Politics and Governance
2025 • Volume 13 • Article 9114
https://doi.org/10.17645/pag.9114

cogitatio

ARTICLE

Open Access Journal

Learning to Lead at the WHO: Thailand's Global Health Diplomacy at the World Health Assembly

Joseph Harris [1] and Suriwan Thaiprayoon [2]

[1] Department of Sociology, Boston University, USA
[2] Division of Global Health, Ministry of Public Health, Thailand

Correspondence: Joseph Harris (josephh@bu.edu)

Submitted: 31 July 2024 **Accepted:** 9 January 2025 **Published:** 10 March 2025

Issue: This article is part of the issue "Novel Perspectives on Status in Global Politics" edited by Miriam Prys-Hansen (German Institute for Global and Area Studies), Ali Bilgic (Loughborough University), and Clemens Hoffmann (University of Stirling), fully open access at https://doi.org/10.17645/pag.i392

Abstract

One of the largest delegations at the governing body of the WHO—the World Health Assembly (WHA)—hails from a small country in Southeast Asia. While Thailand's presence through the 1990s was small, its delegation and engagement at annual WHA meetings grew substantially from the early 2000s through the 2010s, coming to rival that of the US. Thailand has tabled important resolutions at the WHA. The country serves on the WHO's Executive Board; officials serve on politically sensitive drafting committees and have played important roles in high-profile resolutions. How and why did Thailand invest in building a presence at the WHO and what dividends have accrued from it? This article explores the development and growth of Thailand's unique approach to global health diplomacy at the WHO, based on nearly 70 interviews with officials from the government, international organizations, non-governmental organizations, and academics. The country's growing prominence at the WHA was part of a deliberate investment strategy that required sustained political and economic resources which allowed the country to play credible leadership roles and begin to take a proactive (rather than reactive) approach to set the global health agenda, attaining status through its growing "epistemic power" in the process.

Keywords

development; diplomacy; epistemic power; global health; Global South; hierarchy; international order; international relations; status; world order

1. Introduction

One important marker of the resource disparities between rich and poor nations in global health negotiations has long been the size and capacity of a country's representation at politically significant

international forums. While US and European countries regularly bring large delegations and significant technical expertise to international global health forums, poor nations have tended to send fewer delegates with less training and experience, owing in part to the financial resources required to send them and a lack of existing technical capacity to draw on. To address this resource gap and the discrepancies in "epistemic power," at times international non-governmental organizations (NGOs)—from the South Center to Knowledge Ecology International to OXFAM and Doctors without Borders—as well as progressive academics and representatives from the secretariat of the WHO, have supported delegations from Low-and-Middle-Income Countries (LMICs). However, to the extent that poorer countries have participated in such meetings, it remains that delegations have often been small and symbolic, frequently reserved for senior officials and diplomats.

As the site for negotiations on agreements that are critical to public health and human life, including the Framework Convention on Tobacco Control, amendments to the International Health Regulations, and a pandemic treaty, the WHA—the governing body of the WHO—looms large as a critically important norm-setting forum where glaring resource disparities are often on display during negotiations. How do resource-constrained nations on the global periphery ascend global status hierarchies, underpinned by substantial differences in resource endowments, in technical areas that are critical to public health and human life? How do they grow the size of their global health delegations and achieve reputations for technical acumen on global health issues that countries in the Global North and Global South both look to in global health?

At a time when growing attention is paid to "decolonizing" global health and development, this article explores an important case of positive deviation related to capacity building in international relations, tracing how a small country from Southeast Asia—Thailand—came to have one of the largest and most active delegations at the WHA. In the process, stories of Thailand's health policy successes have been regularly used by the WHO on issues that range from introducing the concept of universal health coverage in the 2010 *World Health Report* (with the search term "Thai" coming up 40 times, and by contrast, Rwanda, Ghana, and Mexico—also with notable universal coverage policies—being referenced just 23, 16, and 16 times respectively) and in pointing to lessons the world can learn from its Covid-19 response (WHO, 2020a) alongside countries at much higher levels of economic development, including the Republic of Korea and New Zealand.

Development scholars have for a long time been concerned with improving humans' *material* conditions, measured through the reduction in poverty, growth of GDP per capita, and movement up global production chains, as captured in the studies of the Asian Tiger economies forty years ago. However, considerably less attention has been paid to important *symbolic* aspects of development that are underpinned by material conditions, or the process that would lead a country to invest so heavily in representation at a forum like the WHA.

2. Capacity Building for Niche Diplomacy by Middle Powers

Diplomacy has been defined as the "core site of global governance and world politics" (Wiseman, 2015, p. 327), involving the "social construction of international political reality," reproducing, and sometimes remolding, "social institutions, rules, and norms" (Ambrosetti, 2012, p. 66). With the international order in mind, Keohane (1969, p. 296) writes that "middle powers" are states "whose leaders consider [they] cannot

act alone effectively, but may be able to have a systemic impact in a small group or through an international institution." Canada and Australia are classic examples of middle powers in the Global North, although the term has been extended to include such middle powers in the Global South, such as Brazil, Mexico, Argentina, Turkey, South Africa, and Malaysia (see Cooper, 1997; also van der Westhuizen, 1998 on South Africa).

Within the field of diplomatic studies, there has been tension between theoretically driven studies that emphasize the patterned behavior of diplomatic practice and focus on the everyday routines of what diplomats "do" and "say," and those that privilege history and individual diplomats' intimate knowledge, with the former offering greater conceptual contributions and the latter greater empirical ones (Wiseman, 2015). A subset of important work concerned with the practice of governance and diplomacy has explored the dynamics of governance within international organizations, including the International Monetary Fund (Babb & Chorev, 2016; Kentikelenis & Seabrooke, 2017; Kentikelenis & Stubbs, 2023), the World Trade Organization (Conti, 2010; Hopewell, 2016), the World Bank (Goldman, 2005), the WHO (Chorev, 2012; Irwin & Smith, 2019; Renganathan, 2012), and the UN Security Council (Wiseman, 2015).

A second body of work has examined how middle powers pursue advantage in international relations through "niche diplomacy," which involves "concentrating resources in specific areas best able to generate returns worth having, rather than trying to cover the field" (Evans & Grant, 1991 as cited in Cooper et al., 1993, pp. 25–26). One important aspect of these returns is the accrual of status and recent research has examined the pursuit of status by rising powers (Gómez, 2017; Jagtiani et al., 2022; Mukherjee, 2022). Research on middle powers in areas such as security politics has shown how skillful diplomacy and reputational competence can lead countries to punch above their weight in particular domains of international affairs (Adler-Nissen & Pouliot, 2014).

