African perspectives in global health diplomacy

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Abstract

Health has been brought into foreign policy processes for several centuries, through diverse approaches that differ across countries and regions, albeit with both risks and benefits for public health. This paper explores, through a review and analysis of published literature in English, the perspectives that have informed African health diplomacy; particularly in Anglophone Sub-Saharan Africa. A thematic analysis of literature on health diplomacy in Africa pointed to common themes in African diplomacy on health, including: a liberation ethic; African unity and interdependence; and developmental foreign policy. Examples are provided that demonstrate how these perspectives have specifically informed negotiations on global health. The literature also highlights reasons for caution in raising health as an issue of global diplomacy, including: loss of sovereignty; the disguised role of private actors; a focus on development aid; and weak attention to underlying determinants of health. Nevertheless, the authors argue that a rising demand for African resources and the emergence of south-south alliances raise new possibilities for advancing African perspectives in global health diplomacy, particularly if supported by strengthened regional co-operation, greater policy coherence between health and other sectors *within* African countries, and by effective involvement of the public sector and civil society.

Introduction

Effective engagement in global health is particularly important for African countries, who face major deficits in access to key determinants of health and some of the highest disease burdens globally, with significant costs to national economies and individual households (AU, 2010); (WHO, 2010). Elements of globalization and widening global inequalities in wealth have particularly disadvantaged African countries and communities, undermining opportunities for human security (Labonté & Shrecker, 2008; EQUINET SC, 2007). At the same time, increased demand for the mineral and natural resources in the continent, increasing levels of social connectedness and the emergence of new global forces offer new leverage for African countries in global diplomacy (Vieira, 2012; Musiitwa, 2012). This paper explores the perspectives that have informed African diplomacy, particularly for Anglophone Sub-Saharan Africa, and the implications for what this means for African engagement in the field of global health diplomacy (GHD).

Global health diplomacy as a field
Diplomacy is a foreign policy process through which actors negotiate their interests in political interactions. Foreign policy seeks to: ensure a nation's security from external threats; contribute to a country's economic power and prosperity by promoting international trade and investment; support order and stability in countries; and promote and protect human dignity (Fidler, 2005). 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).

Health has been brought into foreign policy processes for several centuries, as a *goal* (as in the global responses to treatment access for people living with HIV); as a *tool* to secure economic or security interests of states (as in management of cross border health risks); and as an *outcome* in the collective negotiation of competing interests (such as on the international recruitment of health workers). Health has been a matter for international co-operation. It has thus been used as a tool of soft power in diplomacy; specifically to make a state look better in the eyes of others and to establish a state's reputation (Fidler, 2005). 'Soft power' refers to the persuasive ability to attract or co-opt others to achieve desired outcomes through shared values, agenda, culture and legitimacy, as distinct to the use of threat or financial coercion (Nye, 2011).

As globalization has intensified social interconnectedness and the transnational movement of capital, information, goods and services, greater attention has been paid to GHD. Cross border concerns such as HIV have precipitated the negotiation of global instruments such as the July 2000 UN Security Council (SC) Resolution 1308 on *the responsibility of the Security Council in the maintenance of international peace and security: HIV/AIDS and international peacekeeping operations,* and the 2005 revision of the World Health Organisation's (WHO) International Health Regulations (IHR) (Fidler, 2009; Cooper, et al., 2007). While containing public health risks to security and trade have remained dominant concerns, conceptualizing health as a human right and a human security issue has, since

2000, led to global agreements that challenge economic interests such as the 2005 WHO Framework Convention on Tobacco Control (FCTC) and the 2001 Doha declaration protecting public health in the World Trade Organisation (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), or assert human rights such as the 2012 UN resolution on universal health coverage (Fidler 2009; UN 2012).

Diverse perspectives in global health diplomacy
GHD has obtained increasing prominence as a field. A Google Scholar search with the term yields 88 000 results, with the same number of results for the year 2012 alone, as in the whole decade spanning 1990-1999. In considering African engagement with GHD, it is important to note that it is not a monolithic field. Diverse paradigms and goals characterize health diplomacy, reflecting a diversity of political histories and philosophies, experience and interests in relation to globalization and internal challenges (GHSi, 2012).

