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Original Research Article

Global Health Diplomacy and Access Inequality in the Global South: A Comparative Study of HIV/AIDS and COVID-19

Agboola, Oluwafemi, PhD
Department International Relations, Atiba University, Oyo, Nigeria
***Email**: agboolaoluwafemi01@gmail.com / oluwafemi.agboola@atibauniversity.edu.ng*
***ORCID**: 0009-0005-5703-3326*

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ABSTRACT

Inequities in access to medicines, vaccines and health technologies continue to remains a major challenge in global health governance, majorly in the Global South. The present study underscores the importance of global health diplomacy as a contributor to inequity in access to health services on an international scale by drawing parallels between the HIV/AIDS epidemic and the COVID-19 pandemic. The methodology employed in this study is qualitative comparative case study design that is a methodology in which documentary evidence is used in the form of peer-reviewed articles, academic books, international organizations' policy documents and reports. Theories: Dependency Theory and Liberal institutionalism. These two theories will be used to examine the impact of structural inequalities and global partnerships on global health outcomes.
Findings show that global health diplomacy has facilitated global cooperation, resource mobilization and institutional response to big health crises.However, the disparities in drug production, patents and technologies, and geopolitical power are still important drivers of access. During the HIV/AIDS pandemic in many Global South countries, there was a restriction of access to antiretroviral (ARV) drugs due to patent barriers and high treatment costs. COVID-19 pandemic also highlighted inequalities in vaccine nationalism, inequitable vaccine procurement processes and limited technology transfer.
WHO, UNAIDS, the Global Fund and COVAX were active in improving relations, but had limited capacity to ensure equitable distribution. The study finds the need for improved technology transfer systems, increased pharmaceutical manufacturing capacities, increased IP action and increased accountability within the global health institutions to move the agenda forward on international health equity.

1. **Introduction**

There has been a dramatic shift in the linkage between health and international politics in the 21st century. Health has transcend beyond being viewed based on a domestic policy concern to becoming a major issue within international governance, global security, development engagement, and foreign policy. Increased movement of people, urbanization, climate change, economic interdependence and globalization have contributed to the spread of infectious diseases across borders, making coordinated, global-level responses to today's health challenges a necessity (Kickbusch, Silberschmidt, & Buss, 2007; Fidler, 2010; Davies, Kamradt-Scott, & Rushton, 2015). For these reasons, international relations other nations have turned global health as a research interest on world politics.

One major development in this transformation is the emergence of Global Health Diplomacy (GHD) which refers to the processes through which countries, global organizations, non-governmental organizations, pharmaceutical corporations and other stakeholders negotiate and coordinate reactions to transnational health issues while targeting political and economic interests (Kickbusch et al., 2007; Lee & Smith, 2011).Unlike conventional diplomacy, which was mainly about military security, territorial sovereignty and trading, the concept of GHD is a broadened interpretation of security, where health is an important part of international stability and sustainable development.

The importance of GHD has been brought to light by significant health crises, such as the HIV/AIDS epidemic and the COVID-19 pandemic. The HIV/AIDS situation revealed many inequalities in access to medicines, particularly in Sub-Saharan Africa, due to high drug prices, stringent IP laws, inadequate healthcare systems and limited pharmaceutical

production (Farmer, 2001; Piot, 2012). While access was enhanced by these and other advocacy and diplomatic efforts, such as through UNAIDS, the Global Fund and intellectual property reform, many developing states continued to require access to foreign resources and technologies (Correa, 2007).

Likewise, the COVID-19 pandemic has revealed the frequent inequities in global health governance. Even with the rapid scientific collaboration and vaccine development, there was not equal access. Many states in the Global South had to wait for the supply of vaccines, which were supplied in large quantities to the Global North through advance purchase consensus, due to a combination of restricted production capacity, financial constraints, and vaccine nationalism (Moon et al., 2022; Harman, 2023). The developments showed that not only medical but also political and economic power games affect access to health technologies.

