UNIVERSITY OF PAVIA

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HEALTH DIPLOMACY: AN EFFECTIVE TOOL FOR PUBLIC DIPLOMACY?

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I. CONTENTS

II. LIST OF FIGURES, IMAGES AND TABLES.

III. LIST OF ABBREVIATION AND SYMBOLS.

ACTs	Access to COVID -19 Tools.
ALBA	Bolivarian Alliance for the Peoples of Our America.
AMC	Advance Market Commitment.
AMR	Anti-microbial Resistance.
CMB	Cuba Medical Brigade.
COVID-19	Coronavirus Disease 2019.
COVAX	COVD-19 Vaccine Global Access.
FCTC	Framework Convention on Tobacco Control.
GAVI	Global Alliance for Vaccine Initiative.
GHD	Global Health Diplomacy.
G7	Group of Seven (7).
G20	Group Twenty (20).
HiAP	Health in All Policies.
HIC	High Income Countries.
HIR	Harvard International Review
HRF	Human Rights Foundation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome.
IO	International Organization.
IHRs	International Health Relations.
LMIC	Low Income and High-Income Countries.
MDGs	Millenium Development Goals

PAHO	Pan American Health Organization.
PD	Public Diplomacy.
PIP	Pandemic Influenza Preparedness.
PPE	Personal Protective Equipment.
SDGs	Sustainable Development Goals.
SARS	Severe Acute Respiratory Syndrome.
SSC	South-South Cooperation.
TRIPs	Trade Related Aspects of Intellectual Property Rights.
UHC	Universal Health Care.
UN	United Nations.
UNDP	United Nations Development Fund.
UNICEF	United Nation International Children's Emergency Fund.
UK	United Kingdom.
UPR	Universal Periodic Review
US	United States of America.
WHO	World Health Organization.
WTO	World Trade Organization.

IV. DECLARATION

I declare that this thesis is my work, and wherever I made used of the work and ideas of others – I have acknowledged them in quotations and references to the best of my knowledge.

Signature:

HASSAN HYDARA

V. ACKNOWLEDGEMENT

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VI. DEDICATIONS

I dedicate this thesis to my God, Allah (S.W.T) Glory be to Him, the Exalted for my life, strength, and wisdom, and acknowledge all His Favours on me, and academic journey in particular. I send salutation upon Muhammad (S.A.W.), the messenger of Allah, his family, and his followers.

I dedicate this to my family whose unconditional love and support I continue to draw strength on.

ABSTRACT (LINGUA ITALIANA).

Questa tesi esamina la diplomazia del settore sanitario come strumento efficace di diplomazia pubblica in grado di promuovere progetti di collaborazione interstatale inclusivi delle organizationi internazionali (IOs). La proliferazione delle piattaforme dei social media e della popolazione digitale ha collocato la diplomazia pubblica al centro di nuove tendenze nel settore della diplomazia fondate su un approccio critico ed efficace nel proiettare influenza fuori dai confini nazionali, nelle organizzazioni inter/intra-statali e presso le opinione pubbliche. In questo quadro, il candidato ha selezionato case studies che consentissero utilizzo e l'approfondimendo, delle tematiche discusse dalla letteratura sull'argomento e cercato risposte alle principali ipotesi di ricerca poste dalla tesi. L'integrazione della salute nella politica estera ha fatto sì che le questioni sanitarie si inserissero nella "politica alta" a livello internazionale/globale e, dal post-COVID -19, sono divenute parte integrante della sicurezza, delle politiche commerciali ed economiche collocandosi ell'agenda globale. Questa tesi pone in risalto, attraverso lo studio dei casi di Cuba e dell'OMS, l'influenza della diplomazia pubblica a livello internazionale nel settore della salute e le sue ricadute su stati, IOs e opinioni pubbliche.

(Translated using Deepl online translation).

ABSTRACT.

This thesis examines health diplomacy as an effective public diplomacy tool to promote collaboration in addressing common public health issues at the level of states and non-state entities. The surge in social media platforms or digital population has positioned public diplomacy at the core of critical diplomatic approach, effective in projecting influence over states, inter/intra-state organizations (IOs) and populations in general. The candidate applied a case study research approach to review and build on existing literatures with the purpose of searching for answers to the main research questions posed by this thesis. The integration of health into foreign policy has moved health issues into ‘‘high politics’’ within international spheres and since post-DOVID -19 it has integrated this sector into those of security, trade, and economy and, making it into a crucial item on global agenda. This research shows via the two test cases of Cuba and WHO through which public health diplomacy can be effectively projecting over receiving states, non-states and individuals.

INTRODUCTION

Traditionally, diplomacy is seen to be an activity solely conducted by governments and other public institutions who focus on mainly security, economy and trade however, now, diplomacy consist of both hard and soft issues hence, public diplomacy which embodies several phenomena in diplomacy such as health diplomacy, climate diplomacy, science diplomacy, cultural diplomacy to name a few – unlike other diplomatic approaches, PD targets both authorities and general population and is employ by states as well as non-state entities.

Scholars such as Gregory (Gregory, 2008, p. 276) define PD as: “means used by states, associations of states, and non-state actors to understand cultures, attitudes, and behaviour; build and manage relationships, and influence opinions and actions to advance interests and values” quoted in (SpringerLink, 2021). This definition which will be adopted as a working

definition or concept and closely paying attention to others as and when necessary. In his concept, he integrated the key actors of this research interest: state and non-state actors. Also, the key issues at hand, health, or medical diplomacy as they would use in relevant section in some sections of this work of course, under the greater umbrella of public diplomacy.

Similar concept layout by Gagnon (2012), formulate it as a two-step influence process: emphasizing on the sender, medium and the receiver, he noted first, an actor employs direct or indirect communication to create supportive public opinion in another state; and second, the informed foreign public influence its government to adopt a friendly policy towards that actor. PD has everything to do with soft power, a form of diplomacy and cooperation which is non–coercive, flexible, and inclusive approach. The targets go beyond states but also individuals and organization.

This research examines how effective health diplomacy is as a public diplomacy tool employ by states and non-states actors for both bilateral and multilateral cooperations in addressing health issues. The study will employ a case study method to examine the surging influence of health diplomacy using the Republic of Cuba and World Health Organization (WHO) as the cases for state and non-state actors of this study. The thesis is divided into three chapters in addition to the introductory framework section and conclusion – each chapter contains various subsections as necessary and consistent with the objective of the study.

The rationale behind the author's case selections are because the Republic of Cuba as a state actor, is one of the leaders in health diplomacy with history of over 5 decades of collaborating

and forming relations around the world through its medical missions abroad and medical training offered at home – World Health Organization (WHO), is the main United Nations agency established to coordinate global health issues, and equally has several decades of history in coordination, implementing and regulating global health issues.

Additionally, Cuba as a state actor and a member, has a smooth cooperation with WHO and has a history of active participation in the institution's fight against major global health emergencies such as Ebola epidemic in West Africa and recently concluded COVID -19 pandemic both of which Cuba responded swift and substantively to strengthen WHO fight against these health crises.

1.1. Research Objective.

To investigate the increasing integration of health into foreign policy and global agenda in international organization, and to unravel the effectiveness of health as an effective tool for public diplomacy.

1.2. Research Questions.

This thesis aims at providing answers to three main research questions:

a) Whether public health issues can generate successful health diplomacy initiatives?

b) How international organisations (IOs) have or have not the capacity to shape the global health agenda?

c) To what extent has health issues been integrated into foreign policy?

1.3. Hypothesis.

Health diplomacy as a component of public diplomacy can facilitate the projection of state and international organization's (IO) identities and initiatives.

1.4. Scope of the Study.

This study is intended to explore the integration of health into foreign policy and public diplomacy in a global institution. Although, the literatures on global health and public diplomacy, including the exercise of soft power is vast within the field of in international relations however, I would limit this study to global health in relation to diplomacy and international relations. In light of the uncovered results, I would draw conclusion on whether health diplomacy is an effective tool in public diplomacy and global health initiatives.

1.5. Methodology of the Study

This research adopts a case study design to analyse secondary materials surrounding the topic. A case study is an appropriate methodology for in-depth study or investigation with the aims to build understanding about a phenomenon or issue (Yin, 2004, pp.13-24) quoted in Baxter and Jack (2008, p. 545). According to Yin (2009, p.18), quoted in Gagnon (2010 p.130-132) it is highly an appropriate research method when 'how' or 'why' questions are being asked about a contemporary set of events or issues over which the researcher has little or no influence, as is the case in this study.

Additionally, this study adapts the criteria outlined by (Curtis et al., 2000), for purposive case study selection is used as a guide to the case selection of this study. These measures include relevance to the conceptual framework, research objectives and research questions; with potential to generate quality information about the phenomenon being studied; ability to derive lessons learned for other contexts.

Moreover, scholars such Creswell (1998), argues that case studies look at individuals or organizations from simple through multiple or complex interventions, relationships, communities, or programmes perspectives of key actors that help to establish a comprehensive understanding of experiences and outcomes in a specific case (Creswell, 2014 p.241). Moreover, to highlight a key strength of this case study method is that it can incorporate in one way to enhance the rigour of the research results and achieve a more complete representation of context through the use of multiple methods and data sources (Farmer, 2006, p.3).

1.6. Literature Review & Theoretical framework.

The literature review of this study is focus on materials on health diplomacy as a public diplomacy tool, and its influence on bilateral and global collaboration with the aim of supporting and informing the main research question in this study: Whether public health issues can generate successful health diplomacy initiatives? Health diplomacy and the level of integration into foreign policy. Also, the internationalization of health issues within the sphere of global health, whether public health issues can generate successful health diplomacy initiatives? And how international organisations (IOs) have or have not the capacity to shape the global health agenda? Literatures relevant to the main case study and each of the background cases will be review and their content will be categorized and feature into various chapters for this study.

Health diplomacy can be a product for various diplomatic practices either in bilateral diplomacy and/or multilateral diplomacy. First, it is important to give a contextual framework or background to public diplomacy (PD); the effort to find some order, direction, and research

agenda in PD has been very frustrating because it has been marred by confusing terms, definitions, methodologies, and research questions. This is not unusual for a new multidisciplinary scientific field that must integrate theories, models, and ideas from several disciplines (Godsin, 2014). But in PD this conceptual chaos seems to have been more severe and challenging than in the development of other disciplines or subdisciplines in the social sciences. Still, a definition of the core concept acceptable to most scholars in any scientific field is needed to advance both research and practice and it is important to highlight some of these definitions and for the purpose of this study at to adopt a working definition.

Some scholars of PD have suggested that it is still a fussy concept that many actors use in quite different ways for quite different purposes and tasks. Literally, the study of PD begins with a different definition of the phenomenon. It appears that 30 years ago, Signitzer and Coombs (1992), PD experts, offered the first modern definition of PD as "the way in which both government and private individuals, and groups influence directly or indirectly those public attitudes and opinions which bear directly on another government's foreign policy decisions" (Signitzer and Coombs, 1992 as cited in Marschlich, 2022 p. 2).

Additionally, Sharp defined PD as "the process by which direct relations with people in a country are pursued to advance the interests and extend the values of those being represented" (Sharp, 2005, p. 106, as cited in SprinkLink, 2021). PD is also defined as "is used by states, associations of states, and nonstate actors to understand cultures, attitudes, and behaviour; build and manage relationships; and influence opinions and actions to advance interests and values" (Gregory, 2008, p. 276, as cited in AAPSS, 2008). And Cull, proposed a much shorter definition PD "is one of the ways in which an international actor seeks to

manage the international environment" (Cull, 2008, p.6). Gregory's definition may be too long for some, and Cull's wording may also be too short for others. Most PD scholars agree at least on the main characteristics of PD: actors, goals, and process (Gilboa, 2016, p. 72).

For this research, Gregory's definition will be adopted as a working concept and closely paying attention to others as and when necessary; for his encompasses the main objective of my research: state and non-state actors. Also, the main issue at hand health or medical diplomacy as they would use interchangeable in some sections of this piece of course, under the greater umbrella of public diplomacy.

PD is a broader concept with layers of approaches which indicates a double-faced flow of influence as put forward by Gilboa ''first, an actor employs direct or indirect communication to create supportive public opinion in another state; and second, the informed foreign public influence its government to adopt a friendly policy towards that actor. PD is designed to bring about understanding for an actor's ideas and ideals, its institutions and culture, as well as its national goals and policies'' (Gilboa, 2008, p.1). PD has everything to do with soft power, a form of diplomacy and cooperation which is non–coercive, flexible, and inclusive approach. The targets go beyond states but also individuals and organization.

The definition of health diplomacy like many new disciplines is faced with unanimous or contested definitions among scholars however, they appear to converge on key points, as recognized in World Health Organization (WHO) framework. An example, of such definition forwarded it as ''a means to better health security and population health; to improved relations between states and a commitment of a wide range of actors to work together to

improve health; and achieving outcomes deemed fair and supporting the goals of reducing poverty and increasing equity'' (Mclnnes and Lee, 2006, as cited in DiPLO, 2023, pp 1-4).

States engage with other states and organizations based on their foreign policy goal through a well-defined and established practice in other words through diplomacy – upon this reality that states elevate and relegate issues in its foreign policy base on time and context. Since the turned of the millennium, health has become a major concern to the world warranting its integration into MDGs and SDGs and a critical item in global agendas. Some countries took this alert and elevated health issue in their foreign policy and engaging with partners through it.

CHAPTER ONE

1.1. Health Diplomacy: An Effective Response to Global Health Threats?

As the saying, "most things exist before they are named." (Murphy, 2014, p.23). The term health diplomacy (HD) or global health diplomacy (GHD) has come to inhabit political discourse within and across borders with increasing persistent since the end of the Cold War 2 in the 1990s, the beginning of the new millennium particularly in international technical documents and world scientific literature. To begin with, it is necessary to put forward some key definitions by scholars in this field to create working definitions and ease comprehension of terms and concepts whenever substituted and interchangeably used. For this purpose,

health diplomacy, Global health diplomacy may sometimes be use together, interchangeable, and independently.

Health diplomacy is a diplomatic approach that focuses on advancing health issues and the general well-being of people in the targeted geographical area or national borders (DiPLO, 2023, pp. 1-3). It involves using health-related issues to build relations, foster cooperation, and promote peace and stability between countries (GHP, 2013). Health diplomacy integrate health into foreign policy and global agenda. At various levels, it brings together a variety of participants in areas that affect public health all around the globe (GHP, 2013). This was evident in various global health emergencies and most recent, the COVID-19 pandemic which has test health infrastructures of individual countries and the global community. Health ministers, foreign ministers, financial ministers, and global health institutions.

