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ASIA'S PARTICIPATION IN GLOBAL HEALTH DIPLOMACY AND GLOBAL HEALTH GOVERNANCE*

David P. Fidler**

ABSTRACT

This article provides a framework for thinking about Asian approaches to and impact on global health diplomacy and governance that might contribute to more sophisticated analyses on Asia in global health politics, diplomacy, and governance. First, the article examines the "rise of Asia" and "rise of health" as overlapping but unconnected developments in international relations. Second, it analyzes how the shift of power and influence towards Asia, largely caused by China's and India's emergence as great powers, affects global health politics and potential Asian contributions to global health diplomacy and governance in the future. Third, the article looks at normative ideas that characterize Asian approaches to international cooperation and how these ideas affect Asian participation in global health diplomacy and governance. Fourth, the article considers Asian practices on international health cooperation, which include bilateral relations, regional activities, and participation in multilateral organizations. The article ends with conclusions about Asian conceptualizations of and contributions to global health diplomacy and governance.

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KEYWORDS: Asia, Global Health Diplomacy, Global Health Governance, Global Health Politics, the Five Principles of Peaceful Coexistence, APEC, ASEAN
I. INTRODUCTION

Although global health diplomacy and global health governance have grown as topics of interest in global health and international relations, the perspectives and roles of Asian countries and the Asian region in global health diplomacy and governance have not been as frequently addressed. Whether and how Asian countries have conceptualized and contributed to global health diplomacy and governance are increasingly important questions as Asia emerges as a more prominent region for political and economic activities. Analyzing Asian perspectives of and participation in global health diplomacy and governance is difficult because of the political, economic, and cultural complexity of the Asian region and the quantity and diversity of problems addressed through different diplomatic and governance mechanisms. This article provides a basic framework for thinking about Asian attitudes towards, approaches to, and impact on global health diplomacy and governance that might contribute to more sophisticated conceptual and empirical work taking place on Asia in global health politics, diplomacy, and governance more generally.

This article's analysis contains four parts. First, the article examines the “rise of Asia” and “rise of health” in international relations. These two
developments are not often linked or connected, except when experts identify health as a new, non-traditional security threat Asian countries have to address or as a “global problem” strategies against which require the Asian government involvement. Put another way, the rise of Asia has had little to do with the rise of health as a foreign policy, diplomatic, or global governance issue, and vice versa. However, Asia’s growing economic, political, and strategic importance is significant for exploring how Asian governments conceptualize global health challenges and what contributions Asian countries have made or can make to global health diplomacy and governance.

Second, the article analyzes how the shift of power and influence towards Asia, largely caused by China’s and India’s emergence as great powers, affects global health politics currently and potential Asian contributions to global health governance in the future. This power shift has positive and negative implications for Asia’s participation and place in global health diplomacy and governance. How Asian countries view their new power and influence will shape how they conceptualize global health as an issue and how they approach global health diplomatic and governance activities.

Third, the article looks at normative ideas that characterize Asian approaches to foreign policy and international cooperation. The key norms are the Five Principles of Peaceful Coexistence (Five Principles), first articulated in 1954 by China, India, and Burma, but which have become tenets of Chinese and Indian foreign policies and Asian regional diplomacy, especially in the Association of Southeast Asian Nations (ASEAN) (see Box 1). The Five Principles are: (1) mutual respect for territorial integrity and sovereignty; (2) mutual non-aggression; (3) mutual non-interference in internal affairs; (4) equality and mutual benefit; and (5) peaceful coexistence. The Five Principles apply to health problems as to other policy topics, and, thus, are relevant for understanding how Asian countries think about international cooperation on health.

Fourth, the article considers Asian practices on international health cooperation, which include bilateral relations, regional activities, and participation in multilateral organizations. Asian diplomacy includes health in all these contexts, but the activities tend to be State-centric because they utilize traditional, sovereignty-sensitive mechanisms of cooperation. Asian countries have not been prominent in more innovative global health governance mechanisms developed in the past 10-15 years. This review of Asian diplomatic practices also considers some Asian-specific controversies and the future of global health diplomacy and governance in an Asian-centric international system.

The article ends with conclusions about Asian conceptualizations of and contributions to global health diplomacy and governance. A key
conclusion is that, to date, there is nothing distinctive about Asian conceptualizations of or contributions to these activities. Asian power, shared principles, and diplomatic practices have not caused or driven the recent transformations of health as a foreign policy issue or the manner in which global health governance has evolved over the past decade. The article identifies some possibilities for a more pronounced Asian role in global health diplomacy and governance, as well as highlighting obstacles facing Asian countries, especially China and India, in blazing a more Asian-influenced future for global health.

II. RISE OF ASIA, RISE OF HEALTH, AND MULTIPOLARITY IN WORLD AFFAIRS

As many books, articles, and media reports have analyzed, the past two decades have witnessed, simultaneously, the growth in political, economic, and strategic importance of the Asian region and health’s increased prominence in foreign policy, diplomacy, and global governance. By and large, the literature on Asia’s new significance and the analyses on global health’s new importance do not overlap, meaning that experts do not explain these phenomena as interdependent or even interconnected. This observation has important implications for trying to understand Asian conceptualizations of and contributions to global health diplomacy and governance.

To begin, the lack of connections between the rise of Asian countries and the unprecedented political importance global health has achieved indicate that Western countries, especially the United States and European nations, are the major force behind the transformation of global health as a foreign policy issue and diplomatic concern. The increasing influence of Asian countries in world affairs has produced debates about “Asian values,” an “Asian way” of policy-making and diplomacy, the “ASEAN way” of regionalism, and contributions to international law of Asian civilizations and cultures. Mahbubani and Chesterman, for example, describe the “Asian way” of approaching diplomacy and governance as having positive and negative features:

The positive aspects of this approach to diplomacy and governance include respect for diversity, consensus-building over conflict, pragmatic approaches rather than lofty principles, and gradualism rather than abrupt change. The negative aspects

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5 S.T. Lee Project Study Group on Global Health Governance, Overview and Guidance for Participants of Global Health Governance Study Group Workshop (Sept. 2009) (on file with author) (noting that the majority of contributions to global health governance have come from Western developed countries).
can be that the desire to avoid confrontation prevents meaningful agreements being concluded in a reasonable timeframe, or that the appearance of consensus merely masks the true politics at work.⁶

Discussions and debates about the “Asian way” of conducting international relations have not involved much, if any, attention on Asian attitudes towards health domestically or globally. As analyzed more below, Asian countries have addressed health challenges during Asia’s rise to greater political and economic prominence, but these efforts at health diplomacy have not produced or characterized the larger geopolitical shift of power and influence towards Asia.

