
Global Health Diplomacy: A Theoretical and Analytical Review **FREE**

Celia Almeida, Fundacao Oswaldo Cruz, National School of Public Health Sergio Arouca

<https://doi.org/10.1093/acrefore/9780190632366.013.25>

Published online: 28 February 2020

Summary

The end of the Cold War brought far-reaching world changes in many areas, including the health field. A number of “new” terms emerged (such as *global health*, *global governance*, and *global health governance* or *global governance for health*), among them *global health diplomacy* (or *health diplomacy*). There is no single, consensual definition of this term, and still less are there theoretical and analytical frameworks or empirical data to help understand its meaning and practice more clearly. *Global health diplomacy* is a *sociopolitical practice* involving the *global health policy community*, which promotes the interrelationship between health and foreign policy both at the national level, through cooperation projects or international actions and, in international arenas, by acting in *global political space* in the widest range of spheres, whether health-sector-related or otherwise.

Keywords: global health diplomacy, health diplomacy, health in foreign policy, global governance, global health governance, health sector governance

Subjects: Public Health Policy and Governance

Introduction

Most things exist before they are named.

(Murphy, 2014, p. 23)

The terms *health diplomacy* (HD) and *global health diplomacy* (GHD) have come to inhabit political discourse with increasing persistence since the end of the Cold War in the 1990s, particularly in international technical documents and world scientific literature. The latter historical period was a landmark of change, and had important repercussions in the international arena (Held, 2014).

Other significant developments in this history include the growing prominence of and different framings applied to health on countries’ foreign policy agendas in the 2000s, followed by a substantial increase in funding for *global health* (e.g., Fidler, 2004, 2007a, 2009, 2013).

The terms HD and GHD mean different things to different authors, and were coined to address the notion of global health, which appeared around the same time. The terms are often associated with contemporary globalization, but are also in dialogue with yet another, earlier expression: international health.

The term GHD is also very often associated with *international cooperation in health*, *global health governance*, or *global governance for health* (e.g., Birn, Muntaner, & Afzal, 2017; Buss & Faid, 2013). The latter two, coined in the same period, are also cause for debate and are regarded as being constructed “collectively,” although their “architecture” is still a subject for speculation (e.g., Fidler, 2007b).

This article revisits the context surrounding these themes, summarizes the definitions and critical analysis of GHD (or HD), as well as the term’s historical origins and development in the light of the process of world change. Our intention is to interrelate possible meanings, and state probable theoretical and analytical pathways that might illuminate the practical use of this expression.

The first section presents some of the main definitions of the term GHD (or HD) from a critical perspective, and comments on existing reviews. The second briefly discusses the changing landscape of international arenas and the concept of *global governance*. The third revisits the discussion of global health governance and global governance for health. The fourth section examines the debate about health in foreign policy, analyzes the concepts of *diplomacy*, *diplomacy and health*, and *hard*, *soft*, and *smart powers*, and offers a brief review of the meanings of GHD (or HD) in different countries (such as the United States and Cuba), in some blocs of countries (European Union, UNASUR), coalitions (BRICS), and regions (South America, English-speaking sub-Saharan Africa, and East African countries). The fifth and final section returns to the term GHD (or HD), in order to reconsider it in the light of the previous discussions of concepts and analytical frameworks.

Two dimensions of GHD (or HD) that may assist in the related (and much needed) conceptual elaboration are identified: its interrelationship with foreign policy, and its health-related diplomatic activities. The former considers the changing meanings of the relationship between health and foreign policy over time, and the latter addresses diplomatic action in health as a social and political practice, absorbed and exercised by health advocates.

The initial assumption is that analysis of the term calls for inter- and transdisciplinary approaches. The intention here is to contribute both to the elaboration of the concept of GHD (or HD), and to analyzing it as a concrete practice.

Brief Literature Review: Definitions and Analytical Insights

There are quite a number of publications on health diplomacy (HD) and global health diplomacy (GHD), as well as some methodologically targeted literature reviews on their definitions and on the subject of health in foreign policy. There are also articles offering functional explanations of possible outcomes, and a few annotated literature reviews. However, there appears to be no systematic review of the terms or their definitions.

About Definitions

The terms used in the literature are not homogeneous. Some authors refer to HD (e.g., Buss & Faid, 2013; Feldbaum & Michaud, 2010, Fidler, 2013); more use GHD (e.g., Kickbusch, Silberschmidt, & Buss, 2007; Lee & Smith, 2011; Ruckert, Labonté, Lencucha, Runnels, & Gagnon, 2016); while others use the two terms interchangeably (e.g., Katz et al., 2011). In Brazil, the term “health diplomacy” is used to designate any—not only Brazilian—activity in the national, regional, or global international arena with regard to issues affecting population health and individual health anywhere in the world.

The publications also treat a number of different terms as though they were synonymous, whereas they actually mean different things: *global health public diplomacy* or *public diplomacy in global health* (Ornstein, 2015), *medical diplomacy* (Bourne, 1978), *disease diplomacy* (Davies, Kamradt-Scott, & Rushton, 2015), *global health and diplomacy* (Watt, Gomez, & McKee, 2014), *regional health diplomacy* (Gyngell & Wesley, 2008; Hamzawi, 2008; Herrero & Tussie, 2015), and others.

There is also the term *thematic diplomacy*, which refers to the specific purposes of health-related diplomatic activities (such as *public diplomacy*, TB control, *pharmaceutical diplomacy*, *AIDS diplomacy*, *environment diplomacy*, and *humanitarian diplomacy*).

Some authors have offered summaries of definitions of GHD (e.g., Lee & Smith, 2011; Ruckert et al., 2016) that reflect what is to be found in the available Anglophone literature. Nonetheless, it is worth examining points highlighted by significant definitions of GHD or HD given in the literature in the 10-year period from 2007 to 2017 (Table 1.)

Table 1. Some Common Definitions of GHD or HD (2007–2017)

Global Health Diplomacy or Health Diplomacy	
Definition	Author/Reference
“Health is a catalyst for the rearrangement of powerful interests within government. It sets a new standard against which foreign policy can be measured. Health moves foreign policy away from a debate about national interests to one about global altruism.”	Horton (2007, p. 807)
“The term global health diplomacy aims to capture (...) multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health.”	Kickbusch, Silberschmidt, and Buss (2007, p. 230)
“[Global health diplomacy is] an emerging field that addresses the dual goals of improving global health and bettering international relations, particularly in conflict areas and in resource-poor environments.”	Adams et al. (2008, p. 316)
“[GHD is . . .] the cultivation of trust and negotiation of mutual benefit in the context of global health goals.”	Bond (2008, p. 377)

Global Health Diplomacy or Health Diplomacy	
Definition	Author/Reference
"Health Diplomacy is the chosen method of interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems, and securing the right to health for vulnerable populations."	Health Diplomats, cited by Lee and Smith (2011, p. 1)
"Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care."	Koplan et al. (2009, p. 1995)
"'Global health diplomacy' refers to both a system of organization and to communication and negotiation processes that shape the global policy environment in the sphere of health and its determinants."	Kickbusch and Kökény (2013, p. 159)
"[A working definition of health diplomacy is] the policy-shaping processes through which States, intergovernmental organizations, and non-State actors negotiate responses to health challenges or utilize health concepts or mechanisms in policy-shaping and negotiation strategies to achieve other political, economic, or social objectives."	Fidler (2013, p. 693)
"GHD refers to international diplomatic activities that (directly or indirectly) address issues of global health importance, and is concerned with how and why global health issues play out in a foreign policy context."	Michaud and Kates (2013, p. 24)
"Global health diplomacy (GHD) has emerged as a concept to describe the practices by which governments and non-state actors attempt to coordinate efforts to improve global health."	Ruckert et al. (2016, p. 61)
"GHD focuses on international negotiation, which includes a range of processes, from finalising agreements between multilateral or bilateral aid donors and recipient countries, to the processes of making binding and non-binding international agreements in health or related to health."	Smith and Irwin (2016, p. 1)
"[GHD] refers both to formal multilateral and bilateral decision-making around health, and to the interaction between health and foreign policy concerns (such as 'health security') involving negotiations and cooperation among a range of state and non-state actors."	Birn, Muntaner, and Afzal (2017, p. S38), based on the findings of various authors, most cited in this table

These selected definitions show that there has been little change over the course of a decade. Some convey an extremely positive view of the capacity of GHD to overcome world health problems (Adams, Novotny, & Leslie, 2008; Bond, 2008; Health Diplomats, n.d.); others emphasize the ability of health problems to influence foreign policy (Horton, 2007; Kickbusch, Novotny, Drager, Silberschmidt, & Alcazar, 2007); and still others warn that GHD can be used to attain goals unrelated to health (Fidler, 2013).

Although there is no consensus on any one definition, almost all of them do display features in common: references to the interconnection between health and international relations, and to certain key elements (i.e., the use of multi-actor, multilevel negotiations to resolve disputes and forge agreements relating to health). However, all the definitions take a descriptive, functional, or instrumental approach to GHD, at the same time referring to global health or “global health challenges” as givens or knowns, without asking why (or how) a health problem comes to be defined as “global” (Lee, 2009). Finally, with few exceptions, they are explicitly or implicitly normative, as Eggen and Sending (2012) note: “[...] many of the texts aim to convince readers about the importance of the health in foreign policy rather than trying to offer explanations backed by empirical data” (p. 7).

Fidler’s working definition (2013) is descriptive without being normative and “identifies two contexts for diplomatic activity in health”: the first has to do with responses to health challenges proper (e.g., epidemics, cross-border health hazards); and the second incorporates health “into the overall package for improving relations among countries” (p. 693).

Reviews of the Literature on GHD or HD

The reviews confirm that the literature contains different definitions of global health diplomacy (GHD) or health diplomacy (HD) and uses different frameworks that serve various purposes depending on their authors’ points of departure and worldviews. They also refer to the polysemy of the term, and the vast number of actors that have come to operate in this area since the 1990s at the national, international, and transnational levels. They differ in the search strategies they apply to the (predominantly Anglophone) literature, and in the objectives they are oriented toward (Table 2).

Table 2. Literature Review Summary

Author Reference	Methods	Findings
Katz, Kornblet, Arnold, Lief, and Fischer (2011)	The authors examined 106 articles on GHD, published in peer-reviewed scientific journals from 1970 to 2010. Of these, 76 (about 72%) first appeared in the 2000s.	The authors identify GHD as a collective effort favorable to the great powers, such as the United States. They describe the term GHD as “a term also used by academics and practitioners for activities ranging from formal negotiations to a vast array of partnerships and interactions between governmental and

Author Reference	Methods	Findings
		nongovernmental actors” (p. 505), and point to the differences between the distinct spheres in which participating actors operate. They confirm the perception that, although the term has entered the mainstream, it has a variety of different meanings (p. 506).
Blouin, Molenaar, and Pearcey (2012)	Covering the period 1998–2012, the authors examined the role of GHD, including what they refer to as “South–South diplomacy” in Africa, with the focus on key challenges for health and strengthening health systems. Their study selected three areas for research: the WHO Code on International Recruitment of Health Workers; access to essential drugs through South–South partnership; and the involvement of African actors in global health governance.	The authors sought to identify researchers’ theoretical and conceptual frameworks, research strategies (methodological choices), and analytical tools. Their main conclusions indicated that studies in this field were scarce in Africa, and that the core focuses were on how governments use “health” to attain other strategic, economic, or ideological goals and on international discussions or negotiations to improve global health through collective action (p. 5). Most of the studies reported on were descriptive, few made their theoretical frame of reference or methodological strategy explicit, and practically no empirical studies were found.
Martins et al. (2017)	Bibliometric survey of only one database, the US National Library of Medicine (Pubmed), up to August 2016, using descriptors identified by Medical Subject Headings (MeSH). As “health diplomacy” does not figure in that database, “synonyms” (world health, or world and health; international cooperation or international and health; internationality and health or health and diplomacy) were used, which—although questionable—may be taken as preliminary proxies. Surprisingly, this study did not use words in Portuguese or	The authors found that publications on the subject began to appear in the 1970s, then did so with growing frequency from 2007, peaking in 2013 and then “stabilizing,” and that the early authors came mostly from professional backgrounds in institutions in the United States (61%), Switzerland (14.8%), and Brazil (5.6%), with certain institutions predominating in these three countries. These figures, they explained, did not correspond completely with the number of publications by country, which are led by the United States (53.7%) and United Kingdom (25.9%)—which is nothing new, given that both are home to large numbers of indexed print and online journals. The survey found that the commonest types of

Author Reference	Methods	Findings
	Spanish as descriptors. The study found 54 publications, which were analyzed in detail.	publication were editorials (38.9%), confirming efforts that have been made to introduce the subject into political and academic debates; “review/reflexive” articles (29.6%); and case studies (22.2%) (p. 231).
Ruckert, Labonté, Lencucha, Runnels, and Gagnon (2016)	The authors carried out a critical literature review over the period 2002–2014. They searched two academic databases—Scopus and Web of Science—and Google Scholar, collected only English-language articles, and, by means of successive reviews of abstracts and complete articles, and by using the NVivo 10 software, established a coding tree. Of the 135 articles finally selected, only 49—those containing implicit or explicit reference to international relations theories—were reported on (p. 62). Their review was designed specifically to identify the international relations theories implicit or explicit in the various authors’ arguments.	Although not systematic, this review did provide a good summary of the main definitions and viewpoints from which various authors have approached GHD. It also analyzed the underlying driving forces at three levels—international/global, national/domestic, and individual (celebrity activism and policy entrepreneurs) (pp. 62–65). Briefly, the authors concluded that the most important variable in the GHD discussion was power relations among actors, because of the asymmetrical interrelations among them, not in the health sector alone, but also in other sectors and policy areas that reflect in populations’ conditions of life and health. They found that realist theory predominated, and argued that international relations theories (particularly constructivism), together with a policy analysis approach directed more specifically to agenda-setting and policymaking alternatives (as developed by Kingdon, 1984), were essential to a better explanation of the concept and practice of GHD (Ruckert, Labonté, Lencucha, Runnels, & Gagnon, 2016, pp. 64–65).

Source: Prepared by the author from the publications mentioned in the table.

Another finding has been that the definitions do not constitute concepts, which are understood here as words or terms that operate a theory (have a theory—or an inter- or transdisciplinary approach—“behind” them, guiding their elaboration) and make it possible to explain certain realities and practices in specific circumstances.

To some authors, HD or GHD is a new field of multidisciplinary and multi-professional knowledge and practice, whose object is health and related negotiations (Buss & Faid, 2013; Kickbusch et al., 2013). Ruckert et al. (2016) also argue that “there has been little effort to comprehensively examine and synthesize the theorization of its practice, drawing on international relations theories” (p. 61), especially those as constructivism and agenda-setting political science theory. Indeed, a number of authors note the lack of theoretical and conceptual bases from which to develop solid frameworks for analyzing health diplomacy and GHD—and it is certainly true to say that more meaningful dialogue is needed between health and international relations theories and other disciplines. That dialogue, meanwhile, is still in the process of construction. However, building new theoretical and analytical frameworks that interrelate concepts and theories from different disciplines is a major challenge that is not always successfully met (Jones, Clavier, & Potvin, 2017). This is a complex, inter- and transdisciplinary construction; i.e., it involves diverse social science and political science disciplines, as well as critical political economy.

The insertion of the word “global” into global health (which has replaced the term “international health”), and thus into GHD, reflects the specific nature of the contemporary globalized world, and of the myriad actors operating in the international arena. It seems important, then, to revisit some notions (such as global governance and global health governance) that may afford a better understanding of GHD, its etymology, and its connections with broader dynamics (the changing landscape of international arenas since World War II).

The Changing Landscape of the International Arena and of Global Governance

It is important to understand something of the global context and the changes from which the terms and practices known as global health diplomacy (GHD) or health diplomacy (HD) have emerged.

A Little History

A century before World War I (1914–1918), the world was already under the governance of a few public and private organizations (Murphy, 2014). That particular period in the globalization of industrial capitalism ended with World War I, the depression of the 1930s, and World War II (1939–1945).

World War II is known to have had a devastating international impact, drastically remodeling the world order, and consequently (most importantly) radically transforming global power (Anderson, 1995; Arrighi, 1996; Fiori, 2007). When it ended, instruments of multilateral governance were set up, with the United Nations Organization (UN) at the center of a new system of public and private organizations that, for about 30 years (1945–1975), leveraged rapid economic change.

Multilateral financial organizations (those that were part of the Bretton Woods System—the World Bank, International Monetary Fund, and others), and foreign trade organizations (the General Agreement on Tariffs and Trade, or GATT, created in 1948), were designed primarily

to open up borders to foreign trade, and were key to so-called postwar economic globalization. “The geopolitical stability engendered throughout the post-war years was a precondition for economic globalization,” and international cooperation grew considerably as part of that process (Held, 2014, p. 62). A number of transnational agencies also emerged at this time, along with new global policies, involving states, intergovernmental organizations, and international nongovernmental organizations, in addition to countless pressure groups.

In the second half of the 1970s, the world experienced its first major economic crises since the war (1975 and 1978). From the mid-1980s onwards, contemporary globalization can be seen to have accelerated and expanded (Fiori, 2005, 2018), with a “strengthening of the neoliberal agenda (. . .) and the empowerment of markets over States in almost all the world’s countries” (Gonçalves & Inoue, 2017, p. 20; free translation).

The end of the Cold War (in around 1989–1991) laid bare the complexity of the new world order, as evidenced by the technological, economic, geopolitical, sociocultural, and ethical changes that have been ongoing ever since, and the growing visibility of the grand cast of cross-border, and increasingly global, actors operating in international areas (Fiori, 2005, 2018; Held, 2014; Weiss & Wilkinson, 2014).

Held (2014) summarizes the overall trends that characterized that change (Table 3).

Table 3. Post-Cold War Trends in Global Governance, and Their Meanings

Trend	Significance	Change
Greater interrelation between domestic and international political arenas	Relations among nation states/ governments and international organizations are neither linear nor one-way, but reflect differentiated pressures and circumstances. Some dimensions of these interrelations are particularly important (e.g., foreign trade rules and intellectual property rights; international financial crises; climate change, and so on).	Global problems mobilize a diversity of actors at various political levels, and result in different forms of governance, with impacts on decision-making processes in both the national and international spheres, spreading and driving cross-border arrangements and transgovernmental networks.
Emergence and growth of powerful new nonstate actors	These actors have always engaged in political discussions, particularly at the national level, in the form of lobbies, aggregating and channeling diverse interests and, to some degree, molding states’ behavior in international forums.	These actors have also come to influence international policies directly, working with organizations and institutions in this arena. This has resulted in a far more complex system of governance.

