INSTITUTE FOR EUROPEAN STUDIES

EL-CSID

Policy|paper

The EL-CSID project is coordinated by the Institute for European Studies (IES)

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 693799.

Securing Global Health through Diplomacy: From One-Way Transfer to Multi-directional Knowledge Exchange

Dr. Annamarie Bindenagel Šehović
University of Warwick[1]

Issue 2017/2 • September 2017

Background

Since the International Sanitary Regulations were adopted in 1851, the twin issues of international and global and health security have been on the international diplomatic agenda. States and increasingly non-state-actors (NSAs) have engaged with one another through traditional as well as newer forms of diplomacy in order to stem the tide of various initially infectious diseases, from cholera to HIV and AIDS to non-communicable diseases (NCDs). This diplomacy wrought the International Health Regulations (IHRs) of 1969, updated in 2005 (2007), as well as the Framework Convention on Tobacco Control. A Framework Convention for Global Health, focusing on universal health coverage (UHC) is being negotiated. At this juncture, the United Nations Security Council (UNSC) and, among others, the U.S. National Security Council, the World Health Organization (WHO), and the German Foreign Office (AA), have also raised the profile of and established health security desks, further propelling health to the heights of the diplomatic agenda.

Newly, or newly re-emerging diseases present the latest health security challenges to be addressed by health diplomacy. The urgency of responding to these challenges is increasing as population movements and (always) fluid borders raise the attendant questions of how to secure the health of both mobile and sedentary populations. Movement implies both transfer and exchange, not only of people, but also of knowledge. This Policy Paper first traces such transfer to identify whether it is one-way or multi-directional. Second, it bases its results on primary-source findings from recent fieldwork in South Africa, drawing on policy, culture, science and industry transfers and / or exchange. Third and finally, and with a view towards both the independent role of the EU and its place within the G20, the Paper articulates a number of proposals to enhance knowledge exchange in the service of international health diplomacy for global health security.

Health Diplomacy for Health Security

Health is one of a litany of global challenges. This means that while any response to such challenges requires state action, adequate addressing of global, as opposed to merely international, health must go beyond the state.

> *The policy authority for tackling global problems still belongs to the states, while the sources of the problems and potential so¬lutions are situated at transnational, regional or global level.*[2]

It is at the state level that the initial answers to the questions lie: **Who** identifies which global problems constitute priorities? Who decides which priorities are **translated** into a response? And **how**? Yet beyond the answers themselves, responsive action is scattered globally, not merely inter-nationally.

Global is not the same as inter-national. As indicated in the box below, 'international health diplomacy' refers to traditional, state-based diplomacy. In international health diplomacy, states and a limited number of others advocate for and, critically, are responsible for implementing, mutually beneficial health regulations. The International Sanitary Regulations initially, and the International Health Regulations (IHRs) contemporarily epitomize these efforts. That these operate under the auspices of the World Health Organization (WHO), constituted by Member States, further underscores the *international* nature of this arrangement. That states themselves can constitute a threat to health security underscores a limit to this arrangement.

Brief trajectory of (global) international health diplomacy

1851:	International Sanitary Regulations
1969:	first International Health Regulations (IHRs)
1996:	Pieter Piot (scientist) becomes first head of UNAIDS (HIV and AIDS)
2000: (2006, 2011, 2014 – EVD)	o Richard Holbrooke (U.S. diplomat) to UNSC (diplomacy for health security) o Millennium Development Goals (MDGs) (science diplomacy)
2003:	U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (diplomacy for health security)
2005 (2007):	most recent International Health Regulations (IHRs) (health diplomacy)
2009:	Global Health Security Initiative (USA) / est. of health diplomacy desk (USA)
2012:	Global Health Program launched by WHO (health diplomacy)
2015:	German Foreign Ministry establishes office for Global Health Security (health security)
2016:	Centre for Zoonoses, University of Pretoria (RSA) (science for health)

At the global level of analysis, three dimensions come into play that are relevant here: diplomacy *of* or *for* health, as well as health science for diplomacy.[3]

First, diplomacy *of* health includes the elevation of health to an issue of international, notably security, concern. This is best revealed by the bringing of first HIV (2000) and then Ebola Virus Disease (EVD) (2014) to the attention of the United Nation's Security Council (UNSC). Never before had health made it to this epicentre of international diplomatic agenda-setting.

