

# Concepts in and perspectives on global health diplomacy

## Interim Working paper

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In the Regional Network for Equity in  
Health in East and Southern Africa  
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This working paper has been developed to draw input from those working in the field on African approaches to and perspectives in health diplomacy. It is being circulated to critical thinkers, diplomatic, official, civil society, technical and other actors and forums on the continent for their input on the discussion points and a revised version integrating and acknowledging these inputs will be prepared in the second half of 2013.

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## Executive Summary

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) is implementing a three year policy research programme to address selected challenges to health and strengthening health systems within processes of global health diplomacy (GHD). In the June 2012 inception workshop for the programme, delegates called for a paper that explains the concepts and emergence of global health diplomacy, the different approaches being taken in GHD, including African approaches.

Health has been brought into foreign policy processes for several centuries, as a *goal* of foreign policy; a *tool* of foreign policy, to secure economic or security interests of states and an intended outcome in the collective negotiation of competing interests. Yet the concept of GHD is an emergent one, with diverse meanings ascribed to the terms used and without a shared definition. There are also debates about whether it is in the best interest of public health to raise health as a global foreign policy issue, given the very different premises, norms and goals of foreign policy and health. Diplomacy primarily emerges from and is framed by security issues. It initially and largely responds to public health as containment of risk. What then are the possibilities of raising health as a goal rather than a tool of foreign policy? What are the risks of raising health goals within foreign policy platforms?

Given the de facto rise in health diplomacy, this paper explores these questions, to inform debate and dialogue in Africa on raising health within global diplomacy. We briefly present the roots and emergence of GHD, and the debates on raising public health within global diplomacy. We outline how the concepts of and approaches to GHD differ across countries and regions. We explore the perspectives that have informed diplomacy in Africa, and ask what this means for African engagement in GHD, and for public health in Africa.

At various points in this paper we raise questions on what implications the developments described have for health diplomacy in Africa. Given the limitations of documented evidence on African approaches or analysis of health diplomacy from an African lens, it is difficult to draw conclusions. We thus raise questions that we hope will provoke dialogue, debate and response. We ask how the liberation ethic, unity and developmental foreign policy as key features that have informed African diplomacy are crafted for the 21st century and used for health? How do strong commitments to sovereignty, non interference and self determination that are central to nation building relate to concepts of shared risk, shared responsibility and human rights that are positioning health as a sustained and structuring driver in global diplomacy?

The paper describes the emergence of new diplomatic forces in health and new alliances across countries, including collaboration across emergent economies in the South. It also highlights the need for continued regional collaboration and integration as a foundation for such interactions, particularly given the role of African unity as a principle in global engagement.

This first draft is an inception working paper based on public domain documents that we accessed to raise questions and discussion points to invite reflection and response from critical thinkers and actors on and from the continent. Our primary question is to ask "Are there African approaches to health diplomacy, and in our current global context, what approaches will advance health and human dignity in Africa?"

The questions we ask are summarised overleaf.

We will integrate the insights and views from this feedback and produce a second revision of the paper in the second half of 2013. We hope that the paper will continue to encourage reflection, dialogue and debate.

In summary:

*In relation to the emergence and history of health diplomacy, we ask:*

How has the history of African countries affected or shaped diverse African country perspectives on (health) diplomacy?

It is argued that there is a shift in GHD, in the thinking about and positioning of human security, in addressing health as a human right and in making common vulnerability, shared risk, and shared responsibility a basis for collaboration across borders, with new avenues of influence and actors. How have these trends been experienced (or not) in Africa? Do they represent a shift in the hierarchy of interests or power in global diplomacy? What implications do they have for advancing health in Africa?

*In relation to raising health in global diplomacy, we ask:*

Given current contestations with regards to GHD as a concept, the different goals and frames used, and the asymmetrical power relations in global processes, is it in the best interest of Africans for achieving health goals to raise health as a foreign policy issue? Is health a priority in African foreign policy?

In what contexts or on what issues is it beneficial for Africa to raise health as a foreign policy issue?

*In relation to different perspectives on and approaches to global health diplomacy, we ask:*

How have African countries (differently) experienced and engaged with the diverse diplomatic paradigms that exist?

What positive potential and risks does the alliance of emerging economies (BRICS, IBSA) hold for African negotiations at global level on health? How far is south–south diplomacy addressing the economic, social, and environmental development and justice concerns in African countries? Are these interactions strengthening African capacities and control in addressing health and its determinants? What model and goals of diplomacy are being advanced by African countries through South–South co-operation?

*And in relation to perspectives on and approaches to GHD in Africa, we ask:*

What (diverse) diplomacy paradigms and approaches have African countries used to advance interests and engage the asymmetries in power that affect negotiations on health goals? Can African countries have leverage in GHD when using development paradigms shaped by others?

What have been the benefits and costs of unity as a key element of African diplomacy on health?

How is the liberation ethic being crafted for the 21st century? What foreign policy perspectives will take forward in African countries the unfinished processes of nation building, decolonization, democracy and human dignity necessary for health?

Do principles of non-interference and sovereignty limit the possibilities of addressing shared risk, and shared responsibility as a basis for global collaboration on health?

What perspective in health diplomacy is needed to advance health in Africa? What transformation should be (and is) taking place domestically within African countries to more effectively advance this perspective?

We invite you to send your thoughts, comments, materials and examples on these questions and on African interests and approaches to health diplomacy to [admin@equinetafrica.org](mailto:admin@equinetafrica.org)

## Introduction:

EQUINET, with support from IDRC Canada and in association with the ECSA Health Community is implementing a three year policy research programme to address selected challenges to health and strengthening health systems within processes of global health diplomacy (GHD). In the June 2012 inception workshop for the programme, delegates noted that making decisions on health policy demands negotiation across a wide range of actors and processes, beyond countries, beyond health, and beyond state actors. Health outcomes within countries are increasingly influenced by determinants that lie in global processes, such as through trade and resource flows; risks with cross border effect; rules affecting the sharing of information, knowledge, technology and biodiversity or global frameworks of rights and norms.

Diplomacy is a foreign policy process through which actors negotiate their interests in political interactions. It has been described as an instrument in pursuit of power, survival and self-interest, with collective action an outcome only when interests converge (Gagnon 2012). Foreign policy seeks to ensure a nation's security from external threats; to contribute to a country's economic power and prosperity by promoting international trade and investment; to support order and stability in countries and regions important to a nation's security and economic interests and to promote and protect human dignity (rights and assistance) (Fidler 2005).

Health has been brought into foreign policy processes for several centuries, as described in the next section. Health has been a *goal* of foreign policy (as in the negotiation of global responses to treatment rights for people living with HIV); a *tool* of foreign policy, to secure economic or security interests of states (such as in building legitimacy and alliances or in the management of cross border risks) and an intended *outcome* in the collective negotiation of competing interests (as in the negotiation of agreements on recruitment and migration of health workers).

A rising profile of global health concerns and actors, and of global negotiations on health issues has led to the emergence of global health diplomacy (GHD) as a concept. There does not, however, appear to be a consensus definition of GHD, nor of the terms used in GHD, like "global health", "health diplomacy", "global public goods" and "global health governance". Lee and Smith (2011) in a review of emerging understandings of GHD defined it as "*negotiations involving traditional and new diplomatic processes aimed at reaching formal and informal consensus on global health concerns*". It appears, however, that the concept of GHD is an emergent one, with diverse meanings ascribed to the terms used and without a shared definition. Is a globally shared definition possible or desirable at present? A later section in this paper outlines the diverse paradigms and goals that are being applied in GHD from different countries and regions, reflecting in part their political histories and their experience and interests in relation to globalization. A shift in the balance of power in the late nineteenth century, the wartime importance of Asian politics in the 1940s, the creation of the United Nations (UN), the onset of the Cold War and the geopolitical reconfiguration of the international state system with the rise of Brazil, Russia, India, China and South Africa (BRICS) have challenged how diplomatic practice is carried out (Kennedy 1992, Van Straelen 1993, Macro 2005).

There are also debates about whether it is in the best interest of public health to raise health as a global foreign policy issue, given the very different premises, norms and goals of foreign policy and health. Diplomacy primarily emerges from and is framed by security issues. It initially and largely responds to public health as containment of risk.

When is health being raised as a goal rather than a tool of foreign policy?  
In what contexts is it beneficial to raise health as a tool or goal of *foreign* policy, considering that it is every country's responsibility to ensure the health of its population?