Trend	Significance	Change
Change in application of international regulations	The different forms of governance produce diverse regulations, compliance with which has traditionally been secured by punitive sanctions.	Increasingly, regulations have been enforced through alternative means and instruments, such as “voluntary arrangements” or “initiatives.” The spread of new forms of regulation (incentives and capacity-building) may be more powerful than punitive measures as instruments for changing behavior.

Source: The author, from Held (2014, pp. 64–65).

This dynamic was reflected in a significant growth in international treaties and regimes, which substantially altered the legal framework within which states operated, as well as in the number of international conferences, forums, and meetings of key bodies as part of the international decision-making process. In this way, a complex web of mechanisms was woven for coordination and specific collaborations, entangling nation states in a wide variety of global governance mechanisms.

The most recent phase of that globalization (from the 2000s on) attests to an intrinsic relation with information technologies, leading to what Singer and Friedman (2014) call hyper-connectivity, analyzed by Rocha (2014), and which affects the process decisively by affording access to actors that formerly had little influence (Gonçalves & Inoue, 2017; Schmitz & Rocha, 2017).

It is that context of change that frames our discussion here.

Global Governance

The term *governance* concerns the ability to govern, which entails administering interests and constructing political force in order to attain certain goals. On the domestic or national plane, that definition relates to government at different levels and in different dimensions. In the international or global sphere, governance takes on different meanings, which relate to the need for a certain order to exist in the world, whose constituent elements are the multiplicity and diversity of actors operating in that sphere and their respective agendas. However, that “order” can change at specific points in history.

The term “global governance” gained visibility in the late 1980s and early 1990s, but has antecedents that relate back to the discussions of *hegemonic stability* or the concept of *world hegemony* (Kindleberger, 1973; Gilpin, 1987, cited by Fiori, 2005, pp. 61–63) sparked by the economic crises of the 1970s. The question under discussion was whether or not, in order for a world system made up of nation states to be kept stable and in some kind of order, there was a need for a “power above all others” or a “global power legitimated by other States, thanks to the ‘convergent’ efficacy of its world governance” (Fiori, 2005, p. 62; free translation). In other words, the United States’ leadership in conducting world affairs since World War II was being called into question, and the debate focused on the (possible) crisis in that leadership

and how world governance was then to be organized. The long academic debate over the need for “stabilizer or hegemonic countries” and “world hegemonies” led to what was subsequently agreed should be named “global governance” (Fiori, 2005, p. 63).

Concretely, with the end of the Cold War and the “disappearance of the bipolar geopolitical regime,” the “ethical and ideological base on which cooperation among the leading capitalist powers rested also disappeared” (Fiori, 2005, p. 71). That moment of transition to an uncertain order was seen as a possible return to chaos and anarchy (the possibility of which, from a realist perspective, is ever-present), leading to the development of thought about (and the restructuring of) the “new world order.”

Authors generally consider global governance to refer to the totality of formal and informal manners and mechanisms by which the world is governed (Weiss & Wilkinson, 2014), i.e., a polycentric, multidimensional, multisector, and multi-actor system (Held, 2014). Murphy (2014) argues that the term is used in various different ways and that, in the contemporary context, it is more reasonable to think of it as the kind of governance necessary for a given level or issue (or to respond to certain inter- and transborder issues of collective interest).

In the international relations field, the term’s theoretical origin is close to liberal institutionalism. Accordingly, it is necessary to differentiate between *global governance* and the *international regime*, the latter of which is defined as principles, norms, rules, and decision-making procedures around which actor expectations converge in a given issue-area (Gonçalves & Inoue, 2017, p. 31, free translation). These authors state that “regimes are contemplated in the concept of governance,” but they have a “greater degree of institutionalization than governance [...] they center on specific formal arrangements” (Gonçalves & Inoue, 2017, p. 31). The “definition of regime is related to its thematic delimitation, while the notion of global governance spans the intersections, interactions, overlaps and conflicts among regimes, as well as other relations” (Gonçalves & Inoue, 2017, p. 32). As international organizations and different institutions have gained “density” (most noticeably since the 2000s), the concept of *regime complex* has developed to deal with this breadth; nonetheless, it preserves the thematic focus (Gonçalves & Inoue, 2017, pp. 34–35).

The array of mechanisms by which global governance is exercised surpasses formal interstate relations (although these continue to be a key part of the dynamic) (Held, 2014, p. 63). It particularly involves relations between global-level decision-making processes and associated national or local implementation, and vice versa (the global effects of local actions), and the interrelations between actors and the mechanisms they use, at all world levels. New institutional arrangements and transgovernmental networks act in parallel with multilateral organizations, as well as with purely private actors that set up their own *governance institutions*, driving the spread of new types of *global governance*.

Some of these mechanisms are more influential than states: e.g., financial markets and the private-sector standards increasingly used as guiding principles in various areas, in alliances or public-private partnerships (PPPs) that bring together corporations, nongovernmental organizations (NGOs), and states. These PPPs are particularly powerful in some areas, such as *global health governance* (under Global Health Initiatives, GHIs, and other specific

arrangements) (Almeida, 2017; Held, 2014; Ruckert & Labonté, 2014). There are also less visible lobbies for a variety of interests, such as the mainstream media (Weiss & Wilkinson, 2014).

On the other hand, “the normative basis of what constitutes ‘good governance’ has been the subject of much scholarly and policy debate” (Lee & Kamradt-Scott, 2014, p. 3). This generally refers to the public sector in developing countries and takes on different meanings depending on who is doing the defining. As Lee and Kamradt-Scott (2014) wrote:

the UN Development Programme (UNDP) frames good governance principles within the context of sustainable human development and poverty alleviation (. . .) In contrast, the World Bank has focused on creating efficient and effective public administration that cast democratic governments in the role of, inter alia, enabling markets to thrive as a core component of economic development. (p. 3)

In any case, in spite of the voices contesting the different perspectives and meanings, “good governance” has been made the central focus of donor control over recipient countries (Lee & Kamradt-Scott, 2014; Sachy, Almeida, & Pepe, 2018).

Lastly, Gonçalves and Inoue (2017) argue that two elements are particularly significant: “the power aspect in governance—moving away from the more ‘managerialist’ and normative readings; (. . .) and the question of scale—which means problematizing the *global* aspect of governance” (p. 50), making it possible to investigate: “Good for whom? And good for what purposes?” (p. 54).

Put differently, *power* is accumulated from multiple different sources of authority (including economic, military, technical, ethical, and moral authorities), and is thus a *relational* concept. The problem is the complexity of all that emerges from those dynamics, particularly in a world with an enormous diversity of “authorities” and voices wanting to be heard (Lee & Kamradt-Scott, 2014), but with a very strong *hegemon*, the United States, responsible for conducting the world system since the postwar period, and also the “new world order,” since the 1980s, acting as a strong imperial power, mainly in the new century (Fiori, 2018, 2019).

In summary, global governance is seen as not only hierarchical, but also horizontal at all levels; a process of political cooperation and coordination among actors building coalitions, provisional consensuses, commitments, or bargaining, and that varies between one sector, field, or issue and another (Held, 2014; Murphy, 2014). In each case, the power configurations and policies are different, and are not controllable by any single actor. This does not mean, however, that all actors gain an equal voice or vote (or even influence) in agenda-setting or policymaking. In this complex interdependence, the notion of shared global problems assures that multilateralism can moderate (but not eliminate) the asymmetries of power (Held, 2014).

Kennedy (2008, p. 832) adds that “we will need to think about global governance as a dynamic process in which legal, political and economic arrangements unleash interests, change the balance of forces, and lead to further reinvention of the governance scheme itself.” Accordingly, global governance forms part of the permanent process of world change.

GLOBAL GOVERNANCE: KEY IDEAS

1. The term global governance has emerged as a manner of understanding the important changes in the dynamics of the world system (made up of nation states) attendant on the decline and end of the Cold War (1989–1991), and with a view to building and conducting a “new world order” (different from the previous bipolar order).
2. It emphasizes the importance of collaboration among states and nonstate actors to address the changes in world dynamics, mounting demands, and scarcity of resources.
3. It stresses the need for new institutional arrangements to deal with growing cross-border flows, which in turn pose the need for changes in decision-making processes in various different national and international forums.
4. It is seen as not only hierarchical, but also horizontal at all levels, a process of political cooperation and coordination among actors building coalitions, provisional consensuses, commitments, or bargaining, which varies between one sector, field, or issue and another.
5. It draws attention to the question of **power** at the different levels—from local to supranational—and recognizes the role of the different forces and interests involved at each level, and in specific situations and issues.
6. Power configurations and policies in each situations and type of issue are different, and this means that the various actors do not have equal say or vote (or even influence) in agenda-setting or policymaking.
7. In all cases, the nation states continue to be extremely important actors in the world system, whether this dynamic is seen as anarchic (in the realist approach) or is viewed in terms of the world hegemony approach, i.e. the hegemony of a specific country—a hegemon—or countries (the leading capitalist powers) over the system, which entails permanent struggle among these actors.

An understanding of global governance (and related discussions in the literature) is useful in order to grasp better the meaning of global health governance, a term which was also coined in the 1990s, and which is of interest to our discussion here.

Global Health Governance

There are various definitions of global health governance (GHG), and the term suffers from a lack of accurate theoretical and conceptual formulations. Its application also varies, generating confusion about how the term should be applied, where its boundaries are, what problems are to be tackled, and what goals are to be achieved (Lee & Kamradt-Scott, 2014).

Reviews of the literature on the subject show that GHG is seen as a set of mechanisms designed to respond to *new health problems*. Fidler (2010) wrote that GHG “refers to the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and non-State actors to deal with challenges to health that require cross-border collective action to address effectively” (p. 3). The author warns, however, that “this definition’s relative simplicity should not obscure the breadth and complexity of this concept” (p. 3).

The main question to be addressed in this discussion is thus how global health is to be defined; i.e., how does a health issue come to be classed as a “global health problem” requiring collective action?

Kay and Williams (2009, p. 3) note that, generally speaking, global health is structured as a measurable category based on decontextualized *problem-solving* approaches, whose solutions are regarded as valid for the whole world. There are also only limited analyses of the influence of any given paradigm on global health agenda-setting.

In this light, Lee (2009) examines “the strong positivist tradition in the history of public health from which thinking about global health has emerged,” and analyzes “four main perspectives—and the institutions, ideas and interests behind them” (p. 28). These approaches (biomedicine, security, economism and human rights) and their meanings have framed the terms of the discussion and shaped international policies in this field (Table 4).

Table 4. Key Perspectives Shaping the Terms of the Discussion, the Global Health Policy Agenda, and Global Health Diplomacy

Approaches	Historical Components and Meanings	Policies
Biomedicine	A broad system of beliefs and theories about diseases characterized medical practice until the mid-19th century. These conceptions were replaced by the biomedical model, centered on the scientific and technological advances of that time and which have proliferated since then, particularly in the postwar period, generalizing a reductionist focus on the physical causes of disease.	This focus has been dominant in the WHO since its creation, despite the broad definition of health that figures in its Constitution, inspired by the European social medicine of that time (Brown, Cueto, & Fee, 2006; Almeida, 2013, 2016). The biomedical approach has predominated in practically all national and international health policies over time, and continues to predominate to this day.
Social Medicine	Social Medicine had its formal origin in the revolutionary movements that arose in France in 1848 and spread to other European countries, but its principles date back to the 18th century. It stressed that the occurrence of diseases is related to	Primary Health Care (PHC) and Health for All in the Year 2000 (1978). This approach takes the form of international cooperation in health focused on causal factors in the health status of

Approaches	Historical Components and Meanings	Policies
	social issues and incorporated the study of social structures as fundamental determinants of the health-disease process. Social medicine saw a revival (mainly in Latin America) in the late 1960s and 1970s, advocating long-term strategies centered on the social determinants of health.	individuals and populations. The idea was short-lived: In the 1980s this perspective was replaced by the notion of <i>selective PHC</i>.
Economism	From the 1980s onward, simultaneously with the biomedical model and complicit with it, economic rationalism came to dominate the terms of the debate, proposing changes to financing, organization, and service provision.^(a) This trend became established in the 1990s, and entered the new century.	The central features of health sector reform policies are the preponderance of market and business mechanisms and the reduction of public service provisions. These reforms were actively proposed as conditionalities for macroeconomic adjustment programs conducted by the World Bank (Almeida, 2016). Several new indicators were defined to measure investment in health, such as Disability Adjusted Life Years (DALY), Years of Life Lost from Premature Mortality, and Global Burden of Disease (GBD), among others. The primary focus has been on a few diseases and selected health issues, and new initiatives have been created.^(b)
Security	The end of the Cold War ushered in a new National Security agenda including factors beyond the traditional ones, among them “health,” and leveraged by the September 11, 2001 terrorist attacks in the United States.	Reflecting the subordination of health to powerful interests.
Human Rights	In the health sector, this focus seems to be rooted in social medicine (Lee, 2009) and has been gradually reactivated since the late 1960s, and more strongly since the beginning of the 21st century. But the results have been frustrating.	Grounded in a substantial legal framework conceived, reviewed or drawn up after the horrors of the World War II,^(c) this approach has being deliberately disregarded by neoconservative reforms, since the eighties.

- a** *Note.* Particularly the World Bank, philanthropic foundations (Bill and Melinda Gates, and others), and other private actors.
- b** The Millennium Development Goals (MDG) launched in 2000, and the Sustainable Development Goals (SDG) launched in 2015; global health initiatives (GHI) and Public-Private Partnerships (PPP) began to become prevalent in the second half of the 1990s, and have grown exponentially since the turn of the century. See, for example, the Global Fund to Fight AIDS; Malaria and Tuberculosis (created in 2002); and PEPFAR, which fights HIV/AIDS (created in 2001), among many others. There has been a focus on outbreaks, epidemics, and possible pandemics with major potential economic impacts (as fears are fanned by the media), alongside a neglect of the effects on populations, as seen in recent responses to Acute Respiratory Syndrome (SARS) and avian influenza. See also the United Nations Environment Program (UNEP), which was founded in 1991. The UNEP Finance Initiative was launched in the same year, when a small group of commercial banks joined forces with UNEP to catalyze the banking industry's awareness of the environmental agenda. UNEP has worked closely with industries to develop environmental management strategies, and has begun to work with forward-looking organizations in the financial services sector. More information is available on the UNEP Finance Initiatives website <http://www.unepfi.org/about/background/> (accessed February 14, 2018).
- c** A few examples include: the International Covenant on Economics, Social and Cultural Rights (1966); International Convention on the Rights of the Child, PHC, and Health for All by the Year 2000 (1978); a human rights approach to HIV/AIDS (1980s onwards); the UN Commission on Human Rights (2002), and the People's Health Movement, a civil society initiative.

Source: The author, from Lee (2009) and others cited in the table.

Lee (2009) sees these approaches, often competing or in opposition to one another, as pervading the global health agenda and policy decision-making processes, and as subject to the worldviews of the actor (or actors) involved and their power in dispute over certain policies.

A “health problem” may be highly important in a given region and affect various countries with high rates of morbi-mortality (such as diarrhea and dehydration in children under 5 years old, caused by malnutrition or lack of basic sanitation), but not be regarded as a global health problem. On the other hand, HIV/AIDS infection was (and still is) classified as an important global health problem, even though rates of incidence and prevalence in a country may be no greater than those of a number of other diseases in that same country. Therefore, the definition of global health is variable, both descriptively and prescriptively, and in both cases its uses are embedded in “particular normative frameworks,” which depend on whoever is formulating the problem and its solution (Lee & Kamradt-Scott, 2014, p. 4). Descriptively, global health is used for certain issues (e.g. epidemics, pandemics, neglected diseases) or needs of specific populations (e.g. the poor, those with HIV/AIDS) in particular geopolitical areas (e.g. low-income countries). Prescriptively, global health is used as a rationale for certain international strategies (e.g. universal health coverage, *health security*). In the words of Lee and Kamradt-Scott:

the theory and practice of global health must be critically understood within the context of shifting material and ideational circumstances. This social construction of the term has had direct implications for the “practice” of global health and how, in turn, it impacts on material reality. (2014, p. 4)

Along the same lines, Sparke (2009, p. 132) revised the economicist approach, which has been hegemonic since the 1980s. The author defines *economism* as the belief in the primacy of economic factors to explain any issue in the world or to justify policy proposals. This economic determinism is strongly criticized, and the term has gained a pejorative connotation: “In academic arguments and polemics today the term further implies that an insistence on such

primacy is either theoretically essentialist or ideologically interested” (Sparke, 2009, pp. 132–133). However, Sparke argues that this perception too is mistaken and is another form of reductionism:

It risks obscuring the actual force of particular economic policies in globalised regimes of governance, and it meanwhile abstracts important arguments over how the political and economic interconnect in the world at large into entirely academic or epistemological issues.

(Sparke, 2009, pp. 131–132)

Sparke (2009) distinguishes three dominant types of economism: (1) market fundamentalism, (2) market foster care, and (3) market failure, identified by their blanket discourses on the operations of capitalist markets. These three forms of economic interpretation and argument are used to organize discussions on global health and GHG (Table 5).

Table 5. Types of Economism, Rationales, Uses, and Contradictions

Types of Economism	Rationale	Uses and Contradictions
Economisms of Market Fundamentalism	This is the most dominant, common, and notorious among neoliberal political and economic discourses. It has been “normalized” in microeconomics classes and courses, and persists in the discourses of the G8, WB, IMF, WTO, World Economic Forum, etc. Critical of “big government,” it trusts to invisible market regulation to achieve “good growth,” and thus “good health.” “Poor health” is a lack of integration into the network of global capitalism.	The measures it advocates are often seen as less restrictive, and as resulting from necessary, rational economic calculation in financial priority-setting. In fact, they turn “care for human life into care for human capital” (Sparke, pp. 134–135). Examples: cost-recovery policies and cost-effectiveness analyses; user fees and healthcare cutbacks; Quality Adjusted Life Years (QALYs); Incremental Cost-Effectiveness Ratios (ICERs); Willingness to Pay (WTP) metrics; free trade regulations related to pharmaceuticals.
Economisms of Market Foster Care	This has been defined as “the inherent efficiencies of individual choice-maximising behaviour, market-based governance and capitalism growth.” However, it has been argued that certain areas of global governance only work efficiently and sustainably when market access is facilitated for the poor and sick, i.e., when they are	Interventions proposed are for focused action, generally on relieving a few, specific diseases by means of vertical programs financed by private funds; reducing infant mortality, with “specific packages”; and other such initiatives. These are

Types of Economism	Rationale	Uses and Contradictions
Economisms of Market Failure	“adequately prepared for integration” (Sparke, 2009, p. 135). Global health problems are explained in terms of the “poverty trap” (Sachs, 2005). These theorists thus associate the biomedical approach with economic instrumentalism, to the greater benefit of self-interested capitalist investments. Abandoning the metaphor of the global economy as a lever, this arises out of a critique of the previous economisms, to focus on economic inequalities, associating them with health inequalities, and relating market failure to health failure. The epidemiological approach is also used to explain differences between countries, local regions, and cities—“the pathology of inequality” (Sparke, p. 148). It also utilizes multidisciplinary approaches that bring other categories into the discussion.	regarded as important steps toward leveraging individuals out of poverty and into the market. Examples: macroeconomic adjustment policy conditionalities (1980s onwards); the World Bank’s “fair adjustment” (2017); the Commission on Macroeconomics and Health, which aims to “mak[e] investments in order to make the world safe and secure for economic globalisation” (Sparke, pp. 143–145). A number of studies have shown that economic inequalities and poor health (disease) are statistically, even predictively, correlated. However, this approach ends up hostage to findings in specific spaces that are, nonetheless, embedded in broader contexts shaped by interdependent historical features permeated by forms of codetermination and overdetermination. Criticisms and reformulations led to the work of the WHO Commission on Social Determinants of Health (2005–2008).