From as early as the 14th century, European foreign policy interactions sought to contain cross border health risks *to* trade, economic and security interests. This has remained the core of health diplomacy in Europe and North America over subsequent centuries. From the 1800s, health has also been raised as a humanitarian issue in Western foreign policy, with scientific and humanitarian collaborations even occurring between military and/or Cold War antagonists on vaccine development (Hotez, 2001). Post-World War Two, and with the independence of colonies, health - as an instrument of soft power - grew more prominent in Western foreign policy, including through the discourse on development aid (Kennedy, 1992; Van Straelen, 1993; Macro, 2005). Non-state actors (civil society, private corporations and private foundations) have had a rising presence in Western diplomacy. Some European countries have joined those in the south to assert common vulnerability, shared risk, and shared responsibility as a basis for collaboration across borders, such as France and Norway's involvement in the 2007 *Oslo Ministerial Declaration* (Mogedal & Alverberg, 2010). At the same time, the 'war on terror' and the financial crisis of the 2000s have kept national security and economic interests at the core of US and European global diplomacy (Lee & Smith, 2009; Fidler, 2009; Zacher & Keefe, 2008).

The decline of bipolar superpower competition in the 1990s, the growth of social media and the rise of Brazil, Russia, India, China and South Africa (BRICS) have enabled new forms of co-operation, the opening of new political/diplomatic spaces; and opportunities for interactions at the global level, such as through south-south co-operation. In turn, these developments have had an influence on the practice of GHD (Alcazar, 2008; Lee & Smith 2009; Fidler, 2009; Kennedy, 1992; Van Straelen, 1993; Macro, 2005). Countries in the south have strengthened their power in diplomacy, including at the global level, through regional economic and political arrangements such as Mercosur, Southern African Development Community (SADC) and the South Asian Association for Regional Co-operation (SAARC), and by engaging in alliances, such as the Non Aligned Movement, and more recently the BRICS and the India - Brazil - South Africa Dialogue Forum (IBSA) (Alden & Vieira, 2005).

Chinese diplomacy has projected China's status as a developing country, and focused on widening access to resources and markets for its own modernization. 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.   This is reported to have positioned China less as a 'transformer' of global systems than as using its growing influence to address national interests of accessing technology and raw materials to accelerate the country's transition from manufacturer to innovator (Jiang, 2006).

Cuba and Venezuela use public diplomacy within their own region, as well as globally, to protect their security and national interests. Public diplomacy refers to a government's use of aid, culture, media and exchange programs to influence how they are seen by citizens in other countries. Both countries have used a critique of neoliberal globalisation and a discourse of unity, solidarity and shared interest to evoke a commonality with countries sharing similar colonial legacies (Castro, 1987; Bustamente & Sweig, 2008). Their critiques of inequality and injustice in globalisation are communicated through ideas, culture, art, and other approaches that have the power to influence public perceptions and generate symbolic capital.

Other countries have used diplomacy to actively seek benefits from globalization, such as Thailand (on WTO agreements and public health) and Indonesia (on virus sharing). 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 (Chaturvadi, 2005). Brazil has made improving global health a key goal of its foreign policy and has sought to increase its global influence through a proactive south-south cooperation strategy, in which health is an important part (Gagnon, 2012). Brazil's "structural cooperation in health" addresses health determinants, and the country argues for health to take precedence over trade in key global platforms, such as on compulsory licensing of medicines. It has thus taken leading roles in negotiations on access to anti-retroviral medicines (ARVs), on the implementation of the FCTC, and on counterfeit and falsified medicines. Its diplomacy makes links between Brazil's domestic politics, norms and experience and its negotiations at the global level. The links are made by supporting a rights-based approach to health and civil society inclusion in participatory policymaking, by drawing attention to upstream determinants of health (or 'causes of the causes') and a need for policy coherence across sectors (Gagnon, 2012; GHSi, 2012).

Costs and benefits of raising health in diplomacy
Notwithstanding these diverse perspectives, there are debates, including in Africa, 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 (Gagnon, 2012; EQUINET, 2012). Diplomacy primarily emerges from, and is framed by security issues, and largely responds to public health as containment of risk. Fidler (2005) suggests that bringing health into foreign policy can be conceptualized in three ways, as

regression, remediation or revolution. As *'remediation'*, health is addressed through the traditional hierarchy of foreign policy and has no special, transformative or ethical role in international relations. It is sporadically raised when there are threats to the material interest of states, such as from highly transmissible pandemics or bio-weapon threats, or because of its potential impacts on economics and trade. A *regressive* framing occurs when health is purely addressed as a security issue, overriding public health norms and values. As '*revolution*', health is raised as a right, goal and shared global responsibility that has a transformative role in foreign policy. This was argued to have occurred in the global funding to ensure universal access to treatment for HIV.