Given the de facto rise in health diplomacy, this paper seeks to explore these questions, to inform strategic thinking and debate in Africa on raising health within global diplomacy.

We briefly present the roots and emergence of GHD, and the debates on raising public health within global diplomacy.

We outline how the concepts of and approaches to GHD differ across countries and regions. We explore the perspectives that have informed diplomacy in Africa, and ask what this means for African engagement in GHD, and for public health in Africa.

As we have written the paper it is clear that much relevant perspective and experience is not documented, especially from Africa. So this first draft is an inception working paper, based on a review of literature, in which we raise questions and discussion points for reflection and response from critical thinkers and actors on and from the continent.

We will integrate the insights and views from this feedback and produce a second revision of the paper in the second half of 2013. We hope that the paper will continue to encourage reflection, dialogue and debate.

## **The emergence of global health diplomacy**

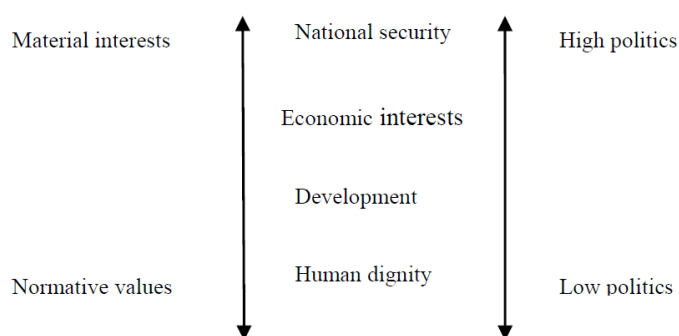
### ***Controlling health threats to national security and economic power...***

The Black Death, a pandemic of bubonic plague, was one of the most devastating pandemics in human history, peaking in Europe between 1348 and 1350. It is thought to have spread west from China or central Asia on merchant ships. It is estimated to have killed 30% of the population of China and 30 to 60 percent of Europe's population. It catalysed major attempts on the part of political authorities to control the movement of infected travellers and ships, with Venice and Milan preventing ships from infected regions from entering their ports, and the Republic of Ragusa isolating travellers suspected of carrying the plague for 40 days. (Zacher & Keefe 2008) These early efforts sought to balance commercial interests with public good. In 1851, the French government organized the first International Sanitary Conference, inviting a number of European powers to negotiate a convention that could deal with the arrival of diseases such as cholera and yellow fever in Europe through international trade. A total of 14 such conferences were held between 1851 and 1938, with an increasing number of countries participating (Zacher and Keefe 2008). A century of such international cooperation directed at preventing and controlling disease culminated in the establishment of the World Health Organization (WHO) and the International Sanitary Regulations in 1951.

The emergence of health in international diplomacy in Europe thus sought to contain the cross border health risks to continued trade (as much as the trade risks to health). This perspective has been a driving force for GHD and has been dominant in much of the past centuries of GHD in high income countries in Europe and North America. This goal is consistent with a primary function of foreign policy, that is ensuring national security, order and stability and contributing to economic power and prosperity (generally through trade and investment). These functions are often termed *high politics*.

Foreign policy can also serve functions of promoting and protecting human rights and dignity, termed *low politics* (See Figure 1). These latter functions in foreign policy have generally been deliberately separated from those of high politics, as they have been perceived to involve technical, scientific, non-political, and humanitarian endeavours disconnected from security and economic interests (Fidler 2005). Health has also been used for soft power, as a means of attraction that seeks to make a state look better in the eyes of others. It is a long term strategy to establish a state's reputation, including in alliance building. While it is not possible to make direct attributions between soft power and positions on other areas of interest, it is argued to have leverage value.

Figure 1: The hierarchy of foreign policy objectives



Fidler (2005)

### ***Including in the colonisation of Africa***

Health diplomacy in colonial Africa appeared to be largely driven by security and economic interests, with limited attention to matters of human dignity. Africa's colonization, mainly by European countries, sought to conquer and occupy, trade and draw benefit from resources from the continent, accompanied by evangelism with its populations. The early spread of western medicine in Africa addressed these colonial imperatives during the slave trade (1400s-1800s) and during the colonization and settlement of the continent. Developments in 'tropical medicine' were used to prevent illness and provide medical treatment for European explorers, missionaries, colonial administrators and their families. They were also used for soft power, to spread western religion and medical systems and weaken African religions, explanations and systems for managing health and disease, building links between churches, schools and hospitals and later theological training colleges and universities (Emeagwali 1998). Early public health laws and measures identified and controlled the spread of risks, segregated settlements and infected people to control the spread of disease to settler groups, with limited attention to ensuring healthy environments for local communities (Mokaila 2001). These actions indicated a primary concern with containing health risks to colonization and trade. Around this, medicine was used in evangelism to legitimize colonial states and de-legitimise African culture and systems, and services were provided to ensure the labour for economic activities. It can be argued that the earliest experience of health in foreign policy in the continent was thus one of economic, social and cultural domination.

Struggles for decolonisation in the 1900s thus linked improved health to issues of control over resources and power. The liberation ethic framed international engagement from movements within the continent in that period, and is further discussed later, particularly in terms of how far it continues to inform a self-determined diplomacy agenda from African countries. Within international discourse, the pursuit of decolonization was reframed as a pursuit of 'development', repositioning former colonial powers as 'developed' providers of aid and newly independent countries as 'developing' and recipients of aid, reframing the relations.

Was there significant difference between African countries in their experiences around how health was used in the colonial policy? Has this affected diplomacy positions today? How does the current (diverse forms of) health diplomacy from African countries reflect (or challenge) the history of the past century? How has this history affected the emergence of African perspectives in diplomacy?

Health issues have become matters of global foreign policy when cross border public health risks become sufficiently significant to call for new measures and interactions between states. Recent shocks such as the HIV and SARS pandemics challenged the

methods and instruments in the traditional architecture of global health governance and posed risks to economic and trade interests (Cooper, Kirton & Schrecker 2007). Revision of the International Health Regulations (IHR) (effected in 2005) was in large part precipitated and given momentum by the international spread of SARS and its impact on the global economy. The spread of HIV and its impact in Africa were perceived to raise national security interests, leading on 17 July 2000 to the first ever UN Security Council (SC) resolution on a health-related issue, (Resolution 1308) on *the responsibility of the Security Council in the maintenance of international peace and security: HIV/AIDS and international peacekeeping operations*.

Security has thus been a consistent motivator of foreign policy exchange. Indeed, only rarely in the 1800s and 1900s did things work in the other direction, with humanitarian and human dignity elements of foreign policy affecting security and economic interests. 'Vaccine diplomacy' is said to be one such area. In the early 1800s when England and France were at war, British doctor Edward Jenner's smallpox vaccine was widely used in both countries and Jenner was elected as a foreign member of the Institute of France. Jenner himself observed in a letter to the National Institute of France, "*The sciences are never at war.*" In the 1950s the US developed the polio vaccine with some collaboration with the Soviet Union, despite the cold war. In the 1990s, ceasefires were implemented in conflict situations to allow for immunisation campaigns (Hotez 2001). Nevertheless security interests generated sufficient mistrust in the 2011 World Health Assembly to delay debate on the destruction of the remaining smallpox stocks for a further 3 years (Hwenda and Larson 2011).

### ***Globalisation and a new health diplomacy in the 21<sup>st</sup> century?***

Alcazar (2008), analysing speeches to the UN General Assembly, observed that while economic themes were more commonly raised after the 1950s, a Cold War focus on the arms race inhibited the expression or consideration of social themes, for fear that they may be used in security debates.

The UN social agenda grew in the 1990s at the end of the 'cold war' through a rather rapid series of conferences on social themes, including: the UN Conference on Environment and Development (Rio de Janeiro, 1992), the World Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), the Fourth World Conference on Women (Beijing, 1995), the UN Conference on Human Settlements (Istanbul, 1996), and the World Food Summit (Rome, 1996) (Alcazar 2008). As the social themes gained profile they opened new domains of foreign policy debate.

In the early 2000s political attention to health in global policy became even more intense and sustained. With the end of the Cold War, the acceleration of globalization, the intensification of global interactions, the growth of social media and communication and the visibility of pandemic communicable diseases and rising non-communicable diseases came new forms of co-operation, political space, information resources and interactions with non state actors. Billions of additional funds were mobilised at the global level for health. The World Health Organization (WHO) passed new conventions, including the International Health Regulations 2005 (IHR) and the Framework Convention on Tobacco Control (FCTC), and a range of new global health initiatives and programmes were established (Fidler 2009).