The chapter argues that inequalities in access to medicines, vaccines, diagnostics and health technologies lie at the root of underlying structures of global political economy. International health outputs continue to be shaped by various factors such as differential technology, pharmaceutical concentration, intellectual property systems, financial disparities, differential bargaining power, etc. (Benatar, 2013; Labonté & Gagnon, 2010). Such challenges are especially relevant for the Global South, where the impacts of the history of colonialism, dependency and limited access to influence over the decisions of international institutions continue to shape health governance outcomes (Dados & Connell, 2012).

In this study, the authors examine the intersection between Global Health Diplomacy and access inequality in the Global South, using a comparative case study of HIV/AIDS and COVID-19. Uses Dependency Theory and Liberal Institutionalism as complimentary theories. Dependency Theory elucidates how structural inequalities and unequal international economic transactions contribute to dependency on international health resources, while Liberal Institutionalism implies that global institutions help to enable relation and collective response (Frank, 1967; Keohane, 1984).

The study addresses the issue of unequal access to key health resources, despite recent progress in the field of global cooperation. It highlights how GHD has changed, the political and economic factors of access inequality, contrasts the diplomatic responses to HIV/AIDS and COVID-19, and recommends ways to improve the equality of global health. The study contributes to the theoretical literature on the relationship between global health governance and debates in international relations around power and cooperation, as well as to the practical discussion by analyzing two major health crises and providing recommendations for enhancing global health cooperation and changing the status quo in technology transfer and pharmaceutical production, and in the system of intellectual property governance.

Finally, the chapter sets the stage for a wider understanding that global health diplomacy is a sign of global cooperation and international inequalities and disparities already in place. To achieve this, equal access to health resources must be facilitated through better institutions, but also with a focus on structural changes to health conditions which still influence health outcomes internationally.

1. LITERATURE REVIEW

The aim of this chapter is to examine the previous scholarly debates regarding Global Health Diplomacy (GHD) and inequality in access to health services in the Global South with a specific focus on the HIV/AIDS epidemic and the COVID-19 pandemic. It develops conceptual problems, theory and empirical research to lay the groundwork for the study and to seek gaps in the literature. With the spread of modern health problems, diseases have proven to have international effects on security, diplomacy, economic development and global governance, eliminating the national boundaries of spread (Fidler, 2010; Davies, Kamradt-Scott, & Rushton, 2015). This has resulted in the incorporation of health into the agenda of IR.

Global Health Diplomacy is the processes through which governments, global organizations, civil society groups, private corporations, and other actors negotiate and coordinate reactions to transnational health challenges (Kickbusch, Silberschmidt, & Buss, 2007). It represents the cross-over between public health goals and foreign policy concerns as increasing awareness has emerged of the need for international collaboration to address health issues. Lee and Smith (2011) define GHD as a set of multiple actors in different states operating under complex governance structures that produce health outcomes based on political, economic and diplomatic conditions.

But as the debate demonstrates, there is a lack of consensus among researchers as to whether, or to what degree, global health diplomacy actually works for equality or is strengthening existing inequalities. Liberal institutionalists believe that establishing norms and enhancing the collective response to common problems by reducing unpredictability, global institutions promote cooperation (Keohane, 1984). The experience of institutions like the World Health Organization (WHO), UNAIDS, the Global Fund, and COVAX are representative of how multilateral mechanisms can activate resources and coordinate responses to health crises. On the other hand dependency scholars and those concerned with political economy contend that unequal distributions of wealth, technology and decision-making power continue to affect global health governance, this time in favour of the Global North (state) and against the Global South (people) (Frank, 1967; Amin, 1976; Labonté & Gagnon, 2010).

An issue that has been prominent in global health governance is the inequality of access. It is inequalities in access, cost and distribution of essential medicines, vaccines, diagnostics and health care technologies. Medical innovations have increased dramatically, but not evenly, between the Global North and developing regions (Farmer, 2001; Benatar, 2013). These inequalities were revealed by the HIV/AIDS epidemic, however, as many developing countries faced challenges in accessing affordable ARVs due to the patent restrictions, high pharmaceutical prices and limited health care systems (Piot, 2012). Conversely, the COVID-19 pandemic revealed many inequities including vaccine nationalism, inequity in purchasing power and limited production capacity in many countries in the Global South (Moon et al., 2022; Harman, 2023).