The lack of any prominence for health in Asia’s political emergence raises the question what Asia’s trajectory of increasing political, economic, and strategic importance means for health diplomacy and global governance. In geopolitical terms, Asia’s rise changes the structure and dynamics of the international system, moving it away from the quasi-hegemonic, American-centric, post-Cold War system into an Asian-influenced multipolar arrangement in which China and India emerge as great powers. This still-unfolding change in the international system cautions that the transformations in health diplomacy and governance in the post-Cold War period may reflect the system that prevailed during those years. In other words, the changes seen in health as a political, diplomatic, and global governance issue over the past 10-15 years are not permanent and are unlikely to continue or reappear in the foreseeable future.⁷

In the new, emerging system, international relations will reflect both solidifying multipolarity and continued globalization. Put another way, States will confront many collective action problems caused or exacerbated by globalization, including health challenges, but producing effective cooperative solutions will be harder in a multipolar system. The U.S. National Intelligence Council characterized this more difficult political, diplomatic, and governance context as potentially exhibiting “multipolarity without multilateralism.”⁸ This emerging geopolitical context means that what China, India, and other Asian countries want will matter more in terms of the international competition for material power and ideas, but

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⁷ See, e.g., David P. Fidler, The Challenges of Global Health Governance (Council on Foreign Relations, Working Paper, May 2010) (arguing that the revolution in global health governance that occurred over the past 10-15 years has ended and that the political conditions needed for more radical changes in global health governance in the near future will not be present).
Asian preferences might not prevail if opposed by other geopolitical heavyweights.

Cooperation and collective action might only be effective on problems, such as virulent and mobile infectious diseases (e.g., pandemic influenza), where countries share strong converging, reciprocal interests in addressing such common threats. More epidemiologically and politically complex global health problems, such as improving the social determinants of health (e.g., poverty, education, gender equality) within countries as identified by the World Health Organization (WHO) Commission on the Social Determinants of Health, could face greater difficulties. In short, the emerging multipolarity created by their rise to greater power and influence might limit the ability of Asian countries to influence global health diplomacy and governance significantly should they attempt to do so.

III. IMPLICATIONS OF ASIAN POWER FOR GLOBAL HEALTH GOVERNANCE

The "rise of Asia" refers to the realization in international relations that political and economic power and influence is shifting towards Asia. The catalyst for this dramatic shift has been the sustained, significant economic growth achieved by China, India, and Southeast Asia. One prominent marker for this shift in power and influence is the decision to have the Group of 20 (G-20) replace the Group of 8 (G-8) as the premier international forum among the world’s most important economic powers. The G-8 had only one member from Asia (Japan), but the G-20 has five (China, India, Indonesia, Japan, and the Republic of Korea). For global health diplomacy and governance, this power shift has positive and negative features that deserve examination.

A. Positive Features of Asian Power for Global Health Politics

In terms of positive features, economic growth has contributed to progress in Asia with respect to the Millennium Development Goals (MDGs) developed by the United Nations (U.N.), which include health-specific objectives (e.g., reducing the burden of HIV/AIDS, tuberculosis, and malaria; reducing child mortality; and improving maternal health) and goals on improving key social determinants of health, such as poverty reduction, education, empowerment of women and girls, and ensuring environmental sustainability. For example, the U.N. reported

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that "[t]here was a dramatic fall in the poverty rate in Eastern Asia – thanks in large part to rapid economic growth in China, which helped lift 475 million people from extreme poverty."\textsuperscript{11}

The positive health implications of Asian economic growth do not, however, owe anything to global governance institutions, instruments, or initiatives specific to global health. Asian economic growth has occurred because of, among other things, domestic economic reforms inside Asian countries, negotiation of bilateral and regional trade and investment agreements, foreign investment in Asian economies, and Asian participation in the multilateral World Trade Organization (WTO).

A second positive aspect of the shift in power and influence towards Asia has been that this transition has, so far, been peaceful. Previous shifts in geopolitical tectonic plates have produced tensions, rivalries, and conflict. Both China's and India's increased power and influence have caused nervousness, suspicions, and some balancing behavior regionally and globally, but, to date, this historic shift has not triggered war or threats of war, which is good for global health given how devastating war is for population and individual health. Asia has not been free of armed conflict in the past 10-15 years, but the conflicts that have occurred (e.g., the Indo-Pakistan conflict in 1999; the Tamil Tiger insurgency in Sri Lanka; the Taliban/Al Qaeda insurgency in Pakistan; the Naxalite insurgency in India) arise from problems that have little, if anything, to do with Asia's growing geopolitical gravitas. But, the lack of armed conflict among countries related specifically to Asia's rise has nothing to do with health diplomacy or governance.

A third potentially positive feature is more speculative and controversial but is still worth mentioning. As China and India emerge as great powers, they may wish to compete more effectively with the United States, Japan, and other powers in the "soft power" or "smart power" arena of global health. Already, China views health activities as part of its soft-power efforts in Africa.\textsuperscript{12} Likewise, India incorporates health cooperation as part of its efforts to improve political and economic relations with African countries.\textsuperscript{13} Multipolarity could stimulate more competition for leadership in global health, with different national

\textsuperscript{13} Africa-India Framework for Cooperation, presented at India-Africa Forum Summit, at 8-9 (Apr. 8-9, 2008) (outlining cooperative efforts in the field of health).
initiatives being created to include health goals or to address various global health problems. Such soft-power competition could bring additional attention, political capital, and economic resources to global health. The potential downsides for global health politics would be that (1) such a “health race” would continue to fragment global health governance instead of contributing to a more consolidated strategy; and (2) global health would become increasingly a policy space in which the great powers pursue their narrow, national interests rather than support broad-based collective action that improves health globally.