The acceleration of globalization, transnational and speculative movement of capital, and the interconnectedness and inequality it has generated, have forced new thinking about national sovereignty and collective action. For example, the AIDS epidemic and global advocacy on the right to treatment, linking human rights and access to medicine, led to a paradigm shift in which global economies and trade policies could be subordinated to protecting the right to treatment and to the protection of public health. In March 2001, in the Council of the Agreement on Trade Related Aspects of Intellectual property Rights (TRIPS), the African Group, under the leadership of the Permanent Representative of



Zimbabwe to the UN in Geneva, Ambassador Boniface Chidyausiku, prepared a draft declaration on the TRIPS Agreement and Public Health, given the HIV pandemic that was ravaging the continent. The historical 2001 provisions of the Doha Declaration provided that the TRIPS Agreement “*can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health and, in particular, access to medicines for all.*” (Article 4) (WTO 2006).

The failure of the negotiations at the World Trade Organization (WTO) ministerial in Cancun in September 2003, the aftermath of 9/11 ‘war on terror’ and pre-emptive intervention rhetoric has been argued to have raised the intensity of both Northern security and Southern economic interests, leading to southern countries actively challenging positions and assumptions of leading northern states, and the emergence of ‘trilateralist’ diplomatic partnerships such as across South Africa, Brazil and India (Chris and Antonio 2005). Emerging economies are increasingly connected in economic and social affairs raising new dynamics in GHD (GHSI 2012).

It has thus been argued that GHD in this century is different to the forms it took in preceding centuries. Diplomatic spaces are being used to reach formal and informal consensus on emerging global health concerns that require collective action across states; with new and diverse actors involved in the negotiations. The end of the bipolar superpower competition for security and power is argued to have opened some space for countries to think differently about security, including in terms of human security, even while the central positioning of the ‘war on terror’ in the 2000s has kept national security at the core of global diplomacy (Lee and Smith 2009; Fidler 2009). While containing public health risks to security and trade have remained dominant concerns, GHD is argued to have now widened in scope, particularly given commitments to global health goals and health as a human right. The December 2012 adoption by the UN of a resolution on universal health coverage, with support from north and south, is argued to further reflect this trend (UN 2012).

New actors have driven change in global diplomacy. Economic actors such as Brazil, China, South Africa and India, each facing their own health challenges, have become more engaged and influential. South-South cooperation organised around exchange of experience and shared results and responsibilities has opened up new avenues of influence. Further, non-state actors (civil society but also private corporations and private foundations) have had a rising presence and in some cases a profound influence in global processes, including in major global health initiatives like the Global Fund for AIDS, TB and Malaria (GFATM). Many of the issues now being raised in global policy negotiations, such as maternal health, non communicable diseases, freedom from hunger, safe water, biodiversity and technology transfer fall beyond the scope of the usual pandemic threats.

Moving from disease risk to human security demands a more sustained, central attention to health in global processes. In 2007, the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, South Africa, Thailand, and Senegal announced the *Oslo Ministerial Declaration 2007* with the primary intent of sustaining attention on health as a foreign policy issue. This declaration was an agreement by ministers of foreign affairs from four regions of the world to make common vulnerability, shared risk, and shared responsibility a basis for collaboration across borders (rather than protection of “my borders”). While the agreement respected national sovereignty, it also raised the concern that a nation’s pursuit of pure self interest might undermine the responses necessary for the challenges of growing interdependence (Mogedal and Alverberg 2010).

Do these changes reflect a real new opportunity for health? Do they represent a shift in the hierarchy of interests or power in global diplomacy?

Some argue that the signs above suggest that this is the case, or that at least the opportunity exists for it.

What opportunities and risks do these trends pose for advancing health in Africa? Have health issues been overshadowed by other concerns in African foreign policy engagement? How far does the Oslo declaration and its framing of interdependence and shared responsibility resonate with the foreign policy concerns of African countries?

### ***A structuring role in foreign policy?... or not***

In a diplomatic environment where the economic and trade clusters were regarded as being at the centre of the diplomatic universe, circled by social issues, Alcazar (2008) argued in 2008 that an inversion had begun to take place, where the economic and trade clusters could not only work for their own strengthening, but for social ends, where health has a *structuring* role in foreign policy. He called this the 'Copernican shift'. (This was to be reminiscent of the scene changing correction made in the sixteenth century by Copernicus in proposing that the planets orbit the Sun, rather than the prior Ptolemaic view that the sun and planets orbit the earth).

If this is happening it is not without counteracting forces. The landmark 2001 4th WTO Ministerial Meeting that adopted the Doha declaration was intensely contested. Two documents were tabled for that meeting. Document IP/C/W/312, supported by low and middle income countries contained the position outlined earlier that nothing in the TRIPS Agreement shall prevent members from taking measures to protect public health. Document IP/C/W/313, supported by industrialized countries (who raised political pressure for withdrawal of the former) sought to avoid this. Although the Doha declaration was adopted by consensus and has since been recalled in various other documents and resolutions, it has also become the object of ongoing pressure for reversals through a raft of other diplomatic routes, including TRIPS plus provisions in bilateral economic partnership agreements, trade pressures, new provisions on counterfeit medicines and so on. It has required continued engagement for further amendments to practically realise the intended flexibilities and legal changes in both importing and exporting countries to make them implementable. For example, in 2006 Rwanda passed a law requiring generic medicines to be used for all treatment programmes when available, but also needed to take advantage of a follow up statute in Canada establishing an export system under compulsory licenses to import low cost generic fixed-dose combination anti-retrovirals from a Canadian generic manufacturing company (OSI and AMI 2008).

The experience of the Doha declaration indicates that advances are not events, but processes that grow from early engagement and that depend on sustained follow up, including through regional and international relations. Alcazar (2008) observes that Copernicus' 'Of the Rotation of Celestial Bodies' remained in the Index of forbidden works for 300 years until the second half of the nineteenth century, as an indication that transformation needs a long-term view.

What other significant gains and reversals in health diplomacy have African countries experienced that give insight to these trends?

The events of 2008 threaten a more severe Ptolemaic reversal, however (or an exposure of harsh reality). Ironically, at the same time as the 30 year anniversary of the 1978 Alma Ata declaration on Primary Health Care was being celebrated as a revival of global advocacy for PHC, including through the launch of the report of the Commission on Social Determinants of Health and the World Health Report on PHC ('now more than ever'), there was a confluence of climate, food, energy and economic / financial crises that re-directed political, economic, and intellectual capital away from global health. Fidler (2009) reminds us that similar events took place after Alma Ata in 1978, when the 1979 oil crisis, early 1980s global recession, debt and structural adjustment equally undermined comprehensive PHC as a global paradigm. Such 'crises' are not singular,

separate events, as the name sometimes implies. They emerge within processes that are sustained and inherent within the current neoliberal globalisation.

These 'crises' do generate significant health risks (such as vector-borne diseases; food insecurity; health burdens from unsafe or unaffordable energy sources; malnutrition), but their burdens are largely worse for poorest communities and countries. The social burdens have, however, been overshadowed by threats to security, such as destabilizing population movements, domestic and cross-border conflicts and erosion of government authority (Fidler 2009). Health has had limited profile in the negotiations and decisions on ecological, political, and economic responses. In contrast to the policy articulation of universal coverage, even mitigatory humanitarian and health service responses have been weakened as austerity responses have withdrawn public resources. Hence while the end of the Cold War, the end of bipolar power and the emergence of new actors and resources have opened new spaces for health, and new thinking on rights, vulnerability, shared risk, and shared responsibility, the trajectory of this change is still deeply contested and uncertain.

What has been the experience of global health diplomacy from an African lens- 'Copernican' shift or Ptolemaic reversal?  
What interests, opportunities and risks exist in Africa in giving health a more structuring role in foreign policy? How are different African regions and states engaging with this?

## **Debates on bringing health into global diplomacy**

As noted earlier, health has in the past been conceptualized as low politics, given its values based, technical and scientific nature. This raises questions about whether it has a place in a paradigm where power and strategic interests are paramount, where the measures used include military options. Health issues have only sporadically emerged in past diplomacy, and have not generally been central to states' pursuit of their material interests, power and security.

