Article:
Anderson, E-L orcid.org/0000-0002-0631-8744 (2018) African health diplomacy: obscuring power and leveraging dependency through shadow diplomacy. International Relations, 32 (2). pp. 194-217. ISSN 0047-1178

https://doi.org/10.1177/0047117817751595

African health diplomacy: Obscuring power and leveraging dependency through shadow diplomacy[1]

Emma-Louise Anderson

Abstract

Health crises pose fundamental challenges to international relations and have been a major focal point of contests for global influence, particularly in the global South, where such crises are most acute. This necessitates a focus on the arenas of global health diplomacy and the power struggles that emanate from them, including the often-overlooked agency of African actors within these arenas. Drawing upon a total of 3 months of fieldwork in 2007 and 2014 that included 68 key-informant interviews, participant observations, and informal discussions, this article interrogates the mechanics of multi-stakeholder health diplomacy in Malawi, where a near-permanent state of health crisis and underdevelopment has generated extreme dependency on external health assistance. This article conceptualises shadow diplomacy as the informal networks and channels of influence that run parallel to, but are not recognised as part of, formal diplomacy. This concept reveals how health is key to struggles for leverage by both international and local actors, giving rise to informal and subversive manifestations of diplomacy in the 'shadows'. It enables us to understand not only how Western powers consolidate and obscure their enduring power, but also how the 'shadows' benefit African political elites as they leverage their dependency to subvert global power structures for their own ends. It disrupts the external/internal binary of international donors/African states and reveals that these are not monolithic actors but instead comprised of complex individuals with multi-faceted motivations and divided loyalties.

[1] The author would like to thank Alexander Beresford, Sophie Harman, the editorial team of IR, the anonymous reviewers and the POLIS reading group at the University of Leeds for feedback on this article.

Global health diplomacy has emerged over the past decade as a new area of diplomacy within the context of shifting donor-recipient relationships, novel types of health alliances and the rise of 'south-south' cooperation.[1] It is of importance because health crises - including the outbreaks of Ebola in West Africa and Zika in South America - pose fundamental challenges for international relations and it is in arenas of health that battles for global influence are played out.[2] Global health diplomacy complicates understandings of diplomacy because it extends into new spaces with diverse actors and manifold forms of negotiation.[3] It encompasses different levels, including 'core diplomacy' with high-level inter-state negotiations over health (notably within the World Health Organisation) and 'multi-stakeholder diplomacy' where various bilateral and multi-lateral organizations work with national governments to develop, implement, and monitor national and regional health initiatives. It is the latter that is of interest here because it extends the gaze of International Relations (IR) to state and non-state actors that have not traditionally been recognised as participants in foreign affairs and to new forms of negotiations, including among technical experts within donor agencies and government ministries.[4]

It is recognized that global health diplomacy is a nascent area and requires further conceptual development.[5] The concern here is what can be learned from rethinking based upon how it plays out in African realities.[6] This is important because the scholarship on diplomacy more generally - and global health diplomacy specifically - tends to be western-centric in its concern and focus; to some extent obscuring African spaces, actors and forms of diplomacy. The dominant concern in work on global health that does engage with Africa is with perceptions of and reactions to Africa as a threat to global health and a site for diplomacy.[7] Typically the continent is perceived as 'acted on' by the West[8] and, more recently, other

powerful global actors, including China.[9] In recent years, there has been emerging interest in non-Western understandings of IR[10] and Africa's place within the discipline.[11] This article contributes to scholarship that lays emphasis on Africa's position as not merely 'acted on' but also as an 'actor in' global politics.[12] There is a small body of work within the global health scholarship on Africans as actors[13] and yet the focus of the health diplomacy scholarship remains on relatively powerful states and actors, notably South Africa.[14] Furthermore, there is a proclivity to apply Western conceptual frameworks to African cases.[15]

Although multi-stakeholder health diplomacy is a phrase that is used in the global health literature and a useful descriptor, it lacks conceptual development. This article builds upon the existing literature to question what we can learn about multi-stakeholder health diplomacy within African contexts where there are highly asymmetrical donor-recipient power relations because of dependency on health assistance. Malawi is examined as an 'extreme case'[16] because it is dependent on external assistance for 81 percent of the total health expenditure.[17] In this context multi-stakeholder health diplomacy is useful for understanding the complexity of how diplomacy is not just occurring between states - there is also the crucial role of other actors including donors, non-governmental organisations, private philanthropists and private sector health providers. Moreover, it draws attention to the individual technical advisors, programme managers and consultants working within these organisations. The analysis interrogates the mechanics of multi-stakeholder health diplomacy – questioning what it looks like in practice, where and how it takes place, and how it is perceived by those individuals engaged in diplomacy. This focus is important because the precise nature of donor-government relations remains an undocumented black box on which political scientists have built political and economic models that assume great asymmetries of power between donors and recipient governments. This article shines a light into to this box and tests some of these assumptions using qualitative methods that allow for rich descriptions of the negotiation process.

The analysis takes an actor-oriented perspective[18] to fill gaps in our knowledge in IR, particularly in terms of understanding non-Western perspectives and locating Africans as actors in global politics. It draws upon a total of three months fieldwork in Malawi (during June – July 2007 and June - July 2014). Data was gathered from NGO, government and donor reports. 68 semi-structured key-informant interviews were conducted with a broad spectrum of key players in health diplomacy – 44 in 2007 and 24 in 2014. These included: civil servants in government, technical advisors from major international donors and private philanthropists working with and within the government, programme managers and technical assistants with major international donors, private sector health providers, implementers, international non-governmental organisations (NGOs), civil society organisations and consultants. Initially the interviewees were approached through key organisations working in the health sector and high-level gatekeepers including the Attorney General and Minister for Gender. Further participants were identified through a process of snowballing, which extended the scope of the research beyond what was originally envisioned and enabled access to actors whose roles were confidential. Given the sensitivity of some of the issues raised, trust was established through these personal recommendations and building rapport during the course of the interviews. The interviews covered topics of the respondent's role and background, their perception of the health priorities (how these differ between actors and changed over time), the response to those priorities, the challenges they face and the expectations on them in their role. The respondents are referred to here in the ways in which they themselves requested. In 2014 participant observations were also conducted of the 'National HIV Prevention Symposium' and HIV Technical Working Group meetings; and a series of informal discussions were also conducted. This rich data enables examination of the nuances of the ways that these actors negotiate and navigate the structural constraints and the complexities of their identities, perceptions,

motivations and loyalties. The concern is with how power plays out and what it tells us about diplomacy, not with normative concerns about what is best in terms of health outcomes.

The article begins with the historical and political context of development assistance in Malawi to introduce the context of aid dependency. It is argued that despite limited power over domestic health policymaking, the spaces for diplomacy are in transition with shifting opportunities for negotiations. It then moves on to examine the mechanics of multi-stakeholder health diplomacy and develop the concept of shadow diplomacy. This extends from Reno's conceptualisation of the 'shadow state'[19], to recognise the informal networks and channels of influence that run parallel to, but are not recognised as part of, formal diplomacy. This concept reveals how health is leveraged not only by external powers but also African political elites in ways that obscure, consolidate and extend their power. First, it enables us to understand how Western powers conceal their continued power over the global South and it is argued that this takes three forms: 1) through directing health initiatives and the policy making process in the shadows; 2) infiltrating the structures of the state by embedding external technical advisors within government ministries; and, 3) the use of diplomacy processes and instruments to extend their control. Second, it is argued that the shadows also benefit African elites as they leverage their dependency to subvert the global power structures, including for their own personal gain. This takes four forms: 1) through extraverting health issues; 2) playing more power actors off against each other; 3) strengthening their negotiating position through 'evidence-based diplomacy'; and, 4) subverting the health system for private gain. The final section argues that shadow diplomacy is useful for advancing how we understand 'Western' and 'African' actors in global health diplomacy.