Second, diplomacy for health is broader, and includes diplomatic efforts on the parts of States to increase awareness not only of health crises but of (their proffered) solutions. These include diplomatic efforts by state and non-state actors to facilitate access to anti-retroviral (ARV) medications to fight HIV and AIDS, as done by Brazil and India, with regard to HIV and AIDS; and in a different vein, by Indonesia in its invocation of 'viral sovereignty' (2007) in a contest over access to an anti-influenza vaccine.

Third, health (science) for diplomacy in turn includes research and innovation enabling the development and production of, among other health interventions, ARVs, for example. It also encompasses that of biological and chemical weapons as well as of anticipatory and exploratory research on emerging infectious diseases (EIDs) and concomitant and co-morbid health complications, most notable with regard to HIV and tuberculosis (TB).

Health (science) for diplomacy highlights an important related point: that health diplomacy and health security are not one and the same. On the one hand a host of definitions places the focus of 'global health diplomacy' on the State – as in 'global health as foreign policy'.[4] The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) falls under this description, wherein the emphasis lies on the 'strategic use of global health interventions' in developing States to achieve foreign policy goals, notably for the giving as opposed to receiving State.[5] Similarly, health security refers especially to the security from infectious diseases – such as HIV and EVD – primarily for the benefit of protecting developed States from the import of such infections. Health (science) for diplomacy, by contrast, can promote health for security in both developing and developed states, especially when it emerges from developing country contexts and is communicated with developed states.

In other words, health diplomacy, in both of its guises, can contribute to health security.

Nexus of health diplomacy – health security

Health diplomacy: diplomacy of / for health	Health security / defence
Health (science) for diplomacy – security	Health security – human security

Health diplomacy and health security can selectively prioritize state or human security. This Policy Paper argues that the choice of that prioritization is predicated not on knowledge transfer but on knowledge exchange. While the very idea of transfers necessarily presupposes that one 'has knowledge' to be transferred, and infers that the other side lacks this knowledge,[6] knowledge exchange allows for multi-directional learning and application of lessons.

Multi-directional Knowledge Exchange

Multi-directional knowledge exchange as used here refers to the transmission of health policy knowledge both from States to NSAs and other actors, as well as from the latter back to the former. Inherent in the idea of multi-directionality is its lack of linearity. It involves "hybridity, synthesis, tinkering with models, adaptation and 'localisation'".

> *The notion of 'localisation' concerns the local adaption, indigenisation and modification of policy into new formats. Localisation is one ending or outcome of policy mobilities; that is, transfer and/or diffusion is never an unmediated action, for the processes of transmission itself involve (mis)interpretation, mutation and revision en route.*[8]

In other words, knowledge transfer into policy is not merely a question of relocation: it includes linguistic translation, local adaptation, customization: a process of both translocation and transliteration. The result might look completely different in different contexts and countries. "Something is either lost, or learnt, in translation."[9] For example, early (1990s) HIV and AIDS awareness campaigns designed in the United States targeted men who identified as homosexual. However, men who sleep with men (MSM) in Latin and South America as well as much of eastern and southern Africa did not self-identify as homosexual. The campaigns missed this population. One negative consequence was a slew of new infections, including in female sexual partners, and a critical window of opportunity to quell early HIV epidemics was lost. A second positive consequence was a change in language and campaign outreach to each of these infected and affected populations.[10]

While some of these trials and errors in knowledge transfer and translation happen organically – at the grassroots levels - aiding and abetting theses process of multi-directionally are constellations of uniquely global actors. These range, for example, from:

1. Consortia of individual and networked academics:
2. National communication network(s) among state officials;
3. States influenced by geographically proximate neighbouring states;
4. Leader states pioneering the adoption of a policy that 'laggard' states subsequently follow; and
5. National government(s) as vertical influence for prompting emulation.[11]

The attributable exchanges take into account knowledge transfers across time, space and degree. This can result in policies that look increasingly uniform across the globe. It can also produce starkly differentiated policies adapted to divergent environments, both at the State and at the sub-State levels.[12] This Policy Paper focuses in particular on the knowledge gained in tracing such multi-directional transfers pertaining to in HIV and AIDS and Ebola Virus Disease between the EU to South Africa.

