

## Global Health Diplomacy: Insights from Afghanistan and the South Asian Region

### Abstract

Historically, Europe had treaties, which today are considered under the laws of global health diplomacy. Global Health Diplomacy (GHD) has grown to become a key component of contemporary international relations, connecting health with foreign policy, security, and development. As acknowledged in the Oslo Declaration (2007) and later UN resolutions, global health diplomacy directly helps intersectoral agencies in emergency crises around the world. As outbreaks like SARS, Ebola, and COVID-19 demonstrated, no state can handle global health threats in isolation, making diplomacy an essential tool. GHD shows how much it helps Afghanistan from a health aspect as a country in a fragile state that has experienced of war for several decades. The war has destroyed all the health infrastructures, resulting in high rates of maternal and infant mortality as well as a general lack of access to necessary care. Since 2002, Afghanistan's Ministry of Public Health has worked with foreign donors, especially USAID, WHO, and the World Bank, to implement the Basic Package of Health Services (BPHS). Although the program could restore the health infrastructure a lot and decrease the rate of deaths, sustainability is still constrained by political instability and reliance on donors' assistance. South Asia is the home of 25% of the world's population, faces a number of regional challenges and problems, including health disparities, climate change, and communicable and non-communicable diseases. Between India and Pakistan, the shared borders, migration, and geopolitical rivalries all have an impact on health diplomacy. While SAARC (South Asian Association for Regional Cooperation) and BIMSTEC (Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation) provide frameworks for collaboration, development is hampered by poor institutions and political instability. However, initiatives like Vaccine Maitri, cross-border polio campaigns, and disease surveillance networks show how GHD can promote stability and health security. This study examines the development and use of GHD in Afghanistan and South Asia, making the case that health diplomacy is a strategic tool for peace and resilience as well as a humanitarian necessity in fragile environments.

**Keywords:** Global Health Diplomacy, Health Systems, Health Policy, SAARK



# Mili

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## دیپلوماسی صحت جهانی: درس‌های از افغانستان و جنوب آسیا

