International Journal of Trend in Research and Development, Volume 9(4), ISSN: 2394-9333
www.ijtrd.com

India's Health Diplomacy Policy

Zha Gongfei
School of Political Science and Public Administration, China University of Political science and Law, Beijing, China

Abstract: This paper takes India's health diplomacy as the subject of study mainly based on the two following reasons. For one thing, all the countries have been increasingly interdependent in the era of globalization. The domino effect is enormous. Therefore, health diplomacy has become increasingly important in current national diplomatic affairs. For the other, India is large developing country in Asia and major emerging economy in the world. With rapid development of India, India is playing an increasingly important role in global health governance. Health diplomacy of India conducts in characteristics and cutting edges, providing extremely particular contributions to global health governance. India possesses absolute advantages in exporting advanced techniques of medical science and education and producing economically affordable generic drugs. Besides, its characteristic health diplomacy lies in multilateral health negotiations on behalf of developing countries, defending national interests of its own and other counterparts.

Keywords: *India; Health Diplomacy; Characteristics; Goals*

Historically, health activities and diplomacy have been intertwined for a very long time; yet the relationship between the two has not been prominent or given adequate attention, leaving health on the periphery of foreign policy. With the rapid development of globalization, the interdependence of countries has increased and non-traditional security issues have become more prominent; the emergence of global health issues has increased the responsibility of governments for health, and health issues have become more important on the global political agenda (three of the United Nations' Millennium Development Goals (MGDs)). The emergence of health in foreign policy necessitates a major transition in national and international administration. This trend has resulted in an increase in the regularity with which nations employ diplomacy to address health concerns to establish health governance at the national and international levels. Overall, the impact of health issues has increased steadily over the past few decades, generating major attention and an extraordinary shift in the relationship between health and diplomacy, and has become a subject of continuous study.

I. THEORETICAL ANALYSIS OF HEALTH DIPLOMACY

1. Health and National Security, Economic Interests of the Linkage and Development

In an age of rising globalization challenges, the meaning and scope of "security" have changed. Globalization has been defined as "the process of increasing human interaction across spatial, temporal, and cognitive boundaries, resulting in greater connectivity"[1], bringing with it many new collective action issues such as climate change, population movements, and disease epidemics, as well as the need for nations to cooperate more than ever before to address common threats. To combat common threats, nations must collaborate more than ever before. The rapid pace of globalization has also contributed to a shift in the international political environment, with the international community shifting its focus from high-level political security, traditional security, and hard power to low-level political security, non-traditional security, and soft power; or "security" referring not only to the macro-level security of states and other large entities, but also to individual and community group security. It also includes security at the micro level, including individuals and community groups. Historically, health has been categorized as low-level politics, associated with humanitarian activities, science and technology, non-political events, and not associated with traditional security factors such as national security, economic interests, or as a strategic tool of diplomacy, i.e., the perception that international health tends to focus on normative values of human dignity and is less relevant to the pursuit of material gain, power, and security by states, which is a misconception.

Notably, the fact that health has been undervalued in foreign policy in the past does not imply that health is irrelevant to considerations such as economic interests and national security, but rather that it has not received adequate emphasis and attention. The pursuit of the state's essential objectives of security, economic interests, development, and human dignity is a key function of foreign policy, but this does not imply that the state can achieve a harmonious balance between each purpose. In the past, economic concerns dominated foreign policy, and the relationship between economics and health was erroneously viewed as a causal one – "wealth health" - with the assumption that the production of riches would inevitably lead to health.[2] This is not the case, the relationship is reciprocal, as demonstrated by the social, economic, and political changes generated by the three plague pandemics throughout history. The horrific catastrophe caused by the development and use of biological weapons during WWI and WWII provided the basis for a link between health and national security, yet this link did not develop, and the international community used arms control bans ("the Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gaseous Bacteriological Methods of Warfare" signed in 1925, the 1972 "Banning of Bacteriological (Biological) and Toxin Weapons", and "the Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on Their Destruction") to effectively mitigate the threat of biological weapons, but States have not supplemented arms control treaties with health cooperation tools such as education and

[1] Lee K., *Globalization and health: An introduction*, London: Palgrave Macmillan, 2003.

[2] David P. Fidler, Health and Foreign Policy: A Conceptual Overview, *The Nuffield Trust*, 2005，pp4-5.

exchange of public health knowledge and public health protection (e.g. development of drugs and vaccines) as a means of disarming the threat of biological weapons.

The international community has begun to pay more attention to public health issues in foreign policy considering the rapid pace of globalization and the increased threat that health problems pose to the growth and development of national security and economic interests in terms of speed, volume, and diversity of change. According to relevant scholarly research, between the first International Health Conference in 1851 and the San Francisco Conference in 1945, which announced the establishment of the United Nations and called for the establishment of an international health agency, the basis for international health cooperation was the common threat faced by countries (epidemic infectious diseases) and the interest of the international community. [3] However, the period's international health conferences were impeded by the lack of scientific understanding, and the participating nations were frequently unable to establish a consensus on pertinent health concerns. After the Second World War, the connection between health and human rights increased understanding of the relationship between health and foreign policy, which can be traced to the 1946 Constitution of the World Health Organization and the 1966 International Covenant on Economic, Social, and Cultural Rights. Although health diplomacy dates back more than 160 years (to the inaugural International Conference on Health in 1851), the relationship between health and diplomacy has only been established in the last decade or so. The Oslo Ministerial Declaration, issued in March 2007 by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, was a significant effort to integrate health issues into foreign policy. The Foreign Policy and Global Health Initiative (FPGH) calls for closer ties between global health and foreign policy and seeks to improve the achievement of health governance objectives through diplomatic collaboration.[4] In 2008, the UN General Assembly highlighted the "close link between foreign policy and global health and their interdependence"[5], and following resolutions 64/108 (2009), 65/95 (2010), and 66/115 (2011) confirmed this relationship. The UN General Assembly underlined the intimate relationship between foreign policy and global health in resolutions 64/108 (2009), 65/95 (2010), and 66/115 (2011), and resolution 64/108 reinforced the key conclusions of the Oslo Ministerial Declaration.

2. Definition of Health Diplomacy

Health diplomacy, also referred to as "health diplomacy" or "medical diplomacy", is a relatively new field, and although scholars and experts have explored it to varying degrees and provided different definitions, theoretical research in this field is still in its infancy, and definitions have yet to be developed. Relevant definitions have yet to be developed and fully defined. To better define health diplomacy, this paper explores the concept of "health diplomacy" using the "5W+1H" approach (when, who, where, what, why and how).

The circumstances and scope of health diplomacy (when and where). In the 21st century, in the context of "one world, one health", the health of any country can no longer be protected by its government alone, and the international community has generally acknowledged the global nature of health challenges. The global nature of health issues has gained widespread recognition in the international community, and the term 'health' has gradually morphed into 'global health', which is used by scholars and practitioners in a wide range of activities, so that health diplomacy today generally refers to global health diplomacy. The majority of experts and academics view global health as the most recent expansion and evolution of tropical medicine international health international public health, an evolution that also reflects the expanding scope of health issues, which have evolved through national international global scales. Global health refers to "health challenges that transcend national boundaries and governments and require the application of global forces determining human health"[6] in order to promote global health and attain global health equity. This includes handling large-scale epidemics, developing infectious diseases, climate change, international development concerns, and the continuously expanding global health insurance business. In this new era, the scope of health diplomacy is therefore worldwide and can include any health-related issues on the planet.