Evidencing Multi-directional Knowledge Exchange

HIV and AIDS (hereafter HIV), as well as Ebola Virus Disease (hereafter EVD), emerged locally to become both inter-national and global challenges – and policy priorities. Notably, in the course of their transnational spread, both epidemics became translated into global health and security problems. Ultimately, however, the responses to each both hinged on the transliteration of responses – translocation – (back) into local settings. In other words, initially local health crises were framed as global security threats; responses conceived at the global level in turn had to be adapted locally in order to be successful, so as to stem the intra-state spread of these epidemics. The roles that culture, science and industry played in this political and policy process is critical.

Both HIV and EVD erupted in minefields rich in cultural (mis-)understanding. In each case, conflictual histories of deep distrust revolved around unresolved histories involving missionaries, at times vaccines, and blood.[13] This results in two schisms: on the one hand, an outright rejection of interventions to ostensibly respond to an outbreak such as attacks on Medicines Sans Frontiers' volunteers in West Africa during the Ebola outbreak of 2014-2015. On the other hand, it leads to a less obvious, but nevertheless lethal apathy to science such as documented in recent research conducted by the University of Heidelberg's School of Public Health[14], as well as the Northwestern University's School of Public Health[15], and corroborated by experts at the University of Pretoria[16] and in the education sector in Cape Town[17], documenting falling uptake in medical preventions and treatments against HIV and AIDS.

These mis-conceptions are further undermined by with widespread myths promising a cure through sex with a virgin. In the mid-2000s, as HIV-incidence and prevalence reached unprecedented heights in South Africa, the euphemism was of 'sugar daddies.' older men whose material support of younger women (girls) were said to award them inoculation or cure of HIV. As of ca. 2016, the discourse has evolved to where those formerly known as 'sugar daddies' are not referred to as 'blessers.' This transliteration is more than a semantic shift: it masks the practices that continue to – and in fact are accelerating – the spread of HIV. Far more insidious, it stymies the efforts of policy makers and researchers to craft a message that captures and counters the deceptions (again) fuelling the re-expansion of epidemic.

Yet initial answers also lie embedded in these very mis-exchanges. In the South African context, religious groups – locally embedded and elevated to the state level – came together in the spirit of 'Ubuntu' – I am what I am because of who we all are[18] – to response to HIV and AIDS. This assemblage of Buddhist, Catholic,[19] Jewish and Muslim[20] organizations drafted both inaugural social and scientific guidelines for coping with the epidemic.[21] As new challenges have arisen, including drug use and prostitution, compounding the HIV and AIDS epidemic, these organizations have continued to respond

in a spirit of Ubuntu. It is a lesson other states and regions grappling with epic challenges of disease, drugs and economics could well use.

This points to a critical insight: that key international and global challenges are locatable upon a scale weighing orders of magnitude. In other words, these challenges are not divergent so much in their content as in their context and their gravity. Accordingly, the appropriately effective and culturally applicable responses to them hinge upon multi-directional knowledge exchange as opposed to one-way transfer.

Academic discourse, both social and (laboratory) scientific, offers cases in point. The very emergence of HIV and EVD highlight the need for cutting-edge research into zoonoses, but also into the dissemination of that research. While South Africa, including through its Centre for Sexualities, AIDS and Gender (CSA) and Centre for Viral Zoonoses, both at the University of Pretoria, as well as the Health Economic AIDS Research Division at the University of Kwa-Zulu Natal, boasts world-class research, getting the message out is a persistent academic, but also policy, problem.