The term Global South is essential to comprehend these disparities. The Global South are states that share historical

experiences of colonialism, economic dependency, technological marginalisation, and limited influence in international institutions (Dados & Connell, 2012). These historical and structural conditions are still influencing contemporary dependence, such as the dependence on foreign pharmaceutical technologies and financing of health services (Frank, 1967; Amin, 1976).

Results from the practical studies offer different opinions on the effectiveness of global health diplomacy. Programs such as PEPFAR, UNAIDS, and the Global Fund, to achieve the purposes of the program, have contributed to the success of HIV/AIDS access to treatment and the maintenance of global relation (Piot, 2012). These gains do not diminish, however, deeper structural inequalities, as is argued by Farmer 2001 and Benatar 2013. On the other hand, Harman (2023) argues that the COVAX has shown the limitations of current international health frameworks in addressing geopolitical competition and disparities in power relations, while Moon et al. (2022) acknowledge COVAX as a key tool for ensuring vaccine cooperation.

The literature thus presents an ongoing debate: can global health diplomacy be effective in incorporating the uneven global health structures or does it predominantly deal with the consequences of these inequalities? The purpose of this study is to contribute to this debate by comparing and contrasting the impact of HIV/AIDS and COVID-19 on the developing world in the light of Dependency Theory and Liberal Institutionalism. Whilst Dependency Theory explicates structural unevenness in access to health resources, Liberal Institutionalism indicates the role of global cooperation and institutions in tackling global health issues.

2. THEORETICAL FRAMEWORK AND METHODOLOGY

This chapter presents the theoretical and methodological approaches used in the study. The study uses two analytical frameworks that are used in parallel: Dependency Theory and Liberal Institutionalism. These theories can provide understanding regarding how structural inequality and cooperation at the global level affects access to medicines, vaccines, and health technologies.

A critique of the modernization approaches which attributed underdevelopment to internal weaknesses, may be traced back to the period between the 1960s and 1970s and might be called Dependency Theory. According to dependency scholars, the basic organization of the international capitalist system creates dependency between the Global North and the developing countries (Frank, 1967; Amin, 1976). According to the theory, there is a relationship between the core countries and the peripheral countries, where the core countries possess capital, technology, industrial production, and scientific innovation while the countries of the Global South rely on the other countries for their needs (Frank, 1967).

This study is dependent on the concept of Dependency Theory because it offers a justification for disparities in pharmaceutical products and health technologies. HIV/AIDS demonstrated the effects of patent rights, high medicine prices, and insufficient manufacturing capacity on access to ARVs in many developing countries (Farmer, 2001). COVID-19 also highlighted the reliance of many countries in the Global South on foreign manufacturers of vaccines due to limited technological capability and inequitable global supply chains (Moon et al., 2022). Foreign structures, however, are often overemphasized and national institutions, leadership and policy choices underemphasized (Cardoso & Faletto, 1979); yet, this is not always observed in Dependency Theory. In spite of such criticisms, however, the theory is a key explanation of common inequities in global health governance.

Liberal Institutionalism offers a counterpoint view through its focus on the need for cooperation and institutions on the global stage. The theory states that there is no single authority in the global system, but that countries may achieve collective goals via global organizations, rules and norms (Keohane, 1984). Institutions reduce uncertainty, improve the flow of information, promote cooperation, and offer a means to solve common problems (Keohane & Nye, 1977).

This theory is fundamental since global health problems are interdependent and necessitate intercountry responsibilities. During critical health emergencies, institutions such as the World Health Organization (WHO), the UNAIDS, the Global Fund and COVAX have strengthened global coordination, financing, disease monitoring and resource mobilization efforts (Keohane, 1984). But critics say Liberal Institutionalism does not take into account power differences among global institutions; in many cases, powerful states dictate institutional decision-making and resource distribution (Mearsheimer, 1994). These weaknesses were evident in the distribution of COVID-19 vaccines, via vaccine nationalism and the disparity in buying power.

This study can be explained with the help of the combination of Dependency Theory and Liberal Institutionalism. Dependency Theory explains the structural determinants of inequitable access to health resources, while Liberal Institutionalism explains how the global institutions try to respond to global health challenges in a cooperative manner. They also demonstrate the possibility of coexistence of cooperation and inequality in the global health governance.