### خلاصه

به صورت تاریخی، اروپا دارای معاهده‌های بوده است که امروزه در چارچوب قانون‌های دیپلماسی صحت جهانی مورد بررسی قرار می‌گیرند. دیپلماسی صحت جهانی (Global Health Diplomacy - GHD) به یکی از مؤلفه‌های اساسی روابط بین‌الملل معاصر تبدیل شده است که صحت را با سیاست خارجی، امنیت و توسعه پیوند می‌دهد. همان‌گونه که در «اعلامیه اوسلو» (۲۰۰۷) و قطعنامه‌های بعدی سازمان ملل تصریح شده است، دیپلماسی صحت جهانی به‌طور مستقیم به نهادهای سکتوری در زمان بحران‌های اضطراری جهانی یاری می‌رساند. چنان‌که شیوع بیماری‌هایی مانند سارس، ابولا و کووید-۱۹ نشان داده‌اند، هیچ دولت به‌تنهایی قادر به مقابله با تهدیدهای جهانی صحت نیست، از این رو دیپلماسی به ابزاری حیاتی تبدیل شده است. دیپلماسی صحت جهانی نقش مؤثر در کمک به افغانستان از منظر صحت ایفا کرده است. کشوری که در وضعیت شکننده قرار دارد و دهه‌ها تجربه‌ی جنگ را پشت سر گذاشته است. جنگ تمامی زیربنای اساسی را متاثر کرده و باعث افزایش میزان مرگ‌ومیر مادران و نوزادان و نیز کمبود شدید دسترسی به خدمات ضروری صحت گردیده است. از سال ۲۰۰۲، وزارت صحت عامه افغانستان با هم‌کاری تمویل‌کنندگان خارجی، به‌ویژه اداره انکشافی بین‌المللی ایالات متحده (USAID)، سازمان صحت جهان (WHO) و بانک جهانی، بسته خدمات صحت اساسی (BPHS) را تطبیق نموده است. هرچند این برنامه تا حد زیادی توانست ساختارهای صحت را بازسازی و میزان مرگ‌ومیر را کاهش دهد؛ اما پای‌داری آن هم‌چنان به دلیل بی‌ثباتی سیاسی و وابستگی به کمک‌های خارجی محدود است. جنوب آسیا که ۲۵ درصد نفوس جهان را در خود جای داده است، با چالش‌ها و مشکل‌های منطقه‌ای گوناگونی از جمله نابرابری‌های صحت، تغییرات اقلیمی و بیماری‌های ساری و غیر ساری روبه‌روست. در میان کشورهای هند و پاکستان، مرزهای مشترک، مهاجرت و رقابت‌های ژئوپولیتیک بر دیپلماسی صحت تأثیر می‌گذارند. هرچند سازمان‌ها انجمن هم‌کاری‌های منطقه‌ای جنوب آسیا (سارک) و ابتکار خلیج بنگال برای هم‌کاری‌های چندسکتوری تخنیکی و اقتصادی (بایمستک) چارچوب‌ها برای هم‌کاری فراهم می‌کنند، توسعه در این حوزه به دلیل ضعف نهادها و بی‌ثباتی سیاسی با کندی مواجه است. با این حال، ابتکاراتی نظیر برنامه «واکسن مایتری» (Vaccine Maitri)، کمپین‌های مشترک مبارزه با فلج اطفال و شبکه‌های نظارت بر بیماری‌ها نشان می‌دهد که دیپلماسی صحت جهانی می‌تواند به تقویت ثبات و امنیت صحت کمک نماید. این تحقیق به بررسی سیر تحول و کاربرد دیپلماسی صحت جهانی در افغانستان و منطقه جنوب آسیا می‌پردازد و استدلال می‌کند که دیپلماسی صحت نه‌تنها یک ضرورت انسانی در محیط‌های شکننده است؛ بلکه ابزاری راه‌بردی برای صلح و توانایی محسوب می‌شود.

کلمه‌های کلیدی: دیپلماسی صحت جهانی، نظام‌های صحت، سیاست‌های صحت، سارک



# ملي

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**Introduction:**

The global health diplomacy historically goes back to the early 19<sup>th</sup> century; the quarantine treaties of European port cities such as Venice and Marseille were among the first to establish formal quarantine regulations to prevent the spread of epidemic diseases like the bubonic plague (Fidler, 2001). These cities developed bilateral and multilateral agreements outlining quarantine procedures for ships, goods, and travelers, which marked some of the earliest examples of international health cooperation. Health diplomacy has emerged as a contemporary diplomatic strategy aimed at advancing public health while safeguarding national interests. Global health diplomacy is responsible for improving global health and working jointly with both state and non-state actors to resolve health challenges internationally. The international relations politically deal with the health sectors globally through the international organizations such as WHO, Gavi, the Vaccine Alliance, UNAIDS, Médecins Sans Frontières (Doctors Without Borders), OECD Health Division. The diseases causing pandemic are directly in touch with the Global health diplomacy, like the Covid-19 pandemic, or the outbreak of SARS in 2003, the Ebola outbreaks in Guinea, Liberia, and Sierra Leone, the largest and deadliest Ebola outbreak in history, 28,600+ cases, 11,325 deaths declared a Public Health Emergency of International Concern (PHEIC) by WHO in August 2014. In 2007, the foreign ministers of seven countries issued the Oslo Declaration, identifying global health as 'a pressing foreign policy issue of our time. The countries prioritize global health on their foreign policy agenda, as the health issues are global and have significance, since a moderate political society without healthy people has no worth, neither inside states nor outside states, World Health Organization (WHO). (2007).