Source: The author, from (and all page references to) Sparke (2009, pp. 134–154).

All three “labels” are useful heuristically, but they “provide an economic base-map [a concept-mapping metaphor] that frames how the global in global health is understood” (Sparke, 2009, p. 137). These different geographies of “global” not only distinguish different economisms as modes of representation; they also have profound consequences in terms of how health problems are structured as “global” (or not), and how global governance is exercised.

In short, competing discourses on global health are constructed and materialize in global policies promoted and advocated by different organizations, institutions, agencies, and coalitions (Fidler, 2010; Kay & Williams, 2009).

That is the context that frames the discussion of GHG, as Lee and Kamradt-Scott (2014, pp. 4–5) warn. They argue that the term emerged from the extensive academic production on international cooperation, and that its “parameters” were defined on the basis of a series of papers commissioned by the World Health Organization (WHO) in the late 1990s. They highlight the difficulties underlying any intention to formulate concepts, and the lack of clarity about what is to be governed, for whom and for what purpose. On the other hand, they analyze “different ontological variations of GHG” (p. 5): first, “the scope of institutional arrangements deemed to fall under the rubric of GHG”; second, “the perceived strengths and weaknesses of existing institutional arrangements known as GHG”; and third, “the ideal form and function of GHG.” As a result, these variations also disclose differences in how GHG has been conceptualized and used and the authors identify “three distinct uses of the term GHG” in the literature.

The first use—globalisation and GHG—refers “to the institutional actors, arrangements and policy making processes that govern health issues in an increasingly globalised world,” and “it has emerged directly from concerns about the inner workings, and external relationships, of the WHO” (Lee & Kamradt-Scott, 2014, pp. 5-6). The second conceptualization—global governance and health—describes “how global governance institutions outside of the health sector [e.g., World Bank, IMF, WTO, OECD and others] have influenced the broad social determinants of health,” and “much of this literature is also critical of the promarket orientation of these institutions”; however, paradoxically, “this literature has focused on improving good governance within these institutions” (p. 6). Finally, the third use concerns “what governance arrangements are needed to further agreed global health goals.” Actually, “it is not only responding to the impacts on health of a globalising world, but seeking to achieve particular goals such as access to medicines, health equity or primary health care, or principles such as human rights and social justice” (Lee & Kamradt-Scott, 2014, p. 6).

As Lee and Kamradt-Scott argue: “global health is (always) defined in terms of the poor, vulnerable and disadvantaged,” and the prescription refers to the health needs of the developing world. “Innovation in institutional design is again advocated, but for the purpose of achieving a specific end, rather than to improve health governance more generally” (Lee & Kamradt-Scott, 2014, p. 6). In synthesis, according to the authors:

It is argued that each of these distinct concepts, often used interchangeably within the existing literature, derive from particular normative frameworks which, in turn, shape their conceptualisation of the scope and purpose of GHG. The application of these distinct concepts is often unreflexive, resulting in a lack of conceptual clarity in this rapidly emerging subject area.

(Lee & Kamradt-Scott, 2014, p. 5)

The work of the Lancet-University of Oslo Commission on Global Governance for Health (*The Political Origins of Health Inequity: Prospects for Change*), used this third concept of GHG. Its final report showed that “in the contemporary global governance landscape, power asymmetries between actors with conflicting interests shape political determinants of health” (Ottersen et al., 2014, pp. 1–2).

It identified “five dysfunctions of the global governance system that allow adverse effects of global political determinants of health to persist” (Table 6).

Table 6. Dysfunctions of the Global Governance System and Inequity in Health

Dysfunction	Meaning
Democratic Deficit	Certain actors, such as civil society, health experts, and marginalized groups, insufficiently participate or are insufficiently represented in decision-making processes.
Weak Accountability Mechanisms	Inadequate means to constrain power and poor transparency make it difficult to hold actors to account for their actions.
Institutional Stickiness	Norms, rules, and decision-making procedures are often impervious to changing needs, and can sustain entrenched power disparities, with adverse effects on the distribution of public goods for better health.
Inadequate Policy Space for Health	Inadequate means exist at both national and global levels to protect health in global policymaking arenas outside the health sector, so that health may be subordinated to other objectives.
Missing or Nascent Institutions	International institutions to protect and promote health (e.g., treaties, funds, courts, and softer forms of regulation, such as norms and guidelines) are completely or almost completely absent in a range of policymaking areas.

Source: The author, from Ottersen et al. (2014, p. 2).

Indeed, health sector governance has been the subject of intense scrutiny by the different actors in the area—donors, a variety of multilateral (including financial) organizations, developing country governments (recipients of foreign aid for health), private companies, and other civil society actors. The list of criticisms is long, spanning both the policies introduced and political interference at the national level by powerful global actors (Feldbaum & Michaud, 2010; Lee & Fidler, 2007; Sachy et al., 2018). The overall impression is that GHG is at best inappropriate, and at worst, dysfunctional (Lee, 2009) or even bankrupt (Kay & Williams, 2009) and ineffective (Fidler, 2010).

Kay and Williams (2009) reiterate that the primary and ascendant discourse in this process is that of neoliberal political hegemony, and assert the importance of analyzing the key tensions, competing worldviews, and *fissures* involved in global governance. The construction of identities, interests, and power relations that take account of this social-political-cultural hegemony is crucial to this discussion.

Kamat (2004) regards this context as an age of reassessment and broad restructuring of public goods and private interests, including considerable efforts by major global public actors (the United Nations, World Trade Organization [WTO], World Bank, and others) to establish the “neoliberal international economic order.” To that end, specific strategies are being formulated that go beyond economic reforms, with a view to driving far-reaching political, operational, and cultural change at the global and local levels to fit the parameters of the neoconservative conception of democracy. Two of these strategies are particularly important to this process: The pluralization of the public sphere, applied at the global level (e.g., a number of private actors, including business representations with the legal status of NGOs, are admitted as participants in international health forums¹); and the depoliticization of the private sphere at the local (or civil) level (e.g., a number of originally community-based NGOs have been coopted as donors’ local-level administrative implementers of specific programs, such as the PEPFAR, the US President’s Emergency Plan for AIDS Relief, and the Global Fund).² Both strategies strengthen the trend toward privatization of the public sphere (Kamat, 2004, p. 157). In short, there is an active, ongoing endeavor to build up the structuring power of neoliberalism (and more recently, the ultraneoliberalism) connecting the international and local levels.

GLOBAL HEALTH GOVERNANCE: KEY IDEAS PRESENTED IN THIS SECTION

1. GHG is a set of mechanisms designed to respond to new and old health problems at the “global level,” which became much more complex and difficult to address in the post-Cold War period.
2. The term “GHG” refers to the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and nonstate actors to deal with “challenges to health” that require cross-border collective action.
3. It is important to an understanding of how global health is defined; i.e., how a health issue is categorized as a “global problem” requiring collective action.
4. The manner in which “health problems” and “health challenges” come to be considered “global problems” is reflected directly in international policies, programs, and interventions at the national and global levels; i.e., how the term “global” is defined is of crucial importance.
5. The literature presents varied definitions of GHG, which has resulted in distinctive uses of the concept despite the utilization of multidisciplinary approaches, and overall, rarely are the theory and practice of GHG brought together.
6. GHG has been scrutinized, and its effectiveness questioned, intensely by the different actors in the field.
7. This criticism has resulted from the enormous changes that have taken place since the end of the Cold War, together with unprecedented growth in funding for global health and the increasing importance of health in international relations.
- 8.

This critical context reflects the complicated landscape in GHG, composed of overlapping and competing regime clusters, forming a global health governance regime complex. The complexity of GHG, and of its coordination, also speak to the discussion of how health is framed in foreign policy and addressed by diplomatic actions.

The complexity of GHG, and of its coordination, also speak to the discussion of how health is framed in foreign policy and addressed by diplomatic actions.

Framing Health in Foreign Policy and Diplomacy

Before discussing relations between health, foreign policy, and diplomacy, it is worth reviewing some concepts.

A country's foreign policy is a public policy (Box 1), although it is distinguished from other public policies by certain specific features; for instance, it is implemented outside the state's borders. Nonetheless, just like any other public policy, it results from diverse domestic institutional-bureaucratic arrangements, as well as from the meshing of a variety of national policies (Salomón & Pinheiros, 2013, pp. 40–41). Understanding foreign policy as a public policy raises the question of its formulation and implementation, which is influenced—as with any other public policy—by the demands of, and conflicts among, all kinds of domestic groups and international policies and pressures.

BOX 1: What is a *Public Policy*?

A *public policy* is a set of programs, actions, and decisions taken by national, state, or municipal governments, with the direct or indirect participation of public and private actors. Its formulation and implementation thus presuppose dealing with different—and generally conflicting—interests and perspectives. In theory, it is designed to assure citizens' rights as defined in a country's Constitution, or the citizens' rights of various groups in the society—a given social, cultural, ethnic, or economic segment of the population.

A public policy may be a *policy of state* or a *policy of government*. A policy of state is any policy enacted, or to be applied, independently of the government of the moment, because it is written into the Constitution. A policy of government, meanwhile, depends on the particular government empowered to conduct affairs of state. Each government has its projects and interests, which in turn inform its public policies. Accordingly, any policy of state is implemented by governments and may undergo alterations in how it is operationalized.

Foreign policy is not to be confused with “mere external action, a broader concept including all kinds of contacts by a government, whether planned or not, with another actor outside its borders” (Salomón & Pinheiros, 2013, p. 41).

A foreign policy has *bilateral* dimensions—that is, involving the country’s relations with other specific country or countries—and *multilateral* dimensions, which relate to the country’s participation in international organizations and forums, where it interacts with various other countries at the same time (e.g., the World Health Assembly of the WHO) or in coalitions (e.g., the BRICS, the coalition between Brazil, India, China, and South Africa).

Diplomacy, in turn, is defined in *Webster’s* dictionary as “the conducting of relations between nations” (Watson, 2005, p. xvi). Nonetheless, Watson preferred a “rather more precise definition (. . . of) diplomacy as the process of dialogue and negotiation by which states in a system conduct their relations and pursue their purposes” (p. xvi), adding that: “I also think it preferable not to use the word diplomacy as a synonym for the foreign policy of a State, although this usage is also frequent” (p. xvi).

In the same way, these two concepts—*foreign policy and diplomacy*—differ from the concept of *international relations*, which is how a country relates in general with other countries and institutions in the world system.

Foreign Policy and Health

There is a vast literature discussing the place of health in foreign policy. The discussions range from description of the contexts in which health is considered to have been included on the foreign policy agenda, and the respective historical backgrounds of these contexts, to attempts to explain why these developments happened, and the role of various factors in those dynamics. Not uncommonly these analysis are based on specific issues or on the experience of specific countries. Conceptual and analytical studies are less frequent.

Authors note that, over the centuries, perceptions of the importance of health in foreign policy have changed (Table 7).

Table 7. Links between Foreign Policy and Health: Turning Points

International Health and Foreign Policy: Period and Characteristics		Global Health and Foreign Policy: Period and Characteristics
<i>From the Mid-19th to the Mid-20th Century</i> ^(a)	<i>Post-World War II and During the Cold War (1948–1990)</i>	<i>Post-Cold War (Since 1990)</i>
• Health was not considered a priority, but a marginal issue, in foreign policy.	• The UN and WHO were founded. • International health actions and cooperation in health began to be directed to the health	• Continued macroeconomic adjustment policies, and increasing inequalities and inequities in health.

International Health and Foreign Policy: Period and Characteristics		Global Health and Foreign Policy: Period and Characteristics
<i>From the Mid-19th to the Mid-20th Century^(a)</i>	<i>Post-World War II and During the Cold War (1948–1990)</i>	<i>Post-Cold War (Since 1990)</i>
- Foreign policy and health were linked occasionally in order to minimize the constraints that health measures (quarantines or workplace safety standards) placed on national economies, economic expansion, and international trade; or to control epidemic diseases (such as cholera, malaria, and yellow fever) that hampered economic investments (e.g., during construction of the Panama Canal).^(b) - These threats interfaced with political, economic, social, and environmental factors, which shaped both their emergence and their spread. - Although these health problems reflected the interdependence among states and demanded cooperation, they were not considered prominently in foreign policies.	problems of developing countries, on the basis of a “scientifically oriented humanitarianism” approach (foreign aid for development and donations), the organization of which was left to “technical experts and physicians, rather than to politicians and diplomats.”^(c) - During the Cold War, the priority was on national security as related to the economic development of the major polar powers and their allies (both considered from a military perspective). - In this period, national security concerns and studies concentrated on the emergence and spread of nuclear weapons (the arms race).^(d) - Macroeconomic adjustment policies began in the 1980s.	Important structural and political changes in international relations and in the position of health in foreign policy,^(e) as the <i>national security agenda</i> was redefined:^(f) There has been an increase in the number of issues that may threaten national security, among them disease and the environment; Domestic and international issues have become more interrelated, because of the greater interdependence resulting from contemporary globalization, in the health sphere, as well as in other policy domains; There has been proliferation of nonstate actors (transnational corporations, NGOs, terrorist groups, mafias, other criminal organizations, and so on), now operating internationally, with impacts on

International Health and Foreign Policy: Period and Characteristics		Global Health and Foreign Policy: Period and Characteristics
<i>From the Mid-19th to the Mid-20th Century^(a)</i>	<i>Post-World War II and During the Cold War (1948–1990)</i>	<i>Post-Cold War (Since 1990)</i>
		international relations and foreign policy; and The state has been displaced as the preferential, central actor on security issues; this is now challenged by the emergence of a complex, diversified political map, featuring a diversity of actors with differentiated power resources participating actively in global governance, and by other critical perspectives, such as the human rights discourse. • Health and foreign policy overlap in a new perspective: <i>health security</i>.^(f)

a Weindling (2006); Fidler (2005, 2009).

b Fidler (2009); Feldbaum et al. (2010); Cueto (1996, 2008).

c Fidler (2009, pp. 12–13).

d Walt (1991).

e Fidler (2009).

f Ingram (2005); McInnes (2009).

Although historically it can be said that health has been an object of international cooperation and diplomacy, this relationship has changed direction over time, a process which differentiates what have come to be known as the international health and global health periods.

The political shift in international relations in the 1990s was also reflected in how health was situated on foreign policy agendas; these began to give especial importance to its connection with issues of *national security* (Almeida, 2017; Ingram, 2005; Labonté & Gagnon, 2010). The meaning of the term “national security” also shifted with the passing of the bipolar world (Ingram, 2005; Vieira, 2007).

Foreign Policy and Health Security in the Post-Cold War Period

Traditionally, security problems were related to threats to state sovereignty resulting basically from war, invasion, or occupation. That essentially military perception has changed into a discourse of threats originating in other fields (Almeida, 2013; Davies, 2008; Fidler, 2009).

The world has certainly experienced a proliferation and spread of diverse risks expressed in the arena of health-related problems (Fidler, 2013), such as:

- emergence and re-emergence of communicable diseases (HIV/AIDS, SARS, avian influenza, and others);
- drug-resistant pathogens (e.g., multi-drug-resistant tuberculosis);
- the spread of chronic noncommunicable diseases connected with products that are harmful to health (tobacco, alcohol, illicit drugs, processed, and ultra-processed industrialized foods);
- effects of pollution and environmental changes, and an exponential rise in violence.

The way in which these events have concentrated themselves and converged within a short space of time (from the 1990s onwards) is unprecedented in human history (Fidler, 2005, 2009). However, it was their connection with specific geopolitical interests that endowed them with strategic significance, particularly at the turn of the century.

Ingram (2005) examined the relation between diseases and national security, calling it the *new geopolitic of disease*. The measures taken to control the HIV/AIDS epidemic are paradigmatic in terms of how health became a national security issue (Ingram, 2005; Vieira, 2007), while the endeavor to control SARS evidenced foreign interference in nation states' sovereignty in addressing these problems (Feldbaum et al., 2010; Feldbaum & Michaud, 2010).

The impact of contemporary neoliberal globalization is another key aspect of this dynamic. Concretely, it has substantially heightened the sensation of *vulnerability* present in societies—although this varies between developed and developing countries (Table 8).

Table 8. Sensation of Vulnerability in Developed and Developing Countries

Vulnerability	
Developed Countries ^(a)	Developing Countries ^(b)
Sensation of vulnerability is concentrated in fear and insecurity caused by exponentially increasing levels of: • Cross-border flows (of products, pollutants, persons, and pathogens); • Violence (terrorist attacks, criminality, drugs, uprisings); • Abrupt economic setbacks; and • Environmental catastrophes.	Sensation of vulnerability is nearly structural, and also expressed in fear and insecurity caused by: • The persistence of poverty and lack of access to goods and services, resulting from historical shortcomings aggravated by the impacts of inequalities, in turn exacerbated by contemporary globalization processes; • An exponential rise in violence (by governments, civil wars, ethnic or fundamentalist conflicts, external attacks, drugs, criminality, and so on); and • Increasingly frequent “calamities” and “natural disasters.”

a Note. Fidler (2005, 2009);

b Almeida (2013).

That whole dynamic emerged simultaneously with the redefinition of the *national security agenda*, which included concerns that reinforced the economic and political strength of the major powers on new bases (Feldbaum et al., 2010; Fidler, 2009, 2013; Ingram, 2005). McInnes (2009) argued that:

the securitization of health refers to the manner in which health security is no longer seen solely at the individual level, but at the national level: as a potential threat to the well-being of states and to international stability (...) this is a relatively novel development and can be traced back to the second half of the 1990s and early 2000s.

