealing with global health has the potential to contribute to improved health for all.

First, as a human-centered approach, the focal point of human security is individuals and communities. It is important that people recognize their right to health and then ask for health services that they deserve. People’s proactive participation as the rights-holder will help strengthen the health systems that will respond more effectively to their health needs.

Second, the human security approach highlights people’s vulnerability and tries to help them build resilience to current and future threats. Those who face violent conflicts or natural and/or man-made disasters find themselves even more vulnerable to health challenges, as their already limited access to basic social services further deteriorates. Therefore, it is important to look beyond the health sector and take a multi-sectoral, comprehensive approach, in which health is seen within the context of various threats affecting people’s well-being.

Third, the human security approach allows us to strengthen the interface between “protection” and “empowerment.” The “protection” strategy, through which basic social services are provided, is of course crucial. Nevertheless, at the same time, the “empowerment” strategy is equally critical so that people can take care of their own health and build their own resilience to cope with various threats. It is important to look at the interface between these two strategies.

It is imperative for those who have political and economic power not only to create a protective environment by providing vital services, but also to empower individuals and communities so that they can have more control over their own health, allowing them to live in dignity.

2.4 Emerging and Re-emerging Infectious Diseases Challenging the SDGs

In this section, the author analyzed two contemporary global health threats that were not anticipated when the SDGs were adopted: Ebola Virus Disease and COVID-19. Reference will be made to the Targets 3.b and 3.d of the SDG 3 (see Table 2.2). It is argued that they have urged us to re-visit the needs to reform global health governance in achieving the SDG 3.
2.4.1 2014 Ebola Virus Disease Outbreak in West Africa

Ebola Virus Disease (also known as Ebola hemorrhagic fever) is an acute viral infection that was discovered in present-day South Sudan in 1976. It can only be contracted through blood and other bodily fluids, but it is extremely virulent and infectious. Although there have been 10 Ebola outbreaks in Africa, the first large-scale outbreak re-emerged in West Africa in 2014. Over 28,000 people were infected, and more than 11,000 people died by January 2016.

The author interviewed survivors, health workers and medical professionals, government officials, staff members of NGOs and UN agencies in Conakry, the capital city of Guinea, in addition to the staff members at the UN Secretariat as well as its funds and programmes in New York, the WHO and Médecins Sans Frontières (MSF) in Geneva and London, during the period of 2015–2016.

The author reviewed the disease’s outbreak in Guinea and transmission to the neighboring countries in West Africa. The subsequent actions taken by local and international actors are analyzed. Then the author answers the following two research questions (Katsuma 2017):

1. Why didn’t the WHO declare a Public Health Emergency of International Concern (PHEIC) sooner?
2. What forced UN Secretary-General to establish the UN Mission for Ebola Emergency Response (UNMEER)?

After answering these research questions, the author discusses policy implications for global health governance, not only for Africa but also for the rest of the world.

2.4.1.1 Background

In December 2013, a boy died of hemorrhagic fever in the southeastern forest region of Guinea, near the border with neighboring countries of Sierra Leone and Liberia. This boy is believed to be the first victim of the Ebola Virus Disease in Guinea. The Ebola virus was confirmed in March 2014, based on laboratory test results, and the Guinea’s Ministry of Health declared an Ebola outbreak. In the same month, the MSF, an international NGO, issued a warning that the “geographical expansion was unprecedented (MSF 2015),” and then expanded its activities in Guinea and Liberia.

Yet, Guinea’s Minister of Health and WHO’s then Director-General, Dr. Margaret Chan, did not draw attention to the Ebola Virus Disease in West Africa at the WHA held in Geneva in May of that year. Consequently, international response was not mobilized.

In June, with a growing sense of crisis, the MSF stated that the Ebola outbreak was now “uncontrollable” (MSF 2015) and requested greater support. The steering committee of the Global Outbreak Alert and Response Network (GOARN) prompted a more effective guidance from the WHO. Accordingly, WHO Director-General declared a Grade 3 emergency in July, within the Emergency Response Framework (ERF), and gave increased priority to Ebola within the WHO. Then, in August, the WHO and the Governments of Guinea, Liberia and Sierra Leone launched a joint response plan. It was later at this stage when WHO Director-General finally declared Ebola a PHEIC.

A few days later in Guinea, then President Alpha Conde announced a state of emergency, and formed the National Coordination for the Fight against Ebola. Under the leadership of the Ebola Response National Coordinator, Dr. Sakoba Keita, full-scale activities were started to be implemented in Guinea.

