

Global Health Diplomacy
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Thomas Novotny, MD MPH
Vincanne Adams, PhD

Introduction

Health diplomacy may be defined as a political change activity that meets the dual goals of improving global health while maintaining and strengthening international relations abroad, particularly in conflict areas and resource-poor environments. Although there are historical precedents for health diplomacy (examples are found in early missionary work, colonial and post-colonial health development aid, faith-based and other non-governmental efforts, and now the new global health philanthropies,¹) the imperatives of disease globalization, persistent international conflicts, and new threats to human security call for defining global health diplomacy as an academic discipline for our times. This paper provides a prospective overview of the content of global health diplomacy, defines areas of interest, and sets out an agenda for development of knowledge, pedagogy, and service in the field.

Background

Understanding what this new discipline may encompass begins with a recognition that the most effective international health relationships are carried out in an ethical manner sensitive to historical, political, social, economic, and cultural differences between nations and peoples.² This understanding is further informed by the changing political environments such as those in Bolivia, Ecuador, Brazil, and Venezuela; failed diplomacy and nation-building efforts such as in Iraq; changing human security threats due to emerging and re-emerging infections such as HIV/AIDS, TB, and SARS; changing nuclear power structures such as those in North Korea, Pakistan, and India; changing global health governance structures such as the Global Fund for AIDS, TB, and Malaria;³ changing environmental conditions that may affect long-term human welfare such as global warming; and changing economic development conditions that have created enormous disparities and questions of social justice in China, India, and elsewhere. Added to this are the persistent development and diplomatic uncertainties for countries of the Former Soviet Union and in the Middle East. These are complex problems, requiring improved leadership in both health and diplomacy in order to bring about conflict resolution, equitable distribution of resources, and improvements in human health and development.

While encompassing the social science, political science, and humanities disciplines, Health Diplomacy requires new interdisciplinary approaches for health sciences education to prepare professionals who will manage persistent and emerging global health challenges.⁴ Future global health leaders need to better understand the pathways to resolving international conflict through effective foreign health assistance; to overcome unilateralism and work with others towards common health objectives; to improve economic growth and stability among poor nations through health development; to cope with the challenges of disease globalization; and to recognize the linkages between peace, health, and economic stability throughout the world. To do this, they must relinquish any sense of hegemony due to resource imbalances, military capacity, or GDP expenditures on foreign assistance; all those metrics are changing, and should change, in order to achieve global health as a public good.

Global health diplomacy skills can assure good global health governance within and by multinational organizations, appropriate utilization of scarce resources, and sensible international relations among donor nations and between these nations and the developing world. Thus, health

diplomacy crosses over disciplines to include elements of human rights and social justice; foreign policy; development economics; cultural and social determinants of health; and bioethics. Challenges to national sovereignty caused by changing global health problems, by increasing recognition of human security needs, and by changing structures of global governance⁵ demand that 21st-century health professionals must understand much more than is currently taught in the health sciences curricula. Successful health diplomacy requires training new leaders who will have both a solid understanding of international relations and a solid experiential base in health assistance from which to develop careers, whether in government or in non-governmental institutions.⁶ Health diplomacy is not only the job of diplomats or health leaders in government structures, it is a professional practice that should inform any group or individual with responsibility to conduct research, service, programs, or direct international health assistance between donor and recipient institutions.

Historical Perspectives

Multilateral organizations such as the United Nations (including the World Health Organization) and the World Bank were established after World War II for reconstruction and development. They later grew to provide more than just direct assistance, and they became normative and information-generating organizations, driving health systems reform through conditional lending and technical input to recipient countries. Later, these organizations changed by political fiat and by the demands of resistant multinational health problems such as HIV/AIDS, TB, and Malaria. Historically, we can recall successes from post-World War II re-development efforts under the Marshall Plan in Europe, and even in post-nuclear Japan through direct medical assistance by the US military. Successes have also been demonstrated by such diverse actors as Cuba (in providing direct medical assistance and training to poor nations), the Scandinavian countries (that contribute direct foreign assistance well above the recommended 0.7% of GDP level),⁷ and the Physicians for Social Responsibility (who won the 1985 Nobel Peace Prize for physician-to-physician contact to reduce nuclear threats between the United States and the Soviet Union). The interests of global peace are surely served by such efforts and by effective models of health development assistance. What is important today is understand clearly the impact of these historical approaches and the new governance models that have grown so rapidly in the 21st Century.