B. Negative Aspects of Asian Power for Global Health Politics

The negative implications of the power shift to Asia for global health diplomacy and governance are three. First, the health benefits of economic growth depend on such growth continuing, which, as the global economic crisis of 2008–10 proved, is not guaranteed. Although China and India have weathered this crisis better than others, it took a terrible economic and social toll that set back achievement of the MDGs.\(^{14}\)

Second, the power shift means that multipolarity will characterize the structure and dynamics of the international system, which, as described above, might make effective cooperation on collective action problems in global health more difficult. A soft-power “health race” among the great powers would not necessarily produce effective collective action and would multiply global health initiatives without an overall strategy. In addition, the multipolarity that emerges might not be stable because rivalries could develop (e.g., China v. United States) that result in political, economic, and military resources being expended in ways that provide no global health benefits.

Third, the growth of Asian power and influence does not eliminate massive domestic problems Asian countries face, especially China\(^{15}\) and India.\(^{16}\) To maintain their great power status, China and India might focus more on their own serious domestic political, economic, and social problems, including health, and not increase significantly their support for, or take leadership roles in, diplomatic initiatives or global health governance. Improvements in domestic health conditions in China and India would, given the size of their respective populations, benefit global health outcomes, but these improvements would not rely heavily on global

\(^{14}\) See U.N., supra note 11, at 4.

\(^{15}\) Chang-fa Lo, Values to Be Added to an “Eastphalian” Order by the Emerging China, 17(1) INDIANA J. GLOBAL LEGAL STUD. 13 (2010).

\(^{16}\) David P. Fidler & Sumit Ganguly, India and Eastphalia, 17(1) INDIANA J. GLOBAL LEGAL STUD. 147 (2010).
health governance mechanisms, with the exception of international development assistance.

**IV. ASIAN PRINCIPLES AND GLOBAL HEALTH DIPLOMACY AND GOVERNANCE**

Although Asia is diverse politically, economically, culturally, and in terms of civilization development, Asian countries have exhibited solidarity on basic normative ideas for participating in international relations – the Five Principles of Peaceful Coexistence. The importance of the Five Principles in Chinese, India, and Asian foreign policy, regional efforts, and participation in multilateral forums is well known both historically and in contemporary international relations:

Pan-Asian support for the [Five Principles] has deep roots in the emergence of Asian societies from imperialism, and the Five Principles have resonated strongly in Asia to the present day. The Five Principles laid the basis for the Association of Southeast Asian Nations (ASEAN) in 1967 and were reinforced in the 1994 creation of the ASEAN Regional Forum on security issues. More recently, the first India-ASEAN summit in 2002 explicitly referred to the Five Principles, and China and India jointly celebrated the fiftieth anniversary of the Five Principles in 2004. Outside Asia, both China and India have used the Five Principles to shape their relations with countries across the Middle East and Africa.\(^\text{17}\)

Thus, the Five Principles constitute the normative framework Asian countries, at present, utilize as material power and political influence move their direction. Asian countries have given no indication that global health falls outside the scope of the Five Principles. Thus, the Five Principles remain important for how Asian countries conceptualize global health diplomacy and governance now and in the foreseeable future.

**A. Sovereignty and Non-Intervention**

Asian emphasis on the Five Principles in global health runs counter to trends witnessed in this area of enquiry over the past 10-15 years. For example, support for a strong sovereignty principle clashes with many arguments made in global health that traditional notions of sovereignty are

an obstacle and that effective global health governance requires less emphasis on national sovereignty and more attention to internationalized or globalized governance approaches. In this regard, Stevenson and Cooper argued that the actions of Asian countries in global health episodes — China and SARS, Indonesia and avian influenza A (H5N1), and Burma and HIV/AIDS — illuminate “sovereignty as an impediment to progressive global health governance.”

Discourse on global health governance also contains frequent assertions that States must be held increasingly accountable domestically and internationally for their performance in health contexts. Such accountability requires the ability for the international community to scrutinize and, if necessary, interfere in the domestic affairs of States unable or unwilling to protect and promote health effectively. This increasing demand for accountability is connected with renewed efforts to emphasize and strengthen the human right to health, but it is perhaps most dramatically seen in the development of a purported new principle of international law called “the responsibility to protect.” The Asian preference for a strong principle of non-interference in the domestic affairs of sovereign States stands athwart this movement for global accountability of governments for health in their territories and opposes the principle of the responsibility to protect and similar interventionist notions connected with concepts of human rights and humanitarian imperatives.

Literature on global health governance also contains arguments that the capabilities and authority of international organizations, especially WHO, should be strengthened and expanded. Moving in this direction requires greater institutionalization of global health policy and, potentially, greater legalization through adoption of more binding rules, for example, in the mould of the WHO’s Framework Convention on Tobacco Control (FCTC) and International Health Regulations (2005) (IHR 2005). However, applications of the Five Principles have, especially in the regional context, demonstrated Asian preferences for weak institutions and utilization of non-binding strategies and solutions. As Mahbubani and Chesterman noted, the Asian “preference is still for consultative, non-binding forums that avoid issues of national sovereignty.” ASEAN provides the best example of this Asian predilection because this regional organization “is associated not with sovereignty-reducing integration but with the “ASEAN Way”: a

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18 Stevenson & Cooper, supra note 3, at 1380.
20 INT’L COMM’N ON INTERVENTION & STATE SOVEREIGNTY [ICISS], THE RESPONSIBILITY TO PROTECT (2001).
22 Mahbubani & Chesterman, supra note 6, at 3.
process of consultation and consensus that is identified with many of the cultures in the region.”  

