Human Security, Multi-polarity, and Development Assistance for Health

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Development assistance for health (DAH) constitutes a critical vehicle of collective action in global health, one that has seen the rise and involvement of emerging powers like India and China. Through their DAH, both countries actively seek to widen their global health footprint. This paper measures China and India's DAH through Sen and Ogata's human security framework and attendant principles of health security. It argues that their health assistance largely falls short of advancing health and human security of citizens in countries that receive their DAH. Strategic, not health concerns gain precedence. Though their DAH is having a positive impact in empowering citizens in recipient countries through the development of health facilities and transfer of skills and knowledge, it is not being entirely done on recipient's terms nor is it deployed by engaging with their public health systems.

INTRODUCTION

Global health appears to have reached a watershed movement. After a decade of unprecedented attention and funding for global health issues, fault lines emerging threaten to disrupt and roll back the surging momentum[1]. One significant development that global health actors have to contend with is the emergence of multi-polar global politics characterised by a diffusion of geopolitical and material power to Asia. Gradually, Asian powers like China and India are flexing their muscles on the global health stage. Looking ahead, effective global health governance to address transnational threats to human health, including infectious diseases, rise of non-communicable and chronic threats, addressing health system deficits and the health effects of climate, energy and food crises, will be made more contentious by the rise of these emerging powers.

No doubt, their rise will also impact the application and relevance of human security in global public health. This field represents a critical component and battleground of human security. Strengthening health security of citizens across the world attains importance given the capricious nature of trans-boundary health threats. Consequently, equipping public health systems and officials to face those challenges represents a pivotal priority as global health financing is being determined and disbursed. Thus, equally important is gauging whether

global health donors are deploying finance to that end. This paper attempts to measure whether the development assistance for health given by emerging health donors, China and India, strengthens or undermines the human security of their recipient countries, vis-à-vis public health.

In order to achieve this outcome, this paper is structured as follows. The first section introduces the concept of human security and delineates which conceptual understanding is being used for the purposes of this paper. Following that, the global development assistance for health (hereafter DAH) milieu is presented and briefly mapped to give a sense of the amounts of funding being disbursed for health at the global level. Next, I move to present China and India's DAH by describing how they perceive development assistance, how much they disburse, context determining the thrust of their assistance, institutions that govern this issue in both countries and in what form assistance finally manifests. Subsequently, I measure their DAH against three principles of human security to gauge whether their DAH advances the security of communities and citizens that receive assistance.

CONCEPTUALIZING HUMAN AND HEALTH SECURITY

Over the past two decades, human security as a concept has been cast and recast as a means of recalibrating security in an era shorn of geopolitical rivalry and surging global threats. A growing recognition of the limitations surrounding global security debates thrust the concept to the fore. Security of human beings and communities were found to be conspicuously absent and limited space existed to integrate concerns and consequences of under-development, including hunger, poverty, disease, environmental degradation and a whole host of concerns that were furiously rising. The UNDP moved to intellectually introduce and map this particular dimension of security, with an emphasis on expanding the scope of security beyond states and nations to individuals.[2] Seven components of security were underscored: economic security, food security, health security, environmental security, personal security, community security and political security. They urged for attention and action directed towards ameliorating these seven aspects of human insecurity.[3] Conceptual elasticity, however, complicated calls to action as criticisms concerning the wideness of the concept mounted.

One note-worthy critic, Canadian government took it upon themselves to reconfigure their foreign policy upon the concept. Doing so, however, required sharpening aspects that fit actionable interests and sidestepping components that were overwhelming in terms of application.[4] Consequently, Ottawa focused on elevating aspects of

'human insecurity resulting from violent conflict' over threats emanating from underdevelopment. To move this forward, Canada called for a greater reliance on 'soft power' and normative suasion – by building coalitions with like-minded middle powers, developing country governments, NGOs, academics, businesses and ordinary citizens.[5]

The Japanese government also unveiled their interpretation. Recasting the concept as consisting of two equally important aspects – 'freedom from want and freedom from fear,' Tokyo challenged the Canadian tendency of privileging aspects of conflict and violence over basic concerns of human survival and dignity.[6] Instead, Japan emphasized a human security that 'comprehensively covers all menaces that threaten human survival, daily life, and dignity, such as poverty, environmental degradation, illicit drugs, transnational organized crime, infectious diseases such as HIV/AIDS, outflow of refugees, and anti-personnel land mines, and to strengthen efforts to confront these threats.'[7] Under the Commission on Human Security, co-chaired by Prof Amartya Sen and Sadako Ogata, human security was redefined as 'protecting individuals and communities freedom from fear, freedom from want and freedom to live in dignity."[8] Flanking the emphasis on freedom from fear, the report also underscored challenges unrelated to violent conflict like food, health, education, and basic material sustenance, which arguably have a greater bearing on human wellbeing.