Nonetheless, the WHO-led international measures were considered inadequate, and the MSF made an emergency declaration in September that “the world is losing the battle to contain it. Leaders are failing to come to grips with this transnational threat” (MSF 2015). After that, UN Secretary-General established UNMEER, which was unconventional.

As a result of the expanded international response, together with efforts made by each country, the WHO said all known chains of transmission have been stopped in West Africa in January 2016.
2.4.1.2 Why Didn’t WHO Director-General Declare a PHEIC Sooner?

WHO’s International Health Regulations (IHR) 2005, agreed upon by member States, allow WHO Director-General to declare a PHEIC. Following the H1N1 flu (2009), wild poliovirus (2014), Ebola virus (2014), and Zika virus (2016), Ebola virus (2019) pandemic forced the WHO to declare the fifth PHEIC. Out of these, the action taken by the WHO for the Ebola outbreak has been criticized for its delay in making a PHEIC declaration (Garrett 2015; Gostin and Friedman 2014).

At first, opinions were split within Guinea between the government and the MSF. Although Guinea’s Ministry of Health acknowledged an Ebola outbreak in March 2014, there was no perceived need for an international response. On the contrary, the MSF alerted the international community that the spread of the disease was unprecedented in the same month, and that it had become uncontrolled in June. Against this backdrop of conflicting views, it is possible to say that the WHO decided to respect the Guinean government’s opinion. Still, only a few months later, the WHO was eventually forced to make a PHEIC declaration, and the President of Guinea announced a state of emergency, as the infection reached as far as Conakry, the capital city of Guinea.

Several reasons delayed the PHEIC declaration. First, because this was the first Ebola outbreak in West Africa, the Guinean government did not have sufficient experience in responding to the disease. Moreover, the government was optimistic, believing that even if an outbreak occurred in the southeastern forest region of Guinea, it would not affect Conakry. From the fear of a PHEIC declaration triggering economic damage, the government did not proactively disclose information. This caused a strain on the relationship with the MSF that had requested a rapid international response from the international community from the outset.

The second reason is related to the organizational structure of the WHO. It was originally anticipated that the WHO Regional Office for Africa (AFRO) would take the lead for further support. However, due to its limited human resources and funding, AFRO was not able to fulfill its expected roles successfully. The WHO declared a Grade 3 emergency within the organization itself in July, but the PHEIC declaration was not made public until August, out of consideration for the governments’ intent of the member States, such as Guinea.

2.4.1.3 Why Did UN Secretary-General Establish UNMEER?

Even though the WHO made the PHEIC declaration in August 2014, and then international response mobilized, the prospects of the Ebola outbreaks ending was bleak. In September, UN’s then Secretary-General, Mr. Ban Ki-moon, established UNMEER, based on the resolutions made at the Security Council and then at the General Assembly. While political and peace missions led by UN Secretary-General are familiar to many, UNMEER was an unconventional UN health mission to fight a communicable disease. It operated until July 2015 when the activities were handed over to the WHO.

There were several reasons for establishing UNMEER. First, as limitations of the WHO’s capability to lead and coordinate field activities became apparent, the UN needed to demonstrate its strong leadership. It was unprecedented for UN Secretary-General to take a lead in the fight against a communicable disease. Although temporarily, the WHO showed hesitance because it appeared that UNMEER would be structured above the WHO. This caused tension between UN Secretary-General and WHO Director-General, who would not generally be in a superior-subordinate relationship.

The second reason was that although a proposal for the Office for Coordination of Humanitarian Affairs (OCHA) to take the initiative and then utilize the Central Emergency Response Fund (CERF) for Ebola being a humanitarian crisis was made, this did not come to fruition. Humanitarian crises due to natural disasters and armed conflicts were increasing, and it was decided that OCHA neither had the experience, framework, nor funding to undertake
this new type of humanitarian crisis caused by a communicable disease.

Finally, a large amount of funds needed to be mobilized immediately. The quickest way to do this was to have a new UN mission endorsed by the Security Council and the General Assembly, allowing the UN Secretariat to have access to its regular budgets.

However, UNMEER was heavily criticized within Guinea, as the value-added effects of its activities were considered questionable.

### 2.4.1.4 Implications for Global Health Governance

Based on the lessons learned from Guinea, a few policy implications for global health governance may be summarized as follows.

First, it is crucial that each country acquires the minimum core public health capacities required for crisis management according to the IHR, which should be supported by international development cooperation. In this context, achieving the Target 3.d of the SDG 3 is very important: “Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks” (see Table 2.2).