Afghanistan is a fragile and conflict-affected state in South Asia facing challenges in both the Political and Health sectors. The provision of equitable, affordable, and high-quality healthcare constitutes one of the most critical social services that fragile and conflict-affected states are frequently unable to ensure due to systemic instability and limited institutional capacity. The fragile and conflict-affected states directly needs the existence of a donor for the nation, to fulfill the requirement of the nation through it, The United States of America through the USAID and other NGOs helped Afghan health system by the estimated of 1 billion dollars since 2002, for basic health and essential hospital services, treatment of communicable diseases, family planning, and private sector engagement (SIGAR, 2015; USAID, 2015).

The importance of the GHD in the realm of political science is remarkable, especially the foreign diplomacy of modern states in the reconstruction of fragile and conflict-affected, with special reference to the health system. Afghanistan after passing of several decades of wars faces high rate of instability in health sector, unfortunately the state of war has no attention to the promotion and stabilization of health in a country, a state in war has no place to prioritize health to the rest, rather that establishment of arm and allocation of budget for the destruction, it's not only the case to the Afghanistan but to every state which is in involve in war. During times of conflict, brain drain especially the loss of medical doctors, often serves as an early indicator of an impending national crisis. Unfortunately, Afghanistan has suffered extensively, having endured over four decades of war. While the security situation has improved, the Afghan people still require sustained global attention, particularly in the healthcare sector.

Despite the growing recognition of Global Health Diplomacy (GHD) as a bridge between public health and international relations, its application in fragile and conflict-affected contexts like Afghanistan and the broader South Asian region remains limited and uneven. Afghanistan's decades of war destroyed much of its health infrastructure and weakened governance, making international health assistance not only a humanitarian necessity but also a strategic diplomatic tool. While initiatives such as the Basic Package of Health Services (BPHS) and donor-led partnerships demonstrated the potential of GHD to save lives and rebuild systems, these efforts remain fragile and heavily donor-dependent. At the regional level, South Asia faces shared health vulnerabilities including pandemics, climate-related health risks, refugee crises, and cross-border disease transmission that demand cooperative responses. Yet, entrenched political rivalries (particularly between India and Pakistan), weak institutional frameworks such as those within SAARC, and resource disparities among member states continue to obstruct meaningful regional health diplomacy. This lack of sustained collaboration undermines collective health security and limits the region's capacity to respond effectively to transnational health challenges. Therefore, there is a pressing need to examine how GHD can be institutionalized and strengthened in both Afghanistan and South Asia. Without addressing the political, institutional, and resource-related barriers, health diplomacy will remain ad hoc, leaving fragile states and the wider region vulnerable to recurring crises.

This research is significant for several reasons, contribution to academic knowledge by focusing on Afghanistan and the South Asian region, which is relatively underexplored intersection of public health and international relations in fragile and conflict-affected contexts. While much of the existing literature on Global Health Diplomacy (GHD) emphasizes global institutions and high-income states, fewer studies examine how GHD functions in regions characterized by political instability, weak institutions, and persistent health crises. This research fills that gap by providing a contextualized analysis of Afghanistan's experience and the broader regional dynamics in South Asia. The findings of this research offer practical insights for policymakers in Afghanistan, South Asia, and beyond. By identifying both the successes (such as the Basic Package of Health Services and cross-border disease control efforts) and the barriers (political rivalries, weak regional mechanisms, and donor dependency), this study provides evidence-based recommendations that can help governments, international organizations, and NGOs design more effective health diplomacy strategies. In an era when pandemics, climate change, and humanitarian crises transcend borders, this research underscores the role of health as both a security and development priority. For South Asia a region marked by deep political divisions yet shared vulnerabilities the study highlights how GHD can serve as a confidence-building measure, fostering cooperation even in tense geopolitical environments. The research also holds global significance by illustrating lessons that other fragile states and regions can learn from Afghanistan and South Asia. International donors and organizations such as USAID, WHO, GAVI, and China's Health Silk Road initiative play a pivotal role in shaping GHD in the region. This research provides valuable insights into how external actors can better align their interventions with local and regional priorities, ensuring sustainability and resilience rather than temporary solutions.