Quite amenably, this reconfiguration better suited the concept's application in global health. Ogata and Sen's report identify health as one of the many issues central to human survival and quality of life. Three principles gain significance when attempting to operationalize human security in the health area. First, adopting a community-centric approach by placing communities at the heart of policy planning, given a deep understanding of their respective contexts. The second principle calls for building systemic resilience to sustainably tackle current and future health challenges as globalization discriminately unleashes an array of epidemiological challenges. And the final principle involves strengthening the interface between protection and empowerment in public health. Protection entails strengthening the preventive capacity of communities to meet rising health threats whereas empowerment calls for enhancing the capacities of individuals and communities' to sustainably assume health responsibilities.[9]

This understanding of human security also, broadly, comports with prevailing Asian conceptions of security that stress concerns of want and deprivation compared to previous iterations that exalted human rights and adherence to international norms. As Amitav Acharya points out, many Asian countries have embraced such a broad conception of human security since it coheres with prevailing conceptions of comprehensive

security in Asia, a rubric that enlarges the scope of security to include non-military threats endangering order and stability.[10] Asian governments have come to rue the human costs of economic crises and the need to insulate their citizens from episodic shocks, which gives credence to them being more palatable to this reconceptualization of human security, further justifying our need to gauge whether China and India are receptive to the rubric's principles when shaping their respective development assistance policies.

Given its applicability to health as a salient component of human wellbeing and its amenability to cohere with Asian understandings of comprehensive security, this paper will define human security as promulgated by the Commission on Human Security - as 'protecting individuals and communities' freedom from fear, freedom from want and freedom to live in dignity."[11] Furthermore, I will also use principles advocated by the report with reference to concept's application in the health realm to probe whether China and India's DAH enhances or undermines the human security of their recipient nations. Before delving there, it is necessary to briefly map the dynamic global DAH landscape.

GLOBAL DEVELOPMENT ASSISTANCE FOR HEALTH

Broadly speaking, the financial and technical assistance that global health actors and institutions provide to developing countries for health related purposes is referred to as development assistance for health.[12] The ongoing revolution in global health has, directly and indirectly, revolutionised development assistance for health (DAH).[13] The landscape is now teeming with new actors, ideas and significantly, new funds directed to improve health systems and outcomes globally.[14] To better grasp the multitude of global health pledges and scrutinize whether funds are being allocated in an efficient, equitable, and accountable manner, systematic efforts have led to a tracking system that delineates DAH in terms of flows, channels, modes, and volumes.

According to recent estimates collected and analyzed by the Institute of Health Metrics and Evaluation (IHME) in *Financing Global Health: Continued Growth as MDG Deadline Approaches* (2011), global development assistance for health (DAH) stood at $25.7 billion in 2009, up from $5.82 billion in 1990.[15] Global DAH more than doubled from 2001-2008 from roughly $11 billion to $24 billion, but the global recession dampened the astonishing DAH growth rate as pledges waned, from 2008, to reach an estimated $28 billion in 201116. Of DAH for which recipient regions can be traced, Sub-Saharan Africa was the largest recipient in 2009 with roughly $7.61 billion being deployed on their shores, followed by South Asia with $1.85 billion and East Asia and

Pacific receiving $1.48 billion. Disease-wise, growth in DAH for HIV/AIDS, tuberculosis and health systems declined in 2009; funding for malaria, maternal and neo-natal health, and non-communicable diseases accelerated.[17]

Extricating China and India's role from this global DAH landscape requires us to unpeel their respective DAH agendas and incumbent activities. What follows is a brief narrative on the DAH both countries provide amidst a shifting global context, institutions that govern it, how it's channelled, where it reaches, and finally, in what form it largely manifests. To make better sense of their respective DAH trajectories and attendant implications for human and health security, it is necessary to take stock of their respective DAH agendas.

