2
Global Health Governance and Role of States

Introduction

This chapter discusses the realm within which PEPFAR is implemented and recipient states play a role, that is, global health. The engagement to be pursued throughout this chapter departs from an exercise of reflection on the leading narratives on this topic by scholars, activists and policy makers. In this regard, context is very crucial: global health was elaborated in parallel with the emergence of human security as a paradigm of Western foreign policy for the post-Cold War, and this has held consequences in terms of the 'securitisation' of health-related issues. This intertwines with dimensions of social change inside the West in the last three decades under the influence of the sociology of risk, yet also juridical-institutional changes at the level of the World Health Organisation's (WHO) International Health Regulations (IHR), which underwent revision in 2005. Nonetheless, the governance of global health remains faulty, as the plethora of national and international, public and private entities involved in global health are subject to no kind of world government. Global health governance's incoherent status ultimately invites the appraisal of the role of traditional actors – states – in this domain, including weaker, smaller ones.

These narratives frame the analysis of global health and hold an impact on the terms of analysis of broader relations between the United States government through PEPFAR and the national governments of the countries where PEPFAR has been implemented. By looking at and discussing these narratives one aims at a more critical understanding of the role PEPFAR recipient states are meant to play.

R. Pereira, *Recipient States in Global Health Politics*

Human security and the construction of global health

The realm of health affairs outside the domain of individual states is traditionally denominated as international health. Since 1948, with the establishment of WHO, it remained mostly confined to its interstate framework and its IHR created in 1969. Another landmark was the signature in 1989 of the WHO's 'Health for All Declaration', also known as the Alma-Ata Declaration, in which member states committed to the attainment of the best health conditions to their populations. However, it also featured in development aid to the Third World and military agendas during the Cold War. Nevertheless, in retrospect, David Fidler (2005: 180) argues this was a field of 'low politics' compared to the supreme politics of war and peace under United States-Soviet bipolarism that neorealist theories of International Relations prominently explained and reinforced.

The end of the Cold War in the late 1980s to early 1990s brought about foreign and security policy consequences that started to be conceptualised in another way, including in the domain of international health. One consequence was the rise of an understanding of security based on individuals and population groups rather than on states. Human security is the 'paradigm' that growingly started to be laid down onto the nascent European defence and foreign security policies and the Middle Powers Initiative, for instance. It derived from the intellectual labour that urged for attention to forms of violence and insecurity beyond the formal interstate warfare. It was also very influential among the United Nations system in conflict prevention, peacekeeping and post-conflict reconstruction missions. It was so defined by the United Nations Development Program (UNDP):

> Human security can be said to have two main aspects. It means, first, safety from such chronic diseases as hunger, disease and repression. And second, it means protection from sudden and hurtful disruptions in the patterns of daily life – whether in homes, in jobs or in communities. (UNDP, 1994: 23)

As a result, human-related phenomena such as epidemics, migration, trafficking in drugs or environmental damage began to be conceptualised as threats to stability inside countries, regions and even the world, in a context in which state confrontation was growingly understood as obsolete. So-called 'new threats' like those are far more disruptive and killing than wars between armies, and hold indirect consequences for

the whole of the international community. As far as epidemics go, they deteriorate many populations' living standards in developing countries, particularly in Africa, and thus contribute to the damage caused by phenomena such as civil wars (Kaldor, 1999) and 'failed states' (Zartman, 1995), that is, states 'unable or unwilling' to offer the residents basic public goods such as food, access to health or public security. Human security appeared together with familiar agendas for the post-Cold War such as human rights, democratisation, the rule of law, and the market that, once implemented, could reduce instability and conflict in general. In addition to that, viruses emerge as threatening in terms of the globalisation of trade and travel at a larger geographical scale, particularly in the context of outbreaks.