THE HISTORICAL AND POLITICAL CONTEXT OF DEVELOPMENT ASSISTANCE FOR HEALTH

In order to interrogate multi-stakeholder diplomacy in Malawi it is important to briefly introduce the historical and political context of development assistance for health. External involvement in health in present-day Malawi dates back to missionary medical work and the establishment of hospitals and dispensaries in the late 19th century under British colonial rule.[20] Health care provision from the 1930s to the end of the 1980s was comprised of a public/private mix of mission hospitals coexisting alongside government district hospitals. From independence in 1964, there was increased state control and leadership of health provision under Hastings Kamuzu Banda with the expansion of government legislation and bureaucracy.[21] From 1981, the health system was hollowed out by structural adjustment policies: the underlying free-market ideology required the rolling back of the state and efficiency cuts, which had implications for the health services with the liberal registration of medical practitioners, the expansion of private-sector provision and the introduction of user fees.[22] Although traditionally, Malawi performed well in terms of the World Bank requirements and has been considered a 'strong liberaliser', increases in foreign direct investment and economic growth failed to materialise.[23] Whilst a number of other African states have experienced relatively high levels of economic growth – leading to the emergence of a narrative that 'Africa's rising'[24] - Malawi remains among the poorest countries in the world with a gross national income of 240 USD in 2014.[25] Economic growth reached 6 percent but inflation was 24 percent because of the continued depreciation of the kwacha and the withdrawal of donor budgetary support.[26]

Despite 50 years of independence, foreign aid accounted for 40 percent of Malawi's national budget in the financial year 2013-2014 and 40 percent of that came from the United Kingdom's Department for International Development (DfID).[27] This dependency on external funds was particularly acute in terms of health assistance, which accounted for 89 percent of

the Ministry of Health budget and 81 percent of total health expenditure.[28] The main donors were the Global Fund, World Bank, DfID and Norway, which had been resourcing a pooled fund for health through the Sector-Wide Approach (SWAp) (introduced in Malawi from 2004), and the US Government, particularly through the President's Emergency Plan for AIDS Relief (PEPFAR).[29] Dependency on external funds was most apparent for HIV with 99 percent coming from donors: 705 million USD from the Global Fund and 528 million USD from PEPFAR.[30] Although HIV prevalence remained high - only stabilising at around 11 percent from 2011 - the prioritising of a single disease was disproportionate to its health burden and had warped the health sector such that local facilities lack the capacity to respond to other critical health issues.[31] This was fundamentally at odds with the priorities of local communities[32] but ultimately, donors are accountable to the taxpayers in their home countries, as donor and NGO representatives reflect.[33] For example, the policies and strategies of DfID are formulated in London and driven by the interests of the UK rather than those of Malawi.[34] The health system is highly fragmented with multiple parallel health systems where assistance comes from a coterie of donors who partner up with implementing partners.[35] Donors may engage with local partners, other donors, or NGOs and Watkins and Swidler describe how, with respect to AIDS funding, money 'flows chaotically both downward and sideways'.[36] The team leaders are based in Washington and London, whilst technical advisors based at the country level are required to participate in donor grouping meetings and ensure the delivery of programmes.

By 2014, the health sector was in crisis because of the risk to donor funds. A 2012 audit revealed mismanagement of the Global Fund Grants[37] and the subsequent retraction of Global Fund resources had a knock on effect and the other donors followed.[38] Furthermore, an audit of donor funds to the Government in 2013 revealed an estimated 30 million USD was not accounted for – popularly known as the 'Cashgate' scandal. Although the Ministry of Health

was not directly implicated, one donor technical advisor explains how the donors retracted their on-budget support because they could 'not be seen to be supporting a government that is corrupt'.[39] One programme manager at a major donor pointed to systematic failures and explained that 'Cashgate was the final nail following the decline in faith in governance'.[40] In 2014, DfID ended its bilateral funding (having already withdrawn support to the SWAp and the Central Medical Stores), the German Gesellschaft für Internationale Zusammenarbeit (GIZ) was withholding its funding and the Ministry of Health had a tenuous relationship with the Global Fund.[41] Resource mapping reveals that funding continues to be channelled to certain donor priority areas including disease-specific interventions (most notably for HIV/AIDS), whilst the majority of cross-cutting systems funding comes from the government and is underfunded because it is not attractive to donors.[42] A Programme Manager with a major donor highlights how 'the decline in donor funding has led to the collapse of the health system for example there is a lack of the most basic drugs such as paracetamol.'[43] During the first months in office of the Democratic Progressive Party Government of Peter Mutharika (elected in May 2014) there were reports of shortages of blood, antiretroviral (ARVs) drugs and condoms.[44] These were indicative of the incapacity of the major hospitals in Lilongwe and Blantyre and the health centres across the country, particularly those in more remote areas. And yet, shifts in the funding landscape - with the decline of 'traditional' donors and the increasing place of 'non-traditional' aid donors including China and new forms of private philanthropy such as the Gates Foundation - also provide new opportunities for negotiations. Within these broader shifts in development assistance there are new relationships and novel forms of diplomacy that actors engaged in health diplomacy can capitalize on.[45]

It is in this context of acute dependency on external health assistance and shifts in the health funding landscape that multi-stakeholder health diplomacy takes place in Malawi. The

concern now is to interrogate what we can learn about the mechanics of multi-stakeholder diplomacy.

OBSCURING WESTERN POWER

When seeking to locate Africans as actors in global health diplomacy an obvious place to begin is their role in developing global health initiatives and policies. Walt, Lush and Ogden argue that global health initiatives are not simply ideologically driven and imposed from the 'top-down' by international organizations. Rather, they often originate from the 'bottom-up' in low-income countries before forming global policies and over time, complex, context specific policies become simplified into guidelines for global best practice.[46] The development of Option B+ as a modification of the World Health Organization (WHO) recommendations for Prevention of Mother-to-Child Transmission (PMTCT) programs[47] has been promoted as a major global health initiative originating from Malawi. Option B+ was the initiation of lifelong antiretroviral therapy for all HIV-positive pregnant and breastfeeding women irrespective of their CD4 count[48] or clinical stage.[49] External stakeholders highlight that it was 'government-led' and conceived from the 'bottom-up' in response to the specific needs of Malawi, despite some international scepticism and concerns including about the cost of implementation. The rhetoric is one of 'partnership' through national consultations and decision-making with support of donor-funded technical advisors and international NGOs[50] The global roll-out has been promoted as a process of 'south-south learning', with Malawi showcased as a model for other countries.[51]

However, it is well-established within the literature on development assistance that the rhetoric of 'partnership' and 'government-led' conceals enduring Western power and the reproduction of asymmetrical aid relations.[52] The concern here is to develop greater nuance in understanding how multi-stakeholder health diplomacy takes place within contexts of acute

dependency on external assistance. It is argued that shadow diplomacy enables us to understand how Western powers obscure their continued power in three ways: 1) through directing the process in the shadows; 2) embedding themselves into the structures of the state; and 3) the use of diplomacy processes and instruments.

First, interviews and informal interviews discussions with representatives of international donors and NGOs in Malawi reveal that despite the rhetoric, they endeavour to 'lead from behind' in the shadows on the development of initiatives and policies across the health sector.[53] In the case of the development of Option B+ it is attributed to Malawi and yet, the WHO update reflects earlier recommendations from major donors such as PEPFAR.[54] As Lie argues in his work on 'developmentality', donors make their policies those of the recipient in order to 'govern at a distance'.[55] Participant observation of the development of national HIV policy and informal discussions reflecting on the process draw attention to some of the ways external actors seek to capture ostensibly participatory process and extend their control. The development of the National Strategic Plan for HIV and AIDS 2015-2020 was celebrated for taking a 'highly participatory and consultative approach in which all the relevant stakeholders participated'. The plan highlights how this included bringing together international and national experts, programme managers, development partners and relevant stakeholders at the 2014 'National HIV Prevention Symposium'.[56] During the breakaway group discussions at the symposium international experts and the national representatives of donors, NGOs, the Malawian government, National AIDS Commission, networks of people-living with HIV and Traditional Authorities signed to confirm their attendance. And yet, the facilitator was a representative of a major international donor and determined who spoke when and which contributions to the discussion were recorded on the flip chart from the discussions. The international experts and donor representatives dominated the conversation, whilst the PLHIV and Traditional Authorities mostly remained silent. Only those responses that were deemed by

the donor representative to 'fit' were written down.[57] Moreover, in an informal discussion with one donor official working in infectious diseases she highlighted that ultimately what mattered was working on the final draft and that she would leverage her position to ensure her role in that.[58] The identities of those involved in the final drafting of the policy are not provided in the published document (which is solely attributed to the National AIDS Commission) and this obscures the fundamental role of external actors. Shadow diplomacy plays a fundamental role beyond the formal national consultation processes with the donors and their international implementing partners informally directing the process in the shadows. Echoing the arguments of Crawford on Indonesia, the rhetoric of 'partnership' serves to mystify enduring asymmetrical power relations between donors and recipient countries and how initiatives are externally driven.[59]

Second, Western actors extend and conceal their power by embedding themselves into the structures of the state through their technical advisors in the Ministry of Health. In response to concerns over accountability – particularly in the wake of 'Cashgate' - a number of donor representatives reported how these technical advisors are working as their 'eyes on the ground' within ministries in roles that are shrouded in secrecy.[60] As one such technical advisor in the Ministry of Health explained, 'Now the donors are taking a new path of bringing in independent persons in the systems whenever they are giving funds, as opposed to waiting to audit when things are done'. He explained that his role included acting as a fiscal agent to sign off payments and use third party agents to verify the details of the training activities.[61] Interviews with these technical advisors revealed that there is a blurring of the roles and identities of these actors – some perceived themselves as part of ministries and had complex and, at times, conflicted loyalties.[62] There was a degree of silence around the nature of their work but what is of interest here is how this complicates health diplomacy. Shadow diplomacy reveals how negotiations do not simply occur between donors and national governments as clearly distinguishable

external/internal entities where the donors are infiltrating the state.[63] The locus of multi-stakeholder health diplomacy is in the shadows within ministries between technical advisors, consultants and civil servants with complex identities and motivations. A point returned to in the final section.

