Thesis for the degree of Master of Political Science

Global Health Diplomacy: Understanding Burundian Position

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세계보건외교: 부룬디의 정책적 시각을 중심으로

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Abstract

The World Health Organization (WHO) emphasized the global health diplomacy (GHD) as an emergent practice that not only identifies and understands changes that influence global public health, but provides a capacity to support collective action to mitigate health risks among state members of WHO.

For the last decade, GHD was then embraced on national, regional and continental levels. Several countries in the European Union (EU) integrated health in all the state policies as a first step and established policies under which all the countries of EU should abide. GHD on the national level was motivated by different reasons though protecting the citizen's health and efficient response to cross-border diseases were the main motivations. The Schengen space helped the EU member states to establish GHD through several declaration such as the OLSO Ministerial Declaration.

This research first gives more light on global health diplomacy. Beyond the known case studies of developed and developing countries which adopted GHD, this study also focuses on under-developed countries, which try to achieve GHD goals as defined by WHO through regional communities. The purpose of this research is to understand the position of Burundi in terms of GHD which mainly analyze how far the Burundian government has gone in terms of adoption of GHD as recommended by the WHO.

In order to achieve this goal, we studied case studies of leading countries which adopted GHD. We choose two countries within the developed countries (Switzerland and Norway) and one country among the developing countries (Brazil). For the African continent, the African Union (AU) recommended the state members to adopt GHD through the regional communities and the AU will stand as an overseer of the GHD progress within the continent. Thus, we also considered one of the regional community in which Burundi is member (East African Community) as a case study.

The African Union being the overseer of GHD on all regional communities in Africa was also taken into consideration. We particularly focused our attention to our case study (Burundi) and explored

on how far this country is embracing GHD. Within the East African community (EAC) in which Burundi is a member, we found out that Burundi is part of the regional GHD strategy to mainly fight against cross-border sicknesses. However, Burundi is less involved within the EAC GHD strategies compared to other members within the EAC community.

This study also reveals that on the current state, the only neighboring country of Burundi and non-member of the EAC which is the Democratic Republic of Congo (DRC) would be a serious threat in case a cross-border issue arises. This is due to the fact that the different communities in which Burundi and DRC are included have less mechanisms of fighting abrupt epidemic case compared to EAC. The Kingdon Multiple Stream model contributed to explore the leading factors which led other countries (community) to adopt GHD. Additionally, the Kingdon Multiple Streams Model was used to address a series of recommendations both to EAC community as well as to the Burundian government on how GHD would be strongly adopted both on the national and regional level.

세계보건외교: 부룬디의 정책적 시각을 중심으로

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한글 요약

세계보건기구 (WHO)는 갑작스러운 의료상황에 대비한 세계적인 보건외교(GHD)를 강조했다. 이것은 세계적인 공공의 건강에 영향을 미치는 변화를 잘 알고 이해하는 것뿐 아니라, WHO 의 회원국 안에서 건강을 위협하는 위험요소와 우려를 완화시키기 위해서 총괄적인 활동을 돕기위한 가능성을 제공하기 위한 것이다.

지난 수 십 년 동안, GHD 는 지역적, 국가적, 대륙적으로 일어나는 모든 수준의 이슈들을 포용해왔다. 유럽연합(EU)의 여러나라들은 우선적으로 보건의 문제를 통합해왔고 정책들을 수립해왔다. 국가적 차원의 GHD 는 여러가지 다른 이유들로 인해 동기부여 되었다. 특히 국경을 넘는 질병에 대한 효과적인 조치와 국민건강을 지키는 일이 주요 관점들이었다. 솅겐조약(Schengen)은 EU 회원국들이 OLSO Ministerial Declaration 같은 몇몇의 선언을 통해 GHD 를 설립하도록 도왔다.

이 연구는 세계적인 보건외교에 희망을 준다. GHD 회원인 선진국과 개발도상국 경우 외에도 이것은 아직 개발이 되지 못한 국가들에게도 초점을 맞춘다. 그리고 이것은 WHO 에 의해 정의된 GHD 의 목표를 성취할 수 있도록 노력한다. 이 연구의 목적은 GHD 의 관점에서 부룬디 정부가 WHO 에서 권고하고 있는 정책을 수용하는 범위에 대하여 파악하고 이해하는데 있다. 이 목표를 성취하기 위해서 우리는 GHD 에 소속되어있는 나라들의 경우를 연구했다. 우리는 선진국인 두 나라 스위스와 노르웨이와 개발도상국 브라질을 선택했다. 아프리카연합(AU)은 GHD 에 가입하도록 권고했다. 그리고 아프리카연합은 아프리카의 각 나라들이 GHD 진행과정을 계속해서 감독해 나가고 있다. 그래서 이 연구에서는 이에 대한 사례연구로 아프리카 동쪽의 부룬디를 고려했다. 아프리카의 GHD 감독관인 아프리카연합 또한 고려되었다. 이 연구를 통해 특별하게 나의 모국인 Burundi 에 집중했고 언제 GHD 가 실현될 수 있는지를 연구했다. 우리는 부룬디가 멤버인 동아프리카연합(EAC)에서 부룬디가 국경을 넘는 질병과 싸우는 주요한 나라라는 것을 발견했다. 그러나 부룬디는 다른 EAC 나라들 중 아주 작게 관련되어 있었다.

이 연구는 부룬디의 주변의 나라와 EAC 의 멤버가 아닌 콩고가 국경을 넘는 질병의 발생에 대해 아주 위협이 된다는 것을 드러냈다. 이것은 EAC 에 비교했을 때 부룬디와 콩고가 포함되어있는 지역들이 갑작스러운 유행성 질병에 대항해 싸우는 장치가 부족한 사실때문이다. Kingdon 의 Multiple Stream 모델은 GHD 에 소속되어있는 다른 나라를 이끈 요인을 파악하는데 기여했다. 덧붙여, 이 모델은 지역적 국가적 향상을 위해 얼마나 강하게 GHD 에 소속되어야 하는지를 EAC 나라들과 Burundi 정부에게 권고하기위해 사용되었다.

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He is always the wind beneath my wings.
This thesis is dedicated to them.

Abbreviations

GHD: Global Health Diplomacy
WHO: World Health Organization
EU: European Union
FDHA: Federal Department of Home Affairs
FOPH: Federal Office of Public Health
FDFA: Federal Department of Foreign Affairs
EAC: East Africa Community
NGO: Non-Governmental Organizations
UNICEF: United Nations International Children 'Emergency Fund
PAHO: Pan American health Organization
WHO: World Health Organization
OMD: Oslo Ministerial Declaration
AU: African Union
SARS: Severe Acute Respiratory Syndrome
HIV/AIDS: Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
SADC: Southern African Development Community
OECD: Organization for Economic Cooperation and Development
UN: United Nations
FPGH: Foreign Policy and Global Health
EAIDSNet: East African Integrated Disease Surveillance Network

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Chapter 1 Introduction

1.1 Motivation of study

Health has attracted a significant attention in the global domain as a major contributor of development of countries. It has been put into foreigner policy (international relation policies) and economic agendas to prioritize national interest and into social agenda as a social value and human right as the global pandemics increase as well as the epidemic sicknesses (Fidler 2009, 2).

The United Nations called out governments, since 2008 in his General Assembly, to integrate global health into their foreign policies (Institute of Medicine of the National Academies 2009). To overcomer health issues which transcend national boundaries, states and non-states actors need to work together and negotiate responses to these issues. The process of negotiating for global health has been referred to as Global Health Diplomacy (Garrett 2007, 16).

GHD involves the process of policy-shaping for global health and negotiations about health challenges at national and international level, thus there is a need of cooperation between governments involved into GHD in the main objective of improving global health and protect other realms which could be affected by health issues such as political, economic or social sector (Owen 2005,2).

Among typical case studies of the practice of GHD is found the 2003 Northern Nigeria issue where the boycott of Polio vaccination created a global health crisis. To resolve the crisis, diplomatic actions were taken by the Global Polio Eradication Initiatives, the United Nations and the United States government (Kaufman & Feldbaum 2009, 2).

Brazil also provides a case study of the practice of GHD with the Framework Convention on Tobacco Control, pursuing to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke (Bliss 2010). The GHD as adopted by Brazil aims to achieve its health goals at the domestic, regional and global level, helped by the coalition of diplomats, civil society organizations, NGOs advocating through negotiations (Vidigal 2010, 38).

As countries become more interconnected through regional communities, health issues also become increasingly global. States actors have the prerogative to work together along with a variety of non-state actors on issues related to trans-border health.

For the last decade, Burundi has integrated several regional communities with more interaction among the state populations which can be a source of trans-border diseases. As the available data shows (table 3 and table 4 in chapter 5), Burundi has been strongly affected by trans-border diseases compared to other countries in EAC

region. Therefore, this research ensures the examination of current facility of Burundi to efficiently and quickly react to diseases which may arise within the communities in which it is member or on a global level. This research also analyzed three case studies which have successfully adopted GHD and derived key lessons on how Burundi can better adopt and embrace GHD within EAC.

To better contribute to this research, the first overall research question explored by this study is: (1) What are the influential factors (motivating reasons) for the adoption of Global health diplomacy? In other words, what are the motivating and influencing factors that urged the countries (regional communities) which adopted GHD to do it. The other question is: (2) Why and how Burundi should better adopt Global health diplomacy based on WHO's goals? This question seeks to understand the current position of Burundi in terms of GHD and what should be done to improve its position.