As a result, while traditionally states attracted analytical focus, in the last ten years, entities such as viruses, and the diseases and epidemics that they provoke, were growingly elaborated as threats to security. Indeed, pathogenic agents only constitute threats to humans when they first infiltrate human ecology and afterwards penetrate and develop themselves within the human body. Viruses as such do not pose any threat. What is actually convertible to a threat status are peoples, societies and, in the last analysis, states, as part of a complex social and political impact that the multiplication of infected people feeds and arguably provokes in a context of fast global relations (Elbe, 2003; Ban, 2003; Brower, 2003; Saker et al., 2004; Owen and Roberts, 2005; McInnes and Lee, 2006). If one perceives detection, prevention, care and eventual cure of populations as the major measures against disease, one defines as security objective the contention of the multiplication of the number of people carrying the agent, despite the ethical problems it may entail (Elbe, 2006). The linking of viruses to security is consummated in the depiction of 'securitised people' as those 'at risk', 'vulnerable' and making up 'dangerous classes' (Hardt and Negri, 2004). In other words, they are a reflection of the epidemiological estimates on the several diseases, yet, particularly, the major epidemics. In the case of HIV/AIDS, in Southern and Eastern Africa they are the general population, while in China, India, Russia and the West, they are drug injectors, migrants, homosexuals and the general mass of the marginalised ones. Eventually, they led to the almost blurring of traditionally separate disciplinary fields such as International Relations and Public Health.

Together with an exercise of social constructivism, liberal-institutionalist approaches gained prominence in the analysis and policy recommendation of international/global mechanisms of response to the manifold viral and epidemic manifestations. The 'securitisation'

of health and disease was embedded institutionally under the revised International Health Regulations of 2005, and is found in the rhetoric and rationale of multilateral and bilateral initiatives, such as the Global Fund, established in 2001, or PEPFAR, launched in 2003.

Western risk society and the politics of technicalisation

Global health is eminently a Western invention with the aim of making sense of globalisation and a new paradigm of human security-based foreign policy. As remarked, the problems of health and disease were already subject to international discussion and resolution. However, the West-led hegemony of globalisation in terms of worldwide socio-economic relations fuelled by technological advances in information and communication created a landscape in which those problems, among other human/population-related ones (migrations, environmental degradation, scarcity of energy resources, urban insecurity), were bound to have direct and indirect security consequences for the Western world and its lifestyle. In other words, 'threats' like those were undermining of what Anthony Giddens has called 'ontological security' (Giddens, 1990), building on the notion of 'risk society' (Beck, 1992) as a latest stage of Western modernity, in which, after wealth and power, risk and impotence emerge (Beck, 1995). Although in the industrial age, there was already a notion of risk, it was considered a price to pay for the material progress of societies through social protection systems and other compensatory mechanisms. Accordingly, Western societies do not aim at maximising risks, yet minimising them through the implementation of emergency measures against increasingly incontrollable risks, such as nuclear proliferation, global warming or even large-scale pandemics. For Beck (2006), the best response is 'precaution through prevention'.

This sociological reading has proved to be very influential in the way responses to epidemics and viral outbreaks started to be conceptualised by political analysts and policy makers of global health. Along with human security policies, the inevitability of the occurrence of direct and indirect effects at a global scale has led to a very large epistemological consensus around the definition of preventive and curative measures aimed at the sources of those risks. As a result, global health governance has become, in the words of James Ferguson (1994), an 'anti-politics machine'. Global health governance became an eminent 'technical' field, in which what largely is at stake is the formulation and implementation of 'good' policies, informed by 'good practices', and accompanied with disbursement and allocation of resources to projects serving those

in need. In the case of the major epidemics (HIV/AIDS, tuberculosis and malaria), this is observed in the manner biomedical responses attained supremacy, although preventive measures were also clearly emphasised. Rather than an implication of the political communities, as it used to happen during the Cold War, global health governance bypasses political contingencies and aims at 'fixing' the 'issues'.

Global health governance's constitutionalism

A major feature of the post-Cold War international environment, namely in the area of health and disease, is the dissemination of governmental alongside nongovernmental actors. Apart from states and WHO, international organisations such as the United Nations constellation and the World Bank joined in, followed by many old and new large developmental and humanitarian NGOs, philanthropic organisations and initiatives and private companies, such as pharmaceutical companies. Often many of these entities have sat together under the aegis of public-private partnerships, a model of governance that got boosted in the context of post-Cold War acceleration of neoliberal reforms led by the major Western states, the World Bank and the International Monetary Fund, as described in the previous chapter. In the domain of global health, two major examples of PPP are the multilateral Global Fund and the bilateral PEPFAR. After a previous phase of being rendered to 'low politics', influential David Fidler observes this change of landscape, in which health and disease concerns attain centrality in the foreign policy of major states and generate many actors and agendas, as a 'revolution' (Fidler, 2008).

