

Key Players in Global Health

How Brazil, Russia, India, China, and South Africa
Are Influencing the Game

A Report of the CSIS Global Health Policy Center

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INTRODUCTION

Katherine E. Bliss

After the head of economic research at Goldman Sachs, Jim O'Neill, coined the term “BRICs” in 2001 to refer to the world’s four key emerging economies—Brazil, Russia, India, and China—which he projected would both surpass the Group of Seven in economic growth and also increase their share of global gross domestic product, most discussion focused on how to best incorporate the BRICs into existing global economic governance efforts.¹ Nearly a decade later, however, the BRICs’ engagement on global health policy and governance issues is a substantial component of their overseas activities and international relations. Although each of the BRIC countries is home to a large and, in most cases, a growing population, and is confronting its own challenges in the health arena, each country has nevertheless, in its own fashion, embraced global health as a critical component of its international outreach and contribution to global policy activities.

As the moniker “BRICs” gained currency, the BRIC countries themselves adopted the term and began viewing themselves as a unique configuration—either as the BRICs or as members of a similar alliance also incorporating South Africa, such as IBSA (India, Brazil, and South Africa) and BASIC (Brazil, South Africa, India, and China). During the past 10 years, these five governments, with their newfound economic strength, have worked to shore up their places in the international system, either by flexing their muscle through existing organizations such as the United Nations Security Council or by strengthening alternative organizations in order to challenge the traditional international political status quo. And for some of the BRICs, it turns out, their engagement on global health policy has proven to be an important means of advancing their own sovereign interests.

In recent years, as leaders of the Group of Eight (G-8) have taken on global health as a topic relevant to security as well as economic growth and trade, making major commitments to bolster overseas commitments on such issues as infectious diseases and maternal and child health, the BRICs and South Africa have likewise become influential players in the global health game. Indeed, at the 2007 G-8 Summit in Heiligendamm, Brazil, India, China, and South Africa, along with Mexico, were invited to join the ranks of G-8 “outreach countries” in an acknowledgment of their growing global influence on economic development issues, including health.² Whether as member states in international organizations, as bilateral donors, or through participation in international financial consortia such as the G-20, Brazil, Russia, India, China, and South Africa are using their wealth and status to influence the outcome of global health policy discussions, and many are supporting overseas health-related activities to foster solidarity, create alliances, and strengthen their international position.

1. Jim O'Neill, *Building Better Global Economic BRICs*, Global Economics Paper 66 (New York: Goldman Sachs, 2001), <http://www2.goldmansachs.com/ideas/brics/building-better.html>.

2. Jim O'Neill, “Current Answers (and Questions) about BRICs and the N-11,” in *BRICs and Beyond*, edited by Goldman Sachs Global Economic Group (New York: Goldman Sachs, 2007), <http://www2.goldmansachs.com/ideas/brics/book/BRIC-Full.pdf>.

This volume represents the first step in an 18-month initiative that will involve the CSIS Global Health Policy Center and CSIS programs on China, Russia, South Asia, Africa, and the Americas in carrying out work focused on the BRICs' and South Africa's emerging global health activities, practices, and strategies in the area of health diplomacy. Beyond research and the dissemination of timely analysis, this initiative also aims to facilitate the development of partnerships between CSIS and institutions in each country to support shared research projects, to organize international discussions, and to disseminate policy analysis and recommendations intended to encourage greater understanding of the ways in which approaches to global health policy and cooperation are changing.

The goal of CSIS in undertaking this initiative is to shed light on the rationales and domestic factors driving each country's decisionmaking regarding when to engage outside its borders on global health matters, to identify the bilateral and multilateral partnerships that appear to be most important in each context, to understand how and when each country determines whether to pursue bilateral or multilateral relationships, and to offer policymakers in the United States and elsewhere an opportunity to learn how other countries are conceptualizing their work on health, and, in the process, shifting the nature of the game. During the next year, CSIS will convene meetings in Washington and in each of the BRIC countries and South Africa, and in the fall of 2011 it will organize a final conference featuring the perspectives and conclusions from each of the projects in the five countries. We anticipate releasing a collection of papers from each joint CSIS and partner institution session as well as a final report summarizing the major issues and lessons learned throughout the broader initiative.

This first set of papers is organized around a series of questions focusing on the history of each country's engagement in the global health area; the philosophy that motivates each nation's global health outreach and cooperation; the relationship between each country's domestic health conditions and its international work; the legislation and bureaucracies that support governments' work on global health; the most relevant international organization, multilateral, and bilateral partners; and the implications for the United States and other countries looking toward the future.

One key conclusion is that, even though these five countries are often conceptually grouped together thanks to their position as emerging economic powerhouses, and even as they frequently do collaborate as BRICs, IBSA, or BASIC on issues related to health, their own histories and domestic outlooks on health and foreign policy are rather different and leave an indelible imprint on the vision that each brings to the issue of international cooperation. The ways in which each country approaches its global health outreach differ considerably, but there are nevertheless a number of common themes.

The fact that most of these five countries have actually been engaged internationally on health issues for quite a long time may come as a surprise. In chapter 4 of this volume, Judyth Twigg focuses on Russia's more recent transition from aid recipient in the 1990s to donor in the last decade; but, as she points out, the history of Soviet-era health outreach, including the training of foreign doctors at Soviet medical schools, is well known. Perhaps less well known, however, is the fact that Brazil, India, and China have also been carrying out international work on health for a long time. As Charles Freeman and Xiaoqing Boynton show in chapter 2, beginning in the 1960s China began sending medical missions to Africa as a gesture of anti-imperialist ideology and solidarity. For Brazil and India, Katherine Bliss and Uttara Dukkupati show in chapters 1 and 3, respectively, that each country has witnessed 1960s-era agencies originally intended to coordinate the receipt of assistance evolve into institutions focused on donor outreach and cooperation. But as Twigg

emphasizes for Russia, the transition from recipient to donor is not always smooth. The chapters on Russia, China, Brazil, and India in this volume all underscore the difficulties that countries can face in training and deploying development professionals, crafting and implementing legislation to authorize transfers of money to foreign governments, and addressing popular concerns over funds spent overseas. They highlight, as well, the pressures to ensure transparency and accountability regarding international outreach and spending that these emerging global health players will face over time.

Governments' motivations for becoming involved in global health policy debates and cooperation programs vary and depend to a large extent on domestic health and political conditions. Freeman and Boynton show that China began doing work on health as an expression of revolutionary solidarity. China, they point out, is often accused of adopting a "no-strings-attached approach" to curry favor with recipient countries and generate favorable trade arrangements for precious commodities; however, they remind us that the principle of nonintervention also energizes China's work on global health and its reluctance to set conditions on aid. Bliss shows that Brazil's overseas work on health is motivated both by the Federal Constitution of 1988's articulation of the human right to health and by the idea of South-South solidarity and horizontal cooperation rather than vertical assistance. As Jennifer Cooke shows in chapter 5 on South Africa, South-South alliances and securing a higher profile for African nations within the global health agenda have also motivated South Africa's leaders. Although the Indian government has explicitly engaged in overseas activities since 2003, Dukkipati shows that it continues to prioritize the use of diplomacy and international connections to improve conditions at home while at the same time promoting its private sector and the expansion of a medical tourism industry to attract overseas visitors to its state-of-the-art hospitals. In most of these five countries, where despite economic growth social inequalities persist, striking the right balance between global outreach and paying sufficient attention to domestic concerns is a delicate process that involves a calculus as to the likelihood that spending money away from home will lead to protests over the government's failure to address the needs of the citizenry.

Not surprisingly, the World Health Organization (WHO) emerges as a critical venue for each country's engagement on health, although the enthusiasm with which each government approaches its work with WHO varies considerably. Following the 2003 outbreak of severe acute respiratory syndrome (SARS), China began to embrace a more participatory approach to health within international organizations and lobbied hard to have Hong Kong native Margaret Chan seated as the WHO director-general in 2007. At WHO meetings, Brazil has demonstrated leadership on the negotiations of the Framework Convention on Tobacco Control, and it plays an active role on the WHO Executive Board. But India's and Russia's approaches appear to be focused more at the regional level. Indeed, India appears to contribute to WHO policies more through the work of the skilled Indian staff members employed by WHO and its Regional Office for South-East Asia than through the engagement of India's mission to the United Nations in Geneva. Russia has worked to support in-country work on HIV/AIDS, avian influenza, and public health preparedness, and in September 2010 it hosted the WHO Regional Committee for Europe. South Africa has earned greater visibility within WHO for its efforts to respond to the HIV/AIDS pandemic and was singled out for its progress by UNAIDS head Michel Sidibé at the 2010 World Health Assembly.

All the BRICs and South Africa have interacted with the Global Fund to Fight AIDS, Tuberculosis, and Malaria as both recipients and donors, although in some cases the donation of funds has been purely symbolic. Brazil, Russia, and South Africa are all classified by the World Bank as

upper-middle-income countries, and China and India are designated as lower-middle-income countries. In this context, these countries are limited to applying for funds to support programs focused on specific population segments, such as extremely vulnerable or impoverished sectors. China has been an active Global Fund member and hosted the 16th board meeting in the city of Kunming. However, China's total contributions to the fund, \$16 million, are far less than its awards of nearly \$2 billion to date. Brazil's awards of \$45 million far outweigh its \$200,000 total contributions since the fund's inception, and India's \$10 million in donations pales in comparison with its \$1.1 billion in receipts. Russia's \$354 million in receipts, however, is not significantly more than its \$254 million in donations. For some countries, legislative restrictions complicate the direct allocation of money to foreign governments or entities—and some, like Brazil, choose to engage with the Global Fund by supporting other countries in making successful grant applications. Nevertheless, considering that in the recent recession many financially hard-hit donor countries have had to scale back or eliminate commitments to multilateral enterprises, the fact that the relatively economically stable BRICs and South Africa have not stepped up their commitments to the Global Fund may raise questions about their commitment to global health leadership in the long term.

It is clear that scientific cooperation and innovation is an important aspect of these five countries' approach to global health engagement. India's private-sector pharmaceutical research and development institutions are engines of economic growth and featured aspects of the country's outreach on health. Moreover, in recent years India has begun developing a medical tourism sector to reach out to foreign patients as a way of sharing its research and expertise. Brazil's quest to promote its "health industrial complex" also reflects the importance the government attaches to using biotechnology, as well as vaccine research and production, as an engine of economic development. Like India, Brazil has a well-developed generic drug industry. Indeed, India and Brazil have frequently joined forces in rejecting the European Union's and United States' invocations of patent protections and law enforcement processes against the widespread distribution of their generic products. Within the World Trade Organization, they have argued for greater use of the flexibilities regarding public health within the Trade-Related Intellectual Property Rights Agreement. However, China, which also has a burgeoning research and development sector, sees patent protections as increasingly important to safeguarding its innovation and profits. South Africa's research institutions are at the forefront of HIV/AIDS interventions and work to develop partnerships with universities in Sub-Saharan Africa and beyond.

On health security topics, the five countries' approaches also differ. Russia's health outreach to its neighboring Central Asian countries is motivated, in part, by its concerns that immigrants from that region are introducing infectious diseases upon arrival in Russia. The 2003 SARS and 2005 avian influenza outbreaks made China realize that if the government failed to embrace more transparent reporting and disease management processes, it might be viewed by others as an unreliable global partner. Brazil, however, rejects the supremacy of security in discussions about health, consistently arguing that international action on health should be motivated by a sense of solidarity and common purpose rather than an effort to create an epidemiological shield or contain disease outbreaks in less fortunate areas.

Since the G-20 is a process that some, but not all, of the BRIC and South African governments have embraced as having potential for replacing the G-8 and serving as a major forum for broad discussions on development, we have invited analyses examining how the South Korea and France G-20 summits are likely to approach health. The brief chapters focusing on these summits follow the longer assessments of the BRICs' and South Africa's approaches to the issues. As Victor Cha

and Sudeep Chand show, respectively, in chapters 6 and 7, examining the upcoming Seoul G-20 Summit, there is a place for development issues on the agenda, which may offer some opportunities for a discussion of health. In chapter 8, Heather Conley and François Delmas, looking toward France's hosting of both the G-8 and the G-20 in the summer of 2011, show that France's own overseas work on health—and its embrace of health activities within the G-8 context—may make the summit negotiators more likely to ensure a spot for health within the G-20 proceedings. Yet both chapters note that any effort by the G-20 to commit to supporting health cooperation in the same manner as the G-8 is a long way off.

For the G-20 Summit in Seoul on November 11–12, 2010, and beyond, whether and how the BRICs and South Africa use this forum to engage on global health remains to be seen.³ At a June 2010 conference hosted by Chatham House, with participation by CSIS, the speakers concluded that “there is an opportunity to integrate health and development issues into the G-20 agenda for economic growth, potentially through the newly established G-20 Working Group on Development, even though these issues are not currently perceived to be central to its agenda.”⁴ It is clear that each country is stepping up its work on global health through its official development assistance—as a bilateral donor, through its work in multilateral institutions, and by supporting overseas health-related research and innovations. Yet it also seems unlikely that the non-G-8 countries within the G-20 will want to let the major industrial powers in the G-8 off the hook when it comes to their existing commitments on health in the developing world. In the end, how the BRICs and South Africa choose to move forward on global health will depend in large part on their own histories of international interaction on health, on their continued financial growth, and on the extent to which engaging in foreign activities does not conflict with their domestic health and development priorities.

3. Sudeep Chand, J. Stephen Morrison, Peter Piot, and David L. Heymann, “From G8 to G20: Is Health Next in Line?” *The Lancet*, June 23, 2010, <http://download.thelancet.com/flatcontentassets/pdfs/S014067361060997X.pdf>.

4. “Conference Summary: What Is Next for the G20? Investing in Health and Development,” Chatham House, September 2010, 3, <http://www.chathamhouse.org.uk/publications/papers/view/-/id/954/>.

1

HEALTH IN ALL POLICIES BRAZIL'S APPROACH TO GLOBAL HEALTH WITHIN FOREIGN POLICY AND DEVELOPMENT COOPERATION INITIATIVES

Katherine E. Bliss

Brazil has long been an influential player in regional and international health policy discussions. More recently, it has also become a contributor to the field of health-related official development assistance in other countries. The majority of its 150 international health cooperation activities have been developed in the last 5 to 10 years. Under President Luiz Inácio “Lula” da Silva (2003–2010), Brazil has experienced an economic boom fueled by growth in commercial agriculture, deepening industrialization, and rising commodity prices, leading to reductions in social inequality, the expansion of the middle class, and greater revenues for use in funding overseas activities. Lula has personally spearheaded efforts to strengthen Brazil’s international relationships, and engagement on health is just one of several areas in which the country has intensified its global outreach with the intent of supporting alternatives to what it views as relationships and institutions dominated by the “global North.” Brazil’s insistence on supporting South–South initiatives and focusing on cooperation and solidarity, rather than assistance, have earned it international respect. In the multilateral arena, its leadership on such issues as the Framework Convention on Tobacco Control, universal access to HIV/AIDS medications, and the role of intellectual property rights in global health policy discussions has been particularly notable.

Although figures for the total value of Brazil’s global health activities are difficult to obtain, some analysts project that overall spending on overseas development projects—including all loans, grants, technical assistance, and in-kind contributions—could reach \$4 billion per year.¹ Brazil’s technical cooperation programs with Latin American, African, and Asian countries have enabled this nation—which itself has channeled the fruits of its recent economic growth into state-led efforts to expand social services for its most vulnerable sectors—to solidify cultural affinities, fortify bilateral relationships, and share its experience with other countries that it views as fellow travelers on the development trajectory. It is not yet clear if Brazil’s incoming president, Dilma Rousseff, Lula’s former chief of staff, will continue her predecessor’s high-profile foreign policy activities; however, it is likely that Brazil will nonetheless maintain a presence in the field of overseas health and development cooperation as long as it is politically palatable and economically feasible.

“Health in All Policies”

Brazil has long played a leading role in international public health activities, starting in the early twentieth century, when it joined other Latin American nations in crafting hemispheric agreements concerning port sanitation, migrants’ and travelers’ health, and such communicable

The author is grateful to Katryn Bowe and Kathleen Murphy of the CSIS Global Health Policy Center for their research assistance.

1. “Brazil’s Foreign-Aid Programme: Speak Softly and Carry a Blank Cheque,” *The Economist*, July 15, 2010.

diseases as bubonic plague and yellow fever.² As a member of the World Health Organization since its inception in 1948, Brazil has more recently exercised notable influence in international negotiations on such issues as intellectual property rights and tobacco control.³ In 1959 Brazil established a National Commission for Technical Assistance to coordinate the requests for technical assistance it received from developed countries, and since the 1960s, it has provided development assistance to other developing countries.⁴ But despite its long experience in the realm of international health diplomacy, it is a relative newcomer to the field of health-related official development assistance, with the majority of its 150 international health cooperation activities having taken shape in the past 5 to 10 years. As noted above, although figures for the total value of Brazil's international activities are difficult to obtain, Brazil's cooperation activities with Latin American, African, and Asian countries have enabled a nation that has itself been successful in extending state-provided health care to the majority of its population to solidify cultural affinities, strengthen bilateral relationships, and share its experience with other developing countries.⁵

Brazilian engagement on global health issues is driven by the Federal Constitution of 1988, which states that health is a human right; thus it is the state's responsibility to deliver health care nationally and free of charge.⁶ These constitutional provisions led to the creation of the Sistema Universal da Saúde (SUS) in 1990. Brazil's public health sector now covers 190 million people, and is considered to be the largest such public system in world. The country's international engagement is in part premised on the belief that it can share its own successes and lessons learned in implementing the SUS and its other domestic health programs with other countries "in development."

Brazil's activities as a global health partner are also informed by the concept that health activities can serve as an engine of domestic industrial development. This perspective manifests itself in two ways—first, in the conviction that a healthy population can better engage in productive activities; and second, in the belief that Brazil should develop its "health industrial complex" and amplify its activities in biotechnology research, vaccine and pharmaceutical production, and the dissemination of its products internationally, to create jobs and promote economic growth.⁷

2. Marcos Cueto, *The Value of Health: A History of the Pan American Health Organization* (Washington, D.C.: Pan American Health Organization, 2007), 46.

3. Kelley Lee, Luiz Carlos Chagas, and Thomas E. Novotny, "Brazil and the Framework Convention on Tobacco Control: Global Health Diplomacy as Soft Power," *PLoS Medicine* 7 (2010): 1–4, <http://www.plos-medicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000232>.

4. Lúcia Cabral and Julia Weinstock, "Brazilian Technical Cooperation for Development: Drivers, Mechanics and Future Prospects," Overseas Development Institute, September 6, 2010, 3, <http://www.odi.org.uk/resources/download/5002.pdf>.

5. Brazil's stated principles of health cooperation include "commitment to life; health as a universal right and the State's obligation; equality between the States; cooperation between nations for the progress of humanity; respect for national sovereignty, economic independence, equal rights, and non-intervention in the nations' domestic affairs; actions based on horizontality; respect for cultural diversity; autonomy of the countries' and sustainability of actions; integration/articulation; ability to resolve and efficiency; teamwork; development of partnerships; organization and modernization; protagonism of the countries; institutionalization and recovery of local history; social participation and control"; *Health Cooperation: Brazilian International Health Activities Bulletin* 1(2009): 3.

6. Article 196, Constituição da República Federativa do Brasil, <http://pdpa.georgetown.edu/Constituitions/Brazil/brazil88.html>.

7. Suzanne Jacob Serruya, Reinaldo Guimarães, Itajai Oliveira de Albuquerque, and Carlos Morel, "Research and Innovation in Brazil: The Institutional Role of the Ministry of Health," *Global Forum Update on Research for Health*, vol. 5, <http://www.isn.ethz.ch/isn/Current-Affairs/Security-Watch/>

But even if Brazil's government believes health-related research and product innovation can serve as an economic engine, the country's global health strategies are also motivated by the belief that the right to health is more important than economic gain. This perspective underpins its position that intellectual property rights should not impede broad access to life-saving medicines. The premise that all countries should have access to information and innovative technologies to both fight disease and improve health informs the position that it is not appropriate to use law enforcement mechanisms to protect patents at the expense of people's access to necessary medicines. Thus, Brazil has repeatedly advocated for greater recognition of the flexibilities within the Agreement on the Trade-Related Aspects of Intellectual Property regarding public health.⁸ At the Sixty-Second Meeting of the World Health Assembly in 2009, Brazil led efforts to ensure that any new products developed to confront the H1N1 influenza pandemic would be made available to all countries.⁹ The belief that health protection factors should outweigh trade considerations also led Brazil to embrace the Framework Convention on Tobacco Control in 2003. Despite the fact that the country is a significant tobacco exporter, and the government faced pressures from the domestic tobacco industry to limit its support for the convention, the country's diplomats were successful in crafting an independent and health-centered approach to the issue in international discussions.¹⁰

Finally, Brazil articulates its engagement in health-related overseas activities as an expression of partnership and solidarity with other developing countries. The government prioritizes horizontal over vertical relationships and casts its partnerships as South–South cooperation, firmly rejecting the notion of a vertical, top-down approach to assistance. Its policymakers argue that international cooperation should be an “exchange of experiences” and that projects should be developed through dialogue and not motivated solely by donor-country interests. Brazilian diplomats stress, in particular, that the focus on cooperation and health within international relations should not be determined by a strict security agenda, particularly if that agenda is driven by donor countries.¹¹ As Brazil experiences its own transition from aid recipient to donor country, it has also embraced the notion of triangular cooperation, and thus it undertakes joint work with Canada, Cuba, France, Germany, Italy, Japan, Spain, the United Kingdom, and the United States in third countries in Latin America and Africa.¹²

Detail/?page544=1&ots591=4888caa0-b3db-1461-98b9-e20e7b9c13d4&size544=10&lng=en&id=93600; Carlos Augusto Graboïs Gadelha, “Development, Health-Industrial Complex and Industrial Policy,” *Revista de Saúde Pública*, 2006, 40. As Gadelha et al. observed in a recent article about the development of the “health industrial complex” in Brazil, the health sector can play “a significant role in fostering economic growth and national competitiveness.” See Carlos A. Graboïs Gadelha, Pedro R. Barbosa, José Maldonado, Marco Vargas, and Laís Costa, “The Health Economic Industrial Complex: Concepts and General Characteristics,” *HEIC Report: The Newsletter of Fiocruz Health Innovation Research Group* (Oswaldo Cruz Foundation) 1 (2010): 2.

