

Interview



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Q1
In your impressive, nearly four-decade career in global health, particularly with the World Health Organization (WHO), how have strategies and attitudes about global health responsibilities changed over that time?

In that period, we moved from an understanding of international health to global health, which implied the strong global interconnectedness between countries and peoples with regard to health. It was also a period when many more actors and influential people became part of the global health universe next to the WHO, new organisations like the Joint United Nations Programme on HIV/AIDS (UNAIDS); the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI); many more civil society organisations; and of course, the Bill and Melinda Gates Foundation. The range of private sector actors has increased as well, think of the tech industry. Attitudes and approaches have changed over time, from a strong commitment to primary healthcare, to strong vertical programmes, back to strong universal health coverage commitments, for example. There are many more strategic alliances, also owing to the Sustainable Development Goals (SDG), and now of course, following the coronavirus disease

(COVID-19) pandemic, the need to work together across countries and sectors is becoming more evident by the day. Global health is global, it is not a new word for health in developing countries according to a development aid model.

Q2
You have been involved in both health promotion directly to the public, and in developing health policy and governance programmes. Which strategy, in your experience, has had a greater impact on global health?

I don't think you can juxtapose this. People are social actors, and they need to be able to have the knowledge to take care of themselves and their loved ones, but this does not happen in a vacuum. That's why the strategy of 'empowerment' has been so important: what other mechanisms need to be in place so that people's voice on their health needs is heard. But the best health promotion programme cannot replace decisive action on the social determinants of health; it is inequality, poverty, and racism that kills. This means that strategies to address health inequalities are critical; this also includes action on the commercial determinants of health, for example, protecting children from marketing harmful to their health. The role of the state is always central: think of taxes on unhealthy goods,

labelling of unhealthy products, and regulations for safe working conditions and housing. The list is long. At the global level, this can mean looking at trade strategies or agreeing to international rules, such as the Framework Convention on Tobacco Control.

Q3
You have championed the ‘Health in All Policies’ strategy at the WHO. In this time of economic difficulty and environmental urgency, how can this role for health action be emphasised in governmental and organisational planning?

There is no better time. Health is central to all other ‘crisis’ agendas; COVID-19 shows us there can be no health security without social security, and no economic development without a healthy population. Economic and health development go hand in hand. Global Health has long argued this. The same is true for the environmental agenda; think of the local level where a policy to increase cycling will lead to more exercise as well as better air quality. Now in ‘corona times’ it can also be safer to cycle than to sit in public transport. We speak of cobenefits: by working together, other sectors benefit as does health. Any Health in All Policies agenda must work from that premise.

Q4
You now work as an independent global health advisor. After moving away from organisations such as the WHO, do you think that the political side of these organisations helps or hinders their efforts to improve global health?

Health is always political and it would be negligent for any health strategy to neglect that. Politicians have interests, as do other groups in society, and countries have national interests, which they bring to the international level. That is why it needs international bodies, such as the WHO, where these interests are negotiated; we have called this health diplomacy. What we are seeing right now is different from that: it is using health as a political tool in a geopolitical stand-off. This type of politicisation is something we have not had before, and it is incredibly dangerous for the health of the world. On the other hand, a large majority of countries has agreed to come together to jointly address the development, production, and distribution of COVID-19 vaccines. Within about 4 months, the world has created a new mechanism of sharing — not perfect, but quite extraordinary.

Q5
There seems to have been an evolution of your strategies to improve global health over your career: from community health promotion, to health literacy and individual education, to health diplomacy and policy approaches. Has your opinion of effective strategies changed over time, or do you think there is a role for each of these strategies (community promotion, individual education, political policy) in global health?

No, my opinion has not changed; for me this is consistent, and just always draws on different aspects of the Ottawa Charter that I helped launch and develop. The five areas of the Charter,

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policy, environments, community action, personal skills, and changing the healthcare system, are interdependent. Over time, new dimensions and movements have emerged to address these different aspects. Take the fact that the Ottawa Charter was the first WHO document to mention the need for ecological changes; I wrote one of the first texts that brought health promotion in line with the ecological challenges (Good Planets are Hard to Find). For me personally as a political scientist, looking more closely at global governance became important following my experiences at the WHO.

Q6 Your education background is not in healthcare. Do you think more clinical professionals should be involved in global health, or is an understanding of economics and politics valuable in the global domain?