So what does the increasing profile of health in foreign policy imply? What positive and negative consequences does it have for public health? What does it mean for the strategic interests of countries with high health burdens and needs in an inequitable global environment?

Various motivations have been given for profiling health in global diplomacy, apart from the obvious one that it is a reality that must be engaged with. It is seen to be necessary for improved global security and health protection, to inform sustainable development; to encourage a human rights approach to health; and to meet ethical and moral imperatives (Hoffman, 2010). At the same time, it is not clear that raising health in diplomacy is strategic given that it brings on board concerns about sovereignty and non-intervention in the domestic affairs of states; and foreign policy and diplomatic processes and histories that are outside that of health. Gagnon (2012) argues from analysis of GHD in high and middle income countries that their primary motivation for a raised focus on global health is still self-interest, to protect security and economic interests, although there is some concern for enhancing their international reputation. Some countries, discussed later, have seen diplomacy as a vehicle to pursue international solidarity and health as a human right.

The transborder nature of 'global' health diplomacy also raises caution in the public health community as it may disguise a more direct and influential hand of specific national or private interests, including in global health institutions. The power wielded in global health by private actors such as the Gates Foundation is an example of this (Smith et al 2010). Such foundations and private-public initiatives appear to have more de facto

access and influence in global processes than representatives of health ministries or diplomats from foreign ministries.

Given current contestations with regards to GHD as a concept, the different goals and frames used, and the asymmetrical power relations in global processes, is it in the best interest of Africans for achieving health goals to raise health as a foreign policy issue? Is health a priority in African foreign policy?

### ***GHD Platforms for revolution, remediation or regression?***

Fidler (2005), suggests that the rise of health in foreign policy can be understood in three different ways: as revolution, remediation or regression.

As '**revolution**', bringing health into foreign policy is transformative. It collapses the distinction between high and low politics and provides a new values based political space in international relations, with health and human dignity as the ultimate goal. An example is in the global commitment to and resourcing of ensuring universal access to treatment for HIV. This is associated with the rise in health rights and health equity as political values and obligations of the global polity. As reflected to some extent in the 2007 Oslo Declaration, it is linked to a rethinking of traditional notions of security, economic interests, development, (common vulnerability, shared risk, and shared responsibility) of borders and sovereignty as limiting collective responses, such as for solidarity financing for health.

As '**remediation**', health is addressed through the traditional hierarchy of foreign policy shown earlier. It has no special, transformative or ethical role in international relations, but is an issue to be addressed through traditional foreign policy approaches or as a strategic vehicle through which security and economic goals can be achieved. Its profile is raised when there are threats to the material interest and capabilities of states, such as due to highly transmissible pandemics such as AIDS, SARS and influenza, or because of the potential economic impacts of investments in health products and services. This effectively limits the focus to a small number of communicable disease and bio-weapon threats, with others being 'neglected diseases', or to health services and commodities that have significant cross border economic returns.

In the third perspective, '**regression**', health's integration into foreign policy is a regressive development, indicating that health problems are getting worse, that public health norms and efforts are failing and health is becoming a security concern. For example the UN Secretary-General's High-Level Panel on Threats, Challenges, and Change lamented the 'dramatic decay in local and global public health capacity' (*Report of the Secretary-General's High-Level Panel* 2004). In this perspective, health may have become politically important, but in a way that undermines the values integral to health, threatening what was special about health in international relations in the first place.

Generally, evidence suggests that a 'revolutionary' transformative process is not (yet) happening as a dominant process. Despite evidence of some important advances, foreign policy engagement with global health is still largely crisis driven, inconsistent and limited largely to responses to diseases. It is not sustained nor does it connect effectively with global health policy concerns for universal systems, primary health care or social determinants of health. Foreign policy makers are still largely concerned with global health problems that pose a direct threat to their national interests, particularly given the range of post 2008 political, economic, demographic, and ecological challenges. The sporadic attention to health issues undermines the sustained attention needed for reform of systems and institutions and thus weakens their leverage in addressing upstream determinants (Fidler and Drager 2009; Fidler 2005; Gagnon 2012). The transformative leverage that health issues have is also partly determined by the extent of transformation taking place *within* countries. The ability to strategically use these windows of opportunity depends on the domestic organisation of actors and processes around health as much

as on international processes. For example countries using a whole-of-government approach for health have been found to have stronger potential for coherence in global health diplomacy, with stronger collaboration across government actors and greater policy coherence giving greater strategic capacities for advancing health interests (Gagnon 2012). Policy coherence leads to strategic capacities in GHD through clear policy direction and common values, through co-ordinated national strategies for global health (eg UK); and through a clear, unified national position endorsed across sectors (eg Thailand).

What perspective in health diplomacy is needed to advance health in Africa?  
What transformation should be (and is) taking place domestically within African countries to more effectively advance this perspective?

## Diversity in concepts and approaches

As noted in the beginning, despite its increasing prominence, there is no shared definition of GHD. The “*public health community has offered multiple definitions of health diplomacy.* (Feldbaum and Michaud 2010). As discussed in the previous sections, international relations (IR) theory – with its focus on international conflict and cooperation - traditionally centres on the intersect between *security and health* as central to GHD, with security used to bring health issues to the realm of 'high politics.' (Davies 2010). Drager and Fidler (2007) agree on GHD as being the intersect between foreign policy and health, but emphasise the *trade-health* nexus as the 'cutting edge' of GHD. Kickbusch, Silberschmidt and Buss (2007) focus more on the multi-level, multi-actor *negotiation processes* that shape and manage the global policy environment for health. Fauci (2007) in contrast conceptualizes GHD as a tool for fostering *positive solidarity relations* between states, such as through Cuba sending health personnel to support health systems in foreign countries. It appears that these different views are perhaps akin to the story of the 6 blind men and the elephant, each describing the part they feel as the elephant, each only partly right and all individually wrong!



Prior sections have also noted a potential diversity of perspective on the integration of health in GHD, and of whether health is used as means or end. Historically, it was observed that in general, political and foreign policy interests are central, and health issues are used to achieve these objectives (Feldbaum and Michaud 2010). This was earlier observed to largely be the practice in industrialised countries. North American and European diplomacy have historically carried out approaches that have prioritized security and economic interests, although with more recent participation by European countries in multi-country initiatives that have advanced health as a global collective responsibility.

There is, however, a diversity of approach to GHD globally. New global actors such as Brazil, China, India and South Africa have given greater emphasis to “South-South” cooperation, to systems, technology transfer and social determinants of health, through models of global diplomacy that are anchored in their own (different) political and social philosophies, to address their own internal challenges (GHSi 2012; Table 2). While earlier sections raised paradigms of health diplomacy practices in Europe and North America, the diplomacy of countries in other regions are discussed below, including in relation to Africa, and of Africa countries in the subsequent section.