Although the term "medical diplomacy" dates back to 1978, the use of the term "global health diplomacy" (GHD) did not really become mainstream until after 2000, with the US not announcing the formation of a government global health strategy until 2009 (Kaiser Family Foundation, 2012; see also Fidler, 2008; Kickbusch et al., 2007; Smith et al., 2010). The export of Cuban doctors abroad has frequently been discussed as a longstanding case of bilateral health diplomacy (Feinsilver, 2010; Kirk, 2015). Covid-19 has led to greater attention to the symbolic capital countries have sought to gain through health diplomacy (Feldman et al., 2024; Suzuki & Yang, 2023). And, indeed, the Foreign Policy and Global Health (FPGH) Initiative, launched in 2006 by seven countries—of which Thailand is a part—illustrates "niche diplomacy" prioritizing health as a foreign policy tool that has helped promote the image of Thailand (Pibulsonggram et al., 2007). However, with few exceptions (Elbe et al., 2023; Harris, 2017; Helleiner, 2014; Thaiprayoon & Smith, 2015; Wenham, 2018), research on the specific role that peripheral nations have played in forums of global health governance where diplomacy is practiced has been a less visible focus of the literature.

Work on health diplomacy at the WHO has illuminated the organization's "dual role" as a venue where consensus is reached over contentious issues, as well as the secretariat's role as the primary provider of expertise, interpretation, and technical support in negotiations over global health conventions, codes, guidelines, and standards (Renganathan, 2012). Research has demonstrated how the secretariat has maintained a measure of autonomy, despite pressures from member states and the Executive Board (Chorev, 2012). While in many cases norms are agreed on before the WHA even meets, rituals limit who may take

part in the exercise of power, and both informal settings and closed-door resolution drafting committees can impact the shape, content, and wording of resolutions (Irwin & Smith, 2019).

This article extends the literature by analyzing what a resource-constrained country on the global periphery (Thailand) has done to build the capacity to engage in global health diplomacy at the WHA and the wider implications for middle-income countries. Building on and adapting earlier work (Adler & Bernstein, 2004; Shiffman, 2014; Sondarjee, 2023), our analysis centers on the process by which Thailand expanded its "epistemic power" (which we define as authoritative knowledge based on competing claims to technical skills, structural positions, and normative concerns) and improved its position and status relative to larger economic powers through capacity building at the WHA.

Amid a lack of substantial economic capital, we argue that Thailand's growing ability to set the global health agenda rested not just on homegrown technical knowledge wrought from the country's considerable domestic health policy achievements (in areas such as Universal Health Coverage and tobacco control), but more pointedly, on the deliberate expansion of its delegations' growing size and command of a range of technical issues as well as intimate knowledge of and involvement in rituals at the WHA from which it had previously been excluded. The country's experience institutionalizing a place for itself in the inner sanctum of the governing body of the WHO (through engagement in resolution-making and creation of a large "Thai Village" well known to the Secretariat and other delegations)—as an LMIC from the Global South frequently representing Global South interests through a participatory approach—improved the country's structural position within the global health hierarchy and provided a more powerful normative basis for articulating policy measures aimed at enhancing social justice globally, all the while providing the country with a measure of symbolic capital that granted it recognition, prestige, influence, and status.

In training its focus on the process of capacity building in global health diplomacy, this article takes a sociological approach that thinks about these issues through the lens of nation branding (Bandelj & Wherry, 2011; Farber & Taylor, 2023; Rivera, 2011) and impression management in relation to others (Aronczyk, 2013; Goffman, 1959). Work in this vein points to the need to draw on qualitative approaches and get inside individual cases to understand better how nations on the periphery are connected to global nodes of power—where international reputations are cemented—and the politics and processes by which countries improve their positions in global status hierarchies. This is, however, the first account that examines how a peripheral nation improved its status at the WHA, as well as the first history of Thailand's GHD at the WHA in the English language, extending existing work in Thai (Sursattayawong et al., 2022).

3. Methods

This article is part of a larger project on Thailand's contributions to global health. This account is informed by in-depth interviews with approximately 70 different key informants with intimate knowledge of Thailand's public health policies, including its work at the WHA, attendance at a number of relevant international, national, and regional meetings (including the WHA), archival research in Thailand and Geneva, and existing literature in Thai and English. Informants included Thai policymakers responsible for the policies, bureaucrats, academics, and officials from other relevant national governments, international organizations, and non-governmental organizations who knew Thai policies. Participant observation was used to corroborate information given by interview respondents, as Bueger (2014, p. 399) suggests it is the most

appropriate method to derive insight from diplomatic practice. The project received human subjects' approval from the Boston University Institutional Review Board and Thailand's Ministry of Public Health (MOPH) Institutional Review Board. To offer this novel contribution of the rise of a peripheral nation at the WHA, data were analyzed alongside existing research to build a chronological narrative of the events. Substantive issues that came up repeatedly in interviews were coded by theme and subsequently featured in the analysis. Our interview protocol is included in the Supplementary File (Appendix A).

4. Developing GHD Capacity at a Time When the Term Did Not Exist

Approaching the turn of the millennium, Thailand's delegation to the WHA numbered just three people (interview, former director, Bureau of International Health [BIH], September 11, 2017), a size not uncommon for resource-constrained developing countries. The delegation attending the Executive Board meetings in 1999 found the experience frustrating, with many English-language documents to go over and insufficient staff to manage the job effectively (interview, former director, BIH, September 11, 2017; interview, professor, Mahidol University Global Health (MUGH), September 6, 2017). Even though the country's Ministry of Foreign Affairs (MFA) and MOPH were involved in political representation, the relationship between the two at the WHA could not be described as purposive or strategic. As first-time attendees, those attending likened the experience to being thrown into a pool without instructions on how to swim (interview, professor, MUGH, September 6, 2017).

By comparison, US and European delegations brought much more sizable and impressive delegations to the WHA, which they used to draft resolutions and guidance. In particular, the US delegation left an impression on some delegates. They did their "homework" on issues and staked out particular positions (interview, former director, BIH, September 11, 2017). One delegate long involved in Thailand's GHD work recalled:

> We see the example…the US. They come with a full team. They're well prepared. They have a big file…for each agenda….They have studied very thoroughly. The way they negotiate is very smart….We learn of the capacity that they have, and we need to build some capacity to be well prepared like that….They even have [a] legal advisor [on] the team….They know when they have problems…who to call. But for Thai people, they just only have two people, and they have to discuss among themselves, use their own knowledge or experience to fight. It's kind of like street fighting—[a] street fighter, fight[ing] with the world…heavyweight champion. (interview, professor, MUGH, September 6, 2017)

Thailand's experience at the WHA was emblematic of its experiences at other international forums (Patcharanarumol, 2006). The former BIH director remarked: "We think that in many international forums developed countries are much stronger than developing countries. We've [seen] many times [that] the resolutions and agreements from these international meetings…only benefit developed countries" and that sometimes they "force developing countries to follow" them (interview, former director, BIH, September 11, 2017). While the delegation at that time had a modest amount of technical knowledge, it was small, and though its normative concerns were rooted in justice, its structural position within the global health hierarchy was relatively weak. Although it was a member state afforded participation in the assembly, it did not play an active or central role in important aspects of the WHA.

