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Candice Moore[1]

[1]University of the Witwatersrand, International Relations Johannesburg, South Africa
(candice.moore@wits.ac.za)

ORCID ID:
orcid.org/0000-0002-0051-8155

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Article

BRICS and Global Health Diplomacy in the Covid-19 Pandemic: Situating BRICS' diplomacy within the prevailing global health governance context

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Abstract

BRICS have been cast as a bloc with the potential to make significant changes in Global Health. The management of the Covid-19 pandemic has shown divisions in the bloc and the limits of its ability to formulate policies or even act upon previously agreed positions. This paper employs an examination of BRICS Health Ministerial declarations and an analysis of power in International Relations to reflect on BRICS' Global Health diplomacy during the Covid-19 pandemic, covering the key questions of vaccine research and development, vaccine nationalism, and travel bans. It finds that multiple dimensions of power matter in Global Health leadership.

Keywords: BRICS; Global Health; Covid-19; Global Governance.

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Introduction

In 2011, the then-Director General of the World Health Organisation (WHO), Margaret Chan, opined that the BRICS were a 'bloc of countries with a … great potential to move global public health in the right direction…towards reducing the current vast gaps in health outcomes and introducing greater fairness in the way the benefits of medical and scientific progress are distributed…' (Chan, cited in Harmer et al., 2013). Great expectation accompanied the BRICS for much of the last decade, and the COVID-19 pandemic seemed the perfect opportunity for the proving of 'emerging' power[1] because it appeared to present

[1] 'Emerging power' is a label given to a group of countries in the early 2000s to indicate their increased presence in the global economy, and increased influence in multilateral decision-making. They included: India, China, Brazil, South Africa, amongst others.

an opportunity for new powers to show leadership and initiative, not only in material terms, but to understand Chan's statement above, also, as importantly, in ideational terms.

The spread and impact of the virus has taken an enormous toll on the global economy, on individual national economies, and also on global governance- areas in which the emerging powers have made strides over the last two decades. Everything we know about emerging powers – their preferences for South-South cooperation, desire to promote multilateralism and pro-development outcomes (see Moore, 2011) – many of them positive attributes, in literature developed over the past 20 years, has, however, been called into question by the manner in which some of these powers have demonstrated muted leadership during the pandemic.

It is important to measure this seemingly harsh judgement against reality: what is the current Global Health context within which emerging powers, such as the BRICS, must operate? What is their own track record, in terms of commitments and promises made? Can it be said with certainty that economic growth in the BRICS over the past three decades for some (China) and the past two decades for others (India and Brazil) has led to the alleviation of health risks on a large scale in these countries? Sadly, this is not the case, and greater wealth has actually led, on balance, to greater inequality and inequitable access to healthcare for many (Kickbusch, 2014). In addition the developing contexts of emerging powers become more significant when it is considered that the resounding message from various quarters over the last decade is that Global Health inequality will not be resolved in the health sector alone, but will depend on improvements in human development across the board (a raft of global agreements and regional initiatives has supported the idea of 'Social Determinants of Health' or SDH, see Donkin et al, 2018).

Leading health civil servants for each of the BRICS states prematurely claimed in 2014 that "(a)t the global level, [the BRICS] offer a solid, distinctive voice and perspective on Global Health" (da Silva Junior et al., 2014). This is far from established, and in fact may have been more of a wish than reality at that stage. The common experience of declining health outcomes (relative to economic growth and population growth) over the last two decades notwithstanding, there remains, unsurprisingly, very little reason why we should look at BRICS as a collective in Global Health. "The BRICS countries vary greatly in terms of their burdens of disease, health systems, interests in the global pharmaceutical trade, engagement in the international arena and much else" (McKee et al., 2014). Yet, Covid revealed gaps in Global Health governance that presented opportunities for leadership, and the World Health Organisation, an institution already buckling under pressure before the Covid pandemic, is now struggling to find its way (Lee and Piper, 2020). As this article reveals, the extent to which leadership may come from BRICS should not be overestimated, however. With this backdrop in mind, the research question this paper addresses is: *why were the BRICS unable, or unwilling, to assume a leadership role as a collective at the height of the global Covid pandemic in 2020-2021?*Answering this question will lead to clearer insights as to what may be expected in Global Health from the BRICS collective going forward.