(McInnes, 2009, p. 43)

In the first half of the 1990s, there were attempts to shift the analytical focus in the international security order,³ and in 1994, the United Nations Development Programme (UNDP) launched the *human security* perspective (with the *Human Development Report*), proposing a shift in focus from states and territoriality to people and communities, and from the dynamics of threat-defense to solidarity, interdependence, and unequal development. Then in 2003 the UN Commission on Human Security also adopted this approach in its report *Human Security Now: Protecting and Empowering People*, as did some other countries—Norway and Canada (Vieira, 2007). The definition adopted by the Commission framed human security in terms of the protection and expansion of human freedoms, which entails both protecting against sudden threats of whatever kind and empowering people to provide autonomously for their own lives. The International Monetary Fund (IMF) and the World Bank

also included the new paradigm, in a quite particular form, holding individuals responsible for their own health security (Almeida, 2016; Pereira, 2010). In fact, that concept—human security—was of more use to critical analysis than to international policies.

All in all, this shift was complex and involved diverse variables, but reflected the fact that the converging threats had repercussions in the four traditional core dimensions of foreign policy: protecting national security, preserving and expanding national economic power and wealth, fostering the development of strategically important regions and countries (foreign aid), and supporting human dignity and human rights (humanitarian assistance and donations) (Fidler, 2009).

Meanwhile, McInnes (2009) asserted that “the security agenda remains very much international rather than global” (p. 55). In other words, it is directed toward hazards that threaten certain players. He highlighted two factors that were crucial in this dynamic: a focus on specific transnational hazards rather than on clear and present dangers, legitimating “enlightened self-interest and humanitarian concerns” as an important component of the new security agenda; and “individual agency,” whereby powerful actors have advocated that agenda strategically (p. 55).

Other Approaches to Framing Health in Foreign Policy

In the first decade of the 21st century, linkages between health and the global policy agenda were decoded as framings of health in foreign policy. A number of authors have discussed the different manners of framing health in public policy: the health security basis is the best known, most studied, and most criticized; other approaches—more openly favoring the private market—frame *health as development* or as *trade* or a *commodity*; and yet others—which figure in various countries’ official discourses and rationales, but seem more ideational or to conceal particular goals and interests—frame it as *humanitarian aid*, a *global public good* or a *human right*. Accordingly, there is no consensual view on the subject, and it is often stressed that “health interventions are being used to justify and advance traditional foreign policy interests” (Eggen & Sending, 2012, p. 17).

Each of these framings has been the subject of its own vast literature, none of which can be examined in detail here, where our intention is very briefly to state their key underlying assumptions or rationales.

The arguments of development- or trade-centered framings take the line that globalization has created numerous health issues that are inherently *global*, as regards both their causes and their effects (Labonté, 2008), which entail health hazards and problems. One of the underlying premises of this frame was that “health is no longer simply a consequence of growth, but one of its engines” (Labonté, 2008, p. 471; Labonté & Gagnon, 2010, p. 5). Even so, when health is framed as development or trade within foreign policy, this placement is directed toward serving the particular interests of developed countries (Feldbaum et al., 2010; Sachy et al., 2018; Sparke, 2009) (see Appendix 1). Obviously, there are exceptions to this, but they are scarce and occasional; e.g., HIV/AIDS control in Brazil and international support for the right to drug treatment for HIV/AIDS patients and carriers (Lima, 2017).

Some authors note that criticisms of the framings of health as development/aid and trade in foreign policy have given rise to other approaches, e.g., viewing it as a global public good or a human right (e.g., Labonté, 2008; Labonté & Gagnon, 2010).

There is discussion, however, of the concept of *global public goods* (GPGs), which derived from *public goods*, an economic concept that classifies goods as *private* or *public* (Kaul & Faust, 2001; Labonté, 2008). But, since the 1990s, with the implementation of the restrictive neoliberal macroeconomic rationality, there has been a great deal of debate over whether or not health or healthcare (particularly medical care) are public or private goods (Almeida, 2002) (see Appendix 1).

On the other hand, there is also discussion of health's role in humanitarian actions. Although present in official discourse, these dialogues often mask the geopolitical strategies of major powers (Fiori, 2018, 2019). The question then is: "are humanitarian actions functions of foreign policy or not?" (Thieren, 2007, p. 219), given that the altruistic values guiding such actions are person-centered, and thus in opposition to foreign policies. These debates have led to the development of a "new humanitarianism" (Thieren, 2007, p. 219) (see Appendix 1). As Juliano Fiori (2018) analyzes, "the end of the Cold War provided permissive conditions for the consolidation of liberal global governance and the growth of international humanitarianism" (p. 1). However, by the 1990s, the humanitarian sector (agencies and NGOs) had embraced "the neomanagerial ideology and tightened its organizations along corporate lines" (p. 2). At the same time, "proponents of the 'new humanitarianism' would be more open to working with Western militaries to ensure the protection of aid operations" (p. 2), and the hegemony of the great powers, especially the United States.⁴ Finally, theoretically, when access to healthcare is considered a *human right* rather than an optional beneficial activity, this strengthens the framing that regards health as a public good. A number of international laws have been developed requiring that *human rights* be respected, and states have adhered to treaties (binding and otherwise) in that regard (see Appendix 2). There is also advocacy for human rights by civil society movements, such as the People's Health Movement, and others.

However, "nations rarely invoke human rights treaty obligations in their foreign policy choices" (Gagnon & Labonté, 2011, p. 195), even though they should do so (see Appendix 1).

In summary, in spite of the proliferation of normative declarations and substantial civil society advocacy on the importance of the human right to health, the practical realities are quite different (Labonté, 2008). The new US National Security Strategy, published at the end of 2017 (the first year of Trump's government), is a novelty at a time when "international politics is going through a moment of great instability and accelerated transformation" (Fiori, 2019, p. 44). "Far from promoting a final and permanent peace, the new security strategy situates the US in an inter-state system in which war is possible at any time, in any location, with any rival, enemy or former ally" (Fiori, 2019, pp. 43), without any consideration of human rights. The situation is even more dramatic at a real-world level, particularly when one considers the increasingly radical neoliberal policies implemented since the start of the second decade of the 21st century.

Hard, Soft, and Smart Power in Foreign Policy

Power is a key concern in international relations and, more specifically, in a country’s foreign policymaking and implementation. The manner in which a country “exercises power” in the world system is a significant feature of its foreign policy.

The literature contains many definitions of power, all of which have been questioned and reworked (Changhe, 2013; Nye, 2013). Nye (2013) explains that, in politics and diplomacy, power is the “ability to affect others to get the outcomes we want” (p. 559). In that light, Nye (2013) argues that it is important to diplomacy to understand “what actors or agents can do within certain situations” (p. 560). This does not mean disregarding structural forces, but the focus on agents or actors makes it possible to “specify *who* is involved in the power relationship (the scope of power) as well as *what* topics are involved (the domain of power)” (p. 560). Also, a “policy-oriented concept of power depends upon a specified context to tell us who gets what, how, where, and when” (Nye, 2013).

On the other hand, Fiori (2005, 2018, 2019) argues that to exercise power requires material and ideological instruments, but what is essential is that power is an indissoluble, asymmetric social relationship, which only exists when exercised, and in order to be exercised, it needs to reproduce and accumulate constantly. It is this historical dynamic that structures the competitively aggressive relationship among nation states and historically characterizes the world system.

These observations make it easier to understand the concepts of hard power, soft power, and smart power, developed by Nye in different studies, all discussing the United States’ exercising of power in the world system, based on a liberal or pluralist approach. These concepts are important to the purposes of this study, because of debates in the literature as to whether health figures in foreign policy as a soft power (or as part of the *low politics* of foreign policy) or has been promoted out of that realm to the level of *high politics*, even though not forming part of traditional hard power.

It is not our intention to pursue that discussion here, but merely to note the meaning of these concepts, because they are useful in considering how health can be integrated into different countries’ foreign policy agendas. State power includes both hard and soft components, which can be combined to produce *smart power* strategies. Definition of these concepts also highlights the fact that they are neither static nor sufficient or autonomous, but overlap in different situations and specific contexts (Table 9).

Table 9. Levels and Types of Power in Foreign Policy

Levels and Types of Power	Definition	Use of Powers
High Politics Hard Power	Traditionally, what distinguished a major power (or “great power”) was its “strength for war.”	Economic power has become more important than in the past (Nye, 2013).

Levels and Types of Power	Definition	Use of Powers
	<i>Hard power</i> is generally associated with tangible, material resources, i.e., force (usually military) and wealth (money) (Nye, 2013).	Geo-economics has not replaced geopolitics, but since the late 20th century the boundaries between them have become less clear. “Many of the terms (...) such as ‘military power’ and ‘economic power’ are hybrids that combine both [material] resources and behaviours” (Nye, 2013, p. 564).
Low Politics Soft Power	<i>Soft power</i> relates to intangible resources, such as institutions, ideas, values, culture, and perceived legitimacy of policies. It is defined as “the ability to affect others to obtain preferred outcomes by the co-optive means of framing the agenda, persuasion, and positive attraction” (Nye, 2013, p. 564).	Some intangible resources, such as <i>patriotism</i> and <i>morale</i> , affect the ability to fight and triumph, and “threats to use force are intangible resources, but belong to the category of <i>hard power</i> ” (Nye, 2013, p. 564).
Hard and Soft Power Combined Smart Power	<i>Smart power</i> was defined to counter the misperception that soft power alone can produce effective foreign policy. As a concept, <i>smart power</i> is evaluative, as well as descriptive. It is defined as “the ability to combine hard and soft power resources [successfully] into effective strategies” (Nye, 2013, p. 565).	This combination can be used in differing contexts and is available to all state and nonstate actors.

Source. The author, from Nye (2013).

The distinction between *power resources* and *power behavior* is thus relative, because “resources often associated with hard power behaviour can produce soft power behaviour depending on the context and how they are used” (e.g., the behavior of US Navy hospital ships in situations of catastrophe or war) (Nye, 2013, p. 564).

Obviously, there is a great deal of discussion around these concepts. Nonetheless, the idea of smart power may be useful in thinking about, for example, international activities in health by great powers (e.g. the United States).

In the case of developing countries (e.g., Brazil, Cuba), soft power is used more often in bilateral cooperation and alliances, which have little power, however, to influence global governance for health. The same is true of the BRICS coalition, which, although of undisputed

importance, has advanced little beyond making proposals and, even in international health forums, rarely takes common positions that go beyond the interests of its constituent countries (Huang, 2018).

These considerations pose the question of diplomacy, as concept and practice; i.e., what does diplomatic action consist of?

Diplomacy: A Conceptual Review

The origin of the term diplomacy dates back to the 8th century, but its content has varied progressively over the centuries. It was only in the 19th century that diplomacy became definitively established and, from then on, began to develop its distinctive manners of operating. In the 20th century, alongside with technological advances and far-reaching changes in the world system, together with a broader need for diplomatic political action, the role of diplomacy far outgrew its classical functions.

Diplomacy in Times of Change

Diplomacy is generally considered an instrument of foreign policies, a profession which, like others, hinges on lengthy, specialized practical learning and is not accessible to lay people (Cooper, 2013; Jönsson & Hall, 2005). It is “rarely analysed or extensively explored (. . .) the conceptual wealth of the literature on diplomacy is quite limited and, to a great degree, divorced from the development of political theory” (Sofer, 1988, p. 196). This scant attention to the concept is due in part to a clear separation between the practical activity of diplomacy and related theoretical thinking.

Jönsson and Hall (2005) pursue a multidisciplinary critical inquiry and their theorization focuses not on *diplomatic methods* (such as *negotiation*), but rather on diplomacy as an *institution* (p. 3).

The English School of international relations has devoted more attention to the concept of diplomacy as an institution,⁵ and as *co-constitutive* of the *international system (or society)*⁶ (Jönsson & Hall, 2005). In their theory-building, Jönsson and Hall also consider constructivism and postmodernism approaches, taking the assumptions of *relationism* and *processualism*, as well as the rationale of historical sociology. Also, from the postmoderns, they absorb the idea that diplomacy is a *social practice*, integrated and incorporated into other *sociopolitical practices* that generate conventions for diplomatic conduct, particularly that of its agents. In their words:

Social spaces are arenas (...) wherein actors orient their actions to one another (...) a social space [is] “institutionalized” when there exists a widely shared system of rules and procedures to define who actors are, how they make sense of each other’s actions, and what types of action are possible. Institutionalization is the process by which a social space emerges and evolves.

(Jönsson & Hall, 2005, pp. 39–40)

Faithful to the *processual approach*, Jönsson and Hall (2005) point to two important dynamics to be taken into consideration': "the institutionalization of diplomacy, and diplomacy in times of changing polities and identities" (p. 25).

As an institution, diplomacy should be seen as a set of norms, rules, and conventions that define the behavior of individuals who play diplomatic roles at different times, and in different situations and contexts, even in the absence of organizational structures, such as chancelleries. In the words of Jönsson and Hall: "we launch our inquiry from a top-down, relationalist/processual vantage point (...) We proceed from a notion of global political space (...) Diplomacy, in this perspective, is about dynamic relations that help differentiate political space" (2005, pp. 24–25).

In this light, far from being homogeneous, contemporary *international society* is considered to comprise relations involving common values and conceptions, but also antagonistic values and interests, all interrelated by contracts or ties forged in negotiations. It is not a peaceful field, but one prone to conflicts and breaches of the rules. International society thus constitutes a web of connections, a differentiated process-guided political space, while diplomacy, as an institution co-constitutive of that space, also contributes to its differentiation and reproduction.

Along the same lines, Cooper, Heine, and Thakur (2013) see diplomacy as resting essentially on the need for protocols and codes of conduct to assure order, stability, and predictability in international relations. Even though certain diplomatic practices can be traced back millennia, "there are significant elements of continuity alongside major elements of adaptation and innovation. While some traditional forms of diplomacy retain relevance, newer forms are also gaining prominence" (p. 25). Undoubtedly "the world of international relations—the *field* in which diplomats operate—has [been] changed substantially" by at least five new developments (Box 2) (Cooper, Heine, & Thakur, 2013, pp. 5–6).

BOX 2: New Developments in the World of International Relations

- 1) The rapidly expanding *numbers and types of actors*.
- 2) The *domain and scope* of the subject matter or content (extending well beyond traditional high issue foreign policy).
- 3) The *levels* at which diplomatic engagement and activity take place.
- 4) The *apparatus and machinery* of foreign relations and diplomacy.
- 5) The *modes, types, and techniques* of diplomacy.

Cooper, Heine, & Thakur (2013), examining the changing nature of diplomacy, focus on its institutional foundations, on the complex set of processes in various fields, on the broader global context, and on the meaning of modern diplomacy in that dynamic, specifically in the 21st century. In their analysis, they apply "the central lens" of the framework of 'club' and

‘network’ diplomacy, in order to capture the often hybrid duality “in which continuity and change interact and merge,” as a core characteristic of this process of change (p. 35) (Table 10).

Table 10. Characteristics of Club Diplomacy and Network Diplomacy

Types and Characteristics of Diplomacy	
Club Diplomacy	Network Diplomacy
<i>Traditional diplomacy:</i> • a small number of players; • highly hierarchical structures; • written communication; and • little transparency.	<i>Contemporary diplomacy:</i> • greater interrelations among a far larger number of actors (particularly non-diplomats); • more horizontal structures; • a significant discussion/negotiation component; • other means of communication; and • greater transparency.

Source: The author, from Cooper et al. (2013, p. 22).

Cooper (2013) also pointed out that, following the end of the bipolar world order, world power was restructured, and as a result a number of new problems presented challenges to the world system, demanding that it develop new attitudes, actions, and patterns of conduct, nationally and internationally. Issues calling for diplomatic action have spread from the sphere of high (war and peace) to low politics (health, the environment, development, science and technology, education, and so on) (Cooper et al., 2013, p. 25). Of these, the authors most prominently highlight the environment (p. 13) and health (p. 14), and reiterate that “diplomacy has become a critical instrument in an age of complex interdependence and globalization” (p. 22).

Cooper (2013) also noted that authors have been questioning what a “diplomat” is in this new context, given that “diplomacy has spread to many other entities and across many categories of people” (p. 41). The concept of *polylateralism* is defined as “an approach that takes into account a wider set of relationships involving not only disparate organizations, but individuals with global interests” (Cooper, 2013, p. 41). Using the “network” approach, Cooper et al. (2013) have concluded that “the diplomat of the 21st century must manage the complex relationship of the club while also tending this ever-expanding network” (p. 23), because the duality persists (p. 49).

Dialogue among independent, sovereign states acting in an environment of close ‘interdependence,’ ‘interconnectivity,’ and extreme complexity, remains the enduring essence and key component of diplomacy. Fidler (2009) warns that these two terms—interdependence and interconnectivity—do not mean the same thing (Table 11).

Table 11. Differences between the Concepts of Interdependence and Interconnectivity

Interdependence	Interconnectivity
• “Means that two countries are mutually dependent with respect to specific activities, events, resources or problems.” • This can create strong national incentives to engage in collective action, <u>but</u>: ◦ Interdependence does not eliminate differences in national interests; and ◦ Collective action often requires difficult, time-consuming negotiations on cooperative strategies. • <u>Example</u> Communicable diseases and potential spread of epidemics and pandemics require mutual interdependence in order to be controlled; i.e., “the ability of one country to protect the health of its population can directly depend on whether another country has the capacity to detect and respond to mobile, readily transmissible communicable pathogens, and vice versa.”	• Does not involve relationships of “mutual dependence” among states. • Exists between the trade interests of the developed country and the health interests of the developing nation, <u>but</u>: ◦ Such linkages often do not generate reciprocal incentives to engage in serious, effective collective action. ◦ Gaining foreign policy traction in this context proves more difficult and often produces tension between economic and health interests. • <u>Example</u> Noncommunicable diseases. Developed country exports of processed foods high in added sugars may contribute to the prevalence of childhood or adult obesity in a developing country; but the health, security, and economic well-being of people in the developed country do not depend on whether the developing country controls or reduces the prevalence of obesity in its territory.

Source: The author, from Fidler (2009, p. 18).

Accordingly, *diplomacy* responds to the recognition that there are various, permanently interacting decision-making processes (and decisions) in play, and is the practical endeavor to reconcile differing political wills hemmed in or driven by the dictates of circumstances.

Diplomacy and Health

Global health challenges often evidence *interdependence* and *interconnectivity* among countries, but this does not produce “harmony of interests among states in engaging in effective collective action” (Fidler, 2009, p. 18).

The array of problems in the health field that must be addressed by diplomatic activities has expanded ‘vertically’ and ‘horizontally’ (Fidler, 2013, p. 694). The ‘vertical expansion’ has come about in established areas of diplomacy, e.g., infectious diseases, trade, pollution, labor laws, and war. ‘Horizontal expansion’ has occurred when different actors have focused on problems that had previously not come to the attention of diplomacy; e.g., noncommunicable

diseases and the health effects of recent developments in capitalism, which have caused considerable deterioration in the social determinants of health. “Analysing how health diplomacy differs with the various threats requires breaking them down into categories that reveal characteristics observable in practice” (Fidler, 2013, p. 694) (Table 12).