Alternative multinational models, including private-public partnerships, have developed as a result of efforts by various groups to augment or, in some cases bypass, the authority of multinational organizations. Focused programs addressing immunizations (Polio Eradication), core diseases (PEPFAR, Global Fund), or health systems reform (World Bank) have seldom taken a broad view of how these programs integrate across donors and within recipient health agencies. Public health systems, then, have been weakened by virtue of disease specific investments.⁸ The System Wide Approach (SWAP) was a major attempt by the World Bank, WHO, and other donors to integrate and coordinate health assistance, but results of this effort are mixed. Now, with so much investment from the private sector driving health agendas, the need for horizontal management of global health interventions is becoming more and more critical. It is difficult for recipient countries to manage all the new inputs, and therefore the donors more than ever, need to have a sense of integrated development programs. Global health diplomacy may broaden the perspective of these approaches to assure better application of the funds to long-term infrastructure development. This is a critical element for the new philanthropies especially.

Economic self-interest groups (International Federation Pharmaceutical Manufacturer's Association, International Chamber of Commerce, etc.), and philanthropic organizations such as the Rockefeller Foundation, the Rotary Club, the Bill and Melinda Gates Foundation, and others have added to a growing brew of international actors with varying agendas. These activities may have dual roles in demonstrating commitment to public welfare that provides both a personal and

corporate outlet for contributions to the global public good. Faith-based or faith-related NGOs have been providing various types of international assistance in both relief and health development projects throughout the globe. These are not restricted to Christian organizations, and they include the International Red Crescent and Israeli Magen David Adom organization as significant players. Non-governmental (NGO) groups such as *Médicins sans Frontières* (MSF) provide both long-term and very immediate assistance in disasters, and they have succeeded in conducting health diplomacy without the benefits or restrictions of governmental politics. Each of these groups, as well as bilateral donors, can be more effective, less obtrusive, and more cognizant of working within and not ON partners by having better-trained staff and volunteers. As globalization expands markets, opportunities, and health risks, health professionals must increasingly know more about the determinants of health in a global community, about the historical effectiveness or ineffectiveness of health assistance, and what forms health assistance might take in different environments.

When and where health development efforts have succeeded, such success depended on effective relations between stakeholders, whether donor or recipient nations, health systems, village recipients, or NGOs. Nevertheless, little attention has been paid to what sorts of training might be required to ensure such successful outcomes in health development. The same is true for the application of scientific research resources between developed and developing nations. The question of what makes an intervention diplomatic, just, and fair, and how such diplomacy may be learned is seldom explicitly addressed in health sciences training. Establishing Health Diplomacy as a field of applied research and pedagogy may bring these concerns and opportunities to light. A capable health diplomat will acquire complex understanding of the structures, programs, approaches, and the pitfalls surrounding them in order to achieve success in whatever the chosen target problem. Complex training and experiential learning is necessary for this capacity.

Rationale for Training in Health Diplomacy

Health diplomacy training must focus on ethically, legally, socially, politically, economically, and culturally informed knowledge acquisition. Such training requires shifting perspectives in order to understand the relationships between local and global, poor and wealthy, donor and recipient, and various disciplines. Health diplomacy requires a willingness to reflect critically on the ways in which effective health interventions are accounted for: who benefits, who is accountable for outcomes, and what tools are appropriate for measuring success. It must focus on power dynamics, where hegemonic relationships no longer produce the best diplomatic results.⁹ Instead, sensitivity to power imbalances and recognition of mutual interests may be more characteristic of health diplomacy than of traditional diplomatic approaches by the dominant nations.

