Human security and global health governance

Sigrun Møgedal 14.05.10
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Institute of International Education, NY, USA

Human Security and Human Vulnerability

At a time when global interconnectedness and interdependence have been so dramatically and concretely exposed   – financial crisis, pandemic, climate change, food crisis - , it is not hard to understand why we need human security. We have a collective encounter with human vulnerability, hitting people and countries of affluence as well as those of poverty – differently but visibly.

Human vulnerability is concrete – in front of our eyes and in our lives, wherever we live. The world is not a secure place. Not for nature, not for people and not for livelihoods, technologies and social systems.

This is in itself nothing new. Yet, what may be new, or at least stronger, is the insight that the major threats and forces we face – in environment, financial systems and health – are *vulnerabilities we have in common.* Its impact is different, so is the opportunity to cope and protect. But both vulnerabilities and opportunities to protect are so obviously interconnected across the globe.

Human Security has been around for a long time, with a solid rationale. Yet it does not fit well into the departmentalised approach we normally use for national and international policy development and action. Rights, development and security have their own institutions, processes, stakeholders and history. So have environment, humanitarian action and health. We have never been good at linking these together and each of these streams of engagement has hard fought successes and remaining stumbling blocks. Who are the agents for rights, development and security –for whom and what comes first?

Generating momentum forward

The integrating imperative of the human security approach is *the focus on and commitment to the human – to people where they live their lives*. It is the same people in the same communities who claim their rights, need protection from violence; whether social, sexual or armed, have aspirations for environment and livelihoods and need health services. People and communities have capacities for resilience, innovation, problem solving and managing change which are keys to human security.

The report of the Secretary General is hopeful: "Human security is a *practical approach* to the growing interdependence of vulnerabilities facing peoples and communities" – and explains that this as "people-centred, comprehensive, context-specific and preventive responses", "promoting multi-stakeholder responses that enable the protection and empowerment of people and communities".

It is easy to agree. These words echo language and insights from breakthrough events in Alma Ata, Rio, Cairo and Beijing. It is true that progress has been made. But progress has been fragmented and compartmentalized. In the international community we are good with words but have not a good track record of responding with necessary change in structures and ways of doing business.

The question is whether we now, with the new understanding of major threats and vulnerabilities we have in common, can use this opportunity to find practical building blocks for human security and better bridge the gaps,
- between where the people live to where the power sits in local, national and global governance
- between the rights community, the development community, the humanitarians and the traditional security domain

The reality in which we live confirms these gaps every day.
The reality in which we work resist change every day.

Two days ago, in opening a meeting on Armed Violence in Geneva, Norwegian Minister Støre highlighted the need to bridge security, rights and development: "Armed violence prevents development and causes human rights violations , and individual traumas. Armed violence creates an atmosphere of fear and insecurity. Armed violence fosters a culture of impunity and undermines trust in key public institutions. At the same time, we know this much: *sound, sustainable and people-centred development* can reduce the problem of armed violence significantly. The achievement of the Millennium Development Goals (MDGs) is our chosen approach to this goal. Secretary–General Ban-Ki Moon has identified armed violence as one of the key obstacles to the achievement of these goals by 2015."

This is a promising signal that also in the traditional foreign policy domain, there is now a growing focus on bringing together *people-centred development, people-centred security and rights* – possibly also overcoming some of the divides in positions on the utility of human security and making it serve as an integrating force in the worlds efforts to achieve the millennium development goals.

The case for health at the core of human security
We are here to explore health in this context, and to what extent human security can be applied as a framework for improving global health governance - to more effectively address the health threats that vulnerable populations face on a daily basis.

Before we discuss global health governance, we have to start where people live. Any health governance that likes to govern, but fails to communicate with and respond to the needs, fears and capacities of people for health and their ability to cope with threats to health, will fail.

Using a similar reasoning as for armed violence, health is not only a matter of freedom from want. It is also freedom from fear, empowerment and dignity.

Poverty, inequities and discrimination based on ethnicity and gender is violent and undermines health. Diseases cause fear. Inequity in access to protection and survival undermines security.

So here we are with the most critical building block for applying human security as a framework for improving global health governance; *the need to build governance from bottom up, with a focus on people and communities, their values, energies and opportunities, - where they live*. Coping mechanisms combine both resilience to threats and innovation for survival - safeguarding livelihoods, protecting dignity and relationships - and capturing opportunities.

States and service delivery, whether public or non-state, may or may not enable the potential in community action. Unfortunately this potential can also be undermined by the way services are provided.

We said close to the same when the world agreed on Health for All in Alma Ata in 1978. And already then we could build on concrete examples.

Both in *Norway and in Japan* the history of building up effective services for mothers and children started with communities and not the least women, organising themselves for self help and bridging gaps with public and private service provision. In Norway this was closely associated with the women's movement, fight for equal rights.