However, for Fidler (2004) it was not until 11 September 2001 attacks in the United States of America, the so-called case of 'Amerithrax' soon after 11 September 2011 and the outbreaks of severe acute respiratory syndrome (SARS) in 2003 that global health governance's 'constitutionalism' was reconfigured. Eventually, the WHO's IHR were revised and incorporated with an element of security in it. From a juridical-institutional point of view (Pereira, 2008), Fidler understands the role of WHO and its IHR as the key contents of international health's constitutionalism, whose historiography, obviously, stretches way back in time. It kicked off in the 1830s, as the first international hygienist conference took place in search of a response to a cholera epidemic affecting Europe at the time. Afterwards, other international conferences alike occurred throughout the 19th and early 20th centuries. Finally, they paved the way for the League of Nations' Office of Health Affairs and

WHO. Founded in 1948, WHO has gained reputation for inculcating an international cooperation regime based on the 1969 IHR, consolidating what Fidler (1999) has called *Microbialpolitik*, that is, an international agenda fundamentally guided by allied fight against disease. In Fidler's view, the 2001–2003 events above and their corresponding structuring responses of contingency constitute a turning point in the understanding of epidemics as object of national and international security. This period inaugurates 'the new world order in public health', in which global health governance likens the United States federal model in the context of crisis in health at the global scale. The functions of that model are: provision of national security; regulation of international trade; preparedness support and response to epidemic crisis; and protection of human rights (Fidler, 2004). Broadly, such 'new order' reiterates the post-9/11 counterterrorist response, in which all areas of governance in the United States were merged towards a more efficient and engaged reaction. However, this shift is still troublesome. The 2005 revision of the IHR diverted WHO away from its mandate, since it may be specifically serving national and international policies.

> Less clear is whether the new IHR might embroil WHO in the politics of national and international security to the detriment of its core public health functions. Although it makes some experts uncomfortable, the potential for terrorism involving weapons of mass destruction connects public health to security concerns. (Fidler and Gostin, 2006: 92)

The 2005 IHR revision calls for the necessity to establish partnerships with other 'interested' sectors, notably the armed forces. At the same time, the new IHR allows the possibility of 'containment at the source', beyond the typical border controls for people and goods (WHO, 2007). Such situation allows foreign interventions to be triggered regardless of state sovereignty, namely with military means, for the sake of epidemic contention. In sum, these novelties reflect a real change in the purposes of the IHR.

Fidler's juridical-institutional explanation has been complemented by a more radical approach in terms of whom and what constitutes the governance of global health. This approach implies that a plethora of other defining actors, such as private companies, nongovernmental organisations, networks and partnerships and even Hollywood 'celebrities' (Drezner, 2007), needs to be inserted together with the traditional actors. Like major states and WHO, those agents maintain intense

power agendas and regulating capacities, particularly under a framework which jeopardises national sovereignty given the possibility of 'containment at the source', as presupposed in the 2005 IHR. Moreover, since Fidler's constitutionalism seems to overestimate the role of epidemic crisis and response as contextual facts, that is, the outbreak event and the demanded quarantine measure, a complementing approach that embodies structural elements in the machinery of public health, such as surveillance and hygiene mechanisms administered by national and international agents, is required.

An historical analysis of disease surveillance stretches back to the 17th century, as epidemic surveillance departs nationally in metropolitan Europe, and increasingly expands onto the colonies. This regime is consolidated with the international hygienist arrangements of the 1830s (Bashford, 2006). As a result, it has helped to consolidate a system of security that one recognises today. Michel Foucault's (1984) work on the analytics of liberal political power from the 17th century onwards has been found highly helpful in this regard. Rather than simply deposited on domestic and international institutions of statehood, power permeates an insidious, comprehensive web of institutions and practices, governmental and nongovernmental, local and international, yet commonly affiliated to ideals of liberalism and free trade. Unlike in earlier absolutist regimes, power is conceived to both foster life and impede it to the point of death. The object of such power consists on human beings at the aggregate level, as well as life in general. Designated as 'biopower', it expresses the 18th century scientific effort of measuring and regulating all dimensions of life, such as birth, mortality, schooling, employment, criminality, and so on. This change has implied thinking the human being as an *être biologique*, a natural species, yet with political life and power. Biopower is therefore 'totalitarian' in the way that it is aimed at the totality of the population. Issues of health and disease become particularly pertinent in this framework of analysis of power.