Table 12. Categories of Health Treaties and Diplomatic Action

Category	Characteristics	Diplomatic Activities
Communicable Diseases (Fidler, 2013, pp. 695–696)	Reflect the diversity of diseases in time and place, and the political interests they affect. They are a priority because they: • constitute real cross-border hazards; • place states in a situation of interdependence; • stimulate technological advances and conflicts in relation to the production of, and access to, medicines.	Although this category is historically dominant, diplomatic action is in tension with the principles of public health: the imperative is short-term, not directed to the causes of diseases and outbreaks, and dissipates once spread is controlled. This dynamic has driven the focus on disease-specific initiatives. At the same time, diplomacy has been—and is—fundamental in other correlated areas: intellectual property rights law, patents and access to medicines; international trade in medicines, etc., e.g., the Doha Declaration.
Noncommunicable Diseases and Health Harms (Fidler, 2013, pp. 696–698)	The WHO and UN have pushed to elevate the priority of these diseases. • They place states in a situation of both interdependence and interconnectedness. • The WHO and other experts have had to reframe the threat to include not only the burden of disease, but also the economic consequences, into the development agenda and into the national macroeconomic arena, bringing these risks closer to more prominent political, economic, and foreign policy	Diplomatic activities have been more frequent with respect to noncommunicable disease threats that involve cross-border movement of pollutants and products (interdependence). Noncommunicable diseases associated with individual behavior and product consumption (e.g. smoking, inadequate diet and exercise, and drinking) generate interconnectedness among states, which tends to reveal divergence of interests and/or political indifference more than incentives for diplomatic action.

Category	Characteristics	Diplomatic Activities
	interests of states (e.g., the Framework Convention on Tobacco Control, FCTC).	
Health-System Capacity Problems (Fidler, 2013, pp. 696–698)	One complaint that has been made about health diplomacy is its failure to produce and sustain initiatives that help low-income countries build and maintain sufficient health-system capacity to handle the health problems they face. Other questions relate to the code on the international recruitment of health workers, and brain drain.	Diplomatically, health-system incapacity proves difficult to address effectively. Building health-system capacity in low-income countries constitutes a development task, but, as such, the challenge creates political problems and potentially expensive, open-ended financial commitments from donor countries. This agenda is attractive to neither donor nor recipient states, as evidenced by the limited aid spent on strengthening health systems. On the contrary, vertical programs fragment health systems and are unsustainable in the long term (Sachy, Almeida, & Pepe, 2018). However, migration of health workers in some situations impact health systems, and can be a diplomatic matter too.
Social Determinants of Health (Fidler, 2013, pp. 698–699)	“Social determinants of health (SDHs) identify the structural drivers of the conditions of daily life—inequitable distribution of power, money, and resources” (Fidler, 2009, p. 20). In other words, the political, economic, and social conditions—such as poverty, access to education, gender inequalities, and environmental degradation—affect societies’ health outcomes. Although the Millennium Development Goals (MDGs) and SDGs continue to receive support, the gap between rhetoric and	Diplomatically, SDHs constitute an even broader agenda than that of building health-system capacity. They require strategies against political, economic, and social practices far beyond the health sector, meaning sustained, intrusive diplomacy in many areas is necessary. Development strategies make the most logical diplomatic location for such multisectoral solutions.

Category	Characteristics	Diplomatic Activities
	reality highlights diplomatic problems that limit progress on SDHs.	

Source: The author from Fidler (2013, pp. 695–699), and other authors cited in the table.

In summary, Fidler’s endeavor is to explain which “health challenges” are of interest to diplomacy and which are not (or not so regarded), highlighting the difference between these fields of practice (Fidler, 2013).

Finally, how each country, bloc, or region perceives global health diplomacy, GHD (or health diplomacy, HD) and uses these terms, reflects the motivations underlying the ways in which health is framed in foreign policy and diplomacy. This dynamic is complex and remains difficult to understand, particularly because of the sparse production of and access to empirical data about it. From a review of selected publications, it is clear that the global health policies and strategies differ greatly around the world. Some differences and specificities can be identified, for example, those of some countries (the United States and Cuba), regions (European Union, South America, and sub-Saharan Africa and East African countries), and blocs and coalitions (BRICS and UNASUR) (see Appendix 2).

Global Health Diplomacy (or Health Diplomacy): What Are We Talking About?

To analyze and discuss the term of global health diplomacy, GHD (or health diplomacy, HD) and learn its meaning is a major challenge for any researcher—not only because of the extensive literature in existence, but also, and primarily, because of the lack of precision in the related theory and analysis. No accurate systematic reviews have endeavored to disentangle the term’s etymological, historical, or theoretical origins. On the other hand, it is an intriguing research topic, because the empirical data are scarce, and a sound analytical framework has yet to be developed to interpret them. This article offers no answers, but does offer insights that should be considered in order to help us better understand GHD.

The topic of GHD (or HD) is by definition an inter- and transdisciplinary area, and is a new issue in the collective health field (Almeida, 2015). As Blouin, Molenaar, and Pearcey wrote:

A lack of theoretical underpinning of analysis means that the literature on global health diplomacy is still relatively fragmented and not clearly structured around key research problems or questions. Multiple disciplines, from international law, public health, political science and other social sciences, are active in the field and there is no agreement drawn from shared theory on what the main components of a research agenda on GHD should be. (2012, p. 5)

The term GHD (or HD) emerged in the 1990s and early 2000s. It appeared at the same time or shortly after other correlated terms, such as global health and global health governance. This simultaneity is no coincidence: it consists of the repercussions, in the health sector, of a broad dynamics of world change set in motion by the ending of the Cold War.

The end of that period was marked by far-reaching changes—economic, technological, political, social, and cultural—to structures that had been created in the previous bipolar era, the abolition of whose borders unleashed and drove powerful forces. This ushered in a new and challenging situation in the world system, which necessitated a revision of the power relations among the actors involved, including nation states, multilateral organizations, and many others that were to gain greater visibility from then on. It was this context that gave rise to the various demands for mechanisms of governance of that new world order. The complexity of this dynamic is far from minor; quite the contrary.

That historic time also marked a turning point in health sector governance. It witnessed the transition from the millennial international health period to what was termed the global health boom. Despite a reluctance on the part of some authors to accept this new denomination (e.g., Herrero, 2017; Peters, 2017), there is a vast literature that warrants and attests to the change in name, even though the meaning of this new term is also the subject of controversy. The divergences or discussions relate primarily to the meaning of the word *global*.

As Singler (2016) wrote: “The way in which issues are framed influences how problems are conceptualised, what possible responses are seen as effective and desirable, and thus to which ends political and economic resources should be devoted, an insight of immense importance” (p. 1). In other words, the manner in which “health problems” are framed in international arenas, and then become “global issues” and enter the global health agenda, is a very important question.

There is, however, a consensus as regards the context and conjunctures that opened up in the 1990s and, consequently, the facts that gave material form to the change to the concept of global health. The main difference between the two periods—those of international health and global health—resides in the place of health on the foreign policy agenda and in the type of governance (or *collective action*) required to address the problems identified at the time.

Accordingly, it can be inferred that the first dimension of the concept of GHD (or HD) lies in the relation between health and foreign policy, which in turn influences the health sector governance.

Fidler (2010) recalls that collective action on health hazards of various types began as early as the mid-19th century, before multilateral health organizations were set up; but HD has been practiced for thousands of years, although it has changed over time. During the international health period, links between the health and foreign policy realms were fragile, “because they did not have an impact on the fundamental concerns of statecraft: power, influence, security, and survival” (Fidler, 2010, p. 4). In the first half of the 20th century, as conditions of life and health improved in the developed countries (where the problem of infectious diseases was considered to have been solved), attentions turned to the low- and middle-income countries. Following World War II, a strategic shift took place, as multilateral organizations were set up and policies were directed toward European reconstruction and economic development of the developing countries based on foreign aid and international cooperation. During the Cold War, health issues were subsumed by geopolitical confrontation between the two main powers (the USSR and the United States), and although they “occasionally flared into the foreign policy mainstream” (Fidler, 2009, p. 13), they were always framed within the political and ideological bipolarization of the time, thus becoming of marginal utility as an instrument for furthering national interests. That situation changed with

the new conjuncture ushered in by the fall of the Berlin Wall, a state of affairs in which health, foreign policy, and international cooperation were interlinked—once again, but differently—in a single political discourse.

Very briefly, in the new world conjuncture of the 1990s that followed the end of the Cold War, health problems meshed more closely with the global political economy, a situation that would lead to repercussions on the political map and for international security. Relations between health and foreign policy came to greater prominence in the first decade of the 21st century, but there is no historical precedent for this growing interest, which involves a complex, ambiguous interplay, shot through with uncertainties.

In other words, health interventions came to be deployed as instruments for geopolitical ends. Those developments were driven by specific episodes in both fields (those of health and security), which converged and were actively framed to establish connections among diseases, geopolitical space, and power, with a view to strengthening the *enforcement* capability of the major powers, in the name of national security.

In that context, the necessary *collective action* (or ‘health governance’) would be very different from that which was implemented during the international health period (see Table 8). Health sector actions alone would be insufficient to address that complexity, which was seen to have led:

many health policy makers (...) to advocate for more political attention on health by appealing more directly and forcefully to the national interests of States in terms reflecting the traditional functions of foreign policy (...) emphasizing health as important in its own right and supporting the right to health.

(Fidler, 2009, p. 15)

Along the same lines, McInnes (2009) asserted that the “driving force behind this shift originated largely within the public health sector, motivated by a desire to secure greater political attention to global public health needs” (p. 55). That is, the securitization of health (the way health was first framed in foreign policy) was a potent idea that developed outside the traditional security community. In other words, “[health] security is socially constructed. What matters therefore is not the degree of risk, but whether key actors can make a case using the vocabulary of security” (McInnes, 2009, p. 56). It can thus be deduced that this process constituted a strategy by health policymakers and other health actors (including the WHO) to ensure that health continued on the international agenda.

Health security aside, health has been framed in many other different ways in foreign policy—e.g., in the contexts of development, trade, GPGs, and of human rights—and “each of these frames has implications for how global health as a foreign policy issue is conceptualized” (Labonté & Gagnon, 2010, p. 1). However, “differing arguments within and between these policy frames, while overlapping, can also be contradictory” (Labonté & Gagnon, 2010, p. 1). Also, certain framings (e.g., health as a public good or a human right) are very often no more than rhetoric masking other foreign policy objectives.

Meanwhile, toward the end of the 2010s, strong doubts were cast on the effectiveness of global health governance, as a consequence of a number of events that occurred concomitantly or sequentially inside and outside the health sector. These dynamics exposed the complexity of the health sector arrangements that had been put in place in the wake of the changes brought on by the end of the bipolar era; changes which had caused competition and cooperation among the very diverse actors involved in the process—both in the domain of the multilateral organizations and in the new parallel institutions.

This clash resulted from the unprecedented growth in funding for global health that had taken place since the beginning of the 2000s, and also the importance that health had come to assume in international relations. The growing influence of policymakers, activists, and philanthropists, and of new programs and public-private initiatives that had emerged to address specific problems (e.g., HIV/AIDS epidemic control and international public health emergencies), are also part of this process. On their own, neither national health systems nor multilateral organizations had the capacity to cope with this multiplicity of “threats.” In addition to the use of long-standing institutions and well-established international legal regimes relevant to global health, new norms, legal frameworks, and *regimes* were introduced to administer the complexity of the interactions. Global health governance also became more important in regimes designed to achieve non-health objectives, as in *trade and health controversies* within the WTO, and regional or bilateral types of agreement. In the words of Fidler (2010):

These transformations have produced a complicated governance landscape, composed of overlapping and sometimes competing *regime clusters* that involve multiple players addressing different health problems through diverse processes and principles. Together, these regime clusters form a *global health governance regime complex* in which states, intergovernmental organizations, and nonstate actors apply old and new institutions, rules, and processes to strengthen collective action against health threats. (pp. 1–2) (my emphasis)

In other words, “in order to improve global governance *for* health we may have to better understand how the global governance *of* health is operating today” (Roemer-Mahler, 2014, p. 96). Authors have argued that, while the role of the nation state continues to be preeminent and essential, the former *geographical horizons of global health governance* have been revised and *reterritorialized*, creating a *new political space*, constituted by a permanent struggle and negotiations between a great diversity of public, nongovernmental, and private actors.

These considerations lead into a second dimension of the concept of GHD or HD, relating to diplomacy proper. In the formulation by Jönsson and Hall (2005) and Cooper et al. (2013), diplomacy is constituted as an institution and, as such, a social practice integrated and incorporated with other *social-political practices*. Accordingly, *diplomatic practice* is exercised under certain conventions, norms and rules, in a dynamic relation that helps differentiate *political space*—in this case, *global political space*. *Social-political spaces*, in turn, are arenas of dispute and conflict, and of steadily growing complexity. This has led the traditional practice of diplomacy to be revised with an eye to appeals for action in other previously underexplored fields, such as health problems, which extend beyond the diplomatic “comfort zone.”

Authors reiterate that health problems have increased exponentially in complexity since the second half of the 20th century, both vertically and horizontally, which has necessitated making changes in diplomatic practice to deal with the countless demands resulting from this process. Contemporary diplomacy also has to cope with different *policy decision-making processes* in various fields, but not all of these receive the same level of attention, because some are resolved on the basis of diplomatic action alone, while others are solved by working together with health professionals and different actors, and still others are not considered susceptible to diplomatic action (see Table 12).

Meanwhile, Fidler (2013) warns that the health field has been neglected as an object for thinking in the realms of international relations, foreign policy, and diplomacy. He sees this disregard as having consequences (p. 691): the lack of dialogue between the health and foreign policy communities has obscured any understanding of the changes underlying this context.

In the first decade of the 21st century, growing interest in health as a foreign policy concern was expressed in greater diplomatic activism around “health hazards,” as defined in line with certain specific standpoints and interests. At the same time preventive actions, in relation to both contagious infectious and chronic degenerative diseases, were neglected. The latter pose more difficult challenges, in that they involve powerful private actors (e.g., those in areas such as processed foods, alcoholic beverages, pollution, and environmental contamination, etc.). Even landmark achievements, such as the Framework Convention on Tobacco Control, are of only relative importance, because their global results have far from satisfactory, and the confrontations continue, particularly with the raw material and manufactured product industries.

When serious consideration is given to the social determinants of health (economic austerity, cutbacks in social policy funding, mounting inequalities, mass migrations, epidemics of previously controlled infectious diseases, resistance to antibiotics, rise of noncommunicable chronic diseases, and so on), all that is happening in the world affects health adversely, exponentially increasing the vulnerability of populations. On the other hand, Singler (2016) noted: “The mobilization of resources towards addressing health issues often depends on the extent to which these issues are framed in terms of the interests of the most powerful actors in the global health governance arena, usually Western sovereign states” (para. 3, p. 1). This means that health itself is not always (or almost never) the central issue and that economic crisis and national setbacks or even other events, interfere adversely in countries’ foreign policy priorities.

Therefore, “the foreign policy-health relationship may change again under the influence of other significant structural, political, and economic changes that may arise to reshape world affairs. In other words, this relationship is neither static nor permanent” (Fidler, 2009, p. 17). In 2009, Fidler was already arguing that “health’s relationship with foreign policy (...) tends to be crisis driven (...) Put another way, foreign policy demand for health actions is highly elastic, waxing when disease crises appear and waning when crises fade from the political spotlight” (Fidler, 2009, pp. 21–22).

Lastly, but no less important, health is not only an issue of soft power in foreign policy, that for a time “flirted” with foreign policy at the high-politics level, as argued previously, but also forms part of what Nye (2013) termed smart power—the combining of hard- and soft-power

resources into effective strategies (see Table 9). Smart power can be exercised by great hegemonic powers (as the United States has been demonstrated since the 1990s, and recently in Venezuela, in 2019) or perhaps by emerging powers (countries aspiring to that status in the world system, e.g., Russia or China).

Meanwhile, GHD (or HD) has different meanings and uses in different countries. On the one hand, it can be said that nation states, even when forming part of blocs or coalitions, vary significantly in their formulation and operationalization of global health policies and strategies. On the other hand, the literature refers more often to countries', blocs', or coalitions' policy- or strategy-making for global health governance (GHG), and rarely for GHD (or HD) (see Appendix 2). Also mentioned in the literature is the potential power of certain regions, blocs, or coalitions to innovate in HD actions and to drive alternative means of surmounting the complexity of GHG (e.g., UNASUR and BRICS) (Herrero, 2017; Huang, 2018). In any case, even when it comes to innovations, frequently countries prioritize their own interests.

From all these discussions, it can be inferred that GHD or HD are terms developed to refer to a certain *sociopolitical practice* designed to keep health on the international relations agenda. That effort first grew out of the framing of health as health security and later gained new momentum from the political use of social epidemiology and the social determinants of health. This endeavor has been conducted by the *global health policy community*—at the national level, by promoting the interrelationship between health and foreign policy by means of cooperation projects or international actions; and in international arenas, by acting in *global political space*, in the widest range of spheres, whether health-sector-related or otherwise. This realization, which emerged from the review conducted for this article, may constitute a first step toward developing an analytical framework and sounder conceptual elaboration.

Despite the countless problems and specificities of foreign policy in relation to health issues, “health advocates have found ways to influence the permanent dialogue” (Fidler, 2007a, p. 244). They have also managed to spread the notion worldwide that health and disease are the consequences of broader dynamics, an idea which can be extremely prejudicial in certain contexts, as has been demonstrated since the 1990s. Meanwhile, the dynamics of relations between health and foreign policy are unstable and laced with subterfuge.

Accordingly, even though “the latest cycle of the rise and fall of health diplomacy” (Fidler, 2013, p. 705) has come to an end, the future of GHD (or HD) will depend on the stamina of the global health and health diplomacy policy community in continuing to inhabit *global policy spaces*, and advocating for ideas and practices that are able to “conquer hearts and minds” in a more and more competitive, difficult, and “insensitive” international arena. As Fidler quite rightly remarked in 2013:

However, just as the rise of health diplomacy might not be as spectacular as thought, its fall from its present stature does not presage a diplomatic sunset. Rather, the relationship between health and diplomacy will lose high-level foreign policy traction (except in times of crises) and operate more through functional, technical efforts and confront too many problems, in too many geographical and diplomatic locations, with too little political gravitas, and with not enough resources—a situation previous generations of health experts navigated without losing their abilities and passion for doing good.