Professor Catherine Burns and colleagues at the University of Pretoria are mapping the precipitous decline in first authorships attributed to South African researchers since the advent of HIV-related (research funding) since the mid-1990s.[22] In other words, as local South African researchers collaborated with – and accepted funding from – in this instance notably U.S.-based universities, the share of their first (sometimes, second, third, fourth and further) authorships on the resulting research papers fell. On the one hand, this trend is a career-killer for (young) scientists. On the other hand, the trend evidences and reinforces the notion that developing countries provide 'evidence' and 'experience' in a practical sense, while developed countries formulate theory. In addition to being a particular sore point for South African academics, it has contributed to scepticism over the science: both laypeople and policy-makers have expressed doubt over the extent of South Africa's TB epidemic, and worse, outright denied the existence of MDR- and XDR-TB.[23] This despite the fact that the instances of TB, including MDR- and XDR-TB are at an all-time high in South Africa. According to Professor Lynne Webber at the University of Pretoria's Department of Virology, if in 2007 one patient on the hospital ward was co-infected with HIV and TB, doctors-in-training would come running. In 2017, if one patient is not co-infected, then they come running. Professor Webber and her colleagues wear the metal, HAZMAT (Ebola) mask to guard against infection.

Such side-lining of research acumen can also have further consequences, including a) resistance by local researchers to share evidence and insight; b) emigration of such researchers, contributing to further 'brain drain', and discrediting institutions in developing contexts; and c) lead to a dangerous disconnect between relevant, local and 'global' research. It also reinforces the above-mentioned cultural disavowal of interventions, whose consequences are detrimental to health security, and sometimes deadly.

Intimately involved in this tense exchange of evidence and experience as part and parcel of knowledge production and (sometimes) transfer is the private sector, both in science and in industry. Notably multi-national corporations with vested interests – mines, production facilities – in South Africa launched unprecedented corporate social responsibility (CSR) programs to try to tackle the HIV and AIDS epidemic. Companies such as Anglo Group Ltd and Daimler (now Mercedes Benz) established employee-

benefits' schemes to stem the tide and contain the costs of HIV and AIDS. The company has an HIV-rate of ca. 5-7% of active employees.[24] Its interventions and outreach continues and extends broadly into communities to offer education in financial management to create economic conditions conducive of health security. Yet both the German[25] and EU Chambers of Commerce[26] in South Africa emphasized that companies would not respond to the burgeoning TB epidemic to anywhere near the same extent. Despite sunk costs, industry would expect the state to deal with a (new) health security crisis.

This places the onus for health security back at the level of the state. Yet the evidence indicates that states alone not only cannot but do not preside over the knowledge, capacity or capability to respond to crises and to implement health security. The challenge then becomes how to harness inter-state including non-state cultural, science and innovation diplomacy, for global health security.

Policy Implications and Recommendations

Taking both State and human security into account offers a new lens through which to analyse the implications of health crises for health diplomacy for health security. While policy remains national, (health) challenges are increasingly global. While they may differ in their orders of magnitude – HIV and (XDR)-TB higher in southern Africa, NCDs currently still higher in Europe – the luxury of treating each disease in a silo is becoming too costly. Co-morbidities are on the rise. Concurrent crises – exacerbated by cross-border migration of disease and populations – is shifting from being the exception to becoming the rule. It is high time for a new conceptualization of health diplomacy for health security.

As outlined in the box above, the 2003 launch of the U.S. President's Emergency Program for AIDS Relief (PEPFAR), might be seen as a first effort squarely aligned with U.S. foreign policy – state security – interests. This is iterated in the U.S. National Security Strategy of 2010, it was argued that "the U.S. has a "moral and strategic interest" in advancing global health."[27] Reflecting the state-centric strategic prioritization accorded to health security to be promoted and protected through health diplomacy, the U.S. identified three main criteria for 'strategic health diplomacy': (i) disease prevalence; (ii) treatment potential; and (iii., geostrategic) value of affected areas.[28]

A second incarnation of health diplomacy for health security might be represented in the opening of the U.S. Global Health Diplomacy Office[29], as well as those of Germany[30], and the WHO[31]. However, each of these conflates health security with primarily (state) defence, and prioritizes the security of the State or Member State above that of the individual human being. In order for the focus to shift from state to human security, a parallel shift from one-way transfer to multi-directional exchange is necessary. This is predicated first and foremost on the recognition that exchange is vital not only for national or inter-national health security, but for global health security.