This study aimed to analyze and demonstrate the role of Global Health Diplomacy (GHD) as a vital tool for peace, stability, and development in fragile states like Afghanistan and across

the wider South Asian region, while identifying pathways to strengthen regional and international cooperation in health security.

### **Methodology**

This study adopts a qualitative and descriptive research design, focusing on secondary data analysis through a critical examination and synthesize of existing information on Global Health Diplomacy (GHD) in Afghanistan and the South Asian region. Data was collected exclusively from secondary sources, including: peer-reviewed journal articles, e-books, and scholarly publications accessed through digital libraries and PDF sources, publications from international organizations such as WHO, World Bank, USAID, GAVI, and UN agencies, government reports and official health policy documents, particularly from Afghanistan's Ministry of Public Health (MoPH), and other credible websites of regional organizations (e.g., SAARC, BIMSTEC) and health-focused institutions providing data on regional cooperation and diplomacy.

The collected documents were reviewed, categorized and analyzed thematically to identify patterns, successes, challenges, and gaps in the practice of health diplomacy; A comparative lens was applied, examining Afghanistan's experience alongside broader South Asian initiatives; Special attention was given to recurring themes such as donor dependency, institutional weaknesses, regional rivalries, and opportunities for cross-border collaboration.

Using secondary data is both practical and relevant for this study because primary fieldwork in Afghanistan and South Asia is limited by accessibility, security, and resource constraints; A vast body of existing literature, official reports, and online resources already provide rich data on health diplomacy in fragile and regional contexts; Synthesizing this data allows for a comprehensive and critical understanding of GHD without duplication of existing studies.

### **Results**

#### **Health & Diplomacy**

Fidler & Kickbusch (2001) have parlayed their impeccable credentials as pioneers in the codification of health diplomacy as a discipline into assembling a remarkable group of authors to explore further the relevance of diplomacy to health concerns of the 21st century. As a recognized field, now we can vast our research more related to diplomacy and health issues, which will lead the researchers to overcome the achievements and successes in this field.

Diplomacy has historically been in touch with national security and defending territorial integrity mainly against military threats in the past; at present, a strong relationship has been established between health and diplomacy. United Nations General Assembly (2009), a new concept of global health diplomacy (GHD) was adopted by the United Nations General Assembly (UNGA) Resolution 63/331 and reaffirmed by UNGA \ resolutions 64/108,2, 65/95,3 and 66/115. Adoption of GHD by the United Nations has numerous features for the recognition of GHD globally, for example: (1) Improving Health on the Global Agenda: These resolutions make health a strategic global issue linked to peace, development, and security rather than just a domestic or humanitarian one. Promotion of Intersectoral Cooperation: GHD promotes cooperation among health professionals, diplomats, and legislators, stressing the need for international and cross-sectoral cooperation to address health issues. Basis for Upcoming Measures and Policies:

The resolutions lay the groundwork for future frameworks that specify how nations and international organizations should use diplomacy to address health issues.

The fundamental goals of foreign policy, such as maintaining security, fostering economic growth, aiding in the development of low-income nations, and protecting human dignity, are all impacted by global health. The vastness of diplomacy in the era of science and technology, where the world is like a village and access to resources is easy, highlights the linkage between diplomacy and health to the nearest point. The outbreak of epidemics and coping with global viruses like HIV or Hepatitis created an interrelation between diplomacy and health. Countries around the world are focusing on securing a welfare state, and it's not possible until a country has a good level of services in the health sector. Relations among states could be established on any subjects but diplomatic and health are pivotal and common due to its importance in international relations and global community, no country could fulfill all its needs itself that's why. As former UN Director-General Kofi Annan (2004), "No state, no matter how powerful, can by its own efforts alone make itself invulnerable to today's threats. This assertion highlights the reality that health challenges, from pandemics to environmental crises, are inherently transnational in nature and require collective action. Effective foreign policy must therefore integrate global health as a central pillar, recognizing that cooperation, information-sharing, and joint preparedness are essential for protecting populations. In this interconnected world, a nation's security and prosperity are directly tied to the resilience of the international community, making health diplomacy not only a tool of humanitarian concern but also a strategic necessity for sustainable global stability.