CONTEXTUALIZING CHINA AND INDIA'S DAH

At the outset, it is important to state that overseas development assistance (ODA) or 'aid', finds new meaning when examined from an emerging power vantage point. As both countries have espoused in various official documents, their respective conceptualizations of ODA differ greatly from prevailing western conceptions. For Delhi and Beijing, ODA is firmly couched under the rubric of South-South cooperation and mutual benefit; solidarity is forged under a shared understanding that both donors and recipients are in development mode and assistance is thus given to advance each other's efforts on that path. In fact, the White Paper on Chinese Aid officially enshrines this, "China is the world's largest developing country, with a large population, a poor foundation and uneven economic development. As development remains an arduous and long-standing task, China's foreign aid falls into the category of south-south cooperation and is mutual help between developing countries."[18] Dovetailing this understanding, India's Joint Secretary in Ministry of External Affairs describes how India officially perceives development assistance as the government christened its new development agency this summer, "We do not like to call ourselves a donor; we call it development partnership because it is in the framework of sharing development experiences. It follows a model different from that followed in the conventional North-South economic cooperation patterns, hence the designation of Development Partnership Administration, it is administering our development partnership projects."[19]

Tacitly, China and India have been providing development assistance, to this end, since the cold war. Beijing transferred DAH to African countries in the early 1960s to fuel national development and self-sufficiency. Maoist tenets of equity and universality shaped the

content of health assistance, with preference given towards enhancing primary health access to millions of rural Africans, bestowing a lifeline for these countries to meet unforeseen health challenges.[20] Beijing also sought to advance the inculcation of a non-western medical model abroad, one that was not heavily tilted towards heavy hospitalization and curative care. The propagation of this rural-centric health approach presented an alternative for populations ravaged by disease and deficits, financial and institutional.[21] As geopolitical exigencies waned and the economy surged in the 1980s, assistance became subsumed under the rubric of bilateral economic cooperation.[22] Geo-economics equalled geopolitics in importance. And this focus further intensified under the context of the Forum on China Africa Cooperation (FOCAC), which grounds bilateral cooperation on sustaining mutually beneficial partnerships forged through south-south cooperation.[23] Assistance became a 'two-way street' as mutual benefits were eyed through economic cooperation, trade, and market access. China also commenced multilateral health cooperation, pooling their assistance with additional funding from several UN agencies.[24]

India's development diplomacy was also driven by ideological and political exigencies. Since independence, India's principal geopolitical priority has been regional security and prosperity. Thus, Delhi directed a large share of its ODA within the South Asian neighbourhood. Countries like Afghanistan, Bhutan, Bangladesh, Nepal, Sri Lanka, Maldives and Myanmar received and continue to receive a lion's share of India's overall assistance, some of which manifests as DAH.[25] Strengthening structures of regional security have assumed greater significance now; Delhi hopes assistance will accrue dividends, not only advancing amity across a region littered with hotspots and by doing so, insuring its own territorial and economic security.[26]

Following its regional focus, India's burgeoning relationship with Africa has attained special import. Multifaceted and complex in nature, Delhi's engagement with Africa is now twinned on strategic and economic grounds. For decades, India's relationship with Africa was clothed under a rubric of decolonisation that trumpeted self-sufficiency and national autonomy in a world fraught with thorny problems and shifting alliances.[27] South-south solidarity imbued Indo-African diplomacy. Delhi's current Africa policy is reflective of shifts in global politics that has thrust both onto the global spotlight. Pragmatism pervades. Economic and commercial considerations now drive diplomatic engagement; India has become adept at leveraging ODA to unlock markets for its increasingly ambitious private sector. India has preferred not to impose stringent terms for its assistance but chosen to go 'softer' by providing technical assistance and training programs that

educate development professionals across Africa.[28] Delhi is also avidly exploring development diplomacy through emergent institutional forums such as BRICS, BASIC and IBSA, all of which signify opportunities produced by a fluid geopolitical context, increasingly propitious to different modalities of emerging power cooperation in global politics.[29]

ENUMERATING CHINA AND INDIA'S DAH

No doubt, the DAH that both countries provide is still limited relative to other global health actors. It is important to indicate that lines between China and India's ODA and DAH sometimes blur; some assistance channeled to strengthen technical and infrastructural capacities invariably end up benefitting the health sector. However, for the purposes of this paper, I have attempted to distinguish between them throughout this article.