The first section of the article introduces some key aspects of the Global Health landscape and the role of the BRICS to date, as well as the methodology to be employed in the analysis. The second section looks at the experiences and performance of each BRICS nation during the pandemic. The third section deploys Barnett and Duvall's (2005) 4-way typology of power to answer the research question, by focusing on the areas of vaccine research and development, vaccine nationalism and travel bans. The final section concludes.

The Global Health Landscape and the BRICS

The Global Health landscape

A multi-actor Global Health structure emerged after the end of the Cold War and collective BRICS health initiatives, along with the increasing influence of non-state actors, are further evidence of this. The first BRICS Health Ministers meeting[2] took place in Beijing in 2011. The following year's leaders' Summit issued the directive for the institutionalisation of the health ministers' meetings. The 2012 Delhi Declaration (Brics Information Centre, 2012) declares that henceforth Health Ministers' Meetings would become part of the annual system of meetings around the Summit, along with the meetings of Ministers of Foreign Affairs, National Security Advisors, Finance Ministers and Trade Ministers. This was to "address common challenges in the most cost-effective, equitable and sustainable manner". Among these common challenges were listed: universal access to health services; access to health technologies, including medicines; increasing costs, and the growing burden of both communicable and non-communicable diseases (Brics Information Centre, 2012). In the Beijing Declaration (Brics Information Centre, 2011), Health Ministers committed to 'initiate, champion and support a raft of Global Health measures' (Harmer et al., 2013)[3]. These included:

- Affirming the central and leading role of the WHO
- The iteration of strong views on areas of reform for the WHO (including in the areas of transparency, strategic decision making and financing)
- The identification of shared public health challenges, including inequitable access to health services and medicines, growing health costs, infectious diseases like TB and HIV, and also growing rates of non-communicable diseases.

[2] Methodologically, the article utilizes the communiqués of the Health Ministerials to obtain detail on BRICS' global health agenda. The Summit declarations are scant on detail and the Health Ministerials are sanctioned by the Summit. Their work also feeds into the final Summit Declarations, but detail is omitted.

[3] McBride et al (2019) note that with regard to the SDG3 targets, there was overlap in the focus of BRICS, G7 and G20 in their focus on emergency preparedness and universal health coverage, but divergence in the areas of environmental pollution, mental health and maternal and child health.

- Priority areas were also identified. These included collaboration:
    - To strengthen health systems and overcome barriers to access
    - For transfer of technology
    - To increase access to safe medicines.

Importantly, the bloc underscored its commitment to Universal Health Coverage, a concept that was introduced to the Global Health discourse by the WHO in 2005, but with which some, like Brazil, already had some experience (McBride, 2019). The bloc also determined to keep the WHO out of issues related to Intellectual Property Rights enforcement (Brics Information Centre, 2011). In addition, BRICS Ministers have always made explicit their belief in the 'interdependence between public health and socio-economic development' and reiterated the 'impact of foreign policy on health outcomes'. BRICS Health Ministers met on the margins of the 70th World Health Assembly in 2017 to "share experiences and innovations on people-centred reforms as a cornerstone to making progress towards universal health coverage" (World Health Organization, 2017).

The Health Ministers agreed to "discuss and coordinate positions on issues of common interest as well as to identify areas for cooperation in public health" (Brics Information Centre, 2011). Observers have noted already, however, how BRICS have missed an enormous opportunity for funding and collaboration: BRICS countries account for nearly 50% of global TB cases, and yet the grouping has not reached the levels of collaboration that would be expected. Observers note that while BRICS have established a TB Research Network and are working on a genomic-surveillance network "funding and collaboration could be at much higher levels" ("'BRICS' nations are collaborating on science but need a bigger global platform.", 2021).