### **U.S. Health Diplomacy and the Rebuilding of Afghanistan's Health System (2002)**

The U.S invested a lot in the health services of Afghanistan after 2002. The most detrimental health problems were experienced by women and children. For example, in 2002, For every 100,000 babies born, more than 1,600 mothers lost their lives a devastating reality for Afghan families, this meant that pregnancy, which should be a moment of joy, often became a life-threatening risk for Afghan women and pregnancy was the primary cause of more than half of all deaths among women between the ages of 15 and 49. Birth (UN Development Program, 2004). On the other hand, children had high rates of morbidity and mortality due to infectious diseases and malnutrition. This situation was too tough to be handled in a short time or without having a huge amount of budget. In 2002 the NGOs as the most important source of primary healthcare, as they delivered approximately 80% of all health services in Afghanistan 2002 (Sabri et al., 2007; Afghan Ministry of Health, 2002).

Financing Afghanistan's health system in the early 2000s was one of the greatest hurdles to recovery. When the Afghanistan Transitional Administration (ATA) took power in 2002, families were shouldering almost 90% of the country's total health costs. For most households, the biggest expense was buying essential medicines and supplies—often a heavy financial burden for already struggling families (World Bank, n.d.). Only about 10% of the country's healthcare costs came from outside sources, mainly international donors, while government spending covered just a fraction.

With weak institutions and unemployment hovering around 40% (ANDS, 2008), the Afghan government had little ability to raise and pool tax revenues that could support public healthcare. The reality was stark: in 2002, government health spending amounted to just \$1 per person, and the total national spending on health was only \$16 per person (WHO, n.d.).

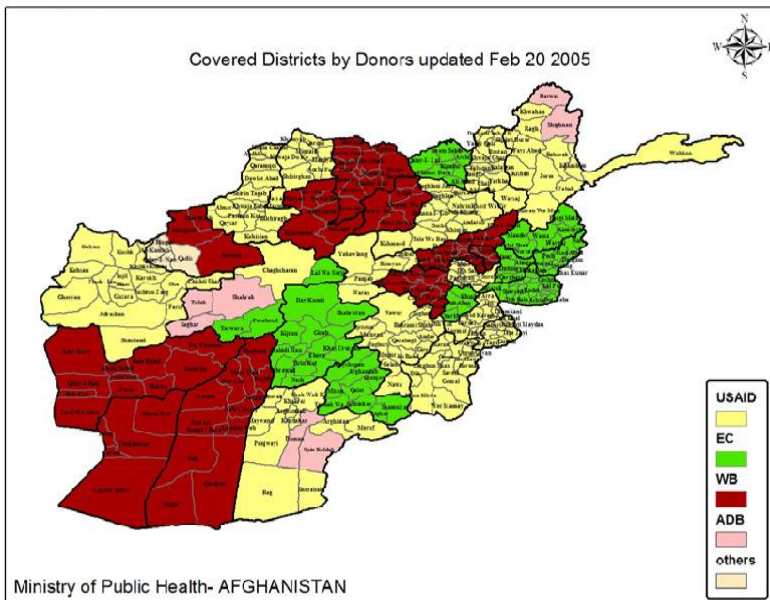
For millions of Afghans, this meant that even basic medical care was either unaffordable or completely out of reach.