Contrary to previous absolutist regimes, biopower, or biopolitics as it was later reformulated, necessitates to be rationalised and justified (Foucault, 1984: 258), and Foucault's later concept of governmentality embodies that necessity. It accounts for a discursive-material device (*dispositif*) of security embodying rationalities and technologies of government. They comprise 'discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions' (Foucault, 1980: 184). These technologies do not necessarily use violence to force people to do what the sovereign likes (Lemke, 2001). A major manifestation

of the sovereign power's governmentality is found in the figure of the 'medical police' (Carroll, 2002). In fact, governmentality as rationalities and technologies of government largely corresponds to a general idea of police activity: 'practices of inspection and surveillance, information and intelligence gathering, and direct intervention (to the point of deadly force) in private, familial and commercial matters' (Carroll, 2002: 465). The medical police did not resort to deadly force; yet it pursued a variety of sanitary techniques in order to guarantee 'health and safety' among the population from now onwards (Carroll, 2002: 465).

A number of historical examples from the British Empire demonstrate the century-old political importance of medical intervention at a global scale. Alison Bashford (1999) has looked at the 1881 smallpox epidemic in Sydney, Australia, as an illustration of the more administrative facet of such medical policing through the establishment of the local health authority, that is, the Board of Health in the British Colony of New South Wales. Although smallpox epidemics were not 'uncommon' in the 19th century, that one precipitated key bureaucratic changes. Policing was primarily about carrying out activities animated by socio-political concerns rather than exhibiting state presence. Thus, one should mention the police role that charities pursued, as Carroll (2002) shows in the case of colonial Dublin, Ireland, hygienic activities in the 18th century. The ultimate function of health policing was to potentiate the general health status of the populations, not just for the sake of political economy but also to prevent scarring contagions and epidemics that could undermine the body politic. Bashford (2006) reports that, in function of the establishment of border epidemical check-ups and quarantine systems, surveillance mechanisms were installed at the global scale uniting metropolises and colonies. National surveillance and hygienist measures moved beyond from the national sphere on to the rest of the world, cementing Western power territorially and biologically, as the 1881 smallpox epidemic in Sydney above illustrated. As mentioned, a cholera epidemic affecting the European powers in the 1830s paved the way for the several international hygienist conferences during the 1800s that led to the establishment of the international sanitary institutions in the two world wars' interval.

Yet, in that period, health issues were essentially taken as technical matters by the League of Nations' Health Office, a predecessor of WHO. According to Bashford, its mission was to collect information from the national administrations, in order to control diseases such as malaria, smallpox and sleeping sickness, in close collaboration with the Economics Office of the organisation. General population-related dossiers tended to

be studied in their migratory and trade dimensions, excluding issues such as birth control and sexual and reproductive health. The author provides several examples on how, despite direct enquiry, those latter matters were untouched by the League of Nations under the basis of not being part of the organisation's mandate.

An important role in the systems of information on populations between colonies and metropolises was played by the educational transnational institutions of tropical medicine of the British Empire. Founded in the late 19th century, the schools of tropical medicine in London and Liverpool were instrumental in the research and dissemination of epidemiological facts and practices at the field level. Supported by organisations such as the Rockefeller Foundation, the Red Cross, the business community of Liverpool (with vested interests in the Caribbean, West Africa and Latin America), the schools' agendas ranged 'from the medical concerns of a fading Empire to a national and international school of public health, moving towards integration of domestic and global health concerns' (Wilkinson and Power, 1998: 288). Tropical medicine as a distinctive discipline in the curricula of medical studies was born with the objective of facilitating the settlement of Britons and other Europeans in threatening environments characterised by pests such as smallpox, malaria or yellow fever (Arnold, 1997). But it also held the mission of improving the lives of natives engaged in the colonial businesses, therefore pursuing the 'benevolent' task assigned to imperialism. Nevertheless, Cameron-Smith identifies tropical medicine across the British Empire 'as a discourse that constructed the space of the tropics as Other and thus as racially pathological' (Cameron-Smith, 2007: 16). In turn, Jama Mohamed (1999) shows how colonial rule on medicine in Somaliland during the first half of the 20th century benefited from health interventions, vaccination namely, as it improved public health. The medical mission was therefore to '[popularise] the Government, and [to identify] the administration with the people's welfare' (Mohamed, 1999).