There are diverse views on the risks and benefits to public health from bringing health into diplomacy. While foreign policy negotiations on sustainable development and human rights are perceived to have the potential to advance public health (Hoffman, 2010), concerns are raised about loss of sovereignty, national authority and local voice in GHD (Gagnon, 2012; Haynes, et al., 2013). Bringing public health into diplomacy subject's public health norms to different paradigms, policy processes and histories of foreign policy. In a context where global social institutions such as WHO are seen to be weak and subject to conditional funding, this is argued to water down public health authority and attention to the underlying determinants of ill health, compromising health policy (Haynes, et al., 2013). The trans-border nature of GHD may disguise the more direct and influential hand of specific national or private interests, with concerns that private foundations such as the Gates Foundation 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 (Smith, et al., 2010). Weak collaboration across government actors, limited policy coherence nationally, and the sporadic attention given to health in foreign policy, is argued to weaken the leverage needed to reform global processes and institutions that can address the upstream, structural determinants of health (Fidler & Drager, 2009; Fidler, 2005; Gagnon, 2012).

GHD is thus a field that is evolving and contested, reflecting the perspectives and power of dominant actors in the global economy, although with new influences, spaces opening and voices being heard. There are potential benefits in raising health in global diplomacy, but also risks. This paper thus explores, within this context, what perspectives African countries bring to this contested terrain of global health diplomacy, and the implications for their interactions in promoting health.

Methods

The paper is based on a desk review of published literature conducted between August and November 2012. We included peer-reviewed journal articles, book chapters, academic reports, and documents from African and intergovernmental forums. We included publications post-2000, but also materials pre-2000 if they had high relevance to the analysis. We used key word searches in online libraries such as Google Scholar, Google Books, pubmed, medline, PAIS International, and other political science and foreign policy online journal libraries. For the information on the history and diverse perspectives on GHD we used 'global', 'health', 'diplomacy', 'foreign policy', 'north-south' and 'south-south'

as search terms. For the information on Africa the key word searches included 'Africa' and regions in Africa as search terms, together with 'global', 'health', 'diplomacy', 'foreign policy' and 'south-south'. Because the search was conducted in English, the research mainly covered Anglophone Sub-Saharan Africa and thus the findings are limited to these African countries. We recommend similar research of documents for Francophone and Lusophone African countries, given the likely diversity of perspective, and do not seek to generalize our findings to these countries. The 369 papers retrieved were reviewed first as abstracts and the selected papers as full papers. The 32 papers specifically on Africa, and total of 55 papers relevant to GHD in Africa, included in this paper, were selected based on the criteria that they included content, comment or analysis on the history, country or regional perspectives on GHD in Africa, and on African foreign policy on health or its determinants, even if this was not the primary theme of the paper. The papers covered west, east and southern Africa. We triangulated evidence from the papers sourced using a thematic analysis to generate the themes that emerged most commonly in the literature on African diplomacy generally as well as in African health diplomacy, and to document examples of practice that reflected those themes. In the absence of a clearly articulated African approach to diplomacy, the thematic analysis: 1) provided a means to identify the ideas and perspectives most commonly or consistently reflected in the published discourse on African health diplomacy and policy, 2) as an indication of key perspectives that have informed foreign policy engagement in the African countries, 3) as a basis for exploring their application to health, and 4) the implications for African engagement in GHD. We subjected the papers to a peer review by diplomatic and health personnel in Africa and senior foreign affairs and health officials at an East Central and Southern Africa Health Community (ECSA HC) Training workshop on GHD Nairobi November 2012 (noted in the acknowledgements).

We found limited published literature specifically on GHD from an African lens. Due to limited resources we were not able to include grey literature. 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. We thus propose to do a further stage of work in the future to interview key actors on the issues raised in the literature, to draw further evidence and analysis. We are cautious of over-generalising what is "African" in a very diverse continent. The inclusion of documents in English would underestimate the diversity in approaches across African countries in different sub-regions and language groups, and we note above that the paper primarily refers to Anglophone Sub-Saharan Africa and particularly East and Southern African countries.