### **Coordinating, Financing, and Delivering Health through Health Diplomacy**

U.S. health diplomacy in Afghanistan was not only about policies and negotiations—it was about rebuilding a system that could save lives. From 2002 onward, Afghan and international actors worked together to repair a health sector devastated by decades of conflict. Officials from the Afghan Ministry of Foreign Affairs, USAID, and the World Bank recalled how negotiations shaped joint activities aimed at strengthening Afghanistan's health services and the government's capacity to manage them (personal communications, 2013). The partnership of two institutions stood at the center of assistance and cooperation. USAID, as was started working under the guidance and supervision of the U.S State Department, provided huge funding for the development assistance, while the Ministry of Afghan Public Health, empowered by the Transitional Administration in 2002 to design domestic health policy (Sondorp, 2004), took the lead in defining the country's health priorities.

Donors like the World Bank, European Commission, and WHO worked along with the USAID and other US assistant departments, which played a vital role in turning the plan into action. These activities led to the creation of the Basic Package of Health Services (BPHS) in 2003, a bundle of essential health services designed to reach every Afghan, regardless of income. For many families, this was the first time in years that basic healthcare—such as maternal care, vaccinations, and treatment for common illnesses—was available close to home and without crippling costs.

In practice, health diplomacy meant more than policy it meant mothers surviving childbirth, children being vaccinated against preventable diseases, and families no longer forced to choose between food and medicine.



**Figure 1:** Covered Districts by Donors, Updated Feb 20, 2005

**Table 1:** *Bundle of Health Interventions Included in the Basic Package of Health Services (BPHS) in 2003*

<ol style="list-style-type: none"><li>1. Maternal and newborn health<ul style="list-style-type: none"><li>• Antenatal care</li><li>• Delivery care</li><li>• Postpartum care</li><li>• Family planning</li><li>• Care of newborn</li></ul></li><li>2. Child health and immunization<ul style="list-style-type: none"><li>• Expanded program on immunization (routine and outreach)</li><li>• Integrated management of childhood illnesses</li></ul></li><li>3. Public nutrition<ul style="list-style-type: none"><li>• Micronutrient supplementation</li><li>• Treatment of clinical malnutrition</li></ul></li><li>4. Communicable diseases<ul style="list-style-type: none"><li>• Control of tuberculosis</li><li>• Control of malaria</li></ul></li><li>5. Mental health<ul style="list-style-type: none"><li>• Community management of mental problems</li><li>• Health facility-based treatment of outpatients and inpatients</li></ul></li><li>6. Disability<ul style="list-style-type: none"><li>• Physiotherapy integrated into primary health care services</li><li>• Orthopedic services expanded to hospital level</li></ul></li><li>7. Regular supply of essential drugs<ul style="list-style-type: none"><li>• All essential drugs required for basic services</li></ul></li></ol>
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**Source:** Ministry of Health. "A Basic Package of Health Services, 2003/1382." *Kabul: Transitional Islamic State of Afghanistan, 2003.*

Between the 2003 and 2015 almost 400 Million Dollars spent to the support for the BPHS and EPHS through USAID. This aid covered almost 40 percent of Afghanistan's territory and almost 50 percent of total population (USAID, n.d.).

Afghanistan's Ministry of Public Health (MoPH) faced a major challenge: **how to deliver essential healthcare services to people across the country**. The answer wasn't simple, but there was a starting point. Many non-governmental organizations (NGOs) and private groups already had the skills and experience needed to carry out the **Basic Package of Health Services (BPHS)**. Some were Afghan organizations familiar with the local context, while others were international agencies with years of experience working in fragile states like Afghanistan.

Recognizing this, the MoPH and its donor partners decided to put in place a **decentralized healthcare system**. Under this approach, NGOs would take part in a competitive bidding process. Those that won contracts would then partner with the MoPH to implement the BPHS in specific provinces or districts (World Health Organization, n.d.).

With the focus to the USAID and other NGO's the health sectors recovered itself and could access once again to the medium range of medical services. Afghan women mostly suffered a lot during the instabilities in health sectors; NGOs specifically played a pivotal role for the recover and rebuilding of the health system. Afghan people as ever supported the development project and paved the ground for the reconstruction of hospitals and public health system, eventually during the years health system in Afghanistan reconstructed.