Second, even though WHO Director-General makes the final decision regarding a PHEIC declaration, the health risk evaluation that forms the basis for this decision should be performed scientifically by an independent, dedicated organization.

Third, at the country level, the UN country team (UNCT) should be prepared to coordinate country initiatives and international response to fight communicable diseases, utilizing existing coordination mechanisms, such as the UN Development Assistance Framework (UNDAF) and the thematic groups. The WHO will continue to retain its role as a lead agency in health, but the UNCT should coordinate cross-sectoral activities in the field.

The Ebola Virus Disease spread throughout Guinea, partially due to traditional healers praying over Ebola virus carriers, as well as friends and family members touching infected bodies to bid them farewell. This calls for multi-sectoral approach to fight communicable diseases, including health education, contact tracing and safe burial.

Lastly, if a complex humanitarian crisis accompanied by a communicable disease outbreak occurs in the future, OCHA should become involved in the response, instead of establishing a new UN mission such as UNMEER. The OCHA must strengthen its capabilities to respond to humanitarian health crises by taking initiatives such as dispatching UN Humanitarian Coordinators with experience in infection prevention and control (IPC) and activating the cluster approach for humanitarian coordination (Katsuma et al. 2016).

### 2.4.2 COVID-19: A Global Pandemic

At the end of 2019, there was an outbreak of an emerging infectious disease (EID) in Wuhan, the capital city of Hubei Province, China. Following that, the WHO announced the discovery of the novel coronavirus “SARS-CoV-2” on 12 January 2020. Human infection by this virus is called the Corona Virus Disease 2019 (COVID-19).

#### 2.4.2.1 Unique Features of COVID-19

COVID-19 is a global pandemic, with an extremely high number of human infection cases in general, as well as relatively higher death rates among vulnerable groups, including elderly people and those who have underlying health problems. Since the first report in December 2019, COVID-19 has become a global pandemic all over the world, due to its unique features.

One reason for a high number of infection cases is that asymptomatic or undiagnosed infected people may be spreading the virus. Second, as it is difficult to identify, isolate and quarantine asymptomatic infected people, general mobility restriction measures, including lockdowns, are important to prevent the spread of COVID-19 cases (Katsuma 2021a). However, mobility restriction policy, banning mass gathering events and regulating hospitality and service businesses, would damage the economy and cannot be continued for months.
Much is still unknown about this virus, and there is no end in sight to the pandemic. Although the world now is much different than it was 100 years ago, the scale of its spread invites us compare with the 1918–20 Spanish flu (H1N1 type-A influenza virus). That virus is said to have infected 500 million and killed 50 million around the world (Jordan 2019).

However, SARS-CoV-2 is not an influenza virus but a coronavirus. SARS-CoV-2, causing COVID-19, is the seventh coronavirus known to infect humans. Of the seven, four have spread globally, but cause mild to moderate symptoms only now (HCoV-OC43, HCoV-HKU1, HCoV-229E and HCoV-NL63) (ICTV 2020). The first three cause common colds, as well as severe lower respiratory tract infections among the youngest and oldest age groups. The last one, HCoV-NL63, is an important cause of (pseudo) croup and bronchiolitis among children (ECDC 2022).

The other three, including COVID-19, can cause more severe and even fatal symptoms. The severe acute respiratory syndrome (SARS-CoV), a coronavirus infection discovered in China’s Guangdong Province in November 2002, and identified by the WHO in February 2003, is thought to have spilled over to humans from greater horseshoe bats. By July 2003, it had spread to over 30 countries and territories, with confirmation of around 8000 people infected and over 700 deaths (CDC 2004). The Middle East respiratory syndrome (MERS-CoV), another coronavirus infection discovered in Saudi Arabia in 2012, is thought to have spilled over to humans from the Arabian camel (ECDC 2020). By the end of 2019, it had spread to 27 countries, with confirmation of about 2500 people infected and over 800 deaths.

WHO Director-General declares the sixth PHEIC on 30 January 2020, based on the 2005 IHR. This PHEIC declaration is supposed to allow the WHO to demonstrate global leadership in promoting international cooperation among the member States to combat COVID-19. However, with the “my country first” stance of many high-income countries, including temporary suspension of the payment of financial contribution to the WHO by the U.S.A. in 2020, international cooperation to combat COVID-19 has been insufficient.

The advent of COVID-19 has made it difficult to achieve SDG 3. At the same time, structural challenges have arisen for global health governance, such as global equitable access to essential medical products and the global governance over disease outbreaks on international cruise ships (Katsuma 2021b).