Third, donors use diplomacy processes and instruments to extend their control over recipient governments. This is apparent in the case of the Malawi health SWAp, which was intended to pool donor resources to support the health system and place the government at the centre of health initiatives. Interviews with representatives of international donors and NGOs in 2007 revealed that they perceived the SWAp as problematic because it limits their ability to demonstrate their own impact and bring issues onto the agenda. As a technical advisor working with a major internal donor explained, the multilateral approach means that donors 'do not actually have direct influence on indicators and so forth like you would have in a project.'[64] Likewise, where NGOS are incorporated within the framework they lose the power to critique the government and push their own agendas.[65] The donors use the process of bi-annual reviews, district supervision systems and informal aide-memoires to strengthen their ability to hold the Malawian government to account on its commitments within the SWAp.[66] And yet, the SWAp is a weak mechanism that has been circumvented by the donors because it is based upon a memorandum of understanding that is modifiable and not legally binding.[67] A mid-term review by the Norwegian Agency for Development Cooperation (NORAD) reports that:

> should any development partner offer to provide services outside the framework [of the national health strategy]… the Ministry is unable to say 'no', and must accept what is on offer. Such a viewpoint would indicate that Ministry of Health staff may not feel empowered to prioritise interventions and not hold development partners to account when they stray too far away from agreed strategies and work plans. [68]

Shadow diplomacy draws attention to the more insidious and subtle ways that Western actors exert their influence through the bureaucratic structures, which serve to internalise aspects of neoliberalism.[69] As a result, donors construct the nature of the 'partnership' with the state and limit the very possibilities for manoeuvre.[70] Moreover, the 'promise of incorporation and inclusion' for adopting these structures produces modern, self-disciplined and rational agents.[71] However, this does not necessarily manifest itself in ways that the donors intended, as the final section considers.

This section examined how shadow diplomacy occurs beyond formal multi-stakeholder diplomacy over health initiatives and policies. In accordance with global commitments,[72] donors use rhetoric such as 'government-led' and 'partnership', and yet they continue to 'lead from behind' to ensure national policies and initiatives align with their own preferences. At a more insidious level donors extend their control by permeating the forms and processes of the state.[73] The analysis of the mechanisms of multi-stakeholder health diplomacy reveals how donors embed their technical advisors within Ministry of Health and structure processes and use health diplomacy instruments to hold national governments to account (whilst thwarting them themselves). This not only shifts the locus of negotiations to the shadows within ministries, but it also serves to produce rational, responsible agents.[74] And yet, despite the structural constraints of dependency and the enduring, embedded nature of donor power, African actors can also use the international actors to advance local agendas.[75] The next section examines how shadow diplomacy also entrenches and obscures the power of the African political elites.

LEVERAGING DEPENDENCY

It is well-established in work in African Studies that Africans have long resisted and even changed 'what appears to be their structural fate'[76] and exercised diverse agentic behaviours despite the powerful structures of (neo)colonisation and globalisation.[77] Traditional accounts of the continent's marginalisation, Bayart argues, obscures how dependency has become a 'mode of action' to navigate and even exploit Africa's unequal inclusion in the global order.[78] The concern here is how the concept of shadow diplomacy provides a more nuanced understanding of the ways in which African political elites leverage health dependency to obscure, consolidate and extend their power. Based upon empirical findings from Malawi, it is argued that this takes four forms: 1) through extraverting health issues, 2) playing more powerful actors off against one another, 3) strengthening their negotiating position through 'evidence-based diplomacy'; and, 4) subverting the health system for private gain.

First, African political elites leverage their dependency on external health assistance through 'extraverting' health issues. This draws upon Bayart's argument that African states are outward-facing and responsive to how they can best exploit their situations to compensate for their limited power – what he conceptualises as 'strategies of extraversion'.[79] The Malawian health sector is a site of extreme dependency on external resources. Civil servants working in the Ministry of Health reflect upon how they are outward facing to the donors and must be responsive to shifting donor preferences (for example the preoccupation with issues of gender) and the new constraints that are placed upon them (including efforts to limit corruption).[80] Anderson and Beresford argue that precisely because of such dependency, health issues provide particularly effective leverage and extraversion of crises in particular can mobilise support from the international community.[81] One Technical Advisor working with the Ministry of Health refers to strategies of 'heart-string' diplomacy when reflecting on the ways in which the government plays on emotive health issues in negotiations.[82] The extraversion of AIDS has long been particularly effective, as Swidler writes: 'the cynic in me thinks that AIDS

philanthropy, AIDS research and what might be called AIDS tourism have become Africa's most successful 'export' and certainly a major source of foreign exchange. … AIDS crisis has focused the world's attention on Africa.[83] Such strategies have mixed effects in terms of the actual health outcomes where it is ultimately about gaining and consolidating political power.

Second, the Malawian political elites play more powerful actors off against one another to advance their own interests, especially where there are a multitude of donors, each with competing health programs.[84] This is not a new phenomenon and there has been a long history of African leaders playing off external actors for foreign aid, including playing off the superpowers during the cold war.[85] The rise of China has presented opportunities to African states[86] and the recent Chinese interest in the Malawian health sector - including in the provision of medical expertise to Kamuzu Central Hospital and Mzuzu Central Hospital and Malaria eradication initiatives - provides opportunities for actors in the Ministry of Health despite the withdrawal of support of the traditional donors.[87] During an interview in the immediate aftermath of the announcement of the withdrawal of DfID support, one civil servant reflects on the potential of these new opportunities:

> This Government has said that they are looking for other relationships. As long as we have got our priorities, and plans right whoever is funding and investing, and they are fairly flexible, so long as we are not paying vast amounts of interest on loans… we have the Chinese, the Indians, and a number of other potential people who are beginning to invest a bit more now - Turkey keep coming in and out. A number of countries are trying to invest in infrastructure and so forth.[88]

This is situated within a broader strategy by the Malawian Government of 'looking East', with the strengthening of bilateral relations with China since 2008 under former President Bingu wa Mutharika, which provided his government with options in the wake of the retraction of traditional development assistance to his government in 2011.[89] This has continued under the

current President, Peter Mutharika, and in his Inaugural Speech in June 2014 he stated that the traditional donors are 'welcome to stay' but Malawi will look to 'new friends' including Russia and China.[90]

These neoteric health actors have very different relationships with the government as compared with the traditional donors and diplomacy takes on new forms. A civil servant working with the Ministry of Finance reflected a popular sentiment that 'with the European donors (particularly the UK) it is like a parent-child relationship but with China it is like a brother-brother relationship'. [91] The 'Beijing Consensus' of non-interference and respect for sovereignty is attractive to African governments such as Malawi as a break from 'tied aid' of traditional donors that includes prerequisites of political liberalization or economic reforms (except for the 'one China policy'). In the health sector, China provides technical support including the provision of medical personnel, medicines, equipment and training and prevention and treatment for malaria and HIV.[92] These new forms of involvement are attractive because as one civil servant in the Ministry of Health explains, 'with an aid relationship you keep receiving money but it can go nowhere but the money will keep coming - it maintains dependency'.[93] And yet, it also presents novel challenges and one civil servant reports that the Ministry of Health faces 'issues of knowing what activities are undertaken – new issues of tracking the funding from the non-traditional donors.'[94] A civil servant in the Ministry of Finance highlighted problems with Chinese representatives thwarting the recently introduced Government reporting mechanisms.[95] Where health diplomacy is fundamental to China's soft power[96] shadow diplomacy also enables us to understand how these newer global actors utilise global health diplomacy to consolidate their influence in Africa.