There may be a sense of urgency about developing training in health diplomacy. Increasingly, governments, researchers, and international health practitioners are involved in health emergencies and containment of emerging infections; managing the shifting health risks due to globalization; responding to food insecurity; and responding to continued human and natural disasters due to climate change, ignored political atrocities, and failed nation-building.¹⁰ At the same time, pressures derived from processes of globalization are themselves creating new challenges for health sciences.¹¹

Although not an exhaustive list, the following emergent trends emphasize the need for more effective health diplomacy training and practice:

1. From International Health to Global Health

International health programs may be thought of as bilateral aid activities, vertical top-down disease specific programs, or limited interventions in post-crises situations. However, global health necessitates broader thinking to accommodate globalization; the rapid trans-border movement of diseases, communication, and human populations; the need for multinational and multi-organizational cooperation to solve these problems; and the globalization of science. The shift from international health to a “global health sciences” approach to international health cooperation has provoked two trends: 1) evidence-based medical research models are increasingly deployed in international health interventions, bringing scientific approaches to public health programs that may provide better evidence for effectiveness; and 2) the globalization of biomedical research, while successful in building medical and research capacity in target countries and communities, risks displacing existing public health programs in these partners.¹²

2. The Ethical Vacuum

The rapid spread of biomedical technology runs the risk of inequity in terms of benefits and risks. There is an increasing need for ethically sound and better coordinated approaches across research institutions, aid organizations, and development agencies. These needs address concerns about what is fair and equitable (regarding distribution of resources, accountability, outcomes)^{13, 14} but also more practical questions of ethical conduct in the protection of human subjects,¹⁵ the access to technologies, and the application of genomics.¹⁶ Although human rights issues have arisen as a concern for health development agencies, there is a growing need for institutions to address both equity and ethical standards in global health.

3. The Globalization of Diseases

Although infectious diseases have always been considered global health problems,^{17, 18} non-communicable diseases thought to be the realm of developed countries now are recognized to threaten economies and population health in developing countries.¹⁹ These conditions not only suggest a need for new models of disease management, containment and control, but they also demand recognition as triggers for other development problems. Large scale secondary effects of infectious and non-infectious disease epidemics (from AIDS orphans in Africa to poverty for chicken farmers affected by Avian flu in China to obesity and diabetes in India) need to be understood as problems of globalization. Concerns over security and biosecurity grow as these disease trends and their effects proliferate and as economic development and political stability are affected by them.

4. Non-state International Assistance

New and traditional philanthropies and NGOs (e.g., Google Foundation, Bill and Melinda Gates Foundation, Rockefeller Foundation, Rotary) have altered the relative roles of bilateral and multilateral organizations in global health and health care.⁸ What is the relationship between national/state organizations (such as the CDC) and these non-state organizations? There is a growing need to understand and help mediate their selected priorities while managing the relationships between these resource rich NGOs and existing national health structures. There are shifting obligations and responsibilities that emerge as such interventions affect national sovereignty, global governance, and citizenship. Questions of priority-setting, transparency, and accountability reside in these new aid structures as well.

These contemporary issues suggest the need for a multidisciplinary approach to training health professionals in and conducting research on to define how health diplomacy can be an effective tool in international relations. It is not sufficient for physicians, nurses, public health workers, or development aid specialists to simply know their technical fields in international health contexts. These providers and leaders need to recognize the political, social, economic, historical, ethical, and cultural contexts of intervention that are even greater challenges. This cannot be achieved without critical interdisciplinary training for the next generation of global health career specialists and diplomats.