1.2 Research Objectives

The main objective of this study is to understand Burundian position in terms of Global Health Diplomacy. The Burundian position will mainly show how far Burundi has gone in adopting GHD goals as defined by WHO. The specific research objectives are:

1. Find the leading factors which are indispensable to adopt global health diplomacy.
2. Understand Burundian position for global health diplomacy and suggest a model for GHD's enhancement in Burundi.

This research needs first to explore the leading factors which urged the three case studies to adopt GHD in order to understand how Burundi is adopting GHD and what lessons could be drawn for Burundi to better adopt GHD and improve its position within EAC.

1.3 Research Methodology

In this section, we will discuss the different research techniques used to be able to answer to the research questions.

Case Study Technique: The case study technique enables the researchers to fully understand the specific study on each entity (country or region) based on the why and how GHD was considered by that specific entity. We shall take a least one country among the developed and developing countries. This technique will help to answer the research question regarding the influential factors which pushed some countries to become Leading States to adopt GHD.

Case study refers to the existing and similar study conducted for a different entity. Case study is defined as ideal methodology for in-depth investigation that aims to build understanding about a phenomenon or issue (Pal 2005, 228). Case study is qualified as an appropriate research method when 'how' or 'why' questions are being asked about events which had already happened, yet investigators have got little or no control on the topic (Yin 2003). The criteria which was used to select adequate case studies include: relevance to the conceptual framework and research questions; possibility of collecting rich information about the concept being studied; ability to derive lessons learned from other case study; and feasibility (Curtis 2005,4). As described in the following chapters, three countries and two regional communities were taken as sample namely Switzerland, Norway, Brazil,

African Union and East African Community (EAC). Case study method allows us to incorporate the triangulation of data from different sources using multiple data collection methods as an ongoing part of the research process. Triangulation helps into improving the quality of the research results and achieve a more comprehensive representation of context through different methods and data collection (Stake 2005, 451). Triangulation is based on gathering and comparing data from more than one source then analyze the data to retrieve the most relevant insights (Farmer 2006, 2). Switzerland was chosen due to its position in terms of international health organizations which do not only have their headquarters in Switzerland but also the majority of health related conference are mainly organized in Switzerland. Moreover Switzerland is among the top countries which invest considerable amount to help developing countries in terms of health policies and assistance. Switzerland and Norway belong into developed country.

Norway was taken because of its high implication on the Oslo Ministerial Declaration (OMD). OMD gathered all the foreign ministries of the EU which signed a health cooperation agreement (Ministers of Foreign Affairs 2007). OMD was initiated by the Norway government representative, and for this reason it occupies a respectable position in terms of GHD within the Schengen space.

Brazil outstands as one of the developing country which embraced the GHD within its territory and played a key role to influence other countries within its region to

work hand in hand in order to integrate health into foreign policies. Moreover, other emerging countries such as India and Venezuela have cheap yet affordable medical infrastructures and skills which is essential for establishing facilities such as medical laboratories and generic drugs production (Vidigal 2010, 39).

To fully understand the Burundian position on GHD, a collection of online data about GHD was done. The main data which were obtained are from the East Africa Community (EAC) in which Burundi is a member. The GHD within EAC provides some data such the number of epidemic prevention cases conducted in all the member states of EAC. Those data were useful to better understand the position of Burundi in terms on GHD. More details are given in the chapter five.

2 Scope of the Study

The scope of this research was limited for the following reasons:

- The literature review was based on available library books and web based materials. However, the phenomenon of Global health Diplomacy is still new and many of relevant documents are kept by organizations or government officials. Therefore, we shall be limited to free and available materials.
- Interviews: To strengthen the general findings from the case studies, we had wished to first interview some of the key players within the case studies. Secondly, since our case study refers to Burundi, having interviews with the actors of the GHD in our case study would enhance the trustiness of our findings. However time and resource limitation will not allow us to proceed further.

Chapter 2 Literature Review

2.1Defining and Understanding GHD

GHD is a more recent phenomenon with different definitions advanced by different authors in different contexts. These definitions focus on global health-based perspectives and the role of diplomacy in promoting global health goals. To have a clear view of GHD, we describe the main given definitions about GHD:

- "A political change activity that meets the dual goals of improving global health while maintaining and strengthening international relations abroad, particularly in conflict areas and resource-poor environments" (Adams et al. 2008,1)
- "Multi-level, multi-actor negotiation processes that shape and manage the global policy environment for health" (Kickbusch et al. 2007,1)
- "Winning hearts and minds of people in poor countries by exporting medical care, expertise and personnel to help those who need it most" (Fauci 2007,2)
- "Policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve political, economic, or social objectives" (Fidler 2009)

Within the afore-mentioned definitions, the last definition by Fidler embrace the most the purpose of this study. This is because the leading countries in GHD (Switzerland, Norway and Brazil) made it through policy shaping processes to better fight the health challenges as mentioned in the *Oslo Ministerial Declaration*. In addition to these various definitions, diplomatic activities conducted within GHD contribute to the understanding of GHD. These activities can be divided into three categories (Chattu 2014, 5):

1. Formal international bilateral and multilateral negotiations on health issues: During formal negotiations between and among nations, formal agreements are made concerning health issues resolving.
2. Multi-stakeholder diplomacy often involving countries: Countries collaborate with other countries and additional stakeholders and through negotiations they come to a common agreement related to health issues.
3. Semi-official interactions between health actors from one country acting in another country: This health diplomacy activity reflects the interactions where an official representing a country is acting in a health capacity in another country

These three activities reflect the basic activities of GHD. Each country which is involved in GHD, especially with the main objective of fighting against cross-border diseases, needs to work in collaboration with other countries to better

achieve its objective. Therefore, common agreements would be taken for in order to protect the people within those countries.

The main GHD's objectives, as defined by WHO are (Kickbusch 2007):

- Improve global health while maintaining and strengthening international relations abroad;
- Shape and manage the global policy environment for health; support poor countries by exporting medical care, expertise and personnel;
- Negotiate mutual benefits and responses of health challenges in the global health goals context.

GHD also pursues to "support the development of a more systematic and pro-active approach to identify and understand key current and future changes impacting global public health and to build capacity among Member States to support the necessary collective action to take advantage of opportunities and mitigate the risks for health".

Among these objectives of GHD defined by WHO, our research is more interested with the last objective "to build capacity among Member States to support the necessary collective action to take advantage of opportunities and mitigate the risks for health". Burundi is pursuing this objective by embracing GHD through regional community (EAC).

2.2 GHD: How and Why Health is integrated into Foreign Policy

In international relations, foreign policies have been established as a systematic tool to deal with issues that may arise with other countries. Foreign policies refer to the policies advanced by a state in relation with other states and non-state actors (NGOs) on issues with beyond boundaries consequences. Therefore, health has been integrated into foreign policies as a matter which needs more attention for foreign policy-makers to respond to external health threats that generate international problems and to use health-related cooperation in other to achieve non-health objectives such as utilizing health assistance to increase a state 'influence or keep better relations with other states.

Over the last decade, particularly over the last few years, health has risen in the published literature as a foreign policy issue. Health's rise as a foreign policy issue has been apparent in the proliferation of literature published in this area recently.

In 2007, Carleton University's Norman Paterson School of International Affairs launched the publication of its bulletin entitled Health and Foreign Policy. Also, the Bulletin of the World Health Organization emphasized on GHD, health and foreign policy. An issue of the Bulletin of the World Health Organization focused on GHD and health and foreign policy (WHO 2007). Canadian Foreign Policy's special issue focusing on global health and foreign policy was published in 2009 and in 2010 with multiple articles that devoted to this issue within the Medicine journal.

Chattu stated the interaction and interrelation of health and foreign policy (Chattu 2014, 9). He argued that health may be an instrument of foreign policy to improve relations between countries. For instance, Cuba and Venezuela signed medical diplomacy and the oil-for-doctors trade agreement in 2000. Health may also be a tool of foreign policy to keep a country's good image at home and abroad, for example China and African states agreements for various health initiatives.

Chattu (2014, 10) also mentioned that health is considered as an integral element of foreign policy. The recognition of disease as a major threat to human well-being highlights the importance of including health considerations to ensure national security. Foreign policy makers raised the importance of health to economic and social development as health problems affect their involvement in development and in other areas in which foreign policy makers engage.

Kickbusch (2011, 3) argued that health ministries should have interests in calling for a foreign policy that supports health and must ensure that health interests are embodied in foreign policy main concerns. Health ministers should also strongly advocate against positions which put health in danger (Kickbusch 2011, 3). For these reasons, a strong international health framework is much needed.

This structure calls out member states and non-member states such as NGOs, advocacy groups, foundations, academia, private sector to work together and negotiate responses about global health challenges. In this case, it is not only the

responsibility of health ministers to take the lead in international health, since health has gained political clout and states and non-states actors negotiate health interests in a highly politicized context. A typical example is the negotiations on International Health and the Framework Convention on Tobacco Control which adoption involved diplomats from Ireland and Brazil.