Third, African actors strengthen their negotiating position through the use of 'evidence-based diplomacy'. In Malawi, private sector international consultants and technical advisors work with and within the Ministry of Health to build its capacity to produce quantitative

evidence and comply with donor demand for evidence-based policy making. This is important because, as Rottenburg and his colleagues argue, the emphasis on quantitative knowledge 'privileges the perspectives of those with infrastructure, financial and professional resources and experience in the production of large-scale numerical knowledge'; and yet 'indicators have become powerful advocacy tools', including for grassroots and advocacy groups.[97]

In a context of competition for retracted donor funds, the capacity building in the Ministry of Health bolsters its negotiating position through 'evidence-based diplomacy'. One private sector technical advisor explains how previously the Ministry 'resorted to lots of "heart-string pulling" advocacy for resources for health but now we have them being able to show clearly what their needs are, what the resources available are and a compelling reason for what they can do with more money'.[98] The Ministry was working with the Clinton Health Access Initiative (CHAI) between 2010 and 2014 on annual resource mapping to challenge donor control of information. One civil servant reports that they are now generating data to make better decisions and effectively navigate the opportunities, or, as the put it: 'getting all the ducks in line - this is what we want to do: these are our gaps and who is funding what….so we have got a better picture of what the costs are, what the gaps are, what resources are coming in, where they are going to and where the gaps are in terms of diseases and the health system as well.'[99] A CHAI report considers how the increased visibility on planned investments and interventions has 'informed the allocation of US$300 million to high-impact interventions, and strengthened national ownership and coordination of the HIV response.'[100]

Strengthening 'evidence-based diplomacy' also empowers the government to hold the donors to account. Aid mapping is a useful advocacy tool to reaffirm international commitments to aid effectiveness. Of course, better reporting and mapping of aid is in part about donors extending their control where transparency reduces the ability of the government to misallocate resources, duplicate resources, or use resources strategically. However, one civil

servant in the Ministry of Finance explains how they use comparative tables on the performances of each of the donors to publically shame those that are underperforming.[101] Resource mapping by the Ministry of Health with the support of CHAI provides weight to their criticisms of the fragmented parallel health systems and has influenced the allocation of resources. A CHAI report argued that:

> Results illustrated that harmonization of these systems could save over US$11 million per year. This informed DFID's decision to donate drugs directly to the government's supply chain agency, rather than distributing them through a third party contractor. The change contributed to an estimated reduction of US$3 million in supply chain costs between 2013 and 2014.[102]

The government can also hold donors to commitments to aligning their work with the government's priorities, which in practice tends to only be where there is already goal convergence.[103] Typically collective work towards defining domestic health priorities and commitments to health systems strengthening are overshadowed by dominant themes at the global level including those set out in the Alma Ata Declaration, Ouagadougou Declaration, Millennium Development Goals (MDGs), Poverty Reduction Strategy Papers and the Sustainable Development Goals (SDGs). This includes the diffusion of international norms of gender equality, human rights and community participation.[104] However, one private-sector technical advisor working with the government explained how the National Strategic Plan for HIV was being revised in 2014 so that there is a clear framework to hold donors accountable 'making it robust so it is costed and prioritised' which 'allows for first of all, coordination around the governments priorities and second it allows for better tracking on a biannual basis of what we have achieved against our outputs, accountability for what we said we would achieve and then comparing that to how much money has been spent.' However, they recognise

that it will be hard to implement – 'redirecting them to other priorities takes a lot of guts. So they try to do it with evidence but there may be battels they do not want to fight.'[105]

This shift in Malawi reflects a broader rise of 'evidence-based diplomacy' whereby advocacy groups are 'playing the numbers game' and use scientific evidence to augment their negotiating position with more powerful actors. And yet, Storeng and Béhague highlight that this can have profound impacts on how evidence is produced, ambivalence and a technocratic narrowing of the policy agenda. [106] Participant observation of the formulation of the HIV Policy reveals some of these impacts in Malawi. During an open discussion at the 'National HIV Prevention Symposium' in 2014 one Western consultant raised the issue that there was not sufficient data to determine priority districts and yet, his objection was met with silence because it conflicted with the requirement to produce 'evidence-based policy'.[107] The emphasis on evidence-based policy making impacts on how evidence is produced and participant observation of one stakeholder meeting about the development of the policy revealed that during the process of compiling sufficient data about key populations it violated ethical procedures and led to infringements on the rights of people who participated in the study. [108] Finally, the emphasis on quantitative knowledge impacts on what counts as evidence and the emphasis on measures leads to the silencing of certain perspectives. In an informal discussion after the gender breakaway group at the HIV Symposium one woman living with HIV representative explained that she did not know how her contributions about gender-related stigma could be included after the facilitator raised the issue of measuring in relation to the discussion of gender - so she remained silent.[109]

Moreover, there becomes a façade of evidence as Malawian actors align their actions and rhetoric with donor assumptions to advance their position.[110] Swidler notes with respect to reporting on HIV interventions for children how 'personnel are rewarded for turning in reports without much scrutiny from the home office staff. So in the long run, what these

organizations really need to provide in order to survive is enough children; so that when the infrequent visitor comes, local relationships can be used to mobilize an acceptable number of children or adults to demonstrate that something is happening on the ground.' [111] Where there is a mutual (albeit unequal) dependency between donors and recipients[112] this façade is not brought into question because there is often a shared benefit. The international community need to point to 'success stories' such as the government-led development of Option B+.[113] The performance of a 'partnership' masks donor control but Malawian political elites can also claim political capital. In this sense 'dependency has been a joint venture'[114] and donors rely on local actors to achieve their goals, which has enabled African actors to also benefit.[115]

Fourth, Malawian political elite subvert health assistance for their own private gain. Shadow health systems of informal commercially orientated networks between global and local actors and general rent-seeking behaviour exists alongside the formal structures of the health sector.[116] State resources are exchanged for political loyalties and public office provides the opportunity to support one's own clients through privileged access to public goods.[117] Political elites at multiple levels engage in 'gatekeeper politics', which Beresford defines as the 'political and social structures through which authority and power are cultivated, disseminated, and contested'.[118] This has been one of the main means of mobilising political support in Malawi since independence and the state continues to be a primary means for accumulating wealth despite the rhetoric of democracy since the shift to multiparty elections in 1994.[119] Gatekeeper politics is especially pronounced in the health sector with the sheer scale external resources and the legacy of a lack of Monitoring and Evaluation. Positions within the health sector provide key opportunities for controlling resources and channelling them for personal ends. The Ministry of Finance controls the gate to donor resources and the Ministry of Health responds by lobbying formally within state apparatus but also through interconnections of these elite through patronage ties and personal networks (including extended family and past

experience studying or working together). Informal networks serve to subvert the health sector for personal gain and severely undermines healthcare provision. With the sheer extent of resources into HIV control of this gate is particularly lucrative and there has been reports of scandals of corruption within National AIDS Commission (NAC).[120]

Patronage networks permeate society and, as Swidler considers, 'local people at all levels, at least initially, inevitably regard an international organisation as a potential source of money, goods or contacts that are otherwise unavailable'[121] Interviews with actors across the health sector reveal the strong pressure on them to support their own dependents, including their extended families, communities, employees and clients within their patronage networks.[122] However, it is important to recognise that these expectations extend to 'western' actors who settle in Malawi[123], some of whom are married to Malawians and incorporated into their patronage networks, as some of these actors reflect.[124]

Corruption is a feature of patronage distribution and throughout the health sector has implications for infrastructure, drug procurement and service delivery. As a representative of the Anti-Corruption Bureau (ACB) explains:

> [Where] money is siphoned off it means there isn't enough money to deliver enough infrastructure but also the money that is available to build the infrastructure sometimes in the end the infrastructure is not up to the standard because government officials that are meant to insure the standards have been paid off and low quality is delivered [and]… at an even higher cost.[125]

In this resource-scarce context, medical resources are particularly amenable to fraud because of the demand in a context of shortages. One representative of the ACB points to the Drug Leakage Survey and how 'the procurement process is marred by issues of corruption'.[126] Whilst another reflects upon the broader phenomenon: 'If I go to the hospital and I am prescribed

drugs, for me to access it I have to pay something. I am told the drugs are not available… because they know that the demand for the drugs is higher than the supply'.[127]

Despite the tight corners for health diplomacy, the concept of shadow diplomacy sheds light on the ways in which Malawian actors are resisting and changing what appears to be their structural fate. They are employing their differing situations of dependency as a means for agentic behaviour – leveraging health issues, taking advantage of shifts in the funding landscape (particularly looking to new opportunities from China), strengthening their negotiating position through 'evidence-based diplomacy' and using shadow health systems of patronage to divert resources and opportunities for private gain.