The design of the study is the qualitative comparative case study. This approach is suitable given the research highlights political processes, institutional responses, diplomatic engagements, and structures influencing global health diplomacy (Yin, 2018; Creswell & Creswell, 2018). HIV/AIDS and COVID-19 were chosen as the two health crises because they represent significant global events that created a sense of cooperation on the global level, but also highlighted disparities in access to medicines and vaccines.

Its method of study relies on the secondary data of peer-reviewed journals, academic books, policy documents and WHO, UN, World Trade Organisation, UNAIDS or other reports, and other documents. Documentary research helps systematic analysis of existing evidence relating to global health governance and access inequality (Bowen, 2009).

Analysis of the data is carried out in a qualitative manner using content analysis and comparative analysis methods. Content analysis will highlight the key themes regarding global cooperation, pharmaceutical inequities and health diplomacy, while comparative analysis will assess similarities and differences between HIV/AIDS and COVID-19 reactions (Schreier, 2012; Yin, 2018). The process of source triangulation and the use of credible academic and institutional

sources (Lincoln & Guba, 1985; Creswell & Creswell, 2018) enhance the reliability and validity of the research. Ethical guidelines are upheld by using appropriate citations, correct interpretation and responsible use of secondary sources (Resnik, 2020).

Finally, the theoretical and methodological foundation provides a solid foundation for analysing the relationship between global health diplomacy and structural inequalities in shaping access outputs in the Global South.

3. DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter discusses and analyzes the links between Global Health Diplomacy (GHD) and access inequality in the Global South, using a comparative approach to the HIV/AIDS epidemic and the COVID-19 pandemic. The evaluations is guided by the study's theoretical framework, combining Dependency Theory and Liberal Institutionalism. Despite the growing level of cooperation, the chapter asserts that there are continuing inequalities in technological capacity, pharmaceutical production, financial resources and political influence continuing to influence access output.

4.2 Global Health Diplomacy and the HIV/AIDS Response

HIV/AIDS was a major milestone in global health diplomacy as it became a global political matter concerning medicines access. Since the mid-1990s, however, with the advent of antiretroviral therapy (ART), there has been a marked improvement in survival rates in high-income countries, but the access to ART has been severely limited in many low- and middle-income countries due to its costs, patent issues, and weak healthcare systems (Farmer, 2001).

More importantly, one important reason for the inequality was that the majority of pharmaceutical innovation and production took place in the advanced economies. Many developing states were unable to make generics available at affordable prices due to intellectual property rights in international trade agreements. This led to government and civil society organizations, opposing commercial interests, questioning the validity of existing patent systems, arguing that public health should be prioritized over commercial interests (Correa, 2007).

In addition, limited health care facilities in many countries in the Global South hindered the expansion of treatment. Lack of health workers, poor diagnostic testing capacity and weak distribution networks reduced states' capacity to ensure a precise implementation of large-scale HIV/AIDS programmes (Piot, 2012). Thus, access inequality was not just a health problem, it was also a larger economic and institutional inequality in global health governance (Benatar, 2013).

Slowly, reforms have been brought about in international diplomacy. Developing states pressed for more flexibility in international trade rules, and in 2001 the Doha Declaration on the TRIPS Agreement and Public Health was adopted, which officially recognized the right of States to use mandatory licensing to increase access to essential medicines (WTO 2001). Civil society organizations also played a role in shaping international debates by pointing to gaps in treatment and in calling on pharmaceutical firms to lower prices, for example, Médecins Sans Frontières and other advocacy groups ('t Hoen, 2009).

The creation of organizations like UNAIDS, the Global Fund and PEPFAR has further reinforced cooperation between countries at the global level, through funding and the expansion of treatment programmes in developing countries (Piot 2012). Even though these successes were achieved, inequalities were obvious as access improvements were slow and many populations remained vulnerable to the impact of preventable mortality in the early days of the epidemic.

4.3 Global Health Diplomacy and the COVID-19 Response

The COVID-19 pandemic was a more accelerated and greater challenge to global health diplomacy. While scientific cooperation helped the development of vaccines at unprecedented tempo, vaccine access exposed significant inequalities within the international system.