Who are the participants in health diplomacy (Who)? Today's health diplomacy is characterized by a multiplicity of actors and an approach that numerous experts have termed "multi-levels, multi-participants"[7]. Historically, the state has been the leading authority in the field of health diplomacy, with the Ministry of Foreign Affairs concentrating diplomatic influence. The interconnection of globalization has made health concerns more diverse and complicated, blurring the limits of the state and exceeding the ability of individual governments to handle them through domestic institutions and health and non-health industries. In addition, global health diplomacy combines a number of disciplines, such as international relations, global health, diplomacy, economics, law, and medicine, i.e., it requires a combination of technical expertise, legal knowledge, and diplomatic skills, so that the practice of health diplomacy is no longer limited to traditional diplomats, but involves many other actors; and the large number of agreements reached between governments is not only the result of traditional diplomats' efforts. Numerous agreements between governments have been negotiated not just through traditional diplomatic channels, but also between national institutions, and cross-sector cooperation is now more vital than ever. It is also important to note that the fragmentation and plurality of actors practicing health diplomacy has led to the emergence of multiple legitimate authorities in the diplomatic field, implying that "the more centres of power there are, the more important consultation,

[3] Howard-Jones, N. 1950, The Origins of International Health Work,*British Medical Journal*, May 6, pp. 1032-1037.

[4] Amorim C, Douste-Blazy P, Wirayuda H, Gahr Store J, Tidiane Gadio C, Dlamini-Zuma N, Pibulsonggram N., "Oslo Ministerial Declaration – global health: a pressing foreign policy issue of our time", *Lancet*, 2007, 2 April, pp. 1-6.

[5] United Nations. (2008) Resolution A/Res/63/33. Global Health and Foreign Policy. Available at http://www.who.int/trade/events/UNGA_RESOLUTION_GHFP_63_33.pdf. (Accessed October 13, 2018)

[6] Kickbusch I, Lister G., European Perspectives on Global Health: A Policy Glossary, Brussels: European Foundation Center, 2006.

[7] Kickbusch I, Silberschmidt G, Buss P. 2007. Global health diplomacy: the need for new perspectives, strategic approaches and skills in global health. *Bulletin of the World Health Organization* 85: 230–2.

negotiation, and coalition-building are"[8], which demonstrates the significance of collective action in health diplomacy.

The objectives of health diplomacy(why). The objectives of health diplomacy can be analyzed at both the national and international levels. At the national level, health diplomacy not only "offers clearer opportunities for fostering trust and reciprocal negotiations in the context of global health goals"[9], but it also "creates opportunities for strengthening political alliances and economic relations"[10] and can "assist those in greatest need and win the hearts and minds of people in poor countries"[11]. At this level, the objectives of health diplomacy are generally closely linked to the defense of national interests, the expansion of international influence, and the development of relations with other countries, and in some instances even to the repair of diplomatic failures, which demonstrates egotism. On a global scale, the objectives of health diplomacy are typically associated with global security and development, the cause of human rights, and ethics. The objective may be "to perform, cooperate, resolve differences, improve health systems and ensure the right to health of vulnerable populations"[12] or to "promote stability and growth, ... Stop the spread of extremism, ease migration pressures and reduce the need for humanitarian and development assistance"[13]. Some scholars see global health diplomacy as a "bridge between peace and security"[14].

How to practice health diplomacy (How)? In practice, there are two primary approaches to health diplomacy, namely negotiation and health aid, which interact and support one another. Although there is currently no agreed-upon definition of health diplomacy, it is widely acknowledged that negotiation is a major aspect of this field. Negotiation not only refers to negotiations between multiple actors, such as states, non-states, and other public institutions, but also to negotiations on a variety of health-related topics aimed at reaching formal and informal consensus and compromise on global health issues, with agreements like the Framework Convention on Tobacco Control and the International Health Regulations (2015) being formal treaties reached through collective bargaining. Another option is health assistance, which emphasizes action and might be bilateral or multilateral. Depending on their own circumstances and those of the receiver, each party can contribute, among other things, financial help, humanitarian aid, capacity building, health-related infrastructure development, health care, an exchange of expertise, and assistance with human resources.

What is the definition of health diplomacy? The preceding analysis demonstrates that: first, the scope of health diplomacy varies in different periods and contexts, but generally exhibits a dynamic trend of continuous expansion; second, the borderless nature of health issues and the multidisciplinary knowledge involved in health diplomacy highlight the diversity of participants in health diplomacy; and third, although the goals of health diplomacy are diverse, whether at the national or global level, they are typically linear. Lastly, health diplomacy "involves negotiation, but also a great deal of relationship building and is a component of the management of global affairs"[15], with negotiation and health aid being its primary tools. In conclusion, a combination of these factors defines health diplomacy as the interaction and practice of negotiating and creating connections between many stakeholders in various contexts in the field of health and its determinants in order to achieve national or global goals. The term global health diplomacy refers to the organizational structures, communication, and negotiation processes that create the global policy environment.

II. INDIA'S GLOBAL HEALTH DIPLOMACY

India's increased development assistance and global public goods provision in the health sector are indicative of the rising profile of health in India's foreign policy in recent years. However, India's engagement in global health governance has been very limited, and it has not yet provided a viable alternative model to the current global health governance. India is currently utilizing health diplomacy to build its diplomatic ties with underdeveloped nations and expand its worldwide influence.

1. India's Health Status

India's internal health status is frequently contradictory. The contrast between poverty and wealth is huge. India has achieved the accomplishment of moving into the ranks of lower-middle income countries, becomes the world's third largest economy in terms of average purchasing power. India still carries a significant health burden. Prime Minister Narendra Modi nailed it when he stated, "India is a wealthy country with poor people"[16]. Today, India has a significant disease load, and a big proportion of its population lacks basic health care. As of October 2018, 176 million Indians continue to live in poverty.[17] More than one-third of Indians are underweight, and 1.5 million children die before their fifth birthday.[18] Lack of access to public health care contributes to

[8] Ilona Kickbusch, "21st century Health Diplomacy: A new relationship between foreign policy and health", in Ilona Kickbusch, Tom Novotny, et al. editors, *21st Century Health Diplomacy*, London: Imperial College, World Scientific Press, 2013. p27.

[9] Bond K., "Health security or health diplomacy? Moving beyond semantic analysis to strengthen health systems and global cooperation", *Health Policy and Planning*, 2008, 23:376-378.

[10] Jones K-A. Washington, DC: Remarks at Negotiating Health in the 21st Century Conference, 2009. Global Health Diplomacy: Negotiating Health in the 21st Century. November 2.

[11] Fauci AS.,"The expanding global health agenda: a welcome development", *Nature Medicine*, 2007, 33: 10.

[12] Health Diplomats, "Health Diplomacy," Geneva, http://www.healthdiplomats.com/index.php?page=31_health_overview.

[13] Jones K-A. Washington, DC: Remarks at Negotiating Health in the 21st Century Conference; 2009. Global Health Diplomacy: Negotiating Health in the 21st Century. November 2.

[14] Novotny TE, Adams V, 2008. Global health diplomacy: a call for a new field of teaching and research. San Francisco Medical Society. Online at: http://www.sfms.org/AM/Template.cfm?Section¼Article_Archives&CONTENTID¼2272&TEMPLATE¼/CM/HTMLDisplay.cfm&SECTION¼Article_Archives.