Democratization of health care, through peoples movements, local organisation and integrated responses to local health needs, analysed and defined by the people, took health services out of a focus on institutions to a focus on people in communities in the 60's and 70's, leading up to Alma Ata. My own experience in communities of Nepal in those days made me rethink my role and approach as a medical doctor and engage in work with local health committees, community health workers, traditional midwives, water projects and local insurance schemes.

It was times of hope and times of achievement. Some countries managed to maintain the momentum and develop the integrated primary care model in impressive ways. Thailand and Brazil are in different ways star examples. In other countries the movement was taken over by mass-production of blue-print care models that retained elements of primary care but lost the dynamic interaction with communities and the ability to tailor responses to the diversity of community needs.

But these models were also rapidly targeted as elements of broader movement for political reform – and in some cases - as we saw it in Nicaragua -, health workers and health centres became targets for destruction as part of armed revolutionary struggle.

In the times of apartheid in South Africa and Namibia, efforts to establish community health care models as vehicles for empowerment of people for their own health, was part of the resistance and mobilisation for change. In South Africa post apartheid health and equity in access to health services was very much in the forefront as a peace dividend.

Health has been and is political, because it matters to people.

I note this to underline that *health has a long track record of showing its potential for empowering people in communities*; creating a conversation that combines resilience and change, and linking up with other community needs and imperatives for survival, health and dignity.

When we in the discussions about health care and the health MDGs today talk about *integrated services and health systems as the missing part*, I dare to suggest that this is an outcome of the period when health service planners, providers and funders *lost their connectivity to community health* and wanted to create rapid solutions for predefined priorities.

Aids, Health Personnel and Pandemics
Aids, health personnel and pandemics illustrate recent debates and challenges in health relating to the community-system interface and the challenge of access to services.

Hiv and aids in many ways created a revolution. It started with communities on the move, this time the gay community of the US, suffering through the crisis of an unknown and untreatable disease and when the opportunity to treatment materialised were able to think globally, rather than only their self interest.

We all know the history, how aids was brought to the forefront, right into the security council, and how it set off major mobilisation, including one of the few cross-cutting UN programs when establishing UNAIDS. Other key elements related to global health governance and funding was to mobilize funding and new tools, the political engagement of G8, the establishment of the Global Fund for Aids, TB and malaria, the focus on access to medicines through pushing innovation, patent legislation and generic production.

Hiv and aids is possibly the best illustration of linking health action from the bottom up and forcing global governance to respond. New institutions were created. Although clearly a cross cutting challenge, the dynamics of the global response together with the stigma and denial in countries and on the ground created a "single issue" pyramid of funding and governance. It has delivered, but also generated inefficiencies which we now need to deal with today. Aids as a health issue must emerge out of isolation, but not in a way that will lose momentum and distort the fantastic track record of results.

A recent breakthrough was ending hiv-related travel restrictions, here in the US, in China and many other countries. Again we saw the victory of a people's movement for change.

The challenge today is stopping Hiv transmission. That requires regrouping of efforts and linking up with all the MDGs, in terms of rights, development and security. It requires more than global health governance, and more than global development governance. It clearly makes the case for making

- *national policies "Hiv responsive",*
- *national politics "Hiv accountable" and*
- *communities "Hiv resilient"*

– all illustrations of practical content for human security.

The Health Workforce provides an opportunity to take another look at the interconnections between community health, service delivery and governance at national and global level. Health workers, particularly doctors, nurses and midwives, are in short supply globally, with grossly uneven distribution within countries and regions and across regions.

It is the forces of the market, rather than the forces of governance for effective service delivery that decides who will have access to a skilled, equipped and motivated health worker. This is a risk for human security and for national and global health security.

The capacity to train, retain, finance and manage the workforce is in many countries weak. For donors, financing the workforce has been unattractive and seen as a recurrent expenditure, not an investment. For governments, managing the movement of skilled health workers from rural to urban, between national and local government and between public and private sector, has been a *task where neither the tools nor the incentives have been within reach*. The attraction of health workers to move beyond borders to better jobs, career development, pay and opportunities for the family has for many source countries created "fatal" flows, leaving huge gaps in essential services.

Making the "skilled health worker - community" connection is critical, not just for service access but also for keeping the health worker motivated. Community agents and community health workers are parts of a continuum of care that requires particular attention in the interface between those representing the community and those representing the system.

But community health workers cannot replace the need for formal health workers present at the first level of stationary services. A human security approach calls for investment in the skills, support, presence, mutual trust and accountability between the first level skilled service provider and the people that need these services. Getting in place a skilled workforce for safe delivery in first line and back up maternal services is critical for achieving MDG 5. *Health workers can be and should be multifunctional and multitasking. But they need to be there.*

We have *too little knowledge about the real gaps and discontinuities* in actual and functional presence of skilled personnel at this level, particularly in rural and remote areas. This can only be resolved through stakeholder interaction, awareness, problem solving and systematic monitoring, both at local and national levels. Governments must work with communities, professional associations, private sector and the academic sector to take necessary action. *Community contracts and social dialogue may be as important for motivation and retention as issues of salary and allowances.*

The World Health Assembly has had the governance challenges of international migration of health workers on the agenda for the last couple of years; seeking agreement on a code for ethical international recruitment that seeks the balance between the right to migrate on the one side and the right of people to access services on the other. Even though the proposal for a code is voluntary, the elements of making a fair deal, involving the private sector and having better information available on international flows of the health workforce, remain hard to resolve.