Accurately conveying China's contributions is a fraught endeavour. A byzantine ODA establishment that stretches across the government and the absence of a clear and coherent ODA system complicate the accurate enumeration of China's ODA.[30] Despite these quantifiable quandaries, we can assert that China officially provided $3.9 billion of official ODA in 2010; in terms of DAH, China pledged approximately $757 million from 2007 and 2011 to Africa.[31]

India, like China, lacks concrete datasets delineating its DAH contributions and shares China's troubles in terms of robust aid governance to convey a precise figure of its global health contributions. However, recent estimates render a fair snapshot of funding being disbursed for health purposes. Total funding for ODA grew at an annual rate of 7.4 percent between 2004 and 2010, from approximately $443 million to an estimated $680 million.[32] Vis-à-vis DAH, Devi Sridhar's estimate (2008) pegs India's contributions at $226 million in 2007-08.[33] And since 2009, India has provided roughly $100 million in DAH to nearly twenty countries across South and South-east Asia and Africa.[34]

Once budgeted and approved, DAH is disbursed directly and indirectly through various channels, bilateral and multilateral, some of whom were identified earlier. But this choice fundamentally comes down to the institutional architectures that govern DAH in both countries. As a result, before examining how China and India's aid manifests, it is necessary to understand the institutions that govern ODA and DAH in both countries.

GOVERNING DAH IN CHINA AND INDIA

In Beijing, five institutions govern DAH - the Ministry of Foreign Affairs (MFA), Ministry of Commerce (MOFCOM), Ministry of Finance (MOF), Ministry of Health (MOH) and the Export-Import Bank of China. The MFA is principally responsible for determining the quantity of aid allocated for a recipient country and it 'drafts the annual plan for aid together with the Department of Aid in the Ministry of Commerce.' It also ensures that China's political interests vis-à-vis recipient nations are not subordinated to commercial considerations.[35] MOFCOM is the 'designated central processing unit' (*guiko guanli danwei*) and functions as the administrative apparatus of China's ODA.[36] The MOF processes fiscal allocations for bilateral and multilateral assistance. For multilateral commitments, a second department within the Ministry of Commerce (MOC), the Department of International Trade and Economic Affairs (DITEA), manages the process.[37] The Ministry of Health (MOH) oversees the deployment of Chinese Medical Teams (CMTs) abroad, while the provincial branches of the Ministry of Health assemble teams.[38] And finally, to facilitate inter-ministerial cooperation with global health actors, China's state council has recently established the Global Health Diplomatic Coordination Office.[39] China does not have an autonomous development agency to manage policy coordination; the MOFCOM undertakes this role by working in conjunction with the MFA, MOF, MOH, provincial governments and the EXIM Bank on decision-making and implementation. To enhance inter-agency coordination and communication, the MOFCOM recently established a mechanism to give space for the development of strategic assistance.[40]

India's DAH governance falls on an institutional quartet. International development policy and DAH fall under the purview of the Ministry of External Affairs (MEA). The MEA is also directly responsible for all bilateral assistance.[41] The MEA's two technical arms – Indian Technical and Economic Cooperation Programme (ITEC) and Special Commonwealth Assistance Programme for Africa (SCAAP) administer and manage the technical assistance initiative for development professionals seconded from their home countries.[42] The Ministry of Finance (MOF) provides assistance on budgetary issues. The Ministry of Commerce and Industry's (MOC) participation is pivoted around private sector support and facilitation, especially in recipient countries and finally, the Prime Minister's Office also holds discretionary funds that can be allocated for health related programs in recipient countries.[43] As of now, the Ministry of Health and Family Welfare plays no role in shaping India's DAH. India, after much delay and debate, has established the Development Partnership Administration (DPA), to

implement ODA and DAH.[44] Though situated under the Ministry of External Affairs, the DPA will streamline functions currently split across three different ministries to enhance policy coordination and implementation, leaving aside the role of policy formulation to the political wing of the Ministry of External Affairs.[45] As I shall demonstrate further, the heavy involvement of ministries of foreign affairs and commerce in the determination of ODA and DAH in both countries greatly impact how respective DAH packages manifest.

MANIFESTING CHINA AND INDIA'S DAH

Given a heavy governmental footprint in determining ODA and DAH, both countries prefer to channel health assistance bilaterally. Gleaning at their initiatives, we can find many synergies in their programs; both countries exhibit a tendency to deploy financing to strengthen health infrastructures and capacity, both physical and human. However, there is a clear preference with the Chinese government using DAH to focus more on infrastructurethrough construction of hospitals; whereas the government of India has concentrated on capacity building and technical assistance programs for health professionals.