The BRICS Health portfolio was born at a significant time in Global Health, around the same time as the launch of the WHO reform process in 2011 (focusing on the organisation's financing model and core mission) and just before the holding of the World Conference on the Social Determinants of Health in Rio de Janeiro in October 2011. Brazil's prominence in this focus on health, as well as the BRICS' profiles as middle-income developing countries, created something of an expectation that this would be an issue around which the BRICS collective would coalesce. Again Brazil's influence was felt in the inspiration drawn from the Fortaleza BRICS Summit Declaration, which highlighted social inclusion and sustainable development, on the eve of the expiration of the 2015 Millennium Development Goals. Amounting to a Global Health agenda, some of the key themes that have emerged repeatedly in BRICS Health Ministers' Declarations over the last 11 years include:

- Affirmations of political will to achieve Universal Health Coverage (UHC)
- Highlighting the interdependence between public health and socio-economic development
- Reiterating the impact of foreign policy on health outcomes

- Reiterating their commitment to use TRIPS flexibilities to promote access to medicines, and share experiences with other developing countries
- Reiterating their support for the International Health Regulations (IHR) (2005)[4].

BRICS' prospects for leadership in Global Health should also be seen against the backdrop of their limited agency as a collective within the WHO. This position is made clear by how much influence they hold individually and collectively within the institution, seen primarily through the prism of funding. The WHO's funding comes from two main sources, namely: assessed contributions of member states, and voluntary contributions from Member States and other Global Health partners, such as other UN Organisations, intergovernmental organisations, philanthropic organisations and the private sector (World Health Organization, 2022). Assessed contributions are based upon a country's wealth and population. As such, in 2019, only the US (USD 59 227 935) and Japan (USD 23 156 735) were invoiced more than China (USD 18 948 900) in assessed contributions. The other BRICS hardly feature in this funding equation with the following contributions: Brazil (USD 9 145 765), Russian Federation (USD 7 387 515), India (USD 1 763 035) and South Africa (USD 870 755) (WHO, 2021). Therefore BRICS as a collective enjoy limited influence in the WHO. China on its own, on the other hand, is gradually expanding its influence in the organisation. Experts point out that while China's assessed contributions are the largest in the organisation, these only constitute a small fraction of the budget of the WHO and traditional donors like the US, the UK and the European Commission are still in the lead (Mazumdaru, 2020), along with non-government donors. China's influence also stems from the withdrawal of the traditional powers (like the US, UK and France) from leadership in the handling of the Covid crisis, and the sheer size of China's population. The success of any WHO Global Health initiatives are seen to hinge on Chinese cooperation and participation (Youde, 2021), therefore world health leaders are keen to keep China on-side with any Global Health plans and their implementation.

A brief literature review of BRICS in Global Health

BRICS and the grouping's activities in Global Health have received scant attention in the literature, especially the International Relations literature. A systematic review of the literature was conducted by Harmer et al. (2013). It sought to examine what influence, if any, BRICS exerted on Global Health. It found that overwhelmingly, the tendency in the literature was to describe individual BRICS' impact on Global Health. By the time of their writing, only one article in their sample of 71 journal articles and 23 reports conducted a sustained analysis of BRICS' collective influence. This influence, where studied, was predominantly framed in terms of BRICS' material capabilities and very rarely in terms of ideational impact, with most of

[4] Of the IHR (2005) the WHO website says "The goal of country implementation is to limit the spread of health risks to neighbouring countries and to prevent unwarranted travel and trade restrictions" (WHO online 2022).

those that did focusing on Brazil, with its constitutional emphasis on health access as a human right. There appears to be tepid agreement that the BRICS are willing to assume leadership in Global Health, while at the same time there is an acknowledgement that they wish to be seen as partners and not donors (Kirton et al., 2014; Acharya et al., 2014 find in favour of leadership).

The literature also reveals a divide between those who see a paradigm shift resulting from the BRICS' role in Global Health (Gold et al., 2012) and those who are more circumspect, seeing hints of change that still require institutional backing and the deployment of material capabilities in order to bear fruit (Harmer and Buse, 2014). A third area of focus in the literature is the specifics of BRICS leadership (i.e. the areas on which the BRICS lead). They include Universal Health Coverage (Tediosi et al., 2016, Marten et al., 2014) and non-communicable diseases (NCDs) (Burki, 2012). One article compares Global Health agendas during the SDG period of BRICS, G7 and G20 (McBride et al., 2019). There is no treatment of BRICS Global Health diplomacy during the Covid pandemic, though comparative studies of the countries' experiences with Covid abound, and appear mainly in the Global Health literature (See, as a sample, Dash, et al., 2021, and Oliveira et al., 2021).