8. Maurice Cassier and Marliena Correa, “Intellectual Property and Public Health: Copying of HIV/AIDS Drugs by Brazilian Public and Private Pharmaceutical Laboratories,” *RECIIS: Electronic Journal of Communication, Information, and Innovation in Health* 1 (2007): 83–90.

9. “José Gomes Temporão: Interview,” *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 4–5.

10. Lee, Chagas, and Novotny, “Brazil and the Framework Convention on Tobacco Control,” 1–4.

11. Interview with public official, Brasília, June 2010.

12. “Triangular Cooperation: Brazil Seeks to Integrate Health Actions,” *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 1. Brazil is the only country in the world where the U.S. Agency for International Development has a mission and with which the agency is cooperating in third

Institutional Roles and Legal Constraints

Within Brazil's federal government, international work on health is organized through an inter-agency International Cooperation Thematic Group.¹³ The Ministry of Foreign Affairs and Ministry of Health play the most prominent roles in defining and implementing the country's global health agenda, although the Ministry of Science and Technology's National Council for Scientific and Technological Development also participates in some projects.¹⁴ Within the Ministry of Foreign Affairs, the Agência Brasileira de Cooperação (ABC), which was founded in 1987, takes the lead in carrying out technical assistance projects, nearly half of which have a health-related component. Roughly 16 percent of the ABC's total budget of \$30 million (for 2010) is allocated to health projects.¹⁵ According to a statement by ABC head Marco Farani in October 2009, during the previous five years, the ABC carried out "more than 100 technical missions" focused on health. The majority of Brazil's cooperation partners are in Africa, where the country has expanded its diplomatic presence significantly in recent years; these partners include Senegal, Ghana, Benin, Angola, Mozambique, Guinea-Bissau, Algeria, Botswana, Burkina Faso, Cape Verde, Liberia, Nigeria, Namibia, Kenya, São Tomé and Príncipe, the Democratic Republic of Congo, Tanzania, and Zambia.¹⁶ Foreign Minister Celso Amorim has stated that he also sees Southeast Asia as an area of potential engagement on global health topics.¹⁷ The ABC notes that its principal cooperative activities focus on malaria, HIV/AIDS, universal health care, nutrition, the establishment of human milk banks, environmental surveillance for health, epidemiological surveillance, hospital administration, and technology transfer.¹⁸

Beyond their work on overseas development projects, Brazil's Ministry of Foreign Affairs and the Ministry of Health also cooperate closely when it comes to diplomatic outreach on health matters, with representatives of the diplomatic corps detailed to the Ministry of Health to provide advice on international negotiations and foreign policy as they relate to decisions regarding global health. Whether in regional forums such as the Union of South American Countries' (UNASUR) Health Council or at the World Health Assembly, Brazil's professional foreign policy specialists frequently sit side by side with senior Health Ministry officials to jointly craft the country's approach to key global health policy concerns.¹⁹

Of all the Brazilian agencies carrying out international development assistance, the country's Ministry of Health has the largest budget; its 2007 budget allocated about \$27 million for overseas

countries. Interview with U.S. Agency for International Development official, U.S. Embassy, Brasília, June 2010.

13. "Triangular Cooperation," 2.

14. Eduardo Botelho Barbosa, "Editorial," *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 2; Alcides Costa Vaz and Cristina Yumie Aoki Onoue, "Emerging Donors in International Development Assistance: The Brazilian Case," International Development Research Center, Partnership and Business Development Division, December 2007, 2, http://www.idrc.ca/uploads/user-S/12447281201Case_of_Brazil.pdf.

15. Cabral and Weinstock, "Brazilian Technical Cooperation," 6.

16. Marco Farani, "South-South Cooperation," *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 6.

17. "Interview with Celso Amorim," *Health Cooperation: Brazilian International Health Activities Bulletin* 2 (2010): 4.

18. "Principais áreas da cooperação prestada," *Via ABC: Publicação da Agência Brasileira de Cooperação*, March 2007, 3, <http://www.abc.gov.br/documentos/viaABC-baixa.pdf>.

19. "A pareceria entre o Itamaraty e o Ministério da Saúde," *Via ABC: Publicação da Agência Brasileira de Cooperação*, March 2007, 2.

work.²⁰ Within the Ministry of Health, an international affairs office manages the agency's contribution to global health projects; the lion's share of international cooperation is carried out by the 110-year-old Fundação Oswaldo Cruz, or Fiocruz, which is based in Rio de Janeiro. Fiocruz, which was founded in 1900 to research and develop products to fight the bubonic plague in Brazil, now includes a school of public health, a training center for health technicians, numerous research laboratories, and a Center for International Relations in Health (CRIS) that brings "together its growing number of international cooperation activities in the health field."²¹ Representatives of Fiocruz and other Ministry of Health offices work closely with the ABC to perform the actual technical cooperation, because the ABC does not have its own staff of trained health professionals focused on carrying out international work but instead pays the travel and subsistence expenses for health experts who work abroad under an arrangement with the United Nations Development Program.²² Voluntary contributions made by the government of Brazil to the Pan American Health Organization, the regional arm of the World Health Organization, are also used to support Ministry of Health cooperative activities in the Americas. Between 2005 and 2007, the value of these transfers was reported to have been about \$140,000.²³ Fiocruz has responsibility for research, education, and product development, and thus it concentrates much of its international outreach on helping other governments set up health institutes, laboratories, and schools of public health based on Brazil's experience.²⁴

One challenge faced by Brazilian officials who would like to see their country engage in more international cooperation is that federal law currently makes it difficult for Brazil to donate public funds to other governments.²⁵ Brazil's Congress must pass legislation authorizing the allocation of funds or resources each time the government wants to engage in a cooperative endeavor, making it difficult to provide vaccines or allocate monies in a consistent, sustainable manner. Some policymakers have proposed legislative reforms to facilitate the appropriation of longer-term funds to ensure the implementation of more sustainable projects.²⁶ The fact that there is no general appropriation for overseas cooperative activities, along with the fact that Brazil does not report the funds it provides overseas to the Development Assistance Committee of the Organization for Economic Cooperation and Development, can make it difficult to quantify the total value of the health-related assistance that the country has provided to its overseas partners in recent years.²⁷ But in a statement at the recent United Nations High-Level Plenary on the Millennium Development Goals, Marcia Helen Carvalho Lopes, Brazil's minister for social development and the Fight Against Hunger, noted that between 2003 and 2009 the country had spent \$1.25 billion overseas

20. Costa Vaz and Aoki Inoue, "Emerging Donors in International Development: The Brazil Case," 10–11.

21. Ministério da Saúde, Fundação Oswaldo Cruz, "Casa de Oswaldo Cruz," pamphlet, no date; Ministry of Health, Oswaldo Cruz Foundation, "Fiocruz Center for Global Health (CRIS)," pamphlet, no date.

22. Interview with Ministry of Health official, Brasília, June 2010; Vaz and Inoue, "Emerging Donors," 25.

23. Vaz and Inoue, "Emerging Donors," 10.

24. Interview with public official, Rio de Janeiro, June 2010.

25. Cabral and Weinstock, "Brazilian Technical Cooperation," 11.

26. Interview, public official, Brasília, June 2010.

27. Brazil is an observer of the OECD and has engaged with some health as well as science and technology working groups. It participated in the Sixth Session of the Health Committee of the OECD in 2009 and has access to OECD studies and statistical data related to health but does not contribute to the Development Assistance Committee.

on more than 400 projects designed to address a broad range of development challenges.²⁸ At present, the lack of a full-time development staff within the ABC and other institutions limits expertise in the field of project monitoring and evaluation, an area that will need to be strengthened over time as Brazil expands its international cooperation agenda.

Domestic Approaches and International Activities

Brazil's international outlook on health is framed in large part by its own domestic experience. Since its founding in 1990, the Sistema Universal da Saúde has extended health care coverage from 30 million people to 190 million people. About 80 percent of Brazil's population relies exclusively on National Health Service clinics, while the wealthiest 20 percent opt for a mixed system of private and public access to health care.²⁹ The country's decentralized, state-run health service is the largest such system in the world. In 2006, domestic spending on health totaled 7.5 percent of the country's gross domestic product. But despite good coverage, the quality of care within the SUS is uneven, with typically strong services in the industrial South and weaker services in the rural and more impoverished North.³⁰ Persistent social inequality is also reflected in Brazil's maternal and child indicators. The country has made impressive achievements in extending skilled delivery services to pregnant women in vulnerable communities and remote regions, but despite declines since the early 1980s, its mortality rate for children under five years of age is still high by international standards (i.e., its rate of 19 per 1,000 births ranked 86th among 193 countries in 2006) and reflects significant disparities between rich and poor in the country.³¹ Brazil has worked closely with its neighboring countries, Peru and Ecuador, as well as with South Africa, to share information on its successes and ongoing challenges in providing universal health care access.

Brazil's domestic achievements in the areas of HIV/AIDS prevention and treatment also inspire the country's global health engagement. The National AIDS Program is internationally recognized and received the Gates Global Health Award in 2003. A decision in the 1990s to ensure universal access to necessary antiretroviral (ARV) medications and other treatment, coupled with aggressive prevention campaigns, helped Brazil avoid by 2004 the 1.2 million HIV/AIDS cases that were projected in 1990.³² It was the country's effort to secure free and universal access to ARV medications for its population that led to its successful negotiation of flexibility with regard to barriers to pharmaceutical availability within the Agreement on Trade-Related Aspects of Intellectual Property. In response to what it viewed as the pharmaceutical company Merck's refusal to lower

28. "Brazil MDG Debate," September 22, 2010, <http://www.unmultimedia.org/tv/webcast/2010/09/brazil-mdg-debate.html>.

29. Eduardo J. Gómez, "Brazil's Public Option: What Obama Can Learn from Lula about Universal Health Care," *Foreign Policy*, September 2, 2009.

30. During the 22 years that the SUS has endeavored to extend service to Brazil's citizens, some Brazilians have become frustrated by delays, particularly with respect to access to medicines, and have recently used the court system to demand access to medications based on the constitutional guarantee of the right to health. See Octavio Luiz Motta Ferraz, "The Right to Health in the Courts of Brazil: Worsening Health Inequities?" *Health and Human Rights* 11 (2010): 33–45.

31. Angelica Sousa, Kenneth Hill, and Mario R. Dal Poz, "Sub-National Assessment of Inequality Trends in Neonatal and Child Mortality in Brazil," *International Journal for Equity in Health* 9 (2010).

32. Shawn Smallman, *The AIDS Pandemic in Latin America* (Chapel Hill: University of North Carolina Press, 2006). Between 1998 and 2005, HIV/AIDS-associated mortality rates fell by 50 percent; inpatient hospitalization days decreased by 70 to 80 percent between 1998 and 2005.

the price of the ARV drug Efavirenz in the context of debates over tiered pricing, Brazil invoked compulsory licensing in 2007 to purchase and sell an India-produced generic version of the drug. Brazil has made special efforts to support the development of domestically based civil society organizations dedicated to raising awareness about and promoting action regarding universal access to HIV/AIDS medications.³³

Brazilian diplomats and senior health officials have acted on this conviction regarding the need for universal access to life-saving medications in their relations with international organizations concerned with health care and with these organizations' other member states. For instance, at the 2000 World Health Assembly, Brazil's proposal that the World Health Organization (WHO's) member countries agree to establish a "database of prices of all anti-AIDS drugs" to "allow poor countries to shop for the best deal worldwide" was met with frustration from the representatives of pharmaceutical companies who were observing the proceedings. However, WHO's member states agreed to work together to incorporate elements of the proposal into a new resolution.³⁴ Brazil has authorized \$8 million to establish an ARV pharmaceutical plant in Mozambique to serve Southern Africa, with Fiocruz staff training Mozambican technical staff in the surveillance, inspection, certification, and control of the medication, as well as in production and marketing.³⁵ Moreover, in cooperation with UNAIDS, UNICEF, and UNESCO, Brazil spent at least \$1.4 million between 2005 and 2009 to supply more than 4,000 people internationally with ARV medications.³⁶ The principle of universal access structures Brazil's response to offers of external support for work on HIV/AIDS, as well. In a highly publicized case that drew international attention, in 2005 Brazil rejected \$40 million in funding from the U.S. President's Emergency Plan for AIDS Relief and the U.S. Agency for International Development because it objected to the funding's so-called prostitution clause, which prohibits assisting sex workers; it explained that sexual commerce is not illegal in Brazil and that to refrain from funding organizations that provide assistance to sex workers would contradict its policy of universal access.³⁷

The country's positive experience extending immunization coverage, and the government's efforts to promote vaccine and pharmaceutical research and development, have also influenced external engagement on health. Overall immunization rates are high, at 97 percent. The Fiocruz vaccine plant in Manguinhos, which was built in 2001, is one of the largest vaccine manufacturing centers in Latin America. It produces vaccines for bacterial and viral diseases, including yellow fever, smallpox, tuberculosis, typhoid fever, measles, and meningitis.³⁸ Its primary purpose is to serve the needs of the Brazilian public, but it sells surplus vaccine internationally, and in 2008 it

33. Patrick Larvie, "Nation, Science, and Sex: AIDS and the New Brazilian Sexuality," in *Disease in the History of Modern Latin America: From Malaria to AIDS*, edited by Diego Armus (Durham, N.C.: Duke University Press, 2003), 290–310.

34. Donald G. McNeil, "Patent Holders Fight Proposal on Generic AIDS Drugs for Poor," *New York Times*, May 18, 2000.

35. "Donation Authorized," *Health Cooperation: Brazilian International Health Activities Bulletin* 2 (2010): 6.

36. "Triangular Cooperation: Brazil Seeks to Integrate Health Actions," *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 1.

37. Nicole Franck Masenior and Chris Beyrer, "The US Anti-Prostitution Pledge: First Amendment Challenges and Public Health Priorities," *PLoS Medicine* 4 (2004): 1160, http://www.jhsph.edu/bin/m/l/Masenior_prostitution_plos.pdf.

38. "Fiocruz Vaccine Manufacturing Centre, Manguinhos, Brazil," <http://www.pharmaceutical-technology.com/projects/fiocruz>.

provided yellow fever vaccines to the Pan American Health Organization's revolving fund and to neighboring Paraguay and Argentina to help fight a regional outbreak.³⁹

Despite Brazil's strong performance in the areas of HIV/AIDS and immunizations, as well as its successes in extending health care coverage, it continues to report cases of leishmaniasis, leprosy, and Chagas disease, along with yellow fever and malaria in its Amazon River Basin and Northern regions.⁴⁰ Dengue outbreaks continue to pose a challenge in urban areas such as Rio de Janeiro and in the Amazon region.⁴¹ These, along with emerging health concerns such as cancer and chronic, noncommunicable diseases, are topics that Brazil has raised within the World Health Assembly and at the Group of Twenty's (G-20's) preparatory meetings as issues worthy of greater international attention and cooperation.⁴²

Multilateral, Regional, and Bilateral Partners for Health Cooperation

In 2007, Brazil signaled the importance it attaches to the issue of health diplomacy by joining with France, Indonesia, Norway, Senegal, South Africa, and Thailand in signing the Oslo Declaration on global health and foreign policy. In so doing, it argued for greater integration of health into international relations and diplomatic discussions.⁴³

Multilateral Engagement on Health

WHO has been a pivotal venue for Brazil's engagement in international debates regarding health. By sharing its own experience implementing antitobacco legislation through its Inter-Ministerial National Commission on the Control of Tobacco, for example, Brazil was able to assume a position of leadership within the deliberations on the Framework Convention on Tobacco Control (FCTC) at WHO in 2003, and Brazilian diplomats were ultimately appointed to chair the Inter-governmental Negotiating Body for the FCTC. For many countries, Brazil's own story with regard to tobacco control was compelling. Although it is a large tobacco producer and exporter, Brazil nevertheless chose to prioritize health over trade and followed Canada in becoming the second country worldwide to mandate the inclusion of graphic warnings regarding tobacco's health effects on cigarette packages. It was the first nation to ban the use of the terms "mild" or "light" in de-

39. Fabiana Frayssinet, "Yellow Fever- Epidemic or False Alarm," *IPS News*, January 14, 2008, <http://www.ipsnews.net/news.asp?idnews=40790>.

40. José Angelo L. Lindoso and Ana Angélica B. P. Lindoso, "Neglected Tropical Diseases in Brazil," *Revista do Instituto de Medicina Tropical de São Paulo* 51 (2009): 247–253; Peter J. Hotez, "The Giant Ant-eater in the Room: Brazil's Neglected Tropical Diseases Problem," *PLoS Neglected Tropical Diseases* 2 (2008), <http://www.plosntds.org/article/info%3Adoi%2F10.1371%2Fjournal.pntd.0000177>.

41. "Brazil: 10,000 Dengue Cases per Week Registered in Rio de Janeiro," *EFE*, May 22, 2008; Maria Goreti Rosa-Freitas, Kathleen V. Schreibner, Pantelis Tsouris, Ellem Tatiani de Souza Weimann, and José Francisco Luitgards-Moura, "Associations between Dengue and Combinations of Weather Factors in a City in the Brazilian Amazon," *Revista Panamericana de Salud Pública* 20 (2006): 256–267.

42. Interview with public officials, Brasília, June 2010.

43. Ilona Kickbush and Christian Eck, "Global Health Diplomacy: The New Recognition of Health in Foreign Policy," in *Swiss Human Rights Book: Realizing the Right to Health*, edited by Andrew Clapham and Mary Robinson (Zurich: Ruffer and Rub, 2009), http://www.swisshumanrightsbook.com/SHRB/shrb_03_files/36_453_Kickbusch_Erk.pdf.

scriptions of tobacco products. By forming coalitions and alliances with other developing countries, and by recognizing the contributions of civil society to the discussion, Brazil helped lead the international community to support the FCTC.⁴⁴ Brazil currently sits on the WHO Executive Board, and former Fiocruz president Paulo Buss has served as Brazil's representative to WHO, since 2008. Buss was recently elected to serve as the vice chair of the Executive Board for the 2010–2011 period.⁴⁵

Brazil's position is that protection of intellectual property rights should not impede access to life-saving medicines, which has led to debate and controversies in some international discussions. As early as 1882, Brazilian lawmakers implemented legislation protecting intellectual property rights, but the government eliminated patents for drugs in 1945 in the context of pursuing broader import-substitution industrialization policies. Then, in 1996, Brazil implemented a new law on intellectual property rights in order to comply with the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) and thus be able to join the World Trade Organization (WTO).

Although those who study intellectual property rights in Brazil agree that having patent protections in place has in many ways promoted greater research investments in the country, they point out that its practice of considering "health in all policies" must be taken into account in domestic and international discussions.⁴⁶ In March 2009, for example, Brazil's permanent representative to the WTO, Roberto Azevêdo, brought what has come to be known as the "Losartan Case" before the TRIPS Council at the WTO. In 2008, Dutch and European Union authorities had seized a shipment from India that was bound for Brazil that contained an India-produced generic version of an antihypertension medicine known as Losartan, which was not under patent protection in India or Brazil. However, Merck and Company had patented the drug in the Netherlands under the name Cozaar. The shipment was held in the port of Rotterdam for more than a month before the authorities sent it back to India, with the justification that this measure represented an important step in the fight against counterfeit drugs. In his speech, Azevêdo protested the action, noting that "trade in generic medicines is not only perfectly legal under international [intellectual property] law. It is also desirable from a development and public health perspective. The transit of generic medicines cannot possibly be construed as a violation of patent rights in the country of transit. . . . The Losartan episode and all the other incidents I mentioned earlier are a major source of concern for developing countries because they essentially imperil the public health dimension of the TRIPS Agreement."⁴⁷ By May 2010, Brazil and India had formally disputed the seizure and requested consultations with the Netherlands and European Union to resolve the conflict.⁴⁸

Beyond the United Nations system, Brazil has engaged with the Global Fund to Fight AIDS, Tuberculosis, and Malaria as both a beneficiary and a donor. Between 2001 and 2005, Brazil contributed \$100,000 to the Global Fund, providing additional transfers of \$50,000 each in 2006 and

44. Lee, Chagas, and Novotny, "Brazil and the Framework Convention on Tobacco Control," 1–4.

45. Paulo Buss, "How Brazil Turned One Public Health School into 40," *Bulletin of the World Health Organization* 85 (2007), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636304/pdf/07-101207.pdf>; interview with Ministry of Public Health official, Brasília, June 2010.