**Table 2 BRICS Foreign assistance and global health**

Indicator	Brazil	Russia	India	China	South Africa
Launch of Foreign Assistance Program	1960	1955	1964	1950	1968
Estimated Absolute Foreign Assistance (2010)	US\$400M – US\$1.2B	US\$472M	US\$680M	US\$3.9B	US\$143M
Foreign Assistance Estimated Compound Annual Growth Rate (2005 - 2010)	20.4%	36.1%	10.8%	23.9%	8.0%
Central Assistance Agency	Brazilian Cooperation Agency (ABC)	None currently; RUSAID launch currently on hold	Development Assistance Partnership (oversees administration); central agency to launch in 2012	None currently; MOFCOM manages majority of assistance projects	None currently; South African Development Partnership Agency (SADPA) planned
Foreign Assistance Regional Focus	<ul style="list-style-type: none"> <li>Latin America</li> <li>Africa</li> <li>Lusophone countries</li> </ul>	<ul style="list-style-type: none"> <li>CIS region</li> <li>Looking toward Africa</li> </ul>	<ul style="list-style-type: none"> <li>Regional neighbors (i.e. Bhutan, Afghanistan, Nepal)</li> <li>Increasingly looking toward Africa</li> </ul>	<ul style="list-style-type: none"> <li>Africa</li> <li>Asia</li> </ul>	<ul style="list-style-type: none"> <li>Africa</li> </ul>
Foreign Assistance Sector Focus	<ul style="list-style-type: none"> <li>Health</li> <li>Education</li> <li>Agriculture</li> </ul>	<ul style="list-style-type: none"> <li>Health</li> <li>Education</li> <li>Food security</li> </ul>	<ul style="list-style-type: none"> <li>Infrastructure</li> <li>Information technology</li> <li>Training and capacity building</li> </ul>	<ul style="list-style-type: none"> <li>Infrastructure</li> <li>Industrial development</li> <li>Energy resources development</li> </ul>	<ul style="list-style-type: none"> <li>Peacekeeping</li> <li>Democracy promotion</li> </ul>
Global Health Focus	<ul style="list-style-type: none"> <li>Access to medicines</li> <li>HIV/AIDS</li> <li>Capacity-building/ infrastructure development</li> <li>Social determinants of health</li> </ul>	<ul style="list-style-type: none"> <li>Infectious diseases</li> <li>Disease surveillance</li> <li>NCDs</li> <li>Global Fund</li> </ul>	<ul style="list-style-type: none"> <li>Health infrastructure</li> <li>Health IT</li> <li>Capacity building</li> <li>Medical missions</li> </ul>	<ul style="list-style-type: none"> <li>Medical teams</li> <li>Malaria treatment</li> <li>Health infrastructure</li> <li>Human resources</li> </ul>	<ul style="list-style-type: none"> <li>Limited focus on global health</li> </ul>
Key Innovations and Implications for Global Health	<ul style="list-style-type: none"> <li>Government responsible for majority of country's health R&amp;D/innovation to date; transitioning from generics to biotech innovator with emphasis on affordability</li> <li>Private sector contributions limited though government recently increased investment in R&amp;D; private sector recognized as critical to filling existing gap in product development pipeline</li> </ul>	<ul style="list-style-type: none"> <li>Government focused on infectious diseases, particularly HIV/AIDS</li> <li>Academia considered 'Center of Knowledge and Science' for CIS region</li> <li>Private sector contributions limited to date; government investing in capacity around domestic production, innovation</li> </ul>	<ul style="list-style-type: none"> <li>Vaccine industry with most WHO prequalified vaccines; contributes between 60% and 80% of all UN procured vaccines</li> <li>Private sector spurred global access to generic ARVs</li> <li>Public and private sector working on low-cost service provision for poorest of the poor</li> <li>Government investing in innovation around health technologies</li> </ul>	<ul style="list-style-type: none"> <li>Government investing more than US\$1.3B in R&amp;D for drug development, infectious disease control/prevention</li> <li>Government partnering with the Gates Foundation to fund development, production of new low-cost health technologies</li> <li>Robust health manufacturing sector starting to look to global market</li> </ul>	<ul style="list-style-type: none"> <li>Government focused on infectious diseases, R&amp;D and support for clinical/research trials, particularly around HIV/AIDS and TB</li> <li>Government spurring uptake of next-generation health technologies</li> <li>Private sector manufacturing generic ARVs</li> </ul>

GHSI 2012

### ***China's diplomacy***

The Chinese government has emphasized its belief that China is itself a developing country and that it is inappropriate for any country to intervene in another's domestic affairs. Chinese diplomacy, as articulated by Jiang Zemin in 1996, is based on 'Five Principles of Peaceful Coexistence', that are (1) mutual respect for territorial integrity and sovereignty; (2) mutual non-aggression; (3) mutual non-interference in internal affairs; (4) equality and mutual benefit; and (5) peaceful coexistence. During the Cold War period,

given its political and ideological struggles with the Soviet Union, China departed from its principle of non-interference to support liberation movements in Africa (Youde 2007). Post-Cold War, China is in both economic and military respects accommodating the current economic and strategic order, while speeding up its own modernization and widening access to resources and markets. This is reported to have positioned China less as a 'transformer' of the global and UN system than as using its growing influence to protect its perceived national interests (Jiang 2006). The country has invested significant resources, obtained high levels of foreign investment in science and technology, and built bilateral relations around key raw materials with the goal of accelerating the country's transition from manufacturer to innovator.

China's diplomacy and investment in African health systems through infrastructural development and medical cooperation has assumed a more prominent place, as it has built relations with many African countries and sought to increase its political influence, economic footprint and access to natural resources in the continent (Youde 2010). Since 1963, China has provided medical personnel, equipment and supplies, often for rural, under-served communities, and sometimes as part of a wider infrastructure or economic involvement. China's strategy of noninterference in domestic affairs makes its aid free of conditionality, with a major focus on infrastructure development (Youde 2007). At the inaugural China Africa Cooperation Forum (CACF) in 2000, the Chinese government forgave USD1.2 billion in foreign debt owed by African states and pledged to increase its aid contributions to the continent in all realms, including health, and particularly for the treatment and prevention of disease. In 2009 the Chinese government pledged to build 30 hospitals in Africa, provide USD37.5 million in grants for anti-malarial medicines (that were developed and manufactured in China), and develop 30 malaria treatment and prevention demonstration centres (Youde 2010).

China's engagement in Africa has thus shared features of development co-operation with other regions in that it provides soft power to enhance relations for economic and trade goals, and opens interactions in areas that also have economic benefit for China, such as in relation to mining rights for oil, platinum and other natural resources in Africa (Taylor 2006). While economic benefit may be key to its engagement, China's diplomacy differs in having less explicit conditionality, and its foreign policy position is one of respect for diversity, consensus-building over conflict, pragmatic approaches and gradualism rather than abrupt change (GHSI 2012). This and its soft power investments have yielded positive returns in access to economic resources, in building alliances to stifle attempts to censure it for human rights violations, and in the influence it is perceived to have on policy in African countries (Pew Research Centre 2007). Nevertheless there are also critiques of China's diplomatic engagement in Africa: The appearance of consensus is argued to mask the underlying politics at work (Fidler 2010). Investments in health and infrastructure are argued to be predicated on access to natural resources at limited returns, and projects to use low wage and Chinese labour at the cost of local business and labour (Youde 2010). There is some distrust that the terms of the engagement are mutual. Mutual dialogue and understanding is also weakened by language and other barriers to direct exchange between Chinese and African civil society and academia. Hence for example President Sata of Zambia, when an opposition leader and presidential candidate stated in 2006: "*Zambia is becoming a province — no, a district — of China ... We've removed one foreign power, and we don't want another foreign power here, especially one that is not a democracy*" (Pew Research Centre 2007).

### ***Indian diplomacy***

Other countries in Asia have played important roles in GHD, such as Thailand (on WTO and public health), Indonesia (on virus sharing) and Japan (on human security), but we were unable to find public domain documentation of their foreign policy approaches or interactions with African countries.

India's founding leader, Jawaharlal Nehru, articulated India's foreign policy goals to include the improvement of the international economic and political order, independence

in foreign relations, equal treatment among states and independence of colonies. It placed a premium on the building of peace and co-operation in the world, although with some question on the de facto realisation of these policies given India's role in Pakistan and Bangladesh. India's foreign policy globally is also uniquely affected by the nature of its diaspora of about twenty million people, spanning all continents. While the Indian diaspora has diverse citizenship and language, it is argued to have a common identity in its Indian origin, consciousness of a cultural heritage and attachment to India. The Indian government has thus in recent years upgraded its diaspora on its list of foreign policy priorities as a strategic response to economic globalisation, to give impetus to their engagement in the global economy (Chaturvadi 2005). The effects of this on health diplomacy are not documented or evident.

### ***Health diplomacy in Brazil***

Brazil is noted for its engagement, impact and strategic importance in global health. Improving global health has become a key goal of its foreign policy (Gagnon 2012).

The country's initial cooperation efforts date back to the 1950s, when it started to establish links with Africa and Latin America through various initiatives and technical assistance programmes, and in 1952 raised concern in UN platforms on the economic divisions of the world (Alcazar 2008). Diplomacy in Brazil has since developed to align with a commitment to South-South cooperation, mutual benefit, respect for human rights and shared experiences among developing countries. The country has sought to increase its influence in global governance through a proactive South-South cooperation strategy, in which health is an important part. For example, Brazil has been influential in the India, Brazil, South Africa (IBSA) initiative, the Union of South American Nations and South American Council of Health (UNASUL) and the Community of Portuguese Speaking Countries (Fidler and Drager 2009). It also promotes trilateral cooperation (vs bilateral or multilateral channels) to partner with and leverage expertise, funds and financial capital from countries with capacities and resources in South-South co-operation (GHSi 2012).