[15] Ilona Kickbusch, 21st century Health Diplomacy: A new relationship between foreign policy and health, In Ilona Kickbusch, Tom Novotny, et al. editors. *21st Century Health Diplomacy*, London: Imperial College, World Scientific Press, 2013.

[16] Press Trust of India, "PM Narendra Modi calls for 'long jump' to push socio-economic transformation, " NDTV, April 17, 2017, http://www.ndtv.com/india-news/pm-narendra-modi-calls-for-long-jump-to-push-socio-economic-transformation-1682217.

[17] World Bank, "India Overview," http://www.worldbank.org/en/country/india/overview, Accessed October 29, 2018.

[18] K. Sujatha Rao, Do We Care? India's Health System, New York:

the prevalence of non-communicable diseases such as diabetes and hypertension, as well as communicable diseases like as tuberculosis[19] and malaria, which contribute to high morbidity and mortality. The rates of maternal, neonatal, and infant mortality are among the highest in the world, and there is no assurance of maternal and child health. Environmental issues have become a greater threat to public health as a result of economic expansion at the price of environmental protection, with "approximately 1.1 million people dying annually from air pollution".[20]Moreover, the high quality and low cost of India's pharmaceutical products have made some of its drugs incredibly important on the global pharmaceutical market, also known as the "pharmacy of the world", although a significant percentage of Indians still lack access to crucial medicines. Nearly half of the nation's 24.39 million HIV-positive individuals do not have access to antiretroviral medication.

A schism between the public and private health sectors. India's public health system is inadequate, successive administrations have failed to prioritize the health of its inhabitants, and its public health system is profoundly defective due to "inadequate funding, bad governance, and inattentive government"[21]. Consistently, India's public health spending has been insufficient to satisfy the enormous domestic health demands, and the low health spending share of GDP over the years demonstrates the government's constant disregard for public health. In FY2015-16, for instance, the Indian government spent only 1.02 percent of its GDP on public health, placing it behind low-income nations such as the Maldives (9.4), Bhutan (2.5), Sri Lanka (1.6), and Nepal (1.1) and significantly below the global average of 6%.[22] Global health spending patterns indicate that basic health care demands are rarely addressed until a country spends at least 5-6% of its GDP on health and government spending is a key component. [23]A dearth of healthcare professionals further burdens the healthcare system. According to the most recent data from India's National Health Profile (NHP) 2018, one allopathic government doctor in India treats an average of 11,082 patients, which is far more than the World Health Organization (WHO)-recommended ratio of 1:1,000. [24] Importantly, poor governance in the Indian health system has resulted in inadequate service delivery, and weak accountability, bureaucratic corruption, nepotism, and rivalry for power centers within institutions have diminished the voice of systemic reform. In stark contrast to India's inadequate public health system, the private health sector is thriving. On the one hand, the majority of India's health care is now provided by a large but poorly regulated secondary and tertiary private health sector, and the encroachment of the private sector has left an already weak public sector with a more limited role, making India one of the countries with the highest out-of-pocket health care expenditures. On the other hand, the private sector's provision of high-quality, low-cost healthcare services has propelled India to the forefront of the world's healthcare facilities and medical tourism industry, in stark contrast to the country's high health care costs. Medical tourism has become such a significant export earner in the service industry that the Indian Ministry of External Affairs has a specific visa category for medical tourism.

Over the years, India's past apathy to public health spending has been replaced with frequent policy support and health spending promises, and health is gradually becoming a national priority. India healthcare spending for 2018 was $60, a 4.71% increase from 2017[25], reversing the fall and stagnation observed under the Modi administration. In addition, India announced a new National Health Policy in March 2017 with the objective of boosting public health spending from 1.15 percent of GDP to 2.5 percent of GDP by 2025.[26] In March of 2017, the Indian government announced a draft of its Tuberculosis Strategy for the years 2017 to 2025, which contained a pledge to eradicate the illness in the final year of the plan's duration. This pledge was reaffirmed in the Delhi Call to End Tuberculosis in the WHO South-East Asia Region by 2030, a joint endeavor of 11 Southeast Asian health ministers. [27] The Modi administration introduced the Ayushman-National Health Protection Programme (BHPP) nation-wide in September 2018. Bharat-National Health Protection Scheme (AB-NHPS), which will cover 100 million poor Indian households and offer up to 500 million individuals with medical coverage of up to Rs. 500,000 each year, is the world's largest government health scheme. Whether these goals and promises will be realized remains a significant question, as India is not only plagued by a substantial internal health burden, but also by a reduction in external help that will place more strain on an already strained healthcare system. On the one hand, despite its traditional role as a recipient, India seeks to transform itself into a pure donor over time. From 1967 to 2010, India's net ODA as a proportion of gross national income (GNI) decreased from 2.79 to 0.17.[28] India announced in 2003 that it will only take bilateral aid from the United Kingdom, the United States, Japan, Germany, and Russia, as well as the European Union. In contrast, because India has met the World Bank's requirements for a lower-middle income country, it is no longer eligible for the majority of the help it formerly received, including health care.

Oxford University Press, 2017, xii.

[19] India has the highest incidence of tuberculosis and the second highest burden of multi- drug resistant tuberculosis globally, and tuberculosis is the leading cause of death among Indian citizens.

[20] Health Effects Institute, "State of Global Air 2017," https://www.stateofglobalair.org/data.

[21] Kumar P., "Do We Care? India's Health System", *Indian J Community Med*, 2017, 42:186.

[22] National Health Profile 2018: Here's how well India is healthwise, *The Indian Express*, October 29, 2018. https://indianexpress.com/article/india/national-health-profile-2018-heres-how-well-india-is-health-wise-5228742/.

[23] World Health Organisation, Western Pacific Region- Southeast Asia Region, Health Financing Strategy for Asia Pacific Region (2010-2015), 2009, P. 27.

[24] National Health Profile 2018: Here's how well India is healthwise, *The Indian Express*, October 29, 2018. https://indianexpress.com/article/india/national-health-profile-2018-heres-how-well-india-is-health-wise-5228742/.

[25] Macrotrends, "India Healthcare Spending 2000-2022", https://www.macrotrends.net/countries/IND/india/healthcare-spending.

[26] Richard Downie and Deen Garba, "Accelerating Health Innovation in India", *Center for Strategic and International Studies*, July 11, 2017, p.10.

[27] Dinesh C. Sharma, "New plan to end tuberculosis in south and southeast Asia," *The Lancet*, 389, No.10075 (March 25, 2017): 1183, http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)30817-6.pdf.

[28] World Bank Indicators-India-Official Development Assistance. Available at http://www.tradingeconomics.com/india/net-odareceived-percent-of-gni-wb-data.html.

In 2010, foreign aid to India was only 0.3% of the country's gross domestic product.[29] In recent years, the United Kingdom (since 2012) and the European Union (since 2014) have reduced their help to India, while the United States and the Global Fund, which is mostly funded by the United States, have significantly reduced their assistance.[30]

2. India's Health Aid Policy

(1) India's Choice of Recipient Countries

Since its founding, India has received enormous aid from the developed West, and in the 1980s it became one of the world's top aid recipients.[31] In its capacity as a beneficiary, India has provided effective and distinctive health assistance to other developing nations over the previous decade or so.