### **Health diplomacy and South Asian countries**

One of the most densely populated and health-problematic regions is South Asia, which is home to nearly 1.9 billion people, or roughly 25% of the world's population. Common health issues among Afghanistan, Pakistan, India, Bangladesh, Nepal, Bhutan, Sri Lanka, and the Maldives include maternal and child mortality, infectious diseases (such as polio, tuberculosis, and malaria), rising non-communicable diseases, and health risks associated with climate change. Because of these difficulties, health diplomacy is a vital instrument for international engagement, humanitarian development, and regional stability.

### **Health Diplomacy's Significance in South Asia**

The following highlights South Asia's importance in health diplomacy:

- **Demographics:** Since almost one-fourth of the world's population lives here, any health emergency has an impact on the entire planet.
- **Disease Burden:** As non-communicable diseases continue to rise, high rates of communicable diseases such as TB, dengue, and polio continue to exist.
- **Shared Borders and Mobility:** Disease control is a shared challenge due to migrant workers, refugees, and porous borders.
- **Geopolitical Significance:** China, India, and Pakistan's rivalries affect competition and collaboration in the field of health.
- **Dependency on Foreign Aid:** Diplomacy is essential to health delivery in nations like Afghanistan, which mainly rely on foreign medical aid.
- **South Asian Experiences with Health Diplomacy in Practice a. Bilateral Collaboration**
- **India and its neighbors:** Through its Vaccine Maitri program, India provided more than 66 million doses of COVID-19 vaccines to Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives.
- **Cross-border polio eradication efforts** between Afghanistan and Pakistan are coordinated with WHO and UNICEF because both countries are at risk from population movement across the Durand Line.
- **Disease prevention in refugee camps** is a regional priority, and Bangladesh and India are working together on the Rohingya refugee health response.

### **Multilateral Forums**

The South Asian Association for Regional Cooperation, or SAARC:

In 1992, the SAARC Tuberculosis and HIV/AIDS Center was established in Nepal. established a COVID-19 Emergency Fund in 2020, but its influence was constrained by political unrest.

The Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation, or BIMSTEC, focuses on natural disasters and epidemics while addressing health security and disaster management.

Global Health Partnerships: WHO, UNICEF, GAVI, Global Fund, and USAID are important regional providers of funding and technical assistance.

### **Historical Background**

The United States and the Soviet Union employed health diplomacy in South Asia during the Cold War to gain sway; for example, the Helmand Valley and Kandahar International Airport projects in Afghanistan, which were funded by the United States, also had health elements.

Cuba established solid bilateral ties in South Asia through its medical diplomacy, which involved sending doctors to Pakistan during the 2005 earthquake.

### **Major Obstacles to South Asian Health Diplomacy**

- Despite potential, advancement is constrained by a number of obstacles:
- Political Rivalries: The conflict between India and Pakistan frequently paralyzes SAARC, undermining regional initiatives.
- Inequality of Resources: Afghanistan, Nepal, and the Maldives continue to rely on donors, whereas India serves as a regional health power.
- Weak Institutional Mechanisms: SAARC and other regional organizations are largely dependent on political will and lack enforcement authority.
- Trust Deficit: Rather than being purely humanitarian, nations may view health assistance as having political motivations.
- Border and Refugee Issues: Efforts to control disease are complicated by population movements, such as the Rohingya in Bangladesh or the Afghan refugees in Pakistan.

### **Prospects for Developing Health Diplomacy**

There are also plenty of chances for cooperation in South Asia:

Establishing a health security network throughout SAARC to keep an eye on outbreaks of COVID-19, polio, and dengue is known as regional disease surveillance.

- Collaborative Research and Training: Pharmaceutical technology transfers, telemedicine initiatives, and shared medical universities.
- Climate and Health Initiatives: Regional collaboration on vector-borne illnesses, floods, and air pollution.
- Cross-border patient care, health worker exchanges, and NGO partnerships are examples of people-to-people diplomacy.