Health Diplomacy and Academia

To fully define the academic field of global health diplomacy, three broad focus areas may be considered:

1. Knowledge Generation

The lists of emergent trends and topics of concern, above, begin to outline the terms of reference for the field of health diplomacy. In addition to these topics, however, critical theoretical background work may also be needed in order to support effective action in this field. This might include questions such as: What are the historical contingencies that make global health diplomacy more important than ever in today's world? What are some of the determinants of health inequality in the world today and how can health diplomacy help us address these determinants? What new conditions of globalization and biosecurity warrant the need for a new approach to global health diplomacy? How can health diplomacy mediate relationships between war and conflict, on the one hand, and health interventions, on the other? How can health diplomacy create bridges between worlds (industrialized and industrializing, for example) by way of recognition of shared responsibilities for health development, shared disease risks, and similar issues in global health security? What are the advantages of a "biosecurity" model versus a "health security" model for containing global disease burdens? What difference does institutional form make in health diplomacy (e.g., are local NGOs better than large multinationals; faith-based organizations more effective than secular bi-lateral programs?) What are the historical precedents for health diplomacy, and what can be learned from this history in formulating a new field of research, intervention, and teaching?

2. Pedagogy

A focus on pedagogy refers not simply to the questions of technical training of health professionals but also to how training should be conducted (transdisciplinary, experiential, continuing education). What are the critical skills that should be taught, how should they be taught, where and when should they be taught and to whom should they be taught in order to ensure effective health diplomacy in a globalized world? A focus on pedagogy ensures that the field of health diplomacy is itself able to be translated into practical outcomes among those who become involved in service. What sorts of programs are capable of reaching international audiences and also including priorities generated from the international community setting? What can be done to revise curricula in existing health training programs in order to augment this new field of health diplomacy for a variety of health care professionals inside and outside the United States? How does one 'do' health diplomacy without politicizing medical efforts? How does one build political and cultural sensitivity into a service-oriented medical, nursing, or public health education? What examples already exist for us to draw upon? How can health diplomacy be brought to students in the US Foreign Service Institute? What kinds of training modalities can be effective as continuing education for health professionals and

diplomatic professional alike? How can we creatively bring these two communities together?

3. Service

The growing call for training health professionals in global service requires a critical rethinking of what sorts of “service” are needed in today’s world. Are health professionals trained in infectious diseases capable of making a contribution to global health if they are not also trained in the fields of health development/ area studies/ international relations? Questions about the blurring of boundaries between non-profit versus for-profit versus bilateral aid efforts to intervene in global health are raised. These and other questions collectively inspire us to rethink the meanings of “service” in global health and particularly to question how we define “diplomacy” in these efforts. How do service efforts aimed at clinical relevancy also direct their attention toward problems of social inequality, social justice, and diplomacy? Does a commitment to health diplomacy service always require clinical relevance? What new models for service as providers, researchers, and training can be developed for current health professional students that will simultaneously satisfy their interests in public service as well as provide human resources that measurably and sustainably impact major global health problems that affect the poor?

Consistent with the above, several specific key areas of interest to global health diplomacy scholarship may be defined. This list is meant to be generative of discussion rather than exhaustive of the all possible topics of inquiry.

1. **Clinical Diplomacy.** How can health sciences schools today best prepare health professionals with not only the technical clinical skills they will need but also the social, cultural, political, and ethical competence they will need to be effective health providers and researchers in non-Western settings?
2. **Health Security.** Health security is integral for political security and international relations; health diplomacy provides a framework for establishing the links between governments, multi-national health organizations, and communities that provide global health security, including in travel, trade, and intellectual exchange. In a globalized world, security is ever-more challenging due to threats to national health sovereignty and the rapid spread of information as well as health risks across borders. How can the current global obsession with security be transformed into a health development effort?
3. **Human Rights.** How do researchers and clinicians ensure that standards for the protection of human subjects as well as patients are made as equitable as possible, even when it is impossible to ensure that the same practices for protecting human subjects are followed across cultures and nations? Are human rights models usable in global health research? If not, what other models should/could be used?
4. **Social Justice/Equity.** Increasingly the poorest countries are witnessing a decline in public health infrastructure and research investment as well as declines in several health indicators. The well-described 10-90 Gap in research funding, in which 90% of research funding is provided to populations with only 10% of the burden of disease demonstrates a need for redirection of resources, based on available evidence, to diseases of the global poor.²⁰ How is this redirection accomplished if not by those who are the beneficiaries of the research support? Simultaneously there is an increase in international pharmaceutical research, and enrolling in clinical trials has become a means for the poor to access