India's Foreign Minister Jaswant Singh said on 28 February 2003 that India would no longer accept development money from donors other than the United States, United Kingdom, Japan, Germany, Russia, and the European Union.[32] In the same address, the India Development Initiative was introduced, signaling to the world India's ambition to assume a donor role, with the goal of bolstering development cooperation with developing nations in the global South.[33] India stated that it would provide assistance to these nations based on its own experience with rapid economic development. However, India had previously provided support, primarily technical expertise. As early as 1949, in response to hunger, India donated scholarships and humanitarian aid to a number of developing nations.[34] India's foreign health assistance can be traced back to its earliest support and assistance to neighbouring countries, India remains one of the largest and most numerous aid donors to South Asian countries, which have been a top priority for India's foreign aid efforts.

In the early years of independence, India's primary purpose was to strengthen its neighbors, particularly Bhutan, Burma, and Nepal. Beginning in 1960, India began providing assistance to Bhutan. India assisted Bhutan with its first Five Year Plan in 1961, contributing Rs. 1.07 billion and was a full donor to Bhutan's second Five Year Plan.[35] Despite the fact that India's assistance to Bhutan gradually decreased in succeeding five-year plans, it maintained its most significant contribution.[36] Bhutan and India have maintained close ties in international cooperation to eradicate malaria and smallpox, with India and other countries sending experts to Bhutan and Bhutan sending students to India and other countries for training and study. By 1999, smallpox was eradicated in Bhutan and malaria was better controlled.[37]

India has strengthened its public health capabilities in Bhutan, Nepal, Maldives, Afghanistan, and Africa in particular. The framework for African-Indian cooperation has enhanced the ability of health professionals to respond to influenza pandemics. Afghanistan's capital, Kabul, is home to the Indira Gandhi Children's Hospital, which India has vowed to fully support. The India-India cooperation framework has increased the capacity of health professionals to respond to a pandemic influenza outbreak. Facility enhancements India has developed hospitals in Nepal and contributed to the development of the Maldives' public health system by providing technical training and constructing hospitals. India has developed hospitals in Nepal and contributed to the development of the Maldives' public health system by providing technical training and constructing hospitals. And by assisting each of these nations, India has garnered political or economic advantages.

In the past, India has given assistance priority to South Asian nations, but in recent years, for geopolitical considerations, it has increasingly prioritized collaboration and development in Africa.

India's 2010 budget of $536 million was allocated to financial contributions and loans to foreign nations, including US$12.6 billion in contributions to international organizations and up to an additional US$500 million for the Techno-Economic Approach for Africa-India Movement Initiative. At the 2008 and 2011 summits of the Africa India Forum, India pledged US$547 million to Africa. India promised $5 billion in credit facilities and $547 million and US$700 million, respectively, for aid-related initiatives in Africa. The yearly health budget of India was only about $5.9 billion.[38] The third Africa India Forum Summit, which had been postponed due to the Ebola epidemic, was held in the Indian capital of New Delhi in October 2015, where the Indian government pledged to double the amount of aid to Africa, with an increase of US$10.6 billion in non-reimbursable aid and concessional loans, with a focus on health, energy cleanliness, and other areas.[39]

The pan-Africa E-network, which has contributed considerably to the development of public health in African countries through distance education and telemedicine, is one of India's most well-known and ambitious development projects. The India-Ethiopia telemedicine network, which went live in July 2007, is an example of this. This has enabled doctors in Ethiopia to communicate with doctors in India over the Internet, thereby alleviating the dearth of medical

---

[29] Bijoy, C. J., "India: Transiting to a Global Donor." *Reality of Aid*, 2010.

[30] Richard Downie and Deen Garba, "Accelerating Health Innovation in India", *Center for Strategic and International Studies*, July 11, 2017, p16.

[31] Sagarika Chowdhary，Balendushekhar Mangalmurty and Anil K Singh, "Aid and the PrivateSector：A study in the Context of India"，2011，p3.

[32] Jaswant Singh, "Union Budget Speech 2003–2004", Sansad Bhawan, New Delhi, February 28,2003.

[33] Matthias Jobelus, "New Powers for Global Change? Challenges for Internal DevelopmentCooperation," brieng paper, Friedrich-Ebert-Stiung, March 2007.

[34] Eswaran Sridharan, "The Emerging Foreign Assistance Policies of India and China: India as adevelopment partner", Final Draft, March 2014, p.10.

[35] Gareth Price, "Diversity in Donor ship: the Changing Landscape of Official humanitarian Aid, India's Official Aid Program", HPG Background Paper, September 2005, p.7.

[36] Ibid.

[37] Sven, "An analysis of Bhutan's economic development", *South Asian Studies Quarterly*, 2001(04):14-20+2-1.

[38] The second Africa India Forum Summit was held in Addis Ababa, Ethiopia, on 24-25 May 2011.The theme of the second summit was "Strengthening Partnerships and Shared Visions". Prime Minister Singh announced that India would provide $5 billion in credit to support infrastructure and other development in Africa.

[39] Zhang Hongming, ed., *Africa Development Report (2015-2016): Chinese Enterprises in Africa: Effectiveness, Problems and Countermeasures*, Beijing: Social Science Literature Publishing House, 2016 edition, p. 319.

professionals in Ethiopia. It also enables Ethiopian patients to access diagnostic services from Indian facilities that are of higher quality and more precise. India has started the ITEC-Commonwealth Aid Programme with a special emphasis on distant education and telemedicine for African countries that are historically part of the same Commonwealth as India.

The ITEC-Commonwealth Programme for Africa focuses on telemedicine and online education. India's ambassador to Ethiopia, Guriit Sing.h, stated, "They view this project (telemedicine network) as a low-cost means to transfer India's cutting-edge healthcare and education technology to Africa." This has been a distinguishing characteristic of India's overseas aid. Examples include India's global political advocacy initiative to raise awareness and support for HIV vaccine research and development, the launch of the Pan-African Telecommunications Network in Africa, and the establishment of the IBSA Forum (The India Brazil and South Africa (IBSA) Fund) with Brazil and South Africa, where health issues are a significant area of cooperation and each country is committed to focusing its research on specific diseases.

India's choice of recipient countries India's choice of recipient countries is interlocking and progressive, prioritising countries in the South Asian region, gradually increasing its India's assistance to Africa, and its emphasis on and active participation in multilateral cooperation mechanisms.

(2) Characteristics of India's Health Aid

Initially, India's health assistance to neighboring countries such as Bhutan, Afghanistan, and Nepal consisted primarily of material support; however, it has since shifted its focus to technological innovation and technology export, providing technology-based health assistance such as telemedicine diagnosis and assisting other nations in the development of medical information platforms. It also prioritizes the manufacturing of inexpensive generic drugs.

Bringing down the cost of medications. The focus of India's health assistance to African nations and other regions is also on soft investments, such as the training of human resources and the dispatch of national specialists to help feasibility studies.

Initially, India's international health assistance consisted of material support in the form of cash resources, primarily for its immediate neighbors. Since 2009, India has donated at least $10 million to South and Southeast Asia and Africa, according to available data. Since 2009, India has contributed at least $10 million to health programs in South Asia, Southeast Asia, and Africa through bilateral collaboration. [40] India's health development support includes infrastructural assistance, hospital construction, and hospital provision. By creating infrastructure, establishing hospitals, supplying medical supplies to hospitals, giving medical education, and conducting public health initiatives, the results of economic development are fed back to the people through education, health, and infrastructure.