High-income countries have been able to secure vaccine supplies through advance purchase agreements, while many countries in Africa, Asia, and Latin America have suffered from vaccine access delays due to limited purchasing power, manufacturing capacity, and reliance on outside sources (Moon et al., 2022). The distribution of vaccines was uneven, aligning with the global distribution of vaccines, with better economic and technological resources states being able to obtain vaccines faster.

Vaccines were also turned into a diplomatic weapon. Cooperative bilateral vaccine transfers were consistently linked to foreign policy goals and objectives, whereas competition between major powers influenced international vaccine provision. While initiatives like COVAX tried to improve vaccine equity, their impact was limited as vaccines were scarce and countries competed for them in their procurement (Harman, 2023).

COVID-19 experience has, however, shown that equitable access to scientific innovation is not a foregone conclusion. Rather, access was less driven by domestic production structures, economic resources and geopolitical power.

4.4 Compare and contrast HIV/AIDS and COVID-19.

The parallels and distinctions among HIV/AIDS and COVID-19 are noteworthy. The long-term challenges in accessing treatment for HIV/AIDS and the heightened pressures on vaccine development and distribution for COVID-19 highlighted the importance of these issues. However, in both instances, access inequality was driven by inequities in access to pharmaceutical technologies, pharmaceutical production capacity, and financial resources.

While vaccine nationalism, vaccine shortage, and competition over vaccines were key challenges in COVID-19, IP protection and drug pricing were the dominant hurdles in the case of HIV/AIDS. However, both crises demonstrate the need to recognize that health outcomes are affected not only by what is scientifically available but also by the political and economic environment around the world.

4.5 Discussion of Findings

The results demonstrate the commonly observed structural inequity in global health governance. Although there has been

an increasing degree of cooperation at the global level in access to medicines and vaccines, these disparities can be linked to the technological rights of ownership, manufacturing capacity and bargaining power.

The picture painted from the Dependency Theory is thus substantiated: that many of the Global South states continue to rely on the Global South economies for pharmaceutical technologies and health resources (Frank, 1967; Amin, 1976). Pharmaceuticals are concentrated in advanced economies, leading to inequitable relationships that shape health outcomes.

Global institutions have contributed to enhanced cooperation, financing, and coordination in a positive way from a Liberal Institutionalist point of view. Through institutions like WHO, UNAIDS, The Global Fund and COVAX, it becomes clear how important institutions are to help manage global health crises (Keohane, 1984). But these institutions work within the system of global inequality of power relations, which limits their capacity to overcome the structural inequalities.

The results also reveal that the Global South are often denied timely access to essential health technologies, highly vulnerable to dependence on external support, and limited in their power to participate in global health decision making. Thus, global health diplomacy is a sign of cooperation and inequity, as it constitutes a framework for collective responsibility in the context of an unequal global architecture.

4.6 Summary of Findings

The chapter is all about the fact that:

Increased collaboration through Global Health Diplomacy has not yet eradicated inequalities in access to medicines and vaccines.

HIV/AIDS and COVID-19 demonstrate the persistent impact of structural inequalities in governance of global health.

Global institutions are essential in coordinating and mobilizing resources but they are constrained by geopolitical and economic realities.

In the Global South, access to outcomes remains technologically dependent, pharmaceutical concentrated and is being influenced by unequal bargaining power.

As a whole, the evidence points to the notion that global health governance is marked by institutional cooperation and, at the same time, a high prevalence of structural inequality.

4. SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter concludes the major findings of the study, presents conclusions based on the comparative analysis of the HIV/AIDS epidemic and COVID-19 pandemic, and provides recommendations for enhancing global health diplomacy and equitable access to medicines and vaccines in the Global South. The discussion is guided by the combined insights of Dependency Theory and Liberal Institutionalism, which explicate the relationship between structural inequalities and global cooperation in global health governance (Frank, 1967; Keohane, 1984).

5.2 Summary of the Study

This study underscored the role of Global Health Diplomacy (GHD) in shaping access inequality in the Global South through a comparative analysis of HIV/AIDS and COVID-19. The study indicated that while global health diplomacy has expanded global cooperation, institutional coordination, and resource mobilization, it has not removed frequent inequalities in access to essential health technologies.

