

**VARYING PRESENCE, DIVERGING APPROACHES: THE  
INFLUENCE OF THE EMERGING POWERS ON HEALTH  
COOPERATION IN MOZAMBIQUE**

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### **Varying presence, diverging approaches: The influence of the emerging powers on health cooperation in Mozambique**

*In the last decade the rising powers have received increased attention from policy makers, academicians and development practitioners. Notwithstanding claims about their importance for development cooperation, there is little tangible and evidence-based material to confirm or refute these claims. This article approaches the discussion from the health sector – one of the focal sectors of (a number) of the rising powers. It looks more specifically at the governmental assistance of Brazil, India, China and South Africa to Mozambique and, based on document analysis and more than 60 interviews, analyses whether, how and what kind of influence these emerging powers might exert on the Mozambican health cooperation.*

Keywords: development cooperation, emerging powers, Mozambique, health assistance, South-South cooperation

### **Presença variável, abordagens divergentes: A influência das potências emergentes na cooperação em saúde em Moçambique**

*Na última década, as potências emergentes têm recebido uma maior atenção de decisores políticos, académicos e profissionais do desenvolvimento. Não obstante as afirmações sobre a sua importância para a cooperação para o desenvolvimento, existe pouco material tangível e baseado em evidências para confirmar ou refutar estas afirmações. O presente artigo aborda a discussão a partir do sector da saúde – um dos sectores prioritários de (uma série) de potências emergentes. Examina mais especificamente a ajuda governamental de Brasil, Índia, China e África do Sul a Moçambique e, com base numa pesquisa documental e em mais de 60 entrevistas, analisa se, como e que tipo de influência estas potências emergentes podem exercer sobre a cooperação para a saúde em Moçambique.*

Palavras-chave: cooperação para o desenvolvimento, potências emergentes, Moçambique, assistência à saúde, cooperação Sul-Sul

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One of the main debates in the development literature on ‘emerging powers’, such as Brazil, India, China and South Africa, or ‘South-South cooperation’ is about the question whether and how they are challenging the approaches of ‘traditional’ donors<sup>1</sup> and development cooperation practices as a whole. Some authors go even further and wonder whether these countries are causing a paradigm shift in development cooperation in general or in specific sectors or domains<sup>2</sup>. However, most studies also conclude that there is still insufficient information available about the approaches and the achievements of the emerging powers to refute or confirm the claims. In recent years, health is one of the sectors that has been singled out to study the presence and the influence of one or more of these countries. Since 2011, the health ministers of the BRICS countries even meet annually to discuss, amongst other issues, how to assist and share information and build capacities and address health needs in developing countries. Most existing studies focus on a specific emerging power<sup>3</sup>, and there are publications which compare the efforts of several emerging economies or analyse them as a bloc<sup>4</sup>. The majority of these studies focus on the effects that these countries exert on global health. Studies that compare the emerging powers’ health cooperation in one particular country are very rare. Consequently, there is a lack of insight on whether and how the emerging powers exert influence on the traditional health assistance ‘on the ground’, and to what extent the approaches of these countries converge or differ.

This article<sup>5</sup> intends to address this knowledge gap by analysing the presence and influence of the governmental or state-to-state cooperation of four of the

<sup>1</sup> Traditional donors roughly constitute of the members of the OECD-DAC (Organisation for Economic Cooperation and Development - Donor Assistance Committee). ‘Emerging’ or ‘rising powers’ are also labelled as ‘(re-)emerging economies’, ‘non-traditional’ or ‘non-DAC development partners’, though there might be difference among authors of which countries are included within these categories. For a discussion on the terminology and the constitution of the group of countries, see Mawdsley (2012).

<sup>2</sup> See for instance Davies, 2010; GHSi, 2012; Kharas, Makino, & Jung, 2011; Kragelund, 2010; Manning, 2006; Mawdsley, 2012; Vickers, 2012.