The second distinguishing form of health assistance in India is the export of technology and the development of human resources. The Indian Economic and Technical Cooperation Department of the Ministry of External Affairs, which is responsible for providing technical support to foreign countries, was established in 1964. 158 countries have received technical support from India, totaling more than $3 billion, according to figures. The annual average budget for technical support is $12 million. In addition to providing financial support for technical assistance, India exports medical and health services as part of its technical aid. The overall technical aid received by India exceeds $3 billion, with an annual average of $12 million.[41] India's technical aid comprises the export of cutting-edge technologies in healthcare and education, as well as the training and export of manpower, in addition to financial support for technical assistance.

Technical support focuses on the export of India's cutting-edge innovations in healthcare and education. India's illustrious information technology sector is renowned for its capacity to assist recipient or partner nations in constructing information technology infrastructure platforms that maximize the benefits of information technology. This has enabled telemedicine, education, and health care. As stated previously, India created the Pan-African e-network project in 2007 to enable telemedicine and tele-education, which has offered both patients and physicians in Africa tremendous convenience.

Training and the export of talent are also essential components of India's technical aid. India places a premium on the training of human resources and concentrates on the training and education of local health staff in a variety of ways, including the offer of several scholarships. The objective is to give medical and material aid while also exporting technology, training workers, and developing their workforce. We also deploy Indian professionals to our partner nations to educate and train health personnel in medical and health-related fields. In addition, the program delivers Indian experts to partner nations for exchanges and communication in the fields of health education and health personnel training. In addition, India has introduced the Aravind Eye Care System to provide medical services in the region. The Aravind Eye Care System offers low-cost eye care procedures, handles over 240,000 outpatients annually, and organizes over 1,000 eye screenings. [42] Additionally, Indian ophthalmologists instruct local hospital staff on eye disease screening, pre- and post-operative care, as well as other areas of knowledge transfer.

India has opened medical colleges or training institutes in Bangladesh, Bhutan, and Afghanistan in order to provide better training. The medical colleges and training institutions in Bangladesh, Bhutan, and Afghanistan provide a more thorough education to the indigenous medical staff. India has also created facilities for continuing education in Ethiopia. India has also established centres in Ethiopia to train surgeons in pertinent continuing education courses. Additionally, the Hyderabad Health Centre in India has recurring gatherings. In addition, the Hyderabad Health Centre in India organizes frequent seminars to refresh local physicians' medical and diagnostic skills through continuing education in several fields. In addition, the Hyderabad Health Centre in India organizes quarterly seminars to refresh local physicians' understanding of

[40] Fudan School of Public Health,"The role of emerging countries in global health governance - the case of Brazil, India, South Africa and Russia", January 2017, p. 20.

[41] Tang Lixia and Li Xiaoyun, "A Review of India's Foreign Aid", *South Asian Studies Quarterly*, Vol. 3, No. 3, 2013, p. 4.

[42] Acharya, S., etal., "BRICS and global health", Bulletin of the World Health Organization, 2014,P. 386-386.

medical care and diagnosis through continuing education in several fields. English language training centers have been established in Cambodia, Laos, Myanmar, and Vietnam to facilitate communication and the exchange of medical knowledge. India has opened English language training facilities in Cambodia, Laos, Myanmar, and Vietnam to promote tele-medicine and tele-education and to facilitate the exchange of medical expertise.

At the Organization for Technical and Economic Cooperation, India provides health workers with training courses, scholarships, etc. In addition to providing permanent scholarships, the organization is consistently growing the number of scholarship recipients. 2008, Africa's First India gave $100 million for health professional training and capacity building. One hundred million dollars to promote the development of the health workforce in African nations. From 1995 to 2006, the number of health professionals trained increased. In the eleven years from 1995 to 2006, the number of trainers in India increased from 427 to 2014. This increase is a result of India's attempts to extend training through the hiring of extra trainers. In the eleven years from 1995 to 2006, the number of health workers trained increased from 427 to 2014, reflecting India's efforts to extend training by expanding the number of trainers in order to export human resources.

Thirdly, its health assistance also includes an active engagement in international cooperation mechanisms, which is dominated by cooperation in the study of the virus and the development of technology. India, along with Brazil and South Africa, founded the IBSA Forum and is primarily responsible for HIV/AIDS research. In addition, it participates in the International Centre for Genetic Engineering and Biotechnology (ICGEB), a research center in New Delhi, India, that focuses on hepatitis B and E viruses, human immunodeficiency virus and SARS viruses, dengue virus infections, diagnostics, and vaccine candidate development. India is also a key provider of technology to sub-Saharan Africa, particularly low-cost generic production methods and traditional herbal treatments for ailments such as tuberculosis and AIDS. India also prioritizes technical innovation and cooperation. For instance, LIFE Laboratories in Durban, South Africa, and Tulip Group Diagnostics in Bambrim, India support East Coast Rapid Diagnostics and LifeAssay as joint ventures.The Indian company has promised to deliver to South Africa a variety of diagnostic technologies, including quick malaria testing kits, pregnancy diagnostic kits, and dip stick technology. Not only was a legal agreement inked to transfer the technology, but also to give extensive technical assistance and support. The organization assisted in establishing local manufacturing operations in South Africa to produce kits for use in South Africa and other African countries with high rates of malaria and infectious diseases, as well as adapting malaria diagnostic kits to the high temperatures in South Africa, allowing them to be widely used in Africa. India's Biological E has collaborated with the International Centre for Diarrhoeal Disease Research to create a cholera vaccine in an effort to combat the catastrophic cholera outbreak in Bangladesh and eastern India. India has also been involved in advocating resolutions on mental health concerns within the World Health Organization, and civil society organizations, exemplified by the Jaipur Foot Program, have achieved notable success in identifying means to deliver free or low-cost medical services to the impoverished.

Fourthly, India's dedication to creating cheap medicines and vaccines has significantly increased the accessibility and availability of medicines and vaccinations in developing nations. Through policy safeguards and incentives for innovation, India's pharmaceutical industry has successfully broken the market monopoly of multinational pharmaceuticals in developed countries, providing the world with quality and affordable vaccines, medicines, diagnostic reagents, and other products that have had a significant impact on the promotion of global health care. Antiretroviral therapy medications were priced at US$140,000 for a one-year supply by global corporations in 2000, while the Indian pharmaceutical company Cipla (CIPLA) has reduced the cost of taking the drug to US$1 per day since it began making generic versions more than 10 years ago.[43] India's innovation and development of new vaccinations have made them increasingly affordable, allowing many people in impoverished regions to receive them. These inexpensive vaccines are accessible to a large number of people in economically disadvantaged locations. India is actively collaborating with school institutes, donors, national partner agencies, and multinational companies to develop more affordable vaccines in order to increase its capacity to produce vaccines, conduct more extensive research on vaccines, and increase the effectiveness of its use. The development of affordable new vaccinations.

India is also the leading supplier of vaccinations to developing nations, producing 60-80% of the vaccines acquired by international organizations such as the United Nations.[44] In addition, a number of significant international health organizations rely heavily on Indian vaccine supply, which has earned India the nickname "Pharmacy of the Developing World".

India's foreign aid model is more innovative, exporting information technology and Indian talent alongside its foreign health aid activities, and is committed to drug development and innovation, producing low-cost and highly effective vaccines that can bring substantial economic benefits to both India and the recipient nation.

(3) India's Incentives for International Health Aid

Health aid is an essential component of development aid, and it is also a manifestation of a nation's soft power. Developed nations such as Europe and the United States are maximizing their use of development assistance to aggressively promote their foreign strategy, export ideals, and worldwide image. The causes for India's foreign health assistance as a recipient of aid since its inception include not only domestic political and economic issues, but also the internal and external aspects of the international environment, which have expressed differently during different historical times.