The experience left an impression on the new deputy permanent secretary overseeing global health issues (interview, former director, BIH, September 11, 2017), who was in a unique position to change the status quo as the official holding responsibility for that portfolio and one of the highest-ranking officials in the ministry, just below the politically appointed minister and deputy minister. Those involved realized Thai delegates needed more capacity or "otherwise it would be…a suffering experience":

> The ones who represent Thailand or any developing country cannot fight for [policies] for the benefit of developing countries…the balance of power during that time is not equal, so we decided that we have to do something. (interview, professor, MUGH, September 6, 2017)

One official who went on to lead the BIH later recounted: "We have limitations on language skills. We cannot fight one-[on]-one. That's why we need an army. We need to fight together…to negotiate with developed countries" (interview, former director, BIH, September 11, 2017).

Even when it was only able to mobilize a handful of people in a delegation, Thailand had already developed a reputation for standing up to great powers, such as the US, as an LMIC on health issues at international forums, fighting against the US government at the General Agreements on Trade and Tariffs, the precursor to the World Trade Organization (Chitanondh, 2000; Supawongse, 2007). Whereas richer Asian nations, such as Japan and the Republic of Korea, had responded to US pressure to open their tobacco markets to US companies by simply doing what the US wanted in the late 1980s and early 1990s, Thailand fought against the US government and won important new precedents that benefited all developing countries, including the right to ban tobacco advertising and ability to tax foreign tobacco companies to prevent tobacco use (these measures also provided some level of protection for Thailand's domestic tobacco industry, which now faced international competition).

Thailand's status as an LMIC informed its approach to the WHA. As the former deputy permanent secretary remarked: "Thailand is a developing country, so once you put developing countries priority as the first priority, then you put Thailand as the first priority at the same time" (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017). But even as the country rose the ranks of the socio-economic ladder to become an upper-middle-income-country, the operating principle remained much the same:

> If our principle is to try to reduce the gap between the rich and the poor, between developing and developed countries…Thailand is in the middle. This is our position and principle…we try to negotiate to not just benefit Thailand…we always know what is beneficial to developing countries and global health is also benefitting…our country as well. (interview, former director, BIH, September 11, 2017)

Thailand's GHD efforts therefore involved "using [multisectoral] participation to work on global health issues, using diplomacy as a way to push or collaborate on global health, on global issues, on global collaboration" (interview, program manager, International Trade and Health Programme, International Health Policy Program [IHPP], October 4, 2017).

5. Formation of the International Health Scholars Program

To address Thailand's staffing and capacity gap and prepare officials to attend international forums with appropriate knowledge and the capacity to intervene at meetings, in 1998 with the support of funding from the MOPH BIH, the ministry founded the International Health Scholars program within BIH, which served as the program's secretariat (interview, program manager, International Trade and Health Programme, IHPP, October 4, 2017). While a senior official involved in the program had suggested that Thailand needed "to prepare for political things and…request WHO support for technical things" (interview, WHO official, February 12, 2018, personal views), advocating for the country's interests in global health involved both the political and the technical realms. And the WHO provided support for this capacity-building program (interview, program manager, International Trade and Health Programme, IHPP, October 4, 2017). This support from the WHO for the IHS program, aimed at building development in the short- to medium-term, complemented longer-term WHO funding support for Thai health officials to study Master's and doctoral degrees in health-related technical areas abroad, particularly in Europe.

From the beginning, those founding the program put out calls for applications to a wide range of stakeholders beyond the MOPH who were interested in international health issues (interview, professor, MUGH, September 6, 2017). The program ultimately included people from universities, other ministries (including foreign affairs), the National Economic and Social Development Board, parastatal health organizations (like the Thai Health Promotion Foundation and the National Health Commission Office), the private sector, civil society, and participants whose work related to issues on the agenda (interview, program manager, International Trade and Health Programme, IHPP, October 4, 2017; interview, professor, MUGH, September 6, 2017).

While the need for multi-stakeholder involvement accounted for some of the rationale for casting a wide net, another reason was that investments in a person's training did not always pay off. The director of BIH recalled: "Sometimes you invest in 10 people, you can only get one or two that [are] interested in global health. But [we have] to invest to get some extraordinary people" (interview, former director, BIH, September 11, 2017).

Once selected, the program put International Health Scholars through a rigorous experiential learning program that relied heavily on the scholars' own initiative. One regular delegate involved in the program explained:

> The process of training is…practical. No teaching, no lecture, but…activities every month. Each month, the [International Health] Scholar has to volunteer to propose the agenda to discuss during that month. They have to prepare document[s], to conduct [the] meeting, [do] brainstorming, whatever agenda that they propose. So it's the IH Scholars who [have] to do the job, and they have the secretary to support the team, to send out invitation letter[s], arrange [the] venue, and coffee breaks, but that's it. The content has to come from the scholar themselves. (interview, professor, MUGH, September 6, 2017)

While this part of the capacity-building program took place in Thailand, the even more important part took place at the WHA itself. There, scholars were each responsible for six to seven agendas and were required to intervene on every agenda item on behalf of Thailand as a kind of "on the job training" that was akin to (once again) being thrown into the deep end of a pool (interview, professor, MUGH, September 6, 2017). In addition to delivering reports on the past day's work at daily briefings of the Thai delegation that began each morning

at 7:30 am (interview, professor, MUGH, September 6, 2017, interview, WHO official, February 12, 2018, personal views), scholars were also expected to expand their social networks and social capital by collecting 10 business cards per day. A key official involved in training noted that "it [was] quite a struggle for the first few years" and that initially there was:

> No coach, no mentor, so you have to work on your own. [There were] sleepless nights….It's a struggle. I went to the negotiation table myself, no other people…come to help, just myself and the whole room. You have to fight for this. Don't give up. This is the only instruction, whatever you can do by yourself….I cannot say that I'm good at writing intervention[s]. [One of the senior people involved] will always be the one who [corrects it and] get[s] the final say. But I am the second batch and still survive[d]! (interview, professor, MUGH, September 6, 2017)

Those involved in the program's first few years read reports and draft resolutions but were pressed to be more critical of them and to "spot room for improvement" in order to "change [and] amend" them (interview, WHO official, February 12, 2018, personal views). Those who performed well at the WHA were invited back to represent Thailand again the following year and to build Thailand's ranks over the next five years, although a third batch of scholars was never formally recruited through the same channels (interview, professor, MUGH, September 6, 2017). Dividends from recruiting were not immediate: at the 2004 meeting, there were just two to three international health scholars present at the WHA (interview, WHO official, February 12, 2018, personal views). Over time, as the program grew and developed, Thai officials recognized the importance of mentoring and took a more systematic approach to it. Three people worked on each agenda together—a novice, a coach, and a mentor—and before delivering an intervention, the novice had to first get clearance from their mentor (interview, professor, MUGH, September 6, 2017). This approach dramatically expanded both the depth and breadth of Thailand's technical capacity, while altering the country's structural position from passive participant to active role player on issues of normative importance to countries in the Global South.