Methodology

The article utilizes a qualitative approach, by analysing BRICS' behaviour during the Covid pandemic through the analytical prism of 'power', a central concept in International Relations. The article adopts an interpretivist approach by using the analytical concept of 'power' in International Relations to answer the research question *why were the BRICS unable, or unwilling, to assume a leadership role as a collective at the height of the global Covid pandemic in 2020-2021?* The analysis is conducted by examining the communiqués of the BRICS Health Ministerials to ascertain the BRICS' commitments in the arena of Global Health. These commitments are then compared with BRICS's activities in vaccine research and development (R&D); vaccine nationalism and travel bans, all examples drawn from news reports and reports of international governmental organisations (IGOs). These 3 areas are then discussed in terms of Barnett and Duvall's (2005) 4 types of power.

Barnett and Duvall's (2005) framework yields four types of power, namely:

a. Compulsory power, which "exists in the direct control of one actor over the conditions of existence and/or the actions of another";
b. Institutional power, which "exists in actors' indirect control over the conditions of action of socially distant others" (this is not limited to what can be done within institutions; it is a broader form of power, encapsulating rules, agenda-setting, lines of reporting, etc);

c. Structural power, "which operates as the constitutive relations of a direct and specific…kind" and defines what kinds of social beings actors are; and,

d. Productive power, "which works through diffuse constitutive relations to produce the situated social capacities of actors". Not only does this kind of power produce the social capacities of actors, it shapes actors' self-understandings and perceived interests.

BRICS states are analysed as a collective in the examination of their influence on and power within the Global Health system. In order to say something about their outward posture and leadership potential on Covid-19, however, it is necessary to examine their domestic health profiles and responses to the pandemic, to provide a fuller picture. This is dealt with in the section that follows.

BRICS' national health contexts and COVID-pandemic performance

Brazil

Brazil is a country of great income and social (including health) inequalities. The health sector has been transformed by Brazil's democratisation experience: "most recently, health has been raised to the status of a citizen's right" (Modesto et al., n/d). However, Brazil has had a mixed record against the Covid-19 pandemic. Brazil recorded nearly 23,5 million cases by the end of January 2022, at a rate of 110 844 per million people, higher than any other BRICS nation, and higher than the global average (Johns Hopkins University, 2022). Brazil's domestic response was thrown into disarray by ambivalent leadership and mixed messages from the Presidency under Jair Bolsonaro about the seriousness of the virus. Within its region, Brazil was unable to lead within MERCOSUR as the organisation dithered over the spread of the pandemic within its member states (Alden, Dunst, 2021).

Russia[5]

The country has yet to overcome low basic indicators of health and human welfare stemming from the Soviet period, and which accelerated after the Soviet collapse. Life expectancy at birth fell sharply in the 1990s. "The share of deaths induced by infectious diseases, which are traditionally related to living standards, is also high for a country at Russia's level of development, and the incidence of tuberculosis and other "poverty-related illnesses" remains high, although viral hepatitis infection rates have fallen" (Tompson, 2007, 5). High levels of mortality and morbidity in Russia are associated with "environmental degradation, unhealthy diets and high levels of tobacco and

[5] The bulk of this paper, and indeed this section on the public health context of Russia, had been drafted prior to the Russian invasion of Ukraine that commenced on 23 February 2022.

alcohol consumption (particularly among men), high levels of traffic-related fatalities and a sharp rise in murders and suicides" (Tompson, 2007, 6).

According to the Johns Hopkins University figures, Russia, by early January 2022, had registered some 10,7 million cases. Where the world average is 43 454 cases per million, Russia registered some 73 027 per million. Russia has developed a Covid vaccine, Sputnik, which was the first vaccine to be registered in any nation, but the vaccine has been slow to gain traction, for various reasons (Stronski, 2021b).

Russia's COVID pandemic response has been criticised by observers. By October 2021, Russia had the highest COVID-19 mortality rate among countries in Europe and the second-highest in Asia, after India. However, "(g)iven Moscow's lack of transparency, inadequate testing in some parts of the country, and the Kremlin's penchant for manipulating statistics, the real figure could be far greater" (Stronski, 2021a).