Another characteristic of global health politics identified in the past 10-15 years has been the increased involvement of non-State actors, especially non-governmental organizations (NGOs) and philanthropies (e.g., Carter Foundation, Clinton Foundation, and Gates Foundation). Although the Five Principles are not overtly hostile to non-State actors, they are State-centric principles, embodying the belief that States remain the primary interlocutors of world affairs. The activities of NGOs, especially those engaged in human rights advocacy, and philanthropic foundations endowed with substantial resources can be conduits for outside interference in a State’s domestic affairs. The Asian stress on non-interference through application of the Five Principles creates a more skeptical view of non-State actor involvement in global health than has appeared in global health governance discussions elsewhere.

The principle of non-interference creates other potential problems for Asian perspectives on global health diplomacy and governance. Many global health problems stem from practices, traditions, patterns, and systems embedded in countries, forcing solutions to require significant changes to domestic affairs. For example, inadequately regulated economic activities, such as lax biosecurity and biosafety standards in industrial-scale poultry production, contribute to global health problems, including the spread of zoonoses and antimicrobial resistance. Health-systems reform – a leading global health concern24 – requires transformation of domestic medical, health care, and regulatory arrangements in many countries. Improving fulfillment of the human right to health often involves the need for significant domestic policy reformation across the many policy sectors progressive realization of the right to health directly and indirectly affects.

Similarly, addressing the growing prevalence of non-communicable diseases in countries, such as diseases associated with tobacco consumption, requires serious interventions within domestic societies. Reducing corruption in order to achieve “good governance” – both important goals for improving health systems’ performance26 – involve alterations to political and legal systems. Improving social determinants of health in many nations cannot be achieved without transformations of aspects of government and society, including the political, economic, and social

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24 *Institute of Medicine, Sustaining Global Surveillance and Response to Emerging Zoonotic Diseases* (2009).
conditions that produce poverty, poor education, discrimination against females, and environmental degradation. Preventing and mitigating the health-related impact of climate change will necessitate serious changes within greenhouse gas-producing countries, including China and India.

The principle of non-interference in the Five Principles creates problems for global health actions required to stimulate reforms for health-related challenges, such as those mentioned in the previous two paragraphs, that are embedded in the domestic politics, economics, laws, regulatory capabilities, and governing cultures of sovereign States. As examined below, this observation does not mean that Asian countries avoid international cooperation on these challenges; rather, it means that Asian commitment to the principle of non-interference limits the scope of global health diplomacy and governance on health problems tightly intertwined with the domestic affairs of States.

B. Equality and Mutual Benefit

The principle of equality and mutual benefit in the Five Principles also creates complications and problems for global health diplomacy and governance. This principle harkens back to the unequal treatment and exploitation many Asian countries experienced at the hands of Western imperial powers. This unfortunate heritage makes Asian governments particularly sensitive to political and economic developments that threaten to treat them unequally or inequitably or that produce benefits mainly for other countries.

This sensitivity has been prominent in the controversy caused by Indonesia's stance on avian influenza A (H5N1) virus sharing and access to benefits, such as vaccines, developed through research on such virus strains. Concern about the unequal impact and benefits of patent protection on pharmaceuticals, especially for developing countries, required by the WTO and bilateral trade agreements also reveal this sensitivity about equality and mutual benefit. The principle of equality and mutual benefit informs China's and India's stances on climate change – the Western, industrialized countries caused the problem and should take greater responsibility rather than demanding that developing countries limit their development prospects. This perspective appears in the Copenhagen Accord negotiated in December 2009, which provides that developed and developing countries should cooperate in achieving the peaking of global

27 Marmot et. al, supra note 9.
and national emissions as soon as possible, recognizing that the time frame for peaking will be longer in developing countries and bearing in mind that social and economic development and poverty eradication are the first and overriding priorities of developing countries.\textsuperscript{30}

\textbf{C. Gap between Asian Principles and Thinking on Global Health Diplomacy and Governance}

These examples illustrate how Asian commitment to the Five Principles complicates global health diplomacy and governance and reflects a gap between the post-sovereignty mindset alive and well in global health discourse and the post-colonial insistence by Asian countries on respect for sovereignty and non-interference as fundamental principles in international relations. The emergence of China and India as great powers in a multipolar system has two additional effects with respect to the impact of the gap between post-sovereignty global health approaches and the pro-sovereignty commitment by Asian countries to the Five Principles.

First, as great powers, China and India will increasingly be able to deflect criticisms of their domestic behavior and proposals for health-related outside intervention in their domestic affairs. An example of this ability to shrug off criticism can be found in China’s aggressive measures against influenza A (H1N1), such as quarantines of foreign travelers, which created controversy but which China sustained and increased as other countries scaled back their responses in light of new epidemiological information about the H1N1 virus.\textsuperscript{31}

Second, Chinese and Indian commitment to the Five Principles will shape their relations with other countries, which might prefer the Five Principles-approach to more demanding, interventionist ideas prevalent in Western thinking. As Cooke argued:

\begin{quote}
China’s respect-for-sovereignty rhetoric still resonates for many Africans. China’s often expressed respect for sovereignty and territorial integrity and its policy of noninterference resonate for obvious reasons with many African leaders. But they resonate too with many Africans who view Western lecturing on human rights, economic liberalization, and democracy as condescending and hypocritical. The lack of conditionality or broad consultation attached to Chinese assistance and loans
\end{quote}


\textsuperscript{31} Huang, \textit{supra} note 3, at 140-45.
allows projects to be implemented quickly, with visible and often immediate results.\textsuperscript{32}

The appeal of a Five Principles-based approach taken by Asian countries, especially China and India, might force governmental and non-governmental advocates for more serious domestic changes in countries on the defensive because these countries can seek Chinese or Indian support, which might respond positively to such appeals in order to increase their soft power and open channels of political influence in other countries.