Brazil pursues the concept of "structural cooperation in health". This has two implications. It has argued for health to take precedence over trade in key global platforms and has tried to break with the traditional model of passive, unidirectional transfer of knowledge and technology, proposing rather to support development of each country's existing endogenous capacities and resources. From both President and foreign minister, Brazil has articulated and implemented policy positions where health takes precedence over trade, such as on compulsory licensing of medicines. The country took the lead in trade, development and health negotiations on issues related to access to anti-retroviral medicines (ARVs); during the implementation of the WHO Framework Convention on Tobacco Control (FCTC) and in the discussion on counterfeit and falsified medicines. Brazil's engagement with low income countries centres on strengthening recipient country health systems institutionally, combining concrete interventions with local capacity building and knowledge generation, and promoting dialogue among actors, so that they can take the lead in health sector processes and promote formulation of a future health development agenda of their own.

Partly because of this willingness to adopt controversial positions, Brazil has become a prominent actor in global health governance. It brings a soft power approach to forging agreement on collective global health goals. Its diplomacy makes specific links between domestic politics, norms and experience and global diplomacy. A rights based approach to health, the inclusion of civil society in participatory policymaking, concern for upstream determinants of health and for policy coherence across sectors inform both domestic policy and global health diplomacy (Gagnon 2012; GHSi 2012).



## **Health diplomacy in Cuba and Venezuela**

Cuba and Venezuela both use unique forms of public diplomacy. The term public diplomacy refers to a government's use of aid, cultural, media, and exchange programs to influence the ways in which they are seen by citizens in other countries. Cuba and Venezuela use public diplomacy particularly within their own region, but also globally, to locate themselves within a united front against a common set of enemies, particularly neoliberal globalisation and US aggression. Cuba has been more successful in its diplomacy on these threats to its security than the more economically wealthy Venezuela (Bustamente and Sweig 2008). Their critiques of global capitalism and inequality find sympathetic ears, particularly in Latin America. The Cuban and Venezuelan examples of public diplomacy show that it is not only targeted at state actors, but also generates symbolic capital by aiming at citizens, nongovernmental organizations (NGOs) and others that generate ideas, culture, art, and other messages with the power to influence public perceptions.

Cuba's public diplomacy evoked a commonality between countries sharing colonial legacies. Its call for unity and cooperation in a collaborative struggle against what Castro in 1987 called "*the unjust and obsolete international economic order*" (Castro 1987) had resonance with African anti-colonial and post colonial struggles. Cuban health diplomacy in Africa was framed within a discourse of solidarity and shared interest rather than economic self interest or conditionality, locating returns to its own security within a framework of solidarity and shared ideas. It has been heavily focused on capacity building in the health sector, both training African doctors in Cuba, sending Cuban personnel to Africa, helping to set up medical schools in Banjul and in Equatorial Guinea and sending Cuban professors to teach in medical schools in Eritrea, Uganda, Ghana, Guinea Bissau and South Africa. Its cumulative contribution to the capacity building of health workers is reported to have been greater than that of the G8 countries combined (Hammett 2004). African leaders have acknowledged the unique nature of Cuban involvement in the continent. Nelson Mandela's speech in Havana in 1991, for example, went beyond the usual diplomatic niceties: "*We have come here feeling a great debt to the people of Cuba. What other country can show a history of greater selflessness than Cuba has demonstrated in its relations with Africa?*" (Hammett 2004).

Cuba's medical diplomacy in providing health workers and support for health services is not purely charitable. The Cuban government foots the bill for scholarships and some of the physicians it sends abroad and receiving countries also pay for the services. For example, at the Group of 77 meeting in Havana in 2000, higher income African states agreed to pay for an extra 3000 Cuban doctors to work in Africa, with for example, South Africa funding Cuban Medical Brigades working in Mali, Rwanda and Sierra Leone (Blunden 2008). Cuba's international medical programs bring in substantial sources of revenue, and its influential and wide-ranging international cultural presence helps sustain narratives that boost the island's international relations in the south, its tourist industry from higher income countries and loyalty from Latin Americans against hard-line anti-Castro policies. Venezuela took this a step further with the 2005 creation of Telesur, a Latin American television network meant to compete with CNN and other dominant Western media outlets. By focusing on Latin American news and cultural programming, Telesur hopes to serve as a major platform to help "*integrate a region that currently knows other parts of the world better than it knows itself*" (Frasquet 2006).

How have African countries (differently) experienced and engaged with these diverse diplomatic paradigms?  
What shared and different values, historical ties, strategic and policy issues and interests influence the health diplomacy that exist between African countries and other countries and regions? How are these reflected in current diplomatic interactions on health?

### ***Transformative diplomacy through inclusion, south-south trilateralism***

The descriptions above, although limited in scope and depth, highlight diverse paradigms in diplomacy, whether China's non interference, consensus model to facilitate its access to resources and markets; Brazil's structural co-operation to strengthen its role in global governance; Cuba's public and solidarity diplomacy to promote its security and economy; or India's recognition of the potential influence of its significant diaspora in a global economy.

The financial crisis, its link to neoliberal globalisation and recognition of the deleterious social costs of globalization has raised new debate on global governance, on equitable and sustainable growth, and on global obligations for social protection (Randall 2001). This raises conflicting forces. On the one hand it strengthens the position of states in raising human security as a goal through public diplomacy, solidarity and structural co-operation. On the other hand a context of austerity and security responses to economic, climate, energy and resource 'crises' weakens attention to health.

While the diverse diplomacy approaches from individual countries have their own bearing on these forces, countries have also engaged collectively to strengthen influence over the longer term.

Emergent economies, taking on burdens from the global financial system, have engaged collectively on the rules and decision making structures in global governance. They have increasingly called for more inclusive representation in global institutions, as a principle in reform of financial governance (Randall 2001). While the Northern countries have emphasised operational failings, cost-effectiveness and other policy dilemmas in the UN system, the Southern critique has been rooted in a deeper structural analysis. There has been some accommodation to this. New pillars such as the G-20 and the FSF are bringing industrialized and emerging market economies into institutional mechanisms that are engaging on how the global financial system is and should be governed, to address *the principle of inclusion*. There is concern that this does not tackle fundamental underlying governance problems within the global financial system associated the dominance of neoliberalism and the continuing insulation of monetary and financial power from the processes of democratic accountability (Randall 2001).

Countries have also engaged through regionalism and south-south alliances. Brazil, India, China and South Africa are all regional hegemonic powers, have complex relations with their respective regions and have strengthened their power through regional trading arrangements such as Mercosur, Southern African Development Community (SADC) and the South Asian Association for Regional Co-operation (SAARC) (Alden, Vieira 2005). At a Summit held in April 2011 in Sanya, China, leaders of Brazil, Russia, India, China and South Africa (BRICS) released a joint declaration committing to strengthen dialogue and cooperation in the fields of social protection, decent work, gender equality, youth, and public health, including the fight against HIV/AIDS. Given the technological capacities of Brazil, China and India, technology transfer has been one major focus of GHD in the BRICS. The first BRICS health ministers meeting in July 2011 agreed on collaboration on health systems strengthening, access to medicine and health technology, strengthening of regulatory capacity, research, development and technology transfer and in access to affordable medicines and medical technologies. The 2012 BRICS Summit in New Delhi focused on sustainable development in Africa and global governance. This alliance is explicitly raising the development of common positions in GHD, such as the inclusion on the agenda of the 2013 BRICS health ministers meeting of a common position on the Recommendations of the WHO Working Group on Research and Development (CEWG), WHO Reforms and the strategy for Child Survival.

Forums such as the India - Brazil - South Africa Dialogue Forum (IBSA) have played a role in reform of the UN Security Council and in claims to regional allocation of new permanent seats. Nevertheless, all three states face tensions in regional economic and political co-operation through suspicion among the states of their respective regions of

their economic interests and hegemonic intentions. Their positioning as regional leaders in global processes, such as in the WTO, G8, Global processes on sustainable development and in the BRICS and IBSA alliance does not necessarily confer legitimacy on their negotiating positions. These emergent economies thus face demands for a balance to be sought between their own 'self-interested' diplomacy in south-south alliances, and diplomacy based on regional negotiations and solidarity, to widen benefits to weaker economies in their region. While the creation of solidarity funding such as the IBSA fund to benefit lowest income countries in their region suggests the commitment to solidarity, it is more likely that this will be judged through the translation of economic, trade, technology and other areas of benefit to other states in the respective region, and through regional integration.