Senior mentors involved in Thailand's GHD effort had their own opportunities for training. Beginning in the mid-2000s, Thailand began to chair drafting committees at the WHA (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017), which were challenging in that chairs had to find and bring together different interests and craft sensitive language that actors who were sometimes far apart could get behind. Some 10 years on, it had chaired between 10 and 20 of them (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017). Previously excluded from such important roles, the appointment of Thai delegates as drafting committee chairmen by the secretariat was a recognition of both the country's growing technical reputation in health policy, but also of its delegates' growing awareness of ritual WHA rules, procedures, and capacity to manage powerful actors in closed-door settings. This represented another important step up in the country's structural position within the global health community that provided greater opportunities for an LMIC from the Global South that had created a space for itself at the table to advance normative concerns rooted in justice that were aligned with its identity.

While the WHA was the central focus of training efforts, what trainees learned there was intended to be of use in other forums. One senior trainer remarked: "We use[d the] WHA as the forum for us to learn, but they can apply that when they attend other forum as well" (interview, professor, MUGH, September 6, 2017). Early on, some of the greatest criticism Thailand received for allowing junior people to represent the country came from

senior Thai officials who questioned the value of having such junior people do this but who gradually came to see this made Thailand's interventions stronger (interview, professor, MUGH, September 6, 2017).

The program received around 100 applications in its second year from which 30 to 40 were selected into the IHS program, with a total number selected over the two first years numbering under 100 scholars (interview, professor, MUGH, September 6, 2017). After two years, funding from the BIH ran out (interview, professor, MUGH, September 6, 2017), and, in 2001, the program moved from its location in the formal MOPH bureaucracy at BIH to the newly formed autonomous parastatal organization devoted to solving health-related policy problems through research, the IHPP, of which the deputy permanent secretary was the first director (interview, program manager, International Trade and Health Programme, IHPP, October 4, 2017).

The move to IHPP provided the program more flexibility to go about its operations as opposed to the rigid rules and hierarchy of the formal bureaucracy. Another partnership with MUGH that focused on training for the WHA provided another important foundation for sustaining active involvement and training, even when some high-level officials were not active or linked to political parties not invested in or supportive of Thailand's strong presence at the WHO (interview, former inspector general, MOPH, September 13) and when senior personnel with differing priorities changed (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017).

The IHS program formally ended in 2006/2007 after the funding ceased, but the process that began continued with an even wider group of people involved (interview, program manager, International Trade and Health Programme, IHPP, October 4, 2017). More recently, ownership of the program moved back to BIH because "it's supposed to be that way," as one trainer reflected, but trainers "still keep these [other outlets at IHPP and MUGH though they are] less active" but can be activated when necessary (interview, professor, MUGH, September 6, 2017).

6. Turning the Training Focus Abroad

In 2009, one of the senior officials from MUGH attended an international meeting where she presented her work on capacity building in global health in Thailand (interview, professor, MUGH, September 6, 2017). The Rockefeller Foundation's managing director happened to be in attendance and requested that the team submit a proposal to Rockefeller for funding support (interview, professor, MUGH, September 6, 2017).

While the IHS program originally focused on building the capacity of Thai delegation officials to engage in GHD, gradually the acumen Thailand gained led those overseeing the program to direct capacity-building efforts at other countries interested in building their own GHD skills, primarily in the region. As a former director of BIH noted:

> During the [past] decade, we observed countries like Japan, China, and Vietnam…learned from Thailand when Thailand allowed young staff to join these international meetings. In the past few years, we observed Japan now has policies to strengthen the global health capacity of its staff, China as well. (interview, former director, BIH, September 11, 2017)

However, "other developing countries have limited resources" (interview, former director, BIH, September 11, 2017), pointing to a need for capacity development elsewhere and an opportunity for Thailand to offer it.

The proposal the Thai team submitted to Rockefeller, which was granted, requested three years of funding for three types of workshops: national workshops, regional workshops, and training of the trainer workshops (interview, professor, MUGH, September 6, 2017). The relationship with MFA deepened with MFA representatives invited to serve in some sessions and participate in organizing training of the trainers' workshops (interview, professor, MUGH, September 6, 2017). From that point on, a true curriculum was developed. Thai GHD efforts became much more systematic and began to focus more on the "mass production" of scholars (interview, professor, MUGH, September 6, 2017; interview, WHO official, February 12, 2018, personal views).

The learning objectives of the program centered on helping participants gain knowledge about global health and global health diplomacy, including soft skills essential for negotiations and participating in international meetings, especially for the WHA; sharing Thailand's experience in driving global health agendas to the global level; and supporting capacity building of officials from developing countries in global health (IHPP et al., 2023; EnLight, 2024). This allowed for both further refinement of technical skills but also improvement in countries' structural position through greater capacity to navigate WHA rules and rituals.

The curriculum includes training on how to draft interventions, role-playing exercises in negotiations, lectures by diplomats, and discussion of geopolitics and health. The country's achievements in universal health coverage are featured as a way in which the country leads by example. Instructors are homegrown and have hands-on experience tabling global health agendas and chairing drafting groups at the WHA. Course materials are drawn from real-world experience that is featured alongside other relevant information, drawn principally from WHO sources, using the WHA as a focal point throughout the course. Post-course evaluations have found participant satisfaction with the course, in part because it is based on real-life experiences and is not too theoretical (EnLight, 2024; IHPP et al., 2023).

Thailand's desire to build the capacity of other countries was by no means a purely selfless endeavor. As one graduate of the IHS program who played an important role in further training observed regarding international proceedings:

> We cannot work alone. When we go to attend this World Health Assembly, we can see that to [take up] some of the very controversial issues, we need to have a team. When you fight with the giant and you are very small, you have to have a team…the more active [that] developing countries are, for us, we think the better the policy will be balanced….We build capacity [for] the benefit of public, not private, not the country, not Thailand, not because we want them to support Thailand on particular issues. But for the benefit of all of us…it is not only the fight for Thailand, but for developing countries in general. (interview, professor, MUGH, September 6, 2017)

Having a "team" to fight those battles therefore meant building the capacity of other nations as well. In the context of the Southeast Asia Region, where interactions have not traditionally been confrontational (interview, former inspector general, MOPH, September 13), all countries are "developing countries," and there is no major power (interview, advisor to the Office of the Permanent Secretary on Global Health,

MOPH, December 4, 2017), that meant teaching other nations how to develop and write agendas on behalf of the whole region, rather than just their own country (interview, professor, MUGH, September 6, 2017). In improving country capacity regionally, this work enhanced the technical skills, bargaining power, and structural position of all of the countries that Thailand worked with and increased Thailand's stature as a growing leader in the global health community that could be relied on to take forward collective interests in a participatory fashion.