India

India's primary health challenges from a social perspective are air pollution (indoor and outdoor), child undernutrition, sanitation, employment conditions and gender inequality (Cowling, et al., 2014). Some recent success stories include the elimination of polio and the containment of HIV/AIDS (Chaudhury, 2014). India has also been a leader in the production and export of generic medicines for the treatment of HIV/AIDS and has been active in the politics around trade and intellectual property in the health arena. India still faces a number of health challenges. These include a shortage of health personnel. In 2019 for example, India had 9,28 medical doctors per 10 000 people. Compare this to Russia with 44.4, China with 19.8, and Brazil with 23,11. Among the BRICS, only South Africa fares worse with 7.92 medical doctors per 10 000 people (World Bank Data, 2019). India also faces a lack of access to care challenge, with villagers having to walk long distances to obtain health services in rural areas. Access to healthcare is also intrinsically linked to wealth, with medical expenses having the potential to impoverish people annually (Chaudhury, 2014).

India has led a spirited regional response to the COVID pandemic through the South Asian Association for Regional Cooperation (SAARC), a dormant institution that had not actually met since 2014 (Alden, Dunst, 2021). SAARC is arguably the best-organised region in terms of regional responses to the Covid pandemic. The group maintains a dashboard of daily Covid infections online (http://www.covid19-sdmc.org/), and leaders have met twice virtually. An emergency fund of more than $18 million has been created, with India pledging $10 million (Alden, Dunst, 2021). In addition, many SAARC members have started to remove tariffs on medical devices and PPE, amongst others.

China

Acclaimed as an economic development miracle after reforms that started at the end of the 1970s, China's reputation for health has been slipping, so much so that while China was an example of

health development in the 1970s, it is no longer. Economic growth, rather than bringing about more equitable outcomes, has actually contributed to concerns about health equity from the public and the government (Shenglan et al, 2008).

There are enormous cross-regional inequities of health status between population groups in China. The 31 provinces exhibit clear discrepancies in life expectancy, correlated with prosperity. For example, in Shanghai, life expectancy was 78 years while it was 65 years in the poorest provinces (Shenglan et al., 2008). The disease burden just over a decade ago was shifting from infectious diseases mainly in children to chronic and degenerative disease in adults.

China was the country in which the SARS-CoV-2 virus was first detected in the latter half of 2019. The country has instituted strict measures in a bid to eradicate the virus. China had recorded just 105 411 cases by mid-January 2022, at a rate of 75 cases per million. It had also succeeded in vaccinating some 86% of its population (Johns Hopkins University). China has engaged in vaccine and PPE diplomacy, donating equipment and funds to some 150 countries. In a further dramatic show of solidarity, President Xi had made a pledge that African countries would be the first beneficiaries of Chinese vaccines (Ministry of Foreign Affairs of People's Republic of China, 2021). China has attempted to follow a policy of virus 'elimination'.

South Africa

South Africa's troubled history has left a large imprint on the country's public health status and burden of disease. "Racial and gender discrimination, the migrant labour system, the destruction of family life, vast income inequalities and extreme violence have all formed part of South Africa's troubled past, and all have inexorably affected health and health services" (Coovadia et al., 2009, 817). Coovadia et al. (2009, 820) argue that South Africa has 4 concurrent epidemics, or a quadruple burden of disease, namely: diseases of poverty, non-communicable diseases, HIV/AIDS, and violence and injury. Since the end of apartheid there has been an exponential increase in access to basic services and a number of progressive government policies in the health sphere have been enacted.

South Africa had recorded 3.5 million infections by mid-January 2022, at a rate of 60,648 per million, higher than the world average and higher than India and China among the BRICS (Johns Hopkins University, 2022). The country has had a poor vaccination rate against Covid with the lowest rate of vaccinations among BRICS countries and well below the world average of 50,4% (27,6% as at 20 January 2022).

South Africa has played a leading role in continental vaccine diplomacy during the COVID pandemic. President Cyril Ramaphosa, in his capacity as AU Covid-19 Champion, accounts to the AU Commission on Africa's response to the pandemic. Ramaphosa was instrumental early on in calling for vaccine equity for the African continent, and securing funds for the mobilisation of testing and vaccine development throughout the continent. The African Vaccination Acquisition

Trust (AVAT) was formed under the leadership of Ramaphosa, and marks the first time that the African Union has collectively purchased vaccines (African Union, 2021).