Kickbusch and Liu highlighted in their recent publication with Lancet that in the field or discipline of international relations (IR), the inter-relationship between political entities, primary between states, and by extension critical international actors such as international organisations were more debated. Historically, IR theorists were focused more on war, peace, security, and political economy as the dominant issues of interest in an anarchical international global system in which states operate. The issues of global health system have not received enough attention it deserves even though the threats from transnational nature of many health-related risks arising from rapid increased flow of goods, capital, services, people, technology, and information in the context of globalisation, along with the increased interconnectedness and interdependency in the world, have always being there (Kickbusch and Liu, 2022).

Some international relations and global health scholars have discussed health diplomacy through the lens in relation to other non-coercive approaches such as soft power, or disaster diplomacy a topic which I would discuss in detail in the following chapter though slightly different term. These scholars point to the efforts of global health diplomacy in improving relations between countries and contributing to peace and security. On the other hand, public health advocates might argue that health should not be used for political purposes, but in an interdependent world, few initiatives serve a purely humanitarian objective (The Lancet, 2022). This position seems too pessimist to me because diplomacy has lot to play in the promotion of health across borders and in global fora in fact, arguably without diplomatic efforts, integration of health into foreign policy, global health would struggle to stay this relevant in view of (Fourie, 2024, p.9).

According to Ariansen, global health has attracted substantial global attention, spurred by hopes of its potential to progress the goals of public health and/or foreign policy. The former World Health Organization (WHO), Director-General Margaret Chan declared Global health as heralding a “new era,” while Alcazar wrote as a “radical mind shift” in how we think about health. Others have defined GHD as a “new educational field” which I disagree because integration of health into foreign policy does not change facts about it nor does it change foreign policy engagement rather, it enriches it foreign policy products and create a wider platform for health and it related issues. Amid this enthusiasm, use of the term has been characterized by considerable diversity (Ariansen et al., 2017, p.24). This has made its precise meaning and claim about its contribution to public health theory and practice difficult to assess. Health diplomacy like many new disciplines face a challenge of an agreed definition

and sometimes this extends to it impacts on existing knowledge or sector of which it evolved from and/or strongly associated with.

GHD focuses on international negotiations and agreements on health-related issues, which embodies a various processes and procedures to reach agreements between bilateral and multilateral actors. Actors which actively participates in global health affairs be it donors or recipient countries, and whatever level of their participation in the processes of making binding and non-binding international agreements in health or related to health (Almeida, 2020). The internationalisation of health issues and foreign policy and relations in the promotion of health and global health institutions and their implementation of health regulations and agreed frameworks which have boosted the level of confident in cross border travels.

One of the main debates on global health diplomacy is the dynamic relationship between health and foreign policy tool and foreign policy serving health goals. Health diplomacy carries a unique badge in that it has managed to bring different stakeholders together with a clear goal of fostering cooperation and collective efforts to take on epidemies that pose threat to our commonwealth. In addition, it has attracted from difference countries and serve as a common goal in collaborative research, public health initiatives, medical exchanges, and emergency response efforts (Scott, 2023, as cited in DiPLO, 2023). GHD is often use to monitor and manage and control infectious disease outbreaks, health threats emerging from environment, and other chronic diseases. The COVID-19 pandemic has ticked all those boxes and as unfortunate as it was however, it has created an environment for cooperation of

mutual benefits through the use of health diplomacy initiatives in addressing public health issues (Onyeaka, 2021).

In the work of (Almeida, 2020), he argues that health diplomacy is a process through which actors shape health policies and regulations or frameworks which states, inter-governmental organizations or non-State actors used in engaging and negotiating responses to collective health challenges. They utilize health frameworks or mechanisms as a guide to for all stakeholders who projecting influence in negotiating strategies to achieve other political, economic, or social objectives across borders and global institutions.

Everyone is a stakeholder in public health hence, it is attracting difference perspectives from difference actors: states and non-states actors and other interest groups. The interaction between stakeholders of public and global health issues are relevant in politics for various reasons including the purpose of representation, bilateral and multi-level cooperations geared towards resolving existing barriers for improving health systems, and infrastructures necessary in securing rights to health for all particularly, vulnerable populations (Lee and Smith, 2011, p.1). Although there are Globalisation is increasingly breaking sovereign borders and tying economies and people together. This has made health a global issue for many reasons key among is the movement of people across borders, which meant moving with their health conditions. This makes everybody vulnerable to a major disease outbreaks like pandemic.

Additionally, in 2007, a group of foreign ministers from seven countries developed and developing met in Oslo and agreed to collaborate on health issues and make a point of

departure as well as laying out strategies to address global health challenges through the lens that these countries would use to monitor key elements in their various foreign policies and development strategies. They would consult and engage in broad dialogue on how to deal with policy options to cater this agenda (Fourie, 2013). This initiative was quite significant and farsighted, but it was not the first of its kind or so-called 'a point of departure' in pushing health agenda into foreign policy even though it was not a high politic as it is the case for economic and security issues.

Furthermore, it could be argued that the beginning of the 21st century, health diplomacy moved centre stage as WHO played an increasingly active role in international politics, and its role as a norm-setter in global health was strengthened. The world has clearly entered a new era in the development of global health diplomacy especially during the recently concluded COVID-19 pandemic which has led to a lot of diplomatic activities on global health by virtually involving all heads of state and heads of government during a period when multilateralism is subject to substantial challenges. Many public health advocates want to see a concerted international response to the COVID-19 pandemic, as was the case two decades ago for the HIV and AIDS pandemic (Buse, Tlou and Poku, 2020, pp. 1)

Moreover, looking back at the changes in global health diplomacy over the past two decades informs us how international relations can contribute to policy making in the future. A post-Westphalian system. The COVID-19 pandemic is generating increased interest from international relations scholars on health diplomacy and is showing us that some of the conceptualisations and critiques of global health diplomacy in the first two decades of this century do not hold up, for various theoretical or methodological lapses. The emerging

phenomenon in world has changed to an extent which were never imagine in academic discourse, neither in global health nor in international relations. The challenges facing the world has forced new generation of diverse scholars—not burdened by the old models in international relations or global health—to conduct in depth empirical research and develop new international relations concepts and theories to inform global health diplomacy (Fazal, 2020, p.79).

1.2. Integration of Health into Foreign Policy.

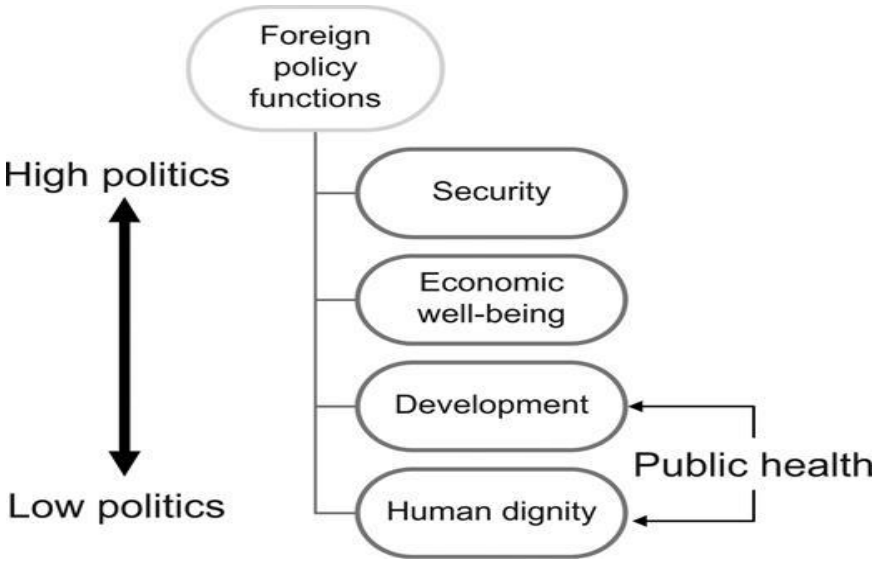
The term ‘‘Population health has’’ has supplanted the concept of public health as quoted in Labonte et, al. (2005, pp. 5-17) which was the health promotion in many Anglophone countries and of course legacies of nineteen-century public health radicalism, Latin America social medicines and social epidemiology. However, these approaches were accused for lack appropriate conceptual to pave the way for a new field or even a subfield to inform foreign policies and global agenda.

According Fidler (2007), among the reasons public health was on a low politics in foreign policy especially, during the 20th century was because many states at the time were faced military threats to their existence and diplomacy rife with political and ideological hostility between the two competing camps in the cold in the cold, and how to organize economic systems, how political and economic development should proceed in developing countries and what constituted human rights.

Fidler, an expert in foreign policy and international relations frequently discuss these functions within a hierarchy of objectives for foreign policy from high politics (security and

economy) to low politics (health and culture). Traditionally health has been categorized as low politics because health activities were perceived as technical, scientific, non-political, and humanitarian endeavours not connected to the high politics of foreign policy. Health was perceived as gravitating toward normative values concerned with human dignity and having less relevance to the state's pursuit of its material interests, power, and security (Fidler, 2007).

Figure. 1.1. Traditional hierarchy of foreign policy function.

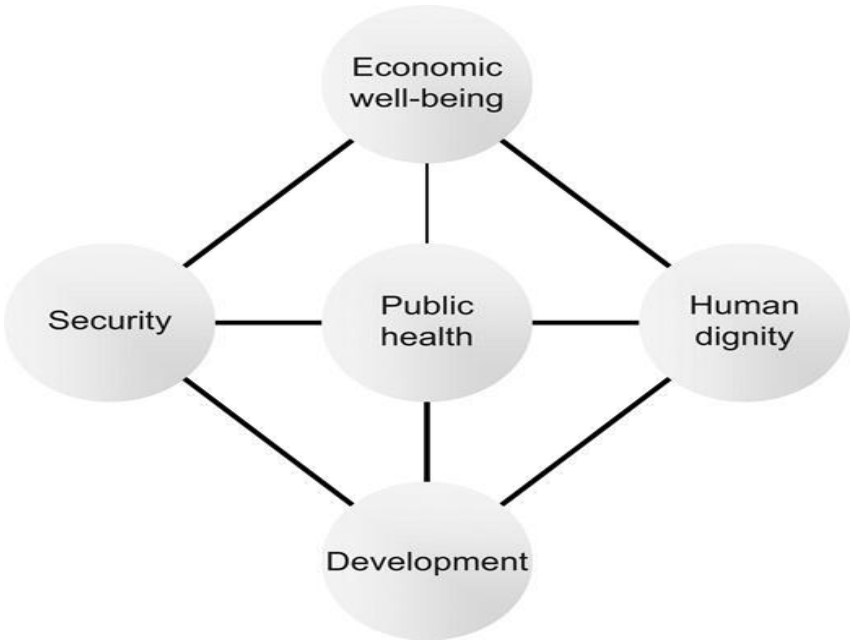


Source: Fidler, (2007).

The figure above shows how foreign policy hierarchy has been traditionally; security in its traditional sense top the ranking which is a demonstration of the realist nature of states in

international system followed by economic well-being which has a great relations with security and last on the hierarchy of foreign policy is the Development and Human Dignity which health is a part of hence 'low politics' however, health especially public health is beyond the traditional categorization as Fidler and other scholars categorized rather health is part of security as we have witness the recent COVID -19 pandemic which pose threats to all countries and territories which led to the recent rise of health issues in foreign policy.

Figure. 1. 2. Public health as an integrated public good (Fidler, 2007).



Source: Fidler (2007).

Based on the above figure 1.2., health is no longer a low politics issues in foreign policy no is it limited to a specific sector in the foreign policy projection rather public health has integrated into foreign policy as a public good, making it the business for all and arguably the centre of all other foreign policy products, a permanent item in goal agenda and diplomatic practice especially in multilateral institutions.

Seemingly, global health has now integrated into the foreign policy of many countries especially rich western countries and pockets of Southern countries like Cuba, China, and global agenda on IOs (Kickbusch et al., 2021, p.10), notably in relation to economic and social development, security, humanitarian affairs, social justice and human rights, and global crisis management. The number of multilateral health negotiations, instruments, organizations, and venues has increased significantly. Health is now part of global negotiations related to food, climate, energy, and water, and is discussed at major global and regional summits (Kickbusch et al., 2021).

Additionally, Klein and Marmor argue that foreign policy is not all about politics, security resolving conflicts about resources, rights, and morals. Although separation of foreign policy from politics would be an impossible task because foreign policy is directed by politicians as head of states and governments. Foreign policy formation is derived from politics and political process to some extent and is usually considered to include the following stages: agenda setting and specification of alternatives from which a policy choice is to be made; policy formulation; policy implementation and policy evaluation (Schreeker, Labonte, De Voglio, 2005).

Overall, health prominence in foreign policy as demonstrated in the EU health initiative, US health desk, UK health strategy and that of other countries such China, Canada and Cuba reflects the rise of health from the margins of low politics into a situation in which health features significantly in all four foreign policy functions. The discursive framing of global health (i.e. health as security, development, human right, commodity and global public good, described later), and other bodies of literature that analyse health's relation to national security, globalization and the protection and promotion of human dignity, support the claim that health is figuring more prominently across foreign policy priority areas (Kickbusch, Austin and Liu, pp1-4).

Schreeker, Labonte, De Voglio, (2005), argues that these developments signify the movement of health from low to high politics, but understanding what this means for health and foreign policy, and how health is positioned and understood within foreign policy, remains unclear. Fidler proposes three conceptualizations to clarify and explain this phenomenon further that can be applied as a framework to help understand why the UK and other countries' global health strategies were developed, and how health is positioned within these strategies.

The first conceptualization of global health diplomacy or the integration of health into foreign policy has given a facelift to health. This perspective argues that health's increasing role in foreign policy is transformative of the health-foreign policy nexus. Health collapses the traditional distinction between high and low politics and provides new political space in which health is an overriding normative value and the goal of foreign policy (Labonte & Gagnon 2010, p.6-14). The rise of conceptualization and integration of health into foreign policy is not a new phenomenon however, the recent surge is believed to be the persisted threats from

disease outbreaks which was among the key motivation for the adoption of Millenium Development Goals of 2000 which position health or global health as an important item in the agenda of the goals. What was perhaps missing was the how urgency it has now on the global agenda whether it is health and environment, climate change, migration and so forth but health remains.