'WESTERN' AND 'AFRICAN' ACTORS IN GLOBAL HEALTH DIPLOMACY

This final section turns to a concluding discussion of what this interrogation of the mechanics of multi-stakeholder diplomacy in Malawi tells us about seemingly 'Western' and 'African' actors in global health diplomacy. It is argued that the conceptualisation of shadow diplomacy complicates our understanding in five ways.

First, shadow diplomacy disrupts the external/internal binary between international donors and African states because, as Harrison argues, donor power is not simply an external force but in more insidious ways they have become 'part of the state'.[128] The analysis here reveals how donors are 'leading from within' the state by embedding their technical advisors within government ministries such that negotiations occur in the shadows within ministries. There is a plethora of diverse actors working within government ministries: transnational African elites and western actors working as consultants and experts in civil servant roles; and, transnational African elites and Malawians working as donor 'eyes on the ground'. Donors are also structuring the very processes of health diplomacy.

Second, and connected to the first point, shadow diplomacy reveals that these are not simply monolithic actors and there are crucial power hierarchies within them; shifting the locus of diplomacy to within donors, the state and other actors. The Government of Malawi is not simply a monolithic 'Malawian' actor. The Ministry of Finance is a key gatekeeper between the various Ministries and the external donors. During the interviews civil servants in the Ministry of Health focused their responses on their efforts to lobby the Ministry of Finance for resources and directed the researcher to key actors in the Ministry to include in the research.[129] For the case of administrative reform in Tanzania and Uganda, Harrison highlights how the ministry of Finance is a 'hegemonic ministry' that regulates budgetary expenditure and is a conduit between the Government and Donors. He notes that 'All bilateral donors negotiate their aid programmes with the Ministry of Finance, many referring to it as the "point of entry" regardless of the nature of the aid programme'.[130] There are also tensions within the donors and some representatives were highly critical of the organisation that they worked for. For example, one respondent (who wanted to be identified as an employee of a major international donor to distance himself from the organisation) criticised the ways in which the Head Office had overruled the work the in-country team had done in developing initiatives and had recalled them to bring their work in line with 'best practice'.[131]

Third, shadow diplomacy is useful for advancing how we understand the complex identities of these Malawian and Western actors who have multi-faceted motivations and divided loyalties. The interviews shed light on the complex history of these actors: many had previously worked for other organisations in the health sector - some of the interviewees in 2014 had been previously interviewed in those former roles with other organisations in 2007. Malawian actors working for international donors juggle their own individual interests, beliefs and commitments.[132] One Technical Advisor reflects on the withdrawal of budget support following Cashgate that 'a lot country representatives working for those organisations are upset

with that decision they have been forced to pull their money out'.[133] For example one Malawian technical advisor had been working with a major international donor for 3 months and was responsible for working with government, participating in the donor grouping meetings and engaging with NGOs on programming and implementing of health programmes in the country with that international donor. She had experience of participating in those meetings for almost 3 years as a representative of another international donor and previously worked for almost 3 years at a consortium of NGOs that included NGOs she is now working with. This complex history means that she has a conflicted sense of her own identity and loyalty, with a strong sense of empathy with the other organisations she is negotiating with.[134]

Fourth, shadow diplomacy also complicates our understanding of African actors because it draws attention to the disciplinary power of neoliberalism in producing rational, responsibilised agents.[135] The interviews and informal discussions revealed how Malawian actors in various ways are balancing their own personal aspirations including for material goods, social mobility and career advancement. Typically, the Malawian elite working in Government have aspirations to work in more lucrative positions for donors or NGOs, undertake university study and to further their careers.[136] Malawian Programme Managers and Technical Advisors working with the major donors typically had lengthy experience in health and were progressing in their career by working with multiple actors including government, FBOs, NGOs and other donors.[137]

Fifth, shadow diplomacy draws attention to the nuances of the agency of these actors despite the power hierarchies. It highlights now Malawian actors are employing their differing situations of dependency as a means for agentic behaviour: leveraging health issues, taking advantage of shifts in the funding landscape, strengthening their negotiating position through 'evidence-based diplomacy' and using shadow health systems of patronage to divert resources and opportunities for private gain. Similarly, the donors and NGOs are not simply 'Western'

actors: the Programme Managers of donors and western NGOs include Malawians, transnational African elites, ex-pats who were Malawian residents and other Westerners who were married to Malawians or intimately connected in other ways to the country due to the long time they had resided there. How these diverse actors understand their roles in health projects and their goals and motivation for participation differs from those understood by donors – as Swidler and Watkins argue with respect to Malawians working on AIDS projects.[138] This understanding is important because it is well-established that donor-local agent relationships tend to be personalized and dynamic.[139] Health systems need to be understood as relational and the fundamental challenges are relationship problems.[140]

CONCLUSIONS

Over the past decade there has been mounting criticism of Western hegemony within the discipline of IR and the marginalisation of non-Western theory.[141] The necessity for re-orientating and redefining IR[142] is brought into stark focus when we consider the realm of global health.[143] As contemporary health crises emerge as issues of 'high politics'[144] they lay bare some of the limitations for understanding and responding to them. The epicentres of these crises lie outside of the West with HIV in Southern Africa, pandemic influenza in South East Asia, Ebola in West Africa and Zika in South America. This highlights the necessity to better understand those regions and actors that are marginalised, particularly the African continent and African actors. As Acharya and Buzan argue, IR theory can be 'enriched with the addition of more voices' and 'periphery perspectives'.[145] So what can we learn about diplomacy from African spaces, actors and forms of diplomacy?

Multi-stakeholder health diplomacy is useful for extending our understanding of the complexity of health diplomacy beyond monolithic state and donor actors to the crucial role of

other actors - including donors, non-governmental organisations (NGOs), private philanthropists and private sector health providers; and the individual technical advisors, programme managers and consultants working within these organisations. It is significant in African contexts such as Malawi where there is acute dependency on resources and health is an important point of leverage to exert influence, which can readily be framed as benevolent. The contribution here is through developing the concept of shadow diplomacy - the informal networks and channels of influence that run parallel to, but are not recognised as part of, formal diplomacy. This is useful for understanding how health is an effective point of leverage giving rise to informal and subversive manifestations of diplomacy in the shadows, not only for external powers, but also African political elites.

Shadow diplomacy enables us to understand some of the nuances of how Western actors strengthen and conceal their continued power through the use rhetoric whilst 'leading from behind', embedding their external technical advisors within government ministries such that diplomacy comes from within and the duplicitous use of diplomacy processes and instruments to extend their control. Furthermore, shadow diplomacy locates Africans as actors in diplomacy: the shadows also benefit African political elites as they leverage their dependency to subvert the global power structures. African political elites develop diverse agentic behaviours that include extraverting health issues, playing off the donors against one another, strengthening their negotiating position through 'evidence based diplomacy' and subverting the health system for private gain. As such, donors aim to impose external agendas on African societies through health assistance and yet, although this leads to change, this is not necessarily in the ways that were intended by the donors.[146]

Shadow diplomacy disrupts the external/internal binary understanding of the relationship between international donors and African states. The locus of diplomacy has shifted from between these actors to negotiations within donors, the state and other actors.

Critically, these are not coherent, monolithic entities but instead comprise of complex individuals with multi-faceted motivations and divided loyalties. These actors may have been produced as rational, responsible individuals but this can have unintended consequences and they exhibit agency despite the structural constraints within which they operate. This highlights the importance of future research into the complex relations between these heterogeneous global health actors.