This leads to three policy proposals:

A. **Preparing the ground to recognize rising health (knowledge) problems.** This has three components. First, recognizing and acknowledging that information is not the same as knowledge. Information abounds on health risks and threats. Knowledge, too, of local vulnerabilities and coping mechanisms, is wide and deep. Communicating information to create knowledge in both the EU and South

Africa is critical. Second, recognizing health knowledge challenges needs to include the exponential growth in their number as exacerbated by migration. For example, while the EU currently hosts a million or more refugees, South Africa has between three and five million out of a population of only 55 million. Third, health knowledge needs to recognize that its challenges are of orders of magnitude: not fundamentally different between the EU and South Africa; between migrants and non-migrants. Many of the vulnerabilities are the same. Each region can therefore benefit from the other's coping strategies through cooperation.

B. **Identifying which entities – State or NSA – are the most appropriate** responders. Allowing interventions by both States and NSAs opens up additional space for active translocation, transliteration and translation, namely of organization or re-organization since these each are uniquely placed to fill in for each other's weaknesses. The particular cycle of their engagement in HIV and AIDS response illustrates this: the role of NSAs rose in the late 1990s when the South African state was overwhelmed; the State assumed a more central role in the mid-2000s with the roll-out of successful National Strategic Plans (NSPs); currently the concurrent rise of HIV incidence and of increasingly drug-resistant tuberculosis is seeing renewed NSA activity.

C. **Conceptualizing plausible, applicable, responses.** Here the emphasis should be on communication: communication between specialists in science, between policy makers, and between clusters of scientific experts and policy makers. Modes of communication that foster multi-directional knowledge exchange as opposed to one-way transfer include most importantly, portals, on-line and institutionally connected, and linked between disciplines. These include biological and chemical sciences, medicine in each of its specialities, as well as human sciences and economics. It is key that these be linked to one another to facilitate the translation and adaptation necessary for interdisciplinary knowledge exchange and adaptation into policy and practice. Such embedded exchange is also critical for building the trust that is instrumental in implementing responses in culturally acceptable ways. Here diplomacy – of and for health – can also play an instrumental role.

At the level of the laboratory, it is not the European zoonotic researchers, but those on the front lines who are most likely to identify first the next source of a pathogen with the potential to spark a global pandemic. Indeed, the internationally renowned German Robert-Koch-Institute's programs explicitly established to foster knowledge exchange illustrate the feasibility of such transfer. These include: the Africa Initiative in Infection Control[32] and the Zoonosis Network[33]. The Robert-Koch-Institute runs the German Research Foundation's[34] 'Africa-Initiative' together with the German Federal Ministry of Education and Research.[35] This was created specifically to conduct knowledge transfer with African academics in the realm of mostly diagnostic epidemiology. Unfortunately, it fails to include cutting-edge research being done at, for example, South Africa's Centre for Viral Zoonoses. Knowledge exchange portals that corral currently separated research silos, and which specifically seek out new sources of and systems of research – zoonoses, NCDs, mental health, re-recurring diseases such as TB – would go a long way towards remedying current information gaps. They would also serve as breeding grounds for innovative, integrated practical and policy responses.

These portals could in turn be connected both through individual people and where necessary, new clustered working groups, to geo-political and political (risk) analysts, such as PUGWASH[36], and policy-makers at the national, supra-national such as in the EU and the G20 at the inter-national and global levels. These practical responses must also take into account and actively integrate systems of belief of how the world works, infusing religion and moral values, business and regulations (rules), and structures of self and social justice into any response[37]. Such portals could be embedded in existing academic, scientific and policy structures.

Conclusion

One-way transfer is inadequate to the necessarily multi-directional knowledge exchange necessary to meet health challenges around the world today. Instead, State and non-state diplomacy for health security is best placed to identify the crises and to elicit responses appropriate to each order of magnitude. Such multi-order diplomacy can facilitate between practitioners and local communities to inform policy where an a recipient entity is prepared (specifically) to listen to the sound of (re)emerging health problems; can identify who is already responding, corral disparate efforts towards a shared goal of responding to a health emergency and establishing health security; and can allow for the adaptation and application of such a response. Multi-directionally translated and translocated knowledge exchange can result in policy that takes these into account is more likely than one-way transfer to be beneficial to both State and human health security because it deliberately seeks and applies the attributes of diplomacy, practice, and culture to policy.