African approaches to global diplomacy on health

Europe's colonization of Africa was characterized by a desire to conquer and occupy, trade and draw benefit from the resources of the continent, and was accompanied by evangelism. 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. Medical services, churches and schools provided a vehicle for soft power, to

spread western religion and medical systems and to weaken African religions, explanations and systems for managing health and disease (Emeagwali, 1998). Early public health laws and measures identified and controlled the spread of risks and 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.

Nationalist movements on the continent from the 1950s framed their international engagement in a liberation ethic of 'decolonisation', linking improved health to economic and political justice and self-determination. As discussed later, this ethic continues to be asserted post-independence, as African countries raise structural issues in the global economy that undermine their authorities' control over or access to resources needed to improve health. In contrast, within international discourse, the pursuit of decolonization was reframed in the post-independence period as a pursuit of '*development*'. This repositioned former colonial powers as 'developed' providers of aid and newly independent countries as 'developing' and recipients of aid. The health sector was one of the major recipients of aid and the policy influence it carried. In a context of contested discourses, Chigas, et al. (2007) highlight that those who can early on "frame the definition of the problem and the terms of the collective debate, can have enormous influence on the subsequent negotiations and their outcomes." The literature highlights three foreign policy perspectives that African countries have commonly used in framing their engagement in diplomacy: unity, the liberation ethic and developmental policy.

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).

The desire for unity has deep roots. Integral to the project of African freedom was the achievement of African 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. However while unity has remained a consistent strategy of foreign policy, it has not always been understood in the same way as a principle across African countries. For some, interdependence implied 'pan-Africanism', with the establishment of a continental government to organise the resources of the whole continent for shared development. For others, it implied 'continentalism' through an alliance of independent states, with

reciprocity at the level of co-operation (Anyaoku, 1999; Landsberg, 2012). In both perspectives, deliberate and consistent unity in the positions that Africa takes in global engagements is seen as central to achieving goals. Any disunity is seen to weaken influence and to open countries to new forms of economic or political exploitation.

Reflecting this, the Africa Group at the World Health Assembly has built a unique level of unity around shared positions in GHD, on issues such as access to essential medicines, strategies on AIDS, or global recruitment of skilled African health workers. South Africa and the Africa group played an important role in ensuring that the Global Fund Board acceded to African demands to include funding for TB and malaria and for African representation on the Board. While a shared colonial past and collaborative struggle against exploitation has fostered unity, equally highly valued principles of non-interference and sovereignty can lead to tensions when policy positions and interests differ, such as in the case between exporters and importers of medicines on the continent. Unity and reciprocity is thus more likely when there are shared policies built through the policy harmonisation processes taking place in African regional community initiatives, as in 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 cross border HIV and AID programmes (SADC 2009).

Liberation ethic and demands of nationhood
A 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 20th century (Ekeh, 1975). Colonial rule subordinated the interests of Africans to the interests of others, making Africans, in Frantz Fanon's (1959) words, "the great absentees of universal history". Independence, sovereignty and self-determination were thus critical objectives for reclaiming Africa's place in international society and for 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 bolstered political legitimacy domestically (Youde, 2007). In challenging foreign policies that were perceived to be unjust, African countries strengthened their unity and influence and built alliances with other countries, such as China (Youde, 2007).

Health was both an argument for and a goal of the application of the ethic, expressed in areas such as medicines access, migration of health workers, control of breast milk substitutes, food security, debt cancellation and fair trade.

One example of this is found in the global negotiation of the 2001 Doha declaration at the WTO. W*ithin* many African countries an active civil society of people living with HIV was sometimes projected as 'oppositional' to state power. Internationally, however, a civil society led treatment action campaign in the context of a devastating AIDS epidemic provided a valuable driver of public diplomacy around the right of access treatment. Civil society played a role in resisting the patenting of life-saving medicines, making them unaffordable, and in rejecting the subordination of public health to trade policy (EQUINET SC, 2007). Overriding African peoples' access to antiretrovirals was seen as a clear example of the injustice of the trade system being crafted at the WTO. In March 2001, in the Council of the Agreement on 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, 2001). 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 above that nothing in the TRIPS Agreement shall prevent members from taking measures to protect public health. Document IP/C/W/313 sought to avoid this, and was supported by industrialized countries, which raised political pressure for withdrawal of the former. The Doha declaration, which was adopted by consensus and backed by continued diplomatic engagement, has legitimized the use of compulsory licensing and other TRIPS flexibilities in medicines access (EQUINET SC, 2007).