This has extended the scope of foreign policy beyond traditional preoccupations with security and economy to a wider phenomenon including but not limited to health. Health and health equity become pre-eminent political values for the 21st century. Additionally, the theory or concept is consistent with health discourses in recent decades focusing on health as a human right and the 'health for all' a serious slogan thanks to the recent pandemic (McCoy, Roberts, Daoudi, et al. 2023, p.1).

Moreover, it has risen as a foreign policy issue because it impacts on the high politics of foreign policy and threatens the material interest and capabilities of the states, especially in globalisation. Health is not only about communicable diseases and attention paid to it is primarily crisis driven or ad hoc. It is not about upstream determinants of health; and the target of foreign policy is not health but mitigating risks and costs of certain infectious disease burdens in other countries (Fidler, 2009). This initiative significant in the recently concluded COVID-19 pandemic when rich and developed countries were busy closing their borders and scrambling for vaccines for their people – COVID -19 exposed them to the moral dimension by mutating and coming in waves: First Wave, Second Wave, Third and Fourth Wave. Consequently, health experts call for global solidarity with the argument the slogan 'no country is safe until every other country is safe.'

As Bekker, alleyne et al., (2018) notes, ‘‘for the global ravages of HIV/AIDS, the fear produced by SARS, the framing of tobacco-and obesity-related diseases as pandemics, and the panic associated with the emergence of pandemic influenza, health would not have its present foreign policy prominence’’. When improving health or health systems in foreign countries is an intended consequence of foreign policy action, the strategic objective is usually something other than health in keeping with the traditionally narrow view of foreign policy. They argue that like many diplomatic products, health is merely a tool, an instrument of statecraft that serves the material interests of the state. The health and foreign policy combination pessimist perspective may acknowledge health’s escaped from the domain of low politics, but they simply interpret this as health becoming another issue like others that foreign policymakers need to grapple with. The continued application of the traditional framework for foreign policy remedies the mistaken notion that health has a special place in international relations. Health as a foreign policy issue competes for attention among many other such issues including prominent global issues such as climate change and environment, migration, and economic crisis (Bekker, alleyne et al., 2018)

Other significant developments in this history include growing prominence of and different framings applied to health on countries’ foreign policy agendas in the 2000s, followed by substantial funding for global health (Fidler, 2013 p.693). Health issues has taken a centre stage in global affairs since the turn of twenty-first century and this was manifested in global programmes such as the Millenium Development Goal (MLDs), succeeded by the Sustainable Development Goals (SGDs) where universal health coverage and access to quality and affordable healthcare is prioritised. This development prompted some countries into

integrating health into their foreign policy, diplomatic relations and some missions even have heath attaches though their role has little to do with global health aspiration except for Cuba which has been a global leader in integration of health in her foreign policy with global view, especially in the global south.

1.3. Globalization of Health Issues.

The recent surge of interest in health especially, global health has been a remarkable global health diplomacy (GHD). Official GHD offices have been established at the World Health Organization (WHO) and at the U.S. Department of State, and offices within governments of many countries now have a broad set of new GHD responsibilities (Michaud and Kates, 2012; Goosby, 2012). Additionally, broader efforts were made for collaboration in early warning and the issue of patten in the vaccine production and mass production during crisis.

Academics have been having discourse on the subject and more than 70% of all peer-reviewed journal articles on GHD since 1970 were published in the last decade, according to a recent analysis. While international engagement on health issues has a history that extends back to at least the 19th century, the renewed emphasis is notable (Katz and Kornblet, 2012). This open the space for a thought-provoking question such as what is driving this interest in GHD, and support for it, and what might it imply for the current and future practices of global health?

Perspectives differ as to whether GHD is driven primarily by global health or foreign policy aims. Global health proponents, for their part, have mostly characterized GHD as a unique opportunity to raise the policy profile of global health. They perceive tying health issues to foreign policy and diplomacy as a recipe for more attention and resources. For example, the

current WHO Director-General has described the new focus on diplomacy as a signal for new era for global health, (Chan, 2011). Arguably without the serious diplomatic efforts most global health successes would have been difficult if not impossible. The debate should have been on how to strengthen the integration of health into foreign policy to match the new prominence of globalisation else it would be followed with no so positives health consequences. More health practitioners should be sent into diplomatic service as health attaché to enhance the capacity of foreign policy practitioners with sufficient knowledge on health for effectiveness of health diplomacy.

There are many politicians and foreign policy practitioners who emphasize how support for health programmes can help achieve foreign policy goals through the application of soft power to exert influence. Sometimes, these two different viewpoints may align however, there are many examples where they do not converge – with foreign policy actors more inclined to economy and national security goals often placing global health as middle or low politics (MSF, 2011). This practice is however, evolving into a more inclusive approach as modern security is seen to encompass, food self-sufficiency, human health, and environmental issues.

Given contemporary trends, we might expect that this would continue to grow in importance however, to ensure international engagements on health and foreign policy are truly a win-win, both foreign policy practitioners and global health proponents need to engage more substantially. In an increasingly interdependent world, it is in the long-term interests of every country to have safe, prosperous, and healthy populations in partner countries, and the diplomatic community would do well to recognize that the global health agenda is a strong tool to achieve these goals (Michaud & Kates, 2013, p.8).

Although the integration of health into foreign policy, the combination of health professionals and foreign policy practitioners or politicians has been perceived as a ‘‘new era’’ for progressive politics and globalization of health however, scholars such as Chan, Store, and Kouchner are critical whether such engagement would lead to a marriage in view of the clouds surrounding it i.e. whether this integration is primary driven by foreign policy, global health or both. The current Director General of WHO, Dr Tedros Adhanom Ghebreyesus viewed this new focus on diplomacy as significant and signalling a ‘‘new era’’ for global health, also some politicians and foreign policy practitioners emphasized how this integration of health in foreign policy is important for the application of ‘‘soft power’’ to achieve foreign policy goals (Chan et al., 2008).

Global health experts could make significant efforts to collaborate and engage with foreign policy practitioners in other words, diplomats well informed about health issues and by clearly drawing the link between these activities and the broader policy objectives of foreign policy. Global health scholars have additional opportunities to seek more visibility and to push for a seat at the table within the context of a broader set of international diplomatic issues with potential health implications such as climate change, migration and human trafficking (Michaud & Kates, 2013 p.24).

According Berridge, the new millennium, 21st century there was a growing fear in medical circles that pandemics would likely to be more frequent and aggressive and he believes this was due to among other things including but limited to increased global interconnectedness. The Severe Acute Respiratory Syndrome (SARS) pandemic of 2003 had sounded a particular alarm. He argue that despite the fact that this was followed by a flu pandemic in 2009, two years later only four countries with missions in the United States of America had diplomatic

officers with full-time health responsibilities (two attachés and two counsellors); and in 2014 (the year of the Ebola epidemic), the USA itself had only eight full-time health attachés posted abroad – five by the Department of Health and Human Services (HHS), two by the Pentagon, and one by USAID (Berridge, 2020).

Additionally, he argues that in assessing embassies in London, according to him as per May 2020, only those of Canada, Iraq, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates currently have a health or 'medical' attachés. He argues most of those concerned with regards to administering the personal health needs of their citizens resident in, or visiting the UK, then with global health diplomacy. This is certainly the case of Qatar, and it is something of a giveaway that the office of the UAE's medical attaché is in Harley Street, famous for its high class, private specialist clinics (Berridge, 2024, pp.5-8).

Moreover, Berridge argues that there are practical reasons for the scarcity of genuine health attachés in the world's embassies, among them are the absence of a clear career pathway for health or medical professionals, which makes the position unattractive to many qualified personnels – and who are in high demand and needed elsewhere especially, public health emergencies such as pandemics. It appears however, that the scarcity of health professionals in foreign service beside other reasons – are the rise of many populists led governments – their attitudes towards global governance frameworks, their pre-occupation with nationalist agendas, and their tendency to disregard diplomacy in general (Berridge, 2024 pp. 2-5).

Furthermore, I believed absence of health officers in embassies could also be attributed to huge gap of doctor deficit or poor health personnel in ratio to the population especially in developing countries where medical or health practitioners are in short supply, coupled with

insufficient health coverage for their population, the significant resource deficit to take care of the people in these countries. Therefore, it I am of the believed that these contributed to the little or lack of representation of health officers in embassies and other foreign missions. Developing countries are faced with hard choices to send their qualified health officer into foreign missions or keep them in their countries. Regardless of the choices, health experts are never enough at home or abroad however, that may be a limitation it should not continue to hold the progress of integration of health and health professionals into foreign or diplomatic missions abroad for effective early warning signals.

These and many reasons necessitate, the rapid integration of health into foreign policy of states, and on the agenda of global institutions to promote global health and foster cooperation among State actors and non-State actors. Health diplomacy provides opportunities for even adversary states to cooperative for common interest.

CHAPTER TWO

2.1. Cuban Revolutionary Health Diplomacy.

In the early days of Cuban revolution, in 1959, the Island country has made health a national priority putting forwards initiatives like public, universal and free system, subordinating economic considerations to the imperative of public health, Lamrani (2021) argues with an annual investment representing the largest share of the national budget. Based on prevention and the concept of the "family doctor," it has improved the inherited poor system and enabled the population of the island to enjoy a level of health protection unique in the developing countries in fact, comparable to that of the most developed countries. Additionally, the World Health Organization (WHO), the Pan American Health Organization (PAHO), the World Bank, among others, as well as the medical journals such as The Lancet, Science and The New England Journal of Medicine have all praised this system and present it as the model or better described as the Cuban Model to be followed for developing countries.

The country has rolled out a universal health care as a basic right for its population and a cardinal responsibility of the state. The revolutionary government soon took the ideology further and with the establishment of National Health System that, over period and of course, through trial and error managed to standout as one of the entrenched and effective health systems not just in the global South but even in the global North. This approached or system has developed into a model lauded by many international health experts and institutions such as World Health Organization (WHO). According to Feinsilver, the Cuban health system has manifested key health indicators such as least infant mortality rate and more life expectancy at birth which is comparable to those of the United States, even though there is a vast

difference in the scope of their economy and infrastructure available to the small island country (Feinsilver, 2010, p.87).

It is worthy of noting that during the same period of despite its economic difficulties, Cuban revolutionary government has had an international dimension for its universal health ideology. Cuban since the inception of the revolution has a keen interest in South-South Cooperation (SSC) and has been a key player and advocate for the transfer of knowledge, technology, and best practices. It has viewed the internationalisation of health as responsibility, a debt of revolution for the support it received from the global South, and this has motivated it medical aid programme as a contribution on its part to the developing countries.

Additionally, this policy in place as early as 1960s though, not the scale and quality it is known today. In 1960, they government sent its first medical mission to Chile during the major earthquake – Feinsilver, added that, three years later, and with the U.S. embargo in place, Cuba went further with its ‘‘first long-term medical diplomacy initiative by sending a group of fifty-six doctors and other health workers to provide aid in Algeria on a fourteen-month assignment.’’ Since then, Cuba has expanded the medical assistance to more than one hundred countries throughout the world both for short-term emergencies and on a long-term basis. Moreover, Cuba has provided free medical education for tens of thousands of foreign students in an effort to contribute to the sustainability of its medical assistance. This is to transfer the responsibility of providing medical assistance to the citizens of those countries to shape their own future.

According to Baggott and Lambie (2018), since it first international health intervention in Chile, Cube then expand it intervention, many more countries have benefited from Cuban health missions, first as ad hoc mission in 'Peru (earthquakes, 1970 and 2007), El Salvador (Dengue fever outbreak, 2000; earthquake, 2001), Nicaragua (earthquake, 1972; volcanic eruption, 1992; intense rains 1991), Guatemala (hurricanes, 1998 and 2005), Haiti (hurricane 1998; earthquake, 2010), Honduras (hurricanes, 1974 and 1998; intense rains, 1999; earthquake, 2009), Venezuela (torrential rains and mudslides, 1999),' and beyond The Americas, its health missions in Indonesia and Sri Lanka (tsunami, 2004), and Kashmir (earthquake, 2005).' These interventions were slowly but significantly sending message of Cuba's foreign policy trajectory and the need to open doors for collaboration and recognition even in the face of United States hostility.

Cuba's health or medical diplomacy first started a way of resistance towards US, and it pressure on the Island for her alignment with former USSR during the Cold War, during this period most of the international dimensions were influence by the bipolar divides and South-South Cooperations however, this approach took a different dimension post-Cold War period.

Feinsilver in his writing argues that even in the 1970s and 1980s Cuba has larger aid programme in a form of civilian particularly, health diplomacy, than it most developed or advanced trade partners: the former Soviet Union and China. The health workers in a form of aid constituted 19.4 percent of the entire medical aid provided by these countries. This according to him generated a considerable symbolic capital as renowned political and IR scholar Professor Joseph Nyre classified it as 'soft power.' Cuba went on to enjoy political backing in the UN General Assembly and other regional and bilateral relations.

Cuba's health diplomacy initiatives group into two: short-term and long-term. It is important to note examine these groups into order to understand in depth the motive and impact of these initiatives that Havana deploy in its foreign policy. Feinsilver (2024) argues that even the short-term plans, there are some with a long-term goal. He categorized Cuba's health diplomacy initiatives into two groups as listed in the following:

1. The disaster relief component.
2. Epidemic control and epidemiological monitoring which the country is actively doing.
3. The on-the job training for health professionals to improve their skills.
4. Direct provision of medical care in Cuba to strengthen its own health care system.
5. Health system organizational, administrative, and planning services.
6. Donation of medicines, medical supplies, and equipment.
7. Vaccination and health education campaigns.
8. Program design for human resource development and for the provision of specific medical services.
9. Exchange of research findings and knowledge transfer through the sponsorship of international conferences and the publication of medical journals (Feinsilver, 2024 as cited in Feinsilver, 2010).

Feinsilver further highlighted the long-term health initiatives of Cuba's health or as some scholars put it medical diplomacy, and he categorized them into the following list:

1. Direct provision of primary health care in the beneficiary country, particularly in the areas where local doctors will not work.
2. Staffing of secondary and tertiary care hospitals in the beneficiary countries.

3. Establishment of health-care facilities (e.g., clinics, diagnostic laboratories, hospitals) in the beneficiary countries.
4. Establishment of comprehensive health programs in beneficiary countries.
5. Establishment and/or staffing of medical schools in the beneficiary countries and/or in-country community clinic-based medical education combined with distance learning under Cuban supervision in country.
6. Provision of full scholarships to study in Cuba for medical school and allied health professional students.
10. Scientific exchanges (Feinsilver, 2024 as cited in Feinsilver, 2010).