2.4.2.2 Global Equitable Access to Vaccines

In preventing infection and the spread of COVID-19, the focus was initially on non-pharmaceutical interventions such as changing personal hygiene behavior, improving the spaces where people gather, and restricting human interaction. Non-pharmaceutical measures remain essential, but pharmaceutical inventions such as vaccines and therapeutic drugs have become indispensable. It is anticipated that vaccines will prevent exacerbation of the disease.

But not all have fair access to vaccines. Attempts by high-income countries to secure as many vaccines as possible for their own citizens have been censured as “vaccine nationalism”. Meanwhile, a lack of funds has meant that low-income countries are unable to negotiate directly with pharmaceutical companies, making it difficult for them to secure vaccines independently. Nevertheless, top earners in low-income countries can partake in “vaccine tourism”, whereby they travel abroad (to the United Arab Emirates, for example) to be vaccinated. This gives rise to concerns that many people in low-income countries, including healthcare professionals, are being left behind.

The COVID-19 Vaccines Global Access (COVAX) Facility, one of three pillars of the Access to COVID-19 Tools (ACT) Accelerator, is an international framework for the co-purchase of vaccines. High- and middle-income countries can self-fund vaccines for 20% of their populations, while low-income countries are provided with vaccines for 30% of their populations free of charge. The Government of Japan held a Vaccine Summit on 2 June 2021 to raise the
funds required for this. However, one of the problems may be that pharmaceutical companies may prefer to negotiate with high-income countries bilaterally, as the willingness to pay of those countries are generally higher than that of multilateral framework such as the COVAX Facility. High-income countries are strongly encouraged to balance the country needs of their own citizens and the global equity in access to vaccines.

2.4.2.3 Intellectual Property Rights and the Access to Medicine

Access to medicines, including vaccines, is essential in the fight against COVID-19, but high prices and short supply have become issues in the oligopolistic market. 62 countries jointly proposed a temporary waiver from COVID-19-related intellectual property rights protection obligations under the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) (WTO 2020). The proposal has been endorsed by more than 100 countries. Many high-income countries opposed it, but the U.S.A. and France are now in favor of the intellectual property waiver.

The Target 3.d of the SDG 3 states the following (see Table 2.2):

Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

The protection of intellectual property rights is an important mechanism for research and development (R&D) organizations to recover their investments. It is also an essential premise for publishing the results. On the other hand, public funding from governments and international organizations have been supporting the R&D and the purchase of pharmaceutical products.

However, in accordance with the Target 3.d, countries must consider temporarily waiving obligations to protect intellectual property rights, while encouraging technology transfer by pharmaceutical companies. Discussions on how public and private sectors should cooperate in the pandemic must also be deepened when a PHEIC is declared.

2.4.2.4 Disease Outbreaks on International Cruise Ships

In February 2020, the outbreak of COVID-19 on the Diamond Princess Cruise Ship attracted widespread attention not only in Japan but also internationally. The flag State of the Diamond Princess was the United Kingdom (U.K.), and the cruise ship operating company was based in the U.S.A. The ship was permitted to dock at the port of Yokohama in Japan.

The United Nations Convention on the Law of the Sea and the International Labour Organization’s Maritime Labour Convention set out the responsibilities of flag States. WHO’s IHR set out the responsibilities of the country in which the vessel is located. Further, the UN Convention on the Law of the Sea provides for the rights and obligations of coastal States vis-à-vis foreign vessels. Although the case involved several actors, the division of roles between the U.K., the U.S.A, and Japan was not clear.

Moreover, although Japan permitted the Diamond Princess to dock, it refused the same permission to the Westerdam (its flag State was the Netherlands, while the operating company was in the U.S.A.). After being turned away by various countries, the Westerdam ended up docking in Cambodia.

With a lack of clarity regarding the roles of the various actors involved, the burden on the coastal States in which such international ships dock is increasing, and it is no wonder why many countries are reluctant to extend support to both passengers and seafarers on such international ships. It is necessary to envision a global health governance mechanism for such event.

Both Ebola Virus Disease and COVID-19 have challenged the SDGs, particularly the SDG
3. They have reminded us that the global health governance needs to be reformed so that international cooperation to achieve the SDG 3 will be facilitated better.