46. Jorge Raimundo, presentation at Brazilian Health Industry Update, Washington, September 28, 2010. See also Kenneth C. Shadlen, "The Politics of Patents and Drugs in Brazil and Mexico: The Industrial Bases of Health Policies," *Comparative Politics* 42 (2009): 41–58, <http://web.gc.cuny.edu/jcp/index.htm>.

47. "Statement by Brazil at TRIPS Council: Public Health Dimension of TRIPS Agreement," <http://keionline.org/blogs/2009/03/04/brazilian-intervention-at-trips-council>.

48. Jonathan Lynn, "India, Brazil Challenge EU at WTO over Drugs," Reuters, May 12, 2010. <http://in.reuters.com/assets/print?aid=INIndia-48429720100512>.

2007.⁴⁹ Between 2007 and 2009, it received funding to carry out work on malaria, and in 2009 received a grant to address the persistent tuberculosis epidemic in urban areas.⁵⁰ Brazil's proposal for work on HIV/AIDS in the 10th round of competitions, however, was not approved, and the Global Fund's total support for Brazil has been \$45 million to date.⁵¹ Brazil did not pledge or contribute in 2008 or 2009, and it did not indicate its intention to contribute in the Global Fund's recent replenishment round despite calls by the Global Fund's head, Michel Kazatchkine, for emerging economies such as Brazil to do so.⁵² Brazil now focuses its resources on working with countries in the Caribbean and in Africa to share the lessons it has learned from its interactions with the Global Fund, including how to prepare successful grant applications.

As an observer of the Organization for Economic Cooperation and Development (OECD), Brazil has interacted with its health as well as science and technology working groups. For example, it participated in the Sixth Session of the OECD's Health Committee in 2009 and has access to OECD studies and statistical data related to health. However, Brazil does not share its overseas cooperation statistics with the OECD's Development Assistance Committee.⁵³ Consistent with its effort to strengthen alternatives to institutions it views as dominated by the global North, Brazil has also signaled its interest in expanding the use of the G-20 as a forum for discussing major international financial and development issues.⁵⁴ For instance, in the preparations for the G-20's Toronto meeting in July 2010, Brazilian negotiators proposed including on the agenda a consideration of the long-term implications of cancer and noncommunicable diseases for economic growth, but in an interview said they were not successful in securing a spot for the topic.⁵⁵

Regional Cooperation and South-South Alliances

Broadly speaking, disaster assistance, triangular cooperation, and strengthening bilateral relationships on health characterize Brazil's health outreach in Latin America and the Caribbean. In response to the January 2010 Haitian earthquake, Brazil, which already had a large military presence in Haiti as head of the United Nations Stabilization Mission there, sent 400 tons of medications, including ARVs, antibiotics, malaria prophylaxis, surgical supplies, and medication kits. It is also working cooperatively with Cuba and the French Development Agency to carry out ongoing health-related work in the aftermath of the disaster.⁵⁶

In South America, Brazil participates actively in Mercosur's discussions regarding trade in health care products and sits on the UNASUR Health Council, which includes the health ministers

49. "Pledges and Contributions," Global Fund to Fight AIDS, Tuberculosis, and Malaria, <http://www.theglobalfund.org/en/pledges/:lang=en>.

50. Interview, public official, Brasília, June 2010.

51. "Brazil: Grant Portfolio," Global Fund to Fight AIDS, Tuberculosis, and Malaria, <http://portfolio.theglobalfund.org/Country/Index/BRA>.

52. "Global Fund Head Repeats Appeal for Emerging Countries to Invest More in Fight against AIDS, TB, Malaria," *The Body: The Complete HIV/AIDS Resource*, September 17, 2010, <http://www.thebody.com/content/art58505.html?ts=pf>

53. OECD, "Working Group on Good Laboratory Practice (GLP)," <http://www.oecd.org/document>.

54. See "O Brasil em 2022," July 30, 2010, <http://www.sae.gov.br/brasil2022/?p=475>. See also Riordan Roett, *The New Brazil* (Washington, D.C.: Brookings Institution Press, 2010), 141.

55. Interview, public official, Brasília, June 2010.

56. Cooperation in Haiti: Brazilian Health Support," *Health Cooperation: Brazilian International Health Activities Bulletin* 2 (2010): 1, 3; "Milk Banks to Reduce Infant Mortality in Haiti," *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 7.

of the 12 member states. In January 2009, Brazil joined in adopting a five-point health agenda; the areas on which the region's health ministers agreed to work include pandemic preparedness, promoting universal access to health care and medicines within the region; and promoting training and capacity building for health professionals. The group is now working to create a South American Health Government Institute and fellowship programs to strengthen educational partnerships and scientific ties among professionals in the region.⁵⁷

Brazil's agreements with its neighboring countries also facilitate cooperation on health. For example, a Binational Health Advisory Commission on the Brazil-Uruguay Frontier allows people on the Brazil side of border to access health care services in Uruguay when there are no clinics nearby; and a Health Working Sub-Group on the Brazil-Venezuela Frontier facilitates joint action on epidemiology, health and environmental surveillance, and the elimination of onchocerciasis among vulnerable indigenous populations.⁵⁸

Cooperative work on health with the Community of Lusophone Nations is also a priority for Brazil. It joined with other Portuguese-speaking nations and former Portuguese colonies in signing the 2009 Declaration of Estoril, which established a Strategic Health Cooperation Plan. Roughly half of Brazil's overseas development funds directed toward Africa flow to the Group of Portuguese-Speaking African Countries, particularly Mozambique, which is the top recipient of Brazilian development support.⁵⁹ The Estoril Declaration prioritizes seven concrete actions regarding health: training and workforce development, health information and communication, health research, the development of the health industrial complex, epidemiological surveillance and health situation monitoring, emergencies and natural disasters, and health promotion and protection.⁶⁰ Beyond its significant bilateral work in Mozambique and Guinea-Bissau, Brazil has joined with the United States in addressing malaria challenges in São Tomé and Príncipe.

Russia, India, and China serve as strategic partners in pursuing outreach on global health issues. Thus, in March 2010, the agriculture ministers representing each country agreed to work together to combat hunger and promote food security.⁶¹ Brazil and China have developed a strategic partnership on health, which involves a technology transfer agreement between EMS, Brazil's largest pharmaceutical company, and Shanghai Biomabs for the manufacture of products in Brazil.⁶² In 2009, a Brazilian delegation led by Minister of Health José Gomes Temporão visited China to cohost seminars on such topics as "Health Policies in Brazil" and "The Reform of the Chinese Health System."⁶³ In the summer of 2010, Brazilian health officials taught a course on health diplomacy in China.⁶⁴

57. "South-South Cooperation: Enduring Initiatives," *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 8.

58. "Access to Health Services without Frontiers," *Health Cooperation: Brazilian International Health Activities Bulletin* 1 (2009): 3.

59. Cabral and Weinstock, "Brazilian Technical Cooperation," 5.

60. "South-South Cooperation: Enduring Initiatives," 8.

61. "BRIC Ministers Reach Agreement on Promoting Global Food Security," *Medical News Today*, March 30, 2010, <http://www.medicalnewstoday.com/articles/183914.php>.

62. "Strategic Partnerships: Business in China," *Health Cooperation: Brazilian International Health Activities Bulletin* 2 (2010): 7.

63. Ibid.

64. "First Executive Training Course on Global Health Diplomacy in China: Graduate Institute and Beijing University Join for Course on Global Health Diplomacy Course," August 8, 2010, http://graduateinstitute.ch/webdav/site/globalhealth/shared/Training/Official%20news%20on%20China_1.pdf.

The alliance between India, Brazil, and South Africa, known as IBSA, has also served as a venue for Brazil's cooperative consultations on health. In 2003, the IBSA members agreed to work together to coordinate international outreach on such issues as education, environment, and health and medicine. They established the IBSA Fund, to which each nation contributes \$1 million a year for collaborative work in such third countries as Haiti and Burundi.⁶⁵ Brazil and South Africa have signed a memorandum of understanding to facilitate the sharing of information about Brazil's Sistema Universal da Saúde with South African officials.⁶⁶ And Brazil and India have cooperated at WHO and in other forums on issues related to generic drugs and intellectual property rights issues, successfully "blocking a controversial resolution backed by the European Commission . . . and [the] WHO-funded International Medical Product Anti-Counterfeiting Taskforce."⁶⁷

Finally, in keeping with its recent efforts to serve as host to high-profile international meetings such as the 2014 World Cup and the 2016 Olympics, Brazil has begun playing a more visible role as the site for international health summits. Thus, in October 2011, Brazil will host a major international conference on the social determinants of health, to provide recommendations and guidance for analyzing the effects of the environment, policies, and attitudes on health and access to health care.⁶⁸

Global Health and Foreign Policy after Lula

Dilma Rousseff was the favorite heading into the October 31 presidential runoff, and her capture of 56 percent of the vote signals strong popular support for a continuation of Lula's political approach. Brazil watchers thus expect her to maintain a number of key Lula policies, but she is also likely to appoint many new Cabinet members, including a new minister of health. Many note that she has always been more focused on domestic issues than foreign policy, and it is not clear if she would continue Lula's push to link health and foreign policy. However, Rousseff is reported to have stated that, if elected, she would establish a new development agency to expand Brazil's overseas engagement.⁶⁹

For the time being, the lack of legislation authorizing broad appropriations for the Agência Brasileira da Cooperação's activities in the global health arena means that projects may continue to develop on an ad hoc basis rather than in a more strategic and sustainable manner. Similarly, without a process for recruiting and placing trained international development officials, the staffing of global health projects will continue to be dependent on the Ministry of Health, including Fiocruz,

65. "The India–Brazil–South Africa Dialogue Forum," IBSA Trilateral Official Website, <http://www.ibsa-trilateral.org/>.

66. "SA, Brazil Mull Cooperation on Agriculture, Health, and Energy," *Engineering News*, July 23, 2010, <http://www.engineeringnews.co.za/article/south-africa-and-brazil-seek-cooperation-2010-07-23>; "South Africa–Brazil to Meet Tomorrow in Pretoria," *Africa News*, July 7, 2010, <http://www.africanews.it/english/south-africa-brazil-to-meet-tomorrow-in-pretoria/>. Interview with Brazilian Ministry of Health Official, Brasília, June 2010.

67. Radhieka Pandeya, "India, Brazil to Take on EU over Regulation," January 30, 2009, <http://www.livemint.com/2009/01/30002200/India-Brazil-to-take-on-EU-ov.html>

68. Interview, public official, Brasília, June 2010.

69. "Brazil's Foreign Aid Programme."

the National HIV/AIDS Program, and other initiatives. The ABC is reported to have developed a strategy for developing a dedicated development staff, but this plan has yet to be implemented.⁷⁰

At present, there does not appear to be much awareness on the part of the Brazilian public regarding the government's international health diplomacy and development spending. As long as the nation's economy continues to grow, Brazilians may accept the overseas work and focus the majority of their attention on fixing domestic health issues, which continue to loom large in debates over the use of government resources within the country. However, if there were to be an economic downturn, or if the segments of the population new to the middle class were to demand greater access to health and social services, the public might well call for a scaling back of overseas initiatives and an exclusive concentration on persistent domestic health challenges.

Conclusions and Future Trends

To sum up, a number of conclusions and future trends can be briefly stated:

- Brazil's global health outreach is premised on the idea of "health in all policies," and themes of solidarity, human rights, and the priority of health over patent protections inform the perspective Brazilian program implementers and policymakers bring to their work.
- As long as Brazil continues to experience economic growth and there is no domestic political backlash against international development cooperation, Brazil is likely to deepen its global health engagement by continuing to exercise leadership in international health policy circles and by expanding its overseas technical activities, particularly in Latin America and the Portuguese-speaking countries in Sub-Saharan Africa.
- Tensions concerning the role of intellectual property rights in public health policymaking are likely to continue to characterize the different approaches U.S., European, and Brazilian negotiators bring to their work at the World Health Assembly and other international forums.
- In international discussions of planning for pandemics and preparedness for public health emergencies, the theme of health security—if delinked from the issues of solidarity and information sharing—is unlikely to be a priority for Brazilians.
- Although Brazil rejects the notion of development assistance in favor of the idea of South–South cooperation as it seeks to solidify those relationships and institutions that it views as capable of undermining the traditional international political status quo, it has also embraced the idea of triangular cooperation and works in concert with countries from the global North to support projects in the global South.
- As the United States scales back some of its work on health in Latin America and the Caribbean, Brazil is strengthening its own regional ties through bilateral agreements and through UNASUR.
- The United States has already engaged in triangular cooperative activities with Brazil in Sub-Saharan Africa and may initiate similar work in Central America. These relationships have the potential to strengthen cooperation and understanding between American and Brazilian health

70. According to Cabral and Weinstock, Germany's GTZ plans to be supporting a course on international development within the National School for Public Administration in Brazil; "Cabral and Weinstock, "Brazilian Technical Cooperation," 19.

professionals and provide opportunities for scientists and practitioners to learn from each country's domestic and international experiences. Such partnerships should be expanded as resources and opportunities allow.

2

A BARE (BUT POWERFULLY SOFT) FOOTPRINT CHINA'S GLOBAL HEALTH DIPLOMACY

Charles W. Freeman III and Xiaoqing Lu Boynton

Health diplomacy has always been at the forefront of China's engagement with other parts of the world. In 1963, China dispatched its first medical team overseas at the invitation of the Algerian government. Since then, China has sent 20,679 doctors to 69 countries and regions in Asia, Africa, Latin America, Europe, and Oceania.¹ The majority of the recipient countries of China's medical aid have been in Africa, a direct result of China's postrevolutionary policy to seek solidarity with countries fighting for independence from Western imperialism. Historically, China's medical aid has been driven by a desire to expand its political influence with countries that Beijing perceived to have a shared interest in opposing colonialism, a great majority of which were, after 1949, African.

During the past 50 years, China's approach to global health considerations has undergone major changes. The Chinese leadership today recognizes that engagement on global health helps build the country's image as a contributor to global welfare. Meanwhile, as the country's demand for long-term, reliable access to natural resources in Africa and Latin America to sustain its rapid economic growth at home continues to increase, Beijing perceives health diplomacy as a convenient instrument for achieving its strategic economic goals. Whereas its early health diplomacy efforts were rooted in a revolutionary intent to support independence movements abroad, current efforts are aimed at bolstering its "soft power" by combating nontraditional security threats, like health crises abroad, in ways that reinforce international stability and thus protect its core interests of domestic stability and economic growth.

The awareness of the threat of health crises struck home for Beijing following a series of sudden, disastrous infectious crises in China, including the severe acute respiratory syndrome (SARS) crisis in 2003. Since that time, the country's engagement in global health matters has significantly expanded to include countries with which it seeks closer economic relations, particularly in South-east Asia, but also resource-rich countries in Africa and Latin America. Thus, China has improved and advanced the public health conditions in recipient countries through its infrastructure programs, the expansion of Traditional Chinese Medicine (TCM), and the training of local medical professionals. It also provides medical equipment free of charge to several African countries, and it conducts joint programs on infectious diseases, particularly malaria. In addition, in the past several years it has participated actively in humanitarian assistance following the devastating earthquakes in Haiti and Chile, and in flood relief efforts in Nepal in 2008 and Pakistan in 2010.

Although China's new health diplomacy strategies have been more transparent and cooperative, the principle of "noninterference in domestic affairs" is still at the core of its engagement on global health. Traditional concerns of national security and sovereignty have restrained it from addressing governance and accountability issues in recipient countries. Its commitment to non-

The authors would like to thank Lynn Huang and Diana Zhang, research interns with the Freeman Chair in China Studies at CSIS, for their assistance with this research chapter.

1. Gao Qiang, then Chinese minister of health, speech on the 45th anniversary of sending oversea medical teams, <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohgjhzs/s3590/200812/38461.htm>.

interference has resulted in its no-strings-attached aid policy in Africa, which is under intensifying international pressure, notwithstanding its relative popularity among governance-challenged African states.

Connections between China's Domestic and Global Health Agendas

China's domestic health record and agenda have had a profound impact on its health diplomacy at bilateral and multilateral levels. As stated above, the outbreak of SARS in 2003 and China's failed attempt to contain it within its borders brought home to the country's leadership the significance of global health challenges, and thus the importance of pursuing global health engagement. Several other infectious challenges, such as avian influenza, HIV/AIDS, and tuberculosis, have served as new drivers for China's commitment to global health engagement.

China's domestic success in improving health care with limited resources provides it with a strong comparative advantage in giving technical assistance to other developing countries. Its experience in addressing its own domestic health challenges can serve as best practices in global health projects in Africa and other parts of the world.

Nevertheless, China's domestic priority to overhaul its own health care system impedes it from continuing to expand its global health engagement. Its economic boom has increased demand for better health care at home, reducing both its capacity to extend health care assistance abroad as well as the domestic political acceptability of stretching its already-thin health care resources and medical personnel by committing them to Africa and other parts of the world.² China recently surpassed Japan to become the world's second-largest economy. Yet the gap between urban and rural incomes in China grew the widest in 2009 since the government launched its reform and opening-up policy in 1978.³ China today still has 150 million people living below the poverty line, and the vast majority of its citizens do not have access to health insurance or consistent medical care. Given the scale of the domestic challenges, China's politically galvanizing Internet community (the "Netizens") have been regularly voicing concerns that China, as a developing country, should fix its poverty problems at home before devoting resources to Africa.

With \$124 billion pledged to reform China's health care between 2009 and 2011, Beijing has made a historic political and financial commitment to improve the nation's health care. In the near to medium terms, the pull on resources and political attention will overwhelmingly be inward. The Chinese government will likely look externally for continued support for its domestic health agenda, rather than actively seeking ways to a leadership position on the global level. Beijing's active expansion of its engagement and contribution on the global health front will remain constrained.

How Is Chinese Health Aid Managed?

China does not have a special government agency that manages its official development assistance, such as the U.S. Agency for International Development. Major decisions on the country's aid poli-

2. Jeremy Youde, "China's Health Diplomacy in Africa," *China: An International Journal* 8 (2010): 151–163.

3. "China Urban/Rural Income Gap Widest in 32 Years," *China Economic Review*, March 3, 2010, http://www.chinaeconomicreview.com/dailybriefing/2010_03_03/China_urban-rural_income_gap_widest_in_32_years.html.

cies and programs are made at the level of the State Council, China's Cabinet. A significant portion of Chinese aid effort is managed by the Ministry of Commerce, through its Department of Foreign Aid. Assistance from the Ministry of Commerce is often part of a larger package of investments and trade deals.⁴ The Ministry of Health also provides health assistance overseas. Provincial health departments are also often involved in the aid process, especially in the case of Chinese medical teams in Africa. The responsibilities for multilateral aid rest primarily with the Ministry of Finance. Across the several different agencies involved, Chinese health aid is poorly coordinated and evaluated; the overall volume of Chinese aid effort is difficult to estimate.

During the last few years, there have been ongoing efforts at the State Council level to facilitate cross-ministry communication and cooperation in China's overseas health assistance. Some Chinese scholars have proposed establishing a "Global Health Diplomatic Coordination Office" within the State Council, to be led by a senior official at the vice-premier level responsible for coordinating the country's global health initiatives.⁵

China's Regional Approaches on Global Health

China's active health assistance and cooperation is concentrated in Africa and Southeast Asia. Although China adopts different strategies of health diplomacy in these regions, its engagement on global health in various parts of the world has served as an effective, convenient tool for advancing its soft power.

China and Africa

China's health programs in Africa date back to the 1960s. According to China's official statistics, since 1963, when the first Chinese medical team was deployed to Algeria, nearly 20,000 medical personnel in 47 African countries have treated 200 million patients.⁶ Chinese medical teams in Africa, which have traditionally been funded by provincial budgets and administered by Chinese provincial health departments, offer an array of medical specialties, including Traditional Chinese Medicine. Currently, there are about 100 TCM doctors in Africa, offering treatments such as acupuncture. In Tanzania, for example, TCM has been used by Chinese medical teams for more than 19 years to treat 10,000 HIV/AIDS patients.⁷

China's health program has also provided donations of medicines and medical equipment to several African countries. Over the years, China-Africa medical cooperation has included infrastructure projects, such as the construction of hospitals and clinics. Additionally, in its increasingly important role supporting UN peacekeeping missions in Africa, China has deployed Chinese military medical units.

4. Carol Lancaster, "The Chinese Aid System," Center for Global Development, June 2007, <http://www.cgdev.org/content/publications/detail/13953/>.

5. Lai-Ha Chan, Lucy Chen, and Jin Xu, "China's Engagement with Global Health Diplomacy: Was SARS a Watershed?" *PLoS Medicine* 7 (2010), <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000266>.

6. David Shinn, "Africa, China and Health Care," *Inside AISA* 3-4 (2006): 14-16.

7. "Medical Teams Continue to Help Africa," *China Daily*, November 2, 2006, <http://www.china.org.cn/english/health/187358.htm>.