Furthermore, he argues that health diplomacy goes far and beyond the Western Hemisphere and that Cuba has dispatched large medical aid program in Africa though difference from the one it used to have in a form of military support to independent fighters and nationalist movements such as Angola during the civil war and the Horn of Africa in the 1970s and early 1980s. Following the withdrawal of troops and the later geopolitical and economic changes of the late 1980s and the 1990s, Cuba's aid programme remained though, it was scaled back to match the situation at the time.

In addition, having suffered a post-apartheid brain drain, the white flights of human and material resources – South Africa began importing Cuban doctors as early as 1996. Already in 1998, 400 Cuban doctors practiced medicine in townships and rural areas to complement the remaining health professionals, and in 2008, their number had increased slightly to 435. In the West of Africa, Cuban doctors began working in the Gambia in 1996, two years after the military takeover in 1994 and since then and through 2009, 1,034 doctors, nurses, and

medical technicians have served there (The Observer Newspaper 2009 quoted in Feinsilver (2024).

Feinsilver further argues that by 2004, there were about 1,200 Cuban doctors working in other African countries, such as Angola, Botswana, Cape Verde, Côte d'Ivoire, Equatorial Guinea, Gambia which I would discuss later, Ghana, Guinea, Guinea-Bissau, Mozambique, Namibia, Seychelles, Zambia, Zimbabwe, and areas in the Sahara. And by December 2005, the Island country was implementing its Comprehensive Health Programme across the Africa in the countries such as Botswana, Burkina Faso, Burundi, Chad, Equatorial Guinea, Eritrea, Gabon, Gambia, Ghana, Guinea-Bissau, Guinea-Conakry, Mali, Namibia, Niger, Rwanda, Sierra Leone, Swaziland, and Zimbabwe (Cuba Copera, 2008).

For example, the case of the Gambia where you have Cuban doctors of diverse specializations and the technical assistance team as pivotal team for both the public hospitals and the School of Medicine and Allied Sciences at the University of The Gambia which owes huge gratitude to the Government of Cuba through the presence of its health professionals in the small West African country since 1996, a 28 years of cooperation in the area of health. Also, hundreds of students and professional have benefitted from scholarship and capacity building training for many Gambians. The Cuban health professionals are key in the significant health coverage in the Gambia as Cuban doctors are found in all public hospitals in the Gambia be it urban or rural in the most challenging of conditions.

Figure 2.1.1. New Group of Cuban Health Professionals Arrived in Banjul on the 22nd of April 2024.

(The Standard Newspaper, 2024).

Cuba's health diplomacy in any forms be it medical aid, health services, health professional or in the form of medical infrastructure has improved, sustained and prevent health system collapsed of many African countries in post-independence especially, countries coming out from civil wars, military takeover, or/and major debt crisis. It is worth noting that most of this intervention came at a dare moment and during a period when Cuba as a country was struggling to protect it revolution in the height of Cold War however, that did not stop from delivering the duty it made incumbent upon itself to give back to human for the support it received from people and states all over the world.

This is not limited to African continent or trouble-stroke countries alone but also in the Caribbeans, Middle East and the Central Pacific Ocean where it has medical teams, train and

strengthen health systems and provide ad hoc disasters relief with its Medical Brigade missions who are specialists in disaster management and emergency health support.

Brouwer (2011), argues that Cuba has established training programmes and facilities in many other countries in an effort to strengthen their health systems. One of the largest was in the Barrio Adentro programme, where Cuban doctors provided training to Indigenous medical students for transition and sustainability.

Moreover, Cuba has also established medical training establishments in Africa (for example, Ethiopia, Uganda, Ghana, The Gambia, Equatorial Guinea, Guinea-Bissau), Central and South America and the Caribbean (Haiti, Guyana), the Middle East (Yemen), and Southeast Asia (East Timor) to boost the number of health professionals in these countries locally kirk (2012) quoted in Baggot and Lambie (2018 pp.171 -175).

Furthermore, Bateman (2013); and Motala (2016), argue that Cuban medical training has been criticized in some quarters. And of the criticism pinned on them were that Cuban-trained graduates often face obstacles in being accepted by local regulatory systems and other professional bodies. They further argue that the defenders of Cuban medical education received it as unwarranted bias and ignorance as factors in this problem, critics blame the quality of Cuban medical training. These were received as politically motivated mostly propagated by the US sponsored scholars and media organizations to create scepticisms in the qualifications and quality of services provided by Cuban doctors.

2.2. Internationalism of Cuba's Health Diplomacy.

The internationalism of Cuba's health diplomacy is not limited purely to unilateral approached. Cuba is involved is also bilateral and multilateral health diplomacy initiatives both within the Americas and beyond participating in different form of aid and trade in health service. According to Feinsilver (2024), Cuba is an important health provider to many international health agency networks around the world for example, Cuba is linked to the Bolivarian Alliance for Peoples of Our America (ALBA) and Peoples' Trade Treaty (an alternatives to Free Trade Area of the Americas proposed by the United States). Though, ALBA initially included only Cuba and Venezuela and later expanded to include Bolivia, Nicaragua. It is currently having 11 member states though, the key aims of the organization is to foster economic integration and Cuba health diplomacy is a key ingredient especially in assisting member states strengthen their health systems, transfer of knowledge and trade in health.

Other countries have also provided medical assistance to third countries mostly less-developed countries through financial assistance to Cuba health initiatives in those countries for example, Switzerland, Libya, South Africa, and Nigeria helped to fund Cuban work in Mali. Germany, Libya, and Nigeria financed Cuban health interventions in Niger. France, Japan, Brazil, Venezuela, and Norway helped to fund Cuban health workers efforts in Haiti. In practice, Cuban health work overseas is funded by a mix of countries and often includes international agencies. Several scholars commented on the key role of international agencies, such as WHO and its regional offices (notably, PAHO) and UNICEF, in bringing Cuba into alliances to help other countries. Cuba's expertise and comparative advantages health care abroad makes it a leader in health emergencies and has increasingly received aid from U.N. agencies to enable the provision of medical relief (Werlau, 2013 pp. 57-67).

Baggot and Lambie (2018) argues that WHO paid Cuban health workers for their work in the West African Ebola crisis. This was at a time when many countries provided funds and equipment, but they were reluctant to commit personnel. Cuba on the other hand, sent 256 health professionals to Liberia, Guinea, and Sierra Leone. They further argue that Cuban health workers in this batch were paid more than they would have received at home (in line with other overseas missions). However, regardless of the pay, it cannot have compensated for the risks involved (2 Cubans died from malaria, and 1 contracted Ebola but survived). Ironically, the U.S. embargo delayed the payments to Cuban staff, and special permission was needed to transfer the funds.

Furthermore, Feinsilver (2014) argues, Cuba's involvement in Brazil's Mais Medicos programme was facilitated by PAHO, which brokered the agreement and provided logistical support, administrative support, training, monitoring, and evaluation. PAHO also disseminated the lessons of the programme to other countries in the region. As noted, the Cuban government initially supplied the majority of the doctors to the programme while the Brazilian government paid the Cuban government for their services.

Cuban medical teams have been consistently cooperating with developing countries in every region and continent regardless of their population sizes and in the remotest of places for example, there are Cuban medical teams working in such in faraway as well as small places such as Timor-Leste (East Timor) in Southeast Asia and the Pacific Island countries of Nauru, Vanuatu, Kiribati, Tuvalu, and the Solomon Islands, none of which might be considered in Cuba's strategic areas of interest. However, Baggot and Lambie, argue that with one nation,

one vote in the UN General Assembly, even these small islands are important where voting is concerned. The medical cooperation programme in Timor-Leste began in December 2003 with the objective of creating a sustainable health-care system by establishing the Cuban-model Comprehensive Health Programme. In 2008, 177 medical professionals were providing a variety of services in Cuba's Comprehensive Health Programme there (Feinsilver, 2024 pp. 5-7).

The expansion of Cuba medical diplomacy has help improved health systems in these countries in turns, Cuba receives recognition and influence in those countries. The perception of Cuba has been steadily rising and more countries have opened to Cuba basically in all continents. The influence of these manifested on global stage especially in the UN General Assembly. This strategic approach of Cuba in positioning itself as a reliable partner for South-south Cooperation, multilateral cooperation and even to some developed countries especially during the COVID-19 pandemic when the government of Cuba sent medical team to help Italy in the fight against COVID-19 pandemic.

Baggot and Lambie (2018) notes that Cuba is able to expand it medical internationalism due to support and cooperations from countries such as Qatar, which has invested in Cuban hotels as well as collaborating with Cuba on health. Also, Norway (which has helped fund Cuban health interventions in other countries) has worked with Cuba on oil production and exploration and also cooperated with the Cuban fishing industry to strengthen the Island’s economy in those areas to help sustained it health initiatives.

In addition, trade with China (which has collaborated with Cuba on pharmaceuticals) has increased sharply in recent years. The duo notes that Cuba has also been able to access products on preferential trade terms with countries it has collaborated with on health – for example Guatemala, Bolivia, and Gambia. They note that Cuba was able to access oil at subsidized prices from Venezuela before troubling economy hit the oil-rich country which according to them slow the oil supply to Cuba as a result, affected the Island's pharmaceutical exports (as noted earlier) and professional service exports. The positive side though, it has led Cuba into expanding cooperation to strengthen economic links with other countries such as Russia, China, and the EU in recent years (Baggot and Lambie 2018, p21).

2.3. Cuba, AS A Leader in Global Health Crisis.

Cuba has been consistently involved in health initiatives including global health crisis since the inception of the medical diplomacy initiative, it has sent medical brigades anywhere they are needed. At first, they started as an ad hoc mission or disaster relief doctors sent to Chile during the earthquake and others including Haiti and Indonesia. The new face of its medical diplomacy has position Cuba in the centre of health issues in the world – from health services to health technology and other infrastructure.

The island country has not limited investment in domestic health or medical health diplomacy but also, making a name for itself in other components of health. As highlighted by Labrador, the country has twenty-four setups for medicine and 40 medical infrastructure centres for nurses in all provinces of the country and trains an average of 10,000 doctors and approximately 30,000 health professionals per year (Labrador, 2010). In view of the size of the country's economy, this is a milestone achieved almost miraculously – at the level of the

university course, the specialty “family medicine” is an obligation for all future doctors. After completing their studies, as per regulation and the quest for quality to the quantity - doctors must systematically complete one year as interns and two years as residents in a consultation centre or polyclinic, in order to complete and validate their formation. This robust training affirms the continuous struggle of the country to be a reference global health (Lamrani, 2021).

To contextualised Cuba’s relevance in global health and appreciate the reason its health initiatives has outgrown its borders and the global South to some extent. Also, Cuba has nearly 50,000 medical professors, more than 100,000 doctors and around 100,000 nurses (Lamrani, 2010). This produce a statistic of an average nine doctors and nine nurses per 1,000 inhabitants, Cuba is today one of the best-endowed nations in the sector (Labrador, 2020, p. 46). Also, for comparison, according to the Organization for Economic Cooperation and Development (OECD), France has 3.4 doctors per 1,000 inhabitants and Austria, the best-endowed European country, has 5.2 doctors per 1,000 inhabitants. As for the United States, the figure is 2.6 doctors per 1,000 inhabitants (Labrador, 2020) quoted in (Lamrani, 2021, p.41).

In addition, the island also has nearly 20,000 dentists and dental surgeons as well as more than 15,000 pharmacists. This assured the population’s health in all fields in fact, it has turned the country into a heaven for medical tourism in the developing countries. To sum up, the Cuban Ministry of Public Health, the National Health System employs nearly half a million professionals, or 13% of the working population, in the 13,000 health institutions in the nation (Lamrani, 2021, p.43).

Cuba's role with the victims of the Chernobyl nuclear disaster of April 26, 1986, in Ukraine, which claimed the lives of 40,000 people and infected millions, is unique. According to Patricia (2009) since the creation of the Program of Comprehensive Attention to Children Victims of Disasters in 1990, within the Institute of Haematology of Havana and the Oncology Department of the Juan Manuel Márquez University Paediatric Hospital, in response to the most important nuclear accident in history, more than 26,000 children aged 5 to 15 received free treatment in Cuba for free with the exception of the traveling cost which was provided by the government of Ukraine. Medina, director of this project also mentioned the participation of the International Fund for Chernobyl, a Ukraine-based non-governmental organization that estimates Cuba's expenditures to be 350 million dollars in medications alone (Havana, Times 17 April 2009).

Moreover, this recognition has transcended its borders giving it even more credibility for example, (Lamrani, 2021, pp.1-2) cited in Open Edition Journals 2021, argues that even reputable medical journals such as The New England Journal of Medicine, The Lancet all recognized and praised this system. Cuba unlike many developing countries has developed its own pharmaceutical industry to cut cost and dependence on Western pharmaceutical industries. It manufactures good amount of the medications in its basic pharmacopeia also, export industry. Resources have been invested in developing biotechnology expertise to make it competitive with in that area as well. Moreover, according to reputable medical journal such as The Lancet notes, "If the accomplishments of Cuba could be reproduced across a broad range of poor and middle-income countries the health of the world's population would be transformed" (The Lancet, 2013).

Furthermore, according to the Human Development Index Office of the United Nations Development Program, notes that Cuba is the only Latin American and Third World countries that are among the top ten nations in the world with the best Human Development Index. on the three criteria of “life expectancy,” “education” and “standard of living” during the last decade (Gener, 2011). The country has maintained this ranking as I am writing this piece in 2024 – in addition UNICEF praise Cuba is an example in child protection and recalls that Cuba is the only country in Latin America – and the Third World – to have eradicated child malnutrition (Lamrani, 2021 p.44)**.**

In faraway lands and in a different continent, in 2006, when Ebola epidemic broke out in West Africa and the World Health Organization has issued an urgent appeal to the international community to come to the aid of Africa. At the time, the institution was in urgent need of polysaccharide vaccines to fight against meningitis A and C which struck twenty-three countries of the continent located in the so-called “meningitis belt, from Senegal to Ethiopia.” According to WHO report at the time, the epidemic affected nearly 100,000 people and caused more than 5,000 deaths per year. This antidote had to be produced on a massive scale to help the 430 million people in the region or risked more deaths (Halla, 2013, pp.53-55).