2.3 GHD: Political, economic and Social Impact

2.3.1 The soft power role of GHD

Factors indirectly related to health such as climate change, access to clean water and sanitation, food insecurity, state fragility can affect the global health. As states have recognized that advancing global health means progressing their own interests, they are increasingly integrating global health into their foreign policies to tackle these issues.

Therefore, GHD has been included into foreign policy as an exercise of soft power and some countries intend to advance their interests through deploying the power and influence on the soft and hard fields.

Kelly (2015, 4) stated that soft power can be considered as a tool of foreign policy and governments are free to use health as a specific tool of soft power. China and Brazil have been successfully utilizing health as a tool of soft power in their foreign policy. Taking the example of China, it has been sending medical doctors to African nations since 1960's. China's health support to African continent aims to forge a

mutual respect between two regions with the foreign policy goal of creating a favorable image of China.

Kirk (2009,17) considers Cuba's health diplomacy as a successful soft power of foreign policy in the fact that Cuba is using neither power nor force to influence or to create cooperation throughout the world by sharing values with other states which is significantly changing relations with aggressive government.

2.3.2 GHD and Peace

According to Kickbusch, global health diplomacy is emerging in order to capture the system and the method of the multi-level and multi actor negotiation. These methods develop the GHD shape and manage the global policy environment for health. Well conducted, GHD can move both health and peace agendas forward and negotiates the responses to common structural challenges that they face (Kickbusch 2007, 1).

Kickbusch emphasizes on the role that GHD can play in focusing on individual health while contributing to the reconstruction of society infrastructure in post crisis situation. At the health and peace interface, efforts including humanitarian ceasefires allow health interventions to take place. For example, the institutions such as UNICEF, PAHO, the Roman Catholic Church, Rotary International and the International Committee of the Red Cross negotiated ceasefires which allowed the

feasibility of their heath activities such as the immunization of 300,000 children annually while immunization was decreasing before peace agreement.

2.3.3 Corruption and GHD

In health sector, corrupt practices can have an economic impact in wasting a great amount of public funds which reduces the capacity of the government to offer good quality services and products, thereby impacting the health situation of the population. Corruption practices have also a negative impact on a government image and trust. In fact, the public institutions' credibility is reduced because of inefficiency and lack of transparency, a donor's trust in the capacity of the government decreases in such countries. Zambia lost its image and trust because of government officials' large-scale corruption which caused the removal of health aid (Michaud et al. 2015, 1&4).

According to the International Monetary Fund (IMF) in its study, it found out a significant, negative impact of corruption on health indicators such as infant mortality, the low immunization rate of children, health spending and this can discourage the use of public health structures. Corruption reduced access to health services and provoked delays in care-seeking behavior especially for poor people in Eastern Europe and Central Asia (Kohler 2011).

A large amount of money is spent worldwide each year to provide health services but it does not fully reach its beneficiaries (WHO 2007); 10 to 25% of global

spending in health system is lost to corruption. Corruption really constitutes a threat to global development efforts and has recently affected the operational work of key global institutions.

However, Kohler & Makady (2013) advanced that the awareness of such an issue within GHD would encourage systematic and pro-active empirical investigation and analysis of global health corruption. Global governance, as a tool against corruption, can reduce the effects of corruption practices by also incorporating the opinions of the minorities in decision-making processes (Kohler & Makady 2013, 9). These authors claimed that government should present the issue of good governance in health and gather empirical evidences of corruption into focus through health diplomacy channel.

2.4 GDH and Policy Making Theory

As specified by Fidler, GHD is policy shaping processes which both involve state and non-state actors in order to efficiently respond to health challenges. In this section, we shall introduce Policy-Making theory in order to understand which policy making theory suits the most GHD.

Policy-Making theory refers simply to the establishment of a given policy. Nevertheless, till now the word policy has not gotten a standard definition from which all the scholars agree upon, however according to (Jiangrong 1998, 16), four sub-functions would gathered together to define what is a policy:

1. Policy should not relate to pure private individual relations which require freedom from being monitored to end up being restrained by any legal social organization.
2. Policy provides direction, regulation, standard or plan by selection, to guide the work or operation within an entity which is led by the policy-making organ. For instance, a price stipulation, a tax rule, or a piece of law.
3. Policy is limited in time. A policy should be valid for a given period. For example, one year, two years, fifty years, or more, but not eternal because it should be cancelled or restructured in case new objectives arise.
4. Policy should start on an existing issue which need to be solved. When a policy is promulgated, the entities (organizations) or people concerned by the policy should be restrained or affected by the policy.

As defined by Fidler GHD is a "policy-shaping processes though which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve political, economic, or social objectives". Thus, policy making theories become the basis within the concept of GHD. In this research, we make use of *Multiple Streams Model of Policy making* to analyze the case studies of countries which already adopted GHD and further to understand the Burundian GHD's position. This model was chosen because it was adopted by other research such as

Tomlin, Hillmer and Hampson for their works related to GHD (Tomlin et al. 2008). More details are given in the following section.

2.5.1 Multiple Streams Model of Policymaking

In terms of policy making, international relations theory coupled with Kingdon's Multiple Streams model is adopted as a heuristic model to gather and organize a comprehensive and relevant set of data from the case studies. Kingdon's Multiple Streams model does embrace the four main components of policy making which are (Walt 2008, 4):

1. Policy context: It refers to the context within which the policy was developed (i.e. context for and reasons why the policy was developed);

2. Process: It shows the policy processes such as how the policy was developed and how it is being implemented;

3. Content: The policy content exhibits the key ideas to be found in the policy such as the global health issues to be addressed

4. Actors: The actors are the different entities involved in the whole process. Who and what role the entities should play in the process.

The four mentioned characteristics give a thorough and comprehensive approach to interpret and analyze a policy.

Multiple Streams Model of Policy making comes as conceptualization of international relations theory. International relations theory is based on the

interaction among the state and non-state organizations in order to establish a policy (Kingdon 2003).

In international relation, a term anarchy is used to emphasize that among the players, none of them is recognized as a common superior authority. The interaction and sharing of ideas among the players will determine how the policy is formulated regarding the political preferences and self-interests of the players (Jackson & Sorensen 2003). Therefore, through the international relations, the players can inter-subjectively conceptualize and express their ideas. Kingdon's Multiple Streams Model which has also been used in international global issues such as climate change was also adopted for GHD.

This model is used to analyze the GHD phenomenon. Kingdon's Multiple Streams Model avails an architecture from which concepts and theories regarding to policy making are incorporated (Labonté& Gagnon 2010, 1). This model was adopted by Tomlin, Hillmer and Hampson as they were analyzing the Canada's international relations and policies (Tomlin et al. 2008). As shown in figure 1, Kingdon's Multiple Streams Model works as follows:

1. Problem Stream: After the general ideas given by the players (state) representatives, the indicators which might be the data concerning a given disease or risk of a disease are gathered together to fully evaluate the prominence of the decision. The focus might be the already existing

disasters such as the SARS (Holmes & Kathryn 2003, 2) which was the focusing event for the Oslo Declaration. This step requires that new ideas should be carefully considered not adopted but debated upon by the specialists. The feedback step might consider the community advocators view also known as civil society in developing countries.

2. Policy stream: This step consists on the policy generation. It starts by offering the viable alternatives which suits the framed issues, then ends up taking off as a policy.
3. Politics Streams: In this phase, the compatibility of the policy is established. All the national politics of the state-members are consulted in order to establish a suitable jurisdiction in regards of all the members.
4. Streams join: In this phase, the different policy windows proposed in the previous steps are confronted with the policy entrepreneurs. The policy entrepreneurs are private specialists who help into policy implementation based on the player's wishes or recommendations.

After a successful stream join step, the policy is said to stand a high probability of being adopted. However, as described in different streams of Kingdon's Model, strong efforts must be devoted to make the three streams meet (through lobbying, research, communication, coalitions, interactions, bargaining, media, etc.)

Nevertheless, the multiple streams model presents strength and weakness

1. Strength

The Kingdon Multiple Streams model contributes significantly to the understanding of the agenda setting process. It offers a flexible model to examine a policy that often born out of irrational, incremental and predictable contexts and provides to policy actors and analysts the most precise description of the policy process (Zahariadis 2007, 5).

The kingdon model has been universal. It seems to have offered a framework that is applicable beyond its original country (the USA) (Solati 2009, 18).

2. Weakness

The Kingdon Multiple Streams model treats its multiple streams as being too independent of each other (Shinn 2011, 17). Each stream has a life of its own, with its own dynamics and rules. It is only during the window of opportunity and with the intervention of policy entrepreneurs, at the right moment that these streams interact. Kingdon's indicators may not be able to gauge policy streams. Some problems may lurk outside of the policy system and evolve over time. Alternatively, an indicator may continue to exist and not show a hidden problem in policy (Mucciaroni 1992, 475). The lobbying which is involved in Kingdon's model (mainly for trans-border policy making) might result in twisting individual interest

with the interests of the party which is represented (country, region or group) to affect the durable effectiveness of the policy.