[1] Ilona Kickbusch and Mihály Kökény. 'Global health diplomacy: five years on.' Bulletin of the WHO, 91(3), 2013:159-159.
[2] See Colin McInnes and Simon Rushton. 'Health for health's sake, winning for God's sake: US Global Health Diplomacy and smart power in Iraq and Afghanistan.' Review of International Studies 40(05), 2014:835-857.
[3] Colin McInnes and Kelley Lee. Global Health and International Relations. (Cambridge: Polity, 2012):1; Kelley Lee and Richard Smith. 'What is 'global health diplomacy'?' Global Health Governance, 5(1), 2011; Kickbusch, Gaudenz Silberschmidt, and Paulo Buss. 'Global health diplomacy.' Bulletin of the WHO, 85(3), 2007:230-232; Kickbusch, Thomas Novotny, Nico Drager et al.. 'Global health diplomacy.' Bulletin of the WHO, 85(12), 2007:971-973; Vincanne Adams, Novotny, and Hannah Leslie. 'Global health diplomacy.' Medical Anthropology, 27(4), 2008:315-323.
[4] Rebecca Katz, Sarah Kornblet, Grace Arnold, Eric Lief and Julie Fischer. 'Defining Health Diplomacy: Changing Demands in the Era of Globalization.' The Milbank Quarterly, 89(3), 2011:503-523.
[5] Kickbusch et al. 'Global health diplomacy: training'; Lee and Smith. 'What is 'global health diplomacy'?'
[6] See William Brown, Sophie Harman, Stephen Hurt, Donna Lee, and Karen Smith. 'Editorial: New directions in international relations and Africa' The Round Table, 98(402), 2009:263–26; Scarlett Cornelissen, Fantu Cheru, and Timothy Shaw, 'Introduction.' in Cornelissen, Cheru, and Shaw (eds.), Africa and International Relations in the Twenty-First Century (Palgrave Macmillan, Basingstoke, 2012).
[7] McInnes and Lee. 'Health, security and foreign policy'. Review of International Studies, 32(01), 2006:5-23; 5. In general see Christopher Clapham. Africa and the International System, (Cambridge University Press, 1996).
[8] See Judith Kaufmann, and Harley Feldbaum. 'Diplomacy and the polio immunization boycott in Northern Nigeria.' Health Affairs 28(4), 2009: 1091-1101; Simon Rushton. 'Health and Peacebuilding: Resuscitating the Failed State in Sierra Leone', International Relations, 19(4), 2005:441-456, 450.
[9] Jeremy Youde. 'China's health diplomacy in Africa.' China: An International Journal 8(1), 2010:151-163. Gordon Shen and Victoria Fan. 'China's provincial diplomacy to Africa'. Contemporary Politics, 20(2), 2014:182-208.
[10] Amitav Acharya and Barry Buzan. 'Why is there no non-Western international relations theory?' International Relations of the Asia-Pacific, 7(3), 2007:287-312.
[11] Carl Death. 'Introduction: Africa's International Relations.' African Affairs, [adv041] 2015:1-6.
[12] Harman and William Brown. 'In from the margins? The changing place of Africa in International Relations.' International Affairs, 89(1), 2013: 69-87.
[13] Amy Barnes, Garrett Brown and Harman. Global Politics of Health Reform in Africa, (Basingstoke: Palgrave Macmillan, 2015); Emma-Louise Anderson and Amy Patterson. Dependent Agency in the Global Health Regime: Local response to donor AIDS efforts, (Basingstoke: Palgrave MacMillan, 2016); Anderson and Patterson. 'Instrumentalizing AIDS Empowerment Discourses in Malawi and Zambia: An Actor-Oriented View of Donor Politics', International Affairs, 93(5), 2017: 1185–1204; Patterson. Africa and Global Health Governance: Domestic Politics and International Structures, (Routledge, 2017)

[14] Jeremy Youde. 'The Development of a Counter-Epistemic Community.' International Relations, 19(4) 2005: 421-439; Garrett Brown. 'Norm diffusion and health system strengthening.' Review of International Studies, 40(5), 2014: 877-896. In general see Alexander Beresford. 'A responsibility to protect Africa from the West: South Africa and the NATO intervention in Libya.' International Politics, 52(3), 2015:288-304; Carl Death. 'Leading by Example: South African foreign policy and global environmental politics', International Relations, 25(4), 2011:455-478.
[15] Death, 'Introduction', 1-2. See also Harman and Brown. 'In from the margins?'; William Brown. 'A question of agency: Africa in international politics.' Third World Quarterly, 33(10), 2012: 1889-1908; Patrick Chabal and Jean-Pascal Daloz. Africa Works, (Indiana University Press, 1999): 142.
[16] Michael Patton. Qualitative Research and Evaluation Methods, (Thousand Oaks: Sage, 2002); Robert Yin. Case Study Research, (Thousand Oaks: Sage, 1994)
[17] Clinton Health Access Initiative (CHAI). 'Case Study: Improving efficiency and effectiveness of HIV spending through resource mapping in Malawi'. December 2014. http://www.clintonhealthaccess.org/content/uploads/2015/08/Case-Study_HF-Resource-Mapping.pdf
[18] Valerie Hudson. 'Foreign Policy Analysis.' Foreign Policy Analysis 1(1), 2005: 1-30; Norman Long. Development Sociology: Actor-oriented perspectives (New York: Routledge, 2001), 6
[19] Reno, William. Corruption and State Politics in Sierra Leone. (Cambridge: Cambridge University Press, 1995), 4.
[20] Charles Good. 'Pioneer medical missions in colonial Africa.' Social Science and Medicine 32(1), 1991:1-10.
[21] Elias E. Ngalande Banda and Henry PM Simukonda.'The public/private mix in the health care system in Malawi.' Health Policy and Planning 9(1), 1994: 63-71.
[22] See Wycliffe Chilowa and Ephraim Chirwa. 'The Impact of SAPs on Social and Human Development in Malawi', in Chilowa (ed.) Bwalo: Forum for Sustainable Social and Human Development in Malawi: Towards Poverty Alleviation, 1, 1997:39–68; Uma Lele. 'Structural Adjustment, Agricultural Development and the Poor', World Development, 18(9), 1990:1207–19; Banda and Simukonda. 'The public/private mix in the health care system in Malawi.'
[23] Chilowa. 'The impact of agricultural liberalisation on food security in Malawi.' Food Policy 23(6), 1998:553-569.
[24] Economist. 'A Hopeful Continent'. March 2, 2013; Jean-Michel Severino and Olivier Ray. Africa's Moment (Cambridge: Polity Press, 2011).
[25] World Bank. 2015. Malawi. http://data.worldbank.org/country/malawi.
[26] African Development Bank. 2014. African Economic Outlook (AEO). http://www.africaneconomicoutlook.org/en.
[27] Interview, Technical Advisor - Major International Donor, Lilongwe, June 26, 2014; International Business Times, November 19, 2013; Moser 2005, 580–4.
[28] CHAI, 'Case Study'.
[29] Interview, Civil Servant - MoH, Lilongwe, June 28, 2014
[30] PEPFAR. 2014. Partnering to Achieve Epidemic Control in Malawi. http://www.pepfar.gov/documents/organization/199568.pdf
[31] Interview, Civil Servant - MoH, June 28, Lilongwe, 2014; MoH and ICF International. Malawi Service Provision (SPA) Assessment 2013-14 MoH, Lilongwe, Malawi and ICF International Rockville, Maryland USA November 2014, xxi https://www.dhsprogram.com/pubs/pdf/SPA20/SPA20[Oct-7-2015].pdf
[32] Kim Yi Dionne, Patrick Gerland and Susan Watkins. 'AIDS exceptionalism', AIDS Behaviour, 17(3), 2013:825-831; Dionne. 'Local demand for a global intervention: Policy priorities in the time of AIDS.' World Development, 40(12), 2012:2468-2477.
[33] Interview, Programme Manager - Malawian NGO, Lilongwe, June 14, 2014; Interview, Programme Manager - Major International Donor, Lilongwe, June 26, 2014.
[34] Caroline Moser. 'Has gender mainstreaming failed?' International Feminist Journal of Politics, 7(4), 2005:576-590, 580-4; See Anderson. Gender, HIV and Risk: Navigating structural violence, (Palgrave MacMillan, Basingstoke, 2015): 125-130.
[35] CHAI, 'Case Study'. On Development assistance more generally see Blessings Chinsinga. 'District Assemblies in a Fix'. Africa Development, XXXII(1), 2007:89–111.
[36] Watkins and Swidler. 'Working Misunderstandings'. Population and Development Review 38(Supplement), 2013:197-208, 199
[37] Office of the Inspector General, Audit of the Global Fund Grants to Malawi, 3 August 2012:1-2. See also Anderson and Patterson, Dependent Agency, 47.
[38] Interview, Technical Assistant – Major International Donor working with the MoH, July 9, 2014
[39] Interview, Technical Assistant – Major International Donor working with the MoH, July 9, 2014.
[40] Interview, Programme Manager – Major International Donor, June 26, 2014
[41] Interview, Civil Servant MoH, Lilongwe, June 26, 2014