The situation illustrates major challenges in global governance for health in support of human security. The health worker issue is concrete, address the links between what communities can do and what the formal delivery system must provide, and has national, regional and global governance based on universal coverage and equitable, sustained access as essential elements of a solution. *Also for managing the interdependence in health, reaching the MDGs and ensuring capacity for making globalization work for all, the basic building block from a health security perspective has to be access for all to a skilled, motivated and supported health worker.*

Pandemic preparedness and response is my last illustration of the challenges in the continuum between the local and the global. While most commonly discussed in national, regional and global terms, we have also seen how preparedness at local level is essential. Bird flu demonstrated how early warning and surveillance depends on trust and collaboration with communities. Swine flu demonstrated the enormous challenge of logistics and communication with the local level, for those that had the opportunity of providing vaccines for their population.

At the global level, nothing we have experienced lately has so clearly demonstrated the dramatic global inequities in terms of access to vaccines, equipment and delivery systems, and how everybody's security was at stake. Yes, mechanisms of solidarity were established, as noted in the report of the Secretary General. But they were inadequate, with a clear potential for major north-south tension and distrust if the pandemic had developed differently.

There is broad agreement that we need a more predictable, dependable and globally fair system to respond to pandemic situations depending on need and not determined by the purse in the acute situation. WHO and its member countries are negotiating what this may require, such as in the context of the International Health Regulations. Countries negotiate rights and responsibilities related to virus sharing, benefit sharing and building response capacity. This is a real test of the realities of governance in health in a globalized world, and a concrete and most challenging human security and health security issue. *The institutions we have are put to the test, but so is the readiness of countries to respond to common vulnerabilities and shared risk with shared responsibility.*

What Security
We know that the word security cause us difficulties, such as the worry about undue interference across borders in the name of security – even if the purpose is health.

When discussing this in the group of seven countries that make up the Foreign Policy and Global Health initiative[1] we have realized that we cannot cope with definitions, and therefore need to state what we *do not include* in the concept of global health security in order to use the concept of global and national health security constructively (not understood in terms of threats to the maintenance of peace and security maintained in the UN Charter). This is applicable to human security as well if we want to apply the concept to health, where one stumbling block is the interpretations of responsibility to protect.

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[1] Brazil, Senegal, South Africa, France, Thailand, Indonesia and Norway

Given this understanding and this caution, the case for bringing together freedom from want, freedom from fear and dignity may allow constructive use of the concepts of health security and human security in the same way as we increasingly talk about food security, energy security, water security and eco security.

There are some interesting examples. The threat of biological weapons early on raised the same concerns in many developing countries as the responsibility to protect. The work on the biological weapons convention has however been able to serve as a bridge, where the case is made for national health and laboratory systems that can detect such biological material. Building capacity and making health systems work becomes a concrete and decisive element in an agreement based on mutual responsibility.

Other examples for meaningful application of the human security concept, relevant to health, can be found in conflict and post-conflict situations with multidimensional causes of insecurity faced by people.

Afghanistan is a case in point, where the resilience to threats and coping capacity in local communities may be the biggest asset for rebuilding of the country. Approaches to health in this type of situation need to maximize dignity and freedom from fear as much as freedom from want, through strengthening and building on local resilience and capacity to cope, - rather than be based on a blue print, centrally managed national service delivery system.

Conclusion

To the question, can human security be applied as a framework for improving global health governance, my answer *is yes - with some caution*.

National and Global Health Security challenges demonstrate the realities of common vulnerability and need for shared responsibility in facing threats to health that affect all, calling for intergovernmental negotiations and buy in from key global, regional and national stakeholders.

Human Security brings to Health Security the broader connections between rights, development and security. It places the focus on people, communities and partnerships as the basic and most essential building block, supported by enabling policies and relevant service delivery from local and national governments and other actors

The human security approach is needed to deal with the challenges of health security: Health Security may be understood as top-down. Human Security makes the case for bottom up.

Health is the bridge than make them complimentary. Both can be abstract concepts and fuzzy talk. Applied to concrete systems and governance challenges, they become objectives that can be linked to evidence and results.

Both Health Security and Human Security need to be placed in a value framework of local, national and global solidarity. There is a need for global health governance that is structured to

match these new realities, with a more "joined up" UN, more "joined up" governments and broader and more effective cooperation with non-state partners – responsive to the capacity of people in communities.

Pursuing these perspectives, human security definitely has promising potential to be applied as a framework for improving both national and global health governance.