India has a vast population, an underdeveloped economy, and a long history of poverty and weak government. However, India stood out in terms of development aid and its foreign health support was highly conspicuous.

[43] Richard Lane, "Yusuf Hamied: Leader in the Indian Generic Drug Industry", *The Lancet*, Vol.386, December 12, 2015, p. 2385.
[44] Yanzhoung Huang, Enter the Dragon and the Elephant: China's and India's Participationin Global Health Governance, the Council on Foreign Relations, Inc., 2013, P.10.

India's foreign aid, on the other hand, emphasizes cooperation between countries and states: "India's development assistance is based on mutual benefit and rejects conditional aid"; it aims for mutually beneficial cooperation and experience exchange. India's foreign aid principles are founded on the Five Principles of Peaceful Coexistence, the Gujral Doctrine, which is devoid of political and economic conditions, non-interference in the internal affairs of other nations, and the pursuit of mutual benefit and win-win scenarios. Hinduism, Buddhism, Islam, and Sikhism are all about supporting and giving to the suffering, as opposed to asking for it. This may have an effect on India's international health aid. Thus, the Indian government asserts that its aid program meets the health requirements of developing nations. In 2011, the Indian Organization for Technical and Economic Cooperation (ITEC) described the ITEC project as "India's earnest effort to share its socioeconomic progress and technological successes with other developing nations." This, however, does not imply that India's health cooperation programs, health assistance, humanitarian aid to countries suffering from severe disasters, etc. are purely altruistic. exports and trade, expanding geopolitical influence, and preserving regional stability are also important to India.

India seeks to establish a pro-India group in South Asia through its health assistance and cooperation with recipient nations, thereby boosting its regional influence and protecting its political interests and national security. Simultaneously, India has been pushing South-South cooperation and portraying itself as a leader in this field, using a variety of foreign aid such as foreign health assistance as a diplomatic tool to reinforce and consolidate its leadership position.

India's export of technology and products for foreign health assistance has opened the door to foreign markets and paved the route for overseas investment. For instance, India's creation of cheap vaccines has made it the leading supplier of vaccines to developing nations and one of the world's most significant vaccine suppliers. The Indian vaccine market was valued at $900 million in 2015, of which more than 50 percent was exported, and is anticipated to increase at a compound annual growth rate of 12 percent to 15 percent in the coming years, with Indian businesses generating one-third of the world's vaccines.[45]. In addition, India enjoys a strategic advantage in Africa due to its robust private sector (mainly small and medium-sized pharmaceutical companies).

The other three primary motives for aiding Africa are gaining access to energy riches, expanding diplomatic influence, and competing with China. Dweep Chanana thinks that India's assistance to certain developing nations is ineffective. The purpose of India's assistance to certain emerging nations is to acquire their oil and other natural resources in order to meet its expanding domestic resource demands. Its health aid in Africa mirrors, in part, its own energy need, with health diplomacy leading to energy diplomacy and a certain geographical predilection. India's desire to develop pro-India groups, to gain political support from African nations, and to become a permanent member of the United Nations Security Council by securing a large number of membership votes from African nations is also a major motivation for its progressive expansion of health aid to Africa and its active promotion of health cooperation with Africa. Acquiring a large number of votes from African nations to become permanent members of the United Nations Security Council would advance China's aspiration for the status of a great power. The final factor is competition with China. India has always been cautious of China because of their border dispute and China's support for Pakistan, and China's rapid expansion has put pressure on India's neighbor. Africa has long been the focus of China's international medical and health aid, and China has long maintained close connections and strong political and economic ties with the majority of African nations, and China's influence in Africa is extensive. India therefore views China as a formidable adversary in its aspirations to strengthen its influence in Africa, get access to African energy sources such as oil, and develop its medical market in Africa, and seeks to counterbalance China.

Foreign health aid for India, even though it adheres to the Gujral Doctrine and the spirit of Bandung, is not sufficient. The primary incentive for India is the political and economic benefits of health aid, as well as its geopolitical impact and the development of pro-India groups. Politically, by expanding its geopolitical power, forming pro-India groups, and expanding its regional influence, and then by gradually expanding the scope of international health aid, so expanding its involvement in global health governance. In India's pursuit for great power status, the political benefits of health aid include increasing geopolitical influence, the formation of pro-India groups, enhanced regional influence, and, with the progressive expansion of international health aid, get more influence in global health governance. The rise of drug exports and commerce has strengthened national interests, counterbalanced China's influence in Africa, and provided access to oil resources. On a cultural level, the export of Indian electronic information technology and health experts has facilitated the dissemination of Indian culture and fostered a sense of Indian cultural identity.

III. INDIA'S MULTILATERAL HEALTH FOREIGN POLICY

1. India's Foreign Policy on Health in the World Health Organization

(1) India's Policy on the International Health Regulations (2005)

The International Health Regulations (IHR) (2005) is a legally binding international agreement by 196 countries, including all WHO Member States, to achieve global health, where countries agree to build core capacity to detect, assess, and report public health events, and also establishes specific measures to be taken at ports, airports, and land crossings to guide and regulate the activities of special health organizations and States Parties since its entry into force.

For India, health governance and the development of the country's health security capabilities are of the utmost importance.

Regarding yellow fever, India's reservation to the IHR (2005) was as follows:

1. The Government of India reserves the authority to treat the entire population of a country as infected with yellow fever in accordance with Article VI and other pertinent articles of the

[45] A Comparison of the Internationalization of the Vaccine Industry in China and India, *Pharmaceutical Economic Journal*, 27 May 2015, p. 3.

International Humanitarian Law (IHR) (2005). The Indian government reserves the right to continue treating a region as contaminated with yellow fever until there is solid evidence that the region is fully free of the disease.

2. In the event of a public health emergency, yellow fever will be treated as a disease of international concern in accordance with Annex 2 of the International Health Regulations of 1969 (as amended in 1983), and all health measures such as disinfection of means of transport, vaccination requirements, and quarantine of passengers and crew as may be required (in accordance with Articles 7, 9(2), 42, and the relevant Annexes) will continue to be taken. [46]

Due to core capacity concerns, India has asked for a two-year extension to comply with the IHR (2005) core capacity by 2016. The India Global Disease Detection (GDD) Regional Centre was created in 2009 to strengthen the capacity of local and regional public health organizations to detect and respond to disease outbreaks. The centre strives to expand surveillance networks and public health laboratory systems, improve outbreak response, and identify emerging zoonotic hazards. Ministry of Health and Family Welfare (MoHFW) to address public health issues, including response to new combination diseases and investigation of outbreaks. GDD collaborates with the Indian Ministry of Health and Ministry of Family Welfare (MoHFW) to combat public health hazards, such as disaster response and the research of outbreaks of novel combination diseases.

The WHO India Works area office has presented a national cooperation strategy that provides the medium-term goal for WHO collaboration and a new approach to WHO cooperation. The strategy is a medium-term vision for WHO cooperation and envisions contributing to the improvement of India's health status while boosting India's participation in the global health agenda. The strategy outlines the medium-term vision of WHO collaboration and aims to promote India's contribution to the global health agenda while contributing to the improvement of India's health condition.