A third approach has been to give greater profile to public roles in diplomacy. As noted earlier, civil society has played a key role in global issues such as access to antiretroviral therapy, global trade and patent rules, health rights, access to medicines, control of risks from tobacco and breast milk substitutes and in supporting uptake of TRIPS flexibilities in India, Kenya, South Africa and Thailand (MSF 2003). Brazil has brought civil society and participatory policymaking into rights based health diplomacy, Cuba and Venezuela have targeted their diplomacy not only at state actors, but also at citizens and civil society within other countries to change public perceptions, while India is integrating effective engagement with its diaspora in its diplomacy.

What options do African countries have and use to engage and confront the asymmetries in power that affect negotiations on health goals?  
What positive potential and risks does the alliance of emerging economies (BRICS, IBSA) hold for African negotiations at global level on health? What does this imply for how countries and the region are and could be engaging with such emergent alliances to advance health?

The next section explores how diplomacy, and specifically health diplomacy in Africa has related to these developments.

## **African approaches to global diplomacy on health**

When we set out to write this paper we planned to present a breadth of information on African approaches to diplomacy in health and to GHD. We found in the process that literature on GHD from an African lens is marked by its absence. We found limited documentation of different approaches across African countries in different sub-regions and language groups (francophone, anglophone and lusophone), although there is some perception that such differences exist. This creates a potential for a biased analysis and over-generalisation of what is "African" in a very diverse continent. Much diplomacy on health in Africa appears to be unrecorded in the public domain, sometimes perhaps deliberately, or it is documented through the lens of northern or global actors.

African countries face strategic opportunities and threats to health in the current global context. After decades of colonialism, post independent states had a limited period of functioning as developmental states, addressing social and economic goals, before they almost universally applied the Bretton Woods institutions' structural adjustment programmes. This and the deeper liberalisation, that followed led to cuts in public spending and weakened the role of the state in both economic activities and social services, with growth largely dependent on extractive industries and the export of primary commodities. In 1980, African countries under the Organisation of African Unity (OAU) drafted the Lagos Plan of Action for the Economic Development of Africa, 1980-2000. The plan oriented development and diplomacy towards ensuring the restructuring of the economic base of the continent, emphasising regional approaches and collective self-reliance. The plan identified that to achieve this in the current global context, African countries would need to build solidarity and work collectively with each other and with developing countries in other regions. In practice this plan has had limited application,

with a raft of international trade and economic measures, 'partnership' agreements; conditions and institutions from northern countries, transnationals and global institutions competing for influence in African development. More recently, with growing natural resource and energy scarcities, there is competition between northern countries and emergent powers like China over African resources and strategic zones. It is a time of potential, but Amosu (2007) also calls it "dangerous times for Africa".

What diplomacy paradigms have African countries used to advance self-determined interests in this context, including on health? Can African countries have leverage in global diplomacy when using development paradigms shaped by others?

### ***Unity and ubuntu***

It is argued that, when compared to Western, or Anglo-American societies, African societies have traditionally given more weight to the rights and interests of the community than the rights and interests of the individual. This takes various names in the continent. The term used in South Africa for example is 'ubuntu' (I am because we are), inferring principles of reciprocity and interdependence (West 2006).

A desire for unity has deep roots. Integral to the project of African freedom was the achievement of African unity. Both slavery and colonial rule had been facilitated by African disunity and weakness. A defence of independence thus demanded some framework of unity, a task that was pursued as soon as the first independent states emerged, and that has resonated through African diplomacy in different platforms, including through the Africa group at the World Health Assembly (Anyaoku 1999). The May 1963 formation of the Organisation of African Unity (OAU) directed its focus on unity to ensure the liberation of those parts of Africa still under colonial rule. A Liberation Committee served as the channel for material and diplomatic assistance to the liberation movements. However while unity has remained a consistent principle of foreign policy, its realisation was not understood in the same way across African countries, with some identifying the goal as the establishment of a continental government to mobilise the resources of the continent for its development and others seeing it as a framework for periodic political consultations and functional co-operation (Anyaoku 1999).

There is a perception that the goal of 'health for all' can only be achieved if there is deliberate and consistent unity in the positions that Africa takes in all global engagements. Any disunity is seen to weaken influence and open countries to new forms of economic or political exploitation. To some extent African unity reflects the cooperation evoked by Cuba among countries with a shared colonial past in their collaborative struggle against exploitation. Unity is practiced as an alliance of sovereign states, respecting principles of non-interference and sovereignty.

This is not simply a rhetorical position. The Africa Group at the World Health Assembly, for example, has been used to build shared positions on issues such as access to essential medicines, strategies for HIV and AIDS, or global recruitment of skilled African health workers. South Africa and the Africa group played an important role within Global Fund in ensuring that the Board ultimately acceded to African demands to include funding for TB and malaria and also for African representation on the Board. Such unity is stronger when there are shared development policies, or existing co-operation and policy harmonisation in regional initiatives, such as in the cross border collaboration on malaria, TB and HIV and AIDS control or in the establishment of the SADC HIV and AIDS Trust Fund to implement shared cross border HIV and AID programmes (SADC 2009). Where domestic policies differ, sovereignty may outweigh unity, potentially disrupting shared positions. If domestic policies and priorities are influenced by external funding - an issue in the health sector of many countries - countries may be vulnerable to bilateral influence, disrupting unity. Economic sovereignty, regional collaboration and policy dialogue that builds shared developmental priorities thus appear to be important contributors to building the leverage role of African

unity, and to shifting it from a defensive position against exploitation to a proactive assertion of shared health goals in diplomacy.

### ***Liberation ethic and demands of nationhood***

A further deep, and possibly dominant, root of African foreign policy engagement lies in the anti-colonial struggles and the processes of nation building that have been central in the 20<sup>th</sup> century (Ekeh (1975). Colonial rule subordinated the interests of Africans to the interests of others, making Africans, in Frantz Fanon's words, "the great absentees of universal history". Independence was thus a critical step for reclaiming Africa's place in international society and formed one of the guiding objectives of the anti-colonial movement (Anyaoku 1999). The liberation struggles, while justifying military action to achieve human dignity, won international support from both sides of the Cold War, from states and social movements.

The liberation ethic continued to inform diplomacy after independence was achieved. It has over-ridden other more traditional security and economic interests in diplomacy. It led frontline states in southern Africa to take a strong stance against the apartheid South African government in the 1980s and early 1990s, despite the negative security and economic impacts on processes of nation building that were important for regime survival. Pursuit of the liberation ethic in foreign policy also brought positive effects. It raised the foreign policy profile of frontline states on the international stage and reinforced political legitimacy domestically (Youde 2007). A decolonization agenda informed African country engagement in many diplomatic processes, including in health issues such as the negotiation of the 2001 Doha declaration, referred to earlier; or the challenge by African Ministers of Health at the WHA on the recruitment and migration of health workers to high income countries.

Former President Mandela and the ANC in South Africa integrated the liberation ethic within foreign policy, linking the pursuit of economic, social and environmental and political rights with the democratic process, domestically and internationally. These principles were used in engaging on economic inequality and an unjust global trading system; in promoting UN multilateralism; in arguing for demilitarization and for peacemaking (Barber 2005). Many countries in Africa pursued similar approaches, the use of a rights framework in South Africa positioned its approach to diplomacy closer to that of Brazil, with its focus on rights based structural co-operation. Many African countries were less willing to use the rights framework if it were to be used as a tool to weaken their national sovereignty. South Africa has experienced palpable tension between the politics of solidarity and sovereignty on the one hand and human rights on the other, as evidenced in its voting patterns on Zimbabwe to Libya in the UN Security Council.

The equality of states, state sovereignty and noninterference in the affairs of other states have been key principles for African countries, including South Africa. For example Zimbabwe condemned the U.S. invasion of Grenada, the Soviet invasion of Afghanistan, and the Iraqi invasion of Kuwait-all for violating the sovereignty of another state. State sovereignty and non interference have been invoked to stifle rebuke on infringements of rights, democratic politics and accountable governance, such as South Africa's efforts to block UN censure of Sudan and Zimbabwe for human rights abuses (Mokhawa 2009). While the link made between the liberation ethic and national sovereignty underlie such solidarity, there is also a risk that this link could contradict paradigms that have emerged in GHD that call for shared risk and responsibility globally, as a basis for collaboration across borders, that with rights based approaches have raised the profile and leverage of health in high politics.