- Enhancing SAARC's Function: Reviving its health-related programs to serve as an impartial forum in spite of political unrest.

#### The Function of Outside Players

- South Asia's health diplomacy has also been influenced by foreign organizations and donors:
- Afghanistan's BPHS and EPHS programs are primarily funded by USAID.
- China: Expanding its health presence through the "Health Silk Road" and Belt and Road Initiative (BRI) projects.
- Leading the COVID-19 response, maternal health, and vaccination campaigns are WHO and UNICEF.
- NGOs: The Aga Khan Foundation, BRAC (Bangladesh), and MSF (Médecins Sans Frontières) offer vital services and cross-border projects.

#### Conclusion

The study of Global Health Diplomacy (GHD) in the context of Afghanistan and the wider South Asian region highlights both the promise and the persistent challenges of using health as a bridge for peace, stability, and development. Health diplomacy, at its core, operates at the intersection of public health and international relations. It provides a platform for state and non-state actors to cooperate on common challenges that no single country can solve alone. The experiences of Afghanistan and its neighbors demonstrate that in regions marked by fragility, political rivalries, and limited resources, health diplomacy has often become not only a humanitarian necessity but also a political tool of strategic importance.

Afghanistan presents a particularly striking case. Decades of war destroyed much of its health infrastructure, created severe brain drain among medical professionals, and left millions of Afghans without access to even the most basic health services. In such a context, GHD was not merely an abstract concept but a tangible lifeline. International donors, especially USAID, the World Bank, and WHO, worked closely with Afghanistan's Ministry of Public Health (MoPH) to rebuild essential healthcare delivery. The creation of the Basic Package of Health Services (BPHS) in 2003 marked a milestone, demonstrating how health diplomacy could translate into actual survival for millions of mothers, children, and families. While challenges persist, this collaborative model showed how fragile and conflict-affected states can gradually recover when health is prioritized within diplomatic and developmental frameworks.

In South Asia more broadly, health diplomacy has taken on multiple forms—ranging from bilateral cooperation, such as India's Vaccine Maitri program during COVID-19, to multilateral initiatives under SAARC and BIMSTEC. Regional responses to polio eradication, refugee health, and natural disasters underscore the interconnectedness of health security. Yet, despite successes, regional health diplomacy remains constrained by entrenched political rivalries, particularly between India and Pakistan, weak institutional mechanisms within SAARC, and resource disparities between larger and smaller states. These limitations reduce the effectiveness of collective action and undermine the potential for South Asia to fully benefit from a coordinated regional health diplomacy agenda.

Nevertheless, the potential of health diplomacy in South Asia is significant. Shared vulnerabilities—whether in the form of infectious disease outbreaks, climate-related health risks, or mass displacement—can act as entry points for cooperation, even in politically tense environments. Joint disease surveillance systems, cross-border medical training, climate-health collaborations, and stronger NGO partnerships can all serve as confidence-building measures while simultaneously improving population health. Furthermore, external actors such as USAID, China through the Health Silk Road, and global organizations like WHO and GAVI continue to play indispensable roles in supplementing domestic and regional capacities.

Ultimately, the lessons from Afghanistan and the South Asian region illustrate a broader truth: global health diplomacy is no longer optional; it is a necessity. In an interconnected world where pandemics, environmental crises, and humanitarian emergencies transcend borders, health is a form of security, development, and diplomacy all at once. The integration of health into foreign policy is not only a moral imperative but also a strategic necessity for sustainable peace and prosperity. For fragile states like Afghanistan, health diplomacy ensures survival and recovery. For the wider South Asian region, it offers a path toward trust, resilience, and shared stability. Moving forward, sustained commitment, innovative partnerships, and genuine political will are essential to transform health diplomacy from episodic responses into a permanent pillar of regional and global cooperation.

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