V. ASIAN DIPLOMATIC PRACTICES AND GLOBAL HEALTH DIPLOMACY AND GOVERNANCE

Understanding Asian conceptualizations of and contributions to global health diplomacy and governance also requires comprehending how Asian countries undertake health cooperation in their respective foreign policies and diplomatic activities. Diplomatic practices can reveal wrinkles in governmental attitudes towards collective action that suggest subtle differences and possibilities not reflected in frequently expressed concerns about power, sovereignty, non-interference, equality, and mutual benefit. Asian countries participate extensively in diplomacy and collective action on health matters, suggesting that Asian governments engage frequently in global health efforts. This Asian participation in global health diplomacy and governance tends to be very State-centric through the predominant use of traditional diplomatic approaches informed by the Five Principles. This approach to international health cooperation and governance is consistent with the general pattern associated with the diplomacy of Asian countries in other policy realms.

A. Asian Participation in Global Health Diplomacy

Like global health governance, the practice of “health diplomacy” and “global health diplomacy” has become an increasingly high-profile topic in global health.\textsuperscript{33} Asian countries have addressed health issues in their diplomatic activities in bilateral, regional, identity- or status-based, and multilateral cooperative endeavors. In the bilateral realm, health diplomacy and cooperation has featured in Chinese and Indian relations with Africa.\textsuperscript{34} Sino-American and Indo-American bilateral cooperation include joint

\textsuperscript{32} Cooke, supra note 12, at 27.
\textsuperscript{33} See supra note 1.
Japan has staked a claim to being a global health leader by increasing its support for health initiatives in its diplomatic activities with other countries.

Regionally, health diplomacy and cooperation feature on the agendas of numerous Asian regional organizations, including ASEAN, the Asia Pacific Economic Cooperation (APEC) forum, the South Asia Association for Regional Cooperation, and the Shanghai Cooperation Organization. Asian participation in identity- or status-based intergovernmental organizations, processes, and initiatives – such as the G-8, Organization of the Islamic Conference, and South-South collaborations – also includes health issues. Table 1 contains brief examples of health activities under these regional and identity- or status-based intergovernmental organizations.

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35 White House, U.S.-China Joint Statement (Nov. 17, 2009); White House, Fact Sheet: U.S.-India Cooperation to Protect the Health of Their People (Nov. 24, 2009).
43 Margaret Chan, Director-General of the WHO, Message at the Opening Ceremony of the South-South Development Expo (Dec. 15, 2009), http://www.paho.org/English/D/WHODGSpeech_SouthSouthGF09_eng.htm (last visited Sept. 21, 2010).
Table 1: Health Activities in Regional, Identity-Based, or Status-Based Intergovernmental Organizations Involving Asian Countries

<table>
<thead>
<tr>
<th>Organization</th>
<th>Example(s) of health cooperation areas</th>
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<tr>
<td><strong>Regional Organizations</strong></td>
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</table>
| APEC | • Health Ministers’ Meetings  
• Health Working Group (influenza preparedness, HIV/AIDS, improving health through health information technologies)  
• Infectious disease surveillance |
| ASEAN | • HIV/AIDS  
• SARS  
• Avian influenza A (H5N1)  
• Influenza A (H1N1) |
| Shanghai Cooperation Organization | • Pandemic influenza  
• HIV/AIDS  
• Tuberculosis  
• Malaria |
| South Asia Association for Regional Cooperation | • Information sharing on infectious disease outbreaks  
• Sharing of health knowledge and expertise  
• Sharing of drug manufacturing capacities  
• Adopting regional standards on drugs and pharmaceuticals |
| **Identity- or Status-Based Organizations and Initiatives** | |
| G-8 | • Access to antiretrovirals for HIV/AIDS  
• Malaria  
• Tuberculosis  
• Avian influenza A (H5N1)  
• Polio  
• Bioterrorism  
• Improving health systems |
| Organization of the Islamic Conference | • Polio  
• Malaria  
• Tobacco control  
• Pandemic and avian influenza  
• Health equity in the Islamic Ummah |
| South-South collaborations | • Health care delivery  
• Food security  
• Child labor  
• Hunger  
• Poverty |
At the multilateral level, Asian countries participate in intergovernmental organizations important in global health governance, such as the U.N., WHO (including its relevant regional offices), UNAIDS, International Vaccine Institute (located in South Korea), the World Bank, and the WTO. Asians have served as the WHO Director-General three times in its history – Hiroshi Nakajima (Japan, 1988-1998), Jong-wook Lee (South Korea, 2003-2006), and Margaret Chan (China, 2006-present). In terms of WHO legal instruments important in global health governance, many Asian countries have become States Parties to the FCTC, and all Asian members of WHO are States Parties to the IHR 2005.45 In terms of other high-profile multilateral efforts, Indonesia and Thailand were founding members of the Foreign Policy and Global Health initiative launched in 2007.46

In terms of more innovative global health governance efforts made in recent years (e.g., public-private partnerships), representatives from Asian countries participate or have participated as board members on the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the GAVI Alliance.47 However, Asian countries have not, to date, become donors in the GAVI Alliance, the International Finance Facility for Immunization, or the Advance Market Commitment for Pneumococcal Vaccines.48

Although Asian participation in global health diplomacy and governance is extensive, this level of participation is not distinctively Asian. The growth of the political and economic importance of global health in foreign policy, diplomacy, and global governance over the past 10-15 years reveals that many countries and regions have increased their involvement in global health as Asian countries have. As argued above, the rise of Asia has not been linked with global health’s increased diplomatic importance, indicating that Asian participation in health diplomacy and collective action has not been considered seminal to the transformation of health as a foreign policy, diplomatic, and global governance issue. Nor does the level of Asian diplomatic activity on health provide insight into whether Asian

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49 GAVI Alliance, Donor Contributions and Commitments: Latest Figures (as of July 2010), http://www.gavialliance.org/about/donors/table/index.php (last visited Sept. 21, 2010).
participation has contributed to the achievement of more effective, equitable, and sustainable results for global health.