Chinese medical cooperation with Africa continues to grow. By 2009, China's grant assistance to Africa had risen to twice the level of 2006, when the Forum on China-Africa Cooperation Summit took place in Beijing. Since the Beijing summit, the Chinese government has built 30 hospitals and 30 antimalaria clinics in Africa.⁸ At the most recent Cairo Summit of the forum in 2009, Chinese premier Wen Jiabao doubled the country's contribution to \$73.2 million for equipment and antimalaria materials for the 30 hospitals and 30 antimalaria clinics it has built, as well as training for 3,000 African doctors and nurses. China has built an image of its health cooperation with Africa as a South-South initiative, which is based upon a special understanding that comes from their shared history of slow economic development. According to a 2007 survey conducted by the Pew Research Center, most African countries view China favorably—92 percent favorably in both Côte d'Ivoire and Mali, and between 67 and 81 percent in Kenya, Senegal, Ghana, Nigeria, Tanzania, and Ethiopia.⁹

China's medical aid to Africa is a key part of the country's comprehensive diplomacy, which over the years has resulted in Beijing's growing influence with African countries and people. Beijing considers health cooperation to be an important, nuanced strategy for forging new political alliances. The country's health diplomacy today contributes to Beijing's quest for a strategic partnership with Africa, which ensures long-term access to energy and other high-value commodities, and new African markets and commercial investment opportunities to fuel the fast-growing Chinese economy.

In the meantime, India has also increased its engagement in Africa in recent years. This dynamic contains potential seeds of rivalry between the two growing powers, as China and India both increase their investments in Africa. China views Africa as one of its emerging markets for its pharmaceutical industry. China-Africa trade in pharmaceutical products has been steadily increasing. The total import export value of health care products between China and Africa increased from \$190 million in 2001 to \$1.14 billion in 2009, with South Africa, Egypt, and Nigeria as the top three export destinations.¹⁰ Though China's no-strings-attached aid in Africa is facing growing international pressure, India has been known to also have its strategic advantage in Africa, owing to its private-sector predominance (mostly small and medium-sized enterprises) on the continent. Today, India remains the leading exporter of pharmaceutical products to Africa. Competition between China and India for the African pharmaceutical market share, particularly for affordable, high-quality antimalaria drugs and antibiotics, is likely to intensify in the next few years. Nevertheless, given the South-South cooperation agenda that both China and India are pursuing in Africa, their growing presence on the continent may also present an immense opportunity to form new collaborative partnerships in the developing world.

Similar potentials for both rivalry and partnership can also be seen between China and Russia with respect to global health challenges. Through the 2001 Treaty of Good-Neighborliness and Friendly Cooperation between China and Russia, the two countries have built a 20-year strategic partnership to include the promotion of humanitarian cooperation in areas including health care. China and Russia also continue to cooperate on public health challenges stemming from drug traf-

8. "The Forum on China-Africa Cooperation and Its Significance for Namibia," November 8, 2009, <http://na.chineseembassy.org/eng/xwdt/t625458.htm>.

9. Andrew Kohut, "How the World Sees China," Pew Global Attitudes Project, December 11, 2007, <http://pewresearch.org/pubs/656/how-the-world-sees-china>.

10. "China Medical Industry to March into Africa Market Steadily," http://fdi.gov.cn/pub/FDI/tzdt/dt/t20100504_121211.htm?fclose=1.

ficking in Asia. The two sides have even expanded talks to trilateral health and medicine conferences with India.¹¹ At the same time, there has been some competition on the front of health care investments in Africa. To gain greater influence in Africa, Russia offered a \$500 million development assistance package to Ethiopia, as a response to China's growing ties in the region.

China and Southeast Asia

In recent years, China has also been actively promoting health cooperation with its neighboring Southeast Asian countries, a new regional priority for its health diplomacy. Its health cooperation in the region—particularly with countries that belong to the Association of Southeast Asian Nations (ASEAN)—focuses on addressing infectious challenges as a nontraditional security threat, due to the region's geographic proximity and high levels of economic interaction with China. The SARS outbreak in 2003 has also provided a catalyst for increased cooperation between China and Southeast Asia. China's initial mismanagement of the epidemic gave way to attempts at enhancing transparency and information sharing with neighboring countries in order to contain its spread. As in Africa, public health has been an integral part of China's soft-power tool kit in Southeast Asia.

China's focus on public health as a regional concern within the expanded China–ASEAN relationship is an integral part of Beijing's efforts to create a stable environment for China's economic growth. China–ASEAN health cooperation began initially under the ASEAN+3 framework, with the first ASEAN+3 meeting of health ministers on SARS that took place in April 2003. The cooperation has since extended to the ASEAN Regional Forum and several other mechanisms, including the “10-plus-1” cooperation framework over nontraditional security issues. In addition, the two sides have established the China–ASEAN Fund for Public Health, whereby China provides technical training to the ASEAN countries, takes part in joint research, and strengthens exchanges in avian influenza prevention and control.

China has demonstrated a new willingness to act as a participating member of the regional community in response to a regional public health crisis. Outside the ASEAN context, China has pursued health cooperation through the Asia-Pacific Economic Cooperation forum (APEC), the East Asia Summit, the Asia Europe Meeting, the Asia Cooperation Dialogue, and the Mekong Basin Disease Surveillance Network, among others. In particular, the APEC health working group has been instrumental in leading the region's response to influenza, in terms of information sharing, transparency, and access to vaccines.

Nevertheless, China's health cooperation with Southeast Asia is conducted in limited formats, largely through forums, declarations, and dialogues.¹² Compared with other major donors in the region, China provides relatively little development assistance and lacks a formal system for determining development goals and allocating aid.¹³ Its pursuit of health diplomacy through bilateral and regional mechanisms in Southeast Asia has been designed to reassure its neighbors that its rise is peaceful and has resulted in real benefits for the region.

11. “Russia–India–China Triangle: Promise and Reality,” June 30, 2010, http://in.rbth.ru/articles/2010/06/30/300610_ric.html.

12. Yanzhong Huang, “China's New Health Diplomacy,” in *China's Capacity to Manage Infectious Diseases: Global Implications* (Washington, D.C.: CSIS, 2009), 91.

13. Thomas Lum, Wayne M. Morrison, and Bruce Vaughn, *China's “Soft Power” in Southeast Asia*, Congressional Research Service Report for Congress, January 4, 2008, <http://www.fas.org/sgp/crs/row/RL34310.pdf>.

Whereas the focus of China's health cooperation with Southeast Asia has been infectious diseases and pandemic preparedness, more upstream challenges such as food safety, trade and labor flows, and climate change adaptation and structural factors related to health access and infrastructure have remained generally outside the China–ASEAN discussions. Also, the new China–ASEAN Free Trade Agreement has raised some public concerns in Southeast Asia about the quality, safety, and future pricing power of imports of Chinese medical devices, pharmaceutical products, and health services.¹⁴

China's Health Engagement in Multilateral Organizations

During the past decade, China has demonstrated growing pragmatism on public and global health issues. It has gradually shifted its passive, reluctant approach to international health organizations to a more proactive, transparent, cooperative one. In pursuit of its new health diplomacy, it has shown a growing interest in participating in health cooperation at the global, regional, and sub-regional levels.

In 2006, Beijing campaigned hard to elect Margaret Chan as director-general of the World Health Organization (WHO). In the same year, China ratified the WHO Framework Convention on Tobacco Control, and hosted, in partnership with the European Commission and the World Bank, the International Pledging Conference on Avian and Human Influenza. In 2005, China accepted the “universal application” principle in revising the International Health Regulations (IHR). With Beijing's blessing, Taipei was invited last year to participate, for the first time since 1971, in the enforcement mechanism of the IHR and as an observer at the World Health Assembly.

China has established effective collaboration with the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which works in close partnership with the China Center for Disease Control on malaria eradication, tuberculosis detection rates, and HIV/AIDS prevention and control in China. China has been active on the board of the Global Fund. In 2007, it hosted the fund's 16th board meeting in the city of Kunming. Though China has been awarded roughly \$1.9 billion total from the Global Fund, its contributions have been a symbolic \$2 million per year, over the past eight years.

The World Bank announced in 2007 that China had, for the first time, become a donor to the loan fund of the International Development Association 15th Replenishment. In April 2010, China's voting shares at the World Bank increased from 2.78 to 4.42 percent, making it the third-largest individual shareholder after the United States and Japan. This shift in part signifies the World Bank's effort to better represent developing countries in its governance structure, and it also seeks to encourage new contributions from emerging economies such as China.

At the recently concluded UN summit on the Millennium Development Goals in September 2010, Chinese premier Wen Jiabao outlined a “six-point proposal to step up China's foreign aid efforts,” which included sending 3,000 medical experts, training 5,000 medical staff for recipient countries, offering equipment and medicine for 100 hospitals, debt exemption, and human

14. “CAFTA Double-Edged Sword for Healthcare Consumers,” *Jakarta Post*, March 2, 2010, <http://www.thejakartapost.com/news/2010/02/03/cafta-doubleedged-sword-healthcare-consumers.html>.

resources development, among others.¹⁵ In the replenishment conference of the Global Fund to Fight AIDS, Tuberculosis, and Malaria in New York in October 2010, China pledged \$14 million over the next three years.¹⁶ Though China's new pledge has more than doubled its prior commitment, its contribution remains small compared with the pledges of the United States (\$4 billion) and even Russia (\$60 million). The total global pledge of \$11.7 billion over the next three years falls short of the Global Fund's desired minimum amount of \$13 billion. China's increased, yet still symbolic, pledge reflects its continuing caution about taking a leadership position within the international health architecture.

Despite progress, the sustainability and scale of China's multilateral health engagement remain somewhat tenuous. The country's overall material commitments to international health organizations continue to be modest. Its self-selected status as a developing country will in the near to medium terms likely determine its dual role as both a recipient and donor country, and will probably limit the prospects for the expansion of its leadership and donations on global health.

Although the upcoming Group of Twenty (G-20) summit in Seoul will likely focus primarily on economic and financial issues, some predict that a development and health agenda might emerge through the G-20 platform. At present, Beijing remains uncertain whether the G-20 is a forum that can advance its own interests, and hence it will likely attend the upcoming summits in a watch-and-see mode.

China's Overseas Humanitarian Medical Relief

In addition to its long-term medical cooperation programs, China is active in providing humanitarian medical relief overseas. Beijing dispatched health professionals and relief workers to Thailand, Sri Lanka, and Indonesia after the 2005 tsunami. Chinese medical relief missions were present in the recent disaster relief efforts in Haiti, Chile, and Pakistan. On top of China's assistance of \$50 million for flood-hit Pakistan as of September 2010, Premier Wen Jiabao announced at the UN Millennium Development Goals summit in September that China would provide another \$200 million to Pakistan's flood relief efforts.¹⁷

Despite the fact that China does not have diplomatic relations with Haiti, the Chinese government sent a 60-person rescue team, with more than 10 tons of disaster relief supplies (with a value of \$1.76 million), which arrived in Haiti on January 14, 2010, 33 hours after the earthquake.¹⁸ The Chinese rescue team, the first Asian team that arrived, distributed medicines through the two Chinese medical stations set up in Haiti. As of January 26, 2010, China had provided more than \$7 million in disaster relief supplies and donated \$3.6 million to Haiti.

Subsequently, China donated \$1.1 million to Chile for its earthquake rescue effort on March 1, 2010, including \$1 million from the Chinese government and \$100,000 from the China Red Cross Foundation. On March 5, 2010, 95 tons of disaster relief supplies (with a value of \$2 million) from

15. "Wen Says Achieving MDGs Remains Long, Uphill Journey, Promises to Expand China's Foreign Aid," Xinhua, September 3, 2010, http://news.xinhuanet.com/english2010/china/2010-09/23/c_13525852.htm.

16. "US Announces Its Pledge to Global Fund for AIDS, TB and Malaria—But Is It Enough?" <http://undispatch.com/us-announces-its-pledge-to-global-fund-for-aids-tb-and-malaria-but-is-it-enough>.

17. "Wen Says Achieving MDGs Remains Long, Uphill Journey."

18. "Chinese Rescue Supplies Arrive in Haiti," January 17, 2010, http://www.gov.cn/jrzq/2010-01/17/content_1512997.htm.

China arrived in Santiago, including 10,000 blankets, 700 tents, 100 sets of electric generators, and 2 sets of water filters.¹⁹ The supplies and donations were delivered to Chile through the Chinese Embassy in Chile. Nevertheless, there has not been much reporting on the evaluation of the efficiency of recent Chinese overseas humanitarian medical relief efforts.

China's Global Health Outlook

Although China will likely continue to pursue and expand its global health engagement, its health diplomacy faces limits and constraints. Its aid efforts remain overwhelmingly fragmented and crisis driven. Reportedly, there have been internal discussions on developing a long-term Chinese aid strategy, but these efforts remain at an early stage.²⁰ Beijing's noninterference principle impedes its ability to address systemic problems in aid-recipient countries. The lack of aid coordination between China and traditional Western donor countries creates ineffective, overlapping efforts in areas where health care resources are scarce. Beijing will face growing pressure to adjust its no-strings-attached aid policy, and to ensure that its assistance complements the overall efforts by the international community.

China also faces key constraints by its traditional concerns of national security and sovereignty when engaging with multilateral organizations on global health. When Taiwan attempts to use the "universal application" principle to facilitate its diplomatic efforts for formal WHO participation, the principle is viewed by Beijing as a potential threat to its sovereignty.²¹ Such constraints will ultimately undermine China's incentive to engage in and expand international health cooperation.

Practical factors also loom over the success of implementing China's health diplomacy. China's economic growth has increased domestic demand for health care services, which undermines financial and career incentives for Chinese doctors to join medical teams abroad. Difficulty in recruiting professionally trained medical personnel would negatively affect the quality and efficiency of China's medical aid programs, which remain outdated and weakly linked to measurable health effects. As recipient countries continue to demand higher-end medical aid, China needs to find new models of aid giving, particularly in areas of capacity building and health systems strengthening.

China has pledged to increase collaboration on health with Brazil, India, South Africa, and Russia. During the 63rd World Health Assembly in Geneva this year, the health ministers from the BRICs issued a joint press release on health and development, which reiterated the BRICs' commitments to cooperation on the health-related Millennium Development Goals.²² Meanwhile, China has continued to expand its cooperation with the United States on health issues, including HIV/AIDS and influenza, since 2005, when a memorandum of understanding to establish a collaborative program on emerging and reemerging infectious diseases was signed between the Ministry of Health and the U.S. Department of Health and Human Services. Discussions on health-related collaboration have been included on the agenda of the U.S.-China Strategic and Economic Dialogue. As the two countries look to improve their health care systems at home, the

19. Chinese Ministry of Commerce, <http://yws.mofcom.gov.cn/aarticle/b/x/201003/20100306807263.html>.

20. J. Stephen Morrison, "The Prospects for Engaging China with Global Health Issues," in *China's Capacity to Manage Infectious Diseases*.

21. Yanzhong Huang, "China's New Health Diplomacy."

22. Press release of ministers of health of Brazil, China, India, Russian Federation, and South Africa, May 24, 2010, <http://www.china-un.ch/eng/hom/t696514.htm>.

scope of United States–China health cooperation will continue to expand. With China’s growing aid programs in Africa, it is essential for the United States and China to coordinate their assistance efforts through dialogues and cooperation.

Policy Implications for the United States

China’s global health initiatives to this point have been largely crisis driven, ad hoc, and fragmented, but its increasing engagement on health issues outside its borders has significant policy implications for the United States. China’s health programs, particularly in Africa, create the potential for cooperation with the United States on capacity building and strengthening local health systems. China’s packaging of medical aid to Africa with a no-strings development model has strategic implications for the United States. China’s engagement in these areas does, however, provide openings for new partnerships and future innovations between the two countries, if the two sides can realize a cooperative effort.

The United States should engage China to better coordinate its Africa health programs with the investment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the World Bank in Africa to maximize the efficiency of various programs on the ground. The two countries should work together to ensure that China’s initiatives complement the work of other donor organizations and countries, and are integrated into a broad, coherent global strategy. The United States, along with the international community, should start a broader dialogue with China on transparency and governance issues. Multilateral mechanisms, such as the G-20, present opportunities for urging China to increase its engagement in international health organizations.

China’s health engagement remains, for the most part, weakly linked to measurable health effects. The United States and China should work together to evaluate the impact of existing programs, and to identify key areas for future assistance to strengthen health systems and sustainability.

3

INDIA'S APPROACH TO GLOBAL HEALTH INNOVATION AT HOME

Uttara Dukkupati

In the realm of public health, India is an anomaly. On one hand, it has among the lowest public health expenditures in the world coupled with appalling health indicators for an emerging economy. On the other hand, its private sector and research scientists include some of the world leaders in their fields. India's global health engagement follows three paths: "health diplomacy," through involvement in the global health organizations; an emerging role as an aid donor; and a largely private role centered on innovation. The first two paths fit the traditional model of health engagement; the third is probably India's most creative and effective form of international involvement. How India and the United States can integrate India's shifting role in the global health sector into their broader bilateral relationship remains to be defined.

India's Domestic Health Picture

India's health engagement at large is inextricably linked to the country's domestic health agenda. Despite recent improvements, India's domestic health indicators are surprisingly weak compared with its dynamic recent growth. According to India's National Aids Control Organization, in 2007 the country was home to more than 2.5 million individuals infected with HIV. Life expectancy is still 3 years lower than the global average of 67 years. The country faces a crushing communicable disease burden of malaria, tuberculosis, and diarrheal diseases along with a growing urgency to tackle chronic diseases such as diabetes, cancer and heart disease.

Furthermore, the country is critically short of hospital beds, nurses, and doctors. And in addition to this inadequate medical infrastructure, India faces problems of quality. The private sector has entered the medical field to fill gaps in demand but with little guidance or regulation from the government. Problems of quantity and quality are compounded with issues of equity. An estimated 43.3 percent of the country's low-income rural residents do not seek care when they are ill because of financial concerns, compared with only 1.9 percent of its rich urban residents.¹ The trend is not improving, with the rate of out-of-pocket payments increasing from 70 percent in 1987–1988 to more than 80 percent in 2002–2003.

India's health spending as a percentage of its gross domestic product is among the lowest in the world. In 2009, India spent 5.2 percent of its GDP on health care, of which 4.3 percent was by the private sector. The Indian government only spent 0.9 percent on public health. In a 2007–2008

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1. Winnie Yip and Ajay Mahal, "The Health Care Systems of China and India: Performance And Future Challenges," *Health Affairs* 27 (2008): 923.

study, the World Health Organization (WHO) ranked India 171st out of 175 countries in public health spending.²

India's Policy Framework

In 1983, the Indian Ministry of Health came out with the National Health Policy, which was revised in 2002. The 1983 plan was broad in scope and called for universal access to health services by 2000. By 2000, this had not been accomplished. The 2002 plan renewed the call for access to health care for all, achieved through a mix of policies, including health education programs and health volunteers in villages across the country. In 2010, many of these programs remain to be implemented.

The country is also working to meet the goals outlined in the National Rural Health Mission, launched on April 12, 2005, to define a road map to achieve the goals of the National Health Policy. The purpose of this mission was to “provide accessible, affordable, accountable, effective and reliable health care, especially to poor and vulnerable sections of the population in rural areas.” The mission was to operate nationwide but has given priority to 18 especially vulnerable states. It was created, in part, to help India get the best results from an increase in its public health spending, from 0.9 percent to 2 to 3 percent.³

India's robust international engagement in the health field seems paradoxical, given the formidable public health challenges it faces at home. Indeed, it has always exported medical talent and continues to do so. Indian doctors are critical to medical systems throughout the English-speaking world. At home, Indian research scientists have made international reputations in the medical field; “medical tourism,” as we will see, brings foreign patients to Indian facilities.

Health Diplomacy: Helping India First

The first objective of India's international engagement on health is to shore up the country's health performance. India is a major recipient of funds from both multilateral and bilateral donors, including the World Bank and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. International sources provide 1.7 percent of the funds that the country expends on health care, but closer to 7 percent of government expenditures. More important, international donors have sometimes been willing to invest in new experimental areas of health spending. International donors, for example, were leaders in funding the country's HIV/AIDS program, and they provided a significant share of funding for its family planning program, especially in its early years. U.S. funding started India's National Family Health Survey. India's practice in soliciting international aid funding, whether for health care or for other purposes, has been to make its donors fit into the Indian context rather than the other way around. Because of the country's size, it has been quite successful in this attempt, though this has not been without friction.

Besides classic foreign aid, India has received a regular flow of research grants from U.S. and other international health institutions, and it has used these to build up its scientific and research

2. “India Ranks 171 out of 175 in Public Health Spending, Says WHO,” *Times of India*, August 11, 2009, <http://webcache.googleusercontent.com/search?q=cache:-IH4XzC1WAcJ:timesofindia.indiatimes.com/india/India-ranks-171-out-of-175-in-public-health-spending-says-WHO-study/articleshow/4879566.cms+in>.

3. Prasanna Hota, “National Rural Health Mission,” *Indian Journal of Pediatrics* 73 (2006): 193–195.

capacity. It is the single largest country user of capacity-building grants from the National Institutes of Health's Fogarty AIDS International Training and Research Program. Internationally funded research efforts have made their mark on its research capacity, and they have created an effective network linking its domestic research scientists with their international counterparts.

One unique institution is the Public Health Foundation of India, which was established in 2006 with funding from the Indian government, international donor institutions, and private sources. This foundation has launched a network of public health schools in India with links to the premier public health institutions in the United States and Britain. Its initial purpose is to create capacity in India, but it also has considerable potential to participate in international capacity building.

India and the International Health Institutions

India is an active participant in international health organizations. It has frequently had a representative on the Executive Board of WHO and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. However, participation in international health organizations does not appear to be a high diplomatic priority for India. The country's representation in international health organizations is implemented through a combination of ministries, institutions, and specific programs. There is no single lead ministry. The occupants of the professional positions who represent India in these health organizations are not yet looked on as strategic leaders in the manner of the country's executive directors at the multilateral development banks, for example. Nonetheless, India does get high-level international exposure from its talented citizens who work as international civil servants at WHO, the United Nations system, and the World Bank. Many of these are among the best of the country's civil servants, and they thus go on to serve in these international posts after reaching the top in the country's elite government services.