BRICS, the pandemic and power

In assessing the extent to which any actor in International Relations is able to achieve its aims and objectives, the concept of 'power' is central. The BRICS' impact on international politics has typically been examined in terms of hard power capabilities and their capacity to balance against US hegemony (compulsory power). The Global Health setting provides an opportunity to examine the other aspects of BRICS' power, and the 4-way typology of Barnett and Duvall (2005) provides a useful way of doing this.

Barnett and Duvall (2005) suggest that their typology of power be used in an additive manner to analyse the varieties of technologies of power in international politics. This framework will be utilised here to analyse the workings of BRICS' power in the Global Health system broadly and in relation to the Covid pandemic specifically. For Barnett and Duvall (2005, 42), power is "the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate". Power is inherently social and depends on 2 elements: i) social interactions or the constitution of social actors and ii) the specificity of social relations. Of relevance to the current analysis, Barnett and Duvall (2005, 42) aver that, "Analysis of power in international relations…must include a consideration of how social structures and processes generate differential social capacities for actors to define and pursue their interests and ideals". To what extent BRICS forged their own path (were able to influence other states or exert power) in Global Health during the pandemic will be analysed in terms of three areas in which historic developing country interests came up against the interests of the Global North during the pandemic, namely: vaccine research and development, vaccine nationalism, and travel bans.

Vaccine Research and Development

Vaccine research and development during the early stages of the Covid-19 pandemic was unusual due to the speed of the vaccine research and development processes, as well as the "unprecedented financial investments and scientific collaborations" (WHO, 2021) during the crisis. Developing countries faced difficulties in this regard, in face of WTO Trade-Related aspects of Intellectual Property Rights (TRIPS) that protect innovation in international trade. India and South Africa initiated an application for a TRIPS waiver in October 2020. Proponents of a temporary waiver of TRIPS argued that without this, rich countries would benefit immediately from new treatments on the market, while poorer nations would be left behind. This exercise of institutional power saw WTO regulations controlling the outcomes for distant others – millions infected with COVID-19 worldwide. This scenario highlighted the historical inequities built into the establishment of the

WTO and its reach into Global Health issues through the TRIPS negotiations and subsequent agreements. These decisions were historically fraught with tension and mired in controversy (Hoekman and Kostecki, 2001: 283). BRICS members India and Brazil have always been vocal on the need to separate issues of counterfeit goods, for example, from intellectual property rights more broadly, and held this position during the Uruguay Road negotiations. The two-year struggle to grant the Covid-19 vaccines waiver was finally concluded in June 2022 with a WTO Ministerial Decision on the TRIPS Agreement (World Trade Organisation, 2022).

In spite of a long history of defending WTO TRIPS flexibilities in relation to public health, BRICS were slow to act in unison on securing a TRIPS waiver for IP protections governing Covid-19 medicines and diagnostics. As far back as 2012, the BRICS established a network of technological cooperation to promote access to medical products through the use of WTO Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities. The health ministerial has, in most of its meetings, sought to underline that trade agreements should not undermine the TRIPS flexibilities (Harmer and Buse, 2014). BRICS have long called for the avoidance of TRIPS measures impacting on countries' responses to public health emergencies (Beijing Ministerial 2011, Brasilia Ministerial 2014, Geneva Meeting 2013, Geneva Meeting 2014, Geneva Meeting 2015, Geneva Meeting 2016, Geneva Meeting 2019, Curitiba Ministerial 2019, Virtual Ministerial 2021) but interestingly, there was little overt initial support for South Africa and India when they lodged the application for a waiver on IP protections governing Covid-19 vaccines, diagnostics and therapeutics in October 2020. Lower- to Middle Income Countries (LMICs) and NGOs were their only supporters at this time (DW, 2021). The remaining BRICS came on board six months later, offering their support in May and June 2021, and were joined by APEC. Some other high-income groupings, such as the EU remained sceptical of the waiver application, and counter-proposed with measures that would ensure equitable access to vaccines and treatments, rather than focusing on development and production.