[42] Interview, Technical Assistant – Major International Donor, Lilongwe, June 26, 2014.
[43] Interview, Programme Manager - Major International Donor, June 26, Lilongwe, 2014.
[44] Participant observation, HIV Technical Working Group Meeting, June, Lilongwe 2014.
[45] On the case in general see Sophie Harman and David Williams. 'International development in transition.' International Affairs 90(4), 2014:925-941. On Malawi see Anderson and Patterson, Dependent Agency, 9-10.
[46] Gill Walt, Louisiana Lush and Jessica Ogden. 'International Organizations in Transfer of Infectious Diseases', Governance, 17(2). 2004: 189-210
[47] WHO. 'Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach'. Geneva, Switzerland: WHO Department of HIV/AIDS; 2010. Revision. http://www.ncbi.nlm.nih.gov/pubmed/23741771
[48] Cluster of differentiation 4 - which indicates how well the immune system is working and is the strongest predictor of HIV progression
[49] Malawi MoH. 'Malawi's Revised Policy for PMTCT and ART'. Lilongwe, Malawi, 2010. WHO. 'Programmatic Update: Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants'. Geneva: WHO, 2012; WHO. 'Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection'. Geneva: WHO, 2013.
[50] Management Sciences for Health (MSH). 'Option B+ in Malawi'. August 28, 2012. https://www.msh.org/news-events/stories/option-b-in-malawi-the-origins-and-implementation-of-a-global-health-innovation; WHO Regional Office for Africa. 'Implementation of Option B+ for Prevention of Mother-To-Child Transmission of HIV'. WHO: Brazzaville, 2014, xi,5,27; Mary Kieffer, Megan Mattingly, Anja Giphart et al. 'Lessons Learned From Early Implementation of Option B+'. Journal of Acquired Immune Deficiency Syndromes (1999). 2014;67(Suppl 4):S188-S194.
[51] WHO Regional Office for Africa, 'Implementation of Option B+.
[52] Jon Harald Sande Lie. 'Developmentality: indirect governance in the World Bank–Uganda partnership.' Third World Quarterly 36(4), 2015: 723-740; Rita Abrahamsen. 'The power of partnerships in global governance', Third World Quarterly 25(8), 2004: 1453-1467; Gordon Crawford. 'Partnership or power?.' Third World Quarterly 24(1), 2003: 139-159; Graham Harrison. 'Post-Conditionality Politics and Administrative Reform: Reflections on the Cases of Uganda and Tanzania', Development and Change 32(4), 2001: 657-679.
[53] Informal Discussions, representatives - Major International Donors and International NGOs, Lilongwe, June-July, 2014. Interview, Head - Major western service provider, July 3, 2014; Interview, Programme Manager – Major International Donor, Lilongwe, July 10, 2014.
[54] PEPFAR Scientific Advisory Board. 'Recommendations for the Office of the US Global AIDS Coordinator', Washington, 2011. http://www.pepfar.gov/documents/organization/177126.pdf. Similarly in work on performance-based financing (PBF), Barnes, Brown and Harman argue that donors were keen to present this initiative as originating in sub-Saharan Africa and proliferating through 'south-south learning' and yet it 'exemplifies the production and reproduction of knowledge that fits with donor priorities and objectives'. Barnes et al., Global Politics of Health Reform.
[55] Lie, 'Developmentality'.
[56] National AIDS Commission (NAC), 'National Strategic Plan for HIV and AIDS 2015-2020', NAC: Malawi, 3
[57] Participant Observation, National HIV Prevention Symposium: Reinvigorating HIV prevention in Malawi, Bingu International Conference Centre, Lilongwe, 30 June - 2 July 2014
[58] Informal Discussion, Programme Manager – Major International Donor, Lilongwe, July 2, 2014.
[59] Crawford. 'Partnership or power'. See also Alan Fowler, 'Introduction - Beyond partnership: getting real about NGO relationships in the aid system.' *IDS 'bulletin* 31(3) 2000: 1-13.
[60] Interviews, Programme Manager – Major International Donor, June 26, 2014; Interview, Technical Advisor – Major International Donor working in the MoH, Lilongwe, June 26, 2014; Interview, Technical Assistant – Major International Donor working in the MoF, June 27, 2014; Interview, Programme Manager – Major International Donor, July 4, 2014; Interview, Programme Manager – Major International Donor, July 9, 2014
[61] Interview, Technical Advisor – Major International Donor working in the MoH, Lilongwe, June 26, 2014
[62] Interview, Technical Advisor – Major International Donor working in the MoH, Lilongwe, June 26, 2014
[63] On administrative reform in Uganda and Tanzania see Harrison, 'Post-Conditionality Politics and Administrative Reform'.
[64] Interview, Technical Advisor – Major International Donor, Lilongwe, July 26, 2007.
[65] Interview, Head – NGO, Lilongwe, July 11, 2007.
[66] Cindy Carlson, Monique Boivin, Arnold Chirwa, et al. 'Malawi Health SWAp Mid-Term Review', NORAD Collected Reviews 22, 26 January 2008, 9-10 https://www.norad.no/globalassets/import-2162015-80434-am/www.norad.no-ny/filarkiv/vedlegg-til-publikasjoner/malawi-health-swap-mid-term-review---summary-report.pdf

[67] Mark Pearson. Impact Evaluation of the Sector Wide Approach Malawi, DfID Malawi, 22 June 2010; Interview, Technical Advisor – Major International Donor, Lilongwe, July 26 , 2007
[68] Carlson et al. 'Malawi Health SWAp Mid-Term Review', 10
[69] Harrison, 'Post-Conditionality Politics and Administrative Reform', 668
[70] Lie, 'Developmentality'.
[71] Abrahamsen, 'The power of partnerships in global governance', 1464
[72] Including the Paris Declaration on AID Effectiveness (2005) and the World Bank's adoption of the Comprehensive Development Framework (1999).
[73] Harrison, 'Post-Conditionality Politics and Administrative Reform'
[74] Abrahamsen, 'The power of partnerships in global governance', 1464
[75] Swidler, 'Syncretism and subversion', 271-2
[76] John Lonsdale. 'Agency in Tight Corners: Narrative and Initiative in African History'. Journal of African Cultural Studies 13 (1), 2000:5-16.
[77] Frederick Cooper. 'What is the concept of globalization good for? An African historian's perspective.' African affairs 100.399 (2001): 189-213, 190. See also Anderson and Patterson, Dependent Agency.
[78] Jean-François Bayart. (Trans. Stephen Ellis) 'Africa in the world: a history of extraversion.' African Affairs 99(395), 2000): 217-267.
[79] Bayart, 'Africa in the world'.
[80] Interview, Civil Servants - MoH, Lilongwe, June 26-28, 2014.
[81] Anderson and Beresford. 'Infectious Injustice: The political foundations of the Ebola crisis in Sierra Leone', Third World Quarterly, 37(3), 2016:468-486.
[82] Interview, Technical Advisor – Private Sector Organisation working with the MoH, Lilongwe, July 9, 2014.
[83] Swidler, 'Syncretism and subversion' 283
[84] Anderson and Patterson, Dependent Agency, 9-10.
[85] Brown, 'A question of agency'.
[86] Ian Taylor. *China's New Role in Africa*. (Boulder: Lynne Rienner Publishers, 2009).
[87] Interview, Civil Servant - MoH, Lilongwe, June 28, 2014. More recently see Embassy of the People's Republic of China, 'Remarks by H.E. Ambassador Shi-Ting Wang at the Handover Ceremony of Medical Equipment', MoH, Lilongwe, 2 August, 2016
http://mw.china-embassy.org/eng/sghdhzxx/t1395057.htm
[88] Interview, Civil Servant - MoH, Lilongwe, June 28, 2014.
[89] 'China, Malawi unveil new chapter in bilateral ties', Window of China, 25 March, 2008. http://news.xinhuanet.com/english/2008-03/25/content_7858327.htm. 'Bingu goes China to save Malawi economy', Nyasa Times, Lilongwe, 7 November, 2011. http://www.nyasatimes.com/bingu-goes-china-to-save-malawi-economy/.
[90] 'Mutharika Tells West Russia China Will Be Malawi's New Friends', Nyasa Times, Lilongwe, 2 June 2014. http://www.nyasatimes.com/2014/06/02/mutharika-tells-west-russia-china-will-be-malawis-new-friends/.
[91] Interview, Civil Servant - MoF, Lilongwe, June 30, 2014.
[92] Peilong Liu, et al. 'China's distinctive engagement in global health.' The Lancet 384.9945 (2014): 793-804; Drew Thompson. *China's soft power in Africa: From the' Beijing Consensus' to health diplomacy*. China Brief V(21), 2005: 2-3
http://s3.amazonaws.com/academia.edu.documents/31333038/cb_005_021.pdf?AWSAccessKeyId=AKIAJ56TQJRTWSMTNPEA&Expires=1470408415&Signature=GsRJpQj%2FdEj6McrlBLQlwuiOb%2B8%3D&response-content-disposition=inline%3B%20filename%3DSudan_Chinas_Outpost_in_Africa.pdf
[93] Interview, Civil Servant - MoH, Lilongwe, June 28, 2014
[94] Interview, Civil Servant - MoH, Lilongwe, June 28, 2014.
[95] Interview, Civil Servant - MoF, Lilongwe, June 27, 2014.
[96] Kingsley Edney, "Soft Power and the Chinese Propaganda System', Journal of Contemporary China, 21(78), 2012:899-914; Edney, The Globalization of Chinese Propaganda, (New York: Palgrave Macmillan, 2014).
[97] Richard Rottenburg, Sally E. Merry, Sung-Joon Park, and Johanna Mugler, eds. The World of Indicators: The making of governmental knowledge through quantification, (Cambridge University Press, 2015), 1,4.
[98] Interview, Technical Advisor – Private Sector Organisation working with the MoH, Lilongwe, July 9, 2014.
[99] Interview, Civil Servant - MoH, Lilongwe, June 28, 2014.
[100] CHAI, 'Case Study'.
[101] Interview, Civil Servant – MoF, Lilongwe, July 1, 2014.
[102] CHAI, 'Case Study'.
[103] Interview, Independent Consultant – working with Major International Donor, MoH and Major Service Provider, Lilongwe, June 29, 2014.