The integration of tropical medicine's culture and history when linked to the rise of 'medical police' is particularly illustrative of both the character of this early securitisation of infectious diseases and the apparatus of biopolitical instrumentalisation at the global level. Beyond international and national political institutions, culture, science and medical practice informatively contribute to the historical power regime. In more recent times, hygienism remained notably instrumental with regard to the implementation of powerful white-supremacist regimes such as the one South Africa experienced during the apartheid period

(Youde, 2005). According to Youde, the legacy of public health intervention as historically anti-black population transpires from the 2000 conflict between South African government, notably President Thabo Mbeki, and the international AIDS community. Mbeki claimed that the international community's AIDS discourse was a Western neocolonialist discourse expressing Africans' inferiority as a race to tackle their own problems (Youde, 2005). This episode was particularly dramatic since South Africa was holding, as it still does, the highest rate of HIV infections in the world.

The conceptualisation started by Foucault on liberal power – as driven by political-economic ideology and not institutions – leads to an image of an assemblage of various entities. '*Nébuleuse*' is an apt alternative word to assemblage that one borrows from Robert W. Cox (2005) to model the 'constitutionalism' in global (health) governance, contrasting with Fidler's adoption of the United States federal model. The end of the Cold War and the rise of global neoliberal agendas performed by an enlarged quantity of institutions in many different sectors of activity (trade, development, humanitarian, and so on) and at different scales (local, national, regional, global) confirmed the reformulation of the state as sovereign political unit and accelerated the networking of biopolitical-like modes of power. This '*nébuleuse*' builds on strong political density, where many networks of governmental and nongovernmental agents interact formally and informally at a global level. Global public health constitutes a quite solid domain for the analysis of those phenomena and the power relations they embody. They feature grand public-private, bilateral and multilateral funding, managing and implementing programmes, initiatives and entities: WHO, PEPFAR, Global Fund, World Bank, UNAIDS, Clinton Initiative, Bill and Melinda Gates Foundation, and a vast range of international NGOs in the field. Once inserted in the broader global governance, the health system as a regime of global surveillance consolidates the supremacy of an international arena dominated, not by anarchical relations of individual units of sovereignty in the form of states, as put by the neorealist tradition of International Relations (Waltz, 1979), but by a hegemonic world system of liberal sovereignty (Bickerton et al., 2007). In the field of 'global health', ultimate examples of such endeavour stretches as far as the project of medicalisation of populations, as explored by Stefan Elbe (2010). If it is true that this explanation is not fully applicable to the whole world, namely in terms of the 'modern world' of powerful states of regional prominence, such as India, China and Russia (Cooper, 2004), this is particularly compelling with regard to the postcolonial world.

Contradictions of global health governance

While the narratives around post-Cold War Western foreign policies rooted on human security and globalisation have arguably dominated the global health governance literature, another narrative, focusing on the contradictions that the international-political economy of health has exposed, has gained its own currency.

Adrian Kay and Owain Williams (2008) have drawn attention to the fact that global health governance is highly part of the larger processes of global governance, based on liberalisation and commodification. The results of global liberalisation and commodification are particularly noticeable in a number of instances. Since the market of health professionals has opened itself up to 'globalisation' it has allowed an easier transfer of human resources from lower-paying countries to better-remunerating ones. As a result, countries and regions already with very low scores in terms of health care find themselves struggling even more with the loss of medical and nursing personnel. In turn, as far as the manufacture and distribution of drugs go, particularly antiretroviral ones, the protection of patents pursued by, mostly, West-based pharmaceutical companies and their states, in order to maintain high levels of profit, constitutes another front undermining access to better health in poorer countries. For Kay and Williams, the leading global health governance literature fails to take contradictions like those into account.