Initially, five-day GHD training workshops involving participants from other countries took place in Thailand and involved participants from China, Bangladesh, Sri Lanka, Vietnam, Nepal, and Indonesia, but over time included three-day workshops that took place in other countries (interview, professor, MUGH, September 6, 2017). Thailand brought its experience in the field of global health over the past 30 to 40 years (interview, former director, BIH, September 11, 2017). These trainings helped junior and mid-level officials new to the WHA "know the process and [rules] of the meeting…how to react and respond, how to draft [a] resolution…how to negotiate with other countries" (interview, former inspector general, MOPH, September 13). Following the conclusion of Rockefeller funding, Thailand's GHD program transitioned to domestic funding sources, drawing on support from organizations that were friendly to the cause but who stood apart from the state, including the Thai Health Promotion Foundation (an autonomous parastatal) and MUGH (interview, professor, MUGH, September 6, 2017). Workshops held in other countries pay the Thais for their work and cover hotel and air travel, some using government money and some drawing on WHO support (interview, professor, MUGH, September 6, 2017). While the training has mainly focused on helping to build capacity in the Southeast Asia Region, this has been in part due to the similar cultural backgrounds and perspectives (interview, former director, BIH, September 11, 2017). However, a trainer long involved with the efforts noted that "we are open for any countries who are interested in building capacity" (interview, professor, MUGH, September 6, 2017).

As the size of Thailand's own delegation grew to regularly number 40, 50, and 60 delegates, the cost of sending people grew concomitantly for expensive air tickets and lodging in Geneva, so the departments participating were asked to draw on their own budgets to finance the trips (interview, former director, BIH, September 11, 2017; interview, professor, MUGH, September 6, 2017). A Strategic Framework for Global Health Diplomacy was developed in 2011 but was not approved by the cabinet, and a military coup took place in 2014, disrupting the approval process. The coup concentrated power in military hands and led to the creation of a new constitution that aimed to preserve conservative interests and representation in parliament. While these political changes to the country's leadership and core institutions had a significant impact on Thai society, including important domestic policies, the country's civil service continued its work largely as before. A new process of creating a Strategic Framework began in the National Health Assembly in 2015, which ultimately tasked MOPH and MFA with putting one together (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017). The founder of the program drafted the strategy in cooperation with partners, with BIH as the focal point (interview, official, MFA, September 6, 2017).

This framework provided a clearer basis for a strategic approach to working together (interview, former Deputy Permanent Secretary for Foreign Affairs, January 31, 2018). It was ultimately discussed at the country's National Health Assembly and approved by the Cabinet in 2016, which set up a National Global Health Committee in 2016 (interview, advisor to the Office of the Permanent Secretary on Global Health,

MOPH, December 4, 2017; interview, official, MFA, September 6, 2017). Although MFA and MOPH had worked together on health issues previously, and Thailand's involvement in the FPGH Initiative—led by Norway—dates back to 2006, 2016 might therefore be considered the year when Thailand's government at the highest levels began to appreciate the value and power of Thailand's reputation in global health and how it might be directed to issues of foreign affairs. Subsequently, the BIH was rebranded as the Division on Global Health in 2017. However, as a practical matter, few outcomes practically resulted from the Strategic Framework, as improved cooperation and coordination between MOPH and MFA actually took place *before* the plan was implemented through the workshops that had already been taking place (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017). In other words, the framework simply put to paper what had already been happening vis-à-vis the close working relationship that had been created. This close relationship could be seen, for example, in a ministerial event chaired by MOPH on the sidelines of the 2017 WHA, which took up the theme of addressing the health of the most vulnerable for an inclusive society set by MFA (2022).

7. Impact

How has Thailand's growing epistemic power been used? As mentioned previously, Thailand has already made its mark in a number of policy areas critical to public health and human life from HIV prevention and tobacco control to universal health coverage and essential medicine. It has likewise provided technical assistance to countries on a range of these and other issues, both through WHO forums and other ones, as well as bilaterally. Thailand's investment in building a strong cadre of representation at the WHA built on its existing brand in public health and helped cement the country's status as a provider of expertise, rather than as a receiver of aid, having made the transition to upper-middle-income country. One official remarked:

> [Thailand was] among the first [Low-and-Middle-Income Countries] to do UHC, so [it's] a luxury toy for the masses…[it] can show the world that [it's] strong enough to be a little donor…[it doesn't] receive any overseas development funding anymore…instead [it] wants to donate…[the MFA] wants to focus on CLMV countries [Cambodia, Laos, Myanmar, Vietnam]. (interview, WHO official, February 12, 2018, personal views)

As one official from the MFA noted: "We realized we had a lot to share…[and] a lot to learn" (interview, official, MFA, September 6, 2017). MFA was very supportive of Thailand's capacity and development efforts, having seen the work of people in the program at the WHA (interview, professor, MUGH, September 6, 2017). However, they saw the value of it as being not just about capacity development but rather being about something "much wider than just capacity building" (interview, official, MFA, September 6, 2017), as what Thailand contributed at the WHA also created a good image for Thailand—a small developing country with a crucial role in shaping the global health direction. Whereas 25 years ago, only mid-level MFA staffers would join the delegation in Geneva, today the ambassador himself tries to contribute a lot and send a team (interview, WHO official, February 12, 2018, personal views).

Global health advocacy can also lead to improved health outcomes, with Thailand assisting on particular issues, like rabies, that help people in countries like Myanmar and Nigeria (interview, WHO official, February 12, 2018, personal views). For some, being passive on issues holds a stigma; being proactive is better (interview, former inspector general, MOPH, September 13). For Thailand, it has taken "time to move from someone

who [is] used to sitting at the table…waiting for people to come…to become someone who reached out to other people, asked for their opinion [and] asked for their support" (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017). Holding a mantle of leadership on critical development issues, by contrast, offered the country important reputational currency and status. The former BIH director remarked that Thailand's work at the global level "can show countries…that when you have [a] strong public health system, you can be resilient to global health trends" (interview, former director, BIH, September 11, 2017). Moreover, it provides an opportunity to "encourage many developing countries…to move forward and achieve universal coverage," while also showing that "Thailand [is] a good example for migrant health development" (interview, former director, BIH, September 11, 2017) as both documented and non-documented migrants are covered by the Migrant Health Insurance Scheme. The benefit package of this scheme includes health screening for communicable diseases and essential medical treatment (Fung, 2024).

In some cases, specific interventions Thailand has made at the WHA have followed some of the landmark health policies it put in place at the national level. From 2006 to 2008, Thailand declared compulsory licensing on a number of essential medicines, including a first and second-line drug for treating HIV/AIDS, cancer drugs, and heart disease medication (Wibulpolprasert et al., 2011). Around the same time, Thailand played two important roles at the global level related to these issues. First, Thailand made important contributions to commission work for the Global Strategy and Action Plan on intellectual property (interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017), benefiting both the country and developing countries with limited expertise on those issues more generally. Second, this work led to a WHA Resolution 60.30 on public health, innovation, and intellectual property in 2007/2008 (interview, former WHO director of public health, innovation, and intellectual property, November 29, 2017), which required the WHO to be available to provide technical assistance for member state requests related to public health and trade. Thailand was subsequently the first country to draw on WHO technical assistance in support of its compulsory licensing policy in the face of US pressure. While the mission report to Thailand formally stated that it "is not intended to make any evaluation or assessment of the use of TRIPS flexibilities in Thailand" (WHO, 2008, p. 2), the report's findings amounted to validation of the country's actions by the international organization responsible for health and was "widely interpreted to confirm the validity of government use licenses and their compliance with the TRIPS Agreement" at a time when international pressure remained significant (Wibulpolprasert et al., 2011).