To strengthen health infrastructure, China has supported the construction of more than 100 hospitals and healthcare clinics in Africa and has donated large amounts of medical devices, equipment and commodities.[46] In fact, 27 hospitals were green-lighted after the 2006 FOCAC Summit in addition to the transfer of medical equipment.[47] Delhi has supported the construction of hospitals and clinics across South Asia and given ambulances, medicines, and medical equipment to support health response capacities of nations in their neighbourhood. Majority of Delhi's health projects are in the range of $20,000 to $3 million, with a mix of large-scale infrastructure projects in energy and sanitation and small-scale programs that focus on training.[48]

Capacity building and technical assistance is a critical plank in India's DAH. IT assistance has been given to several African governments to develop e-health platforms. In fact, one of India's signature DAH achievements is the creation of Pan Africa Telemedicine and Tele-education network, which electronically links hospitals and universities in Western Africa to their counterparts in India to facilitate knowledge sharing.[49] India has also supported the training of foreign health workforces through scholarships and training programs; its two-flagship training programmes Indian Technical and Cooperation Programme (ITEC) and Special Commonwealth Assistance for Africa Programme (SCAAP), take the lead on this front by empowering foreign technicians with the skills to undertake development projects of different

size and scale.[50]

China has also offered human resource training and scholarships for foreign students and officials to study and gain functional expertise in areas such as family planning, malaria treatment and prevention and Chinese medicine; in fact, in 2008, Premier Wen Jiabao announced a five-year program to train 1,000 healthcare practitioners across Africa.[51] On the malaria front, China supports various programs in Africa based on its own experiences in tackling the disease. Under the FOCAC framework in 2006, Beijing announced $37.6 million in grants for 30 malaria treatment centers and pledged an additional $73.2 million in 2009 to further that cause.[52] Each malaria center is furnished with diagnostic and treatment equipment as well as two Chinese experts transferred to train African medical personnel.

China's track record in despatching medical teams abroad to address health deficits is deep. Chinese health assistance in the early 1960s was channelled principally through the deployment of medical teams far and wide. Through 2009, Beijing reported that China has sent roughly 21,000 workers to over 70 countries across the world.[53] Most of these tours consisted of teams made up of 12-15 physicians and lab technicians primarily servicing rural populations that had difficulties accessing primary healthcare.[54] India has a much smaller footprint in this area. Delhi has sent medical missions on an annual basis to Africa and has deployed 15 healthcare providers and free medicines for Afghanistan as part of its comprehensive assistance package to facilitate Afghani reconstruction.[55] Finally, India's capacity building support across Africa in the health sector links their domestic pharmaceutical sector with recipient countries, which enables the former to supply low-cost generic drugs, especially anti-retrovirals to combat the AIDS menace across the continent.[56]

Multilaterally, both countries are increasing their financial assistance, though funding pledges pale in comparison to their bilateral commitments. China has pledged $30 million to the Global Fund for the 2003-13 period, with $25 million being already paid; in 2009 it gave $2 million. Besides this commitment, China gave $12 million to the WHO in 2009. China has also lead in governing regional health, coalescing support to strengthen and institutionalize regional disease surveillance under the aegis of the ASEAN to confront emergencies like the Avian Flu.[57] India's multilateral global health commitments are limited. Delhi gave $2 million the WHO and the Global Fund in 2009 and makes minor annual contributions to UNICEF and UNFPA; to date, it has disbursed $11 million to the Global Fund since 2006. India, however, has lead to counteract polio; it has provided $1.49 billion since 2003 to the Global Polio Eradication Initiative (GPEI), a public-private partnership

spearheaded by the WHO with assistance from national governments, Rotary International, US Centre for Disease Control and Prevention and UNICEF. India has also cooperated regionally on health through the IBSA (India-Brazil-South Africa) mechanism.[58] IBSA funding has resulted in the construction of a health centre in Burundi for HIV/AIDS prevention and treatment, strengthening the capacity of Burundi's health professionals to combat HIV through technical cooperation, knowledge sharing, and capacity building.[59]

CHINA AND INDIA'S DAH AND HUMAN SECURITY

For development assistance of health to advance human security of citizens in recipient countries, it needs to fulfill three basic components – assistance needs to target priorities and concerns identified by recipient country since the focal point is to enhance the security of communities and people. Second, DAH needs to be directed at reducing people's vulnerability to current and future health challenges by creating an enabling environment for citizens and communities so they are prepared for sudden shocks. Therefore, assistance needs to be formed in a holistic manner. And finally, DAH needs to strengthen the interface between protection and empowerment. Protection calls for building a safety net to prevent, anticipate, and protect against health threats. And empowerment entails channelling assistance to bolster domestic health capacities of communities and individuals such that they can quickly assume responsibilities to deliver domestic health services. To gauge assess whether China and India's DAH advances human security of their recipient countries, we need to measure their approach and actions against these principles.