> The current literature on GHG [global health governance] constructs a concept of global health that implicitly naturalises the neoliberalisation process and pushes analysts to seek technocratic and political solutions to adverse trends in population health across the globe. (Kay and Williams, 2008: 21)

Another set of incongruences have been put forward by authors that aggregate around the ethics of human rights and social justice, concerned with the social determinants of health, that is, by having a structural perspective of health condition's political economy (Williams and Rushton, 2009: 11–12). Mainly disseminated by the activist nongovernmental community and some academics, mostly from North America and Western Europe, this discourse is eminently targeted at Western countries as donors and leaders of globalisation (MSF, 2008; Schrecker, 2009). This ethics appeals to further international regulation of negative practices (such as contracting health staff from the Global South or protecting resolutely pharmaceutical patents) and further financial

commitment to global health programmes. This stance fails to have a lasting influence in terms of actual political change. Yet, even if they could have it, their terms of the debate are located under a population-centred framework, in which affected political communities, particularly poorer, developing states, are supposed to have little or no autonomy in the face of larger states and private companies.

As a result, global health governance started to be regarded as a domain of failure, since the alluded contradictions and disputes do not suggest coherence of policies (Williams and Rushton, 2009). The idea of governance of the 'global' does not mean that there is an actual governmental form for that 'global', although the social constructivism that permeates much of the analysis suggests it. Here, Fidler's (2004) post-Westphalian, liberal-institutional 'constitutionalism' is found wanting, since the international system is still primarily driven by a more traditional set of actors, namely states.

Global health governance and role of state

The failure of global health governance as a domain of coherence among the many actors that struggle inside it invites a reassessment of the character of such domain, by looking precisely at the most stable and consistent in the international arena: states. In an article, James Ricci (2009) criticises an overemphasis by global health governance authors on the propelled reduced relevance of the state in the field. He cautions against the overreliance on the pulverisation of non-state actors of different types as redefining the post-international juridical feature of governance. He argues that, despite the prominence of such organisations as the Bill and Melinda Gates Foundation, states are still main funders of global health initiatives, PEPFAR being a case in point (Ricci, 2009: 7).

The leading narratives on global health governance largely reduce the African state to the status of recipient of external funding in exchange for compliance with the policies recommended by the funder, multilateral or bilateral. However, it should be remarked that there are differences between multilateral and bilateral arrangements in terms of participation.

Multilateral structures such as the Global Fund and the broader United Nations system tend to favour the inclusion of representatives and citizens of recipient countries in technical and even leadership positions. For instance, at this time of writing, Michel Sidibé of Mali is the head of UNAIDS, and Tedros Adhanom Ghebreyesus of Ethiopia was

the chair of the Global Fund until September 2011. In turn, bilateral programmes are majorly led by the donor country, as it happens in the case of PEPFAR. Although recipient countries are made part of a 'partnership', it is clear, as it will be discussed in the case of PEPFAR in Chapter 5, that the relationship is vertical, rather than horizontal. In either case, the national governments of recipient countries in Africa are urged by major governments and NGOs from donor countries and international organisations to behave with 'responsibility' and 'leadership' in the adoption of recommended institutions and policies. As a result, several governments in Africa, namely those of the countries under analysis in this book, with the exception of South Africa for a certain period, have responded positively to the external pressures toward observance of international community's policies and have engaged in a relationship with those institutions, even if in asymmetric terms. In this framework, the state is assigned the role of mediator and facilitator in the process of providing goods and services for the populations in need. In turn, this role as mediator or facilitator is enhanced and ameliorated through policies of direct assistance to state agencies and their representations (for example, clinics, hospitals and health-extension programmes) and 'capacity building' in several organisational areas.