B. The Image of Asia as a Source of Global Health Problems

Rather than being recognized for heightened level of diplomatic endeavors on health, Asia and Asian countries have been more frequently associated with problems that challenge or threaten global health diplomacy and governance. These episodes include Asian countries being (1) the origin and epicenter of dangerous outbreaks, especially SARS and avian influenza A (H5N1); (2) threatened by the continued spread of HIV/AIDS, AIDS-associated sequela (e.g., tuberculosis), malaria, and dengue fever; and (3) in danger from negative health impacts predicted to be caused by climate change.

In addition, Asia has been the location for global health controversies that are suggestive of the difficulties the rise of Asia might present for the development of global health governance, especially concerning application of the Five Principles. For example, Asian opposition to the responsibility to protect principle blocked attempts to address health and other humanitarian concerns Western States and NGOs raised after Cyclone Nargis hit Myanmar\(^5\) and the Sri Lankan government defeated the Tamil Tiger insurgency.\(^2\) Similarly, Indian, Chinese, and ASEAN refusal to interfere in Myanmar’s domestic affairs has allowed that failing State to cause and exacerbate domestic and cross-border health problems – HIV/AIDS, malaria, illicit drug use and trafficking – that undermine national, regional, and global health.\(^5\)

Similarly, Asian support for Indonesia’s claims of “viral sovereignty” over avian influenza A (H5N1) virus strains collected in Indonesian territory challenged the legitimacy of WHO’s Global Influenza Surveillance Network, damaged global efforts at H5N1 surveillance, and contributed to the establishment of a new intergovernmental negotiating process supervised by WHO on virus and benefit sharing that has yet to reach any mutually satisfactory solution.\(^5\) As observed above, the Indonesian stance and Asian backing for it reflected long-standing Asian

\(^{51}\) No Shelterfrom the Storm: Cyclone in Myanmar, 387(8579) ECONOMIST 78, 78 (May 10, 2008).
\(^{52}\) Asia-Pac. Centre for the Resp. to Protect, Cyclone Nargis and the Responsibility to Protect: Myanmar/Burma Briefing No. 2, (May 16, 2008).
\(^{53}\) Stevenson & Cooper, supra note 3, at 1384-89.
concerns about unequal, potentially exploitative regimes and practices in international relations. Yet, despite Asian support for Indonesia’s position, no other Asian countries have followed Indonesia’s lead and refused to share influenza virus samples for purposes of global surveillance for either influenza A (H5N1) or pandemic influenza A (H1N1).

The clashing Chinese and Taiwanese perspectives on sovereignty generated controversy and diplomatic problems during the negotiation of the IHR 2005 that nearly damaged the negotiations severely. Taiwan wanted to use the principle of universal application included in the IHR 2005 to heighten its legitimacy as a sovereign State, but China refused to budge on its position that it maintains sovereignty over Taiwan. The China-Taiwan problem is not unique to global health, but the problem’s flare-up during the IHR 2005 negotiations revealed that even global health is not important enough to China for exceptions to core claims of national sovereignty to be tolerated.

Concerns about Asian attitudes towards human rights have also arisen in global health. One source of these concerns was the controversial “Asian values” debate in the 1990s that pitted assertions about Asian cultural understandings of rights against more universalistic perspectives advanced by human rights advocates and international bodies. Ginsburg has argued that “[t]he greatest conceptual innovation of Asian states in international law in the past several decades has been a regressive one, namely the idea that “Asian values” offered an alternative to liberal universalism.” Although the Asian values debate did not focus on health, the debate raised worries among those who believe that universal human rights are a critical feature of contemporary global health politics.

Added human rights discomfort concerning Asia flows from the weakness of human rights institutions and processes in the Asian region. Unlike Africa, the Americas, and Europe, Asia does not have regional human rights machinery. The nearest thing to such machinery is the ASEAN Intergovernmental Commission on Human Rights, which ASEAN established in October 2009. Not surprisingly, this new development has been controversial, especially whether the ASEAN members really intend to create a robust mechanism given their attachment to sovereignty and non-interference in domestic affairs. The Commission has been called the

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56 Ginsburg, supra note 23, at 33.
“world’s most toothless human-rights body” and “remarkable and ... an essential first step toward ASEAN’s stated goal of respecting and protecting human rights.” Although it is too early to evaluate the Commission’s performance, continued ASEAN and Asian adherence to the principles of sovereignty and non-interference would make the eventual development of an effective regional human rights regime doubtful. The fulfillment of human rights relevant to health is, under the Five Principles, a matter of a country’s internal affairs in which other States or international organizations cannot interfere.

China and India have also generated controversy in global health for, so far, refusing to negotiate binding reductions in greenhouse gas emissions as part of a new global agreement on climate change. China and India were key players in the negotiation of the Copenhagen Accord in December 2009, a non-binding political agreement under which they and other countries made voluntary commitments to reduce greenhouse gas emissions. Assessments of the Copenhagen Accord and its potential impact on climate change vary significantly. Failure to make progress on mitigating climate change and adapting to the anticipated damage climate change might cause could be a tragedy of enormous magnitude for global health.

Overall, Asian practices reveal significant Asian diplomatic engagement with health issues bilaterally, regionally, and globally, as well as Asian involvement in controversies that threaten global health and the development of global health governance. Both themes are consistent with application of the Five Principles in the global health context. The Five Principles do not prevent Asian countries from engaging in diplomacy and collective action and, through these engagements, contributing to global health diplomacy and governance through bilateral, regional, and multilateral efforts. As one analysis put it, “[t]he vast majority of Asian

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60 U.N. Framework Convention on Climate Change Conference, supra note 30.
governments now understand that collective action does not erode, but instead protects sovereignty.\footnote{Mahbubani \& Chesterman, \textit{supra} note 6, at 2.}

In these respects, Asian practices are similar to those of countries in other regions, which have also scaled up their foreign policy and diplomatic activities on global health. Asian countries appear, thus, to be reacting to global health challenges, engaging in global health diplomacy, and contributing to global health governance in ways similar to many non-Asian nations. Locating distinctive Asian attributes in Asian participation in global health diplomacy and governance proves a difficult and potentially misleading exercise. To date, most Asian involvement in global health diplomacy and governance activities reflects the Asian preference for traditional diplomacy and collective action strategies that do not create significant sovereignty problems or open the political doors to outside interference with domestic affairs.

