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RACHEL IRWIN, RONALD LABONTÉ & ARNE RUCKERT

The study of global health is more a collection of health issues than a research field in its own right (Kleinman, 2010). By extension, health diplomacy also lacks a clear research agenda leading to fragmentation in research questions and approaches; this is partly due to the lack of a coherent definition of concepts like 'health diplomacy' and 'global health diplomacy' – a point made in Marten et al's commentary in this issue (Lee & Smith, 2011; Blouin et al., 2012). However, tied to this is the core issue: much scholarship on global health diplomacy is neither theoretically nor methodologically rigorous - a gap which was the impetus behind the creation of the *Journal of Health Diplomacy* in 2013.

This is also the main argument of Blouin et al who examined peer-reviewed articles, book chapters and academic reports writing on global health diplomacy from 1998 to 2012. They found that most scholarly articles tend to be descriptive, without explicit conceptual frameworks; even when used, theory tends to be under-utilised (Blouin, et al., 2012). They also found most articles neglect to include a methods section; this gives the impression that the literature is primarily based on secondary sources, rather than 'observation, interview or analysis of new evidence' (Blouin et al., 2012).

This lack of methodological and theoretical rigour matters. Research is inherently iterative, based on the co-evolution of theory and data collection, yet any cursory review of the health diplomacy literature would find that a disproportionate amount consists of commentaries or editorials. Original research, when it exists, tends towards the same set of case studies, such as the Framework Convention on Tobacco Control, virus-sharing in Indonesia and the International Health Regulations (full disclosure: the editors of this journal are equally guilty of having focussed on one or more of these cases at times). The point is simply: How can theory move forward if no new empirical data is gathered and analysed?

The outcomes of action in health diplomacy (however defined), of course, should be in line with the WHO's constitutional purposes: to promote the highest attainable standard of health as a fundamental human right. This aspirational goal is not owned by the WHO or its member states but, if extended to the social, political, economic and commercial determinants of health, suffuses the entire multilateral system of global governance. By some measures, 'successful' health diplomacy may simply exist in getting a certain wording in a resolution or a particular country to increase its health aid spending – a narrow approach. Yet it might also apply to ensuring that all foreign policy decisions, and all subsequent multilateral governance fora, take greater account of the health impacts of negotiated agreements: a 'health in all policies' approach. In doing so, in moving from a

concern with global health governance to one of global governance for health, the contours of which a recent Lancet-Oslo Commission struggled to define (Ottersen et al., 2014), we might expect successful health diplomacy to manifest as better health outcomes for all strata of populations in all countries.

But this (equivalently aspirational goal to that of the WHO's mandate) requires a greater theoretical unpacking of the conditions and constraints on promoting and achieving global health equity through process of multilateral negotiations and novel governance approaches. Theory allows us to understand power and legitimacy. It helps up to unpack the complicated networks of individuals, institutions and competing interests involved in negotiations, regardless of sector, that significantly affect health. It also allows us to analyse how 'health diplomats' perform the day-to-day rituals of diplomacy.

In this issue

Perhaps the state of scholarship is not as dire as it may seem, as highlighted by the articles in this issue which propose a wide variety of theoretical and methodological approaches to analysing health diplomacy.

Michelle Gagnon looks at governments' health & foreign policy strategies, with a focus on the UK's *Health is Global: a UK Government strategy 2008-2013*. She combines David Fidler's health and foreign policy conceptualisations – revolution, remediation and regression – and Kingdon's Multiple Streams Model of Policymaking (MSM) to unpack the role of policy communities and policy entrepreneurs. Catherine Jones's commentary, similarly, looks at national strategies on global health. Again, with a focus on the UK, she suggests analysing the policy process from institutional, network and policy regime perspectives, all potentially useful theoretical threads knitting us towards a greater whole.

Sonya Jakubec and Janet Rankin use Dorothy E. Smith's institutional ethnography (IE) to explore the 'right to health' as part of the 'global mental health' regime. The IE approach combines both theory and methods to link institutional organisation and everyday life practices, focussing on the interdependent pathways that control quotidian life, and how these controlling tropes affect relationships between evidence, research, policy translation and institutional design (or re-design, or reinforcement).

The Marten et al commentary posits that power is fundamental to understanding health diplomacy, as indeed it must be. The authors also call attention to the need to focus on outcomes and understanding how to define, measure and achieve 'successful' health diplomacy. Mookherji et al's contribution presents one possible solution to this: Using a case study from Myanmar, they suggest that a theory of change can help us to conceptualise better the processes of global health diplomacy and its underpinning complex relationships. Using such a theoretical modeling could contribute to a more exact defining and assessing of global health diplomacy's 'successful outcomes.'

Finally, the review article by Loewenson et al highlights the importance of history and contextual factors in any understanding of global health diplomacy. Focusing on experiences from Anglophone Sub-Saharan Africa, they touch upon how colonialism,

independence movements and being aid recipients affect African perspectives on health diplomacy, finding common themes such as a liberation ethic, African unity and interdependence, and developmental foreign policy. Their review also highlights the relationship between empirical research and theory: African experiences of diplomacy in and on health differ because of their historically situated contexts.

Conclusions

Although the study of health diplomacy is dominated to some extent by international relations and political science scholars, it is inherently interdisciplinary (as are most novel ideals of the past several decades). We do not call for a unifying theory or approach to global health diplomacy scholarship. To do so would be to kill the innovative if still irritatingly imprecise boundaries of what is attempting to both describe, and to promote, a positioning of health within the foreign policy priorities of nation states; and within the increasingly crowded landscape of global governance venues. Rather, we find that different theoretical approaches offer overlapping and complementary understandings of the processes by which states and non-state actors (a rather imprecise term that itself could use some unpacking!) deal with the intrinsic contradictions that inhere within the social, political, economic and commercial determinants of health – both within nations in their domestic policy formulation, and between nations in the treaties they negotiate or normative declarations they craft. (Indeed, a better understanding of the dynamics between national, multilateral, and then back to national policy-making on health and its determinants is desperately needed, in both theoretical and empirical terms.)

For the moment, there are two common and important themes throughout the articles in this issue that warrant attention. The first theme, somewhat predictably, is that we need to be more diligent and experimental in applying and trying out different theoretical frameworks in the study of health diplomacy. The second theme highlights the messiness of health diplomacy: what is the line between policy-making and diplomacy? How do we unpack the unclear relationships amongst actors, institutions, and – in the case of health – the biological realties of disease and disability? Different theoretical frameworks can help to unpack these complexities and provide a platform for organising and presenting research. Here we present several possibilities and challenge readers to develop their own work further.

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