Lamrani (2021), notes the institution called on all laboratories, both public and private, to produce this type of vaccine. Only two Third World public laboratories responded to this call: the Carlos Finlay Institute in Cuba and the Bio-Manguinhos Institute in Brazil**.** According to him, Cuba immediately responded to the UN and WHO request, dispatching 165 health workers to Sierra Leone, Guinea, and Liberia. This was the largest medical contingent dispatched to the affected region in fact, it was the only medical mission that worked in the

affected countries, treating patients in major and small medical facilities and sometimes in the remotest of regions where other medical could not reached.

This has surged recognition for Cuba's medical health diplomacy initiative in the region and making it a trusted partner to these countries. Beyond this region, WHO the world's premiere health institution praised Cuba's gesture as "what we need most are medical personnel. The most important thing to prevent the transmission of Ebola is to have the right people, the right specialists, and well trained,'' a domain which Cuba have a lot of trained specialists to deal with this kind of humanitarian crisis in the global south where the health system are yet to developed. The entity recalled that "Cuba is world famous for its ability to train excellent doctors and nurses. It is also famous for its generosity and solidarity with countries on the road to progress." WHO went to urge the rest of the world, especially the developed countries, to follow Cuba's path and express the same solidarity with Africa. Cuba has position itself as an example and a leader in global solidarity for humanitarian crisis. The institution termed the Cuban medical team as the largest contingent of doctors, nurses, and specialists in infectious and epidemiological disease control (Kai, 2013, P.14).

Halla notes that Carlos Finlay Institute in Cuba, and the Bio-Manguinhos Institute in Brazil has teamed up and created the vax-MEN-AC vaccine at an exceptional price of $0.95 per dose, a price which is unheard of anywhere, twenty times lower than that produced by multinational pharmaceutical companies. He added that a total of 19 million vaccines have been manufactured and distributed in Africa by WHO, UNICEF, Doctors Without Borders and the International Red Cross, saving tens of thousands of lives. This cooperation was successful and gather enormous praised around the world including the US, where a scientific journal

Science hailed this example of “South-South cooperation” and called for this model to be extended to the rest of the world (Halla, 2013, pp. 58). Cuba passion for cooperation through health knows no boundary except where it is rejected. The Island country continue to pursue new initiative to position herself as a reference in global health and the pursuit of universal health for all anywhere in the world.

The height of this efforts came during the recently concluded global pandemic of COVID -19 which first surfaced in Chinese region of Wuhan in 2019, the following episodes of the Covid-19 pandemic, which saw several countries including Italy to request medical help from Cuba to help fight the virus. A landmark moment in Cuba’s medical health diplomacy initiatives, for the first time, Cuban doctors intervened in Western Europe. Havana sent a medical brigade of 52 doctors and nurses to Lombardy region, Italy, a hard hit by the virus, thirty of whom had fought the Ebola epidemic in West Africa and defeated the epidemic (Bonaldi, 2020).

He argues that after two months of hard work, at a time when little was known about the virus, the mutation and with no vaccine produced yet, the medical brigade fought left a lasting impact on the people especially the hospitals they are assigned to by the host country. At the end of their term, a specialized unit of Cuba’s medical diplomacy called the members of the Henry Reeve contingent returned to Cuba. Bruno Rodríguez Parilla, Cuban Minister of Foreign Affairs, stressed that Cuban aid had been “solidary and free,” and that Cuba was satisfied with “the gratitude of citizens, locals and national authorities” (Lamrani, 2020).

In addition, in November 2020, faced with the resurgence of Covid-19 cases, in other words the Second Wave of COVID -19 pandemic, Sicily launched an urgent appeal to Cuba to receive

help from 60 health professionals to relieve their regional hospitals which were structurally lacking in human and material resources. The Italian press highlighted the vital contribution of Cuban doctors: “This is a race against time to capture professionals from overseas, before other regions do” quoted Renato Costa, who was the COVID-19 emergency commissioner in Palermo behind the initiative, he explained his decision: “The Cuban government has teams of doctors and nurses willing to travel. We asked for their help. We are aware that other regions have followed suit, and we hope we were the first. I am in close contact with the Embassy, which seems to have welcomed our S.O.S.” (Giusi, 2020, pp.80).

Figure 2.3.1. Cuban Doctors and Nurses at Malpensa Airport, Italy, To Help in The Confrontation Against The COVID-19 Pandemic.

Source: Mateo Bazzi / EFE April 2020.

Prior to COVID -19 pandemic, the Cuban medical or health diplomacy was largely view as a solidarity of South-South Cooperation only – the pandemic has cleared the cloud on this perception when Cuban medical brigade entered Italy, a Western European country, one of the biggest in size, population and of course the size of their economy. This reaffirms Cuba initiatives as a global rather than just South-South Cooperation which benefits just developing countries or meant to secure only sympathy from developing countries.

2.4. Soft Power of Cuba's Health Diplomacy.

Cuba has been consistent in its medical diplomacy initiatives and has been collaboration steadily even more countries year-in-ear-out with the exception of 1980s to early 1990s which was a difficult period for developing countries. Many countries were trapped in debt and were more less forced to adopt Structural Adjustment Programme imposed by the International Monetary Fund (IMF) which saw these countries downsized their social spending including health.

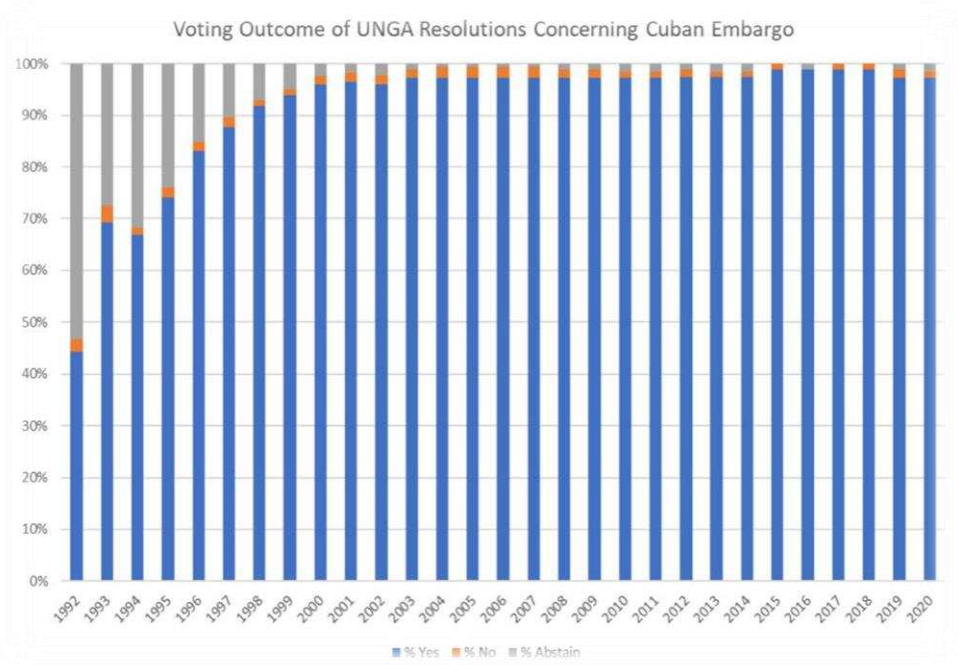
This consistency over a period has earned Cuba a leverage, in other words soft power over partners. Soft power is concept developed by American political science professor, Joseph Nye. He defines it as "the ability to get what you want through attraction rather than coercion or payments." According, Anderson (2010), quoted in George (2017), soft power in foreign policy involves using resources and/or relationships to create certain path in marking an effects or influence. In a bilateral relation, it involves creating an incentive to influence other governments to behave in a way favourable to your own policy. He argues that the term is still underdeveloped in the foreign policy literature, and when used rarely examined on its own in details.

Nonetheless, it is worth examining the influence or soft power driven by Cuba in its health diplomacy initiatives and engagements with other governments and international agencies. As Cuba expands it medical diplomacy, it earns new allies and sympathizers across the world even among countries which were not receptive of its revolution welcome the white coat diplomats such as El Salvador, Honduras, Pakistan and name them. This reception of white coat diplomats (Cuban doctors) projects Cuba's foreign policy and gain sympathy slowly but surely; with such sympathy Cuba's continuing to withstand the pressure, sanctions and punitive measures of its longstanding powerful enemy, the United States.

Additionally, Cuba, managed to outmanoeuvre US increasing sanctions and the calls for maximum pressure on Cuba to isolate and pressure into changing its ways, through its medical diplomacy around the world, pushing far and deeper into U.S. allies to draw sympathy for itself and pushing U.S. into a less favourable light. U.S. punitive actions were unpopular even amongst U.S. own allies and they were reluctant to criticize Cuba as that would appear to be binding towards U.S. position moreover, the call for an end to U.S. treatment of Cuba was a common theme in international summits (Week, 2017).

Though, Cuba continues to struggle with U.S. embargo due to the Island's small size in both economy and population however, it was persistent in the pursue of its priceless foreign policy initiatives, medical diplomacy to reach as everywhere to with its soft power influence on other governments. This has yield benefits for Cuba on the global stage more effectively in Multipolar World. The figure below is evidence of the UNGA voting trend over decades since the inception of votes on the matter.

Figure 2.4.1. Voting outcome of UNGA Resolution Concerning Cuban Embargo.



Source: (Berg, 2022).

The figure above, demonstrate the UNGA votes on End to U.S. Embargo on Cuba have been in the immediate aftermath of the Cold War when Unipolar World was newly instituted. Berg (2022) argues, votes in favour of Cuba was 43 percent due to the abstain vote of the European Countries and many smaller countries who are largely dependent on trade relations with the U.S., also due to absence of other powers however, the rise of Multipolar World has played a significant role in term of positive votes for Cuba coupled with Cuba expansion of medical diplomacy to more regions and countries. This gives Cuba geopolitical power and influence over UNGA members hence the declined in 'absent' and 'No' votes.

Figure 2.4.2. Voting Outcome of UNGA Resolution Concerning Cuban Resolution Based on Era.

Era	Years	Yes	No	Abstain
Unipolar	1992-2007	85.93%	1.86%	12.21%
Multipolar	2007-2021	97.84%	1.27%	0.90%

Source: (Berg, 2022).

Figure 2.4.3. The Latest UNGA Calls for U.S. To End Cuba Embargo for the 29th Consecutive Year.

Source: UN Global News, 2021.

The above figures demonstrate the steady rise of Cuba's influence on other governments at the UNGA since they started voting on the matter in 1992 when the Cold War just ended, and

the dawn of a Unipolar World. At this time, of the entire members of the UNGA under 50 percent voted in favour of U.S. lifting embargo on Cuba; and in 2007, a year characterized by scholars as the end of a Unipolar World marking the beginning of Multipolar World when more players competing for global dominance, this has also translated into more votes for Cuba in the UNGA on the matter as 97.84 percent of the total members voted in favour of U.S. ending Cuba embargo, 1.27 percent against and 0.90 percent were absent or undecided voters.

Cuba's widespread medical internationalism started since the early days of the revolution. In 1960, Cuba sent its first ever medical mission to Chile during the earthquake, then followed it with 56 doctors Algeria, 355 medical brigades added to the to about 1000 health already working in Haiti in short, according to Kirk and John (2009), as of 2009, there were about 40,000 medical in 74 countries and this number increased 130,000 medical in 103 countries, at the time of the latest UNGA vote 2021 calling on U.S. to end embargo on Cuba.

Despite, her population size of 11.27 million people, Cuba managed to mark its presence in majority UN member states, directing treating 130 million patients in these countries hence the soft power influence at the highest diplomacy assembly and bagging 97.87 percent of the total vote of UNGA of 2021. Undoubtedly, Cuba medical health diplomacy has proven to be an effective foreign policy initiative sufficient to outperformed U.S. influence on the UNGA as per 2021 vote.

Feinsilver, (2021) argues that medical diplomacy has well positioned Cuba and earned a symbolic capital of goodwill, influence, and prestige which goes well beyond what would have

been possible for a small, developing country, and it has contributed to making Cuba a key player on the global stage. Huish also echoes this, arguing that Cuba has successfully developed a form of "soft power" among nations of the Global South, increasing opportunities for diplomacy and bilateral cooperation, not just in health, but also in economic and industrial sectors for mutual benefits. It has been particularly skilled at building bridges with economically more powerful countries such as South Africa, Brazil, and increasingly China including supporting receive from some developed countries such as Norway, Switzerland, and Sweden for its role in global health.

This influence has surged exponentially during the COVID -19 pandemic and post-pandemic as more countries have started cooperating with Cuba in health issues but also in economy and political cooperation which I have highlighted in the figures above. Cuba's presence in Western Europe, Italy, Portugal and Andorra was a milestone which was on unthinkable, and only possible in times like the pandemic when all a country care about was the health of their people of course, ideology and allies matters and remain relevant in fact, the importance was visible especially in the access and distribution of vaccines however, it matters little compared to pandemic thus, Cuba's medical brigades initiative gathers so much soft power for the country.

According to Werlau (2013) quoted in Baggotti and Lambie (2018, p176), argues that though, most accounts of Cuban medical internationalism are overwhelmingly perceived positively, but negative aspects have also been raised. Some critics, while acknowledging that Cuba has genuinely assisted countries in need especially developing countries, also question the accuracy of estimates of how many people have benefited.

In addition, some host countries have expressed hostility and scepticism about their use of Cuban health professionals and criticism of their training programs. This has originated overwhelmingly from health professionals, in particular doctors, who have a stake in limiting competition and to guard the quality of the health system as some argue Cuban doctors are ever ready to take extra work and working hours, such hostility has been encountered in Brazil, Venezuela, Portugal, and elsewhere (Hammett, 2007, pp.63-81).

Furthermore, Kirk (2016) quoted in Baggott and Lambie (2018), argues as seen in South Africa, the same complaint by the professions which is fuelled by the media and opposition politicians, was that Cuban doctors lacked relevant experience and that many of them are fresh graduate from medical school. Though, these critics are usually short-lived because as the Cuban doctors began to practice, the media's views became more positive, but negative public perceptions remained as the damage has already been done. They note that these were unfounded – even if their skills and experience did not exactly match their hosts needs initially for whatever reason, Cuban doctors proved to be quick learners. Nevertheless, critics continued to claim that funds would have been better spent hiring South African doctors, despite the substantial number of unfilled vacancies in poor, disadvantaged, and underserved areas where the Cubans mainly worked.

2.5. The other face of Cuban Medical/Health Diplomacy

Contrary to the glittering picture painted of Cuban Medical Diplomacy in previous sections of this chapter, exist another face of Cuban medical diplomacy from both in Cuba and abroad, the beneficiary states and of course in other non-receiving states but unfriendly nations and

institutions such as United States of America and other international organizations which will be discuss in the relevant paragraphs.