There have also been differences across countries, with respect to the paradigms used to advance the liberation ethic in global engagement (Barber, 2005). Some countries, such as South Africa, used a rights framework, similar to Brazil's rights-based approach in structural co-operation. Other African countries were less willing to use the rights framework in global diplomacy as it was seen as a tool to weaken their national sovereignty and to legitimize interference in their affairs, both key concerns in nation building. State sovereignty and non-interference have been invoked to stifle rebuke on infringements of rights, democratic politics and accountable governance in global platforms. Hence, despite pursuing a rights-based approach in global agendas, South Africa also voted to block UN censure of Sudan and Zimbabwe for human rights abuses (Mokhawa, 2009).

The 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 and authority domestically, to consolidate domestic power, reinforce a public image and enhance the domestic legitimacy of leaders. While this is not unique to African countries, recent independence and 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 built a

foreign policy perspective in which leadership survival and consolidation of the 'nation-state' are the primary goal (Youde, 2007). As shown in the earlier examples, while this has been part of a decolonization and liberation agenda, and used to assert injustices in the global economy, it has also raised tensions with the rights frameworks and social movements that support public diplomacy and influence on these same injustices.

Development aid or developmental policy?
After decades of colonialism, independent African states functioned for a limited period of time as developmental states, in using strong public sector intervention to address both social and economic goals. They applied the primary health care approach to reorganise their health systems (EQUINET SC, 2007). After the 1970s they almost universally applied the Bretton Woods institutions' structural adjustment programmes that, with the deeper liberalisation that followed, undermined welfare and the developmental state (Mkandawire, 2003; Olukoshi, 1998). With growth largely dependent on extractive industries and the export of primary commodities, many African states have been marginalised within widening global inequality, and their social sectors increasingly dependent on external funding, within a development aid and humanitarian approach (Osei Kwadwo, 2004). Health and disease issues were thus often raised as 'crises' to trigger policy attention and to motivate external funding (Osei Kwadwo, 2004).

In 1980, African countries sought to craft a development alternative. The Organisation of African Unity (OAU) drafted the Lagos Plan of Action for the Economic Development of Africa, 1980-2000. The plan aimed to restructure the economies of the continent, emphasising intra-regional trade and co-operation and collective self-reliance. To reduce external dependency, the plan proposed that African countries work collectively with each other and with developing countries in other regions. Two decades later the African Union (AU) profiled security and development as key issues in foreign policy, through adding value to the natural resources of the continent and accelerating the political and socioeconomic integration of the continent (Landsberg, 2005).

In practice, such developmental policies have had uneven application since 1980, competing for policy attention with: international trade and economic measures; 'partnership' agreements; aid conditions and policy influence from northern countries, transnationals and global institutions (Osei Kwadwo, 2004). Faced with the constraints to policy space imposed by a hegemonic world order, regional co-operation and integration through organisations such as Southern African Development Community, East African Community, and the Economic Community of West African States provided one means to protect the policy space and unity needed for developmental policies. African countries have protected regional co-operation. Hence, for example South Africa sought to negotiate for and protect wider African and regional interests during its two terms as a non-permanent member of the UN Security Council (Kagwanja, 2008). At the same time countries also entered into economic partnership agreements with a constellation of countries that were not contiguous with existing regional configurations - which with bilateral investment agreements with high income countries and liberalised provisions in global trade, are argued to have weakened regional integration (Munyuki, 2009).

There is also diversity in policy understanding on the continent of what a developmental foreign policy means in the 21st century, leading to inconsistent negotiating positions. For example, the "African Renaissance" adopted in 2001 by South Africa's then-President Thabo Mbeki and the New Partnership for Africa's Development (NEPAD) were framed as an African Union (AU) plan around which foreign engagement could be built. NEPAD was a mix of calls for change in the economic order (market access for Africa's trading goods; fair trade) together with requests for development support (higher levels of aid; debt relief (not cancellation)). It committed to G8 calls for a better-governed continent by establishing a peer-review mechanism (Landsberg, 2005; GHSi, 2012). While NEPAD had formal support at the AU, some African states and civil society regarded it as having fallen short on demands for greater global justice and equality and some states were suspicious of the peer-review mechanism in the absence of corresponding changes in the democratic shortfalls in global governance (Barber, 2005; Alden & Vieira, 2005).