The assumption of a highly obedient state to the international community opens up the possibility of an inverse case. By not being (entirely) compliant with, if not opposed to, good policies and practices, the state is attributed features of 'rogueness' by the international community. As discussed in detail in Chapter 8 on South Africa, a striking case of 'rogueness' concerns the reduction and suspension of antiretroviral treatment programmes in South Africa by the African National Congress-led (ANC) government of former President Thabo Mbeki and his Minister of Health Manto Tshabalala-Msimang. Due to his self-proclaimed dissidence in unequivocally buying into the drug-based response to the HIV/AIDS epidemic in his country and around Africa, he was considered a denialist by many home and international activists and his country's regime a 'rogue democracy' (Baker and Lyman, 2008).[1]

In a broader sense, another major example of 'rogue' recipient state behaviour is the real or perceived deviation of funds disbursed for policy implementation for what is considered illegitimate ends. Often framed in Western circles as 'corruption', this practice sits along other troubling practices associated with the functioning of the social and political fabric, namely electoral misconduct, abuse of state violence and disrespect for the rule of law. As a result, donor countries are often uncomfortable with assisting governmental structures directly (although they

still do it) and prefer NGOs, even if, in some cases, the locally based ones, in some way or another, belong to the state/governmental division of labour, as it happens in the case of Ethiopia. As Chapter 5 on PEPFAR's political origins and political rationales discusses, one major reason for opting out for bilateral mechanisms at the expense of multilateral ones (even though also participating in them) concerns precisely the will to augment surveillance over the expenditure of the recipient state.

Two seemingly different antagonistic types of state emerge out of the literature and policy debates in global health governance. One is the facilitator state, in which the recipient state behaves according to what is expected by the community of funders and policy makers. Another type is the 'rogue' state, in which states deviate from compliance in several regards, from adoption of the 'right' policies to tackle health issues to management and employment of received funds according to pre-established purposes. Certainly, the proposed types are idealised categories within the framework, and therefore subject to debate over the addition of further categories and gradations. Nevertheless, they are applicable to the postcolonial African state, in particular, as opposed to donor countries. This ought to be clearly remarked since suggestions about playing roles as facilitators and/or 'rogues' have also been suggested for donor countries and their policy choices and stances. Moreover, these ideal types do not exclude their coexistence within a single country, that is, the same country can incorporate both types.

Conclusion

Global health governance as a specific realm of relations in the international arena appears in the discipline of International Relations in function with broader post-Cold War developments associated with human security-based foreign policies in Western powers, globalisation-provoked 'new threats' to international security, neoliberalism, and human rights agendas. Given the diversity of interests and agendas by the manifold actors that compose this field, analysts so far have been concurring in arguing about the failure of achieving coherent 'governance' of phenomena as disparate as viral outbreaks and epidemics, with different incidences across the globe. Addressing a gap in the global health governance literature, this chapter explored the role of recipient states and their governments in this realm.

From a reflexive point of view, one could argue that the intellectual constitution and development of 'global health governance' as a distinguishable realm of relations within the discipline of International

Relations offers an example of how liberal and social constructivist theories came to dominate the analysis of the international arena. Global health governance is certainly influenced by the explosive proliferation of governmental and nongovernmental, national and transnational, not-for-profit and for-profit actors in the field, which are seductive for liberal-institutionalist, cosmopolitan approaches to International Relations in the post-Cold War era. In turn, social constructivism is strikingly visible in the construction of causalities (for instance, the link between epidemics and security) that give sense to the enhancement of the international-political study of health programmes, the same applying to the post-Foucauldian use of it, mentioned previously.

The understanding of the role of states in global health governance requires a relational approach, in which its historical and sociological development is pursued under the framework of relations with other countries, particularly powerful ones. This is arguably the cornerstone in the case of states in Africa, in which the question of international asymmetry is striking. Despite emphasising the state, Ricci does not account for the problem of asymmetry as crucial feature of the international system, particularly between the Western and African states, instrumental for any meaningful discussion in global health governance; by the same token, the discussion on African states' participation in global health security talks by Lenias Hwenda and colleagues (2011). Accordingly, even when considering African states as honourable diplomatic players, the international realm of the issue of structural asymmetry is left underdeveloped. They hold that African countries' health-related interests have been overwhelmed by the positions of developed countries. They point at debates on health security initiated by Europe and North America under WHO to demonstrate the need for serious political African engagement in such discussion. However, their recommendation does not consider the issue of asymmetry, either, finding themselves stranded in the idealism of institutional equality. It thus becomes necessary to explore the character of the intervened state, namely in the context of sub-Saharan Africa, bearing in mind the asymmetric state structure of relations in global health governance.