Thailand also played an important role in shaping the Global Strategy to Reduce Harmful Use of Alcohol (interview, WHO official, February 12, 2018, personal views). In this case, Thai delegates worked closely with the member states from the WHO Southeast Asia Region in voicing concerns about the impact of free trade agreements on alcohol consumption and the limited budget of the WHO to address the harmful use of alcohol in the Southeast Asia Region (Patcharanarumol et al., 2013). Working in collaboration with partners in the region, Thailand applied pressure by speaking with "a regional One Voice" and drafted the resolution, using evidence that linked WHO budget allocations to the global burden of disease (Patcharanarumol et al., 2013, p. 1093). On behalf of the 11 member states of the region, Thailand proposed to amend the draft resolution, and the WHA accepted Thailand's proposal, and the draft resolution was amended per Thailand's intervention on behalf of the Southeast Asia Region (Patcharanarumol et al., 2013). While the achievement of consensus on a global strategy that takes on such entrenched and powerful corporate interests can be considered a success, national implementation remains a challenge, with insufficient resources, coordination, and interference by the alcohol industry being cited as barriers to action (Jernigan & Trangenstein, 2020).

By some estimates, the country achieved just five percent of what it proposed (in part because the proposals were too extreme and they did not actively lobby for them; interview, advisor to the Office of the Permanent Secretary on Global Health, MOPH, December 4, 2017). However, this impact should be read in light of the absence of any strategy existing before the Thai intervention.

The WHO Global Code of Practice on the International Recruitment of Health Personnel (Agenda Item 11.5 at WHA63) is one other important example (co-founder, IHPP, December 13, 2017; also see Patcharanarumol et al., 2013). The code aimed to establish voluntary principles for the ethical international recruitment of health workers, provide guidance for countries, and promote cooperation on health worker migration issues, calling for countries to consider the needs of both source and destination countries and the rights of migrant health workers (Patcharanarumol et al., 2013). As the content was particularly contentious, a drafting group was proposed to finalize the code, which would need to be led by a highly competent official who was able to balance the need to compromise with the need to be assertive (Patcharanarumol et al., 2013). The WHO director-general asked Thailand to chair the drafting group, and the drafting group was convened six times over four days, reaching a consensus at 3 am on Thursday, May 20, 2020, after nearly 28 hours of negotiation (Patcharanarumol et al., 2013). Thai training in global health diplomacy made this achievement possible, with the experience itself providing further capacity building for the members of Thailand's team who were involved. A recent review of the code's effectiveness found that the code itself had a wider impact on policy concerning health workforce strengthening at country, regional, and global levels (WHO, 2020b).

The country's involvement in this initiative is built on its long-standing domestic efforts to protect and maintain a strong publicly led universal healthcare system (Harris & Libardi Maia, 2022). In other cases, resolutions put in place at the WHA have been used to protect the country's public health system (interview, WHO official, February 12, 2018, personal views) and to press for reforms at home. Pointing to the credibility of international actors and showing support from other countries that stand behind the country's policy positions can solve "a lot of internal issues" (interview, WHO official, February 12, 2018, personal views). In all three of these extended examples (intellectual property initiatives around access to medicine, the global alcohol strategy, and the international health personnel code), having a strong command of the evidence related to the issues, being able to communicate effectively, build consensus, and being able to draw out shared interests and develop trust with stakeholders proved critical to success.

While capacity has certainly developed, it remains that Thailand does not have a systematic process for determining which issues the country will take up, support, or endorse, or any criteria by which it decides; Thais and international partners both play a role in the agenda-setting process (interview, former inspector general, MOPH, September 13). Rather than *always* being proactive, the process takes place somewhat opportunistically. For example, the Global Alcohol Policy Alliance approached Thailand about taking the lead on alcohol-related issues and driving the agenda because they "know that we have the capacity. It's not easy to table an agenda and move a resolution unless you have the capacity and you know the process, you know the mechanisms" (interview, former inspector general, MOPH, September 13, 2017). The growing relationship between MFA and MOPH should however make a more deliberate and proactive agenda possible over time. Thailand's capacity development has enabled the country to be able to go toe-to-toe with other well-established institutions, like the US Center for Disease Control (interview, WHO official, February 12, 2018, personal views).

Central to this process was the forging of relationships with development partners and international NGOs, like the Rockefeller Foundation, the WHO, the South Centre, and the Drugs for Neglected Diseases Initiative (interview, former inspector general, MOPH, September 13). One official long involved in Thailand's efforts says:

> Our strength is the continuity of people who get involved, and they accumulate, the network, that intellectual capacity…[Someone wants] to communicate with [a] WHO department. They want to communicate with member state[s]. It's easy for us. This is [our] social capital. (interview, former inspector general, MOPH, September 13, 2017)

Ultimately, the cost of attending the WHA en masse has involved a lot of expensive airplane tickets and hotels (interview, official, MFA, September 6, 2017). But in some cases, costs are kept down through communal living and cooking arrangements. The eating of Thai food is one hallmark of life at the "Thai Village"—the name given to the place where the large Thai delegation meets at the WHA. After her appointment as director-general of the WHO, one of Margaret Chan's first stops was to the Thai Village to share a celebratory helping of some traditional Thai "som-tam" (spicy papaya salad) with Thai friends and colleagues—a highly visible mark of the way in which Thailand's improved status and position within the WHA has been institutionalized through its efforts.

The symbolic capital, wrought from experience and the country's unique approach to GHD, has set it apart from other countries, particularly those at similar levels of socioeconomic development. One MFA official involved in Thailand's GHD efforts stated:

> Thailand is considered one of the bigger players in global health….When I took up this portfolio a few years back, I was surprised that when people wanted to push anything through they ran [things by] me first, [asking] "What's Thailand's take on this?" because they wanted just to see what our reaction would be….When the Europeans wanted to push anything through they give us a call saying, "What do you think of this?….I think we are unique…we send about 50 delegates to the Health Assembly each year. (interview, official, MFA, September 6, 2017)

Even larger powers, like China, have followed the Thai model, participating in training and growing their WHA delegations to nearly 80 delegates (interview, former director, BIH, September 11, 2017). Japan has likewise become much more active. Thai officials involved in GHD sometimes contrast their own approach, or model, of training in GHD with that of the Geneva Institute in Switzerland, which they see as more theoretical, while the Thai approach is "more practical, [involving] real experience and practice, rather than using theories" (interview, former director, BIH, September 11, 2017). However, these are not the only important axes of comparison between the two programs: the program at the Graduate Institute generally focuses on high-level (as opposed to junior or mid-level) officials as a five-day executive training program, has a high price tag, and has historically featured few instructors from LMICs. This contrast highlights the distinctive normative basis for Thailand's claims to epistemic power, as a country in the Global South with a homegrown GHD training program focused on the Global South that has received funding and recognition from Global North sources, including the WHO and Rockefeller Foundation.