Nonetheless, in spite of these limitations, certain middle-income countries were not only able – but considered it a matter of national pride - to press forward with vaccine development. These countries included China, Turkey and India. Compulsory power is associated with resources. This relates to the capacity of the BRICS countries to provide financial support for vaccine development initiatives. This support originated both from public and private sources in Western states. These resources were simply not available, or available to a much lower extent in other countries. At no point, at the height of the crisis, did BRICS states actually pool resources in order to develop a vaccine, but the BRICS Vaccine Research & Development Centre that was eventually launched in March 2022, after being agreed to by the collective in the 2018 Johannesburg Declaration.

Vaccine Nationalism

'Vaccine nationalism' is the term given to the practice, mainly but not exclusively, conducted by wealthy countries in the first year of the pandemic, 2020, of pre-ordering millions of doses of as yet

untried vaccines in a bid to be first in line for successful vaccines (Kupferschmidt, 2020). BRICS have stated their commitment to "fair and equitable vaccination as a global public good", and to strengthening "BRICS' capacity for public health emergencies" (Embassy of People's Republic of China in the Republic of South Africa, 2022).

BRICS nations were not averse to the practice of vaccine nationalism. As an example of its compulsory power, gained by being in a position to develop and manufacture vaccines, India's Serum Institute assumed a leading role in vaccine production for the developing world, but had to turn back on its commitment to provide 600-700 million doses of the Astra-Zeneca vaccine to Africa through COVAX[6] because of the Delta variant surge in that country starting in early 2021. It may be argued that in doing so, India squandered some symbolic (productive) power for itself and the developing world more broadly, as it stood to make large diplomatic gains from coming to the world's rescue through its vaccine manufacturing yields. But this position was balanced by India's vaccine diplomacy that saw it donate millions of doses to its immediate neighbours and to COVAX, in terms of its commitments.

The absence of any collective BRICS leadership on vaccine nationalism is underscored by the pronouncements that were made by individual BRICS states, such as South Africa. President Cyril Ramaphosa, in an address to the World Economic Forum (WEF) in Davos in January 2021, noted the country's concerns over vaccine nationalism, calling on those who had "hoarded the vaccines to release [them] so that other countries can have them" (Ramaphosa, cited in Omarjee, 2021). Similar concerns were expressed by India's BRICS Sherpa at the 2021 BRICS Civil Forum ("India opposes vaccine nationalism; calls for greater support to joint proposal with S Africa.", 2021).

Travel bans

In response to the outbreak of new strains of the virus, such as Delta around April 2021 and Omicron in November 2021, some governments instituted travel bans against those states perceived to be the locations where these variants originated. There was an outcry from African nations in December 2021, when, in response to the detection of the Omicron variant in South Africa in November 2021, travel bans were instituted against travellers from South Africa, Botswana, Eswatini, Lesotho, Zimbabwe, Mozambique and Namibia. A second group followed not long after: Zambia, Angola, Malawi, Nigeria and Egypt (Fokazi, 2022). These travel bans were lambasted by Southern African states as not scientifically sound, yielding minimal

[6] GAVI is an alliance or partnership between key actors in global health, including the WHO, UNICEF, The World Bank and the Bill and Melinda Gates Foundation (BMGF). It was created in response to the challenge, evident by the late 1990s, that international immunization programmes were stalling, mainly due to the inability of lower-income countries to afford them. BMGF helped to resolve this problem by proposing a solution that would see manufacturers lowering their prices in exchange for "long-term, high-volume and predictable demand from those countries" (GAVI The Vaccine Alliance, 2022). COVAX is the vaccines pillar of the Access to Covid-19 Tools (ACT) Accelerator, and is co-lead by GAVI. COVAX has the role of supporting the research, development and manufacturing of a wide range of Covid 19 vaccine candidates, and negotiating their pricing.

benefit, yet being highly detrimental to their economies – an issue characteristic of classic North-South tensions.

Yet, not only did BRICS as a collective not speak out on the indiscriminate travel bans, they also participated in them. Brazil closed its borders to travellers from Botswana, Eswatini, Lesotho, Namibia, Zimbabwe and even fellow BRICS member, South Africa. China closed its borders to all but citizens and special permit holders. Russia closed its borders to all non-citizens travelling from Botswana, Eswatini, Lesotho, Madagascar, Mozambique, Namibia, South Africa, Tanzania and Zimbabwe. India did not close its borders at all ("Map: tracking global omicron travel restrictions.", 2021).