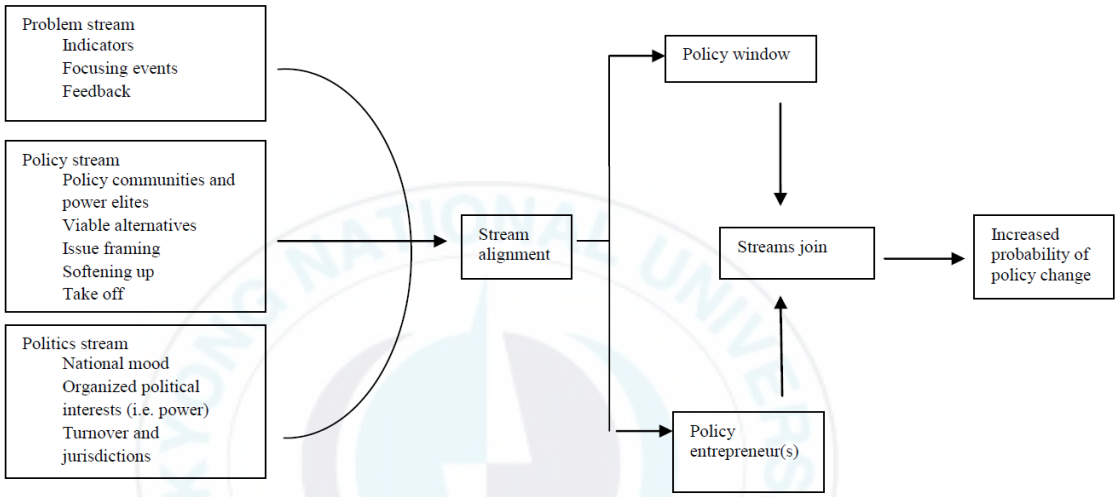

Figure 1 Kingdon's Multiple Streams Model

(Source: Tomlin et Al., 2008).

In the following chapter, we describe the different case studies which were taken which helped us to explore what urged those countries to adopt GHD. The Kingdon's Multiple Streams Model will be used to better understand the influential factors for the adoption of GHD.

Chapter 3.GHD Country Cases

3.1 Introduction

In this chapter we introduce the case studies namely the Switzerland, Norway, Brazil, African Union and East Africa Community. On each case, we describe the motivating objectives which led each entity for the adoption of GHD. We further give the measures which were taken and the involved actors.

3.2 Switzerland Health Foreign Policy

Named as "The Swiss Health Foreign Policy", GHD for Switzerland works as an internal agreement between the Federal Department of Home Affairs (FDHA) and the Federal Department of Foreign Affairs (FDFA). A focus on health was described as the ‘first application’ of the interdepartmental agreement (Silberschmidt 2011). Switzerland GHD was developed from specific objectives towards a set of measures describing how to achieve GHD goals along with the involved actors.

3.2.1 Objectives

Over the five year period (2006-2011), the Switzerland Health Foreign Policy shapes fives main policy goals (FDFA &FDHA 2006, 10):

1. Protect the health interests of the Switzerland population: It includes the protection against transmittable and non-transferable infections and general wellbeing of the population. This must be handled efficiently in participation with worldwide organizations and Switzerland's neighbors. The medium-term goals were to strengthen international monitoring networks for communicable diseases and maintain a high level of protection for Switzerland through international cooperation using efficient measures. This interest also aimed at maintaining the health and productivity of the Swiss population by adapting international strategies and targets to fight non-communicable disease.
2. Harmonize national and international health policy: This goal adapts national policy to the new international and regional policy by getting insights and lessons from international experiences to fortify Switzerland’s health system. The medium-term goals of the interest was to use multilateral and bilateral comparisons to update healthcare system advances and to cooperate more strictly with the EU in areas such as European Centre for Disease Prevention and Control, European Food Safety Authority and other various early warning system. The goal also aimed at managing migration of health professionals to ensure the needs of the labor markets in

industrialized countries and emerging economies were met, without taking the existing workforce of the developing countries.

3. Improve international collaboration on health issues: This goal shaped international health policy considering the health importance in the Switzerland development and economy by considering coordinated foreign policy objectives and national interest. The other medium goals were the strengthening of the normative role of the WHO, to support cooperation between WHO and EU on health issues in order to stimulate better cooperation. Enhancing international access to essential drugs; improving efficiency of multilateral players in health, development cooperation and humanitarian aid were the additional goals. From this part also, promoting research to strengthen the empirical basis for effective health interventions in order to reduce the disproportionate burden of disease in the southern hemisphere was also emphasized.
4. Improve the global health situation: Improving the world's health situation constituted the Switzerland major economic and political interest, particularly in developing countries and countries in transition. A primary target was to reinforce the global partnership for improvement, security and human rights that could meet the recommendation of the WHO's goals. Switzerland might want to make a valid and recognized commitment. In

doing so, the Switzerland was seeking to achieve the following goals: Health system reform in developing and emerging countries and those in transition or in crisis, focusing on efficient and non-discriminatory access to health services and drugs; Making suitable contributions to removing the three significant poverty-related diseases – AIDS, TB and malaria. Paying specific attention to gender issues; donate to global strategies and programs to fight non-communicable diseases; collaborate bilaterally and multilaterally to save people's lives; taking aid to victims of natural disasters and armed conflicts in order to restore health living conditions

5. Safeguard the Switzerland role as host country to international organizations and a base for major companies working in the health sector: Geneva has hosted several international meetings related to international health policy. It additionally has held missions in several countries and offices of more than 200 NGOs. Switzerland tries to keep up and expand its important part as a host nation and gathering venue. Issues including incorporate the effect of health policy on national and international trade policy are also part of the Switzerland agenda. Thus, it aims at consolidating and strengthening Geneva's position as an international center of excellence for public and humanitarian health. This also ensures appropriate protection

for intellectual property as an essential incentive for research in areas such as drugs and vaccines.

3.2.2 Measures

In order to achieve the main five objectives which Switzerland has set, a series of measures were taken to fully achieve those goals (FDFA &FDHA 2006, 14)

1. Measure 1: Establishment of a coordinating office for health foreign policy. Undertaken by the FDFA, the coordinating office is established as a contact point for all relevant inquiries from other offices of the administration and it also takes in charge the coordination of all health matters inside of the FDFA. The coordinating office had also responsibilities to collect and forward relevant information from the FDFA to other involved offices of the government and ensures the coherence of health foreign policy as major aspect of overall Switzerland foreign policy.
2. Measure 2: Creation of an information platform for health foreign policy. The information platform for health foreign policy is set up by the FDFA as a part of its foreign policy information system to be accessible to all concerned offices within the government. This platform holds all essential basic documents and background information, meetings and events in health foreign policy.

3. Measure 3: Produce policy papers on subjects arising in health foreign policy and strengthen academic competence. Undertaken by the FDHA, this measure aims to produce papers focusing on explicit aspects of health foreign policy. The FDHA, in consultation with other offices in the administration, takes in charge this action and in addition; it aims to strengthen scientific competence in international health issues by including international health in the target agreement with the government-funded academic institutions in Geneva and Lausanne.
4. Measure 4: Harmonization with general foreign policy and other sectorial policies. The FDFA coordinates its international work with the general foreign policy of Switzerland and other sector policies. It also frequently briefs other relevant offices on significant developments in health foreign policy.
5. Measure 5 (Joint measure): Creation of an Interdepartmental Conference on Health Foreign Policy. The interdepartmental conference on health foreign policy is both controlled by the FOPH and representatives of FDFA. It describes recent priorities and common projects and is supported by the Interdepartmental Working Group on Health Foreign Policy.

6. Measure 6(Joint measure): Staff exchange and foreign missions. Members of the FDFA diplomatic staff holding a senior position in the international affairs section of FOPH as a mechanism of staff are exchanged.

3.2.3 Actors

The main actors who were involved in the implementation of international health policies are within the Switzerland administration (FDFA &FDHA 2006, 16): FDHA, FDFA, the Swiss Agency for Development and Cooperation (SDC) in charge of development policy concerning health and the Directorate of Political Affairs (DP) in charge of general foreign policy issues. Offices within the FDFA and the FDHA, such as the department of Economic Affairs and the department of Justice and Policy are also included among the actors.

3.3 Norway Health Foreign Policy

Different from the Switzerland approach, Norway was seeking a higher profile on global health issues through initiatives such as the Foreign Policy and Global Health Initiative (FPGH). The Oslo Ministerial Declaration is one of the achievement of Norway in terms of GHD (Sandberg & Andresen 2010, 7).

3.3.1 Objectives

The specific factors, beside the protection of citizen's health, integrate health in each policy and international collaboration for health challenges, which led to the development of the FPGH and the Oslo Ministerial Declaration are defined as follows (Sandberg & Andresen 2010, 13):

1. Leadership in Global Health: Norway had an ambition to make a difference in global health. It has been emphasized that political leaders outside the health ministry in Norway were so much involved from the Premier Minister office.
2. Sustaining foreign policy attention on global health: Norway wanted to maintain its global foreign policy influence: Through the global health aspects. Thus, whether health issues occur or not, the Norway foreign policy influence should continue to have its initial impact.
3. An urgent need for change: Norway has already defined their foreign policy as a traditional way; therefore they needed a new approach to broadening the scope of foreign policy. This would help in solving new challenges that could not be fixed in the traditional ways.

3.3.2 Measures

Norway was directing its GHD program in three main areas which are (Ministers of Foreign Affairs 2007, 3 & Filder 2011, 8):

1. Capacity for global health security: This included preparedness and foreign policy, control of emerging infectious diseases and foreign policy and human resources for health and foreign policy.
2. Facing threats to global health security: This policy comprised conflict (pre, during, and post conflict, and as peace is being built), natural disasters and other crises handling, response to HIV/AIDS and health and the environment
3. Making globalization work for all: This strategy was focusing on health and development, trade policies and measures to implement and monitor agreements and governance of global health security.