Bibliography

1. Bärnighausen, et al, forthcoming.

2. Berry, FS, Berry, WD, 1999, Innovation and diffusion models in policy research, in PA Sabatier (ed) Theories of the policy process, Boulder, CO: Westview Press

3. Conversation with D. Molapo, Johannesbuug, 11 April 2017Conversation with Prof. Dr. H. Dilger, Free University Berlin, 9 November 2016.

4. Conversation with Prof. Solly Benetar, Cape Town, 7 April 2017.

5. Conversation with Prof. Dr. W. Biederbick, Robert-Koch-Institute Berlin, 20 September 2016.

6. Conversation with Sully Timol, retired teacher, Department of Education, Cape Town, 8 April 2017.

7. Correspondence with Bishop Kevin Dowling, Johannesburg, 2003; now in Pietermaritzburg, 2017.

8. Daschle, Tom and Bill Frist (2015) 'The Case for Strategic Health Diplomacy: A Study of PEPFAR,' Bipartisan Policy Center (BPC) (6 November).

9. Epstein, Helen (2007). The Invisible Cure. (New York: Farrar, Straus and Giroux).

10. Feldbaum H, Michaud J (2010). 'Health Diplomacy and the Enduring Relevance of Foreign Policy Interests.' PLoS Med 7(4): e1000226. https://doi.org/10.1371/journal.pmed.1000226.

11. Fourie, Pieter (2013) 'Turning dread into capital: South Africa's AIDS diplomacy' Globalization and Health Vol. 9 (8).

12. German Federal Foreign Office: Global health policy, including Coordinator for the Foreign Policy Dimension of Global Health Issues, available at: http://www.auswaertiges-amt.de/EN/Aussenpolitik/GlobaleFragen/Gesundheit/Gesundheitspolitik_node.html.

13. German Federal Foreign Office: German Partnership Program for Excellence in Biological and Health Security, available at: http://www.auswaertiges-amt.de/EN/Aussenpolitik/Friedenspolitik/Abruestung/BioChemie/Biosicherheit/Biosicherheit_node.html, last accessed 24 March 2017.

14. Interview, Center for the Study of AIDS, Sexualities and Gender, University of Pretoria, 3 April 2017.

15. Interview with Ambassador (ret.) Tom and anthropologist (folklorist) Donna Wheeler, Johannesburg, 5 April 2017.

16. Interview with director of German Chamber of Commerce and Industry, S.A., Matthias Bodenberg, Johannesburg, 4 April 2017.

17. Interview with director of EU Chamber of Commerce and Industry Stefan Shakochek, Johannesburg, 12 April 2017.

18. Interview with Dr. Clifford Panter, via internal telephone, Mercedes Benz S.A., Centurion, 4 April 2017.

19. Interview with Moeketsi Modisenyane, Department of Health, Johannesburg, 12 April 2017.

20. Interview with Prof. Dr. Lynne Webber, Department of Virology, University of Pretoria, 4 April 2017.

21. Interview with Prof. Robert Murphy, XX.

22. Interview with Suraiya Nawab, Islamic Careline, Fordsburg, Johannesburg, 5 April 2017.

23. Kevany, S. (2016). 'New roles for global health: diplomatic, security, and foreign policy responsiveness,' The Lancet Global Health, Vol. 4, No. 2, p. e83-e84 (February).

24. Kickbusch, I., Silberschmidt, G. and P. Buss (2007). 'Global Health Diplomacy: the need for new perspectives, strategic approaches and skills in global health.' Bull World Health Organisation 85(3): 230-2.

25. Kickbusch, I. and P. Buss (2011). 'Global health diplomacy and peace,' Infect Dis Clin North Am. 5(3): 601-10, ix. doi: 10.1016/j.idc.2011.05.006.

26. McInnes, Colin and Kelley Lee (2006). 'Health, security and foreign policy,' Cambridge Review of International Studies, Vol. 32, Issue 1, p. 5-23.

27. Michaud, Josh and Jen Kates (2012). Policy Brief "RAISING THE PROFILE OF DIPLOMACY IN THE U.S. GLOBAL HEALTH RESPONSE: A BACKGROUNDER ON GLOBAL HEALTH DIPLOMACY" (September), available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8360.pdf.