Discussion

The liberation ethic and unity in African diplomacy are both an assertion of interests and also a defensive strategy against the power imbalances African countries face in global negotiations. Embedded in African history, they have relevance for efforts to advance unfinished processes of nation building and decolonization nationally, and to strengthen influence in negotiations on global policies. Unity and shared interest is reflected in unique configurations such as the Africa Group at the WHA, and in public diplomacy and alliances around injustice in global policies, as described in the case of the Doha declaration. The findings also suggest a complex interaction in the role of foreign policy in domestic politics and the consolidation of domestic power, sharper perhaps in Africa due to the recent history of nation building (Youde, 2007). Health has been more successfully framed as a goal of foreign policy and had more sustained attention when the health issues raised have also been important for domestic legitimacy, when they are shared across a number of countries, and are a subject of regional collaboration.

At the same time there appear to be features of African engagement in GHD that have weakened influence and health outcomes. African states have been reluctant to cede authority and policy space to global processes in health, where global institutions are perceived to disguise a more direct and influential hand of specific national or private interests and private actors (Smith, et al., 2010). Addressing long term goals and sustaining global attention to deeper drivers of ill health may be a challenge in the context of foreign policy engagements that are crisis driven and inconsistent, or that are set in the unpredictable and conditional terms of development aid for disease management (Smith et al., 2010; Haynes et al., 2013). In this context, where policy positions are not shared across countries, sovereignty outweighs unity. Lack of consensus on developmental policies weakens the formulation of shared goals in diplomacy, particularly with many global diplomacy processes weakening or bypassing regional institutions. The high level of external influence in the health sector focuses much diplomacy engagement around development aid. Disease and issue focused aid initiatives can be argued to have led to a dominance of remedial, humanitarian engagement in African international relations on

health, with less sustained attention to structural determinants, such as the public health impacts of liberalized trade. A suspicion that the rights approach may lead to interference in national sovereignty and of civil society intentions has weakened the role of these important levers for sustaining attention to health and its structural determinants in global diplomacy.

Emerging trends in African health diplomacy
The diverse perspectives in health diplomacy from Brazil, Cuba, China and other countries described in Section 1.2 suggest that GHD is not a monolithic field, and that new influences and interests are emerging. This raises questions for African countries, further discussed in this section. Firstly, do the perspectives that African countries bring to global diplomacy described in earlier sections provide leverage for their population health? Secondly, what are the possibilities for alliances across these different diplomatic interests and perspectives to advance health in Africa?

Historical concepts of unity, interdependence and the liberation ethic have played a transformative and strategic role in African foreign policy engagement, including in health. However a dominant discourse of disease focused development aid in health and lack of consensus on developmental foreign policy across countries suggest that there are challenges to bringing these perspectives into the 21st century, and to operationalizing them in the interest of public health. At the same time there are also less common, but growing themes in the literature that may become more prominent in future African engagement in GHD, changing this picture.

Growing resource scarcities and a rise in consumption demand from populations of emergent economies have raised competition over African energy, mineral and natural resources. Amosu (2007) calls it a time of potential, and "dangerous times for Africa". African countries and the AU consistently articulate a policy of value addition of strategic resources within the continent and demand for fairer terms of trade (AU UNECA, 2007). Multi-country alliances are raising new possibilities, momentum and space for policy development, including in areas such as technology transfer and innovation. There appears to be both opportunity and demand for African countries to realise their own interests and to negotiate fair benefits for their populations.