8. Conclusion

Thailand's capacity for GHD has been gradually developed over the past 25 years in response to national and international forces, with support from WHO and development partners. Capacity has been developed and strengthened through a unique approach, using the WHA as a GHD learning platform. This has involved building a large delegation with an interest in advancing the benefit of developing countries; increasing Thailand's involvement at the WHA by contributing to a number of WHA resolutions on key global health agendas; and supporting resolutions that advance national health policy and global health, including intellectual property initiatives around access to medicine, the global alcohol strategy, and the international health personnel code. GHD capacity building in Thailand has led to capacity development in GHD in other LMICs, and Thai GHD has also helped to foster new initiatives that extend beyond the WHA, such as ASEAN+3 UHC Network and new efforts within the region to speak with one voice (ASEAN One Voice) that has led the region to have more clout at international forums, including the WHA.

This case study offers important takeaways for other countries. First, the development of GHD capacity can be achieved as part of a deliberate investment strategy that requires sustained political and economic resources. Second, Thailand's strategy enabled the country to shift from taking a reactive approach to a proactive one that included playing significant leadership roles in setting the global health agenda, reaping public relations rewards from the positive image it built of Thailand as a leader in the realm of health policy. Third, the country's approach led to opportunities for the country to play a credible leadership role as a nation in the Global South responsible for some homegrown policy successes and to expand its network and influence through South-South cooperation, exposing some of the limitations of alternative, more theoretical approaches to learning global health diplomacy. Finally, while valuable, it is important to acknowledge the limitations of the data, including the perspectives represented. We offer some important caveats below, as well as suggestions for further research.

While some may count the growth in size and activity of Thailand's delegation and the inclusion of global health in Thailand's foreign policy so centrally as major policy successes, and ones that other countries should follow, some important caveats are worth noting that may limit the replicability of the Thai model. First, Thailand's rise in the region is in part due to the South-East Asia Region's architecture, as a region that contains no major power to block or compete with the country. Second, nearly all WHA resolutions countries fight over are symbolic and non-binding. Third, the WHA voting structure tends to favor developing countries (in contrast to the World Bank and International Monetary Fund where members' financial contributions loom large). Still, it remains that what Thailand has done has been novel and arguably important. However, this is because no other LMIC had really done it before, not because it was structurally impossible.

It is important to note that heightened visibility in public health can draw attention away from domestic issues that governments may wish to make less visible. Symbolic capital has been used for regimes in diplomacy and international relations, and "soft power" is an increasingly important focus of the current government's approach to rule. This suggests that outsiders might evaluate not only the country's heightened visibility in global health on its own but also how that capital is used. Additionally, consistent tracking of the downstream impact of resolutions Thailand has had a hand in developing at the WHA back home in Thailand could be stronger. For all the country's many successes in different public health domains, there are a number of areas where there is room for improvement, including breastfeeding, road safety, tuberculosis control, air quality,

tobacco regulation enforcement, and Covid-19 vaccine rollout (on the latter, see Harris, in press). Even so, Thailand's approach to GHD offers lessons for other resource-constrained nations seeking to ascend global status hierarchies.

Acknowledgments

The authors wish to acknowledge the thoughtful comments and feedback of the reviewers and editors, as well as participants at a panel at the Society for the Advancement of Socioeconomics Annual Meeting in 2024. While this constructive criticism certainly improved the manuscript, any errors or omissions are our own.

Funding

A Fulbright Scholarship provided funding support for Joseph Harris to travel to and conduct fieldwork in Thailand, based in the Ministry of Public Health's Division on Global Health.

Conflict of Interests

The authors declare no conflict of interests.

Supplementary Material

Supplementary material for this article is available online in the format provided by the authors (unedited).

References

Adler, E., & Bernstein, S. (2004). Knowledge in power: The epistemic construction of global governance. In M. Barnett & R. Duvall (Eds.), *Power in global governance* (pp. 294–318). Cambridge University Press.

Adler-Nissen, R., & Pouliot, V. (2014). Power in practice: Negotiating the international intervention in Libya. *European Journal of International Relations*, *20*(4), 889–911.

Ambrosetti, D. (2012). The diplomatic lead in the United Nations Security Council and local actors' violence. *African Security*, *5*(2), 63–87.

Aronczyk, M. (2013). *Branding the nation: The global business of national identity*. Oxford University Press.

Babb, S., & Chorev, N. (2016). International organizations: Loose and tight coupling in the development regime. *Studies in Comparative International Development*, *51*, 81–102.

Bandelj, N., & Wherry, F. F. (Eds.). (2011). *The cultural wealth of nations*. Stanford University Press.

Bueger, C. (2014). Pathways to practice: Praxiography and international politics. *European Political Science Review*, *6*(3), 383–406.

Chitanondh, H. (2000). *The passage of tobacco control laws: Thai david versus transnational tobacco goliaths*. Thailand Health Promotion Institute; National Health Foundation.

Chorev, N. (2012). *The World Health Organization between North and South*. Cornell University Press.

Conti, J. (2010). *Between law and diplomacy: The social contexts of disputing at the world trade organization*. Stanford University Press.

Cooper, A. F. (Ed.). (1997). *Niche diplomacy: Middle powers after the Cold War*. Springer.

Cooper, A. F., Higgott, R. A., & Nossal, K. R. (1993). *Relocating middle powers: Australia and Canada in a changing world order*. University of British Columbia Press.v

Elbe, S., Vorlíček, D., & Brenner, D. (2023). Rebels, vigilantes and mavericks: Heterodox actors in global health governance. *European Journal of International Relations*, *29*(4), 903–928.

EnLight. (2024). *Global health fellowship program (GHFP 2024)*. https://ghfpthailand.com

Farber, R., & Taylor, A. (2023). Global health diplomacy and commodified health care: Health tourism in Malaysia and Thailand. *Studies in Comparative International Development*, *58*(3), 484–510.

Feinsilver, J. (2010). Fifty years of Cuba's medical diplomacy: From idealism to pragmatism. *Cuban Studies*, *41*, 85–104.

Feldman, N., Lutmar, C., & Mandler, L. (2024). Masks down: Diplomacy and regime stability in the post-Covid-19 era. *Politics and Governance*, 12, Article 8646.

Fidler, D. P. (2008). Influenza virus samples, international law, and global health diplomacy. *Emerging Infectious Diseases*, *14*(1), 88–94.

Fung, S. (2024, October 29). Migrant health insurance scheme in Thailand. *Pacific Prime*. https://www.pacificprime.com/blog/migrant-health-insurance-scheme-in-thailand.html#: :text=Migrants%20register%20for%20the%20Migrant,premium%20paid%20by%20the%20workers

Goffman, E. (1959). *The presentation of self in everyday life*. Anchor.

Goldman, M. (2005). *Imperial nature: The World Bank and struggles for social justice in the age of globalization*. Yale University Press.

Gómez, E. J. (2017). *Geopolitics in health: Confronting obesity, AIDS, and tuberculosis in the emerging BRICS economies*. Johns Hopkins University Press.

Harris, J. (2017). Achieving access: Professional movements and the politics of health universalism. Cornell University Press.

Harris, J. (in press). Explaining the unexpected: How and why COVID-19 vaccination faltered in Thailand. In S. Greer, H. Jarman, E. King, & E. Massard (Eds.), *Vaccination politics: The comparative politics of COVID-19 vaccinations*. University of Michigan Press.