India Becomes a Donor

On February 28, 2003, the Indian minister of finance, Jaswant Singh, announced that India would no longer receive development aid from donors other than the United States, the United Kingdom, Japan, Germany, Russia, and the European Union. The remaining 22 countries that had, up until Minister Singh's speech, given aid to India were to conclude their official development assistance programs in the country. They were requested to limit their activity to assisting Indian nongovernmental organizations.⁴ This speech marked the beginning of a changing relationship between India and the aid world. Because of the country's size, it was still a large recipient of aid, but this aid became steadily less important in relation to the size of its economy.

The same speech launched the India Development Initiative, signaling to the world the country's intention to move into a donor role. This program was designed to strengthen development collaboration with developing countries in the global South.⁵ India said that it would model its support for these nations on its "own experience of rapid economic development."⁶ In July 2003,

4. Jaswant Singh, "Union Budget Speech 2003–2004," Sansad Bhawan, New Delhi, February 28, 2003.

5. Matthias Jobelus, "New Powers for Global Change? Challenges for Internal Development Cooperation," briefing paper, *Friedrich-Ebert-Stiftung*, March 2007, 2.

6. Ibid.

India became a net creditor to the International Monetary Fund. In 2004, when India was devastated by the Indian Ocean earthquake and tsunami, it declined foreign aid for relief (although it did accept reconstruction aid), and it delivered extensive aid to its neighboring states, notably Sri Lanka.

Long before 2003, India had actually been a provider of aid, mostly technical assistance. In 1964, the country started the Indian Technical and Economic Cooperation initiative, which established training programs in 154 foreign nations.⁷ Before Minister Singh's 2003 Budget Speech, Nepal was one of the few countries that received financial assistance. After 2003, India became a more active donor, with a primary focus on its immediate neighbors—Afghanistan, Bangladesh, Nepal, and Sri Lanka—and a secondary focus on Africa.

India's entry into the ranks of aid donors coincided with an expanding economy and a surge in foreign trade, including trade with other developing countries. Since its economic liberalization in the early 1990s, India has been clocking at least 7 percent growth, and it expects to resume in 2011 the 9 percent growth it had achieved in the years before the recent global financial crisis. Trade grew at the same time. India's exports to Africa rose by 16 percent in 2003–2004, the same year as Singh's speech. India's economic engagement in Africa involved both the private and public sectors. The process started with energy and industrial cooperation but soon spread into the health sector. Indian pharmaceutical companies have built production facilities in Africa and Latin America that have driven down the costs of many drugs while also expanding the job market and boosting economic development.

India's Health Aid Programs

India's 2010 budget allocated \$536 million for financial contributions and loans to other governments. This includes \$126 million in contributions to international organizations.⁸ Additional funds, upward of \$500 million, have at times been granted for special projects, such as the Team9 West African initiative in 2007.⁹ In 2008, India allocated \$547 million to aid related activities and approved \$2.96 billion in lines of credit to Sub-Saharan African countries. Published statistics do not break out health aid from the overall assistance figures.

Looking at the specifics, India is building public health capacity in Nepal, the Maldives, and Afghanistan as well as in Africa, where the Africa-India framework for cooperation builds capacity for and trains medical professionals to deal with pandemics.¹⁰ India has pledged comprehensive support to the Indira Gandhi Children's Hospital in Kabul, including staff training, management training to improve the quality of care, diagnostic assistance, and infrastructure improvement. India has built hospitals in Nepal, and it has helped the Maldives with its public health infrastructure by

7. Gareth Price, "India's Aid Dynamics: From Recipient to Donor," working paper, Asia Programme, Chatham House, September 2004, 10.

8. Subhash Agrawa, "Emerging Aid Donors: India," *NORRAG News* (Network for Policy Research, Review and Advice on Education and Training), September 2010, <http://www.norrag.org/issues/article/1331/en/emerging-aid-donors-india.html?PHPSESSID=ea018508137f54ef257a1f17bbe581fe>.

9. Matthias Jobelus, "New Powers for Global Change? Challenges for Internal Development Cooperation," 7.

10. Nora Y. Ng and Jennifer Prah Ruger, "Emerging and Transitioning Countries' Role in Global Health," forthcoming in *Saint Louis University Journal of Health Law & Policy*, <http://ssrn.com/abstract=1594795>.

providing technical training and building hospitals. In each of these nations, India has a political or economic interest.¹¹

The international health problem on which India is most engaged is HIV/AIDS. India's aid programs have taken advantage of the success of Indian pharmaceutical companies in producing low-cost AIDS drugs. To bolster its AIDS research, India established the Global Political Advocacy Initiative with the aim of raising awareness of, and support for, the effort to research and develop HIV vaccines. India also contributes modestly to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. From 2006 to 2010, the country donated \$10 million to the Global Fund. In the most recent meeting for the Global Fund's replenishment cycle, in October 2010, India pledged an additional \$3 million.¹²

Some of India's health aid ventures piggyback on the country's most successful industries. Its pharmaceutical industry is currently estimated at \$24 billion and is projected to grow 13 percent in the next year. It exports \$8.3 billion in drugs and services. These exports also constitute a significant portion of its cooperation with the other BRIC nations on health issues. India, along with China, supplies chemicals and active ingredients to Brazil, which produces antiretrovirals locally. This local production has aided Brazil in its attempt to provide free antiretroviral drugs to all its citizens who need them.¹³ As mentioned above, India also supplies antiretrovirals to South Africa.

Many pharmaceutical CEOs have pointed out that India not only can discover and patent drugs at a much lower cost but also can handle product development on a massive scale, again at a much lower cost.¹⁴ Indian AIDS medications were among the first Indian-produced medications approved for international use by the U.S. Food and Drug Administration. India is a partner in global initiatives to develop cost-effective vaccines against the emerging threats of the H1N1 influenza, meningitis, and Japanese encephalitis. India's biopharmaceutical industry currently produces 60 to 70 percent of the vaccines procured by UN agencies to meet the basic vaccination requirements for children.¹⁵

India's legendary information technology industry has also found applications in its health aid programs. India has initiated a Pan-African E-Network project that is dedicated to setting up digital information services in Africa. The program focuses on tele-education and telemedicine.¹⁶

In recent years, India has begun contributing not just intellectual capital but also research resources to international efforts. For example, India along with Brazil has become a top five

11. Vijaya Katti, Tatjana Chahoud, and Atul Kaushik, "India's Development Cooperation: Opportunities and Challenges for International Development Cooperation," briefing paper, German Development Institute, March 2009, [http://www.die-gdi.de/CMS-Homepage/openwebcms3_e.nsf/\(ynDK_contentByKey\)/MSIN-7FJAX2?OpenDocument&nav=expand:Research%20and%20Consulting%5CProjects;active:Research%20and%20Consulting%5CProjects%5CMSIN-7FJAX2](http://www.die-gdi.de/CMS-Homepage/openwebcms3_e.nsf/(ynDK_contentByKey)/MSIN-7FJAX2?OpenDocument&nav=expand:Research%20and%20Consulting%5CProjects;active:Research%20and%20Consulting%5CProjects%5CMSIN-7FJAX2).

12. "Pledges and Contributions," <http://www.theglobalfund.org/en/pledges/?lang=en>.

13. Ng and Ruger, "Emerging and Transitioning Countries' Role."

14. Heather Timmons, "India Expands Role as Drug Producer," *New York Times*, July 6, 2010, <http://www.nytimes.com/2010/07/07/business/global/07indiadrug.html>.

15. "Role of Indian Biotech Industry in Promoting Global Health," paper presented at BioInternational Convention, Chicago, May 3–6, 2010.

16. Ng and Ruger, "Emerging and Transitioning Countries' Role."

supporter of research into developing-world diseases such as a dengue and leprosy.¹⁷ The IBSA Dialogue Forum—comprising India, Brazil, and South Africa—is another medium through which India is taking on a portion of the developing-country research burden. Health is an area of cooperation for IBSA, with each country promising to dedicate research efforts to a particular disease. Thus, South Africa has taken responsibility for tuberculosis research, Brazil is investigating malaria, and India is continuing research on HIV/AIDS.¹⁸

India as a Health Innovator: The Wave of the Future?

India is likely to continue its efforts to increase its domestic rural outreach for health care, to expand international health agencies' funding for these domestic programs, and to use aid to enhance both health and the country's influence in South Asia and Africa. The most rapidly expanding area of India's international engagement on health, however, comes through the private sector, which has developed and shared innovative mechanisms, commercial channels, and products. This is where one can expect to see a real expansion in capacity and in India's footprint—in spite of the fact that the country's institutional structure for health is dominated by the government.

Aravind Eye Care is one example. In the 1970s, Govindappa Venkatswamy, recognizing that the Indian government's efforts to treat a growing backlog of cataract cases were falling short, set out to provide quality care to poor people.¹⁹ Using managerial innovations such as cross-subsidization and organizational efficiency as well as scaling up to reduce costs, Dr. V, as he is commonly known, created Aravind Eye Care. The organization's facilities now treat 2 million patients annually. It has reduced the cost of cataract surgery to under \$20 while maintaining outcomes comparable to those in developed countries.

A significant barrier to widespread cataract surgery in the early 1990s was the dearth of inexpensive intraocular lenses. Aravind built its own manufacturing plant, known as Aurolab, which operates as a nonprofit but paved the way for private, for-profit companies in this sector in India. A host of other medical innovations have originated from Aravind, but most important, the organization has been used as a model for the He Eye Hospital in China. Staff from He have taken training courses at Aravind. Although India's direct or conventional global health engagement might be limited, its ability to devise innovative solutions that can be applied to other developing countries is a significant contribution to global health care.

An area of focus in the medical sector that has seen significant innovation is personnel recruitment and training. Similar to the way in which the information technology sector developed its workforce using specialized methods of instruction, Aravind has pioneered training programs at various medical and administrative levels within its hospitals, the most remarkable and cost-efficient of which is the "sisters" program. Initially, Aravind hired registered nurses to staff its facilities. However, this proved to be too costly, and it was difficult to guarantee an adequate supply of nurses. The sisters program was different in that it brought young, somewhat educated rural women to start out in service roles such as cleaning, housekeeping, and general care. On the basis

17. Donald G. McNeil, "Brazil and India Join the Top Ranks of Governments Supporting Research," *New York Times*, December 22, 2009, <http://www.nytimes.com/2009/12/22/health/22glob.html>.

18. "About IBSA," IBSA Trilateral Official Website, <http://www.ibsa-trilateral.org/>.

19. A. Bhandari, S. Dratler, K. Raube, and R. D. Thulasiraj, "Specialty Care Systems: A Pioneering Vision for Global Health," *Health Affairs* 27 (2008): 967.

of their strengths and abilities, these women have the opportunity to graduate to more specialized paramedical training. The training typically lasts two years. Not only does this program drastically decrease the costs of maintaining a large professional nursing staff, it also guarantees a steady flow of labor. The sisters' local familiarity is also an asset. The turnover of the sisters (who often leave to get married) is an accepted aspect of the program, and its lower costs offset the problems associated with turnover.

A similar emphasis on personnel innovation is placed in the LifeSpring Hospital System, a group of hospitals that provide heavily discounted obstetrics/gynecological and pediatric health care to low-income mothers and children. LifeSpring has an inventive network of partnerships, whereby it teams up with nursing colleges to funnel young, entry-level staff for the hospitals and preempt potential labor shortages.²⁰

India is also home to a variety of creative health organizations that specialize in low-cost, localized delivery. The SocJo Foundation deploys local women as eye care entrepreneurs within their communities, and these women are trained to diagnose basic eye problems and are licensed to sell low-priced glasses. The Medicine Shoppe similarly trains local health workers to act as liaisons and rudimentary care providers to their communities. The Jaipur Foot Program produces prosthetic limbs locally that are tailored to the financial needs as well as the local surroundings of those who use them. With their emphasis on inexpensive solutions for rural populations, these programs could be replicated in other nations and on a larger scale, providing solutions to alleviate both health and social problems.²¹ Indeed, this has already happened with the Jaipur Foot Program. Its prostheses have become internationally known for their suitability for rural populations, and international assistance providers, including the U.S. Agency for International Development, have sponsored similar programs in other countries using Jaipur Foot as their prototype.

Another example of Indian innovation is the Apollo Hospitals Group, a large and sophisticated chain that has managed to limit administrative costs to 7 percent of an admitted patient's bill. Its success rates for surgical procedures are comparable to those of hospitals in developed countries and yet its administrative costs are a fraction of those in the West. Apollo Hospitals has also pioneered \$2,300 bypass heart surgery; this surgery can cost up to 50 times more in the United States. The Apollo Group is just one Indian hospital chain that is increasing access to expensive medical procedures and is therefore at the hub of India's medical tourism trade.²²

India's most advanced private hospitals have sought out foreign patients interested in coming to India for treatments that are less expensive than in their home countries. Though medical tourism is generally a for-profit activity, it increases international access to health care and is a growing contributor to the global health system. Ethiopia, impressed with Indian hospitals' outcomes, wants the country to open hospitals in Addis Ababa, another example of the unintended positive consequences of India's private-sector health-sector innovation.²³

20. Ibid., 964.

21. Ibid.

22. "Innovating around India's Health Care Challenges," India Knowledge@Wharton, July 29, 2010, <http://knowledge.wharton.upenn.edu/india/article.cfm?articleid=4501>.

23. "Ethiopia Wants Indian Hospitals as Healthcare Hub for Africa," *Hindustan Times*, June 18, 2010, <http://www.hindustantimes.com/Ethiopia-wants-Indian-hospitals-as-healthcare-hub-for-Africa/Article1-559709.aspx>.

Telemedicine is another innovation that is developing rapidly in India. Before he was ousted due to a financial scandal, Ramalinga Raju, the CEO of the information technology company Satyam, set up a telemedicine system in Andhra Pradesh that he claimed saved hundreds of thousands of lives. By using scientific medical algorithms, this system was able to give good medical advice about how to handle common symptoms.²⁴ What was put in place in Andhra Pradesh can be replicated in other developing countries with large rural populations. Sierra Leone is already taking advantage of India's growing telemedicine network by sending X-rays and other data to better-equipped Indian hospitals.²⁵

There are many other examples, but these convey the diversity of the private innovations that India's health sector is putting forward on the international scene. The country's still-developing economy and health system allow it to connect directly with the concerns of other developing countries, which face cost constraints that donors do not. Private innovation, added to India's established strengths in research and medical science, will make Indians increasingly important participants in the international search for new and more economical ways to deliver health care.

Governmental support for these initiatives is uneven and unpredictable. On average, nearly 75 percent of health care services and investments in India have been provided by the private sector.²⁶ However, the Indian government, as mentioned above, is trying to deepen its engagement with issues traditionally in the government domain, such as rural health care and making inroads in certain growth industries. The Indian government is expected to invest \$6.5 billion during the next two years in medical tourism infrastructure. It has also launched an accreditation program for hospitals. The tourism ministry is urging all actors to form a "government-industry partnership" along the lines of the National Association of Software and Services Companies (known as NASSCOM) to promote Indian health care.²⁷ Despite these efforts, India's share of the medical tourism market lags behind those of its main competitors. This is partly due to more sustained government support in Southeast Asian nations, such as Singapore, which has a Health Promotion Board under its Ministry of Health to publicize its services abroad.²⁸

One prominent public-private partnership is the Rashtriya Swasthya Bima Yojana—the National Health Insurance Program, known as the Bima Yojana—which was born in the private sector but is financially supported by the government. Since 2007, this program has been providing poor Indian families with \$700 in health insurance in exchange for just 7 cents a year. In a country where out-of-pocket payments as a proportion of income are astronomically high, the Bima Yojana has the potential of saving families from medically related bankruptcy. Already, about 15 million impoverished families have enrolled in it, with private insurance companies vying for more "clients" in exchange for special premiums granted by the government. The Bima Yojana is not yet financially independent, but if it proves to be viable, it could be replicated by other emerging economies.²⁹

24. Ibid.

25. "Sierra Leone Link to India Medics," BBC News, November 3, 2009, <http://news.bbc.co.uk/2/hi/africa/8341276.stm>.

26. Neeta Lal, "India's Medical Tourism Industry," *Yale Global: The Asia Sentinel*, June 2, 2010, <http://yaleglobal.yale.edu/content/indias-medical-tourism-industry>.

27. Ibid.

28. "Health Promotion Board," <http://www.hpb.gov.sg/>.

29. "Innovating around India's Health Care Challenges."

Despite coverage in the press, the Indian public is largely unaware of the nation's contribution to global health. Though they are proud of their large pharmaceutical companies and qualified doctors, Indians are less concerned with the country's role as a donor and are more preoccupied with the government's general inability to deliver services in a timely manner.

Implications for the United States

The United States has a long history of involvement in India's health sector, going back to before India's independence. Its greatest contributions have involved institution building, the creation of centers of excellence in India, and the creation of relationships through which leaders and scientists in both countries could work as professional equals.

The first lesson of this long history is that it is time to deemphasize the “donor–recipient” relationship. The United States and India are in fact doing this, and the U.S.-India Health Initiative created in May 2010 explicitly tries to move beyond the donor–recipient model. The initiative's priorities are polio eradication and tuberculosis research—diseases that predominantly afflict Indians—but also noncommunicable diseases that affect both nations. India's shifting global health role has facilitated this more equal relationship.

Second, it is not just about governments. Both countries need to keep an eye on the innovations taking place in private circles and to mobilize them for the benefit of international health efforts. This is especially important for the United States, which is home to thousands of physicians of Indian origin, many of whom remain involved in private-sector ventures in the Indian health sector.

Third, institutional diplomacy will probably be a lagging area—both for India's contribution and for United States–India cooperation. The energy in India's international health work is moving outside the conventional institutional frameworks, such as the multilateral development banks and WHO. Although India is engaged in these international institutions, this is not where its most creative contributions have been made.

Fourth, some traditional India–United States problems may trip us up again. Most notable is the issue of intellectual property rights (IPRs). India's position on IPR issues has generally favored consumers' rights to affordable medications over the protection of IPRs. However, now that India's role as a pharmaceutical innovator is growing, and as it conducts research on basic molecules, one can expect an eventual shift in its policy priorities toward more rigorous IPR protection.

With India's growing pharmaceutical trade, differing standards of IPR protection are affecting its interests in countries other than the United States. In late 2008, for example, India sent a shipment of generic medicines to Brazil. The shipment transited the European Union, where officials seized the cargo and returned it to India, saying that the medicine, Losartan, violated a European patent. The seizure provoked an Indian case against the EU under the World Trade Organization's Agreement on Trade-Related Intellectual Property. Perhaps more important, Brazil and India stood together in protesting the European action.³⁰ It is too early to tell how India's IPR practices will evolve, and how it will work with other developing countries that may, like India and Brazil, be expanding their pharmaceutical industries.

30. Radhika Pandeya, “India, Brazil to Take on EU over Regulation,” *LiveMint.com*, *Wall Street Journal*, January 30, 2009, <http://www.livemint.com/2009/01/30002200/India-Brazil-to-take-on-EU-ov.html>.

Fifth and finally, one important feature of India's health policy is unlikely to change soon: It will remain domestically driven. India will first and foremost want to address its own massive health needs. These are critical to India's economic future, and the United States stands to gain from a prosperous India.

4

RUSSIA'S GLOBAL HEALTH OUTLOOK BUILDING CAPACITY TO MATCH ASPIRATIONS

Judyth Twigg

Post-Soviet Russia is a relative newcomer to the group of emerging development partners. In just a few years, Russia has moved deliberately through a transition from aid recipient to aid donor, with health one of three clear priority areas for intervention.¹ Explicitly and deliberately, since 2007, Russia has been in a capacity-building phase for official development assistance (ODA): developing and approving the necessary regulatory and legal framework; determining priority areas for assistance; creating and refining channels for interaction with aid-recipient countries and international organizations; developing both bilateral and multilateral mechanisms and channels for assistance delivery; identifying potentially fruitful partners and modes of interaction for ODA with Russia's private sector; and implementing and assessing the performance of a few initial assistance programs.

Russia's current engagement with international partners on health issues revolves around capacity-building efforts harnessing the experience and expertise of multilateral institutions, in particular the World Bank and the United Nations Development Program (UNDP), using the Group of Twenty (G-20) processes where appropriate. In a fairly mature fashion, the Russian government recognizes the need for the development of prerequisite skills and institutions, and it is explicitly undertaking a deliberate process to move in appropriate directions.

Background and Philosophy

The Soviet government expended considerable resources on health assistance as a tool of diplomacy throughout the post-World War II period. In addition to specific projects, the Soviet Union stationed large numbers of medical personnel overseas, and it trained thousands of foreign doctors—primarily from client states—in medical schools across the USSR. The Soviet Union also contributed crucial leadership, expertise, and commitment to the success of the global smallpox eradication campaign in the 1960s and 1970s, as well as other key global public health successes.² For reasons of financial necessity, Russia's participation in development assistance was quite limited in the decade following the Soviet collapse, with the notable exceptions of continued humanitarian aid, contributions to some international organizations, and debt relief for the poorest countries.