By the end of 2021, when most other countries had lifted their travel bans on Southern Africa in response to Omicron, the country's BRICS allies Brazil and Russia had failed to do so ("Malaysia just lifted its omicron ban on SA; no word from allies Russia and Brazil.", 2021). Only the UN and WHO among major global actors stood with Africa in condemning the travel restrictions (United Nations, 2021 and World Health Organization, 2022). In the Emergency Meeting under the auspices of the International Health Regulations (2005), the Committee expressed concern about the "reaction of States Parties in implementing blanket travel bans, which are not effective in suppressing international spread (as clearly demonstrated by the Omicron experience), and may discourage transparent and rapid reporting of VOC [variants of Covid]" (World Health Organization, 2022). The countries implementing travel bans, in fact, disregarded the provisions of the International Health Regulations, which are designed to protect trade from international health emergencies - an instance of the failure of institutional power in face of compulsory and productive power.

The travel bans were an instance of productive power, or the "production of subjects through diffuse social relations" (Barnett and Duvall, 2005, 53). In the operations of this sort of power, the social capacities of actors are socially produced. It relies on and is related to systems of knowledge and discursive practice. Without much justification, therefore, it was possible for a whole swathe of states in Africa and elsewhere to be designated 'red' (meaning high risk for Covid transmission) and 'green' through arbitrary decision-making. This could be regarded as a reflection that neither had BRICS succeeded in 'producing' developing countries as worthy partners in Global Health, nor had individual BRICS states succeeded in doing so within the grouping.

Conclusion

Given the clarity and consistency with which BRICS enunciated what may now be termed their 'health agenda' and their health priorities over the decade between 2011, when BRICS Health Ministers first met, and 2021, the second year of the worldwide Covid pandemic, it came to be expected that BRICS would have played a greater role in health diplomacy during the pandemic than it eventually did. BRICS have, for more than a decade, been unequivocal on the need for health

equity, technology transfer, joint research and surveillance, and access to medicines and vaccines. And yet, when an opportunity arose for global leadership, the BRICS as a collective hardly featured.

This reality exposes the weaknesses of the BRICS as a collective, the inadequate institutionalisation of the health ministerials, and the haphazard nature of their collective policymaking. It is also the result of each individual nation's poor performance in face of the COVID pandemic. The BRICS as a collective could hardly be expected to provide leadership when they each managed the pandemic so poorly individually. Only China, with its draconian measures and commitment to 'eradicating' Covid could be said to have a reasonable track record in managing the pandemic, although this position now seems threatening to its economic growth ("China's economy slows as 'zero COVID' drags down sales, industry.", 2022). More broadly, declining health outcomes and growing inequity across the board over the past few years have also eroded BRICS' moral authority as Global Health leaders.

The preceding discussion has shown, through an analysis of power in BRICS Global Health leadership during the Covid pandemic, that BRICS as a collective are as yet unable to "shape the capacities of actors to determine their circumstances and fate" (Barnett and Duvall, 2005, 42) at the highest levels of global health governance. In fact, the quest for a greater presence in vaccine research and development and greater pandemic preparedness, which predates Covid, has taken the best part of a decade to make progress on. BRICS as a collective were divided and silent on the question of travel bans, even while some participated in the bans. An analysis of power thus does not only reflect BRICS' capabilities in Global Health, but also shines a light on the fabric of Global Health leadership. It is an area that requires multidimensional approaches to power.

Looking ahead, BRICS should institutionalise their health cooperation on the key issues of the day, including research and development on vaccines and pandemic preparedness if they wish to play an influential role in Global Health leadership. BRICS should fashion a clear Global Health agenda (establishing global norms around healthcare access and knowledge sharing/intellectual property in health), and prioritise the issues they can work seamlessly on together, rather than remaining divided due to differences on other issues. Most importantly, BRICS have a role in elevating 'social determinants of health' as a lens through which to analyse and address the challenges facing the developing world, which they claim to represent. There is unequivocal evidence that health is not only a problem of the world's health sector: health inequalities will need to be addressed in the areas of trade, finance and security, and indeed require global political solutions (The Lancet, 2014).

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