As evidenced by the WHO Country Cooperation Agenda: India (2012-2017), India has made compliance with international health norms and its own health situation its top strategic objective. The first three of the four strategic priorities for collaboration are centered on enhancing India's own health status and developing its fundamental capabilities. The first three of the four strategic priorities for collaboration focus on improving India's own health status and core capacity building, while incorporating useful advice from key stakeholders and striking a balance between national priorities and WHO's strategic directions. The first three of the four strategic priorities for cooperation focus on improving India's own health situation and core capacity building, while incorporating valuable suggestions from key stakeholders to balance national priorities with WHO's strategic directions in order to maximize its contribution based on its comparative advantage in national health development.

(2) India's Policy on the WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (FCTC), the first international treaty negotiated under the aegis of the World Health Organization, was ratified on 21 May 2003 by the World Health Assembly and entered into force on 27 February 2005. It is today one of the most broadly adopted treaties in the history of the United Nations, with 181 parties representing over 90 percent of the global population. The WHO Framework Convention on Tobacco Control is a public health convention aimed to promote and safeguard public health and reduce the health and economic impact of tobacco, and it asks for widespread international collaboration among all nations to combat the worldwide tobacco epidemic.

According to data, there are almost 275 million smokers in India, including 2.54 million children, and about one million people die annually as a direct or indirect result of tobacco use. This costs India a whopping $22 billion in health care expenses to treat tobacco-related illnesses.[47]

India is a member of the FCTC and suffers a double burden of communicable and non-communicable diseases. The Indian government is also cognizant that tackling noncommunicable diseases cannot be accomplished just by constructing more hospitals, disease research centers, and training more physicians and allied health workers. Speaking during the seventh session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, Shri J. P. Nadda, Minister of Health and Family Welfare of the Government of India, stated that FCTC is the most effective weapon for combating noncommunicable illnesses. All nations should collaborate to build health systems and enhance collaboration to combat the challenges posed by NCDs. To reach this objective, India advocated for multisectoral action and integrated health planning. While highlighting India's position as an integral part of the post-2015 Sustainable Development Goals, the Government of India has committed to increasing the execution of plans and interventions for noncommunicable diseases (NCDs) and FCTC implementation measures.

India was one of the first nations to ratify the Convention in February 2004, and in 2013 it became the first nation to implement voluntary national targets for the prevention and control of NCDs. In order for India to reach this goal by 2025, a Multisectoral Action Plan was released in early 2016. In addition to launching the second phase of the Global Adult Tobacco Survey, the Centers for Disease Control and Prevention collaborated on surveillance initiatives including the Global Youth Tobacco Survey, the Global School Personnel Survey, and the Global Health Professions Survey. In partnership with the Secretary of the FCTC, a Global Knowledge Centre for Smokeless Tobacco has been developed to serve as a global repository of information on smokeless tobacco.

Moreover, India has successfully implemented a free "Tobacco Quitline" and cessation programs as part of the "My Health My Move Initiative". The Indian Ministry of Health and Family Welfare participated in the World Health Organization's smoke-free tobacco mission in Bangladesh and shared its experience with the Bangladeshi government.

[46] International Health Regulations (2005) India has entered a reservation.

[47] Address by Shri j. p. Nadda, Minister of Health and Family Welfare, Government of India: WHO Framework Convention on Tobacco Control Seventh Session, 1-12 November 2016.

However, there is neither a defined structure nor a source of money for the execution of tobacco control techniques recommended by the Centre for Tobacco Control in India, and ongoing programs include the Tobacco control measures cannot be properly implemented with the current resources supplied by ongoing programs, particularly the National Tobacco Control Programme (NTP).

For India, the top objective is to enhance its health condition, with local health development challenges dictating the direction and rhetoric of international health debates. The Indian government has proposed a multisectoral approach to promote the IHR (2005) and FCTC as a foundation for accomplishing the country's health-related sustainable development goals in conjunction with the World Health Organization.

In order to reach its status as a major power, it is also playing a role in global health governance. Nehru argued that India should be a "big and powerful nation with a strong voice" well before India's independence. After India's independence, he advocated for it to become a powerful, unified, respected, and significant world force. Consequently, it is evident that India's active participation in the health diplomacy of international organizations is a crucial strategic step in its quest to become a world power.

2. India's Foreign Policy on Health in the World Trade Organization

The Uruguay Round was the final round of negotiations of the General Agreement on Tariffs and Trade (GATT), which aimed to reform the multilateral trading system comprehensively, with extensive and in-depth negotiations, the decision to establish the World Trade Organization in 1994, and the signing of the Agreement on Trade-Related Aspects of Intellectual Property Rights. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and four more accords pertaining to public health.

The TRIPS Agreement is a component of the World Trade Organization's legal framework, which protects and governs the outcomes of creative endeavors through legal and economic means.

However, after the implementation of TRIPS, criticism of the agreement from poor nations, academics, and non-governmental organizations has continued to rise. As one of the norms of global health governance, the introduction of flexibilities under TRIPS reflects the competing economic and welfare interests of wealthy and developing countries. As one of the norms of global health governance, the introduction of flexibilities under TRIPS reflects economic competition and welfare conflicts between wealthy and developing nations. WTO adviser Jagdish Bhangwati (Professor Jagdish Bhagwati claims in "Coping with Globalization" that TRIPS impedes the entry of pharmaceuticals into underdeveloped nations. However, India has been especially impressive in its defense of its general interests.

India's importance in the pharmaceutical supply chain of developing nations has earned it the nicknames "global office" and "world pharmacy". Since the 1970s, India's pharmaceutical sector has been expanding at a rapid rate. India generates 20 percent of the world's generic medications as the third largest producer of generic drugs. It exports medicines to more than 200 countries, as well as vaccines and biopharmaceuticals to 150 nations. According to the Indian Pharmaceutical Promotion Council (Pharmexcil), exports hit $14,6 billion in 2012-2013. The export market has surpassed $14,6 billion. The pharmaceutical business has long been one of India's economic pillars.[48]

In 2020, when several medicine patents are scheduled to expire, India's share of the global generic market is expected to climb to 25 percent and pharma sales to $50 billion from the present $25.8 billion, according to a story in the Globe. India's health diplomacy in the WTO has been distinguished by a high degree of adaptability in adapting its domestic health policy to the international regime, with patent law revisions, opportunities to invoke the transition period, and increased compulsory licensing of medicines all contributing to India's singular experience.

(i) Amendments to the Patent Act to permit generic drug production. Under Gandhi's leadership, the Patent Act was amended in 1970 to permit the patenting of methods or processes for pharmaceutical and chemical inventions, but not products, for a period of only five years, and to permit the manufacture of patented products without the patentee's permission after three years of exclusivity. To encourage local implementation, the government provides a compulsory licensing mechanism, a regulatory structure that allows public bodies to authorize other parties to use patented medicines without the approval of the rights holder. Additionally In addition, India has implemented the Bolar exception, which permits generic manufacturers to import, test, and produce copyrighted medications prior to the expiration of the patent period so that the generic can be sold on the market. In addition, India created the Bolar Exception, which permits generic manufacturers to import, test, and produce patented medications prior to the expiration of the patent period, so that generic medicines are immediately available on the market once the patent expires. The Bolar Exception in the Indian Patent Act, which will allow Indian generic producers to compete with one another to ensure continuous availability to affordable medications for domestic and worldwide consumers. This has allowed for the rapid rise of Indian generics, and the accompanying growth of the Indian pharmaceutical industry. The local pharmaceutical industry has expanded significantly.