28. Mukhtarov, Farhad (2014) 'Rethinking the travel of ideas: policy translation in the water sector,' Politcy & Politics, Vol. 42, No. 1, pp. 71-88(18).

29. Novotny & Adams, 2007.

30. Ruger, Jennifer Prah (2012). 'Global Health Governance as shared health governance' J Epidemiol Community Health, Issue 66: 653-661; p. 658.

31. Sabatier (ed.) Theories of the policy process, Boulder, CO: Westview Press, pp. 172–8, also quoted in Stone, Diane (2016) 'Understanding the transfer of policy failure: bricolage, experimentalism and translation,' Policy & Politics (Polity Press).

32. Stone, Diane (2016) 'Understanding the transfer of policy failure: bricolage, experimentalism and Translation,' Policy & Politics (Polity Press).

33. Thakur, Ramesh and Luk Van Langenhove, 2006, 'Enhancing Global Governance through Regional Integration,' Global Governance Vol. 12, No. 3.

34. U.S. Department of State, Diplomacy in Action: International Health and Biodefense, available at: https://www.state.gov/e/oes/intlhealthbiodefense/.

35. U.S. Department of State, Diplomacy in Action: Office of the U.S. Global AIDS Coordinator, available at: https://www.state.gov/s/gac/.

36. Van Langenhove, Luk (2016) 'Global Science Diplomacy as a New Tool for Global Governance,' Focir pensement (United National University / Vrije Universiteit Brussel).

37. World Health Organization: Health Security and Emergency Response, available at: http://www.searo.who.int/topics/health_security/en/, last accessed 24 March 2017.

Footnotes

1 Dr. Šehović is a Research Fellow, PAIS (Politics and International Studies), University of Warwick, UK. She is part of the EU Horizon 2020 project EL-CSID (European Leadership in Cultural, Science and Innovation Diplomacy), under Grant Agreement No 693799. She holds a PhD in Political Science from the Free University of Berlin, and a Master of Management in Public Policy from the University of the Witwatersrand, Johannesburg, South Africa.

2 Thakur, Ramesh and Luk van Langenhove, 2006, 'Enhancing Global Governance through Regional Integration,' Global Governance Vol. 12, No. 3: p. 233.

3 Building on Luk van Langenhove's argument pertaining to global science diplomacy.

4 See, e.g. Feldbaum, 2010; Kickbusch et al., 2007; McInnes & Lee, 2006; Novotny & Adams, 2007; Kickbusch & Buss, 2011.

5 Kevany, p. 7.

6 Conversation with Prof. Solly Benetar, Cape Town, 7 April 2017.

7 See also Mukhtarov, Farhad (2014) 'Rethinking the travel of ideas: policy translation in the water sector,' Policy & Politics, Vol. 42, No. 1, pp. 71-88(18).

8 Stone, Diane (2016) 'Understanding the transfer of policy failure: bricolage, experimentalism and translation,' Policy & Politics (Polity Press), p. 2.

9 Stone, Diane (2016) 'Understanding the transfer of policy failure: bricolage, experimentalism and translation,' Policy & Politics (Polity Press), p. 2.

10 See Centre for Sexualities, AIDS and Gender, itself renamed from the Centre for the Study of AIDS (CSA), University of Pretoria, South Africa.

11 See Berry, FS, Berry, WD, 1999, Innovation and diffusion models in policy research, in PA Sabatier (ed.) Theories of the policy process, Boulder, CO: Westview Press, pp. 172–8, also quoted in Stone, Diane (2016) 'Understanding the transfer of policy failure: bricolage, experimentalism and translation,' Policy & Politics (Polity Press), p. 2.

12 See also Ruger, Jennifer Prah (2012). 'Global Health Governance as shared health governance' J Epidemiol Community Health, Issue 66: 653-661; p. 658.