Since 2000, as Russia's economic situation has dramatically changed, so has its availability of resources for international aid. Although funding for health and other forms of assistance has increased dramatically during the last five years, Russia's ODA efforts have lacked a systematic

1. Education and energy security are the others.

2. William H. Frist, "Improving Russian-U.S. Collaboration on Health," *Washington Quarterly* 30 (2007): 7–17.

approach. In 2007, the Russian Foreign Ministry published a concept paper, “Russia’s Participation in International Development Assistance,” to lay out a strategic vision as well as a rough timeline and set of priorities.³ This concept paper was accompanied by an action plan, however, that was never approved, and the staff who worked on both these documents have since moved on to other responsibilities. As a result, there is no coordinated momentum driving Russian ODA, and no obvious champion.

Within this context, there seem to be three philosophical and practical forces governing Russia’s current activity as an international health donor. First and foremost, ODA is a key element of Russia’s evolution from global aid recipient to global donor, a transition that forms an important part of the country’s self-image as it reemerges into great power status. Russia wants to be seen not as an emerging donor but simply as a donor, operating with the same status as the major existing players. Second, Russia’s focus on global health aligns with its emerging attention to its own domestic health challenges, both of which began to assume political prominence and attract significant federal government resources around 2005–2006. Third, Russia’s concern that migrants from Central Asia could be importing infectious disease over its own borders have produced a geographic focus on that region as the primary target of assistance, and infectious disease—primarily HIV/AIDS and polio—as the key substantive areas.⁴

Institutional Frameworks

Russia’s commitment to the global fight against the spread of infectious diseases clearly stems from its presidency of the Group of Eight (G-8) in 2006, and it was in part seeds planted at that meeting that brought Russia and other new development partners into greater activity and prominence.

International Initiatives

The 2006 G-8 meeting was a major global health watershed for Russia, where it translated an emerging domestic health priority—infectious diseases—into a parallel international priority, and where it took the initiative for monitoring the health commitments of G-8 member states. Psychologically, this was where Russia saw itself emerge as a donor country, on an equal footing with the other great powers. Since then, however, Russia has seemed to prefer the G-20 as a venue for discussions of ODA. For example, Russia’s ODA activities with the World Bank have all highlighted discussions on cooperation within the G-20 framework, with a particular focus on preventing a counterproductive fragmentation of aid efforts as new donors enter the arena.

One of the main capacity-building instruments currently being used is the trilateral framework, where existing or new projects and trust funds of the World Bank, the United Nations and its agencies, and other institutions are used to harness the financial and logistical capacities of the more experienced donors. Through this mechanism, multilateral institutions are working together with Russia to build its capacity to provide assistance to developing countries; aid-recipient coun-

3. “Russia’s Participation in International Development Assistance,” concept paper approved by the president of the Russian Federation, June 14, 2007, http://www.minfin.ru/common/img/uploaded/library/2007/06/concept_eng.pdf.

4. Although Russia perceives that migrants from Central Asia are a significant vector for HIV infection, recent empirical research indicates that the opposite is true: Central Asian migrants are more likely to contract HIV while in Russia, and then take it back to their home countries.

tries are selected according to Russian priorities, and Russian technical assistance specialists and consultants are used. Major efforts in this direction involve the World Bank and the UNDP.

Russia also actively engages with the World Health Organization (WHO), which boasts active in-country programs on tuberculosis, HIV/AIDS, health policy and management, avian flu, and emergency preparedness/response. Moscow hosted the September 2010 meeting of the WHO Regional Committee for Europe, where Prime Minister Vladimir Putin signaled the political priority of health issues within the country with a speech highlighting recent achievements in Russia's fight against chronic disease and pledging full implementation of the Framework Convention on Tobacco Control.⁵ Health Minister Tatiana Golikova further stressed the extent to which the debilitating fires around Moscow this past summer demanded cooperation with WHO to develop common approaches to transnational emergencies.⁶

Russia has also pursued global health dialogues through both the Shanghai Cooperation Organization (SCO) and the Health Working Group of the Asia-Pacific Economic Cooperation forum (APEC). APEC's commitment to addressing health-related threats to trade and security focuses on emerging infectious diseases (particularly avian and human pandemic influenza and HIV/AIDS), the prevention of lifestyle-related diseases, and the improvement of health outcomes through health information technology. In parallel with APEC and SCO efforts, in 2007 Russia also established an agreement with India and China to establish a working mechanism to facilitate cooperation on health and medicine. The three countries have held annual trilateral consultations involving health ministry personnel during the last three years, with the stated intent to pool expertise in controlling HIV/AIDS, tuberculosis, hepatitis B, leprosy, and malaria. To date, these contacts have remained primarily at the level of conversation and consultation.

The Domestic Architecture

The domestic institutional architecture for Russian ODA is very much a work in progress. The 2007 ODA concept paper contains an explicit recognition that the country's own statutory and regulatory structure is lacking; Russia is the only G-8 member whose laws and regulations do not currently address even the concept of ODA, and there is no provision legislatively for a dedicated ODA budget. It is important to recognize that, at this point in time, virtually all of Russian ODA funding for health has taken the form of funds transferred to multilateral agencies. Russian officials have made it clear that only after an effective regulatory, legal, and institutional framework for aid delivery has been established—and there is no indication of a precise timeline at this point—will plans move forward for the implementation of assistance programs on a bilateral basis, including traditional project-oriented efforts. A fledgling international aid agency, the Russian Federal Agency for CIS [Commonwealth of Independent States] Affairs and International Humanitarian Cooperation, known as Roscooperation, was formed in late 2008, but it is an interministerial commission with limited staff and influence.

Russia's ODA capacity-building efforts are not without challenges. Human resources devoted to development cooperation are scarce. There are no university programs of study that train young people in the ODA enterprise. The various government agencies engaged in the process lack capacity and knowledge, yet they are embroiled in considerable political and bureaucratic infight-

5. Russia ratified the Framework Convention on Tobacco Control in mid-2008.

6. *Rossiyskaya Gazeta*, 208, no. 5287, September 16, 2010; and *Moskovsky Komsomolets*, no. 25449, September 14, 2010.

ing—particularly between the Ministry of Finance (which works primarily with the World Bank)⁷ and the Ministry of Foreign Affairs (which works primarily with the UNDP)—over control of the agenda and resources. The Ministry of Health and Social Protection, although it has formed partnerships very recently with WHO on some health assistance issues, has exhibited scant interest in or understanding of ODA. Russia has little experience in managing for results within its own health and social sectors, and so the application of those principles—emerging as essential rules, regulations, and procedures for measuring the effectiveness and efficiency of aid—to Russian ODA is problematic. And foreign assistance is a sensitive topic for a domestic Russian political audience, which is likely to react negatively to expenditures of money, attention, and expertise internationally rather than on critical problems inside its borders; for political purposes, Russian ODA is played almost entirely on the global stage rather than at home.⁸

Domestic Linkages

After decades of Soviet and then Russian government starvation of the social sectors, then-president Vladimir Putin announced in 2005–2006 a series of well-funded new social programs, dubbed the Priority National Projects. The most visible of these was health.⁹ Since then, the Russian National Health Project has allocated significant resources to raising salaries and other incentives for primary care physicians, overhauling the ambulance fleet, purchasing modern equipment, providing antiretroviral medications to HIV/AIDS patients and immunizations to children, and building new centers for high-technology care across the country. Russia now spends an estimated 5.6 percent of its gross domestic product on preventive and curative health care, a significant increase over the last decade.¹⁰ Russia's emergence as a global health donor dovetails with its new-found prioritization of health on the domestic agenda.

Funding and Activities

Russia is in the process of accession to the Organization for Economic Cooperation and Development (OECD), and it does not hold observer status in the OECD's Development Assistance Committee (DAC). Like several other important non-DAC donors, Russia does not disclose its official aid statistics, and so data on its current activities must be cobbled from an array of sources. It is clear, however, that Russia's commitments for overall international assistance, financed almost exclusively from its federal budget, have increased steadily over the last decade: \$50 million in 2004, \$215 million in 2006 (including commitments made under its G-8 chairmanship), \$220 million in 2008, and \$800 million in 2009 (with the spike due to bilateral transfers to CIS countries in response to the global financial crisis).¹¹ With the important caveat that Russia's own socioeconomic

7. The Ministry of Finance also works closely with Rospotrebnadzor (the Russian Agency for Consumer Rights), which acts as the country's chief trade and sanitary inspection authority. Rospotrebnadzor formally sits within the Ministry of Health and Social Protection, but in reality operates largely independently.

8. The World Bank has commissioned a 45-question, nationwide representative sample survey on Russian public attitudes toward ODA, with the results due in the fall of 2010.

9. The others were education, housing, and agriculture, but health has received more funding than the other three combined.

10. Estimates vary, and private spending is particularly difficult to estimate. The 5.6 percent figure is from the Progressive Policy Institute, http://www.ppionline.org/ppi_ci.cfm?knlgAreaID=108&subsecID=900003&contentID=254167.

11. ITAR-TASS, February 17, 2010.

conditions can continue to support it, the Russian government has formally pledged to move toward the UN's recommended target of at least 0.7 percent of GDP toward international aid, although informed observers predict that for the foreseeable future, these numbers will stabilize at \$500 million to \$600 million annually. Speaking at the September 2010 Millennium Development Goals summit, Russian foreign minister Sergei Lavrov boasted about the acceleration of Russia's aid to developing countries in recent years, making it clear that attention to CIS countries would continue to be a priority, as would targeted support for some programs in Africa.¹²

The recently published G-8 accountability report outlines Russia's efforts on disease surveillance and control systems support in developing countries, including designation of fighting infectious diseases as part of Russia's presidency of the SCO in 2009, work through the CIS Coordination Council on Sanitary Protection, and support for innovative financing mechanisms to encourage research and development for vaccines, microbicides, and drugs (including \$38 million set aside in 2008–2010 for HIV vaccine research with CIS countries). Overall, Russia spent \$102.18 million specifically on health assistance reported through the G-8 framework in 2007, and \$110.29 million in 2008.¹³ Russia has also contributed more than \$250 million to the Global Fund to Fight AIDS, Tuberculosis, and Malaria in the last several years, in a successful effort to repay all the funds it had previously received through this mechanism, with a new commitment of an additional \$60 million at the recent replenishment meeting.¹⁴

The World Bank has been the most aggressive third-party facilitator of Russia's ODA efforts on health:

- Throughout 2005, the Bank prepared a series of substantive “issues notes” on a variety of topics relevant to Russia's ambitions as a health donor: “Health System Strengthening,” “Brief for the Russian Authorities on Harmonized Infectious Diseases Surveillance Information Systems in the World: Another Challenge for the G-8 Group,” and “Briefing Note for Russian Authorities on International Agreements for Improving the Coordination and Effectiveness of Global Fund, World Bank, and UN Agencies on HIV/AIDS Activities.” These notes were clearly intended to help prepare Russia for its 2006 presidency of the G-8.
- In 2007, Russia signed an agreement with the Bank and WHO committing \$20 million for malaria control in Africa (Zambia and Mozambique) through a trust fund instrument. The Russia–World Bank Support to Zambia Malaria Control Project, effective in October 2007 and administered by the WHO Global Malaria Program, has generated remarkable outcomes: From 2006 to 2008, population coverage increased from 1.2 million to 3.5 million people; the percentage of households with one bednet increased from 48 to 72; and the percentage of children with parasitemia decreased from 28.8 to 10.2, and children with anemia from 13.3 to 4.3.¹⁵ The availability of outcome data reasonably attributable to Russian-funded interventions should have served as an important lesson in the importance of effective monitoring and evaluation.

12. Press release from the Russian Ministry of Foreign Affairs, September 24, 2010.

13. “Muskoka Accountability Report: Assessing Action and Results against Development-Related Commitments,” “Annex Five: G8 Member Reporting, Health (2010),” http://g8.gc.ca/wpcontent/uploads/2010/06/muskoka_accountability_report.pdf.

14. Donald G. McNeil Jr., “Global Fight against AIDS Falter as Pledges Fail to Reach Goal of \$13 Billion,” *New York Times*, October 5, 2010.

15. Klaus Rohland, presentation, Russia Cares Conference, World Bank, Washington, December 22, 2008.

- In May 2008, the Bank's office in Moscow hosted a conference on "Development Aid Statistics: International Experience and Creation of a Russian Accounting and Reporting System," designed to familiarize Russian staff with international best practices and standards in accounting and provision of data on the Bank's highly concessional arm, the International Development Association; the conference discussions included practical steps for setting up an efficient reporting system for Russia.
- In February 2010, with support from the Bank and OECD, the Russian Ministries of Finance and Foreign Affairs hosted the Moscow International Conference on New Partnerships in Global Development Finance, designed to highlight the growing contributions of new bilateral partners and to promote collaborative efforts to enhance the development impact of interventions.¹⁶ Advancing what has now been labeled the "Moscow Process"¹⁷—following up on the 2006 "Conference on Emerging Donors in the Global Development Community," held under the auspices of Russia's G-8 presidency¹⁸—the conference was an expression of Russia's desire to shape the evolution of ODA through new partners and forms of partnership. Outputs from this meeting included a request from Russia, to other new development partners present (including China, South Korea, Turkey, and Poland), to join in a call to the OECD's DAC to form a "special group" that will focus initially on building capacity for aid statistics and reporting and other aid management concerns.¹⁹ The participants agreed to continue their dialogue through existing channels, including the High-Level Forum on Aid Effectiveness in Korea in 2011.

The UNDP has also actively assisted Russia in the creation of practical joint development assistance projects, aiming for learning by doing in areas that include a focus on health. Initial efforts began in 2004–2005, with a joint UNDP–Ministry of Foreign Affairs project, "Russia as Emerging Donor: Strategic Research, Consultations, and Training," that was clearly intended to guide Russia's thinking as it prepared the official 2007 ODA concept paper. Through a 2009–2010, \$587,000 "International Development Assistance Preparatory Project,"²⁰ the UNDP has now formed partnerships with a number of Russian agencies to demonstrate international best practices in aid administration, including a Russian assistance program for HIV/AIDS control in the CIS countries. The HIV/AIDS project remains in a relatively early phase, involving the mobilization of Russian experts' support for the development a draft regional program on HIV/AIDS, the facilitation of a consultative process within the CIS Coordination Council on HIV/AIDS, and coordination and liaison among relevant CIS stakeholders.

16. "About the Conference," New Partnerships in Global Development Finance, <http://www.mgdf.ru/eng/about>.

17. Russian minister of finance Alexei Kudrin and World Bank president Robert Zoellick used this term in their joint statement at the February 2010 conference.

18. "Emerging Donors in the Global Development Community," presentation at an international conference hosted by the Russian Group of Eight Presidency, Moscow, April 6–7, 2006, <http://www.oecd.org/dataoecd/34/56/36417981.pdf>.

19. "Chairman's Summary: The Moscow Process," Moscow International Conference, New Partnerships in Global Development Finance, February 17–18, 2010.

20. United Nations Development Program, "Support to Russia's Effective Participation in the International ODA Architecture," <http://www.undp.ru/index.php?iso=RU&lid=1&cmd=programs&id=203>.

Long-Term Trends and Implications

Despite numerous challenges, it is impressive how deliberately and carefully Russia is moving forward in developing the capacity for delivering international health assistance. Particularly within the Ministry of Finance and Rospotrebnadzor (the Russian Agency for Consumer Rights), there is a desire to integrate into the overall global ODA architecture smoothly and efficiently, and perhaps even purposefully to enhance donor harmonization and alignment in the process. However, some recent developments may be cause for concern. At two meetings in February and July 2010, 18 Russian ministries were presented with the opportunity to craft proposals for international assistance activities, and there is worry that an uncoordinated grab for ODA resources might result in further turf battles and disarray. The major trend worth watching is the evolution of the domestic institutional landscape for ODA; if an effective manager of the process does not take the reins at this critical juncture, it is possible that deliberate and careful approaches will become clumsy and disruptive.

Russia is in search of its destiny when it comes to global health engagement. It would like to use health as a tool of foreign policy, but it does not yet know exactly how to make this happen. American efforts to engage or collaborate with Russia in this area should recognize the importance of the “donor identity” to Russia’s self-image. At the recent first meeting of the Russian-U.S. Bilateral Presidential Commission’s Health Working Group, several potential global health projects were put on the table, with joint work on polio in Central Asia seen as especially promising. These efforts are likely to prove most fruitful if the United States enlists Russia as an equal rather than junior partner, in both the bilateral arena and as an advocate through institutions like the G-8 and G-20 for the resolution of global health concerns.

5

SOUTH AFRICA AND GLOBAL HEALTH

MINDING THE HOME FRONT FIRST

Jennifer G. Cooke

The transition in South Africa from the administration of President Thabo Mbeki to that of Jacob Zuma, who took office in May 2009, has ushered in a period of relief and guarded optimism among those engaged in public health in South Africa. President Mbeki's early denial of a link between HIV and AIDS and his initial refusal to authorize public provision of antiretroviral (ARV) medicines were a serious blow to South Africa, both in confronting the country's most pressing domestic health challenge and in its global engagement on health. But President Zuma's first 18 months in office have signaled an unambiguous reversal of his predecessor's reluctant engagement on AIDS. The government has set out an ambitious plan to restructure the health care system, with a strong emphasis on expanding HIV and tuberculosis treatment and services. The president has acknowledged that South Africa is not winning the war against AIDS, and, beginning by publicly taking an HIV test on World AIDS Day 2009, he has launched one of the largest national HIV testing campaigns in the world.

On the international front, there no strong signal as yet that the Zuma administration has a deliberate strategy to elevate the issue of global health in international forums or to take up a role of continental leadership on health. To date, there has primarily been an inward focus in the leadership's health strategy as the government seeks to grapple with an overburdened health system and at the same time with a massively deficient educational system and growing social unease driven by high levels of unemployment and income disparities. This may change over time, but Zuma appears to lack Mbeki's ambition to position himself as a pan-African leader and interlocutor on big continental issues of development, security, governance—or health.

At present, the most visible element of the South African administration's foreign policy strategy has been commercial diplomacy, both within Africa and with other emerging economies, most notably the BRICs—Brazil, Russia, India, and China. More robust bilateral commercial partnerships may eventually form the basis for broader engagement on a range of issues, including health, albeit in different forms than the traditional donor–recipient model, a model that will decline in significance if South Africa's current economic growth trajectory persists. Thus, though it is early to gauge Zuma's longer-term global health engagement strategy, his government's early prioritization of outreach to the BRICs and other emerging economies may be an indication of how its health outreach will evolve. Ultimately, forces outside the government—civil society, private industry, and the research and university establishment—may lead international outreach on global health and at the same time push the South African government to take a more active role in regional and international debates.

The Retrenchment in Continental Leadership

On one level, there is an understandable expectation that South Africa would play a leadership role on issues of continental and global import. The country is Africa's largest economy; it is the only African member of the Group of Twenty (G-20); and, along with Brazil, China, India, and Mexico, it is one of the G-8's "Outreach Five." It has been a lead candidate to represent the developing world's concerns within a potentially reformed UN Security Council, and it was singled out as a "critical partner" in the Barack Obama administration's National Security Strategy for its regional and global leadership roles and for "the unique value and perspective that it brings to international initiatives." Former president Thabo Mbeki—despite significant differences with the United States on Zimbabwe, HIV, the invasion of Iraq, and broader ideological debates—was nonetheless seen by the United States and others as a continental leader and important interlocutor on North–South issues like development, equity, and governance. South Africa under Mbeki was among the lead proponents of a more proactive African Union and of the New Economic Partnership for African Development; a key player in African mediation efforts in Burundi, Democratic Republic of Congo, and Côte d'Ivoire; and an active participant in building alliances such as the Africa–South America Council. Although its economic heft puts it in somewhat of a different class than the vast majority of its African counterparts, South Africa in the postapartheid era has consistently represented itself as one voice among many and as an advocate for African countries marginalized within a global system.

So far, there is little indication that President Zuma aspires to the role of international or continental statesman. In fact, his foreign policies may indicate a more pragmatic, nationalist approach and suggest that he may be looking beyond the continent to the world's more economically powerful states, to position South Africa among a new set of peers. In his first year and a half in office, his foreign policy goals have appeared to be more focused on building strategic and commercial partnerships with key states than on taking on the role of African interlocutor.

In particular, strengthening South–South partnerships with the big emerging economies appears to be a priority objective. The president traveled to all the BRIC countries in his first year in office, with a strong emphasis on strengthening business ties. In China, which in the last year has become South Africa's largest export destination, he was accompanied by 13 Cabinet ministers and a business delegation that was almost 400 strong. The two countries signed a comprehensive strategic partnership agreement and a series of memoranda of understanding, largely focused on construction and infrastructure projects. (His visit to Washington to attend the Nuclear Security Summit in 2010 was considerably lower key, and the United States–South Africa Strategic Dialogue, launched later that week, was signed by Foreign Minister Maite Nkoana-Mashabane.) South Africa's hosting of the 2010 FIFA World Cup was considered a symbolic triumph for Africa, but in practical terms its most notable achievement was to profile South Africa's infrastructural and commercial strengths and to highlight its potential as an emerging economic power and viable investment destination.

As one of the countries hardest hit by the AIDS pandemic—and the country with the world's largest population of HIV-infected individuals—South Africa, by all rights, should have been in the last decade a leading international voice in mobilizing an African and international response. President Mbeki essentially forfeited this role with his controversial stance on the links between HIV and AIDS, although it should be noted that under his tenure, the government contributed \$10 million to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the only African

country, beside Nigeria to do so) and pledged \$20 million over 20 years to the Global Alliance for Vaccines and Immunization, known as the GAVI Alliance, an initiative in support of vaccines and immunization.