Additionally, the conventional measures such as establishment of coordinating office for health foreign policy, creation of information platform and strengthening academic implication were also included within the *Oslo Ministerial Declaration*.

3.3.3 Actors

The ministry of Foreign Affairs, the ministry of health and WHO have been involved in the achievement of global health objectives as key global health actors. Health related NGOs have also been dealing with issues which engage the global health such as climate change (Gagnon 2012, 92).

3.4 Brazil Case Study

In Brazil, GHD was mainly defined to improve cooperation rather than assistance (Ministers of Foreign Affairs of Brazil 2011). This was also due to the increasingly and influential global economic role of Brazil. For the last two decades, there were a lot of companies, private companies which have key role in the international trade.

3.4.1 Objectives

Brazil emphasizes in the following aspects (Gagnon 2012, 107):

1. Health in all policies: Brazil decided that health would be part of their foreign affairs policy and since that time, all the new appointed minister of health were very committed to the integration of health in foreign policies
2. Protect citizen's health: Brazil aimed for the equitable accessibility of medicines as a global health priority. For example, Brazil has been successful in reducing significantly HIV/AIDS cases through negotiations and agreement which ensure antiretroviral medications accessibility. Also,

Brazil aimed to work towards social determinants of health and so achieve the MDGs as a global health priority.

3. Collaboration across governments: The collaboration made the Brazil's Ministries of Health and Foreign Affairs to work closely in issues regarding global health policy development and implementation. The two ministry departments had joint missions in which the Foreign Affairs Minister and the Minister of Health worked together in establishing relations with several different countries. The relations were more focusing in South America. In Brazil, the Foreign Affairs Ministry suggested that the Ministry of Health must delegate a representative, a diplomat working together with several divisions of the Ministry of Health to define the policy linked to health on behalf of the Ministry of Health and Ministry of Foreign Affairs. In addition, the Ministries also cooperated closely on diplomatic outreach on health issues with representatives of the diplomatic staff.

3.4.2 Measures

The Brazil case studies adopted already known measures for GHD which are the establishment of coordinating office for health foreign policy and the creation of information platform (Gagnon 2012, 109).

3.4.3 Actors

The main government actors in GHD for Brazil were the Ministries of Health and Foreign Affairs. WHO and the civil society are the non-government actors involved in Brazilian GHD (Gagnon 2012, 112):

1. WHO: The cooperation of Brazil was mainly encouraged by its leading position as an economic power in South America. Thus WHO wanted a strong and leading partner to spread its policies in all the South American countries. More importantly, the Framework Convention on Tobacco Control had to include Brazil due to its large production of Tobacco.
2. Civil Society: Brazil's constitution established the participation of civil society organizations in formulating health policy as a guiding principle. For that reason, health councils at the federal state and municipal level were implemented. Health councils were also involved in formulating health strategies and were in control and execution of health policy

3.5 African Perspective on GHD

The Global Health Diplomacy has been embraced by the Africa as a whole under the supervision of the African Union. The International Health regulations as suggested by WHO include the following (Ravishankar et al. 2009, 5):

- Prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.
- All the state members of the WHO should strengthen core surveillance and response capacities at the primary, intermediate and national level, as well as at designated international ports, airports and ground crossings.

However contrary to the European continent which is represented in one Schengen cooperation, the African continent count tens of geographical organizations which were asked to first embrace the GHD on regional level.

3.5.1 African Union

Africa as a whole has yield to diplomatic interaction for health issues according to the WHO recommendations. The African Union has participated in the multilateral negotiations, State delegations on health issues (William 2012, 10). The AU constitution establishes:

- Specialized Technical Committee on Health, Labor and Social Affairs which reports to the Executive Council.
- Economic, Social, and Cultural Council that addresses health matters. For instance in 2003 the AU Assembly made a Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Infectious Diseases.

- AU adopted nine year (2007-2015) health strategy, promote international health partnerships in Africa. The strategy requires the state members to strengthen cooperation within Africa south-south and north-south collaboration using the regional cooperation

However, the AU plays the role of the overseer on GHD. AU decided that GHD goals should be achieved through regional communities since contrary to the Schengen space where the state members can easily circulate, the free circulation in African states is only allowed on regional communities.

AU comprises the following regional communities as described in figure 2:

1. Arab Maghreb Union (UMA)
2. Common Market for Eastern and Southern Africa (COMESA)
3. Community of Sahel-Saharan States (CEN-SAD)
4. East African Community (EAC)
5. Economic Community of Central African States (ECCAS)
6. Economic Community of West African States (ECOWAS)
7. Intergovernmental Authority on Development (IGAD)
8. Southern African Development Community (SADC)

Among them Burundi is part of EAC and ECCAS. ECCSA is an economic community whereby the health issues are delegated to the second level. Our attempt to analyze the ECCSA implication in terms of health issues could only

conclude that ECCSA was mainly engaged in economic activities (Oppong 2010, 3).

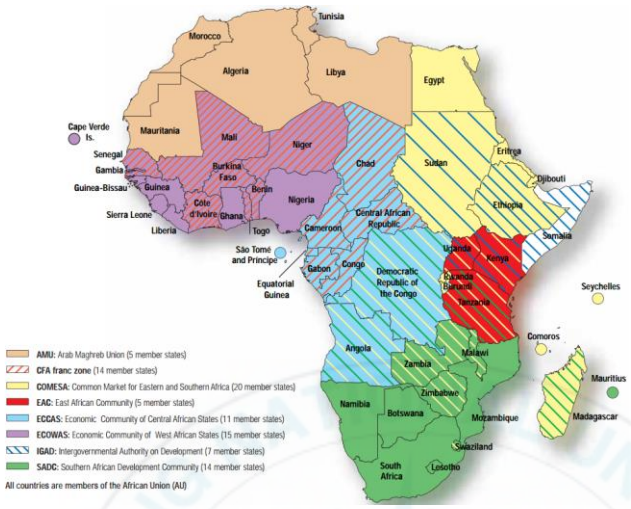

Figure 2 AU regional Communities

Source: UNEP 2008

3.5.2 East African Community

The East Africa Community (EAC) was established in 1999 with three member states which are Kenya, Uganda, Tanzania. Rwanda and Burundi were officially integrated in 2007 and the last summit in January 2016 brought in South Sudan as the sixth member. The main EAC's objectives are to develop policies and programs to widen and deepen co-operation among the partner states in political, economic, social and cultural fields, research and technology, defense, security, legal and judicial affairs and health cooperation.

Following the AU recommendations, which were also based on the WHO's agenda, the EAC has adopted three main mechanisms to foster health diplomacy (East African Community 2006):

1. Sectorial Council of Ministers of Health that meets regularly to discuss regional health matters. Their decisions are presented by the Community Council of Ministers before submission to Summit of Heads of State for approval.
2. East African Integrated Disease Surveillance Network (EAIDSNet) provides mechanisms for the identification, monitoring and control of health threats in the Community.
3. East African Health Research Council was adopted in 2006

These structures work hand in hands with state members to assist these three afore-mentioned structures for the health of the EAC citizen.

Chapter 4 Findings Discussion

In this chapter, we discuss the findings which were retrieved from the different case studies which are the Swiss, the Norway, the Brazil, the African Union and the East Africa community. We first summarize the findings from the case studies in table1 from which we find out the motivating factors which led our case studies to adopt GHD and discuss about Kingdon Multiple stream theory's connection with these motivating factors. Furthermore, we will talk about the similarities on those case studies and then the main difference among the case studies.

4.1 Case studies findings

The following table describes the main findings from our case studies. For simplicity, we describe the objective (motivating factors) which lead each entity to adopt GHD. Then we described the measures taken along with the actors involved in the process.

Table 1 Comparison of Study cases

	Country/Region			Community	
	Swiss	Norway	Brazil	African Union	East African Community
Objective	Protect Citizen's Health Improve international collaboration Integrate health in each policy Safeguard its role of international health organization	Protect Citizen's Health Improve international collaboration Integrate health in each policy Maintain the Norway Position as good and responsible state	Protect Citizen's Health Improve international collaborations Integrate health in each policy Invest in international development	Establishes strategic plan on special disease such AIDS Call for regional Collaboration Plead for WHO support	Improve cooperation among state member for health issues
Measures	Establishment of coordinating office for health foreign policy Create information platform Strengthen academic implication	Establishment of coordinating office for health foreign policy Create information platform Strengthen academic implication	Establishment of coordinating office for health foreign policy Create information platform	Evaluating summits on strategic plan	Sectorial Council of Ministers of Health East African Integrated Disease Surveillance Network
Actors	Federal Department of Foreign Affairs (Switzerland) FDHA Federal Department of Home Affairs (Switzerland Federal Office of Public Health	Ministry of Foreign Affairs Ministry of Health's relations	Ministry of Foreign Affairs Ministry of Health's relations Civil Society World Health Organization	Relay on WHO support and other international NGOs operating in Health sector.	Ministry of Foreign Affairs Ministry of Health's relations
Exceptional Remark	No outside government actors involved SARS was a precipitating event	Inside government actors involved	Civil Society much involved		

4.2 Motivating Reasons for Adopting GHD

From the findings, we could draw out the leading factors which conducted the case studies to build GHD policy. The motivating reasons are mainly made by the core objectives which made those entities to adopt GHD. Then the specific measures which were taken for a better GHD adoption and the different actors which were involved in GHD adoption processes. These three elements (objectives, measures, actors) has been essential to adopt GHD. In fact, specific objectives related to global health have been developed, motivated by the appearance of bad event affecting the global health such as SARS appeared in Schengen space. The motivation would have also been self-interests as it has been in developed countries (Suisse, Norway). After the objectives being developed, strong measures must be established in other to achieve those objectives. Also, actors need to be nominated to lead all the activities within GHD.