Do China and India's DAH Community-centric?

On the first count, it is difficult to confidently assert that China and India's DAH is derived out of recipient interests and desires. On the one hand, both countries have clearly identified and enshrined the need to consult recipient countries before devising assistance. There is a clear operational understanding of obtaining the recipient's consent and gauging their respective needs before crafting assistance measures. As Brautigam notes of Beijing, there is a 'great deal of regard for local ownership of their assistance efforts'.[60] Similarly, Nehruvian tenets of non-interference retain solid import when Delhi devises development policies. Assistance is clearly 'recipient driven' and given in clear response to requests from other countries.[61] As Nehru succinctly stated, 'a government functions for the good of the country it governs and no

government dare do anything which in the short or long run is manifestly to the disadvantage of that country.'[62] In principle, therefore, both countries place considerable importance on needs-based assistance, exhorting development partners to convey their preferences in terms of assistance packages.

But this situation is more complicated in practice. Evidence gathered suggests that the space recipients have in determining assistance, despite clear proclamations from their donor partners to do so, is constricted. First, the comparative advantages of China and India's DAH greatly determine how assistance is structured, effectively foreclosing recipient choices. The palette of options present is not very expansive and the mode of assistance is often preordained. Chinese assistance is heavily tilted towards construction oriented labour intensive projects. Looking at their DAH, we can identify a clear penchant towards investing in building hospital infrastructures and of late, malaria prevention and treatment centers. Since 2006, Beijing has made this goal more concrete, agreeing to build 30 hospitals and 30 malaria centers that will be largely constructed and partially staffed by medical teams being despatched to Africa.[63] And at the 2009 FOCAC Summit, China furthered this commitment by agreeing to provide additional medical equipment for these 30 hospitals and 30 malaria centers with medical expertise to train African health professionals.[64] In addition to shipping Chinese labour to construct hospitals, Chinese medical teams staff and train African health personnel at these hospitals and malaria centers. And more recently, China has also built pharmaceutical factories in Mali, Tanzania and Ethiopia.[65]

Indian health assistance, on the other hand, is stacked towards capacity building, technical assistance, and training. Legacies of two technical programmes – ITEC and SCAAP pre-determine the assistance recipient nations eventually receive; Delhi is leveraging their comparative advantage by offering their technical know-how in myriad areas, ranging from health to agriculture, water and sanitation. India's strength in the area of information and communication technologies also endows itself with the capacity to apply technical knowledge to advance developmental objectives in countries that confront similar challenges without requisite technical capabilities. Indeed, their signature achievements in health involve the development of a joint Indo-African electronic network that electronically links specialty hospitals and doctors in India with identified counterparts in Africa.

Is China and India's DAH Holistically Conceived?

Looking at the governance of DAH in both countries, there is no

evidence to suggest that DAH is conceived in a holistic manner. Policy coordination is lax. The strategic climate and the institutional apparatus governing development assistance have a significant impact on how assistance is devised. Though both powers prefer assistance in areas where they find synergies to their strengths and expertise, it is not undertaken without due reference to geopolitical and increasingly, geo-economic considerations. And as foreign and commercial ministries principally lead in ODA and DAH policy in China and India, strategic, not health or development concerns gain precedence. Moreover, both countries lack an independent coordinating aid agency that could function as a policy arbiter, ensuring public health concerns are reflected in development assistance policies. Disconcertingly, the health ministry plays a marginal role in determining assistance in Beijing whereas it's Indian counterpart, the Ministry of Health and Family Welfare finds no place for itself. Only if assistance fundamentally advances sovereign interests of China and India, and increasingly domestic growth agendas, is it finally approved.

Under Mao, China's underlying motives for transferring health assistance was strategic – vying with Taiwan for diplomatic recognition, bolstering socialist and revolutionary movements in Africa and supporting government capacities in a range of areas, including basic health services.[66] As the economy liberalized and prospered from the late 1970s, political imperatives at home behoved China to ensure that funding also benefits economic transformation and modernization at home.[67] And this shift led to assistance being recalibrated to favour equality, reciprocity, and effectiveness and to promote mutual benefits and trade. This sentiment was captured by a senior MOH official who remarked that health aid must 'not only serve China's foreign policy, but also act as a broker for economic development in China and recipient countries.'[68] In fact, the MOH in conjunction with MOFCOM and MFA, reoriented health assistance in the late 1990s on a more business friendly footing by channelling funding to promote jointly run hospitals and pharmaceutical firms in recipient countries, placing economic concerns at the forefront.[69]