### 2.5 Promoting Universal Health Coverage for Leaving no One Behind

This section discusses how international partnership has been strengthened to promote universal health coverage (UHC). As a case, the 2019 G20 Summit is analyzed to show the role of Japan in promoting the UHC. At the end, UN High-Level Meeting (UN HLM) on UHC in 2019 will be presented as an expanded political commitment made by the heads of State and government of UN members.

#### 2.5.1 UHC and Primary Health Care

In this sub-section, the author discusses how international partnership has been strengthened to promote universal health coverage (UHC). It is also reviewed how the concept of primary health care (PHC) was re-defined in the current movement towards the UHC.

The Target 3.8 of the SDG 3 has two indicators (see Table 2.3). The indicator 3.8.1 is the coverage of essential health services, while the indicator 3.8.2 is the proportion of population with large household expenditures on health as a share of total household expenditure or income.

There has been coordinated efforts to monitor the progress toward the UHC in each country, collecting data on the indicators (WHO and World Bank 2021).

The International Health Partnership (IHP+) responded to the transition from the MDGs to the SDGs by discussing how best the partnership can contribute to the SDG 3. In early 2016, the IHP+ Steering Committee and signatory partners agreed to expand the scope of IHP+ to include health system strengthening (HSS) towards the achievement of the UHC.

It was also agreed to broaden the base of the partnership as the SDGs are relevant for all countries, while the MDGs were for low-income countries only. It was envisaged that the new partnership would broaden the scope to focus on the HSS and domestic spending in all countries.

In September 2016, the Director-General of the WHO formally announced the establishment of the ‘International Health Partnership for UHC 2030’ at a High-Level Meeting to End AIDS during the UN General Assembly in New York. This transformed the IHP+ into the UHC2030. Its mission is to create a movement for accelerating equitable and sustainable progress towards the UHC.

After UHC was included in the SDGs as the Target 3.8 in 2015, Japan hosted the first UHC Forum with the World Bank, the WHO and UNICEF among others in Tokyo on 13–14 December 2017, for the purpose of further mainstreaming the UHC on the global agenda. The co-organizers adopted the “Tokyo Declaration on UHC” (2017), calling for greater

---

**Table 2.3** SDG Target 3.8 and its indicators

| Target 3.8 | Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all |
| Indicator 3.8.1 | Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) |
| Indicator 3.8.2 | Proportion of population with large household expenditures on health as a share of total household expenditure or income |

commitment to strengthen global momentum towards the UHC, to accelerate country-led processes towards the UHC, and to nurture innovation for the UHC.

Interestingly, the PHC is not explicitly mentioned among the Targets within the SDG 3, probably due to the lack of consensus on its definition at that time, in the wake of the debate between the “comprehensive” and “selective” PHC. However, in 2018, after 40 years since the “Declaration of Alma-Ata,” the Global Conference on Primary Health Care was held in Astana, Kazakhstan. The “Declaration of Astana” (2018) states that the PHC is a cornerstone of a sustainable health system for the UHC and health-related SDGs.

2.5.2 2019 G20 Summit and UN High-Level Meeting on UHC

The author demonstrates how international organizations and conferences, such as the WHO, the UN, and the Summit, have been providing their members with arenas for global health diplomacy to promote the UHC. In this sub-section, the G20 Summit in 2019 is analyzed as a case to show the role of Japan in promoting the UHC. At the end, UN High-Level Meeting (UN HLM) on UHC in 2019 will be presented as an expanded political commitment made by the heads of State and government.

The leaders of the G20 met in Osaka on 28–29 June in 2019, and then adopted the “G20 Osaka Leaders’ Declaration” (G20 2019a), in which global health is one of the major issues addressed. The paragraph 30 in the section “Global Health” of the Declaration summarizes the consensus reached among G20 leaders on the UHC. As an outcome of the 2019 G20 Osaka Summit, the consensus on the UHC is significant for the following three reasons (Katsuma 2019).

First, before the leaders met, G20 finance and health ministers were convened to organize a joint session for the first time on 6 June 2019, and then endorsed the “G20 Shared Understanding on the Importance of UHC Financing in Developing Countries” (G20 2019b). The finance ministers of powerful economies have agreed that investing in health at an early stage of development is important for sustainable and inclusive growth. For supporting this argument, the World Bank provided evidence (World Bank 2019). Then, G20 finance and health ministers encouraged low-income countries to mobilize their domestic resources for the UHC. G20 Health Ministers’ Meeting, held in Okayama in October 2019, followed up on the agreement.