Global Health is clearly totally interdisciplinary, but not all understandings of global health programmes follow this dictum, to their detriment. We have seen in the Ebola Crisis how anthropologists were added as an afterthought, and now with COVID-19, the role of political and economic analysis is suddenly considered relevant in order to explain the very different responses by countries and political leaders. Right now, you cannot understand global health without an analysis of geopolitics. People's health behaviour, their health beliefs, and their motivations in turn cannot be understood without the social sciences; you cannot develop a strategy to address opposition to vaccines without behavioural science.

Q7 In recent years, you have leveraged your reputation to advocate for increased female representation in global health. What has been your experience of barriers to women's representation in global health decision-making, and how do you think it can be improved in the future?

I was one of the first senior women in the WHO and I was already a feminist when I joined the organisation. I had been active in the women's health movement in Germany. Experiences were tough but I made my way; I am a resilient person. But I also had very supportive mentors; actually, all of them men. When I joined the WHO, I was different along various counts: nonmedical,

young, and female, so it was also not always clear what people were reacting to. A few years ago, it really hit me that I was still one of the few senior women in global health, so I decided to do something about it. Luckily, this was picked up by many younger women and came at the right time, when a wave of dissatisfaction about being excluded from global health leadership had started to emerge. This is great, and it now also includes a strong call for voices from the Global South and structurally excluded groups in the Global North; it's all about decolonising global health. That's what the young people's movements are doing now, and there are already many fantastic next-generation global health professionals and researchers changing the field.

Q8 You developed the settings-based approach to health promotion in the WHO, creating initiatives for healthy cities, healthy schools, and healthy workplaces. Do you think that this settings focus is the best strategy for addressing the COVID-19 pandemic, or is it more effective to focus on the behaviour and education of individuals?

Again, this is not 'either or': all good public health is a mix of strategies that support one another. The settings approach built on the understanding of creating supportive and enabling environments for people's health behaviours. This also applies during COVID-19; we have the combination of things people need to do (social distancing, hand washing, wearing masks) and the settings related to it, as expressed in the Japanese strategy of avoiding the three C's: closed spaces, crowded places, and close-contact settings. You then need people in control of the settings to act responsibly (in restaurants for example), and in some cases you need regulations like wearing masks in public transport. It is always the combination of strategies that wins out through reinforcement.

Q9 Global health inequalities seem heavily entrenched in economic and geographic situations, including in the current COVID-19 pandemic. Can there be any global strategy for addressing COVID-19 that could be successful across these different contexts, or should the principles of global health be applied in more targeted ways?



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There exists a global strategy to address inequalities: the SDG clearly set the direction of “leave no one behind.” There are many ways to do this in various contexts; right now, we are experiencing a rebound in global poverty and increased difficulties for disadvantaged groups. In many cases, women are again paying the price. What we realise is that we need to invest billions, if not trillions, in global health, and that the usual financing through development aid is totally insufficient. Last years’ United Nations General Assembly (UNGA) called for significant investments in universal health coverage; they have been complemented by the investments that are required for pandemic preparedness. Still, these billions are ‘small’ amounts compared with the trillions of losses experienced economically during the pandemic. We need a rethink of global health financing, and a significant boost in the financing of the WHO if we are to move forward.

In your role as Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva, Switzerland, what do you hope your students will achieve in their global health careers?

After 10 years, I have passed on the leadership of the Global Health centre to two excellent codirectors. I remain chair of the advisory group and still work within the centre. My goal has always been that students understand the political dimensions of global health; that’s why

founding this centre at a Graduate Institute of International and Development Studies was so critical. Politics is about power. We need these students coming from very different disciplines learning to work together during their studies and bringing this analytical mind-frame to wherever they might go on to work.

Your editorial article ‘Health promotion 4.0’ published last year provided a fascinating look at parallels between the foundational attitudes of the Ottawa Charter (1986) and the recent Montreal Declaration for a Responsible Development of Artificial Intelligence (2018). How do you see the role of global health advocates changing as digital landscapes alter health, wellbeing, health data, and medical interventions?

This, in my view, is one of the most important areas of health promotion in the next 10 years. I don’t think the role of global health advocates changes; it’s the areas of advocacy that they need to address that are changing. The digital transformation of our world, of health systems, and of health and well-being is progressing at a rapid speed. It is essential that health promotion on the one hand sees the potential and the opportunities, but at the same time analyses carefully what the dangers could be, in my article I call it “the dark side.” I hope that the next WHO global conference on health promotion in 2021 will take these issues forward and outline approaches based on equity, human rights, and empowerment.