India's DAH conception is equally strategic. From independence till the early 1970s, assistance was given on largely idealistic grounds, reflecting Nehruvian principles of south-south solidarity and national autonomy amongst newly decolonized countries. Development assistance, as a result, was deeply politicized. And like China, liberalization engendered a structural shift in its foreign policy calculus; one recent report aptly captured it, 'With India's reform towards economic liberalization, privatization, and globalization, the country's foreign policy has become also increasingly influenced by geo-economic

considerations.'[70] Within this framework, the Ministry of External Affairs has reaffirmed its role by situating development assistance formulation under the diplomatic corps, while delegating implementation and financing responsibilities to functional arms like the ITEC, SCAAP and EXIM Bank.

Moreover, there appears to be a clear priority given towards 'outputs' in the health assistance provided by China and India.[71] Packages typically consist of initiatives that are directly implementable to fill clear gaps; whether it is Chinese medical teams (CMTs) providing direct care to citizens in hospitals constructed by their counterparts from MOFCOM, shipping medical equipment and instruments, designing electronic health systems or seconding health professionals for training in their respective countries, there exists a clear preference towards channelling assistance to fill a salient need or gap and not taking a step back to understand the larger public health environment and sources of extant health threats in recipient countries.

Does China and India's DAH Strengthen Protection-empowerment Interface?

Finally, the last metric to assess vis-à-vis human security is the interface between protection and empowerment. Specifically, does China and India's global health assistance strengthen public health institutions in recipient countries to prevent, monitor, and anticipate health threats and build capacity of individuals and communities to progressively assume their own health responsibilities; strengthening health security falls on this particular divide.

On this count, looking at both countries' DAH, there is a clear tilt towards empowerment than protection. And the reason behind this is normative; China and India firmly adhere to the principle of non-interference, which restrains them from robustly engaging with public health institutions in recipient countries, required to embolden protective capabilities of health systems. Both countries do not adequately engage with health systems in their recipient countries whilst devising respective health assistance initiatives. Chinese DAH channelled through construction, malaria treatment, transfer of medicines and medical equipment occurs in isolation from the health system; and this has resulted in some glaring deficiencies being papered over by both parties. As Deborah Brautigam notes, inadequate engagement with public health systems has led to 'less appropriate designs, less than optimal locations from a health system standpoint, or inadequate provision of local staff.[72] Moreover, red flags are being raised over the integrity of Chinese pharmaceuticals being despatched to Africa

that have culminated in calls towards strengthening regulation of domestic pharmaceutical production in China.[73] India's principal DAH accomplishments are technical and technological in nature, with no concerted effort present to understand the broader public health system in recipient countries.

Looking deeper, this lack of focus on grasping health contexts in recipient countries emanates from a conspicuous lack of involvement of domestic health actors, particularly civil society, in determining DAH and the relatively low eminence of public health as a policy priority in both countries. And this impedes China and India from mainstreaming health in their health assistance. Successful formulation and implementation of development assistance projects often hinges on the support of civil society actors, who have more experiential knowledge of public health challenges. In China, though NGOs and CSOs have played marginal roles in global health assistance in the mid 1980s, their role has been drastically curtailed.[74]

India's manifest neglect of civil society actors in shaping DAH is discomfiting since the government is now relying on non-governmental organizations for conceptualizing and delivering public health services. To combat HIV/AIDS, the Indian government has 'outsourced' several critical functions like defining the epidemic, charting specific interventions, and treatment delivery to non-governmental actors, all functions that Delhi has traditionally discharged.[75] Therefore, not leveraging non-governmental expertise in DAH is puzzling since potential exists to apply domestic health experiences to bolster public health capacities in recipient countries.

Despite pronounced difficulties in moulding DAH to fortify protective capacities of health systems in recipient nations, China and India have invested considerably in building the capacity of individuals to eventually assume health responsibilities. Zhou Enlai's principles for assistance reverberate to this day, notably his emphasis to not make 'the recipient countries dependent on China but to help them embark step by step on the road to self reliance and economic development[76].' And Nehruvian exhortations of forging south-south ties through development cooperation hold considerable influence as India fashions its capacity building assistance. Empowerment is exalted. However, we need to distinguish between two kinds of capacity building, human and physical.