medical resources. Seldom addressed, corporate health diplomacy may help ensure equity and ethical research for poor and not simply for profit-driven drug development.

- 5. Political Understanding and Advocacy.** Health diplomacy recognizes that government institutions are primary participants in health development at policy and implementation levels. Health development may also be a critical primary ingredient in post-conflict nation building. Jones, et al.,¹⁰ note that key structural and institutional conditions can produce not only health but also social, political, and economic benefits that promote stable nations. Further, health diplomacy highlights the need for transparency in evaluating outcomes of politically-supported health activities. This includes a consideration of “corruption” versus “the cost of doing business” in global health interventions. Who decides, and how should the lack of transparency, corruption, or questionable business practices be managed?
- 6. Crises and Health.** The world is chronically beset by war and ethnic conflict as well as by natural disasters requiring massive international assistance. Global health diplomacy is necessary to assure humanitarian responses to such crises, with a need for global governance, public health infrastructure, and appropriately trained and mobile responders. Where do these people come from, and how can academia better prepare such responders? What diplomatic skills are needed for health workers who commit to service in conflict zones?
- 7. Health Manpower.** There is an imbalance of health manpower needs around the world, with some countries producing health workers for export and others desperately needing health manpower to respond to local needs. In the poorest environments, well trained providers may migrate extenuating health crises and supplying resource-rich countries with human capital at the expense of the originating country. How can this manpower crisis be equitably addressed and how can human resources be assured in countries in desperate need through international cooperation?
- 8. Global Science.** Health diplomacy provides a framework for expanded research on the disease burdens of the poorest populations, and on viable curative and preventive strategies. Health in resource-challenged areas of the world affects the health and economic viability of the rest of the world. Health diplomacy advocates for shared knowledge production, ensured participation of communities as stakeholders in research, and shared dissemination of results and therapeutic benefits. How can health professionals from the developing world be trained as participants in the globalization of medical science? Who should receive this training, how, and where should it be done?
- 9. Global Economics.** Health professionals usually have only vague notions of health economics. Financing for health development is usually left in the hands of economists, Ministries of Finance, or administrators who practice their professions with a sense of market forces, supply and demand pressures, and resource constraints. It is critically important that global health professionals be well-schooled in the standard economic practices such as cost-benefit analysis, cost-effectiveness analysis, and so on, but further, macro-economics and development economics are key fields of knowledge and application. Health professionals and health economists may not seem to speak the same language but they will be better able to agree on development objectives if they can jointly focus their disciplinary perspectives through a diplomatic lens.