Despite initial domestic and international skepticism about Zuma's potential for leadership on HIV—stemming from personal behavior and a record of jarring public pronouncements on HIV and women—his administration has made a dramatic break with Mbeki's policies, and Zuma's domestic commitments and leadership on HIV within South Africa are winning widespread praise. The new administration's priority focus, as one health official in Pretoria put it, is to “put its own house in order” before going global.¹ President Zuma's election was in part a repudiation of his predecessor's leadership style, but it also reflected a growing disgruntlement within segments of the African National Congress that domestic social issues were receiving short shrift because the Mbeki administration was more focused on economic growth and continental leadership.

Ultimately, this domestic leadership on HIV/AIDS may strengthen the president's hand if or when the government chooses to play a more expansive regional and international role. In March 2010, for example, the Global Fund to Fight AIDS, Tuberculosis, and Malaria launched its *2010 Results Report* in South Africa, with the South African health minister, Aaron Motsoaledi, presiding. At the 2010 World Health Assembly, UNAIDS director Michel Sidibé singled out China and South Africa as leading examples of new models for strengthening the AIDS response and at the same time achieving broader health and development outcomes.² With UNAIDS' encouragement, the two countries, along with Nigeria, cohosted a high-level meeting on the sidelines of the September 2010 UN Millennium Development Goals (MDGs) Summit to highlight the “AIDS plus MDGs” agenda, which calls for a synergistic approach to fighting HIV while pursuing the MDG targets.

Domestic Health Challenges Are Paramount

South Africa faces enduring and daunting health challenges, with a burden of disease—most notably HIV and tuberculosis—that threatens to overwhelm the dysfunctional and fragmented domestic health system it inherited from the apartheid era. With the departure of President Mbeki, there is now considerable hope that President Zuma and Minister Motsoaledi will devote the attention, leadership, and resources that the country's health challenges warrant, although given current trend lines and the last decade's lost opportunities, success is by no means assured. The country's public health system, which serves some 80 percent of its population, is underfunded and overstretched, and despite its strong economic growth rates in recent years, the resource gaps remain debilitating.

HIV is not South Africa's only health threat, but the implications of the HIV burden will dominate the country's health policy for decades to come, and HIV is seen by many as the priority platform from which other health challenges can be addressed. The virus continues to spread rapidly in South Africa. With 0.7 percent of the world's population, the country bears 17 percent of the global burden of HIV infection. Its prevalence among 15-to-49 year-olds is an estimated

1. Author's interview with senior health official in Pretoria, August 17, 2010.

2. “UNAIDS Advances Agenda for AIDS plus MDGs during 63rd World Health Assembly,” UNAIDS, May 18, 2010, http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2010/20100518_WHA.asp.

18 percent. By the end of 2009, the public ARV program reported 919,923 people on treatment, with the private sector and nongovernmental organizations supporting treatment for an additional 51,637.³ These treatment figures translate to 56 percent coverage for those in need (based on protocols to initiate treatment when a patient's CD4 cell count falls below 200). The government's stated goal is to reach 80 percent treatment coverage by the end of 2011. HIV incidence remains unacceptably high—with some 350,000 to 500,000 new infections each year—and if current rates persist, some estimates project that South Africa will need to treat upward of 3 million people by 2020.⁴ If new World Health Organization protocols for treatment are widely adapted (i.e., raising the recommended CD4 count for beginning ARV treatment from 200 to 350),⁵ the number of those in need will rise dramatically. Domestic pressures for a “test-and-treat” strategy may increase over time.

The gradual shift in demand from first- to second-line HIV therapy will add another layer of cost. For the foreseeable future, demand for treatment will far outstrip current resources and capacity, and the government will be forced into difficult political and ethical questions on how to prioritize access to treatment and how to balance HIV requirements with other health and development concerns.

HIV prevention must be a central and persistent focus if South Africa is to make headway in closing the treatment gap and avoiding painful political and ethical trade-offs in resource allocation down the line. The expansion of efforts to prevent mother-to-child transmission has been a significant success, with services almost universally available in primary health clinics. But sexual transmission has remained an intractable challenge. South Africa appears to be embracing the “Know Your Epidemic” strategy, which calls for more tailored and targeted prevention interventions and which may move the country away from broad-based communications campaigns. Strong national leadership and vision will be needed to maintain focus on prevention, because there is no strong domestic constituency for prevention, as there is for treatment.

So far, the signs of leadership are good. Zuma and Motsoaledi have acknowledged the mistakes of the previous administration and have laid out an ambitious strategy to combat the country's greatest health threat, HIV/AIDS. In April, President Zuma announced a massive HIV counseling and testing campaign, with an ambitious target of testing 15 million people by June 2011. The country's new national strategic health plan calls for a decentralization, or “down-scaling,” of integrated, comprehensive health services, including nurse-initiated HIV treatment, from largely hospital-based services to some 4,000 primary health facilities, an undertaking that will require significant investments in health infrastructure, health professional capacities, and new forms of task sharing among health personnel. The government has announced plans to train 6,000 nurses in ARV treatment initiation by the end of 2011; as of August 2010, 2,500 had been trained.⁶ At the president and health minister's request, an additional \$1 billion of the 2010 budget was allocated to HIV treatment, and the government is providing hundreds of pharmacies and retail chains with free HIV test kits.

3. “Country Progress Report on the Declaration of Commitment on HIV/AIDS,” March 2010, http://data.unaids.org/pub/Report/2010/southafrica_2010_country_progress_report_en.pdf.

4. Nathan Geffen, “HAART Coverage and Unmet Need in South Africa,” *HIV Treatment Bulletin* 10 (2009): 26, <http://www.aegis.com/pubs/i-base/2009/IB2009-05-26.html>.

5. Currently, South Africa applies the new protocol among infants, pregnant women, and patients co-infected with TB.

6. Author's interview with senior health official in Pretoria, August 17, 2010.

Most South African public health experts have welcomed this new energy and enthusiasm, but some caution that managing expectations and accurately mapping out the cost and personnel implications of these ambitious plans will be critical, and some suggest that the government has rushed into a number of these commitments without adequate attention to the consequences. Already, remuneration for the current public health workforce is a source of political tension. Many health professionals joined in mass public-sector strikes in August 2010, when the National Education, Health, and Allied Workers' Union rejected the government's initial offer of a 7 percent pay raise. Major hospitals shut down in five provinces, with strikers in some instances blocking access by those health professionals who sought to come to work. The August strikes are a stark illustration of South Africa's dilemma in meeting the basic needs of public-sector workers and the demands of politically powerful unions while at the same time attempting to train, retain, and employ a significantly expanded cadre of health professionals. Meanwhile, the government bureaucracy for health, many argue, is oversized, costly, and not always merit based, although downsizing will be an extremely sensitive political challenge.

How Domestic Health Challenges Will Shape Global Health Outreach

The implications of the growing gap between demand and access to ARV treatment—in cost and availability of treatment and health personnel requirements—will likely be most influential in shaping South Africa's foreign policy on health. The resource requirements for the expansion and decentralization of health services, for mounting ARV treatment demands, and for training and retaining public health workers will mean that pressure to mobilize assistance from traditional donors—the United States; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the European Union—will persist. South African constituencies for HIV treatment are organized, politically powerful, and vocal—more so than on any other health or development issue. These groups will ensure that access to treatment will remain a political priority. Before the June 2010 G-20 summit in Toronto, the Treatment Action Campaign joined with the powerful Council of South African Trade Unions and others to urge President Zuma to advocate for international donor resources to support expanded treatment access.

Given the South African economy's size and sophistication, however, particularly compared with those of many other African states, and its status as an “emerging economic power,” the donor–recipient model of health engagement will likely become increasingly obsolete. Currently, South Africa is the single largest recipient of U.S. funding through the President's Emergency Plan for AIDS Relief (PEPFAR), but despite assurances by the U.S. Embassy in Pretoria that there is “every expectation that funding levels will continue,” there is growing anticipation that assistance will decline and ultimately flatline. Some South African officials quietly acknowledge that with appropriate priority setting and political will, South Africa can indeed support its own health system. Already, domestic spending accounts for 73 percent of the country's health budget.⁷ The United States is by far the largest external health donor (with \$526 million in 2009, and a cumulative \$2 billion since 2004), followed by the UK Department for International Development (\$24 million in 2009); and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (\$4 million in 2009, and a cumulative \$201 million since 2004). Very little U.S. assistance goes directly to ARV purchases or

7. “Country Progress Report on the Declaration of Commitment on HIV/AIDS,” http://data.unaids.org/pub/Report/2008/south_africa_2008_country_progress_report_en.pdf.

service delivery; the vast majority is allocated to training and technical assistance.⁸ Both countries are already envisioning an eventual transition, and South Africa will be an early leader in the shift to full country ownership and responsibility.

South Africa's relationship with the Global Fund to Fight AIDS, Tuberculosis, and Malaria got off to a rocky start. Seeking to circumvent the recalcitrance of the Mbeki government to provide treatment, the Global Fund awarded early grants for HIV treatment directly to provincial governments in Western Cape and Kwa-Zulu Natal, despite strenuous objection from the national Ministry of Health. In 2005, the fund suspended a \$51 million grant to LoveLife, South Africa's largest HIV prevention program, questioning the program's impact and citing its failure to redress the Global Fund's concerns. Nonetheless, the partnership is a strong one. As noted above, South Africa was chosen to host the launch of the fund's *2010 Results Report*, and in October 2010, a coalition of South African corporations, part of the United against Malaria Campaign, donated \$250,000 to the fund, a positive indication of broad-based commitment.

South Africa will ultimately need to adapt new models of health service delivery that are more streamlined and cost-efficient and build new partnerships—both public and private—that can provide affordable access to treatment, boost the country's pool of health professionals, and build the institutional and human capacity that the country will require in coming decades to manage multiple health challenges.

South-South engagement will likely be an area for expanded partnerships, and South Africa may look to its partners in the global South with strong public health credentials for training and models of health service delivery that are appropriate for the South African context. Currently, for example, some 300 South African doctors are being trained in Cuba (some 40 have already graduated), part of a six-year program initiated by the South African and Cuban governments. Graduates were impressed by Cuba's emphasis on preventive versus curative health, and the emphasis on primary health facilities.⁹ Brazil may be a powerful model and strong potential partner. Health Minister Motsoaledi traveled to Brazil in mid-2010 with a large delegation of provincial health leaders, and on his return he praised the country's family-oriented primary health centers and cost-efficient model of service delivery.¹⁰

IBSA, a trilateral developmental and cooperation initiative between India, Brazil, and South Africa, was established in 2003, with an initial impetus to advocate for greater global equity in trade and development. A health working group has been established within IBSA, with a stated focus on epidemiology surveillance, sanitary regulations, traditional medicines, and related aspects of intellectual property rights. It is early yet to determine how influential the IBSA health objectives will be; health is one of 17 working groups, and there is little indication of a strategy or implementation plan. In early 2010, IBSA announced its intention to increase collaboration on nanotechnology, with South Africa named to lead in research on applications to health and water. South Africa and China have signed a strategic partnership agreement, and during President Zuma's trip to Beijing, the leaders pledged, among other things, to work cooperatively on "culture, education, media, health, and tourism," but clearly investment and commercial ties were the pre-

8. Author's interview with officials of the Centers for Disease Control and Prevention and the President's Emergency Plan for AIDS Relief in Pretoria, August 2010.

9. Lungi Langa, "South Africa: Cuban Medicine," Health-e News Service, June 8, 2010, <http://allafrica.com/stories/201007080190.html>.

10. Anso Thom, "PHC the Cornerstone of NHI—Minister," Health-e News Service, September 30, 2010, <http://allafrica.com/stories/201009300648.html>.

dominant purpose and focus of the visit.¹¹ Ultimately, expanded engagement with BRIC countries and other emerging economies will open up new opportunities for possible partnerships in areas directly or indirectly related to health.

Engagement with global pharmaceutical companies will be another area for South African engagement. The country's pharmaceutical sector is considered an important element in the government's overall industrial strategy.¹² The growing demand for ARVs and the government's stated objective of increasing local manufacturing output to meet 50 percent of local demand has led the country to encourage increased foreign direct investment in the pharmaceutical industry.¹³ A number of Indian companies have identified South Africa as a promising market and investment destination for generic medicines, although investors may run up against increasing competition as the domestic pharmaceutical sector grows.

South Africa has already expanded domestic production of ARV drugs (for both domestic consumption and an African regional market), and negotiations with individual companies or engagement on global protocols for intellectual property rights will likely be an area for increased engagement by the government. Merck and Company recently granted a voluntary license for the South African generic producer Aspen Pharmacare to make Efavirenz; and Gilead agreed in 2005 to grant nonexclusive licenses to a number of generic manufacturers in South Africa (and India), allowing these companies to produce low-cost generic versions of the ARV drug Viread. These kinds of innovative licensing arrangements may proliferate and ultimately generate more global solutions to ensure that the expanding demand for first -and second-line therapies can be met.

Health Engagement in Africa: Transnational Linkages Outside the Government

Whether or not President Zuma chooses to participate more actively in pan-African health discussions, a number of domestic actors that are outside the public sector have the potential to play an important role in shaping South Africa's standing and strategy on global health and in catalyzing new partnerships with significant regional and global impact. As noted, South Africa's domestic HIV/AIDS constituencies have had a powerful impact within the global advocacy movement, particularly in mobilizing support for universal access to treatment, and there is every indication that they will continue to push the international community on expanded resource commitments.

At the forefront and the epicenter of the HIV pandemic, South African constituencies can mobilize other HIV-affected states in pushing for resources for universal access; for global equity in implementing new World Health Organization protocols; for equity in the quality of the ARV drugs that are administered; for potentially growing mobilization concerning test-and-treat strategies; for a reduction in the cost of second-line therapy; and for tackling the ethical trade-offs that resource constraints may impose. Since the 1990s, South African activist groups, most notably the

11. Forum on China-Africa Cooperation Web site, "Hu Jintao Holds Talks with South African President Zuma," August 27, 2010, <http://www.focac.org/eng/zfgx/t727377.htm>.

12. Author's interview with Elizabeth Sideropolous of the South African Institute of International Affairs in Pretoria, August 18, 2010.

13. South Africa Pharmaceuticals and Healthcare Report Q2 2010" (Summary), Business Monitor International, April 2010. Accessed via Market Publishers, http://marketpublishers.com/report/medicine_pharmaceuticals_biotechnology/healthcare_equipment_services/south_africa_pharmaceuticals_n_healthcare_report_q2_2010.html.

Treatment Action Campaign, have mounted advocacy drives and legal challenges that have played a pivotal role in shaping South Africa's international stance on intellectual property rights, in shaping engagement with—and the pricing structures of—pharmaceutical companies, and in galvanizing global advocacy for universal access to treatment. HIV activists within Africa, and in the developing world more broadly, may look to the South African advocacy movement for leadership and strategy.

South Africa boasts a strong and sophisticated research establishment relative to that of other African countries, and it thus has the potential to become a center of excellence for basic and implementation health research on the continent. Given that the country has the world's largest number of people living with HIV, one of the world's largest tuberculosis epidemics, and high levels of HIV/tuberculosis coinfection, South Africa-based research has a demonstrated potential to make significant contributions to breakthroughs in HIV prevention and treatment, drug resistance, tuberculosis/HIV treatment strategies, improving measures of incidence, and beyond. Most recently, South African-led research at the Center for the AIDS Program of Research in South Africa has demonstrated the potential efficacy of a topically applied vaginal gel in reducing HIV infection, a finding hailed as a breakthrough in HIV prevention with global implications. The KwaZulu-Natal Research Institute for Tuberculosis and HIV, established in 2009, has the potential to become a global leader in basic science research on tuberculosis and HIV. The center, a partnership between the University of KwaZulu-Natal and the Howard Hughes Medical Institute, has signaled that in addition to its research mission, it will work to expand the tuberculosis and HIV research capabilities of scientists throughout Africa. There are numerous research partnerships that link South African and U.S. scientists and epidemiologists; and growing ties with India and other global partners. Given the country's research and university infrastructures, there is considerable potential for establishing training and research hubs that can bolster the capacities for health research in the Southern African region and well beyond.

Finally, South Africa's private sector can play a catalytic role domestically and within Africa. South African mining companies helped make the business case for—and spearheaded the move toward—the provision of free ARV treatment to employees, their families, and, in some cases, the broader communities in which they live. South African manufacturers of pharmaceuticals and medical technologies will find expanding markets within Africa. And as public health resource requirements expand, the government will seek to leverage more fully private-sector resources, services, and skills to bolster public-sector capacities. South Africa's private health sector is relatively well resourced. “Co-location” partnerships, in which private and public health service delivery systems operate side by side within a particular facility, may hold promise in maximizing efficiencies and economies of scale. Private investments in research, training, the development of new technologies, and expanded health information and communication systems all hold promise for strengthening South Africa's domestic response, with potentially broader regional effects.

Future U.S. Engagement

South Africa boasts economic, institutional, and nongovernmental capacities that are lacking among many other partners of the President's Emergency Plan for AIDS Relief. The United States has important stakes in continuing its commitment and building on its health investments in South Africa, because South Africa is a global emerging economy; is a potential regional hub for excellence in research, training, and private-sector partnerships; and will be grappling with the

effects of HIV for decades to come. Already, it has been an early model of a new paradigm of U.S. engagement, with a decreasing emphasis on direct service provision and the purchase of ARVs and increasing investments in training and long-term capacity building. Though the financial component of United States–South Africa health engagement may decline over time, the United States should ensure that the health partnership remains strong. Areas for particular focus and collaboration should include developing more effective HIV prevention strategies and formulating better measures of incidence; and strengthening health information systems, expanded training collaborations, and responses to the country’s increasing burden of noncommunicable diseases, an area that has received scant attention in Africa and the developing world.

Engagement with South Africa offers an opportunity to test and expand sustained partnerships to build long-term capacities. In assistance terms, the U.S. strategy should ultimately shift to catalyze and encourage greater nongovernmental U.S. engagement and partnerships, among universities, medical and management schools, research institutions, and private-sector entities. Long-term, relatively low-cost investments in research partnerships, like the National Institutes of Health’s Fogarty AIDS International Training and Research Program, have had a powerful long-term impact in building South Africa’s cadre of health researchers, with cascading effects into the broader region. U.S. assistance can encourage expanded linkages between South African institutions and other African countries.

In diplomatic terms, health care will remain an essential component of U.S.–South African relations. There will undoubtedly be tensions. Declining U.S. assistance will create anxiety and possible antagonism among South African domestic constituencies, which will insist on the obligation of wealthier nations to sustain financial commitments and fulfill their promises to help ensure universal access. Differences may reemerge concerning intellectual property rights, trade-related intellectual property rights, and access to new drugs and technologies. Disagreements in arenas outside health—the global trade regime, climate change, UN reform—may affect the overall tenor of the relationship, as they have in the past. But the mutual interests far outweigh such areas of potential difference. The United States has every interest in ensuring that South Africa is capable of managing its domestic health challenges and is empowered to play an active and constructive role on health care within Africa, that it harnesses the potential public health benefits in its partnerships with other emerging economies, and that it brings its experience and voice to debates within global governance structures. These objectives warrant continued diplomatic attention and investment.

6

ENHANCING LEADERSHIP ON
DEVELOPMENT AND HEALTH AS
SOUTH KOREA HOSTS THE G-20

Victor Cha

Having returned from Seoul two weeks before the Group of Twenty (G-20) Summit in November 2010, I can attest that there was a buzz in the air—a frenetic pace beyond the normally fast-paced life of this megacity, a sense of anticipation as South Korea prepared to host the world, similar to that felt in the run-up to its hosting of the 1988 Olympics and the 2002 World Cup. The South Korean Lee Myung-bak government has made “Global Korea” its moniker. The concept is that South Korea, long a recipient of the world’s help as it emerged from the ashes of the Korean War, is now giving back to the international community and contributing to the public goods of the international system as a responsible stakeholder. “It’s about time South Korea’s global growth should take center stage,” said Sohn Jie-ae, a former CNN correspondent and now spokesperson for the Seoul G-20 Summit. In an interview with the *Korea Times*, Sohn explained that chairing the global economic summit “will be a new role for South Korea, which can not only show its economic growth, but furthermore, demonstrate leadership.” It is clear from these statements and from the Blue House’s enthusiastic outreach to G-20 members that South Korea intends to take this opportunity as the next summit chair to promote its global image.

As the host for the upcoming G-20 Summit, South Korea is making history on multiple accounts. It is the first non-G-7 member state as well as the first “emerging” economy to chair the summit. It is also the summit’s first non-Anglophone chair. All these firsts signify an expansion of the G-20’s focus, from one resting solely on collective action during the recent global financial crisis to one including international support for developing economies. In this context, South Korea—having just transitioned in a mere 60 years from a developing country to the world’s fifteenth-largest economy—is the model rags-to-riches story for other developing nations. As a recipient turned donor of international development aid, South Korea’s growing strength in the global market reflects the reciprocal effects of official development assistance, and thus it is likely that the country will use itself as an example to emphasize the importance of global development projects at the summit.