Harris, J., & Libardi Maia, J. (2022). Universal healthcare does not look the same everywhere: Divergent experiences with the private sector in Brazil and Thailand. *Global Public Health*, *17*(9), 1809–1826.

Helleiner, C. (2014). Introduction. Special section: Principles from the periphery: The neglected Southern sources of global norms. *Global Governance*, *20*(3), 359–360.

Hopewell, K. (2016). *Breaking the WTO: How emerging powers disrupted the neoliberal project*. Stanford University Press.

Irwin, R., & Smith, R. (2019). Rituals of global health: Negotiating the World Health Assembly. *Global Public Health*, *14*(2), 161–174.

Jagtiani, S., Hoffmann, C., Prys-Hansen, M., & Bilgic, A. (2022). *G20: The Global South's new status-seeking platform*? (Working paper GIGA Focus Global 7). German Institute for Global and Area Studies. https://doi.org/10.57671/gfgl-22072

Jernigan, D. H., & Trangenstein, P. J. (2020). What's next for WHO's global strategy to reduce the harmful use of alcohol? *Bulletin of the World Health Organization*, *98*(3), 222–223.

Kaiser Family Foundation. (2012). *Raising the profile of diplomacy in the U.S. global health response: A backgrounder on global health diplomacy*. https://www.kff.org/global-health-policy/issue-brief/raising-the-profile-of-diplomacy-in-the

Kentikelenis, A., & Seabrooke, L. (2017).The politics of world polity: Script-writing in international organizations. *American Sociological Review*, *82*(5), 1065–1092.

Kentikelenis, A., & Stubbs, T. (2023). *A thousand cuts: Social protection in the age of austerity*. Oxford University Press.

Keohane, R. (1969). Lilliputians' dilemmas: Small states in international politics. *International Organization*, *23*(2), 291–310.

Kickbusch, I., Novotny, T. E., Drager, N., Silberschmidt, G., & Alcazar, S. (2007). Global health diplomacy: Training across disciplines. *Bulletin of the World Health Organization*, *85*(12), 971–973.

Kirk, J. M. (2015). *Healthcare without borders: Understanding Cuban medical internationalism*. University Press of Florida.

Ministry of Foreign Affairs. (2022). *Thailand hosted FPGH health ministerial breakfast on the margins of the World Health Assembly*. https://www.mfa.go.th/en/content/5d5bd0c615e39c30600213d3?cate=5d5bcb4e15e39c306000683e

Mukherjee, R. (2022). *Ascending order: Rising powers and the politics of status in international institutions*. Cambridge University Press.

Patcharanarumol, W. (2006). What and how in the 58th World Health Assembly (in Thai). *Journal of Health Science*, *15*, 649–657.

Patcharanarumol, W., Sawaengdee, K., Thamarangsi, T., Kasemsup, V., Riewpaiboon, W., Srisookwatana, O., Muanpawong, S., Chuenkongkaew, W., & Watananirun, K. (2013). Was the World Health Assembly 63 a real success? (in Thai). *Journal of Health Science*, *22*, 1091–1098.

Pibulsonggram, N., Amorim, C., Douste-Blazy, P., Wirayuda, H., Støre, J. G., & Gadio, C. T. (2007). Oslo ministerial declaration—Global health: A pressing foreign policy issue of our time. *Lancet*, *369*(9570), 1373–1378.

Renganathan, E. (2012). The World Health Organization as a key venue for global health diplomacy. In I. Kickbusch, G. Lister, M. Told, & N. Drager (Eds.), *Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora And Cases* (pp. 173–185). Springer.

Rivera, L. A. (2011). Impression management of stigmatized nations. In N. Bandelj & F. F. Wherry (Eds.), *The cultural wealth of nations* (pp. 114–138). Stanford University Press.

Shiffman, J. (2014). Knowledge, moral claims and the exercise of power in global health. *International Journal of Health Policy and Management*, *3*(6), 297–299.

Smith, R., Fidler, D., & Lee, K. (2010). *Global health diplomacy research*. WHO Network on Global Health Diplomacy.

Sondarjee, M. (2023). Coloniality of epistemic power in international practices: NGO inclusion in world bank policymaking. *Global Society*, *38*(3), 328–350.

Supawongse, C. (2007). *Two decades of tobacco-consumption control in Thailand: Success and challenges*. Tobacco Control Research and Knowledge Management Center.

Sursattayawong, O., Supaaksorn, B., Panichkriangkrai, W., Pachanee, C., & Patcharanarumol, W. (2022). The first online World Health Assembly in history (in Thai). *Journal of Health Systems Research*,*16*(2), 266–279.

Suzuki, M., & Yang, S. (2023). Political economy of vaccine diplomacy: Explaining varying strategies of China, India, and Russia's Covid-19 vaccine diplomacy. *Review of International Political Economy*, *30*(3), 865–890.

Thaiprayoon, S., & Smith, R. (2015). Capacity building for global health diplomacy: Thailand's experience of trade and health. *Health Policy and Planning*, *30*(9), 1118–1128.

van der Westhuizen, J. (1998). South Africa's emergence as a middle power. *Third World Quarterly*, *19*(3), 435–456.

Wenham, C. (2018). Regionalizing health security: Thailand's leadership ambitions in mainland Southeast Asian disease control. *Contemporary Southeast Asia*, *40*(1), 126–151.

Wibulpolprasert, S., Chokevivat, V., Oh, C., & Yamabhai, I. (2011). Government use licenses in Thailand: The power of evidence, civil movement and political leadership. *Globalization and Health*, *7*, 1–8.

Wiseman, G. (2015). Diplomatic practices at the United Nations. *Cooperation and Conflict*, *50*(3), 316–333.

World Health Organization. (2008). *Improving access to medicines in Thailand: The use of TRIPS flexibilities*.

World Health Organization. (2020a, September 16). *Sharing COVID-19 experiences: The Thailand response* [Video]. Youtube. https://www.youtube.com/watch?v=MnxO48joRZQ&t=1s

World Health Organization. (2020b). *Report of the WHO Expert Advisory Group on the relevance and effectiveness of the WHO Global Code of Practice on the international recruitment of health personnel*. https://www.who.int/publications/m/item/2020-eag-code-report

About the Authors

Joseph Harris is an associate professor of sociology at Boston University. He conducts comparative historical research at the intersection of sociology, political science, and global health. He is author of *Achieving Access: Professional Movements and the Politics of Health Universalism* and serves as vice chair of the International Studies Association's Global Health Section, deputy editor at the *Journal of Health and Social Behavior*, and host of the Global Health Politics Podcast.

Suriwan Thaiprayoon is a deputy director of the Global Health Division, Ministry of Public Health, Thailand. She oversees bilateral and regional health cooperation and is a key contributor to the development of the Global Health Action Plan 2021–2027. She also represented Thailand in various regional and global governing body meetings, including WHO Executive Board meetings and the World Health Assembly. She was a technical assistant to the Thai Health Minister during 2014–2015.