The growth of south-south alliances has provided new opportunities for African countries to widen domestic policy space and to increase leverage in global processes. South-south relations date back to the liberation struggles and independence period. Cuba has a long history of sending medical personnel to Africa, helping to set-up and send Cuban professors to medical schools in Eritrea, Uganda, Ghana, Guinea Bissau and South Africa (Blunden, 2008). China has, since 1963, and more so since 2000, invested in health infrastructure development, hospitals and provision of medical personnel, equipment and supplies, often for rural, under-served communities (Youde, 2007; Taylor, 2006). This has leveraged soft power for China's wider economic and trade goals. While there has been some critique of the value added return for African economies, it has been favoured by African countries as having less explicit conditionality, with a foreign policy interaction based on respect for

diversity, consensus-building over conflict, pragmatic approaches and gradualism rather than abrupt change (GHSi, 2012; Youde, 2010). Brazil has since the 1950s established South-South cooperation with African countries on technical assistance, technology transfer and joint diplomacy on areas such as economic inequality, sustainable development, intellectual property and research and development on neglected diseases (Alcazar, 2008; Fidler & Drager, 2009; GHSi, 2012). South-south alliances with these and other countries have brought collaboration on health systems strengthening, access to medicine and health technology, strengthening of regulatory capacity, research, development and technology transfer and have fostered the negotiation of common positions in GHD on these areas (Alcazar, 2008; Fidler & Drager, 2009; GHSi, 2012).

The published literature did not indicate how far African perspectives are informing and shaping the positions in these alliances and this would be an important issue for follow-up inquiry. There was caution noted on the extent to which these alliances are inclusive of all countries, and whether the more powerful BRICS countries seek the same level of transformation of the global economy as their smaller neighbours. The liberation ethic in African foreign policy potentially brings a critical and transformational discourse to global power arrangements. African countries have for example, with others, challenged the hegemony of current economic powers in global decision making, the neoliberal principles governing the system and the continuing insulation of monetary and financial power from the processes of democratic accountability (Randall, 2001). South Africa has joined with other emergent economies to call for more inclusive representation in global institutions and lobbied the G20 for a third Board Chair for Sub-Saharan Africa in the International Monetary Fund (IMF) (Landsberg, 2005; Randall, 2001). While there has been some accommodation of this with the G-20 and the Financial Stability Forum, bringing some emerging market economies into institutional mechanisms and engaging on how the global financial system should be governed, there is also concern that this falls short of the fundamental problems raised with the global financial system. It appears that south-south alliances increase, rather than reduce, the demand for regional integration (such as in SADC, ECA, ECOWAS), particularly in raising the influence of African countries in shaping the agendas and nature of co-operation in these alliances. It is argued that strengthened regional communities will assist in building a balance between the 'self-interested' diplomacy of individual emergent powers in south-south alliances, and diplomacy based on regional negotiations and solidarity, to thus respond to the interests of, and widen the benefits for weaker economies in their region (Alden & Vieira, 2005).

Many of these foreign policy debates and global changes that affect GHD are not taking place in the health sector. If health is to move away from only being a target of humanitarian concern or control of transborder disease risk in foreign policy engagement, and for greater influence of African perspectives within international processes, it will also be necessary to build greater policy coherence and institutional transformation *within* African countries. Countries that have stronger collaboration across sectors in health, greater public literacy and engagement and greater domestic policy coherence have been found to have stronger leverage in GHD, through clear policy direction, common values, and coordinated national strategies leading to a clear, unified national position endorsed

across sectors and addressed in multiple forums (e.g. Thailand) (Gagnon, 2012).

This includes engaging with public and civil society roles in diplomacy. Brazil has brought civil society and participatory policymaking into rights-based health diplomacy, and Cuba and Venezuela have targeted diplomacy not only at state actors, but also at citizens and civil society within other countries to change public perceptions. Constitutional reforms providing social and economic rights on the continent suggest scope for a wider African engagement with rights to health in diplomacy, as asserted in the African Charter on Human and Peoples' Rights (ACHPR) - a uniquely African human rights document adopted by the Organization of African Unity in 1979 (EQUINET, 2012). Civil society in Africa has played an important role in advancing the right to health in global policy, including in access to antiretroviral therapy, trade and patent rules, access to food, water and public services, control of risks from tobacco and breast milk substitutes and TRIPS flexibilities (AMREF, 2013; EQUINET SC, 2007; Haynes, et al., 2013). Bringing African grassroots voices and civil society into participatory policy making at the national level will be necessary to tap civil society's contribution to a global transformative diplomacy that positions health as a key goal.

Disclaimer of Interest: Mark Pearcey currently serves as Managing editor of the Journal of Health Diplomacy. This article has undergone a process of peer-review, independent of him

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