4.2.1 Kingdon Multiple stream theory and GHD policy adoption

Based on the case studies we used the Kingdon Multiple Streams Model to better understand the leading factors which led the case studies to adopt GHD. As mentioned in the Kingdon Multiple Stream Model, this model is made by three main entities namely Problem stream, policy stream and politics streams.

The following figure shows how the model was used to explore the leading factors for each case study.

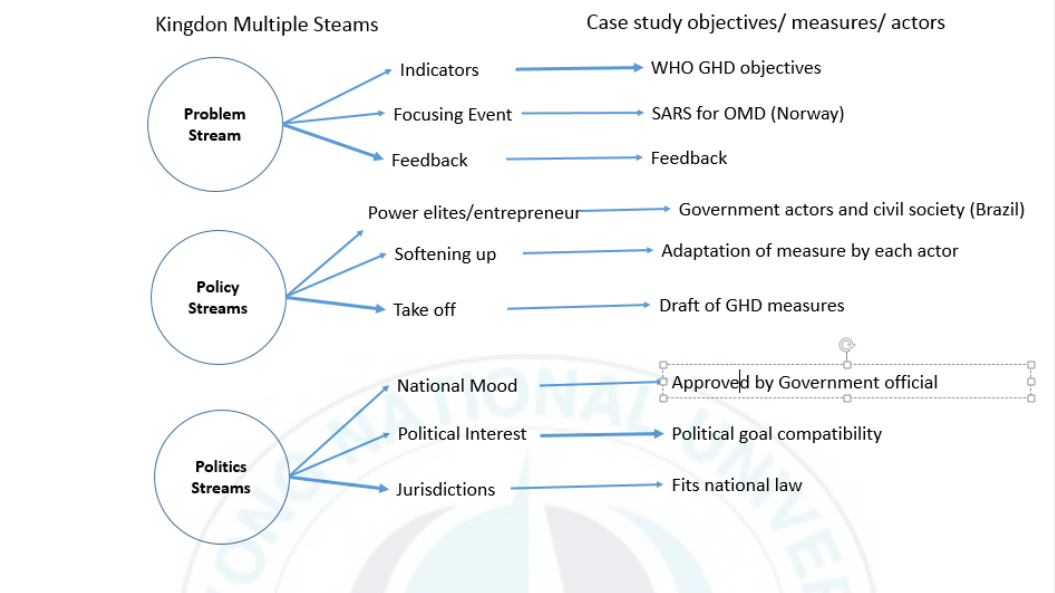

Figure 3 Kingdom Model/ case study

- ✧ Problem streams: As mentioned earlier, problem streams outlines simply why the GHD is needed. The main motivation of GHD is that it is a concept which was initialized by the WHO, thus all members of the WHO are invited to abide by it. Specifically taken each case study, the problem stream for the Norway case also included the SARS epidemic issue. The issue only came to confirm that GHD was needed not only for Norway but for even other communities in which Norway is a member. For the Brazil case study, the Framework Convention on Tobacco Control was the starting point for

GHD. We would say that even though some countries had to wait for important even in order to engage in GHD, looking at the GHD as defined by WHO is enough for engaging in GHD.

- ✧ Policy Streams: The policy streams are the alternative of the policies to be taken at the end. As described within Filder's definition of GHD, the state and non – state representative would provide suggestions of policies based on their views before getting into negotiations. In terms of actors, apart from the government officials, Brazil included the civil society as actors for GHD. Since the GHD is policy process shaping, different actors might suggest a multitude of measure which need to be soften up in order to have a common draft.
- ✧ Politics Streams: Politics streams looks at the compatibility of the policies and the different laws of the state members. For instance one of the measure taken by our case study is the establishment of coordinating offices for health foreign policy. Such a policy has to consider to each state internal policy.

4.3 Case Studies similarities

The following is the main goals for GHD which were both adopted by the case studies:

1. Protect Citizen's Health: The health of each country's citizen is the priority of each government. This goal which is also the principal objective for each ministry of health was included because other new objectives would at the end improve this particular objective.
2. Integrate health in each policy: In simple words, this policy means that health should not be forgotten in every policy. A simple example would a citizen of any country going to get a driving license for the first time. For instance, the Republic of Korea would only check if the candidate sight is enough to drive, however other countries would take that opportunity to request a general medical checkup. This would sound strange like over checking people's health but other states have adopted it under the GHD goals. This particular goal is very crucial because it is related with the cross-border epidemic disease's fighting.
3. International collaboration for Health issues: This is the core of GHD. This means that any sickness from a neighboring country should be timely and efficiently addressed. In the conventional health system, each country had a special institution (teams and laboratories) to intervene in case of such event.

However, in case of African regional communities, GHD went further to recommend the establishment of regional teams for disease surveillance in some region such as EAIDSNet in EAC. All the case studies which we analyzed prioritized this particular goal.

4.4 Case study non- similarities

The case studies which were taken present a number of goals which are not similar from one case study to another:

Switzerland:

1. Safeguard its role of international health organization: The Switzerland had a vision to safeguard its leading position in terms of health diplomacy. For this, for the last two decades, not only the WHO headquarters are located in Switzerland but also important conferences for health issues are hold in Switzerland. This come within the foreign policy of Switzerland as a key player in terms of global health. The Switzerland also injects considerable amount in terms of finances. This is explained by the position of other members of the Schengen space which were once colonizers (France, Belgium, UK) and kept an influencing policy and position in several former colonized countries
2. Non participation of Civil Society: Civil society are non-government organizations and institutions that plead for the well-being of the citizen.

The role of civil society in developed and emerging countries is different. In developing countries, those organizations have increased for the last decades to monitor the government actions in order to help governments to successfully implement their programs. Those organizations have been helpful in developing countries where the quasi- totality of the government are reported not to do much for the population. However, in the case of Switzerland, the civil society were not involved.

Norway

Inside government actors involved: Norway also suffers from a low representatively on the international scene since it was not a colonizer such as UK or Germany. In this way, GHD was seen as one of the best way to help the developing countries as the former colonizer have been doing. Thus, a strong involvement of the country's authorities from the highest level was obvious.

Brazil

Strong participation of civil society: Developing countries implemented the GHD through the help of donators such as the EU or WHO. And one of the recommendation was to include the civil society to monitor under a private angle the implementation of the GHD. This also help in updating GHD based on the people recommendation.

African Union

The African Union decided to delegate the GHD to the African regional communities within the African continent. This was to facilitate the collaboration among the African countries. For instance, the *Oslo Ministerial Declaration* was involving all the EU countries to work together for GHD. However due to the large size of the African continent, a common framework would be very hard to monitor and its efficiency would be questionable since many of the epidemic diseases such as EBOLA mainly focus on one region. In that perspective, AU remained as a referee to check whether the GHD goals are fully being implemented by the different African regional communities such as EAC or SADC.

East African Community

Regional based GHD as recommended by the AU allows to set up measures and strategies for GHD. In the case of EAC, two main structures were created. The Sectorial Council of Ministers of Health which stands as an evaluating organ for the GHD in the region. The structure makes a yearly evaluation based on the pre-aggregated policies and other new or emerging challenges.

East African Integrated Disease Surveillance Network (EAIDSNet) is an institution with a set laboratories and offices in all the state members.

EAIDSNet ensures the identification of any epidemic disease and an efficient remedy to any abrupt sickness. As mentioned earlier, EAIDSNet is the core organ

which all the EAC state members rely on in terms of preventing the trans-border epidemic disease. A close look was then focused on the EAIDSNet.

The objectives of EAIDSNet are to:

1. Enhance and strengthen cross-country and cross-institutional collaboration through regional coordination of activities;
2. Promote exchange and dissemination of appropriate information on Integrated Disease Surveillance (IDS) and other disease control activities;
3. Harmonize disease surveillance systems in the region;
4. Strengthen capacity for implementing disease surveillance and control activities;
5. Ensure continuous exchange of expertise and best practices for disease surveillance and control

Chapter 5 Burundian GHD Position

In this chapter, we first show the existing GHD goals which are already adopted by the Burundian government. Secondly, based on Kingdon's Multiple Streams Model, we locate the GHD position of Burundi along with the possible measures which should be taken in order to strengthen its GHD position.

5.1 Burundi GHD in EAC

As we have seen in the previous chapter, the Burundi position in terms of GHD depends on the EAC health based mechanisms. The risk of causing an epidemic case or being a victim is very high due to the free mobility of EAC citizen within the region. Kenya and Tanzania counts among the most diversified Wild Park in the Word. However though it is benefiting their respective country through tourism income, it is also a threat to the national or regional population health. We analyze the data which we collected from the GHD in EAC in order to understand the position of Burundi in Global Health Diplomacy.