There is a serious risks involved in Cuba sending a large number of its medical professionals abroad leaving the country health facility handicap in providing medical care to its own people. Though, Raul Castro attempted to reorganize the adequate supply of health workers and medication in 2018 however, every time the country expands its international medical coverage in other words, covering more countries and sending more medical personnels abroad - the problem resurfaced (Feinsilver, 2009).

According to Loeb (2024), the government of Cuba sent these medical professionals to countries mostly, developing countries whose health systems are challenge with shortage of professionals – in exchange for diplomatic ties to build a glowing image for the Island country, whilst subjecting these medical professionals in a difficult and restrictive working environment to put it in his own words ‘‘medical servitude’’ where they are usually paid with low wages of which Cuban government keep segment until their return to the island; this posed significant challenges to these doctors who are expected to take care of themselves and their families back home.

Cuban government is also active the business of health where it enters into agreement with foreign government to send in their doctors to strengthen the health systems of these countries in returns received payment in hard currency for the services of these doctors an example of such is the ‘‘oil for doctors’’ agreement it has with Venezuela which allowed the government to receive oil at significantly reduced price; also, it has a similar agreement with Brazil called ‘‘More Doctors Program’’ between 2013 to 2018 which is believed to generate

the country an estimated $360 million dollars yearly in fact, the country is said to have received $7.7 billion in 2018 from the medical services it offered abroad (HIR, 2024).

Figure 2.5.1: Cuban Doctors raised Cuban and Brazilian Flag.

Source: AP Photo/Antonio Calanni 2020.

Loeb argues that the doctors selected for overseas services have little or no options but to go else face with dismissal or remain with little wages they receive as doctors in the country – and those that are send overseas face multiple challenges such as posted in areas with the worst facilities or hard-hit in cases of disasters as seen in the case of Ebola in West Africa

when doctors were sent to the remotest part of the country invested with mosquitoes and not to talk of with limited PPEs to work with. This, according to him led to the death of two Cuban doctors in Sierra Leone from Ebola and Malaria, even those who survived Ebola and Mosquitoes a sizeable number of them developed one form of trauma (Loeb, 2023).

Herzberg (2017), notes that the condition of Cuban doctors in was very restrictive for example, they were prevented from building families in Brazilian and whoever got pregnant were sent back to Cuba as a way of preventing them from giving birth in Brazil which would have given their children's citizenship. This and similar restriction got to an unbearable point – which led to 150 Cuban doctors to filed suits in Brazilian courts seeking verdict to exit from the ''More Doctors Program''. In the case the doctors secured an injunction because the ''More Doctors Program'' according to their lawyers violated the Brazilian Constitution. This verdict allowed the doctors under this program to practised and entered in any contract independently.

In addition, Cuba doctors some faces hostilities in the host countries especially from the local health professionals who out of fear of competition levied serious claims against Cuban doctors that they do not have adequate training and lacks relevant experiences needed by the host countries to perform effectively. Some argue that they lowered the bar set by the local medical professionals as they accept any wages which are seen as unacceptable by the local – this was widely circulated notably in Brazil, Venezuela, South Africa, Portugal to name all but few. According to Baggott and Lambie, these claims were unfounded and were peddle by disgruntle locals and fuelled by the media which exposed these doctors to serious discrimination and resistance by locals of the host countries.

Moreover, the government of Cuba's Medical Diplomacy has been alleged as a form of state sponsored human trafficking by coercing it doctors to participate in this mission. This alarm was raised by the State Department of the U.S. in September 2019 that the glowing image Cuban is campaigning around is in fact, one to condemned because it is against the Palermo Protocol: ''Article 3(b) of the Palermo Protocol unequivocally states that "[t]he consent of a victim of trafficking […] to the intended exploitation […] shall be irrelevant" if threat or use of force and other forms of coercion have been used…'' Cuba was called out by the United Kingdom in UN when the Universal Periodic Review 2018 found Cuba to be engaged in trafficking of its doctors in bilateral medical agreements around the world. The Human Rights Foundation in its August 2022 Report also corroborated the previous claims however, Cuba denied all allegations and called it a mere political propaganda against its successful humanitarian programme (Rodriguez, 2022).

CHAPTER THREE

3.1. WHO in Global Health Governance.

For the purposes of this chapter, it is important to give context as to why WHO and other health related institutions are important in public diplomacy is because international organisations are very important areas in which international relations has been applied to better understand the power dynamics in PD specifically, global health diplomacy. Kickbusch and Liu notes that study shows key efforts in global health diplomacy in including negotiation to uphold health interests, establishment of governance mechanisms, and creation of alliances in global health policy making (Kickbusch& Liu, 2022, as cited in Lancet, 2022).

According to Fidler (2010) applying the traditional international relations concepts of anarchy in international regime, this allows for analytical rigour in deducing possible global health diplomacy outcomes. WHO like other global organizations established to bridge the gap between states where their individual interests diverge in relation to public health for the interest of global health. WHO with support from its members especially, wealth member states have coordinated response to major public and global health crisis be it in one, two or more countries and even regions. These efforts made the institution number reference for global health and health diplomacy platform.

Equally important, is the surging recognition of international organisations as actors in international relations theory, this means that international organisations are not just platforms for diplomacy, but as critical players in global governance with increasing active role in international politics by shaping agendas and influencing negotiations in international space. With WHO broader engagement, Global health has shown that state-centric international relations theorising needs to include international organisations such as WHO and non-state actors to increase its explanatory soft power potential (Pilling et. al, 2020, pp.1-2).

Additionally, one may rightly argue that the discipline of international relations has traditionally and fundamentally deals with the inter-relationship between political entities, initially between states, and then extended to major international actors such as international organisations. This is evident in the early literatures in the discipline of international relations theorists who have focused on war, peace, and security as the dominant issues of concern in an anarchical international system in which states operate. Frenk argues, global health system has not received the attention it deserves. Yet, the transnational nature of many health-related risks arising from the increased flow and outflow of goods, capital, services, people, and technology transfer, and information in the context of globalisation, and the famous term ‘‘centre-periphery-relation’’ (The Lancet, 2022, pp.94-97).

Moreover, the increasing link of health, climate change and their integration into foreign policy brings global health diplomacy into analytical focus. This change is also reflected in the increasing integration of development agencies into foreign policies in other words, health is not seen as an exclusive business of health profession and foreign policy not limited to

traditional areas of interests such as economy, security and the likes in fact, (Kickbusch and Liu, 2022, as cited in The Lancet, 2022) note that as early as 2007, a group of foreign ministers from developed and developing countries launched the Global Health and Foreign Policy Initiative to make the case for health as a foreign policy issue and to ensure a regular debate of global health at the UN General Assembly (The Lancet, 2022).

According to Chorev (2012), under neoliberal pressures, the WHO Secretariat was able to present its anti-tobacco position as consistent with the prevailing neoliberal logic. Tobacco industries despite its wealth and influence was unable to withstand the concerted efforts against it. The WHO Secretariat did so by strategically and explicitly opposing the tobacco industry and questioning its unethical actions as a legitimate exception to otherwise accepted business in a global free market system where profit supersedes, and every other thing followed. Through support and collaboration from its member states, tobacco products are forced to indicate on their products that it is harmful to use and other related risks (Chorev, 12, as cited in The Lancet, 2022).

Davies (2015), notes that studies has been conducted on how the WHO Secretariat can influence the behaviour of states through creation, dissemination, and redefinition or reframing of norms in the international system especially in recent decades; additionally, (Kamradt and Lee 2011, as cited in The Lancet, 2022), also notes how WHO seeks to claim authority and legitimacy in the absence of direct authority over its member states who in term nature are sovereign, and how negotiation processes at WHO address the perceived benefits of negotiating parties indifferent to their sizes and economy (The Lancet, 2022).

Taghizade et, al. (2022) argues that despite WHO long history and wide membership, the organization still struggle over lack of authority to investigate epidemics within countries independently, and as mentioned above, it has no enforcement power. The current crisis also reminded states and humanity at large - that even the most powerful governments of the world and the wealthiest people are helpless in the face of the negative consequences of these diseases (Taghizade et, al. 2022 as cited in Frontiers, 2022).

According to the WHO terminology, ‘‘GHD connects public health, law, international affairs, management, and economics, concentrating on negotiations and shaping the global policy climate for health’’. In this definition, the central tenet of GHD is for countries to work together in international fora to address public health issues (WHO, 2014). In addition, Kickbusch, GHD refers to the multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health in health and non-health fora. Moreover, the health problems/threats addressed diplomatically have also become diverse, ranging from neglected tropical diseases, growing anti-microbial resistance (AMR), infectious diseases, accessibility of medicines, sale of unsafe, counterfeit drugs, to brain drain crisis (Kickbusch, 2007, p.85).

Global health diplomacy efforts operate through forms of power that are less obvious and assertive, they are carried out through very subtle and indirect dynamics, such as the power of norms, discourse, expertise, and moral authority, or the institutional power inherent in rules and decision-making processes and the likes. Scholars such as Kickbusch, a leading scholar in health diplomacy notes that the beginning of the 21st century, health diplomacy moved centre stage as WHO played an increasingly active role in international politics, and

its role as a norm setter in global health was strengthened. Under the leadership of Director-General Harlem Brundtland, WHO facilitated the adoption of the Framework Convention on Tobacco Control (FCTC) and the revision of the IHRs which the recent global health responses could not have been effective without it, Kickbusch and Liu quoted in (Lancet, 2022, as cited in The Lancet, 2022).

In 2003, as noted in The Lancet that WHO made use of its constitutional treaty making power for the first time and adopted the FCTC. This came after increasing calls for WHO to be more effective in monitoring and advising members in the face of public health threats that could spill over to neighbouring countries causing a global health crisis. It is noted by many optimists of global health and global affairs literatures such as The Lancet that the FCTC is a landmark treaty, as it is the first and only international instrument that regulates the consumption and commercialisation of consumer products (Burci, 2018, as cited in the BMJ, 2018). Before its adoption, many cashed doubts in how WHO would outmanoeuvre the resistance and campaign from powerful industry like the tobacco producing and advertising companies.

Additionally, Kickbusch and Liu (2022 as cited in The Lancet, 2022) argue that these binding agreements initially strengthened the WHO Secretariat's political authority to promote health in the face of a broad range of social, economic, and political interests. The agreements also made countries recognise that they needed strong representation in Geneva to be able to conduct the many parallel negotiations under way. Health diplomacy is no longer an ad hoc diplomatic activity but a constant throughout the year activity. The occasional meetings of the WHO's governing bodies and the agreements that comes out are now initiated and

negotiated by representatives of members before they are even put on the agenda of conferences, summits, and conventions.

Raoof (2020) notes early warnings are key functions that the institution takes seriously however, the institution is sometimes caught unnoticed largely because of its lack of mandate to investigate disease in member states without the willingness its willingness to cooperate as stated by the WHO former Director-General that "the first window of opportunity to prevent the disease spread to other countries during the past 1 to 2 months is missed. Hence, countries should do their best to avoid missing the second window" (Frontiers, 2020). Viruses such as SARS-CoV-2 do not recognize any nationality, boundaries, or political affiliation, but can nonetheless become important political issues (Kickbusch, 2021). Therefore, managing the current crisis requires the highest political and diplomatic support in all countries.

The economic implications are usually the main concern of states to give out health warnings when a disease outbreak happen in their countries. These were the reasons for many disease outbreaks spilling over to other countries though, some of this turned out to be a positive in disguised as we have seen the in 2003 SARS crisis provided an opportunity for countries to adopt international health regulations to reach a "cosmopolitan moment" to address the weaknesses in responding to its outbreak (Kickbusch, 2020 as cited in Frontiers). The current outbreak, COVID-19 pandemic is unlike any other, for the first time a disease outbreak has affected both the developing and developed countries in such a short time and exposed the weaknesses the health system of individual state and global health system as a whole leading the integration of health into the foreign policy of all countries during the period in fact, a good number of countries still maintain it in their foreign policy – more countries were

supporting and cooperating with WHO with the exception of few including United States, Tanzania and North Korea.

Taghizade et al. 2021 quoted in (Frontiers, 2021) in the case of previous epidemics of HIV, SARS, H1N1, MERS, Zika, and Ebola, they have mostly affected specific regions/nations or the global South more than the North, and therefore the support came in from the rich nations in Western Europe and North America however, the COVID-19 pandemic has broken this tradition due to its indifference to the status of countries and regions in fact, most rich and powerful countries have been more affected with more cases and registered more deaths prompting panic, scrambled and competition to protect borders and secure vaccines. These lack of solidarity, and nationalist movements in addressing the domestic economic and health crises led to the devastating result countries experience and still struggling to recover the economic loss and trauma brought about (Chattu et al., 2021, pp.1-4 as cited in The Lancet, 2021).

Another milestone in global health governance was the WHO Pandemic Influenza Preparedness (PIP) Framework which was also adopted thanks to another unfortunate outbreak. During the avian influenza A (H5N1) outbreaks in late 2006, Indonesia refused to share virus samples with WHO by asserting sovereignty over viruses isolated within its territory, grounded on the Convention on Biological Diversity. The decision by the Indonesian authorities was driven by concerns that pharmaceutical companies in HICs would use the free access to virus samples from WHO to develop patent, and sell vaccines at an unaffordable price (Irwin, 2010, p.3).

One of the most notable health diplomacy outcomes related to the Ebola health security crisis was that political attention to health has increased substantially in political spheres in and outside of the UN and its agencies. This outbreak has raised the level of alertness in both developed and developing ones were increasingly being concern about the surge in outbreaks of diseases with potential to shutdown global economy. Consequently, under the leadership of German Chancellor Angela Merkel, she has launched health as a priority at the 2015 G7 Summit of Germany in Schloss Elmau, and then introduced at the 2017 G20 Summit in Hamburg (Kickbusch et al., 2017 p. 8, as cited in The Lancet, 2022).

According to Matsumura (2019), for the first time, there was a meeting of G20 Health Ministers under the German Presidency to discuss health a collective concern for the big economies, and subsequently a joint meeting of Health and Finance Ministers under the Japanese Presidency at the 2019 G20 Summit in Osaka was also convened to follow up on the previous agenda to take concrete action in preparation for what was seen as imminent health threats. Some scholars argue these obvious indications that a major public health crisis was on the way, and it was only a matter of 'when' and no longer 'if' – rightly so, at the end of the same year sign of COVID-19 manifested in China Wuhan region.