13 Epstein, Helen (2007). The Invisible Cure. (New York: Farrar, Straus and Giroux).

14 See Bärnighausen, et al, forthcoming.

15 Interview with Prof. Robert Murphy, April 2017.

16 Interview with Prof. Dr. Lynne Webber, Department of Virology, University of Pretoria, 4 April 2017.

17 Conversation with Sully Timol, retired teacher, Department of Education, Cape Town, 8 April 2017.

18 Southern African philosophy, globally associated with former South African President Nelson Mandela and Archbishop Desmond Tutu.

19 Correspondence with Bishop Kevin Dowling, Johannesburg, 2003; now in Pietermartizburg, 2017.

20 Interview with Suraiya Nawab, Islamic Careline, Fordsburg, Johannesburg, 5 April 2017.

21 Interview with Suraiya Nawab, Islamic Careline, Fordsburg, Johannesburg, 5 April 2017.

22 Interview, Center for the Study of AIDS, Sexualities and Gender, University of Pretoria, 3 April 2017.

23 Conversation with D. Molapo, Johannesbuug, 11 April 2017; interview with Moeketsi Modisenyane, Department of Health, Johannesburg, 12 April 2017.

24 Interview with Dr. Clifford Panter, via internal telephone, Mercedes Benz S.A., Centurion, 4 April 2017.

25 Interview with director of German Chamber of Commerce and Industry, S.A., Johannesburg, 4 April 2017.

26 Interview with director of EU Chamber of Commerce and Industry Stefan Shakochek, Johannesburg, 12 April 2017.

27 Michaud, Josh and Jen Kates (2012). Policy Brief "RAISING THE PROFILE OF DIPLOMACY IN THE U.S. GLOBAL HEALTH RESPONSE: A BACKGROUNDER ON GLOBAL HEALTH DIPLOMACY" (September), available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8360.pdf.

28 Daschle, Tom and Bill Frist (2015) 'The Case for Strategic Health Diplomacy: A Study of PEPFAR,' Bipartisan Policy Center (BPC) (6 November).

29 Michaud, Josh and Jen Kates (2012). Policy Brief "RAISING THE PROFILE OF DIPLOMACY IN THE U.S. GLOBAL HEALTH RESPONSE: A BACKGROUNDER ON GLOBAL HEALTH DIPLOMACY" (September), available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8360.pdf.

30 See, German Federal Foreign Office: Global health policy, including Coordinator for the Foreign Policy Dimension of Global Health Issues, available at: http://www.auswaertiges-amt.de/EN/Aussenpolitik/GlobaleFragen/Gesundheit/Gesundheitspolitik_node.html, and German Federal Foreign Office: German Partnership Program for Excellence in Biological and Health Security, available at: http://www.auswaertiges-amt.de/EN/Aussenpolitik/Friedenspolitik/Abruestung/BioChemie/Biosicherheit/Biosicherheit_node.html, last accessed 24 March 2017.

31 See World Health Organization: Health Security and Emergency Response, available at: http://www.searo.who.int/topics/health_security/en/, last accessed 24 March 2017.

32 Author's translation. Original German: Afrika-Initiative in der Infektologie.

33 Conversation with Prof. Dr. W. Biederbick, Robert-Koch-Institute Berlin, 20 September 2016.

34 Deutsche Forschungsgemeinschaft.

35 Original German: Bundesministerium für Bildung und Forschung.

36 Pugwash Conferences on Science and World Affairs.

37 Interview with Ambassador (ret.) Tom and anthropologist (folklorist) Donna Wheeler, Johannesburg, 5 April 2017.

About the author

Dr. Annamarie Bindenagel Šehović is a lecturer on global health policy at the Willy Brandt School and on statehood at the University of Erfurt. She also collaborates on the H2020 EL-CSID project at the University of Warwick. Prior to that, she worked on various aspects of HIV/AIDS policy in South Africa in the private, public, and NGO sectors, university, and community. Dr. Šehović obtained her Dr. rer. pol. in Political Science from the Free University of Berlin. Her areas of expertise include HIV/AIDS and global health policy; the theory and practice of sovereign statehood; and global governance.

The EL-CSID project
is coordinated
by the
Institute for European Studies (IES)
www.el-csid.eu

Institute for European Studies
Pleinlaan 5
B-1050 Brussel
T: +32 2 614 80 01
E: ies@vub.ac.be
www.ies.be

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 693799.