African countries have challenged trade, and Western foreign policies that are perceived to be unjust more through unified positions and alliances with non Western countries, such as China. As a form of public diplomacy, a foreign policy image of states seeking economic decolonization has also been used to bolster domestic legitimacy. This use of

foreign policy for domestic ends reflects a complex dialectic in Africa. Foreign policy is used to project national interests outwards to international platforms, while at the same time being used to assert identity domestically, to consolidate domestic power, reinforce a public image and enhance the domestic legitimacy of leaders. While this is not unique to African countries, it is argued to be more pronounced in Africa, where the demands of nation building in contexts of limited control of domestic economic resources, limited infrastructure connecting capitals and periphery, and insurgent groups in some countries have made leadership survival and consolidation of the 'nation state' a primary goal. (Youde 2007). If this is the case then for health issues to obtain sustained attention in African foreign policy they need to be seen as central to domestic legitimacy (as for example was the case with treatment activism).

### ***Moving towards developmental foreign policy?***

The risks of the current neoliberal globalisation for Africa were apparent well before the 2008 'crises', as global policies and processes undermined the welfare and developmental state, powerful transnationals co-opted and fragmented state power, and African countries were further marginalised within widening global inequality (Osei Kwadwo 2004). Health and disease issues have been raised as both 'crises' to trigger policy attention and external funding, and as development issues to mobilise investment in domestic systems, services and social determinants.

The African Union (AU) has given profile to both security and development dimensions of foreign policy. It asserts goals and has mechanisms for both peace and security and for accelerating the political and socioeconomic integration of the continent (Landsberg 2005). Many African countries are explicitly pursuing developmental foreign policies, raising economic justice, advocating policies that address issues of poverty and underdevelopment and seeking to protect the role and authorities needed for developmental states within international policy agendas and debates. Further, faced with the constraints of a hegemonic world order and a decline in global multilateralism, especially after 9/11, South Africa has used its moral power to leverage sovereignty of African states, and recognition of regionalism, including during its two terms as a non-permanent member of the UN Security Council (Kagwanja 2008).

There is however diversity in the understanding of what a developmental foreign policy means. While challenging the hegemony of current economic powers, South Africa does so by seeking to change the rules and institutions in a global system that disadvantages African countries through negotiation, engagement, South-South partnerships and strategic alliances (Landsberg 2005). South Africa has for example actively lobbied the G20 for Sub-Saharan Africa to have a stronger voice in governance of the International Monetary Fund (IMF) by allocating a third IMF Board Chair to the region, and has used the New Partnership for Africa's Development (NEPAD) as a vehicle for Africa's development when negotiating within IBSA and BRICS process, to seek practical and concrete measures that support the implementation of NEPAD. The "African Renaissance" adopted in 2001 by South Africa's then-President Thabo Mbeki and the NEPAD were framed as African Union (AU) programmes around which foreign engagement could be built. NEPAD sought to extract developmental commitments for African countries, such as higher levels of aid; debt relief; market access for Africa's trading goods; fair trade; and to elevate the status of poverty and development issues to a higher strategic plane in global affairs, raising them as a threat to international peace and security. It also committed to democratic governance (Landsberg 2005; GHSi 2012). The G8 read the NEPAD policies as a means of establishing a better-governed and peaceful continent, and have thus given focus to the peer review mechanism. African countries gave more focus to demands for greater global justice and equality, to be achieved through improved flows of aid, trade access and investment resources. Many rejected the peer review as a compromise to their sovereignty (Barber 2005). Some African states and civil society remain uncommitted or resistant to elements of the NEPAD programme (Alden and Vieira 2005).

How is the liberation ethic crafted for the 21st century? What foreign policy perspectives will support the shifts in power that are needed to take forward the unfinished processes of nation building, decolonization, democracy and human dignity necessary for health?

What have been the benefits and costs of African unity as a key element of African diplomacy on health?

What other and different approaches to diplomacy are being used by countries and regions in Africa not captured here? What domestic values and experience do they reflect and how effective have they been?

Does the position on non interference and sovereignty close the space for addressing shared risk, and shared responsibility as a basis for collaboration on global inequalities, eg as argued to motivate solidarity global financing, universal rights etc?

### ***South-South diplomacy***

In a foreign policy environment where states cannot control the external setting in which they operate, alliances are one means of strengthening influence. African countries have made various alliances noted in the earlier section on trilateralism and south –south diplomacy, including in areas of health. Questions are being asked on how South-South diplomacy is being advanced, including in social dialogue in Africa countries. There is some interrogation of how far African countries are ensuring their own interests within such diplomacy, and how far such diplomacy reflects a transformation of economic relations. What, for example, are the implications for China's stance on non-interference in domestic affairs if a 'sovereign' African state chooses to expropriate resources and materials owned by a Chinese corporation? (Taylor 2006).

How far is south –south diplomacy bringing downstream and processing activities and technologies into the continent (such as local medicine production)? Are these interactions reducing African country dependency? What model and goals of diplomacy are being advanced by African countries through South –South co-operation?

## **Debates and issues**

At various points in this paper we have raised questions on what implications the developments described have for health diplomacy in Africa. Given the limitations of documented evidence on African approaches or analysis of health diplomacy from an African lens, it is difficult to draw conclusions. We thus raise debates and issues in this section that we hope will provoke dialogue, debate and response.

In the paper we reflect on the history of GHD, and ask how Africa's experience of that history, including in periods of slavery and colonization, has affected its own diplomacy in health. We suggest that the liberation ethic and unity as they feature in African diplomacy are both an assertion of interests and defensive strategy against power imbalances in negotiations. They reflect African history, but are also a proactive response to the shifts in power that are needed to take forward the unfinished processes of nation building, decolonization, democracy and human dignity necessary for health.

We thus ask how the liberation ethic and developmental foreign policy is being crafted in Africa for the 21st century? There is a strong commitment to sovereignty, non interference and self determination, seen as central to nation building, and to addressing economic injustice. It is less clear how human rights to health, human dignity and solidarity are being advanced and less unity around using a rights framework for addressing economic, social injustice.

What values and principles will guide African global health engagement in the 21<sup>st</sup> century? Does the position on non interference and sovereignty close the space for addressing shared risk, and shared responsibility as a basis for collaboration on global inequalities, such as in solidarity global financing, universal rights and so on?

We note and explore reasons for the caution and sometimes explicit opposition that some have, to bringing health issues into global diplomacy, notwithstanding the increased profile that health has had in recent years. We ask what opportunities and risks there are for African countries in raising health as a foreign policy issue, and strategically which global health issues and policy processes will offer opportunities for advancing African health. What has been the effect of a 'crisis' model that mobilises aid transfers and humanitarian relief on a more transformative agenda for GHD in Africa? What lessons are there for African countries in the diverse approaches to health diplomacy, including in

- China's non interference, consensus model to facilitate its access to resources and markets;
- Brazil's structural co-operation to strengthen its role in global governance;
- Cuba's public diplomacy to promote its security and economy; or
- India's recognition of the potential influence of its significant diaspora in a global economy?

The paper describes the emergence of new diplomatic forces in health and new alliances across countries, including collaboration across emergent economies in the South. Engaging globally on health continues to take place within intergovernmental organisations like WHO, but increasingly also within such multi-country alliances. These are noted to raise new possibilities and momentum for health diplomacy, including in areas such as technology transfer, and investment in systems and capacities for improving health. Which forums offer the greatest possibility for advancing African health goals? The paper also highlights the need for continued regional collaboration and integration as a foundation for such interactions, particularly given the role of African unity as a principle in global engagement.

Given the more effective negotiation from countries where there is greater domestic policy coherence across sectors and greater engagement of non state actors, we ask what transformation should be (and is) taking place domestically within African countries to position countries to more effectively and coherently advance African health interests in foreign policy?

In writing this paper we have noted and commented that many relevant perspectives and experiences are not documented and available in the public domain from African countries. So this first draft is an inception working paper, based on a review of literature, to raise such questions and discussion points to invite reflection and response from critical thinkers and actors on and from the continent. Our primary question is to ask "Are there African approaches to health diplomacy? And in our current global context, what approaches will advance health and human dignity in Africa?"

We will integrate the insights and views from this feedback and produce a second revision of the paper in the second half of 2013. We hope that the paper will continue to encourage reflection, dialogue and debate.



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**Equity in health** implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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