(Fidler, 2013, p. 705)

Acknowledgments

This article is one product of the research project “Global Health Diplomacy: An Explanatory Multi-Case Study of the Integration of Health into Foreign Policy (Canada, Brazil, Mexico and Chile)—The Brazilian Case study,” funded by the University of Ottawa/Canadian Institute of Health Research, and by a small grant from the Sergio Arouca National School of Public Health (ENSP), the Oswaldo Cruz Foundation (Fiocruz), Rio de Janeiro, Brazil. The author warmly thanks Rosiane Martins do Santos and Alexandre Alvarenga for all their very helpful support with tracking down items in the bibliography and other documents, which proved very useful in preparing this article, and also for helping organize the list of references. The author would also like to thank Peter Lenny (MCIL) for his invaluable contribution to the translation of this paper.

The author is Senior Researcher and Professor, Sergio Arouca National School of Public Health, Oswaldo Cruz Foundation (Fiocruz), Rio de Janeiro, Brazil.

Further Reading

Barnes, A. J., Brown, G., & Harman, S. (2015). Locating health diplomacy through African negotiations on performance-based funding in global health. *Journal of Health Diplomacy*, 1(3), 1–19.

Bueno, F. C. T., Faria, M., & Bermudez, L. (2013). A Cooperação Sul-Sul e as Redes Estruturantes do Conselho de Saúde da Unasul como instrumentos de desenvolvimento regional. *Cadernos do Desenvolvimento*, 8(12), 83–100.

Buss, P., & Tobar, S. (2018). Health diplomacy in the political process of Integration in Latin America and the Caribbean <http://dx.doi.org/10.1093/acrefore/9780190632366.013.24>. *Oxford research encyclopedia of global public health*.

Dodgson, R., Lee, K., & Drager, N. (2002). *Global health governance: A conceptual review* http://apps.who.int/iris/bitstream/handle/10665/68934/a85727_eng.pdf?sequence=1&isAllowed=y. London: Centre on Global Change and Health, London School of Hygiene and Tropical Medicine.

Fidler, D. (2004). Germs, norms and power: Global health's political revolution. *Law, Social Justice & Global Development Journal (LGD)*, 1, 04–1.

Gagnon, M. L., & Labonté, R. (2013). Understanding how and why health is integrated into foreign policy—A case study of health is global, a UK Government strategy 2008–2013. *Globalization and Health*, 9(1), 24.

Garrett, L. (2005). *HIV and National Security: Where are the Links? A Council on Foreign Relations Report*. New York: Council on Foreign Relations.

Herrero, M. B., & Tussie, D. (2015). Unasur Health: A quiet revolution in health diplomacy in South America. *Global Social Policy*, 15(3), 261–277.

Jones, C. M., Clavier, C., & Potvin, L. (2017). Are national policies on global health in fact national policies on global health governance? A comparison of policy designs from Norway and Switzerland <https://gh.bmj.com/content/2/2/e000120?cpetoc=&utm_source=trendmd&utm_medium=cpc&utm_campaign=allijs&utm_content=americas&utm_B>. *BMJ Global Health*, 2(2), e000120.

Khazatzadeh-Mahani, A., Ruckert, A., & Labonte, R. (2018). Global health diplomacy <<http://dx.doi.org/10.1093/oxfordhb/9780190456818.013.7>>. In C. McInnes, K. Lee, & J. Youde (Eds.), *The Oxford handbook of global health politics*. Oxford, U.K.: Oxford University Press.

Labonté, R. (2014). Health in all (foreign) policy: Challenges in achieving coherence <<https://doi.org/10.1093/heapro/dau031>>. *Health Promotion International*, 29(suppl_1), i48–i58.

Tobar, S., Buss, P., Coitiño, A., Kleiman, A., Fonseca, L. E., Rigoli, F., Sealey, K., & Victoria, V. (2017). Diplomacia de la salud: fortalecimiento de las oficinas de relaciones internacionales de los ministerios de salud en las Américas <<https://doi.org/10.26633/RPSP.2017.145>>. *Revista Panamericana de Salud Pública*, 41, e145.

Watt, N. F., Gomez, E. J., & McKee, M. (2013). Global health in foreign policy—And foreign policy in health? Evidence from the BRICS. *Health Policy and Planning*, 29(6), 763–773.

References

Adams, V., Novotny, T. E., & Leslie, H. (2008). Global health diplomacy <<http://dx.doi.org/10.1080/01459740802427067>>. *Medical Anthropology*, 27(4), 315–323.

Almeida, C. (2002). Reforma de sistemas de servicios de salud y equidad en América Latina y el Caribe: algunas lecciones de los años 80 y 90 <<https://www.scielo.org/article/csp/2002.v18n4/905-925/>>. *Cadernos de Saúde Pública*, 18(x), 905–923.

Almeida, C. (2011). International perspectives on the public health implications of 9/11—Health and foreign policy: The threat from health securitisation <<https://onlinelibrary.wiley.com/doi/full/10.1111/j.1753-6405.2011.00714.x>>. *Australian and New Zealand Journal of Public Health*, 35(4), 312.

Almeida, C. (2013). Saúde, política externa e cooperação sul-sul em saúde: Elementos para a reflexão sobre o caso do Brasil. In Fiocruz [et al.], *A saúde no Brasil em 2030: prospecção estratégica do sistema de saúde brasileiro: desenvolvimento, Estado e políticas de saúde* [online]. (vol. 1, pp. 233–327) [Available from SciELO Books <<http://books.scielo.org>>]. Rio de Janeiro: Fiocruz/Ipea/Ministerio da Saude/Secretaria de Assuntos Estrategicos da Presidencia da Republica.

- Almeida, C. (2015). Saúde e Relações Internacionais: novo desafio teórico e metodológico da saúde coletiva. In T. W. F. Baptista, C. S. Azevedo, & C. V. Machado (Eds.), *Políticas, Planejamento e Gestão em Saúde—Abordagens e Métodos de Pesquisa*. Rio de Janeiro: Editora Fiocruz.
- Almeida, C. (2016). El Banco Mundial, la Organización Mundial de la Salud y las reformas contemporáneas en los sistemas de salud. In J. M. M. Pereira & M. Pronko (Eds.), *La demolición de derechos—Um examen de las políticas del Banco Mundial para la educación y la salud (1980-2013)*. Buenos Aires: Editora Universidad Nacional de Luján.
- Almeida, C. (2017). Parcerias público-privadas (PPP) no setor saúde: Processos globais e dinâmicas nacionais <<http://dx.doi.org/10.1590/0102-311x00197316>>. *Cadernos de Saúde Pública*, 33(Suppl. 2).
- Anderson, P. (1995). Balanço do neoliberalismo. In E. Sader (Ed.), *Pós-neoliberalismo: As políticas sociais e o Estado democrático*. Rio de Janeiro, RJ: Paz & Terra.
- Arrighi, G. (1996). *O longo século XX*. Rio de Janeiro, RJ: Contraponto.
- Associação Brasileira de Saúde Coletiva-Abrasco. (2018). Nota da Abrasco sobre a saída dos médicos cubanos do Mais Médicos <<https://www.abrasco.org.br/site/outras-noticias/notas-oficiais-abrasco/nota-abrasco-sobre-saida-dos-medicos-cubanos-do-programa-mais-medicos-para-o-brasil/38190>>.
- Birn, A., Muntaner, C., & Afzal, Z. (2017). South-South cooperation in health: Bringing in theory, politics, history, and social justice <<https://doi.org/10.1590/0102-311X00194616>>. *Cadernos de Saúde Pública*, 33 (Suppl. 2).
- Blouin, C., Molenaar, B., & Pearcey, M. (2012). Annotated literature review: Conceptual frameworks and strategies for research on global health diplomacy <<http://www.equinet africa.org/sites/default/files/uploads/documents/Diss92%20GHD%20Litrev%20July2012.pdf>>. Equinet Discussion Paper 92.
- Bond, K. (2008). Commentary: Health security or health diplomacy? Moving beyond semantic analysis to strengthen health systems and global cooperation <<https://academic.oup.com/heapol/article/23/6/376/572215>>. *Health Policy and Planning*, 23(6), 376-378.
- Bourne, P. (1978). A partnership for international health care <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1431875/>>. *Public Health Reports* 93, 114-123.
- Brown, T., Cueto, M., & Fee, E. (2006). The World Health Organization and the transition from “international” to “global” public health. *American Journal of Public Health*, 96(1), 62-72.
- Buss, P. M., & Faid, M. (2013). Power shifts in global health diplomacy and new models of development: South-south cooperation <http://dx.doi.org/10.1007/978-1-4614-5401-4_21>. In I. Kickbusch, G. Lister, M. Told, & N. Drager (Eds.), *Global Health Diplomacy* (pp. 305-322). New York: Springer.
- Buss, P. M., & Ferreira, J. R. (2010). Diplomacia da saúde e cooperação Sul-Sul: As experiências da Unasul Saúde e do Plano Estratégico de Cooperação em Saúde da Comunidade de Países de Língua Portuguesa (CPLP) <<https://www.reciis.iciet.fiocruz.br/index.php/reciis/article/view/712>>. *Revista Eletrônica de Comunicação, Informação & Inovação em Saúde*, 4(1).

- Changhe, S. U. (2013). Soft power <<http://dx.doi.org/10.1093/oxfordhb/9780199588862.001.0001>>. In A. F. Cooper, J. Heine, & R. Thakur (Eds.), *The Oxford handbook of modern diplomacy*. Oxford: Oxford University Press.
- Cooper, A. F. (2013). The changing nature of diplomacy <<http://dx.doi.org/10.1093/oxfordhb/9780199588862.001.0001>>. In A. F. Cooper, J. Heine, & R. Thakur (Eds.), *The Oxford handbook of modern diplomacy*. Oxford: Oxford University Press.
- Cooper, A. F., Heine, J., & Thakur, R. (2013). Introduction <<http://dx.doi.org/10.1093/oxfordhb/9780199588862.001.0001>>. In A. F. Cooper, J. Heine, & R. Thakur (Eds.), *The Oxford handbook of modern diplomacy*. Oxford: Oxford University Press.
- Cueto, M. (1996). *Salud, Cultura y Sociedad en América Latina*. Washington, DC: Organización Panamericana de la Salud—Instituto de Estudios Peruanos.
- Cueto, M. (2008). International health, the early Cold War and Latin America <<https://www.utpjournals.press/doi/abs/10.3138/cbmh.25.1.17>>. *Canadian Bulletin of Medical History*, 25(1), 17–41.
- Davies, S. E. (2008). Securitizing infectious disease. *International Affairs*, 84(2), 295–313.
- Davies, S. E., Kamradt-Scott, A., & Rushton, S. (2015). *Disease diplomacy: International norms and global health security*. Baltimore, Maryland: JHU Press.
- Eggen, O., & Sending, O. J. (2012). Recent contributions to research on health and foreign policy: A report of the international research initiative “Foreign policy as part of global health challenges.” <<http://hdl.handle.net/11250/277144>> Oslo: Norwegian Institute of International Affairs.
- Feldbaum, H., Lee, K., & Michaud, J. (2010). Global health and foreign policy. *Epidemiologic Reviews*, 32(1), 82–92.
- Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4), e1000226.
- Fidler, D. P. (2004). Health as foreign policy: Between principle and power. *The Whitehead Journal of Diplomacy and International Relations*, 6, 179.
- Fidler, D. P. (2005). From international sanitary conventions to global health security: The new International Health Regulations. *Chinese Journal of International Law*, 4(2), 325–392.
- Fidler, D. P. (2007a). Reflections on the revolution in health and foreign policy <https://www.scielosp.org/scielo.php?pid=S0042-96862007000300023&script=sci_arttext&tlng=en>. *Bulletin of the World Health Organization*, 85, 243–244.
- Fidler, D. P. (2007b). Architecture amidst anarchy: Global health’s quest for governance <<https://www.repository.law.indiana.edu/facpub/329/>>. *Articles by Maurer Faculty*, 329.
- Fidler, D. P. (2009). Health in foreign policy: An analytical overview. *Canadian Foreign Policy Journal*, 15(3), 11–29.

- Fidler, D. P. (2010). The challenges of global health governance. <<https://www.cfr.org/report/challenges-global-health-governance>>. Council on Foreign Relations.
- Fidler, D. P. (2013). Health diplomacy <<http://dx.doi.org/10.1093/oxfordhb/9780199588862.013.0039>>. In A. F. Cooper, J. Heine, & R. Thakur (Eds.), *The Oxford handbook of modern diplomacy*. Oxford: Oxford University Press.
- Fiori, J. (2018). Humanitarian Wars and the Struggle for Ethical Order. *Medium. First published online 31 July 2018.
- Fiori, J. (2019). Humanitarianism and the end of liberal order: Editor's introduction. *Journal of Humanitarian Affairs* 1(1), 1-3.
- Fiori, J. L. (2005). Sobre o poder global. *Novos estudos-CEBRAP*, 73, 61-72.
- Fiori, J. L. (2007). A nova geopolítica das nações e o lugar da China, Índia, Brasil e África do Sul. *Oikos* 6 (2), 77-105.
- Fiori, J. L. (2019). Babel syndrome and the new security doctrine of the United States. *Journal of Humanitarian Affairs*, 1(1), 42-45.
- Fiori, J. L. (2018). Dialética da Guerra e da Paz. In J. L. Fiori (Org.), *Sobre a Guerra*. Petrópolis: Editora Vozes.
- Gilpin, R. (1987). *The political economy of the international relations*. Princeton: Princeton University Press.
- Gagnon, M. L., & Labonté, R. (2011). Human rights in global health diplomacy: A critical assessment. *Journal of Human Rights*, 10(2), 189-213.
- Gonçalves, V. K., & Inoue, C. I. A. (2017). Governança Global: uma ferramenta de análise. In G. O. Schmitz & R. A. Rocha (Eds.), *Brasil e o sistema das Nações Unidas: Desafios e oportunidades na Governança Global* (pp. 27-57). Brasília: Ipea.
- Gyngell, A., & Wesley, M. (2008, April 3). Commentary: Regional diplomacy has new impetus <<https://archive.lowyinstitute.org/publications/regional-diplomacy-has-new-impetus>>. *Australian Financial Review*.
- Hamzawi, A. (2008, June 19-25). Regional diplomacy filling the vacuum <<http://weekly.ahram.org.eg/archive/2008/902/op2.htm>>. *Al-Ahram Weekly*, 902.
- Health Diplomats. (n.d.). Health diplomacy <http://www.healthdiplomats.com/index.php?page=31_health_overview> [website]. Geneva.
- Held, D. (2014). The diffusion of authority. In T. Weiss & R. Wilkinson (Eds.), *International organization and global governance*. New York, NY: Routledge.
- Herrero, M. B. (2017). Moving towards south-south international health: Debts and challenges in the regional health agenda <<https://dx.doi.org/10.1590/1413-81232017227.03072017>>. *Ciencia & Saúde Coletiva*, 22, 2169-2174.

- Herrero, M. B., & Tussie, D. (2015). UNASUR Health: A quiet revolution in health diplomacy in South America. *Global Social Policy: An Interdisciplinary Journal of Public Policy and Social Development*, 15(3), 261–277.
- Horton, R. (2007). Health as an instrument of foreign policy <[https://doi.org/10.1016/S0140-6736\(07\)60378-X](https://doi.org/10.1016/S0140-6736(07)60378-X)>. *The Lancet*, 369(9564), 806–807.
- Huang, Y. (2018). Emerging powers and global health governance <<http://dx.doi.org/10.1093/oxfordhb/9780190456818.013.19>>. In C. McInnes, K. Lee, & J. Youde (Eds.), *The Oxford handbook of global health politics*. Oxford, U.K.: Oxford University Press.
- Ingram, A. (2005). The new geopolitics of disease: Between global health and global security. *Geopolitics*, 10(3), 522–545.
- Jones, C. M., Clavier, C., & Potvin, L. (2017). Adapting public policy theory for public health research: A framework to understand the development of national policies on global health. *Social Science & Medicine*, 177, 69–77.
- Jönsson, C., & Hall, M. (2005). *Essence of diplomacy*. New York, NY: Palgrave Macmillan.
- Kamat, S. (2004). The privatization of public interest: Theorizing NGO discourse in a neoliberal era. *Review of International Political Economy*, 11(1), 155–176.
- Katz, R., Kornblat, S., Arnold, G., Lief, E., & Fischer, J. E. (2011). Defining health diplomacy: Changing demands in the era of globalization. *Milbank Quarterly*, 89(3), 503–523.
- Kaul, I., & Faust, M. (2001). Global public goods and health: Taking the agenda forward. *Bulletin of the World Health Organization*, 79, 869–874.
- Kay, A., & Williams, D. (2009). Introduction: The international political economy of global health governance. In K. Adrian & D. Williams (Eds.), *Global health governance*. New York, NY: Palgrave Macmillan.
- Kennedy, D. (2008). The mystery of global governance <<https://dash.harvard.edu/handle/1/11222700>>. *Ohio Northern University Law Review*, 34, 827.
- Kickbusch, I., Lister, G., & Told, M. (2013). *Global health diplomacy: Concepts, issues, actors, instruments, fora and cases*. New York, NY: Springer.
- Kickbusch, I., & Kökény, M. (2013). Global health diplomacy: Five years on <<http://dx.doi.org/10.2471/BLT.13.118596>>. *Bulletin of World Health Organization*, 91, 159–159A.
- Kickbusch, I., Novotny, T., Drager, N., Silberschmidt, G., & Alcazar, S. (2007). Global health diplomacy: Training across disciplines <<http://dx.doi.org/10.2471/BLT.07.045856>>. *Bulletin of the World Health Organization*, 85(12), 971–973.
- Kickbusch, I., Silberschmidt, G., & Buss, P. (2007). Global health diplomacy: The need for new perspectives, strategic approaches and skills in global health. *Bulletin of the World Health Organization*, 85(3), 230–232.
- Kindleberger, C. (1973). *The world in depression, 1929-39*. Berkeley: University of California Press.