The findings exposed that the HIV/AIDS epidemic revealed significant differences in access to antiretroviral medicines owing to high pharmaceutical costs, patent restrictions,feeble healthcare systems, and restricted production capacity in developing states (Farmer, 2001; Correa, 2007). Although programmes including UNAIDS, the Global Fund, and PEPFAR enhanced treatment access, many states remained dependent on foreign financing and pharmaceutical suppliers (Piot, 2012).

Equally, the COVID-19 pandemic indicated continuing inequalities through vaccine nationalism, unequal procurement systems, technological dependence, and concentration of manufacturing capacity among high-income states. Although mechanisms including COVAX attempted to boost equitable vaccine distribution, their effectiveness was limited by geopolitical competition and unequal international production structures (Moon et al., 2022; Harman, 2023).

The study thus found that access inequality is shaped by the engagement between structural dependency and institutional cooperation. Whilst global institutions enhance collective reactions, they operate within an uneven global political economy characterized by differences in technology, finance, and bargaining power (Benatar, 2013; Labonté & Gagnon, 2010).

5.3 Conclusion

The study summarizes that Global Health Diplomacy represents both a tool of global cooperation and a reflection of current international inequalities. Global institutions including the World Health Organization, UNAIDS, the Global Fund, and other multilateral mechanisms have contributed greatly to coordinating responses to health crises. However, their ability to achieve equitable outputs remains constrained by structural inequalities embedded within the global system (Fidler, 2010; Keohane, 1984).

The comparison between HIV/AIDS and COVID-19 shows that unequal access to health resources is not just a technical issue but a political and economic challenges influenced by intellectual property regimes, pharmaceutical ownership, financial capacity, and geopolitical power. Dependency Theory explicates why many Global South states remain reliant on foreign sources for critical health technologies, whilst Liberal Institutionalism indicates the importance of cooperation and institutional mechanisms in tackling international challenges (Frank, 1967; Keohane, 1984).

Thus, meaningful equity in global health governance demands reforms that address both institutional deficiencies and deeper structural inequalities.

5.4 Recommendations

First, global health governance institutions should be strengthened by enhancing accountability mechanisms, emergency coordination, and equitable resource distribution. The restrictions experienced by COVAX during COVID-19 show that voluntary cooperation alone is enough for ensuring fair access during international emergencies (Moon et al., 2022).

Second, countries in the Global South should expand pharmaceutical manufacturing capacity through investment in vaccine production, research infrastructure, and technology transfer. Greater regional production capacity would minimize dependence on foreign suppliers in the future crises (Benatar, 2013).

Third, intellectual property governance should be reformed to balance commercial interests with public health priorities. Measures including mandatory licensing, technology-sharing mechanisms, and emergency intellectual property flexibilities can enhance access to essential medicines and vaccines, as demonstrated by debates surrounding the TRIPS Agreement during HIV/AIDS and COVID-19 (WTO, 2001; Correa, 2007).

Fourth, regional cooperation should be strengthened through joint procurement mechanisms, pooled financing, and shared pharmaceutical programme. Such approaches can improve bargaining power and minimize vulnerability among developing states.

Finally, global health financing should adopt more equity-based approaches that focus vulnerability and public health needs rather than economic and geopolitical influence.

5.5 Contribution to Knowledge

This study adds to scholarship by integrating Global Health Diplomacy into International Relations analysis of power, inequality, and cooperation. It creates a comparative framework for understanding HIV/AIDS and COVID-19 and shows that global health outcomes are shaped by both institutional cooperation and structural dependency.

5.6 Suggestions for Further Research

Future studies may underscore the role of pharmaceutical corporations in global health diplomacy, the effectiveness of African pharmaceutical manufacturing programs, the relationship between climate change and health inequality, and post-COVID reforms in global health governance.

5.7 Final Remark

Global Health Diplomacy remains integral for tackling transnational health issues. However, without restructuring in international production systems, intellectual property arrangements, financing structures, and institutional authority, inequalities in access to medicines and vaccines will continue to shape health outcomes in future global emergencies (Kickbusch, Silberschmidt, & Buss, 2007).

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