These have amplified the call for integration of health into foreign policy and global efforts to monitor, report and respond to public health issues has increased number of health issues brought to the UN General Assembly and Security Council for discussion in New York, NY, and a crucial conceptual and political breakthrough was the adoption of the 2030 Agenda for Sustainable Development and the 17 Sustainable Development Goals (SDGs) in 2015. These goals are the outcome of a transparent, inclusive process of negotiation, and they set a quite different universal development agenda from the MDGs (Kamau and Chasek, 2018).

Youde (2018) cited in The Lancet (2022) notes that in July of 2020, he has covered range of literatures in political science and international relations, social science and humanities, and global health journals, using the following search terms: “health diplomacy” or “disease diplomacy” or “medical diplomacy” or “vaccine diplomacy” or “mask diplomacy” and “power”. The search terms were based on the focus of the series (the role of power, wealth, influence), and commonly used terms that relate to the concept of health diplomacy; the results have shown that health diplomacy has transcend beyond a fringe concept to a popular theme with increasing interest from scholars, institutions and states. Global health diplomacy demonstrated need for international relations theorist to theorized international organisations such as WHO and other non-state actors in IR discourse to increase its visibility and gives tangible meaning to the terms and relevance; non-state actors such as WHO, MSF, Global Fund for HIV and Tobacco have comparative advantages in global health diplomacy and serves as a neutral platform for harmonizing competing state interests (The Lancet, 2022).

3.2. The Role of WHO in Vaccine Diplomacy.

Kickbusch and Liu (2022, as cited in The Lancet, 2022) highlighted the WTO adoption of the Doha Declaration on the Trade Related Aspects of Intellectual Property Rights (TRIPS) and Public Health, which according to them reaffirms the right of governments in bypassing patent rights to promote access to affordable medicines in the interest of public health. Going against the interest of industrialised economies and the multinational pharmaceutical industry for a greater good and for governments to carry out their core functions as duty bearers during emergency situations, the moral claim of access to medicines as a human right by a coalition

of civil society groups and low-income and middle-income countries (LMICs) changed global norms related to health and trade policies.

According to Friel (2018), the Doha Declaration also helped reassert WHO's authority to communicate with the WTO and its members (especially developed countries) to address the multidimensional challenge of policy coherence between trade and public health. Although, WHO and WTO are separate institutions with different mandate, but they are more or less have the members and complement each other in many ways for example, during health emergencies trade activities suffered and without trade promotion and regulations vaccine productions would be very difficult if not impossible because there would be little attraction for the pharmaceutical industries to invest and produce vaccines for profit.

In addition, Taghizade et al. (2021, as cited in Frontiers, 2022) notes clause 5(c) of the TRIPS Agreement stated that "public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics," can constitute "a national emergency or other circumstances of extreme urgency." This clause provides countries with some flexibility in managing the patents for pharmaceuticals (public goods), especially in situations of "national emergencies" and "other circumstances of extreme urgency" to help countries to response faster without significant placing significant economic burden on themselves in their efforts to secure vaccine for their population (UNDP, 2015). As we have witnessed the coalition in October 2020 by developing countries such as India and South Africa have jointly put up a drafted proposal for a temporary waiver of the Intellectual Property Rights (IPRs) in World Trade Organization (WTO) to address the affordability and accessibility of the COVID-19

vaccines to everyone. However, this proposal was rejected by nine WTO members, including the European Union, though 100 countries showed support for the proposal (Frontiers, 2020).

Moreover, Harvey (2020) and Taghizade et al. (2021 as cited in The Lancet, 2020), argues that while international organisations were rapidly crafting a new governance mechanism to ease Access to COVID-19 Tools (ACT) and accelerators to fast track the development, production, and equitable access to COVID-19 tests, treatments, and vaccines across the globe, high-income countries (HICs) in particular embarked on a scramble of vaccine nationalism, using their wealth and advanced infrastructure to invest in large sums of money to secure exclusive access to vaccines for their populations. In the face of supply constraints during the early roll-out of COVID-19 vaccines and as COVAX, the vaccines of the ACT accelerator, has distributed doses based on the principle of equitable access and fair allocation, the unfortunate politics cripped in when countries initially engaged vaccine diplomacy by sending doses to their friendly allies only and leaving out adverse ones regardless.

Furthermore, the unfortunate behaviour nationalist exclusive vaccine scramble by rich countries brought in renewed scepticism in global governance and solidarity in some quarters in fact, it was amplified by the rise to populism-nationalist headed by President Trump, who went as far as defunding WHO and derailing its initial efforts in managing the pandemic. Though this opened door for a new form of diplomacy, 'vaccine diplomacy' if you like most importantly a new and wider player in global governance and institutional support. Also, during this period, countries practised two forms of health diplomacy as highlighted on The Lancet (2022), one with the aim to establish solidarity, and second, to gain geopolitical advantage over their geopolitical opponents (Hudson, 2020).

GHD is very critical and effective in addressing many of the global health challenges and facilitated the negotiation and establishing of many global frameworks for health regulations as we have seen in the formulation of International Health Regulations (IHRs) of 2005. The Framework Convention of Tobacco Control (FCTC), Universal Health Care (UHC), Sustainable Developmental Goals (SDGs), UN Climate Change Conference in December 2019 and most recently the COVAX Facility in 2020 to address the COVID-19 pandemic (Kickbusch, 2021 as cited in Frontiers, 2021).

The primary goal of health diplomacy during this challenging period was to reduce inequalities by making diagnostics, therapeutics, and vaccinations a global public good accessible to all regardless. GHD served as a bridge for international collaboration in addressing public health issues, improving health services, and rebuilding multilateral institutions by emphasizing universal health coverage for sustainable and equitable growth – this brought back credibility and confidence in global institution and helped saved countless lives (Javed and Chattu, 2020, pp.10).

WHO was blamed by some countries and scholars for not be tough on China for its failure to report early and late closure of its borders to prevent it from spreading across the world which resulted in people traveling in and out from China. (Taghizade et al., 2021) argues, though China was initially seen primarily as the source of the virus, as branded by Trump administration, it has started to provide material and equipment such as masks, PPE to its neighbours, the Middle East, and Europe to soften the resentments. These actions display its engagement in soft power a termed coined by Nye (2004) and change its image in front of the

global community, however, there were also complaints against China for sending the poor-quality masks, and test kits supplied to various countries even though the praised it earned for solidarity overshadowed this (Soylu, 2020).

In addition, states being key players in negotiating binding agreements through the extension of their interests through diplomatic practices (core health diplomacy), they are, by default, part of the GHD (Frontiers, 2021). States cooperations with IOs makes diplomatic engagement at WHO possible and meaningful as the institutions depends significantly on its members to support and fund its operation especially in poor countries where health systems are not developed to response to a major health crisis.

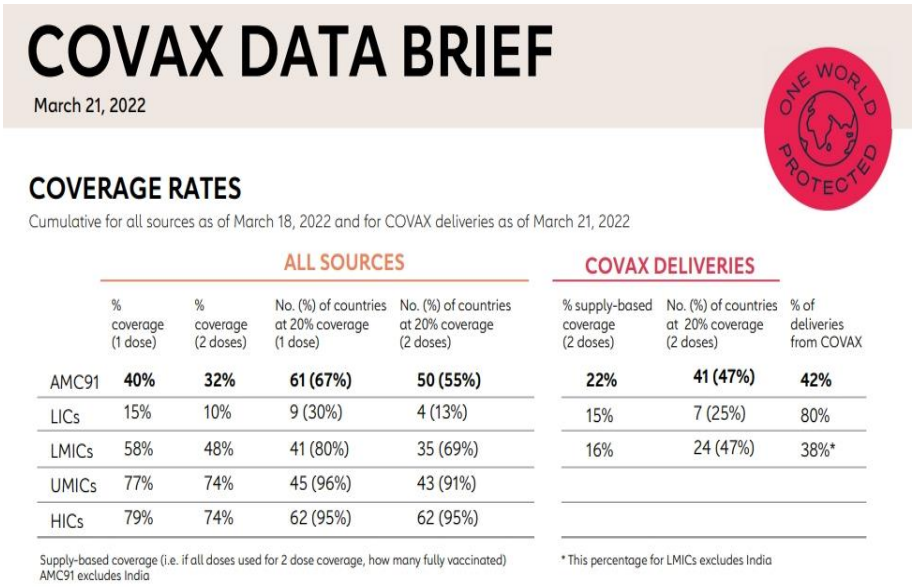
Taghizade et al., (2021) argues that through GHD, countries can cooperate by assisting in whatever possible way they could especially with critical items such as supplying of personal protective equipment (masks, gloves, disposable gowns, disinfectants, etc.), essential drugs, health care resources, working together for new diagnostics, vaccines, etc. as done by some nations through “mask diplomacy”- by sending the face-masks, e.g., China, Taiwan; medical diplomacy- through doctors/ health care staff, and vaccine diplomacy, for example, India by sending vaccines to other countries to gain the goodwill. This COVID-19 pandemic has the potential to galvanize the long-needed global cooperation and has facilitated significant diplomatic reproachment, escalation of relations all thanks to goodwill and solidarity extended to other countries.

In this context, Chattu et al. (2021 cited in Frontiers, 2021) argue that the IPRs regimes should not become a barrier to accessibility and affordability of essential drugs and vaccines for

COVID-19. They note that to succeed and ensure access, India and South Africa should have approached the matter in a different way, by engaging more in GHD with all the involved global stakeholders to get strong support for their joint proposal in the initial stage before reaching the voting stage. According to If the TRIPS waiver request was accepted, access to vital COVID-19 drugs, technologies, and diagnostics could have been greatly improved and swiftly so. As a result, there is a great need for involving physician and diplomats trained in GHD in shaping global trade policies and being the undisputed authorities in the realm of health to counterbalance the overwhelming influence of multi-national companies/corporation.

According to Von Bogdandy (2021) the collaboration from international organizations such as the World Bank, WHO, along with the Bill and Melinda Gates Foundation and other International NGOs, have raised a fund of US$ 8.1 billion and introduced the WHO COVAX initiative for the fair and equitable distribution of an eventually licensed vaccine. The COVAX Initiative is an instrument for a fairer global distribution resulting from successful GHD, but the result can only be assessed after some time based on fulfilling its commitments to the nations. Additionally, Cullinan (2021) notes that currently, there are many challenges with the second and third wave for some countries of COVID-19 pandemic including India, resulting in an acute shortage of vaccines, and the Serum Institute, which had received the contract to manufacture the vaccines under COVAX facility domestic demand and international shipments. As per the latest report 2022, COVAX has a COVID-19 vaccine shortage of 190 million doses, and the few manufacturers that have signed agreements with the facility can only supply later this year 2022.

3.2.1. Figure of cumulative for all sources and for COVAX deliveries as of March 2022.



COVAX DATA BRIEF

March 21, 2022

COVERAGE RATES

Cumulative for all sources as of March 18, 2022 and for COVAX deliveries as of March 21, 2022

	ALL SOURCES				COVAX DELIVERIES		
	% coverage (1 dose)	% coverage (2 doses)	No. (%) of countries at 20% coverage (1 dose)	No. (%) of countries at 20% coverage (2 doses)	% supply-based coverage (2 doses)	No. (%) of countries at 20% coverage (2 doses)	% of deliveries from COVAX
AMC91	**40%**	**32%**	**61 (67%)**	**50 (55%)**	**22%**	**41 (47%)**	**42%**
LICs	15%	10%	9 (30%)	4 (13%)	15%	7 (25%)	80%
LMICs	58%	48%	41 (80%)	35 (69%)	16%	24 (47%)	38%*
UMICs	77%	74%	45 (96%)	43 (91%)			
HICs	79%	74%	62 (95%)	62 (95%)			

Supply-based coverage (i.e. if all doses used for 2 dose coverage, how many fully vaccinated)
AMC91 excludes India

* This percentage for LMICs excludes India

Source: COVAX data brief of March 2022.

Initial scramble for exclusive access to vaccine by wealth countries and regions left low- and middle-income countries helpless until WHO with their Gavi vaccine alliance which delivered considerable number of vaccines to these countries compared to help assist them fight against the virus and safeguard their people. This boosted the administering of vaccines in these countries in fact, the numbers were good in term of vaccines received prior to the COVAX initiative and those received from the initiative.

3.3. The Role of WHO Global Health Diplomacy.

Global institutions are set up to address specific or a set of needs in global governance as is the case of WHO-which was set up for global health governance requiring lot of interactions and negotiations. Kickbusch (2022) argues that global health diplomacy that is carried out at WHO has significance because of its inclusive nature and composite of wider actors from but not limited to 194 member states, its unique role in setting health norms and standards, and its ability to adopt binding instruments negotiated and agreed by its members. Also, the need

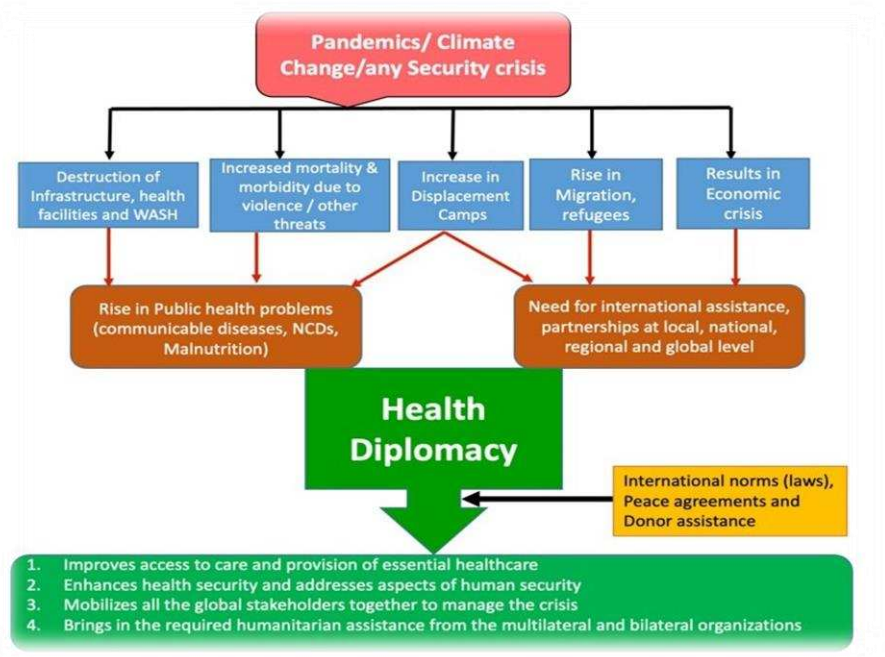
to understand how WHO promotes health outcomes through global health diplomacy, some international relations scholars find it important to study how the WHO Secretariat leadership could influence members in the execution of its constitutional whenever clashes arisen with the interest of a specific or group of members (financially active members) as it sometimes happens (Chorev, 2012, pp.17-40).