<sup>3</sup> For Brazil see Almeida, 2010; Almeida et al., 2010; Buss & Ferreira, 2010; Buss, 2011; Russo & Shankland, 2014; Russo, Cabral, & Ferrinho, 2013; Cabral, Russo, & Weinstock, 2014; Torronteguy, 2010; and a special issue of the *Revista Eletrônica de Comunicação, Informação e Inovação em Saúde*, 4(1) (2010). For China see Bräutigam, 2011; Bräutigam, 2009; Brown, Liang, Hale, & Novotny, 2013; Grépin, Fan, Shen, & Chen, 2014; Liu et al., 2014; Huang, 2013; Shen & Fan, 2014. For India, see Chaturvedi, 2011; James, Shaw, Chatterjee, & Bhatia, 2014.

<sup>4</sup> See Chaturvedi & Thorsteinsdóttir, 2012; Harmer, Xiao, Missoni, & Tediosi, 2013; Bliss, 2010; Bliss, 2011; GHSi, 2012; Kirton, Larianova, & Alagh, 2012; Kirton, Kulik, & Bracht, 2014; Ruger & Ng, 2010; Yu, 2008; Watt, Gomez, & McKee, 2014.

<sup>5</sup> The study features in a four year research (2012-2015) entitled ‘Challenging the status quo. The impact of the emerging economies on the global governance of development cooperation’ commissioned by the Flemish Policy Research Centre for Foreign Affairs, Entrepreneurship and Development Cooperation. Another case study focuses on agriculture and food security in Mozambique. Additional support was received via the Bilateral Scientific Cooperation Tsinghua University – KU Leuven and travel grants from the Belgian FWO.

most cited emerging powers<sup>6</sup>, i.e. Brazil, India, China and South Africa, in the health sector in Mozambique. As such the article will not only contribute specifically to the know-how about Mozambique, but the case study will also allow – on a broader level – to inform the general discussion on emerging powers and health and development cooperation. Besides its scope (a comparison between four countries), the added value of this article also is to be found, in my opinion, in the inclusion of the voices of a diversity of actors, including the representatives of the administration of the government of the partner country, one which is often absent in studies on emerging powers. Mozambique was chosen as a country because it has long standing and relatively good to excellent diplomatic relations with the emerging powers<sup>7</sup> and it is even considered to be the major partner of the Brazilian cooperation (Chichava et al., 2013)<sup>8</sup>. Despite improvements in the health situation in recent decades (Timmermans & Vinyals, 2012), Mozambique still faces serious health challenges, such as the high prevalence of HIV/AIDS cases, the relatively low life expectancy, the high number of tuberculosis patients and malaria victims, as well as the very limited access to potable water and sanitation (Vlaamse Regering, 2009).

## Methods

The research methodology includes four steps. In a first stage (2012-2014), a literature review was used to identify the characteristics of the health and general cooperation of the emerging powers. The main results were published as working papers in 2013 (De Bruyn 2013a, 2013b), while more recent insights contributed further to this article. Additional information was collected via interviews with about ten experts in Beijing, China and Indian, Brazilian and South African experts in Belgium by phone.

A second step entailed the identification of the activities of the emerging powers in the health sector of Mozambique. Useful but unfortunately incomplete information sources included website based data (such as AidData website and Odamoz), available studies (e.g. BRICS Policy Centre, 2014; Chaturvedi, 2015; Russo, Cabral, & Ferrinho, 2013; Zhou & He, 2014), policy documents, newspaper and other media sources (Mozambican or from the emerging powers or other international media). An additional 60 semi-structured interviews to complement

<sup>6</sup> In the remainder of this article ‘emerging powers’ refers to the governmental cooperation of these four countries.

<sup>7</sup> Esp. China, see Jackson, 1995 and Jansson & Kiala, 2009.