- Kingdon, J.W. (1984). *Agendas, Alternatives and Public Policies*. Boston: Little, Brown & Co.
- Koplan, J. P., Bond, T. C., Merson, M. H., Reddy, K. S., Rodriguez, M. H., Sewankambo, N. K., & Wasserheit, J. N. (2009). Towards a common definition of global health <[https://doi.org/10.1016/S0140-6736\(09\)60332-9](https://doi.org/10.1016/S0140-6736(09)60332-9)>. *The Lancet*, 373(9679), 1993–1995.
- Labonté, R. (2008). Global health in public policy: Finding the right frame? *Critical Public Health*, 18(4), 467–482.
- Labonté, R., & Gagnon, M. L. (2010). Framing health and foreign policy: Lessons for global health diplomacy. *Globalization and Health*, 6(1), 14.
- Lee, K. (2009). Understanding of global health governance: The contested landscape. In K. Adrian & D. Williams (Eds.), *Global health governance*. New York, NY: Palgrave Macmillan.
- Lee, K., & Fidler, D. (2007). Avian and pandemic influenza: Progress and problems with global health governance <<http://dx.doi.org/10.1080/17441690601136947>>. *Global Public Health*, 2(3), 215–234.
- Lee, K., & Kamradt-Scott, A. (2014). The multiple meanings of global health governance: A call for conceptual clarity. *Globalization and Health*, 10(1), 28.
- Lee, K., & Smith, R. (2011). What is a “global health diplomacy”? A conceptual review <<http://summit.sfu.ca/item/10865>>. *Global Health Governance*, 5(1).
- Lima, T. G. F. M. S. (2017). *Cooperação internacional do Brasil em HIV/Aids: institucionalização e especificidades nos contextos nacional e internacional*. Unpublished doctoral thesis. Ensp-Fiocruz, Rio de Janeiro, Brasil.
- Loewenson, R., Modisenyane, M., & Pearcey, M. (2014). African perspectives in global health diplomacy <http://www.tarsc.org/publications/documents/loewenson%20modisenyane%20pearcey_african%20perspectives%20in%20GHD.pdf>. *Journal of Health Diplomacy*, 1(2).
- Marimón-Torres, N., & Martínez-Cruz, E. (2010). Evolución de la colaboración médica cubana en 100 años del Ministerio de Salud Pública <http://scielo.sld.cu/scielo.php?pid=S0864-34662010000300010&script=sci_arttext&tlng=pt>. *Revista Cubana de Salud Pública*, 36(3), 254–262.
- Martins, P., Aguiar, A., Mesquita, C., Alexandrino, F., Silva, N., & Moreno, M. (2017). Global health diplomacy: Conceptual framework proposal. *Saúde e Sociedade*, 26(1), 229–239.
- McInnes, C. (2009). National security and global health governance. In A. Kay & D. Williams (Eds.), *Global health governance: Crisis, institutions and political economy* (pp. 42–58). New York, NY: Palgrave Macmillan.
- Michaud, J., & Kates, J. (2012a). Raising the profile of diplomacy in the US global health response: A backgrounder on global health diplomacy <<https://www.popline.org/node/552825>>. *Popline*.

- Michaud, J., & Kates, J. (2012b). The US Global Health Initiative: where does it stand? [https://www.thelancet.com/journals/lancet/issue/vol379no9830/PIIS0140-6736\(12\)X6021-5](https://www.thelancet.com/journals/lancet/issue/vol379no9830/PIIS0140-6736(12)X6021-5). *The Lancet* 379(May 26).
- Michaud, J., & Kates, J. (2013). Global health diplomacy: Advancing foreign policy and global health interests. *Global Health: Science and Practice*. 1(1), 24–28.
- Murphy, C. (2014). The emergence of global governance. In T. Weiss & R. Wilkinson (Eds.), *International organization and global governance*. New York, NY: Routledge.
- Nye, J. (2013). Hard, soft, and smart power <http://dx.doi.org/10.1093/oxfordhb/9780199588862.013.0031>. In A. F. Cooper, J. Heine, & R. Thakur (Eds.), *The Oxford handbook of modern diplomacy*. Oxford: Oxford University Press.
- Ornstein, T. (2015). *Public Diplomacy in Global Health: An Annotated Bibliography* <https://www.uscpublicdiplomacy.org/sites/uscpublicdiplomacy.org/files/useruploads/u33041/Public%20Diplomacy%20in%20Global%20Health.pdf>. Los Angeles: Figueroa Press.
- Oslo Ministerial Declaration, Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand (2007). Oslo Ministerial Declaration—global health: a pressing foreign policy issue of our time. *Lancet*, 2007(369), 1373–1378.
- Ottersen, O. P., Dasgupta, J., Blouin, C., Buss, P., Chongsuvivatwong, V., Frenk, J., . . . Scheel, I. B. (2014). The political origins of health inequity: Prospects for change. *The Lancet*, 383, 630–667.
- Pereira, J. M. M. (2010). O Banco Mundial e a construção político-intelectual do “combate à pobreza.” *Topoi*, 11(21), 260–282.
- Peters, D. (2017, November 2). False distinctions between international health and global health <https://www.globalhealthnow.org/2017-11/false-distinctions-between-international-health-and-global-health>. *Global Health Now*.
- Roemer-Mahler, A. (2014). The rise of companies from emerging markets in global health governance: Opportunities and challenges. *Review of International Studies*, 40(5), 897–918. ISSN 0260-2105.
- Ruckert, A., & Labonté, R. (2014). Public-private partnerships (ppps) in global health: the good, the bad and the ugly. *Journal Third World Quarterly Volume*, 35(9), 1598–1614.
- Ruckert, A., Labonté, R., Lencucha, R., Runnels, V., & Gagnon, M. (2016). Global health diplomacy: A critical review of the literature. *Social Sciences & Medicines*, 155, 61–72.
- Sachy, M., Almeida, C., & Pepe, V. L. E. (2018). Assistência Farmacêutica em Moçambique: a ajuda externa na provisão pública de medicamentos <https://dx.doi.org/10.1590/1413-81232018237.09332018>. *Ciência & Saúde Coletiva*, 23, 2277–2290.
- Sacks, J. (2005). *The End of Poverty: Economic Possibilities for our Time*. New York: The Penguin Press.
- Salomón, M., & Pinheiro, L. (2013). Análise de política externa e política externa Brasileira: trajetória, desafios e possibilidades de um campo de estudos <http://www.redalyc.org/html/358/35827889003/>. *Revista Brasileira de Política Internacional*, 56(1).

- Rocha, M. S. (2017). A Governança Global da Internet. In G. O. Schmitz & R. A. Rocha (Eds.), *Brasil e o sistema das Nações Unidas: Desafios e oportunidades na Governança Global* (pp. 484–511). Brasília: Ipea.
- Schmitz, G. O., & Rocha, R. A. (2017). Desafios e Oportunidades para o Brasil na Governança Global: Uma Breve Introdução. In G. O. Schmitz & R. A. Rocha (Eds.), *Brasil e o sistema das Nações Unidas: Desafios e oportunidades na Governança Global*. Brasília: Ipea.
- Singer, P., & Friedman, A. (2014). *Cybersecurity: what everyone needs to know*. Oxford: Oxford University Press.
- Singler, S. W. (2016). The rise of global health: How did health become a matter of global concern? *Inquiries Journal*, 8 (06).
- Smith, R., & Irwin, R. (2016). Measuring success in global health diplomacy: Lessons from marketing food to children in India. *Globalization and Health*, 12(1), 28.
- Sofer, S. (1988). Old and new diplomacy: A debate revisited <http://dx.doi.org/10.1017/S0260210500113269>. *Review of International Studies*, 14(03), 195.
- Sparke, M. (2009). Unpacking economism and remapping the terrain of global health. In A. Kay & D. Williams (Eds.), *Global health governance*. New York, NY: Palgrave Macmillan.
- Steurs, L., Van de Pas, R., Delputte, S., & Orbie, J. (2018). The global health policies of the EU and its member states: A common vision? *International Journal of Health Policy and Management*, 7(5), 433–442.
- Thieren, M. (2007). Health and foreign policy in question: The case of humanitarian action. *Bulletin of the World Health Organization*, 85, 218–224.
- Torchia, M., Calabrò, A., & Morner, M. (2015). Public-private partnerships in the health care sector: A systematic review of the literature. *Public Management Review*, 17(2), 236–261.
- Vieira, M. A. (2007). The securitization of the HIV/AIDS epidemic as a norm: A contribution to constructivist scholarship on the emergence and diffusion of international norms. *Brazilian Political Science Review*, 1(2).
- Walt, S. (1991). Alliance formation in Southwest Asia: Balancing and bandwagoning in Cold War competition. In R. Jervis & J. Snyder (Eds.), *Dominoes and bandwagons: Strategic beliefs and great power competition in the Eurasian Rimland*. Oxford, U.K.: Oxford University Press.
- Watson, A. (2005). Preface. In A. Watson, *Diplomacy: The dialogue between states*. London, U.K.: Routledge.
- Watt, N. F., Gomez, E. J., & MacKee, M. (2014). Global health in foreign policy—and foreign policy in health? Evidence from the Brics. *Health Policy and Planning*, 29, 763–773.
- Weindling, P. (2006, July–September). As origens da participação da América Latina na Organização de Saúde da Liga das Nações, 1920 a 1940 <http://dx.doi.org/10.1590/S0104-59702006000300002>. *História, Ciências, Saúde—Manguinhos*, 13(3), 1–14.

Weiss, T., & Wilkinson, R. (2014). International organization and global governance: What matters and why. In G. Weiss & R. Wilkinson (Eds.), *International organization and global governance*. New York, NY: Routledge.

Wiebel, H. (2017). Cuban medical diplomacy: A developmental paradox <<http://www.coha.org/cuban-medical-diplomacy-a-developmental-paradox/>>. *Council of Hemispheric Affairs*.

WHO Commission on Macroeconomics and Health & World Health Organization. (2001). *Macroeconomics and health: investing in health for economic development : executive summary/report of the Commission on Macroeconomics and Health* <<http://www.who.int/iris/handle/10665/42463>>. Geneva: World Health Organization.

Appendices

APPENDIX 1: Summary of the Main Rationales Framing Health in Foreign Policy

Health as Development
Health as Trade (Commodities)
Health as Humanitarian Action
Health as a Global Public Good
Health as a Human Right
Health was introduced as a key issue in development in a very particular manner; this occurred primarily in low- and middle-income countries, shortly after World War II, in the form of foreign aid and development cooperation, coordinated and driven by the United States as the hegemonic power. One of the underlying premises behind this policy was that “health is no longer simply a consequence of growth, but one of its engines” (Labonté, 2008, p. 471; Labonté & Gagnon, 2010, p. 5). However, the principle that prevailed was the hegemonic economic rationalism that defines neoliberal globalization (Labonté, 2008; Sparke, 2009); the idea that if economic productivity were increased, purportedly in the recipient countries, foreign trade would be facilitated for the donors. Funding policies were implemented on the basis of this rationale (e.g., MDGs, lauched in 2000, and reinforced by specific commissions (Commission on Macroeconomics and Health (WHO, 2001). These and other events set in motion the <i>geopolitics of disease</i> (Ingram, 2005), resulting in vertical programs of donations, mainly of drugs for only a few diseases (HIV/AIDS, tuberculosis and malaria), distributed in line with specific national interests, and benefiting donor country-based transnational pharmaceutical corporations. Although there were some benefits of these programs, problems proliferated in the form of aid dependency, lack of coordination between donors, fragmentation of national health systems, and the weakening of states’ operational capabilities (e.g., Feldbaum, Lee, & Michaud, 2010; Labonté & Gagnon, 2010; Sachy, Almeida, & Pepe, 2018).

Health as Development

Health as Trade (Commodities)

Health as Humanitarian Action

Health as a Global Public Good

Health as a Human Right

This rationale was strongly encouraged by the neoliberal policies applied to the health sector, which advocated not only introducing market mechanisms into the organization of public health systems, but also expanding private-sector participation in health services and increasing the number of public–private partnerships (PPPs) (Almeida, 2002; Almeida, 2017).

The underlying assumption sees health as a *commodity* rather than as a *public good*. Meanwhile, the issue of intellectual property rights, particularly in pharmaceuticals (which are permanently protected by the WTO) is a source of constant tension between the health and economy sectors, in that patents and technological development are concentrated in private industry, hindering the production of generic drugs at much lower prices at the national level. Some agreements have been important in these dynamics; e.g., the Doha Declaration (against the Agreement on Trade-Related Intellectual Property Rights, TRIPs, and TRIPs Plus) or in driving private trade in services (the General Agreement on Trade in Services, or GATS), intensifying privatizations and inequities in service provision.

Macroeconomic adjustment, market deregulation, and the financialization of investment, all neoliberal policies, are acknowledged to be prejudicial to populations' conditions of life and health. As pointed out by Labonté (2008, p. 475), "Health can be commodified, but it is not a commodity [...] trade treaties, which are intended to promote private commercial interests, are no place to negotiate international rules for health, health care and other health determinants, such as education and water/sanitation" [...] "there are clear conflicts between the health/commodity discourse and that of human rights" (p. 476).

Historically, the altruistic values of humanitarian actions are people-centered, which sets them in opposition to foreign policy as reflecting the interests of countries (Thieren, 2007). This rationale is stated explicitly by nongovernmental organizations (see the Code of Conduct for the International Red Cross and Red Crescent Movement and Nongovernmental Organizations in Disaster Relief, and the SPHERE Project's Humanitarian Charter; Thieren, 2007, p. 219).

The central functions of humanitarian actions would be the provision of aid of all kinds, protection for human rights, and advocacy. The same author mentions, however, that as regards foreign policy, these assertions should be relativized: "Humanitarian arguments often guide foreign policy decisions, but they are often regarded as a means to enhance reciprocity and national image. Humanitarian justifications are no longer altruistic then, but become interest-based and political" (Thieren, 2007, p. 219). This discussion paved the way for the so-called "new humanitarianism."

On the other hand, Juliano Fiori (2019) argues that: "Humanitarianism has been a defining feature of liberal order. But it is not simply a pillar of liberal ideology. Indeed, essential to any universalist politics of the human, its liberal character is contingent. Amid the crisis of liberal order, humanitarian norms and practices are increasingly contested, and the concept of humanitarianism itself is being redefined" (p. 3).

Moral and ethical issues are also raised by humanitarian actions, but prosper only at the level of discourse.

Health as Development

Health as Trade (Commodities)

Health as Humanitarian Action

Health as a Global Public Good

Health as a Human Right

There has been much discussion of the concept of global public goods (GPGs), a term which was derived from public goods, an economic concept that classifies goods as private or public (Kaul & Faust, 2001).

Private goods are counted as property; they are measurable, saleable, and are produced in quantities determined by market laws of supply and demand. Public goods, by contrast, are indivisible, non-excludable, and individuals cannot be prevented from partaking of them. They constitute goods in the public domain, available for all to enjoy; this is only possible if they are supplied through a public system (understood here as a state system). Public goods can have *externalities* and individuals can *free-ride*, i.e., enjoy the good without having contributed to it.

Many *goods* are not only public in consumption, but also in their provision. Therefore, there would be no natural incentive for their production. As a result, states often implement policies that ensure cooperation and equitable burden-sharing, such as taxes and social contributions.

There is a great deal of debate over whether or not health itself or healthcare (particularly medical care) are public or private goods. This discussion has intensified since the 1990s, with the increasingly widespread implementation of the restrictive neoliberal macroeconomic rationality that considers healthcare to be a private good.

Kaul and Faust (2001) also defined *global public bads* (GPBs), which can also be “non-excludable, although their prevention is desirable, rather than their production. Examples include global atmospheric pollution, cross-border drug smuggling, international warfare, the global spread of communicable diseases and the emergence of drug-resistant microbial strains” (p. 870).

As a result, GPGs are generally made available in emergency situations rather than preventively. In addition, Kaul and Faust (2001, p. 870) stated that: “Given the current trend towards increasingly porous borders and growing cross-border activities, many public goods can no longer be achieved through domestic policy action alone and depend on international cooperation [. . . and as a result. . .] GPGs are increasingly underprovided and GPBs are increasingly overprovided.”

Labonté (2008, p. 474) argued that:

At the same time, the underlying theoretical and empirical public good argument—that there exist profound market failures in key areas of human health and survival demanding new forms of global financial ‘risk pooling’ and regulation—is one that is likely to have greater traction with economists in treasury departments than any of the other global health discourses. This is what has in fact happened: ‘health as tradable good’ [. . .] is reduced to goods (such as drugs and new technologies) or services (private health insurance, facilities or providers), the increased cross-border flow of which is designed to maximise profit, not health.

Although international human rights laws and treaties are normative guidelines, binding or otherwise, signatory states should comply with them. Often, however, this is not what happens, leading to strong judicial activism (as in Brazil and Colombia, for example).

Health as Development
Health as Trade (Commodities)
Health as Humanitarian Action
Health as a Global Public Good
Health as a Human Right
Specifically, “balancing individual and collective health human rights is challenging, and there is no clear guidance on when an individual health right claim might compromise a collective health right claim.” Empirical studies show “the difficulty states encounter when aiming to fulfill international human rights obligations in the face of widely conflicting economic, security, and domestic political agendas” (Gagnon & Labonté, 2011, p. 205). More concretely, “[none of those states focused on], even those with reputations as human rights supporters and advocates, comply fully with obligations under the IHRF and its treaties” (Gagnon & Labonté, 2011, p. 205). References to human rights in general, and to health as one particular human right, are broadly normative and lack instrumental detail, and are also frequently subsumed under other concepts (e.g., equity, social justice, humanitarianism). The greatest challenge lies in the competition between human rights and other major themes (such as trade, economic growth, and security) in national and international decision-making processes. In other words, Gagnon and Labonté (2011) stress “the difficulty States encounter when aiming to fulfill international human rights obligations in the face of widely conflicting economic, security, and domestic political agendas” (p. 205). For an analysis of the main international laws and treaties that invoke or regulate human rights or health as a human right, see Gagnon and Labonté (2011); Labonté (2008).