5.1.2 Analyzing EAC GHD Data

In this section, we first analyze the collected data concerning the EAC adoption of the GHD. Those data includes six EAC Health Ministries meetings, 4 EAIDSNET bulletins, two Annual East African Health and Scientific Conference and Exhibition and one integrated regional coordination mechanism on cross-border animal diseases. Figure 3 summarized the types of data which were gotten and analyzed. The analyzed reports cover the period of 2007 to 2012 for the EAC Health Ministries meetings, 2014-2015 for Annual East African Health and Scientific Conference and Exhibition and 2010 for integrated regional coordination mechanism on cross-border animal diseases

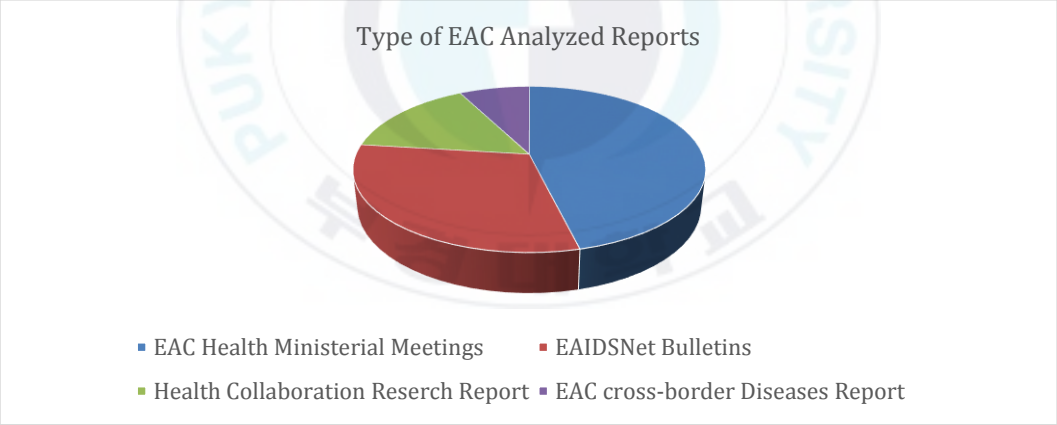

Figure 4 Type of EAC Analyzed Reports

The EAC Health Ministries meeting reports were mainly focusing on the adoption of text and laws for the different health structures of the EAC. This confirms the

role of ministries of heath (including the Burundian ministry of health) as the main players of GHD in EAC.

We also analyzed the core structure for GHD in EAC which is the EAIDSNets because it is the one which detect and fight ant cross-border epidemic issues. Though the structure is supposed to provide a trimestral bulletin for every year since its creation in 2000, we could only find the bulletins corresponding to the year 2011. Further inquiries to get all the bulletins from the EAIDSNet creation could not be fruitful. However though little, a global view is depicted from the EAIDSNet 2011 bulletins. As it is shown in table 2, third quarters of the focus within the EAIDSNet structure were focusing on the Ugandan cases and one quarter on the Tanzanian case.

Table 1 EAIDSNets Focus in 2011

Period		City	Country
1st Trimester 2011	Yellow fever outbreak in Uganda	Karamoja	Uganda
2nd Trimester 2011	Ebola Outbreak in Luwero District, Uganda	Luwero	Uganda
3rd Trimester 2011	Rubella Outbreak in Tanga City, Tanzania	Tanga	Tanzania
4th Trimester 2011	The Nodding Syndrome	Northen Uganda	Uganda

Additional document which summarized the EAIDSNet activities showed that little attention was given to Burundi and Rwanda. This could result of the late integration

of these two countries in the EAC block. As shown in figure 3, Uganda and Tanzania are the leading countries to be involved in EAIDSNet activities followed by Kenya.

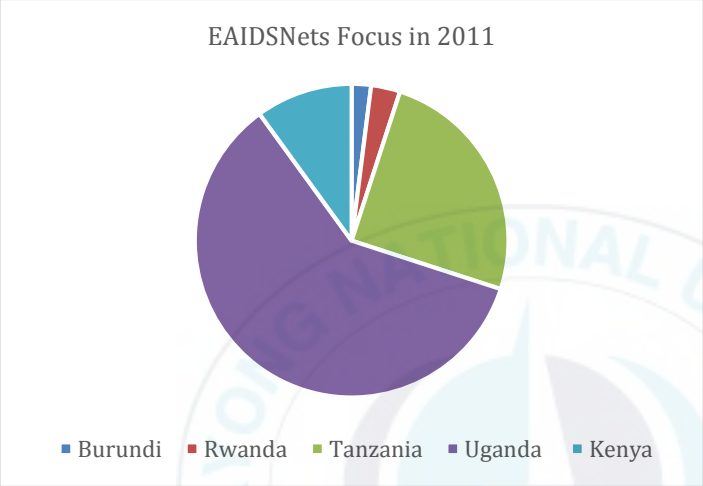

Figure 5 EAIDSNets Attention in 2011-2013

We further analyzed the integrated regional coordination mechanism on cross-border animal diseases which encloses important data for the GHD in EAC. As noted by other researchers, many of virus are transported by domestic animals such as chicken, cow or monkey. For the reason, the number of animal cases was analyzed along with the member states in order to reveal the risks which could be used to enhance the capacity of fighting against those threats. We first analyzed the new castle Disease situation in EAC. Newcastle is infectious viral fever affecting birds such as the bird flu. As shown in table 3, Burundi and Rwanda shows big

figures if we consider the size of the two countries. Though Uganda has the biggest number of cases, Uganda has around fifty million inhabitants whereas Rwanda and Burundi has respectively 11 and 10 million.

Table4 gives the details regarding the Limpy Skin Disease which is a cow based infection. Burundi present in 2008, 88% of all the Limpy skin cases in EAC.

Table 2 Newcastle Disease situation in EAC

Year	2006		2007		2008	
Country	No. Outbreaks	No. Cases	No. Outbreaks	No. Cases	No. Outbreaks	No. Cases
Burundi	-	-	-	-	-	8926
Kenya	54	-	15	286	4	308
Rwanda	-	-	-	-	68	9529
Tanzania	55	-	145	3531	-	3183
Uganda	8	-	10	79934	9	22996
Totals	117	-	170	83751	81	44942

Source: EAC integrated Regional Coordination Mechanism 2010

Table 3 Lumpy Skin Disease in EAC

Year	2006		2007		2008	
Country	No. Outbreaks	No. Cases	No. Outbreaks	No. Cases	No. Outbreaks	No. Cases
Burundi	-	-	-	-	1	4194
Kenya	-	-	51	176	1	2
Rwanda	-	-	-	-	12	96
Tanzania	46	-	128	841	-	207
Uganda	8	-	11	21830	7	260
Totals	54	-	190	22847	21	4759

Source: EAC integrated Regional Coordination Mechanism 2010

To understand the position capacity of Burundi, we also check the institutions which are marked by EAC as EAIDSNet laboratories. As shown in table 5, the

Burundi regional center of EAIDSNet still needs curriculum to be fully functional as of 2010.

Table 4 Institutions in the EAC PS earmarked for development as EAIDS Net centers

Country	Area of recognition	Proposed centre	Status
Kenya	1. Disease surveillance & ICT 2. Field Epidemiology and Laboratory Training Program (FELTP)	♦ Jomo Kenyatta University of Agriculture & Technology – INTROMID/KEMRI/ Ministry of Public Health and Sanitation (Division of Disease Surveillance and Response)	Regional
	3.Telemedicine (eHealth) and HMIS (in-service) and Continuing Professional Development (CPD)	♦ Moi University and National Teaching & Referral Hospital Complex, Eldoret, Kenya (Ministry of Medical Services)	National
Uganda	1.Telemedicine (eHealth) and Continuing Professional Development (CPD)	♦ Mulago National Teaching and Referral Hospital Complex,	Regional
	2.Disease Surveillance	♦ School of Public Health, Makerere University, Kampala, Uganda	National
Burundi	1.Disease surveillance and Continuing Professional Development (CPD)	♦ Institute of Public Health (needs curriculum)	Regional
	2.Telemedicine (eHealth and HMIS)	♦ Central University Hospital at Kamenge (CHUK) of National University of Burundi	National
Tanzania	1.Disease surveillance and HMIS/eHealth	♦ Muhimbili University of Health and Allied Sciences (Disease Surv)	Regional
	2.Telemedicine and Continuing Professional Development (CPD)	• Muhimbili National Hospital, Tanzania (Mainland) and Mnazi Mmoja National Hospital, Tanzania (Zanzibar) – linked	National
Rwanda	1. Disease Surveillance + HMIS + Continuing Professional Development (CPD)	♦ Kigali Health Institute (Need HMIS, Disease Surveillance and eHealth Curriculum)	National
	2. Telemedicine (eHealth) and Disease surveillance	♦ National University Hospitals of Rwanda (CHUB and CHUK)	Regional

Source: EAC integrated Regional Coordination Mechanism 2010

The above collected data confirm that the Burundi integrated the EAC for a better collaboration with other state members to fight epidemic disease. However, the data show that Burundi is not efficiently achieving its objectives and need to improve its capacity in terms of better embracing GHD goals.