Training programmes dominate the focus on building human capital. Incumbent under the despatching of Chinese medical teams is a training component where Chinese doctors staffing hospitals and malaria centers train their African counterparts. All malaria centers possess Chinese experts who arrive for two-month stints to equip African workers with skills and capacities to run facilities. CMT's also facilitate

knowledge transfer by holding lectures, training courses, and imparting beneficial operational practices and have leveraged domestic media outlets and local doctors to amplify their outreach.[77] Moreover, more bilateral health exchanges are increasingly taking place, where African officials visit Chinese institutions for short-term training programmes on issues such as population and family planning, malaria treatment and prevention and other health related topics that are on demand. For instance, the China Training Center for Reproductive Heath and Family Care has conducted ten training programmes for foreign participants under the aegis of MOFCOM.[78] However, it is important to highlight that Chinese medical teams have come under some criticism, of late, for not calibrating their assistance and services enough to fit local contexts and acting more as economic agents advancing commercial interests and technologies of private health actors in China.[79] Despite intermittent difficulties, Chinese DAH has been generally regarded as having a positive net impact in strengthening individual health capacities in recipient countries.

India's training programmes have long been a key pillar in its overseas development agenda. Under ITEC and SCAAP, myriad short-term training courses are available to foreign country nationals in areas ranging from general management and finance modules to specialized training in rural development, agriculture, remote sensing and pharmaceutical education and research.[80] Emphasis is given towards empowering officials in developing countries with professional and technical skills that can be applied in emerging issue areas like health, education, and energy. Under ITEC, Indian experts are also deputed abroad to assist in small-scale development projects as well as undertake joint projects that are of mutual benefit. However, ITEC's scope is limited; as of 2011, 7400 civilian training slots have been allotted under the ITEC and SCAAP to 161 countries, stretching the capacity of the programme's training institutions that also shoulder onerous domestic training responsibilities.[81]

Physical capacity-wise, China holds an upper hand given their extensive experience in developing health infrastructures, notably hospitals, clinics, and transferring medical equipment and drugs to developing countries. As enumerated above, this particular mode of DAH has gained momentum under the FOCAC, which has extended financing to construct 30 more hospitals and anti-malaria centers in addition to millions promised through pharmaceutical drugs and equipment for those health facilities. India has zeroed in on developing electronic health systems and training staff to man those facilities as evidenced by their signature achievements. Of late, they have also invested in building small-scale hospitals in Nepal, Sri Lanka under the

Small Developments Programme (SDPs) under the auspices of the Ministry of External Affairs and through the IBSA Fund, where they have contributed to the establishment of a centre for HIV/AIDS prevention and treatment.[82]

CONCLUSION

More than ever, global health is now inextricably linked with vital national and strategic priorities of emerging powers. China and India have managed their occasional trysts and burgeoning accord with global health governance as a DAH donor, strategically. For decades, geopolitical and ideological priorities have influenced the development assistance for health both powers have disbursed and continue to disburse. This approach gained a fillip as both economies liberalized. But this practice, however, clashes with the desire to strengthen health and human security in countries that receive DAH from China and India. Augmenting the health security of citizens involves DAH donors to shape assistance based on three principles - having extensive consultations with communities and citizens in recipient countries, on acquiring a robust systemic understanding of the public health challenges of recipient countries and also strengthening the interface between protection and empowerment such that individuals and communities are eventually able to possess the skills and capacities to deftly confront and tackle public health challenges.

Chinese and Indian DAH largely fall short of fulfilling this prerogative. Though both countries consult recipient partners of their preferences, Beijing and New Delhi leverage respective comparative advantages to shape their DAH packages with the former choosing to deploy considerable muscle in developing 'health infrastructures' of recipient countries, while the latter deploys domestic strengths in technical and human capacity building. However, this is being done without an adequate understanding of public health challenges or health systems of recipient countries. This is largely due to the governance of ODA and DAH in China and India. Ministries of foreign and external affairs, commerce, and industry in alliance with their financing arms dominate the provision of their development assistance in health.

Global health concerns inevitably entangle with sovereign and strategic concerns in China and India. As their global health footprint widens, both countries will confront a litany of interests and objectives before determining how to best lever financing to address global health challenges. As the public appetite for development assistance declines in the advanced world, global health stakeholders will increasingly rely on public-private and exclusively private financing to fill major gaps.

Emerging powers will also play a greater role here on the strength of their sheer fiscal advantage. And it is critical to understand their DAH role and activities with respect to overarching strategic contexts that generate opportunities for them to engage with other developing countries, attendant domestic institutions that assume the lead in shaping DAH and the modes they choose to deploy that assistance.

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