APPENDIX 2: Perception and Role of GHD in Selected Countries, Blocs, Coalitions, and Regions

BRICS Coalition
European Union and its Member States
South America and the UNASUR^(c)
Cuban Medical Internationalism
Africa region
The United States
Huang (2018) published a recent article on the BRICS coalition. The synthesis presented here is based on this study. The potential force of the BRICS coalition in global health is seen to reside in the institutional limitations and increasing complexity of global health governance (GHG) processes. Health diplomacy (HD), as conducted politically and practically by countries of the coalition (e.g., Brazil and South Africa) could constitute an alternative to existing GHG paradigms. However, these countries’ influence is conditional on three strategic dimensions:

BRICS Coalition
European Union and its Member States
South America and the UNASUR^(c)
Cuban Medical Internationalism
Africa region
The United States
institutionalization, material capacity, and alternative outlooks. Meanwhile, the coalition's influence is considered to be constrained by relatively scant funding for development assistance for health. In addition, its effective contribution is limited by domestic challenges and institutional deficits. One example of these difficulties is the unfavorable conjuncture that has confronted Brazil since a substantial political crisis came to a head there in 2016. That crisis has worsened in 2018 with the election of Jair Bolsonaro as president of Brazil. The BRICS countries have in fact been quite proactive individually since 2005. They have acted jointly (as a "bloc") in important debates and negotiations, such as approval of the Doha Declaration, in discussions on access to medicines and the production of generics, and others. On the other hand, not all of its countries took part in the meeting of foreign ministers (Oslo Declaration, 2007); Brazil has been more present in international health forums than the other BRICS' countries; South Africa, Brazil, and India are generics-producing countries and thus share certain struggles and difficulties in that field; China has been rather "silent" on GHD; and Russia's participation in the BRICS is being questioned, because it is not exactly an emerging country and has participated relatively little in health ministers' meetings. However, cooperation among the countries of the coalition and their activities in certain regions tends to be bilateral in nature; e.g., Brazil in South America and African Portuguese-speaking countries; China in many African countries (with some conflicts with India and Russia on specific issues unrelated to health etc.) and in South America. Despite these relative successes, these countries have often been reluctant to act as a group proper in international arenas on a range of issues, rather allowing their particular interests to prevail. It is argued that the low level of funding available in these countries is offset by cooperation programs, theoretically with no conditions attached, which aim to leverage empowerment of the recipient countries, and create dialogues for experience-sharing and joint learning. This form of HD is seen to constitute one alternative to the GHG currently in place. Despite the rhetoric of the inherent power of solidarity and South-South cooperation, doubts persist as to whether these countries will in fact manage to transform declarations and agreed commitments (based on principles of solidarity, social justice, and new forms of support for development in the geopolitical South) into broader, effective, concrete actions, and relegate (or relativize) their own interests in favor of a new kind of collective action. In short, the coalition's future will hang on its member countries' ability to deal with ongoing changes in global power and surmount their domestic troubles.
Steurs et al. (2018) analyze the development of GHD in the European Union, and inspired this briefing. Relevant documents of the EU and its member states reflect different understandings of global or international health, as well as different framings. The European Commission and its member states have different policies to further global health objectives. While some take a more comprehensive approach, combining domestic and foreign policy objectives and, like the European Commission itself, have released their own "global health strategies" (the United Kingdom in 2008 and 2011, Germany in 2013, and France in 2017), others maintain an "international health" approach, to be pursued via

BRICS Coalition

European Union and its Member States

South America and the UNASUR^(c)

Cuban Medical Internationalism

Africa region

The United States

Regional health and redistributive challenges have driven new experiences of regional integration in health, and inspired the design of regional strategies for better access to health through international negotiations and improved capacity-building in South America.

The case of the 12-member-country Union of South American Nations (UNASUR), founded in 2008 as a political bloc, articulating regional integration and social development, could be considered “new forms of regionalism” as a process of collective action within and for the region (Herrero, 2017, p. 2071). The UNASUR, by the very nature of its constitution, took up health as a key political issue from the outset.

The concept of health has been related to citizens’ rights and has been institutionalized as part of a democratic right within the region. In this sense, health has played a key role in the democratic ethos of the region. There is a strong tradition in the region of *public health* and *social medicine*, which developed an approach linked to social epidemiology, collective health, and the social determinants of health. After the results of neoliberal policies (impoverishment, increased social exclusion, and reduced access to health systems) had become clear, the regional situation became increasingly complex, challenging the notion of *regionalism* and United States-led liberal governance. “These are key to understanding why an essentially political body such as the Unasur took up health issues as a tool, in the social policy context, for self-reliant development in order to build a ‘new regionalism’” (Herrero, 2017, p. 2071). Its vision of regional integration differs from the existing commercial agreements (e.g., Mercosur and the Andean Community).

Despite deep-rooted differences in its members’ health systems, UNASUR has focused on the right to health and health sovereignty, driven by a strong sense of collective action and political integration, including in some regulatory frameworks. It was no coincidence that one of the first UNASUR councils to be set up was the Health Council, together with the Defense Council, and it made great progress. ‘UNASUR Health’ was one of the most dynamic areas of regional horizontal (or South–South) cooperation. This council made great advances in drug policies, human resource training, sanitary vigilance.

Nonetheless, despite these advances (mentioned by other authors—see Bueno, Farias, & Bermudez, 2013; Buss & Ferreira, 2010), the survival of the alliance is at risk, because it is extremely vulnerable to political reverses in the region’s key countries (e.g., that seen in Brazil since 2016). To put this more clearly, in April 2018, Brazil and five other countries (Argentina, Chile, Colombia, Peru, and Paraguay) suspended their participation in the bloc indefinitely after divergences were sparked by Brazil’s Foreign Ministry. Early in 2017, the six countries called for Argentina’s Ambassador José Octávio Bordón to be appointed secretary-general of UNASUR in order to redress its “political bias,” which would mean that UNASUR would have been dominated by the “Bolivarian” (*sic*) countries (which included Venezuela). No consensus was reached on appointing Bordón, and the bloc has been practically inactive ever since. The division between “Bolivarians” and the “conservatives” who now dominate the organization prevents the consensus decision-making required by the bloc’s statutes. Colombia finally left the bloc in 2019, and Chilean president Sebastian Piñera held a meeting on March 22, 2019 inviting the 12 countries

BRICS Coalition
European Union and its Member States
South America and the UNASUR^(c)
Cuban Medical Internationalism
Africa region
The United States
Set up in 1909, during the second US occupation (1906–1909), Cuba’s Ministry of Health is the oldest in the world (Marimon-Torres & Martínez-Cruz, 2010). Following the Cuban Revolution in 1959, there was a massive exodus of doctors: of the total 6,286 doctors, 50% emigrated (Marimón-Torres & Martínez-Cruz, 2010). In the 1960s and ’70s, Cuba reformed its national health system (based on the principle that universal healthcare is a basic human right and the responsibility of the state), embarked on intensive training of health personnel, particularly in medicine and nursing and, by providing free education. Cuba also established a substantial capability for health technology development. Its health system and service innovations became a model for health development during the second half of the 20th century, and “Cuba has continued expanding its medical services and technology over time” (Wiebel, 2017, p. 3), making the country a hub for complex surgeries (organ transplants and heart bypasses, among others), and for research and technological developments (new medicines, vaccines, etc.). With these developments, Cuba has emerged as a victor in the health field, attaining health indicators on a par with developed countries, that have served as a catalyst for improved medical services and universal treatment on the island, and for medical collaboration elsewhere, as a form of “internationalist solidarity” or “health internationalism.” In other words, international cooperation in health has become one of the country’s most important foreign policy instruments, mainly in the form of sending health personnel to other countries that face health difficulties or are political allies. It has also been active in training health personnel to adapt a new outlook. These personnel include both Cubans (through the regeneration of the existing university in Havana and the establishment of new medical schools in practically all the country’s provinces) and foreigners (from Africa, the Americas, Asia, and the Middle East, among others), through the founding of the Latin American School of Medicine in 1998. Also, medical professionals have been trained in allied countries, including the former USSR, China, and Eastern European countries. This process occurred over several stages, according to world and domestic and context (Marimón-Torres & Martínez-Cruz, 2010): 1) <i>1960s–1980s</i>: The “permanent internationalist brigades” began to operate together with the “internationalist mission” modality of free assistance in solidarity, leveraged by the different liberation movements that developed in Africa and Central America. 2) <i>1990s</i>: The USSR disintegrated and the socialist bloc—Cuba’s chief market—disappeared, ushering in the “special period” and intensification of the US blockade of the island. A new modality of cooperation was instituted: “Compensated Technical Assistance or Direct Contract” (<i>Asistencia Técnica Compensada o Contrato Directo</i>), which made it possible to maintain international medical cooperation and bring revenue into the island for the national health system, in view of the country’s difficult economic situation. 3) <i>Late 1990s</i>: With the environmental catastrophes in Central America and the Caribbean, cooperation programs were modified: The Internationalist Mission arrangement was reduced, Compensated Technical Assistance was gradually cut back and the Comprehensive Health Program (<i>Programa Integral de Salud</i>,

BRICS Coalition
European Union and its Member States
South America and the UNASUR^(c)
Cuban Medical Internationalism
Africa region
The United States
There is little available literature focusing on GHD in Africa, and there are a number of different perspectives on the risks and benefits of meshing health and diplomacy. The observations offered here are based on a review of the literature that has been published on the subject in English-speaking sub-Saharan Africa and East African countries (Lowenson et al., 2014). Africa's colonial past has left deep imprints on its countries, not only as regards their development, but also their identity-building, regional unity, cultural traditions, and perceptions of foreign aid and global policies. Although GHD is considered an important "instrument," it is perceived in various different ways, depending on the issue and the actors involved. "African societies have traditionally given more weight to the rights and interests of the community than the rights and interests of the individual" (Lowenson et al., 2014, p. 7). The issue of "continental unity" is one important point, but is also subject to discussions and divergences about countries' foreign policies. "The Organisation of African Unity (OAU) set up in 1963 directed its focus to unity to ensure the liberation of those parts of Africa still under colonial rule" (Lowenson et al., 2014, p. 7). However, any disunity in participation and discussion of global issues is regarded as prejudicial to the continent, because it could open up opportunities for new forms of domination. The continent's natural wealth of resources is coveted worldwide, particularly by the major powers of the North and emerging powers, such as China and Brazil. "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" (Lowenson et al., 2014, p. 7). South-South cooperation, whether bilateral or built on the basis of coalitions such as the BRICS, is welcomed by the authors and considered essential to Africa's development. "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" (Lowenson et al., 2014, p. 10). The liberation ethic and unity in African diplomacy are at the same time an assertion of interests and a defensive strategy against the power imbalance facing Africa in global arenas. Framings of health are most successful when they focus on domestic legitimation, are shared by several countries, and leverage regional cooperation. The continent's high degree of foreign dependence overall, particularly in health, and the lack of consensus regarding regional development, undermine the setting of common goals in diplomacy, mainly because they weaken and bypass national and regional organizations.
While health, foreign policy, and diplomacy, as we have seen, have been linked over time in US policy, the more contemporary and explicit use and application of "health diplomacy" as a concept and pursuit has its roots in the Carter administration of the 1970s (Michaud & Kates, 2012a, p. 5). A more deliberate and concrete engagement with GHD on the part of the US government did not begin to gain traction until after the emergence of the HIV/AIDS epidemic in the 1980s. At that time, the US government increasingly began to see HIV as an international political, economic, and security issue that deserved greater

BRICS Coalition
European Union and its Member States
South America and the UNASUR^(c)
Cuban Medical Internationalism
Africa region
The United States
development cooperation. However, a second group (comprised of Belgium and Denmark) do not have “global health strategies.” Nevertheless, member states continue to be important bilateral players in this field as well, and some of them are powerful donors. “Studies on the EU’s role in global health are mostly confined to the European Commission’s policy and the EU’s representation in the World Health Organization (WHO)” (Steurs et al., 2018, p. 435).
(Venezuela represented by Juan Guaidó) to propose the creation of another organization, the Foro para el Progreso de la América del Sur (PROSUR), as a “regional forum for dialoguing.” Brazil adhered to the proposal. This marks the first time that a regional forum or organization was not proposed by Brazil.^(a)
PIS) was launched in November 1998, first in Central America and the Caribbean and later in Africa and the Pacific. Essentially, the PIS is active in sending <i>medical brigades</i> to remote, inaccessible locations, where there are no local doctors, and they are paid only a stipend to cover basic needs. 4) <i>2000s onward</i>: The Special Programs modality was launched in 2003 in Venezuela—the <i>Barrio Adentro</i> (Into the Shanty) I and II programs, as part of the “Bolivarian Alternative for the Americas” (<i>Alternativa Bolivariana para las Américas</i>, ALBA), with counterpart remittances of oil to Cuba, and also training for Comprehensive Community Medicine students in several countries (Venezuela, Guinea Bissau, East Timor, Gambia, and Tanzania/Zanzibar). This program quickly expanded to more than 40 countries. In 2004 Cuba started “Operation Miracle” (<i>Operación Milagro</i>), designed to provide medical care in Cuba to foreigners, at first from Venezuela and later from 15 Caribbean countries and 12 countries in Latin America, also including US patients; it involved a technology transfer too, for the production of meningococcal vaccine, under an exchange agreement between Cuba’s Finlay Institute and the Bio-Manguinhos Institute of Technology and Immunology, from Fiocruz, in Rio de Janeiro, Brazil. Lastly, from mid-2013 onward the “More Doctors Program” (<i>Programa Mais Médicos</i>, PMM), in cooperation with Brazil and intermediated by the PAHO Brazil office, was a mix of modalities involving compensated technical assistance or direct contract and the PIS, plus medical brigades sent out to work in remote areas. The program was discontinued in November 2018 by Cuba’s Minister of Health, following disrespectful and slanderous declarations about the Cuban doctors by Brazil’s president-elect, Jair Bolsonaro. The incumbent president’s actions have deprived some 20 million people of medical care, as 80% of the doctors enrolled in the program were Cubans, although it was also open to Brazilians; Cuban doctors were instructed to leave Brazil on December 25th 2018 (Abrasco, 2018^(b)).

BRICS Coalition

European Union and its Member States

South America and the UNASUR^(c)

Cuban Medical Internationalism

Africa region

The United States

foreign policy attention. The first mention of AIDS in a US National Security Strategy was made in 1996, and in 2000 the Clinton administration declared HIV to be a national security threat to the United States. The country's diplomats led the effort to have the UN Security Council also declare HIV a security threat. In addition to concerns about AIDS, there were also growing apprehensions about the security, economic, and health impacts of emerging infectious diseases (SARS and pandemic influenza) (Michaud & Kates, 2012a, p. 5).

Accordingly, the United States' participation has been very important in formulating health security as the most important framing of health in foreign policy. By the end of the second Clinton government, and even earlier, the idea of health security was circulating in *think tanks* and in the CIA, and the prevailing view was that problems of severe infectious diseases in other countries (such as HIV/AIDS) could threaten the United States' national security, by destabilizing certain areas and regions in a way that would jeopardize its strategic, political, and economic interests.

Even though various actors are involved in this process, and the link between health and national security was already being discussed, the change was strongly leveraged in particular countries and arenas by the United States' response to the terrorist attacks of 11 September 2001^(c) “[...] bioterrorism was placed much higher on the national security agenda, dragging health along with it willing or not” (McInnes, 2009, p. 44).

In 2009 the Global Health Initiative was implemented, as an effort to launch a “new, comprehensive global health strategy” by the US government, which intended to adopt “a more integrated approach to fighting diseases, improving health, and strengthening health systems” (Michaud & Kates, 2012a, p. 1). Led by the heads of the three agencies that collectively oversee most US global health programs—USAID, CDC, and the Office of the Global AIDS Coordinator (OGAC)—a new GHI office, with an Executive Director, was created at the State Department to coordinate interagency efforts. However, as part of a review of the GHI structure, as mandated in the “Quadrennial Diplomacy and Development Review” QDDR process (Michaud & Kates, 2012, p. 6), the administration announced on July 3, 2012 that, while the GHI “will continue as the priority global health initiative of the US Government,” its office would close and instead, the three leaders of the “core entities” (USAID, CDC, and OGAC) would continue to have a mandate of ensuring the GHI principles are implemented in the field in order to meet GHI goals and targets (Michaud & Kates, 2012b).

Early in the 2010s, the US government announced its intention to create a new “Office of Global Health Diplomacy” at the State Department (known as S/GHD), elevating, at least structurally, the role of diplomacy in US global health efforts. As stated in the announcement, the creation of the office is a recognition of “the critical role of health diplomacy to increase political will and resource commitments around global health among partner countries and increase external coordination among donors and stakeholders.” It also appears to be part of the next phase of the GHI, the administration's effort to create a global health strategy for the U.S. government, with the S/GHD office “champion[ing] the priorities and policies of the GHI in the diplomatic arena” (Michaud & Kates, 2012a, p. 1).

BRICS Coalition
European Union and its Member States
South America and the UNASUR^(c)
Cuban Medical Internationalism
Africa region
The United States

The United States' support for international health programs grew dramatically after 2000, through newly created international assistance programs such as the multilateral Global Fund to Fight AIDS, Tuberculosis, and Malaria, which the United States helped to establish in 2002; the US President's Emergency Plan for AIDS Relief (PEPFAR), created in 2003, alongside a new Office of the Global AIDS Coordination, located within the State Department to oversee US global AIDS efforts; and the 'US President's Malaria Initiative', launched in 2005. Such efforts channeled significantly increased financial assistance into global health, and were described by policymakers as *important not only because they addressed pressing humanitarian needs abroad, but also because they served US national interests and foreign policy objectives* in a variety of ways (Michaud & Kates, 2012a, p. 5; my emphasis).

a Retrieved from: <https://br.reuters.com/article/topNews/idBRKBN1HR2MH-OB RTP> <<https://br.reuters.com/article/topNews/idBRKBN1HR2MH-OB RTP>>. See also: <https://www.politize.com.br/prosul/> <<https://www.politize.com.br/prosul/>>

b See <https://www.abrasco.org.br/site/outras-noticias/notas-oficiais-abrasco/nota-abrasco-sobre-saida-dos-medicos-cubanos-do-programa-mais-medicos-para-o-brasil/38190/> <<https://www.abrasco.org.br/site/outras-noticias/notas-oficiais-abrasco/nota-abrasco-sobre-saida-dos-medicos-cubanos-do-programa-mais-medicos-para-o-brasil/38190/>>

c See also: Fidler (2004); Ingram (2005); Garret (2005); McInnes (2009); Feldbaum, Lee, and Michaud (2010); Almeida (2011, 2013).

(12) Michaud & Kates, 2012..

Notes

1. See for example Almeida (2017).
2. See for example Sachy et al. (2018); Torchia, Calabrò, and Morner (2015).
3. In 1992, at the behest of the UN Security Council, Secretary-General Boutros-Ghali produced the first of a series of documents designed to transform the international security order: *An Agenda for Peace* outlined the new rationale and the methods for moving on from the conception of national security that had guided the whole Cold War period, by now focusing on individual security (Vieira, 2007, p. 144).
4. For a good historical and political analysis of the development of the humanitarianism and the liberal order see Juliano Fiori (2018 and 2019).
5. It is important to differentiate between an *institution* and an *organization* (Jönsson & Hall, 2005; Weiss & Wilkinson, 2014). *Organizations* are formal bureaucracies, with legal standing, physical offices, chief executives, staff, and a substantive focus on operational concerns; for example, multilateral organizations (the UN, the WHO), or ministries. *Institutions* are more process-oriented: They can be defined as persistent, connected sets of formal or

informal rules that prescribe behavioral roles, constraints, and activities, and shape expectations; for example, the “G” groups (G7/8, G20, G77) (Weiss & Wilkinson, 2014, pp. 7–8). That differentiation is key to understanding *diplomacy* as an *institution*. Diplomacy manifested in *organizational form* is a foreign ministry and its representations around the world, quite a recent phenomenon in the context of the long history of diplomatic relations.

6. Jönsson and Hall (2005) justify choosing the term *international society* over *international system*. The latter presupposes permanent, regular contact among *polities*, in such a way as to inform the strategic calculations of those involved. *International society* adds to this dimension the awareness of common values and interests, and is subordinated to a set of rules for relations among “polities,” specified in their *institutions*; the way this set of shared rules is constructed is *processual*, modifying the mechanical notion of a system (p. 33).

Related Articles

Health Diplomacy in the Political Process of Integration in Latin America and the Caribbean

Health Equity Metrics