5.2 Adopted and non-Adopted GHD Goals by Burundi

Burundian government has achieved a set of GHD goals based on the WHO recommendations. Regarding the findings from the three case studies, we could find out the already adopted and non-adopted goals by Burundi. It is trivial that the main WHO goal which concerns the rapid and efficient fighting of any epidemic issue is achieved through the EAC as it was recommended by the AU. Among the achieved GHD goals are:

1. Protect citizen's health: This objective is broad and always comes at the beginning and the end of each health related goal. This particular goal is the priority of each government, thus we assume that all other health objectives convey towards this specific goal

2. Improve regional collaboration: This goal is resolved through the EAIDSNet for the East African Community. We should remind that among the three neighboring countries of Burundi, two are members of the EAC and other one is not. Thus we would say that seventy percent of this particular goal is being achieved though the available data shows less concern on Burundi within the EAC integration block.

Among the main GHD goals, three others are not yet adopted by the EAC and probably the Burundian government:

The non-adopted goals:

1. Integrate health into each policy: Among the GHD goals of EAC, this particular objective is not so much emphasized. As underlined by other researchers, though it looks like over inserting health control in each process, the policy is an effective preventive strategy for GHD. In this case, the EAC should take lesson from the three cases and adopt that policy to strengthen its capacity to improve the health of the region through this goal. This goal needs to be pursued on national level and foreign ministries within each state member. As seen from the Switzerland and Norway cases, each state members ought to create a coordinating office to evaluate the integration of health in each policy.

2. Create efficient information platform for health foreign policy: An establishment of information platform would also be important within foreign ministries of EAC member countries to improve the coordination and coherence concerning health foreign policy. The Switzerland and Norway went beyond the trimestral or annual reports and created a platform to avail information on GHD. This was backed up graduate GHD institute in Geneva where researchers and diplomats contribute in that process of availing the GHD information not only the mentioned case studies but also the whole Schengen space.

3. The objectives concerning the self-interest such as safeguard its international role for Switzerland, maintain the Norway position as good and responsible state for Norway could be hardly applicable for EAC countries because they are relevant to developed countries which invest considerable amount for global health development especially in developing countries.

5.3 Burundi GHD and the Kingdon Multiple Stream model

Based on the findings of this research and according to the Kingdon Multiple Streams model, we analyzed the process of GHD in Burundi by first describing the problem, policy and politics stream and then discussing about the possible merging of problem, policy and politics stream and the concepts of policy windows and policy entrepreneurs.

The policy entrepreneurs includes actors in GHD which influence the creation of different global health policies, generate alternatives after framing issues; soften up a policy and ensure its implementation. In her study, Gagnon admitted that the policy entrepreneurs advanced the policy directions and assumed a leadership role in pursuing “Health is global” policy. She also recognized the role of the policy entrepreneurs in linking the problem, policy and politics stream and after that a policy window or opportunity may open (Gagnon 2012, 117).

The creation of GHD office in Burundi where actors would operate together as a global health team recognized as policy entrepreneurs in Kingdon model is much

needed. In fact, the policy entrepreneurs would timely frame issues concerning how Burundi is embracing GHD within EAC. Policy entrepreneurs would also follow up the stages suggested by Kingdon Multiple Stream model in case an issue is raised and a policy need to be changed or a new policy need to be adopted. This would help Burundian government to better achieve GHD goals at regional level (EAC) and national level as one border (DRC) which is not a member of EAC still constitute a non-negligible threat in case an epidemic disease may arise from that side.

The following part provides the connection of Kingdon Multiple stream model and the GHD findings to address Burundian weakness within EAC and deliver a set of recommendation for a better GHD adoption.

5.3.1 Problem stream

The problem may be stated through feedback on existing activities or through indicators. For our case study, the problem stream includes EAIDSNet activities which showed that little attention was given to Burundi. Besides, taking the new castle Disease and Limpy Skin Disease situation in EAC, Burundi was the most affected in all EAC countries in 2008. The number of animal cases revealed the capability of fighting against those threats and Burundi present the highest risk with little capability. It is obvious that Burundi needs extra measures to first eradicate such sickness and further protect its borders against external health threats and for

the safety of other EAC state members. Also, according to EAC integrated Regional Coordination Mechanism, the Burundian regional center of EAIDSNet, which is among the health institutions in the EAC earmarked for core support of the EAIDSNet laboratories, the center in Burundi still needs curriculum to be fully functional (2010) which could be a serious threat. Therefore, this situation requires the attention and action from the Burundian government.

5.3.2 Policy Stream

According to Kingdon's Model, the policy stream is conceptualized as a "policy primeval soup" where ideas, alternatives are floating, forming policies which are developed by the political actors and could be so far rejected or adopted. For the Burundian government, taking lessons from our three case studies, we would take ideas such as the establishment of a coordinating office for health foreign policy which would include state actors from ministry of health and ministry of foreign affairs, and non-states actors such as NGOs, health experts, civil society. The establishment of this institution would enhance the position of Burundi GHD within EAC and set up health policies regarding GHD goals such as integrating health in all policies.

5.3.3 Politics Stream

The politics streams contain elements such as the national politics to find out that the two above components are suitable with the Burundian laws. However, as

shown in the Kingdon's model, this steps is performs later after the first above steps. This would surely be handled by the EAC health Ministerial Summits but a touch from the ministries of law and justice should be involved. We recommend a proper study of the Kingdon's model to confirm the level of influence of the law makers within the health ministerial summits. This has not been relevant to include law makers since many of the laws of the EAC members are similar, however it could be one day be needed.

5.3.4 Policy Windows, Policy Entrepreneurs

According to Kingdon's model, the policy window is opened once the three streams merge together. The policy entrepreneurs play a role of combining the problem, policy and politics streams. Once the window is opened or an opportunity is presented, the policy entrepreneurs must react quickly to raise the probabilities of their ideas to get retained in decision-making agenda. To be successful, the entrepreneurs have also to capture the attention of the government at the right time and with feasible policy alternatives, thus a probability of a policy to get changed or new policy adopted.

In our case study, the policy entrepreneurs, after merging the problem stream, policy stream and politics stream, would timely raise any inconvenience of Burundi GHD which would lead to better achieve GHD pursuing goals at national and regional (EAC) level.

5.4 Recommendations to EAC

A set of recommendations are given both the EAC and Burundian government for better adopting GHD goals as set by WHO and recommended by AU

Civil society

The EAC should engage further with civil society, and nonprofit organizations so that the suggestions of the citizens could be equally considered. As mentioned in the *Oslo Ministerial Declaration*, the government, multilateral organizations and civil society should be involved in integrating health in foreign policy.

Training health professionals

To strengthen GHD, the EAC should make its best to train and retain health professionals. Within the African region, EAC counts among the region with a considerable lack of qualified health personnel.

Training for health diplomats

EAC member states should initiate a training program for health diplomats among the member states. The European experience has proven its efficiency through the contributions which arose from the Graduate Institute in Geneva endorsed by the WHO. This training of health diplomats provides key ideas for regional health issues solutions.

Skills based partnership

EAC is also encouraged to deeply cooperate with emerging countries such as Brazil and India which have sophistical yet health entities such as laboratories and generic drug industry for advocating timely response of pandemic and epidemic situations.

5.5 Recommendation for Burundi Government

The following recommendations are made to the Burundian government

1. Integrate health in all the policy: This goal was used as a main conducting force to improve GHD. However, this objective can only be implemented on the national level or in case the region have a same political federation which is also the ultimate goal of GHD. The government is recommended to conduct a deep analysis in order to fully integrate health in each policy.
2. Burundi government should reevaluate its position in EAC in terms of GHD specifically the EAIDSNet program since available data show less impact on the Burundian population though the risk is not that negligible.
3. The last and not the least, is the Burundi border with the DRC which is not considered by the EAC health strategy. This border presents a high risk since we could not find any regional mechanism which consider that part of

the country. Therefore, any epidemic situation which would rise from the side of DRC has a high probability of not being timely addressed.

Chapter 6. Conclusions and Future Work

In this chapter, we present the conclusion of our work and the remaining work which we would like to conduct in further studies.

6.1 Conclusion

In this work, we have used the available material in library and e-based search to understand GHD. Furthermore, we analyzed a set of case study to better understand how the GHD is adopted and implemented on national, regional and continental levels. We found that the position of our case study (Burundi) was pictured by the place it occupies in EAC activities on GHD. The online material from the EAC confirmed that less attention was given to Burundi and the risk of epidemic situations is not negligible. Secondly, a potential hazard in terms of GHD might be more severe in case it occurs on the Burundi-DRC border since no regional GHD based activities seem to be available on that side of the Burundian border. We dare to believe that the contribution of this work can bring more attention to Burundi by the stake holders or other EAC state members for a better consideration and integration of all its state members.

6.2 Suggestions for further research

This work was only based on online material to assess the position of the Burundi in GHD. Though the EAC online platform could avail some data which gave us insight on the GHD in EAC and particular in Burundi, we hope to continue this work through a set interview with more updated data. The reports available were covering up to 2012 and our attempt to get more updated data through online request could not be successful. As confirmed by other researcher which performed a slightly similar work for other region of the world, field work empowered by a number of interviews is required to provide more adequate contributions. We are looking forwards on extending this work with field work and interviews for key players of GHD in EAC and in Burundi.

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