However, Asian countries’ interpretation and application of the Five Principles are not fixed and static, and Asian use of the Principles in the future might not mirror their use during decolonization and the Cold War. In those earlier periods, Asian countries deployed the Five Principles defensively in ways that reflected their political and economic weaknesses and their vulnerability to outside pressure and interference from more powerful nations. Although prickliness over perceived outside intervention still occurs, as seen in Chinese and Indian bristling over criticisms of their human rights records, the stronger Asian countries, such as the Asian members of the G-20, no longer equate, for example, economic interdependence with threats of foreign intervention, as is evidenced by the multiplicity of trade agreements these countries have entered.

Asian countries and societies have become more globalized through their sovereign choices to access and integrate into global markets for goods, services, technologies, and investment capital. The most dramatic examples of profound change in this regard in Asia are China and India, both of which for decades after World War II avoided interconnections with Western market economies in order to pursue autarkic economic development. In the early 21st century, China’s and India’s emerging power and influence come from their respective rejections of autarky in favor of deeper, more intense levels of political cooperation and economic interdependence.

These dramatic policy shifts have also helped Asian countries realize their vulnerability to many global problems, such as the spread of infectious diseases, financial crises, and the dangers of climate change, which require international cooperation to address effectively. The globalization of Asian policy making makes many Asian countries less
wary about collective action from the perspective of the Five Principles than they were in previous decades.

Put another way, the Five Principles might operate differently as (1) Asia becomes politically, economically, and strategically important to international relations; and (2) attempts to articulate, advance, and achieve Asian national interests take place in globalized contexts and thus require significant diplomatic efforts at producing collective action solutions. The stronger Asian countries might be experiencing what other rising powers experienced in the past—anxiety about sovereignty and non-intervention decreases in proportion to how a country’s power and influence increases in the international system. The United States experienced this shift as it moved from a weak country’s deep wariness and insecurity about interference from the European great powers (e.g., the promulgation of the Monroe Doctrine warning European countries to stay out of the Western hemisphere) to a superpower’s confidence about its interests and influence globally. Historically, the attitudes of the great powers about sovereignty and non-intervention tend to reflect what they want from other countries and to embody less an unwavering commitment to these principles.

In that light, controversies involving Asian countries probably reflect diverging national interests between other nations and Asian States more than the application of the Five Principles by Asian governments. Although the Five Principles are a distinctive feature of Asian approaches to international relations, diverging national interests occur for many reasons in global health and other policy areas. For example, the United States has been involved in many global health controversies because U.S. interests diverge from the national interests of other countries, but U.S. foreign policy and diplomatic behavior does not embrace the Five Principles.

Caution is also warranted because Asian invocation of the Five Principles might represent rhetorical cover for less principled interests Asian States have for their actions, such as gaining or maintaining access to markets or supplies of essential natural resources. Asian conceptualizations of global health might not reflect the Five Principles as much as they reveal the subordination of global health problems to other strategic, political, and economic interests that Asian countries have. Such an outcome is not limited to Asian behavior in global health specifically or international relations generally.

VI. CONCLUSION: FROM PARTICIPATION TO GREATER CONTRIBUTIONS FROM ASIA

Attempting any synthesis of Asian participation in global health politics, diplomacy, and governance is fraught with danger, especially the problem of losing sight of the political, economic, social, and cultural
complexity and diversity of what commentators call “Asia.” Clearly, this area of study calls out for more and better research and analysis than this article provides. Nevertheless, however limited this article’s analysis is, the effort has produced some potentially interesting observations about Asia’s participation in global health diplomacy and governance.

First, Asian conceptualizations of and contributions to global health diplomacy and governance show few, if any, features one could identify as distinctly “Asian.” The shift of material power and influence towards Asia is moving the world towards a new type of multipolarity, which is a systemic, structural transformation that is not “Asian” in any sense of that concept. More importantly for purposes of this article, this shift in power and influence has little, if anything, to do with Asian participation or leadership in global health politics, diplomacy, or governance. Neither China nor India – the two emerging Asian great powers – has been identified as having been a global health leader in their respective transformations into geopolitical heavyweights; and China and India have emerged as great powers in spite of massive domestic problems that adversely affect population and individual health.

Second, Asian commitment to the Five Principles affects the nature of Asian countries’ participation in global health diplomacy and governance. These principles and Asian application of them are conservative compared to prevalent themes in global health governance literature that discount sovereignty and seek more international accountability of governments for their health performance in their national jurisdictions. The Five Principles are infused with post-colonial memories and attitudes and do not reflect anti-sovereignty and post-sovereignty currents running through contemporary global health governance debates. In short, approaching global health diplomacy and governance through the Five Principles is not innovative and does not account for the increased interest in global health diplomacy and governance in world affairs, its differences from past manifestations of international health governance, and its development in the coming years.

Third, Asian practices in global health diplomacy and governance reveal significant involvement by Asian countries on many issues and in many diplomatic venues. However, as observed earlier, the same type of increased and expanded participation can be found in non-Asian countries and regions, which reflects the general increase in global health’s foreign policy, diplomatic, and governance importance over the past 10-15 years. Actions by Asian countries that have caused, or been involved in, global health controversies might reflect application of the Five Principles, but they also might indicate that the national interests of States in global health simply diverge, hardly something that should be associated with things distinctly Asian.
These preliminary conclusions do not mean that Asian countries have little opportunity to develop more distinctive participation in global health politics, diplomacy, and governance. Three possibilities come to mind. First, China or India could decide it wants to become a leader in global health, both through how it handles its own domestic health problems and how it supports diplomacy, cooperation, and governance among nations. This possibility would involve harnessing Asian power to advance the cause of global health. In fact, experts have identified global health as an area in which Asian countries generally and China specifically could show more leadership.\(^{64}\)