Some IR scholars notes that at the dawn of the 21st century, health diplomacy moved centre stage as WHO played an increasingly active role in international politics, and its role as a norm-setter in global health was strengthened especially in the MDGs. Under the leadership of former Director-General Gro Harlem Brundtland, WHO facilitated the adoption of the Framework Convention on Tobacco Control (FCTC) and the revision of the IHRs. Also, these binding agreements initially strengthened the WHO Secretariat's political authority to promote health in the face of a broad range of social, economic, and political interests. The agreements also sent a strong signal which made countries recognise that they needed strong representation in Geneva (the city of diplomacy) to be able to conduct the multi-level negotiations especially in health and health matters. It could be said that health diplomacy has gone beyond the ad hoc nature to a more sustaining one in other words, it is now a constant activity throughout the year—not only on occasion of the meetings of the WHO's governing bodies as it was in the past (The Lancet, 2023).

The constant threat of disease outbreaks has been alarming, and some countries took steps to adjust their national health policy and infrastructure to give it a global dimension and as well integrate it into foreign policy. These has led to a new form of diplomacy, health

diplomacy unlike other forms of diplomacy, it depends on the willingness of countries both bilateral and multilateral to cooperate for global public goods.

Figure 3.3.1. Global Health Threats and Crises Through Health Diplomacy.



Source: Taghizade et al., (2021).

Collin (2022) argues that WHO play key role in the process through which the FCTC was negotiated, it is noteworthy to show how extensive multi-sectoral diplomacy and has set the basis for multiple actors in a complex environment of a comprehensive legal frameworks

which serve as a guide for member governments in setting agendas. Civil society (non-state actors) also played a vital role in shaping preferences of states during the negotiation especially a critical issue which everyone is a stakeholder in one way or the other (The Lancet, 2024).

The world has clearly entered a new stage in the development of global health diplomacy. COVID-19 has led to a flurry of diplomatic activity on global health, involving heads of state and heads of government during a period when multilateralism is subject to substantial challenges due to the rise of populist in powerful countries. Many public health advocates want to see a concerted international response to the COVID-19 pandemic, as was the case decades ago for the HIV and AIDS pandemic and other diseases (Buse and Tlou, 2018).

Fidler (2020), note that looking back at the changes in global health diplomacy over the past two decades argues that how international relations can contribute to health friendly policy making in the future. He further argues a post-Westphalian system has not been established—especially with regards to health and to some extent quite the opposite has happened. The rise of nationalist leaders and distrust in global institutions has further fuelled the tensions between national and global responses to the COVID-19 pandemic. This tension was clearly manifested in vaccine nationalism which initially left the poor, developing countries behind in securing vaccines for their populations.

Additionally, at the initial stage, bringing actors to the table was not an intensified negotiation effort. The supposed neutral body WHO was facing serious criticisms which initially derailed it efforts before a breakthrough came. WHO is necessary in order to ensure a collective

response to pandemics since the 1918 influenza pandemic were initially stalled because of geopolitics, nationalism, and weak institutions. Primarily, the diplomatic stand-off between the USA and China who are key members blocked agreements at WHO, the UN Security Council, the Group of Twenty (G20), and the Group of Seven (G7) (Hudson, 2020, pp.2-3).

Moreover, Habibi and Burci, (2020, as cited in The Lancet 2021) notes the importance of multilateral agreement on health security as the framework on International Health Regulations (IHRs) adopted in 2005 showed its lapses and provide an avenue for which some countries exploited and disregarded the regulations and have neglected it for their nationalist views as opposed to the global or collective responsibility which everybody member owes to the global public goods. The unfortunate instances where members failed to comply with the obligations to close their borders and blocked the export of critical medical supplies. As per the regulation framework, WHO lack of authority and resources hampered advancement at the speed required, causing delays to their confirmation of human-to-human transmission of the COVID-19 virus and to the declaration of a public health emergency of international concern (The Lancet, 2020).

Harvey (2020) notes that the importance of global health diplomacy has been made clear during the COVID-19 pandemic. As always, the relevance of global health diplomacy comes to the fore in health crisis situations. The response to the COVID-19 pandemic has put diplomacy at the centre stage in international organisations and high-level political gatherings, by engaging in crisis diplomacy and negotiating a joined-up response between countries who otherwise have strained and difficult relationships. As the Director-General of WHO, Tedros Adhanom Ghebreyesus, said: “no one is safe until everyone is safe.”

According to Chorev (2012), global health diplomacy at WHO has particular relevance because of its inclusive nature (composed of 194 member states), its unique role in setting norms and standards, and its ability to adopt binding instruments. To understand how WHO promotes health outcomes through global health diplomacy, international relations scholars have studied how the WHO Secretariat and its leadership can act on its constitutional mandate and if the mandate clashes with the interests of member states especially powerful and rich ones (who are funders of WHO).

Additionally, one key feature of diplomacy is representation and communication the latter which is the art and practice of conducting negotiations in any form necessary for the situation at hand. Bilateral diplomacy the most common and at the core of foreign relations, whereas global diplomacy is practised within a well-established multilateral system, whose key features were set with the creation of the UN and the Bretton Woods Institutions after World War 2 to facilitate peaceful engagement between states. These are frameworks set for predictable and measurable global governance practices which works for all especially, small, and poor countries (Harvey, 2020, as cited in The Lancet, 2020).

Moreover, in (Kickbusch, 2023) notes that for global health diplomacy to be effective for states at WHO, although previously accepted goals and architecture have been consistently challenged, the legitimate order still resides in multilateralism and first and foremost in WHO, because of WHO's constitutional mandate for the establishment of norms and standards, high level of legitimacy through the representation of states, and unique treaty-making power. This role has been manifested again by the proposal to negotiate a global pandemic treaty to

help members response to pandemics in bypassing the patent on vaccine in emergency situation.

Raoof (2020, p.32) notes that COVID-19 was first reported in Wuhan, China, in December 2019 hence the name ‘‘COVID-19’’ and was declared as an international public health concern and a global pandemic by the World Health Organization (WHO) on March 11, 2020. As of May 17, 2021, nearly 162.8 million are infected, and over 3.37 million deaths reported to WHO globally, with the death toll still mounting. As of May 17, 2021, a total of 1.26 billion vaccine doses have been administered (WHO, 2020) thanks to WHO and partners COVAX Gavi vaccine alliance (Frontiers, 2021).

Health becomes the hot cake in global agenda in fact, it has been linked with practically all high politics issues in foreign such as health with security, health with economy, health with development and most importantly health with climate change and environment. According to Kickbusch (2021) health is associated with many global crises either resulting to it or being the result. It is embedded in environment, climate and water issues and are addressed at major global and regional summits, including the G7 and G20 summits. Every SDG that has been negotiated has shown that health is a key component and outcome. Therefore, this explains why GHD plays a leading role in every subsequent round of SDG-related negotiations. Given this background, the global health agenda is now viewed as a common challenge for developing and developed nations COVID-19 offers many different examples of health diplomacy but is mostly characterized by fragmentation (Frontiers, 2021).

Taghizade et al., (2021, p4). Note that the right of health issues in global platforms has led to the first UN General Assembly resolution on the coronavirus (UNGA 270.74) which called for international cooperations to combat the virus in short, we have discussed in in previous section that a few large economies that failed to show their leadership or direction to the other developing nations in many aspects and have failed even in diplomacy with their counterparts. This failure has significant consequences for such countries like the US and the UK as some developing countries were forced by the situation to evaluate their foreign policy and engage with a wider range of partners especially fellow Southern developing countries.

Additionally, he argues that the significant role of GHD strategies in addressing the friction between populism and multilateralism in this context. For example, the WHO incorporates and engages in GHD with its strategic alliance partners to balance and address the challenges posed by the populist agendas to address the critical aspects (equity, accessibility, affordability, and availability of services) for the needy and undeveloped regions/nations.

Furthermore, Nabi (2020) notes that perhaps political leaders apply GHD as a soft tool; instead of taking impulsive actions, the fear of the global community of the spread of coronavirus could have been curbed. Also, Adams and Novotny (2010), The declaration in Oslo of the ministers, a sign of the growing role of global health in foreign policy, calls on governments to move toward a diplomatic approach that addresses public health concerns. However, non-compliance to these ideas and neo-nationalism (particularly) may have resulted in serious problems in the way diplomats seek to preserve strategic relations with their allies (Nabi, 2020).

The impact of the COVID-19 pandemic, the withholding of the funding for the WHO by former President of the US, Donald J. Trump, has resulted in an unprecedented situation which at first constraint the amount of support the institution was able to provide until players like China, Germany and non-State actors like World Bank, Bill and Melinda Gate Foundation etc. eventually came to the rescue of WHO initiative. This has affected the health of people living in the Americas as the Pan American Health Organization (PAHO) being a beneficiary (King, 2020, p.96, as cited in Frontiers, 2021) and the fragile economies, reducing the ability of health organizations to help manage endemic, pandemic, and neglected tropical diseases (The Lancet, 2020)**.** To emphasize, WHO and its six regional offices played a vital role during the recent concluded COVID-19 pandemic, which should be commended especially at a time when global institutions were faced with serious threats from the rising populist leaders.

Aside from the ineffectiveness levied on WHO by populists, it finds itself on the spotlight by human rights organizations such as Human Rights Foundation who accused the organization's associates PAHO of facilitating Cuba Medical Diplomacy oversea missions which they alleged are human trafficking by virtue of the United Nations protocol to prevent, suppress and punish trafficking in human beings also known as 'Palermo Protocol 2003'.

CONCLUSION.

The concludes that in recent decades, health issues have been integrated into the foreign policy of many countries in the world especially during and post-COVID -19 era of global health crisis which has generated successful collaboration in health or health diplomacy between states and non-state actors. Equally, it has also integrated into main foreign policy issues: security and economy which are ranked as 'high politics' according to Fidler's foreign

policy ranking - placing health as a ‘‘low politics’’ below security and economy. However, since the turn of millennium, 21st Century health, especially public health and global health in particular has integrated into security which effectively makes it a ‘high politics’; it has continued to be a threat to lives and livelihoods and globalization in particular. This threat was perceived by global leaders leading to its prioritization in global conventions, summits and agendas such as the Millenium Development Goals (MDGs) and Sustainable Development Goals (SDGs), and these threats has come to light in 2019 when COVID -19 has taken so many lives in almost all countries which declared and collected data on COVID-19, and temporary shutting down globalization.

Public diplomacy is an effective tool to advance health issues on global stage, and project soft power tools for global cooperation which small countries such as Cuba has leverage to gather influence over other states in UNGA and non-states actors. Small states can successfully project their foreign policy goals and make significant impacts in global affairs. It also provides opportunities for international organizations or non-state actors to participate and influence agenda in global stage as has happened during COVID-19 when WHO became the number one point of reference for the health guidelines and managements.

Non-state actors such as WHO, a case in this research are key actors in public diplomacy and are one of the main points in global health diplomacy where members sent representatives to be better place in negotiations of health issues that concern them. WHO also provides guidelines in dealing with health emergencies and access to vaccines. The institution has become the first point of reference in global health diplomacy which is evident in the post-COVID -19 when countries sent permanent representatives to Geneva for health diplomacy.

Though the institution lacks the authority to investigate or put member countries to order yet, it has projected a degree of soft power influence over its members and global citizens at large.

The meeting of foreign ministers from the seven countries in Oslo, 2007 to discuss collaboration in health and was a milestone in the integration of health into foreign policy. Public health and health issues in general are beyond traditional understanding and a 'low politics' thing rather and a more inclusive conception which encompasses various streams. Countries such as Cuba has place it in the centre of its foreign policy for decades and is ripping the fruits of it as evident in the successive UNGA votes for US to end embargo on Cuba starting in 1992 with less than half of the total votes to an impressive 97 percent without coercing any member rather through the use of its health diplomacy approach.

Additionally, the case of Cuba is good example of the effectiveness of public diplomacy in generating support for health issues and through health issues – as the is key player in health diplomacy an employed it for almost all its bilateral and multilateral relations; it has started as a tool for South-South Cooperation which it has invested heavily to gather sympathy for the revolution and influence the actions in global platforms. The Caribbean Island has continued to expand its presence in approximately over 130 countries and at last in developed countries such as Italy, San Marino, and Portugal where they sent doctors to help fight the COVID-19 pandemic at a time when little was known about coronavirus.

Cuba, as a state actor in health diplomacy has gathered influence and project soft power through its medical diplomacy – this has played favourable outcome for the country. The country has managed to outmanoeuvre and registered votes in its favour at the United

Nations General Assembly's votes for US to end embargo on Cuba – one which it has about 50 per cent of the total votes in 1992 and 97.5 per cent of the total votes in 2021.

At last, the first time in its kind, the world has learnt firsthand the extent of globalization: the interconnectedness of cities, regions, countries and of course the people when the virus has invaded and almost shutdown public spaces, markets, and integration. Unfortunate as it may be however it opened the door for countries to collaborate, invest and integrate health issues fully into diplomacy.

The author concludes that though, Cuban health diplomacy is a laudable initiative however, it has substantial elements of human trafficking, forced labour and abusive working environment which contravened UN Palermo protocol (2003), and International Labour Organization (ILO) framework which promotes freedom, security and dignify work arrangement. There is also a clear gap in the policy which basically led to many defections from the oversea missions.

This research is built on the shoulder of the existing literatures in international relations, world politics and global health in relations all in relation to public diplomacy. This study tried to bridge the gap that exist in the literatures on how state and non-state actors infused health issues in their diplomatic practices – and effective they project this in their interactions and agenda setting.

The author hopes this study would inspire more study in this field and expound to bridge the gap between state and state actors pursue of influence through various public diplomacy tools such as health diplomacy in the maintenance global health and collaboration. In the light of threats posed by virus and other forms of disease, states would collaborate and recommit

their support both political and financial to World Health Organization in other to effectively monitor and counter the emergence of disease outbreaks and inform member countries with health guidelines for the protection of all.

WHO and by extension United Nations should provide a comprehensives framework to in-line with relevant international instruments to guide humanitarian health aid or trade in health practices in other to safeguard health personnels sent overseas for missions under bilateral, multilateral, or individual agreements.

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