Currently, South Korea is taking on several massive domestic development projects, which it will be sure to highlight during the G-20 Summit. For instance, the Lee Myung-bak administration’s Four Rivers Project, however controversial, is set to restore, divert, and develop four major rivers in South Korea, while creating thousands of domestic jobs. And the Incheon Free Economic Zone is intended to transform the industrial city of Incheon into the “hub of Northeast Asian business.” South Korea is also promoting the development of its nuclear energy industry as well as green growth in all sectors of its economy. Its emphasis on its own development makes it a convincing advocate for global development at the G-20 Summit, but its development work in recent years has gone far beyond its borders.

In the past few decades, South Korea has become an active member of the international development donor community. In 1991, the Seoul government established the Korea International Cooperation Agency (KOICA) to maximize the effectiveness of its aid to developing countries. It became a member of the Organization for Economic Cooperation and Development in 1996—the first-ever economy to transform its status from recipient to donor. Through these initiatives and others, between 1987 and 2007 the total volume of South Korean official development assistance to the developing world was approximately \$5.7 billion. In 2008, South Korea’s estimated total development aid amounted to \$802.3 million, an almost 15 percent increase from 2007.¹ Most recently, Seoul has sent vaccinations to prevent the spread of H1N1 influenza in North Korea, aid and personnel to help earthquake victims in Haiti, and financial and medical assistance to flood victims in Pakistan.

Because South Korea prioritizes global health quite highly, it diverts nearly 15 percent of its aid budget to health and medical services. Through KOICA, from 2002 to 2006 it donated \$2.5 million to help eradicate avian influenza and other infectious diseases in six of the countries that belong to the Association of Southeast Asian Nations. It has helped provide access to safe drinking water in African countries such as Kenya and Tanzania, and from 2006 to 2009 it launched a number of maternal health initiatives in Honduras, Bolivia, the Dominican Republic, and Vietnam. It has also recently launched the Air Ticket Solidarity Levy. Through this program, Seoul has agreed to donate 1,000 Korean won (about \$1) for each airline passenger departing from Korea, to help treat and prevent HIV/AIDS and Malaria on the African continent. This program is expected to annually generate revenues of around \$20 million. The South Korean government has also established partnerships with key developing countries such as Iraq, Peru, and Cambodia to help develop their capacity by training medical professionals and dispatching Korean medical workers.² Further, South Korea is a donor country to the Global Fund to Fight AIDS, Tuberculosis, and Malaria;³ a regular donor to the United Nations World Food Program;⁴ and an active member of the World Health Organization.

But perhaps nowhere is South Korea’s commitment to global health, development, and human security more obvious than in its relations with its bellicose neighbor, North Korea. For the past decade, in the face of decades of North Korean threats, provocations, and even military action, South Korea has nonetheless remained either the largest or second-largest (behind China) donor of food aid to its northern neighbor.⁵ From 1998 to 2008, both bilaterally and through the World Food Program, Seoul donated an average of 300,000 metric tons of food to Pyongyang each year.⁶ After a brief suspension of aid donations in 2008, the Lee government started 2010 off with donations of food and health assistance, at the request of the North. Most recently, flooding in North Korea has exacerbated an already-catastrophic humanitarian situation, and this has prompted

1. See Korea International Cooperation Agency, <http://www.koica.go.kr/english/main.html>.

2. For more detail, see Korea International Cooperation Agency, “Health: Overview,” 2008, <http://www.koica.go.kr/english/aid/health/index.html>.

3. Global Fund to Fight AIDS, Tuberculosis, and Malaria, “The Global Funds Donor Governments,” 2010, <http://www.theglobalfund.org/en/donors/list/>.

4. World Food Program, “Contributions to WFP 2010,” 2010, <http://www.wfp.org/about/donors/wfp-donors/2010>.

5. See Mark E. Manyin and Emma Chanlett-Avery, *Assistance to North Korea*, Congressional Research Service Report to Congress R40095, March 2010, 20–21, <http://www.fas.org/sgp/crs/row/R40095.pdf>.

6. Ibid., 21–22.

more recent donations from Seoul to Pyongyang, including food, medicine, and construction materials.⁷

In Toronto, the G-20 agreed to adopt a multiyear development plan at the upcoming Seoul Summit. South Korea has stated its intentions, as the cochair of the G-20 Development Working Group meetings, to address both continuous and new development issues in the group's plan, which it is to have a hand in drafting. Its remarkable development experience may prove to be an applicable template for the plan as well. In 1988, Seoul was the host of the Summer Olympic Games; its historic opportunity to show the world its competence as a newly developed state. The G-20 similarly offers Seoul the chance to display its global development and health credentials, and to solidify its position as a leader in the global economic system.

7. Choe Sang-hun, "South Korea to Send Flood Aid to the North," *New York Times*, September 13, 2010, <http://www.nytimes.com/2010/09/14/world/asia/14korea.html>.

7

BRIDGING THE DIVIDE

SOUTH KOREA'S EMERGING ROLE IN GLOBAL HEALTH DIPLOMACY

Sudeep Chand

If the globe was compared to a village, the G-20 is the group of most influential villagers and Korea took the leadership.—SaKong Il, chairman of the Presidential Committee¹

South Korea has achieved considerable success in improving the health of the nation—balancing domestic success and international collaboration. It has a useful story to tell of private-sector-led development, with social protection measures in parallel that include access to health services. Notably, much of this development was done with only short- to medium-term inflows of official development assistance. Health is currently high on the domestic political agenda. Between 1993 and 2008, the annual growth in health expenditures per capita was 7.8 percent, almost double the average for the countries that belong to the Organization for Economic Cooperation and Development (OECD).²

South Korea's activity at the regional level has focused on pandemic preparedness and response. Thus, South Korea, China, Japan, and the Association of South East Asian Nations (ASEAN) held their first health ministers' meeting following the 2003 outbreak of severe acute respiratory syndrome. Collaboration continued in response to the H1N1 influenza pandemic in 2009. In addition, the health working group of the Asia-Pacific Economic Cooperation forum (APEC) has focused South Korea's regional activity on influenza and HIV/AIDS. South Korea also hosts the International Vaccine Institute, a UN-supported center focused on research, training, and technical assistance for vaccines needed in developing countries. This institute, which was established at the initiative of the United Nations Development Program in 1969, pursues innovative solutions to global health problems. Finally, the Joint OECD–Korea Policy Center develops data capacity and policy in cooperation with the Asian Development Bank, the International Labor Organization, the World Bank, and the World Health Organization. It fosters the exchange of policy experiences in areas such as health and social protection across the Asian continent.

At the global level, South Korea has emerged as the first country to turn from an OECD recipient to donor. In 2009, it tripled its commitments to official development assistance, which now constitute 0.09 percent of its gross national income, with further increases forecast to reach 0.25 percent by 2015.³ The Korea International Cooperation Agency is responsible for the management

1. "G20 to Tackle World's Financial Challenges," *Korea Herald*, October 11, 2010, <http://www.koreaherald.com/business/Detail.jsp?newsMLId=20101011000846>

2. OECD, "Health: Improving Health is Vital for Long-Term Growth," http://www.oecd.org/document/54/0,3343,en_21571361_44315115_46155446_1_1_1_1,00.html

3. Fidel V. Ramos, "South Korea: From War to Modernization to OECD to G20 Host in 60 Years," *Manila Bulletin*, August 28, 2010, <http://www.mb.com.ph/articles/274621/south-korea-from-war-modernization-oecd-g20-host-60-years>.

of this aid, with strong policy direction provided by the Ministry of Foreign Affairs and Trade. This agency, which was formed in 1991, has worked with Korean nongovernmental organizations in recent years to provide disaster relief in Indonesia and Haiti. Most of its aid has supported discrete health system projects, in particular the development of capital and human resources, provided to a mix of countries of strategic interest or health needs, such as Vietnam, Cambodia, Iraq, Jordan, Peru, Bolivia, Tanzania, and Kenya.⁴ Threats to health security and additional burdens to the domestic health system also loom large in the context of instability and malnutrition across the border in North Korea.

South Korea's experience hosting the Group of Twenty (G-20) means that "Global Korea" is displaying itself as a broker and leader internationally.⁵ In addition, in 2011 it will host the Fourth High-Level Forum on Aid Effectiveness, an international summit in which government and civic leaders from both developed and developing countries will assess ongoing efforts to make aid more effective. But it is likely that South Korea's own development experience will mean that it chooses to provide aid selectively and opportunistically. In particular, it is likely to engage globally on issues that have a wide relevance to high-, middle-, and low-income countries, motivated to create a secure and resilient environment for economic development.

The Seoul G-20 Summit

In preparation for the Seoul G-20 Summit, South Korea has brought development to the table. In itself, this is a considerable achievement; however, the likelihood is very low that it will be prioritizing health. The donor fatigue that followed the recent UN Millennium Development Goals [MDG] Summit and the replenishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria mean that South Korea will be wary of calls for more development aid. Even within the G-20 Development Working Group, health is nowhere to be seen. Instead, there is an explicit focus on what the G-20 calls the pillars of economic development:⁶

- infrastructure
- private investment and job creation
- human resource development
- trade
- financial inclusion
- growth with resilience
- food security
- governance
- the G-20 platform for knowledge sharing.

4. Korea International Cooperation Agency, "Health," <http://www.koica.go.kr/english/aid/health/index.html>.

5. "G20: Seoul Summit, 2010," http://seoulsummit.kr/blog/blogView.g20?boardDTO.board_category=BD11&boardDTO.board_seq=2010100000002541.

6. "G20 High-Level Development Conference," <http://www.g20development.org/eng/program.html>.

However, these pillars nonetheless present opportunities for improving global health. Some key determinants of health will be affected. Food, water, sanitation, education, and employment may benefit. And a focus on equity or “balance” will be necessary in the long term if health outcomes are to be realized.

Social protection is also an ongoing theme of the G-20 summits. In this context, the high costs of ill health, and associated health care and absenteeism, can undermine economic growth. Notably, the G-20 Toronto statement advocated the use of public health care as a way of strengthening social safety nets in the G-20 states. It may be that this is where South Korea may prioritize health in a limited fashion, given its domestic successes with the South Korean Temporary Livelihood Protection Program and Minimum Living Standards Security Act. It must be noted though that there is a particular narrative on the success of South Korea’s development that tends to overlook the protections that were put in place alongside substantial investment in education and private-sector employment. Moreover, given the intense discussions that are likely regarding issues such as currency fluctuations, it is unlikely that health will receive any substantive focus by the South Korean government at the Seoul G-20 Summit.

Beyond Seoul

The experience of hosting the G-20 Summit may influence South Korea in different directions. There remain risks before the Seoul Summit that the G-20 has overstretched its agenda. This may mean that South Korea will naturally focus on issues concerning global economic imbalances that are solely under the remit of finance ministers, shying away from global health issues.

However, a more progressive summit in Seoul may also be the start of new paradigm. South Korea may gain confidence as part of a new group of countries that promote an alternative consensus on development. A type of development may emerge that is more sensitive to the policy interactions among economics, the environment, and health. At a regional level, APEC claims that its leadership in the region and its wide-ranging economic work programs make it uniquely suited to address the multisectoral impact of health threats. South Korea may, therefore, be well placed to address the cross-disciplinary perspectives that require a focus on global health.

In the past year, the “ASEAN+3” health working group has focused on the dual burdens of infectious and chronic diseases. South Korea may have a strong role, given its domestic interests in health care reform, particularly in financing, human resources development, and technology.⁷ Also, with respect to the core determinants of health, South Korea recently signed the Nigata Declaration on APEC Food Security, recognizing that this is an issue for both human security and growth.⁸ Food security has also emerged as a potential priority for the forthcoming G-20 Summit, particularly with respect to the role of derivatives, exports bans, and agricultural infrastructure.⁹ Aligned with such concerns, South Korea announced a commitment of \$100 million to address food security at the UN MDG summit in September.

7. “Joint Statement of the ASEAN+3 Health Ministers Meeting,” Singapore, July 23, 2010, <http://www.aseansec.org/24936.htm>.

8. “First APEC Meeting on Food Security,” Niigata, Japan, October 16–17, 2010, http://www.apec.org/apec/ministerial_statements/sectoral_ministerial/food_security/2010_fs.html.

9. “G20 Summit to Tackle Global Food Price Issue,” October 14, 2010, <http://joongangdaily.joins.com/article/view.asp?aid=2927148>.

Close cooperation with France, the 2011 hosts of the G-20, should also mean that health issues become more of a priority for South Korea. In particular, the impact of noncommunicable diseases will no doubt have both domestic and international resonance. It is likely to encourage private-sector involvement in development, and innovative ways to fund the MDGs. The use of financial transactions taxes or solidarity levies in areas such as tobacco may be promoted by South Korea alongside a mix of G-20 states such as France, Brazil, and Japan. The institutionalization of the G-20, as well South Korea's promotion of a G-20 Business Summit, may provide a substantive platform for these activities in the medium term.¹⁰

At the Seoul Summit, health issues may receive more attention from South Korean diplomats as a result of their experience not only brokering negotiations among the G-20 nations but also providing outreach to non-G-20 nations. Thus, the inclusion at the summit of Malawi, as chair of the African Union, and Ethiopia, as chair of the New Partnership for Africa's Development, represents a dialogue with two states that have made health a key pillar of their own development. However, perhaps the last word should be given to the man organizing the summit, SaKong Il: "No country ever reduced poverty in an enduring manner without growth."¹¹

10. "South Korea Puts Development on Agenda for G20 Summit," *Guardian*, October 4, 2010, <http://www.guardian.co.uk/global-development/2010/oct/04/south-korea-development-g20-summit>.

11. SaKong Il, chairman of the Presidential Committee of South Korea, http://seoulsummit.kr/blog/blogView.g20?boardDTO.board_category=BD11&boardDTO.board_seq=2010100000002541.

8

GLOBAL HEALTH AND THE G-8/G-20 AGENDA AFTER SEOUL ASSESSING THE FRENCH PRESIDENCY AND ITS PRIORITIES

Heather A. Conley and François Delmas

When the original Group of Six countries—the United States, the United Kingdom, France, Germany, Italy, and Japan—met for the first time in Rambouillet, France, in 1975 to develop a strategy to mitigate significant global economic aftershocks of the 1973 oil embargo and recession, none could have imagined that, 30 years later, one of the group’s defining purposes would be to champion official development assistance (ODA). At the 2005 Gleneagles Group of Eight (G-8) Summit, then-British prime minister Tony Blair secured a commitment to add \$50 billion in new ODA over a five-year period to accelerate the achievement of the UN’s Millennium Development Goals (MDGs), thereby securing the G-8’s leadership role in the development sphere. At the 2010 Muskoka G-8 Summit in Canada, a five-year report card was issued on G-8 member-country ODA performance, and, though the G-8’s ODA commitments rose substantially, they fell \$18 billion short (in current dollars) of its original pledge. Aid for Africa, for example, increased by \$10 billion, but not by the committed \$25 billion. Moreover, performance among the G-8 members was uneven, as the United States and the United Kingdom largely met their aid commitments but Italy and Japan fell behind.

The G-8’s members have become particularly focused on the global health agenda as part of their broader ODA commitments. In 2008, the United Kingdom’s total ODA allocation to health was more than \$1.38 billion, making it the second-largest donor among G-8 countries. A new UK five-year global health strategy was launched in September 2008, which ranges from global health security to health systems, the effectiveness of international institutions, and trade. Germany, whose total ODA commitment to global health was more than \$956 million in 2008, joined forces with the United Kingdom in 2007 to launch an international health partnership that brings together bilateral donors, multilateral organizations, global health initiatives, and partner countries as well as players from civil society and the private sector. And finally, Canada recently launched the Muskoka Initiative, named after the Canadian city that hosted the G-8 summit, through which Canada pledged \$1 billion over five years to significantly reduce the number of maternal, newborn, and children-under-five deaths in developing countries. In 2008, Canada’s total ODA allocated to health amounted to more than \$630 million. At the UN Summit on the Millennium Development Goals held on September 21, 2010, Canadian prime minister Stephen Harper announced an increase in Canada’s contribution to the Global Fund to Fight AIDS, Tuberculosis, and Malaria, raising Canada’s contribution to \$540 million between 2011 and 2013.

France’s Global Health Priorities and Its Upcoming Presidency of the G-8/G-20

As a member of the G-8, France has increased its commitment to global health fourfold during the last decade. In 2008, it allocated \$1.046 billion, of which 75 percent was disbursed via multilateral

institutions, making it the third-largest contributor among G-8 members. France has been particularly engaged with the Global Fund to Fight AIDS, Tuberculosis, and Malaria, providing €1.5 billion, making it the second-largest donor after the United States. France is also the first contributor to UNITAID, and its €141.5 million donation in 2009 constitutes 60 percent of UNITAID's total budget.

As chair of both the G-20 and the G-8 in 2011, France will have a historic opportunity to simultaneously shape both entities' agendas and potentially broaden the focus on global health from beyond the G-8 to include emerging economies. Recently, President Nicolas Sarkozy unveiled his priorities for France's dual G-8/G-20 presidency, which places significant emphasis on a series of economic and political initiatives ranging from the reform of the international monetary system and the regulation of commodity markets to sweeping global governance reforms. Although global health was not mentioned as a priority per se in Sarkozy's announced agenda, he did suggest that the G-20 should include development on its agenda and create a G-20 secretariat that would be tasked with implementing G-20 initiatives.

Can the Global Health Agenda Migrate from the G-8 to the G-20?

As an international forum for coordinating economic policies, the G-20 has not been considered by its members until recently as a relevant framework for tackling larger development or global health issues. When it comes to making significant pledges and financial commitments to achieve the three MDGs devoted to global health (goals 4, 5, and 6), the G-8 has been the traditional forum. Historically, European countries have increased their aid in 2010, relying on multilateral institutions. Thus far, they have not indicated that they would decrease their ambition. They predominantly channel their contributions through United Nations-led initiatives, the World Health Organization, the multilateral development banks, and collaborative and highly visible initiatives such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and UNITAID. During times of great global economic duress, the international community turns to the G-8 to deliver on its aid promises. Despite the most severe global recession, the G-8 has pledged \$5 billion in additional funds.

By comparison with the substantive development role of the G-8, the G-20's added value is not obvious. The G-20 is presently too heterogeneous to share a common vision and agenda, and some G-20 members believe that they must continue to be consumers of, not contributors to, development assistance from the developed countries. However, this does not mean that there would be either room or relevancy for driving forward an agenda on global health issues in the G-20 framework, though the South Korean presidency's promotion of an up-and-coming "shared growth" agenda, including development issues, was well received by many G-20 members.

There are five key potential European trends to watch if or when the global health agenda begins to migrate from the G-8 to the G-20.

First, thus far, the impact of the recent worldwide financial crisis on global health programs has been limited, and European public support for overseas aid is strong despite the economic situation. According to a Eurobarometer report published in September 2010, 9 out of 10 Europeans favor helping people in developing countries, and European support for increasing development aid remains high, at 64 percent, in spite of a decline from 72 percent in 2009. Yet even with this support and in light of the lingering European economic crisis, a small group of highly motivated Euro-

pean donors may not be in a position to mobilize additional financial resources as they implement austerity measures to reduce their public deficits, some of which include freezing ODA budgets. *The trend of a steady increase in financial commitments is likely come to an end.* It is in Europe's and the G-8's interest to extend the group of sponsors to emerging countries as well as to their private sectors.

Second, facing the scarcity of resources, Europeans might promote measures to improve the cost-effectiveness and the overall efficiency of existing international assistance coordination bodies, whose management has occasionally been criticized. There may be calls for streamlining and reducing the number of global health institutions. If this does not occur, some European donors may rethink their multilateral funding approach and resume greater bilateral donor support to gain more visible recognition for dwindling assistance funds.

Third, France and other European countries have championed innovative funding. Since 2006, France has applied a financing airplane ticket levy that funds UNITAID. Europe will continue to develop new innovations (i.e., additional taxes) to continue to fund important initiatives. The G-20 could also be a relevant framework for promoting current and new initiatives.

Fourth, it makes sense to address the quality of pharmaceuticals, intellectual property rights, and equitable access to medicine beyond the G-8 members to include the G-20 framework. This expansion would certainly be consistent with the French thematic approach of globally seeking to strengthen health infrastructures, increase human resource development, address deficits of administrative capacity, and gain access to universal health care.

And fifth, in the case of an urgent global health crisis in 2010–2011 (e.g., a new pandemic influenza virus, H1N1, or SARS), the French leadership should be fully deployed to mobilize the G-8 and G-20 members both politically and operationally.

Conclusion

We are in the midst of an ambiguous, fluid transition involving both the G-8 and G-20. This transition will unfold in fits and starts, and the French G-8/G-20 presidency provides the opportunity to push this transition into the “start” position. During the next several years, incremental ownership of global health issues by the G-20 countries is a reasonable objective. The G-8's focus has turned to meeting existing commitments, measuring results, and finding important new development options that have high value and potentially lower cost. Yet despite this reduction in its overall ambitions, the G-8 will remain relevant in its role as a driver of international development and global public health for the foreseeable future.

With strong French encouragement, the G-20's agenda may indeed begin to embrace development, health, security, and climate change, but only *if or when* its leaders first see incentives to widen the agenda and decide to organize themselves (perhaps to create a permanent secretariat) that will transform the G-20 into a more coherent, deliberative body with clearer internal norms and accountability mechanisms. Finally, this transformation will require that the key emerging economic powers—China, India, Brazil, South Korea, Mexico, Turkey, and South Africa—reach a consensus that the G-20 is indeed the proper forum in which to pursue a broader global development health agenda. Despite France's ambitions, neither requirement has been met thus far. Although this transition's ultimate outcome is neither preordained nor conclusive in direction, it will be a dynamic process.



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