Second, Asian countries could show more flexibility on applying or appealing to the principles of sovereignty, non-interference, and equality and mutual benefits—or perhaps even carve out a global health exception to the Five Principles. China has demonstrated some increasing flexibility on its sovereignty claims to Taiwan in the global health context, allowing, for example, Taiwan to have observer status at the World Health Assembly in 2009.\(^{65}\) Another possible precedent is Asian acceptance of the provisions in the IHR 2005 that subordinate sovereignty to global health interests, particularly the provisions allowing the WHO to use non-governmental sources of surveillance information, declare a public health emergency of international concern—even over the objections of the countries involved in the disease event, and issue temporary recommendations that might have adverse political and economic costs for affected States.\(^{66}\) However, any Asian global health flexibility within, or exception to, the Five Principles would, in all likelihood, be quite narrow because the potential for global health governance concerns to produce frequent interference with domestic affairs is significant, especially with respect to problems associated with the social determinants of health.

Third, Asian countries could focus more attention on making their involvement in health cooperation more effective. In other words, Asian countries could make sure their policies and practices in global health include follow-up and follow-through so that commitments made have positive impact on health. One frequent complaint about many health commitments made in recent years, such as those made by the G-8, is that the commitments are not fulfilled. Asian countries could aim to reduce the gap between rhetoric and reality in terms of health cooperation in which they are involved.

In this respect, Asian countries could begin this process by making sure global health becomes part of the emerging agenda of the G-20’s activities on development at the G-20 summit in Seoul in November 2010. To date,

\(^{64}\) See, e.g., Lo, supra note 15, at 22-23.

\(^{65}\) Huang, supra note 3, at 136.

\(^{66}\) IHR 2005, arts. 9, 12, 15.
G-20 meetings in Washington, D.C. (November 2008), London (April 2009), Pittsburgh (September 2009), and Toronto (June 2010) have not addressed global health problems directly. The most likely place for global health to feature at the Seoul summit is through the efforts of the G-20 Working Group on Development, which is charged with crafting a development agenda for the G-20 for adoption at the Seoul summit. Whether the G-20 will embrace health in any way in its development strategy remains uncertain and controversial. This state of affairs gives something of a black eye to those who have advocated for many years that health is and should be at the very core of development strategies. Efforts by leading Asian members of the G-20 could improve the prospects for the G-20 development agenda to include global health, even if such efforts do not manage to put health at the center of the G-20 development strategy.

A number of obstacles would stand in the way of Asian countries making a stronger and more distinctive contributions to global health diplomacy and governance. To begin, multipolarity only means that dynamics of international politics will change; it does not mean that China, India, or other Asian countries will be able to do what they please. Thus, multipolarity could blunt Asian power and act as a significant political constraint on any Asian country or group of countries attempting to claim a global health leadership role because achieving sustainable diplomatic and collective action on matters important to the national interests of States, especially the non-Asian great powers, might become harder.

China and India might not, however, have the ability to test multipolarity’s constraints on better global health diplomacy and governance because they have to address large and growing internal problems involving health in their own jurisdictions. The requirement for a significant domestic focus might limit China’s and India’s interest in making global health a lodestar of their emergence and interests as great

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68 In analyzing the prospects of global health within the G-20, Garrett argued before the G-20 Toronto summit: Reaching common ground on the global financial issues will be difficult, and if the smaller (and wealthier) G8 cannot put its differences aside long enough to reach consensus on the maternal and child health effort, the issue will definitely not be entertained by the G20. Most of the G20 has already threatened to squash anything that smacks of “mission creep,” and the sole mission is economic growth. In a time of shifting global power, the future of health and development remains uncertain. Laurie A. Garrett, G8, G20: Questions for Global Health (June 24, 2010), http://www.cfr.org/publication/22538/g8_g20.html (last visited Sept. 21, 2010). Similarly, Sridhar argued that “[t]he real test will be how the South Korean government, the first non-G8 host of the G20, resolves the tension between keeping the G20 the premier economic forum, thus not overburdening it with health, climate change and the other major global challenges, and enlarging its mandate on development.” Devi Sridhar, Will Global Health Break the Back of the G20? (Aug. 5, 2010), http://www.globalhealthpolicy.net/?p=141 (last visited Sept. 21, 2010).
powers. Improvements in domestic health in China, India, and the Asian region would contribute much to global health because of the sheer size of the populations concerned, but such domestic health advances would not necessarily have to rely on or need global health diplomatic or governance mechanisms.

More conceptually, the Five Principles, consistently applied, might create sovereignty and non-interference barriers for strengthened collective action on many global health problems deeply embedded in domestic affairs, including non-communicable diseases, health system reforms, human rights, good governance in health-related sectors, and improving the social determinants of health. Asian countries might also use the Five Principles to avoid disputes and controversies on global health issues in their relations with non-Asian nations, such as those in Africa, in order to maintain good relations, economic opportunities, access to resources, and strategic influence vis-à-vis potential rivals.

Thus, the power, principles, and practices of Asian countries might truncate the space for “global governance” and move global health politics, diplomacy, and governance back to a more State-centric, conservative mode of addressing international health problems. As Mahbubani and Chesterman argued:

[T]he Asian style of consensus and consultation may fail when confronted with the need for bold, collective action. Appealing to the lowest common denominator produces \textit{wide}, but not \textit{deep} commitments to change. The result is that many Asian want change at the same time as wanting things to remain the same . . . The danger in such an approach is that decisions may not be made, or that those made will fail to resolve fundamental political challenges by putting rhetoric ahead of substance.\textsuperscript{69}

How Asian countries and their various regional and other cooperative mechanisms respond to the existing and future challenges of global health politics, diplomacy, and governance remains to be seen, but one thing is certain – how Asian countries respond will carry more political weight and normative significance than at any other time in history of the modern international system. Responding effectively to global health challenges has now become Asia’s burden and opportunity.

\textsuperscript{69} Mahbubani & Chesterman, supra note 6, at 6.
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