(ii)The Trips Agreement allows for varying levels of pharmaceutical development and capacity among its members. The Trips Agreement stipulates varying transition periods for its members based on their level of development and pharmaceutical capabilities, with a five-year transition term for developing and transitioning economies. India's Patent Act, which was updated in the past, continues to offer a cover for the country's generic business, which has allowed generic medications to flourish in India for decades. In 2013, for instance, the Indian Supreme Court rejected a patent suit brought by Swiss pharmaceutical firm Novartis against an upgraded version of its revolutionary anti-cancer medicine Gleevec. This was India's first drug patent lawsuit after the TRIPS transition period, which lasted seven years and featured the enforcement of patent protection provisions and the continued supply of low-cost medications in developing nations. The ultimate ruling of the Indian Supreme Court offers an umbrella for the nation's pharmaceutical industry and

[48] China Pharmaceutical Network, http://www.zyzhan.com/news/detail/53787.html

safeguards the interests of the nation's generic drug manufacturers. The ultimate judgement of the Indian Supreme Court continues to preserve the interests of the country's pharmaceutical industry and generic industry.

(iii) Strengthening the framework for mandatory drug licensing and government support for generic drug development. According to the Doha Declaration, each member has the authority to issue mandatory licenses. However, in order to comply with the rules of TRIPS, India had to alter its patent legislation. Following the passage of the Doha Declaration in 2001, India amended its patent law once more in 2002 to increase the scope of patentability. The patent authority now has the jurisdiction to impose a compulsory license if the patent has not been enforced within three years after its issuance.

(iv) Adoption of Patent Act modifications to bring it closer in line with the TRIPS Agreement's standards. Elimination of the previous provision prohibiting patents on pharmaceutical products; modification of the mailbox mechanism to provide that if a significant investment has been made in a pharmaceutical product for which a mailbox mechanism has been filed before 2005, the pharmaceutical company may continue to produce a generic version of the drug even if the patent is subsequently granted by the Indian Patent Office, after payment of a royalty to the patentee. To preserve India's investment in the mailbox system, a number of legislative changes have been made, such as replacing "legally authorized by the patentee" with "in accordance with the terms of the law" in the conditions for parallel imports. Several legislative modifications were implemented to protect the interests of India's own generic manufacturers.

The implementation of India's new patent law in 2009 marked a significant turning point for the Indian pharmaceutical industry. Indian pharmaceutical corporations could no longer disregard the 30-year history of developing generic pharmaceuticals on their own, which was viewed by many Indians as a tightening of drug patent rights. In order to capture the medication business, India thereafter focused on forming partnerships with global pharmaceutical titans.

However, India's new patent legislation is still viewed as extremely lax by the rest of the world, with pharmaceuticals cleared for sale by the U.S. Food and Drug Administration (US Food and Drug Administration). The new patent legislation in India is still considered to be extremely lax. A new medicine can be sold in the United States for nine years. A new medicine has been available in the United States for around nine months, and a generic version has recently reached the Indian pharmaceutical market. Several Indian generic producers are able to produce the same medicine simultaneously.

In conclusion, a liberal social policy model, good timing, the use of WIPO's (World Intellectual Property Organization) The WIPO Standing Committee on Patent Law, a platform for negotiations pertaining to global health governance, and the use of strong flexibilities for developing countries are all recommended. Several factors have contributed to the growth of the Indian pharmaceutical business, including the encouragement of generics and, more recently, research and development. Under the laws and methods of the Indian government, pharmaceutical businesses in India have gradually improved their industry. However, Brian Williams Tempst, Editor and former Chief Consultant of Generics magazine, Vice Chairman, President, Managing Director and President of Ranbaxy Laboratories, UK (India) Dr. Brian Williams-Tempst stated at the 23rd session of the Standing Committee on Patent Law in Geneva in 2015 that while India has a large number of pharmaceutical companies, only one or two have made the transition to innovation. However, this also demonstrates that India recognizes the significance of medication innovation. However, this also demonstrates that India recognizes the significance of drug innovation and has begun the transition from generics to innovative medications.

CONCLUSION

1. India's Health Diplomacy Strengths

First, India has a robust capacity for pharmaceutical and scientific research. India's status as the "pharmacy of the world" and the "pharmacy of the developing world" has led to the manufacturing of affordable generic pharmaceuticals and vaccines that are not only profitable, but also a significant contributor to its health diplomacy initiatives and health cooperation.

Second, India has assisted recipient nations in constructing IT infrastructure platforms that have been essential for telemedicine, education, and health care. It has enabled telemedicine and tele-education in receiving nations, offering considerable ease to both patients and physicians in recipient nations.

Thirdly, India focuses on the export and training of medical workers. Health workers are the backbone of health diplomacy, and India has established a solid foundation for its health diplomacy by offering numerous scholarships and training courses to teach and extend the training of health personnel.

Fourthly, Indian health personnel have participated in forums for health-related negotiations, such as the WHO General Assembly. In numerous health discussions, India has advocated for developing nations and served as a leader for developing nations. This has increased India's impact and appeal in developing country health diplomacy.

Fifth, Yoga, Ayurveda, and Siddha medicine have formed an identity card of India's health diplomacy. At the 69th session of the UN General Assembly, Prime Minister Narendra Modi suggested a Yoga Day, and on 11 December 2014, the UN voted to designate June 21 a day of health diplomacy. The United Nations adopted a resolution on December 11, 2014, designating June 21 as International Yoga Day. One of the most momentous actions was the at the 69th session of the UN General Assembly, he suggested a Yoga Day, which was endorsed by 175 member states. In its resolution 69/131 on December 11, 2014, the United Nations proclaimed June 21 as International Yoga Day. Yoga and traditional medicine have become an extension of India's pharmaceutical industry. According to United Nations merchandise trade statistics, global trade in medicinal plants totaled US$7.592 billion in 2010, with China in first place at US$1.33 billion and India surpassing the United States and Germany in second place with total exports of US$1.3 billion. With exports totaling $791 million, India was the second greatest rival to China in the prospective export trade of traditional medicines.[49] Traditional

[49] Huang Yichen, Wang Shuo and Song Xinyang, "Insights from the yoga craze on the internationalisation of Chinese medicine", *Chinese*

medicine, such as yoga, has become an integral part of India's health diplomacy and a focal point of Modi's health cooperation projects.

India has now established a persuasive case for its health diplomacy activities, such as health aid. For instance, India's health assistance to Nepal, coupled with its advocacy efforts and attention to Nepal's livelihood development, has elevated India's standing in Nepal's total help.

2. Deficiencies in India's Health Diplomacy

There are two primary deficiencies in India's health diplomacy. One, India's domestic population density and health India's health diplomacy has been severely hampered by its own poor health conditions and insufficient capacity building. India's health diplomacy is still controlled by national interests, and the government's overseas health assistance and health cooperation remain centered on enhancing the health of the country. The focus of India's international health assistance and health cooperation remains on enhancing the country's health, defending its generic medicine business, and enhancing its health governance capabilities. The focus of India's international health aid and health cooperation remains on enhancing the country's health, defending its generic medicine business, and enhancing its health governance capabilities. Second, India lacks a global health diplomacy plan, which is not favorable to the long-term development of health diplomacy, and India has a significant distance to travel in building health diplomacy.

Author's Information

Zha Gongfei, female, September 1991, Han nationality, Jiangsu Province Nantong City, School of Political Science and Public Administration, China University of Political science and Law, PhD Candidate, Research areas: International Development; Global Health Governance.

Medicine Culture, 2017, No. 3.