[104] Boli, John and George M. Thomas, 'The world polity under construction: A century of internatuional non-governmental organizing', American Sociology Review, 48, (1983): 171-90. Swidler, 'Syncretism and subversion', 273
[105] Interview, Technical Advisor – Private Sector Organisation working with the MoH, Lilongwe, July 9, 2014.
[106] Katerini Storeng, and Dominique Béhague. "'Playing the Numbers Game": Evidence-based Advocacy and the Technocratic Narrowing of the Safe Motherhood Initiative." Medical Anthropology Quarterly 28(2), 2014: 260-279.
[107] Participant Observation, National HIV Prevention Symposium, Lilongwe, 30 June - 2 July 2014
[108] Participant observation, stakeholder meeting, 9 July 2014.
[109] Participant Observatifauthon, National HIV Prevention Symposium, Lilongwe, 30 June - 2 July 2014; Informal discussion, WLHIV representative, 2 July 2014.
[110] Anderson and Patterson, Dependent Agency, 10-11, 55-61.
[111] Swidler, 'Syncretism and subversion', 279-80
[112] Harrison, Post-conditionality politics and administrative reform, 661
[113] See also Harrison, 'Post-conditionality politics and administrative reform', 661
[114] Stephen Ellis. Season of Rains: Africa in the World. (University of Chicago Press, 2011): 6, 33
[115] Swidler, 'Syncretism and subversion', 277; Anderson and Patterson, Dependent Agency; Peiffer and Englebert 2012
[116] On the 'shadow state' see Reno, Corruption and State Politics in Sierra Leone, 4. On 'shadow health systems' in Sierra Leone refer to Anderson and Beresford, 'Infectious Injustice'.
[117] Bayart. The State in Africa, (Polity Press, Cambridge, 2009 2nd edn, [1993]). See also Victor Le Vine, Politics in Francophone Africa, (Lynne Rienner, Boulder, CO, 2004): 306
[118] Alexander Beresford. 'Power, patronage, and gatekeeper politics in South Africa.' African Affairs 114(455), 2015: 226-248, 229
[119] See Peter VonDoepp. 'The kingdom beyond Zasintha', in K.M Phiri and K.R. Ross (eds.), Democratization in Malawi (Blantyre: CLAIM, 1998), 107; Lewis Dzimbiri. 'Competitive politics and chameleon-like leaders', in Phiri and Ross, Democratization, 88
[120] Hudson Mphande. 'Malawi NAC-gate scandal: Concerned HIV counsellors writes Global Fund', Nyasa Times, December 4, 2014. http://www.nyasatimes.com/malawi-nac-gate-scandal-concerned-hiv-counsellors-writes-global-fund/#sthash.pJOUwL8J.dpuf
[121] Swidler, 'Syncretism and subversion';
[122] See also Amy S. Patterson, 'Training professionals and eroding relationships: donors, aids care and development in urban Zambia', Journal of International Development 28(6) 2016, 827–44.
[123] On this phenomenon in Nigeria see Daniel Jordan Smith. A culture of corruption: Everyday deception and popular discontent in Nigeria. (Princeton University Press, 2010).
[124] Interview, Head - Major western service provider, Lilongwe, July 3, 2014
[125] Interview, Principle Corruption Prevention Officer – ACB, Lilongwe, June 30, 2014
[126] Interview, Senior Corruption Prevention Officer – ACB, Lilongwe, June 30, 2014
[127] Interview, Principle Corruption Prevention Officer – ACB, Lilongwe, June 30, 2014
[128] Harrison, 'Post-Conditionality Politics and Administrative Reform', 669.
[129] Interview, Civil Servant - MoH, Lilongwe, June 27, 2014; Interview, Civil Servant working in the MoH, Lilongwe, June 3, 2014; Interview, Technical Advisor to the MoH, Lilongwe, June 26, 2014
[130] Harrison, 'Post-conditionality politics and administrative reform', 664-5.
[131] Interview, Employee - Major International Donor, Lilongwe, July 07, 2014
[132] Interview, Programme Manager - Major International Donor, Lilongwe, June 6, 2014; Interview, Programme Manager - Major International Donor, Lilongwe, July 4/, 2014; Interview, Health Advisor -Major International Donor, Lilongwe, July 7, 2014; Interview, Programme Manager- Major International Donor, Lilongwe, July 9, 2014; Interview, Programme Manager - Major International Donor, Lilongwe, July 10, 2014; Interview, Programme Manager - Major International Donor, Lilongwe, July 10, 2014; Interview, Programme Manager - Major International Donor, Lilongwe, July 10, 2014.
[133] Technical Advisor, Major International Donor, Lilongwe, July 2014.
[134] Technical Advisor, Major International Donor, Lilongwe, July 2014.
[135] Abrahamsen, 'The power of partnerships in global governance'
[136] Interview, Civil Servant - MoH, Lilongwe, June 27, 2014; Interview, Civil Servant - MoF, Lilongwe, June 30, 2014; Interview, Civil Servant working in the MoF, Lilongwe, July 1, 2014; Interview, Civil Servant working in the MoH, Lilongwe, June 3, 2014; Interview, Technical Advisor to the MoH, Lilongwe, June 26, 2014.
[137] Interview, Health Advisor - Major International Donor, Lilongwe, July 7, 2014; Interview, Programme Manager - UN Organisation, Lilongwe, July 1, 2014.

[138] Watkins and Swidler, 'Working Misunderstandings'. Dionne explores how health and development priorities differ between global health programs and local citizens, arguing that local leaders negotiate differences in global and local priorities to be responsive to constituents. Kim Yi Dionne. 'Seeing like a village: Village Headmen and AIDS intervention' *** REQUEST PERMISSION TO CITE ***

[139] Monika Krause. The Good Project: Humanitarian Relief NGOs and the Fragmentation of Reason'. (Chicago: University of Chicago Press, 2014).

[140] Julio Frenk. 'The global health system: strengthening national health systems as the next step for global progress', PLoS Med 7(1), 2010: e1000089; Lucy Gilson. 'Trust and the development of health care as a social institution', Social Science & Medicine, 56(7), 2003:1453-1468, 1453.

[141] Acharya and Buzan. Why is there no non-western IR theory?'

[142] Ching-Chang Chen. 'The absence of non-western IR theory in Asia reconsidered.' IR of the Asia-Pacific 11.1 (2011): 1-23; Navnita Chadha Behera. 'Re-imagining IR in India' IR of the Asia-Pacific 7(3), 2007:341-368.

[143] McInnes and Lee, Global Health and International Relations, 2

[144] Stefan Elbe. 'The pharmaceuticalisation of security.' Review of International Studies, 40(05), 2014:919-938.

[145] Acharya and Buzan. 'Conclusion: On the possibility of a non-western IR theory in Asia.' IR of the Asia-Pacific 7.3 (2007):427-438.

[146] Swidler, 'Syncretism and subversion', 273