- 10. Translational Research.** Advances in biomedical science should apply to both resource-rich and resource-poor environments. However, technological advances in science are not immediately transferable to all local contexts. Obstacles to distribution are often based on political and economic barriers. Other difficulties arise from the problems of translation itself. Health diplomacy training should consider research translation at two levels: 1) bench science to appropriate clinical interventions, and 2) technological development to local social, behavioral, and cultural contexts. In addition to asking how we might improve upon distribution of appropriate health and science technologies, we also ask: How do relationships between scientists from wealthy nations and local health professionals function in biomedical research? How do we ensure that the technological transfers from resource-rich to resource-poor locations are appropriate to local health needs? How can translational research to apply to the poorest populations be prioritized in the biomedical research institutions of the wealthy nations as global responsibilities?
- 11. Migration and Health.** According to the UN Population Division, there were 175 million migrants in 2000, more than double the total (79 million) in 1960, with more than 40 million migrants estimated in North America alone². Health diplomacy training will enable professionals dealing with migratory populations (whether due to economic forces, conflict, or expanded travel opportunities) to better understand and address the health needs of these persons. What particular diplomatic concerns are raised by addressing refugees of health disasters, AIDS orphans, torture survivors, and economic migrants?
- 12. Medical Tourism.** Increasingly high costs of health care, lack of specific services, and insurance barriers lead patients from many nations to seek medical and especially surgical care in other nations. What sorts of protections are in place to ensure that international medical care meets Good Medical Practice standards, and what impact does this influx of foreign payers have on local health care systems? This includes distribution assessments of both curative high technology care and basic public health care that can aid in decision-making among health care professionals committed to global health.
- 13. The Changing Environment of International Assistance.** What lessons might be learned from the history of missionary, colonial, and more contemporary international medical assistance that can inform today's global health environment? How has religion informed international assistance? How have new non-governmental entities changed the nature of international health assistance? As philanthropies continue to grow their financial capacity to invest in global health (sometimes surpassing state resources), and as states turn to private non-profit foundations to provide health resources, questions about the role of states and multinational and bilateral organizations in health emerge. What interdependencies are created between private philanthropies and state institutions, and how are priorities set by the donor NGOs? Do NGOs help or hinder nation-building efforts in developing countries?

Summary and Conclusions

In the paragraphs above, we have defined the content and potential areas for training in global health diplomacy. We can summarize the academic approaches to global health diplomacy as follows:

- Health Diplomacy as Social Responsibility (how medicine can perform when politics fail): This approach recognizes health aid as a means of improving relations between nations, regions, ethnic groups, and institutions. Health and scientific interactions can

serve as core diplomatic gestures to improve communication, reduce mutual or bilateral threats, and address health problems of mutual importance. Health diplomacy may reduce conflicts when politics fail. Creating donor-recipient relations that support sound outcomes and fairness in the application of health aid, however, is not always straightforward. Humanitarian and ethical principles must be at the heart of such interactions, but realpolitik will drive the end results.

- **Health Diplomacy with Cultural / Political Sensitivity:** This approach explores the changing face of science and research in global health, the growing global concerns about human and national security, and the importance of understanding the social, cultural, and political determinants of global health. This approach recognizes the shifts in international donor aid, the globalization of science and research and the disparities for research funding in developing countries, and the increasing recognition of biosecurity as a driving force for international cooperation in health.
- **Health Diplomacy as Political Negotiation:** This approach recognizes the need for policy-making for maximum impact on health and subsequently on economic and political stability. It is in the interest of all nations to recognize the value of global health as enlightened self-interest insofar as markets, economic development, the free movement of goods and people, and the reduction in costly wars or relief efforts depend on a stable global political environment.

Global Health Diplomacy is both a new and an old concept. It has been practiced in many forms in the past, not always with the hoped for positive results in health outcomes. Health diplomacy may be an alternative to other harsh diplomatic efforts practiced in the recent past, such as isolating rogue nations in hopes that this isolation will make them behave better. Usually, such isolation causes enormous adverse humanitarian effects that then require major international relief efforts. Could not a humanitarian, health-based interaction serve to diffuse hostilities engendered by isolation? This is not to say that health assistance only could supplant diplomatic negotiations, but rather that health development be consciously added to the mix of incentives offered to difficult Nations when trying to change their behavior. The basis for health diplomacy should, however, be non-political. Health is a humanitarian, global public good, and if investments in health can be made such that human resources, financial resources, and good will can be transferred to the highest areas of need with the highest regards for social, cultural, political, and ethical understanding of these areas, the world will be a better, healthier, and less antagonistic place. Incorporating training for Health Diplomacy and career development for health diplomats is a calling and a responsibility of academia, government, and the research enterprise.

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