Second, Japan, as the host of the 2019 G20 Osaka Summit, took a whole-of-society approach in strengthening partnerships, and engaged in policy dialogues with various G20 Engagement Groups. Although the G20 Summit is an intergovernmental process, many non-governmental organizations, particularly G20 Engagement Groups, were given opportunities to provide the host government with policy recommendations.

For example, the Civil 20 (C20) published “C20 Policy Pack 2019” (C20 2019), containing a policy paper on global health prepared jointly by many civil society organizations, in April 2019. The Think 20 (T20) is a research and policy advice network for the G20, consisting of several Task Forces. The Task Force 1 focused on the 2030 Agenda for Sustainable Development, and then published 11 policy briefs. The T20 Working Group on UHC produced one of the policy briefs in March 2019. The policy brief consists of four proposals: (1) leaving no one behind; (2) prioritizing reliable domestic financing and cost-effective best buys; (3) harnessing innovation and access to technology judiciously; and (4) supporting common monitoring mechanisms, mutual learning platforms, and coordinated international cooperation for the UHC (Bloom et al. 2019).

In addition to the above official G20 Engagement Groups, two interesting private initiatives were taken to advocate for the UHC. One is the Health Professional Meeting (H20) organized by the World Medical Association (WMA) and the Japan Medical Association (JMA) in Tokyo on 13–14 June 2019, in which the “Memorandum of Tokyo on UHC and the Medical Profession” (WMA and JMA 2019) was adopted. The other is the Biopharmaceutical
CEOs Roundtable (BCR) organized by the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) in Tokyo on 3–4 June 2019. The IFPMA prepared a joint statement signed by pharmaceutical manufacturers in Japan, the U.S.A. and Europe (IFPMA 2019), and presented it to Prime Minister Shinzo Abe in anticipation of Japan’s leadership in accelerating progress towards the UHC, in resolving unmet medical needs, and in transforming to a new healthcare system utilizing various medical data.

Third, G20 leaders recall the commitment to the 2030 Agenda for Sustainable Development and the SDGs made by all member states of the UN in 2015, and then identified the urgent need to formulate a global health action plan so that the SDG 3 and its Target 3.8 (UHC) can be achieved by all stakeholders in a harmonized manner.

A few months after the leaders of the G20 adopted the “G20 Osaka Leaders’ Declaration” in June 2019, the UN HLM on UHC was held in New York in September. The theme of the HLM-UHC was “Universal Health Coverage: Moving together to build a healthier world.” As the outcome, “Political Declaration of the High-Level Meeting on Universal Health Coverage” (A/RES/74/2) was adopted.

In response to the need of global action plan, expressed by the G20 leaders at the Osaka G20 Summit, the WHO presented a global health action plan (WHO 2019). It was a milestone event to mobilize the highest political support to package the entire health agenda under the umbrella of the UHC.

2.6 Concluding Remarks

This chapter has approached global health diplomacy in combating communicable diseases and in promoting the UHC, as part of the efforts to achieve the SDG 3 by 2030. The principle of “Leave no one behind” is logically endorsed both by the right to health and the HFA.

First, communicable diseases have become perceived as a threat to “human security” in global health, and Japan started to use the concept of human security in global health diplomacy to elevate the level of dialogues. Nevertheless, Ebola Virus Disease and COVID-19, not anticipated when the SDGs were adopted, now urge us to re-visit the needs to reform global health governance.

Second, to promote universal health coverage (UHC), international partnership has been strengthened, particularly UHC2030. In 2019, hosting the G20 Summit, Japan played an important role in promoting the UHC. This led to an expanded international commitment made at UN High-Level Meeting on UHC. It shows that global health has become an important agenda for diplomacy.

Lastly, the SDG 3 is inter-linked with other SDGs. For example, to “ensure healthy lives and promote well-being” for all workers, the SDG 8 (decent work), particularly its Target 8.8 (Protect labour rights and promote safe and secure working environments for all workers), is relevant. It is important to improve occupational safety and health (OSH) by setting international standards through consultation both at the International Labour Organization (ILO) and the WHO, and then implementing them domestically in each country. Therefore, inter-sectoral collaboration, enhancing the synergy, is important when we approach vulnerable populations, with the principle of “Leave no one behind.”

References


Katsuma Y (2021b) Global health governance issues to be addressed jointly by Japan and Germany. JDZB Echo 136:1–2


Global Health Diplomacy to Combat Communicable Diseases...

WHO (2019) Stronger collaboration, better health: global action plan for healthy lives and well-being for all. World Health Organization (WHO)


Open Access This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (http://creativecommons.org/licenses/by/4.0/), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.