<sup>8</sup> Another reason for the choice of the country and sector is given by the interest of the financier of this study, the Flemish Government, whose development cooperation supports the health sector in Mozambique.

and check this information were carried out in Mozambique (Maputo) in March 2013 and October-November 2013 with representatives of the Mozambican government, the emerging powers, other bilateral and multilateral agencies, civil society and the private sector. The results were published in a working paper (De Bruyn, 2014). The first two steps allowed to assess to what extent the emerging powers' initiatives are representative of the overall health and development cooperation of the four countries and thus to what extent lessons can be drawn on a more general level. A next field visit in May-June 2015 which included another 60 interviews, participation in meetings and workshops and project visits, was organised to update the information.

Next, a perception study was carried out to assess a first time the influence of the emerging powers' governmental assistance on the Mozambican officials as well as the traditional development partners<sup>9</sup>.

The fourth and most extensive step encompassed the analysis of the influence of the emerging powers on the governmental (Mozambican and bilateral and multilateral donors) community active in health. The analytical approach is inspired by studies carried out by Harmer et al. (2013) and Harmer & Buse (2014) who assessed the influence of the BRICS on global health on the basis of existing literature. To structure the information they used an "Analysis of Influence Framework", which is in its turn based on the works of the international relations known critical theorist Robert Cox (1981) and Vom Hau, Scott, & Hulme (2012). The framework<sup>10</sup> helps to address the questions "what kind of influence is exercised, how it is exercised, where it is exercised and why" (Harmer et al., 2013). The framework stipulates that there are three types in which influence can be

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<sup>9</sup> The survey was part of semi-structured interviews. Each respondent was given a list of most donors, UN agencies, NGOs and emerging powers in health in Mozambique (and a category other and was asked to provide a top five of actors which influence most the policy regarding health in Mozambique, and which possess most relevant expertise [and know-how to address the challenges] in health of Mozambique (the words between brackets were added when asked the question during the interview). Respondents of governmental and multilateral agencies active in health included heads of cooperation and/or responsible officers for health in Mozambique as well as the representative officials (heads of departments, heads of units) of the national Ministry of Health.

The questions were also submitted to the representatives of the emerging powers, but they did not want to answer the question. The results were analysed as follows: 5 points for each No. 1, 4 for each No. 2, 3 points for each No. 3, etc. In case of *ex aequo*, the points were equally distributed (e.g. in case of two actors identified on the fourth position each of them was awarded 1.5 points).

<sup>10</sup> The framework used by Harmer et al. also incorporates elements of Vom Hau, Scott, & Hulme that focus specifically at the how, where and why question, and offer a number of categorisations of possible answers. However, these types were more relevant to analyse the influence of global politics of development (for which they are indeed used) than for this country/sector study. For this study the answers to 'why, where and how influence is exerted' helped to identify and give more insights into the type of influence. For instance where influence (bilateral, multilateral, coordination platforms,...) is exerted helps to explain the institutional influence, while the reasons why the emerging powers exert influence are explanatory for the ideational influence.

exerted: via material capabilities, ideas and institutions<sup>11</sup>. These three categories were operationalized by looking at financial resources, human resources and other types of technical assistance (material), motivation and reasons to cooperate, principles of development cooperation, approaches to address health challenges (ideational) and types of institutions and actors on the ground, modes of cooperation and coordination (institutional). Besides the already mentioned interviews (totalling 120)<sup>12</sup> and academic and policy documents, information sources included policy documents of the Mozambican government and the emerging powers and reports of the donor committees on agriculture and food security. Important to note is that the findings for this study focus on the period of data collection.

The structure of the article follows the different steps in the methodology. After a concise overview of the health assistance sector, an overview of the presence of the emerging powers in Mozambique is given and it is demonstrated that this presence is indeed illustrative of the countries' overall health assistance. Next, the perception of the influence of the emerging powers by development partners and Mozambican officials is provided. In the largest section, the different types of influence are analysed.

## Brief overview of health cooperation in Mozambique

In the last decades Mozambique recorded a stark increase of its growth rates (up to 8% of GNP). This was after a sixteen year period of civil war, which has been detrimental for the country's social and economic situation. The economic growth can be explained by the discovery of different precious natural resources in the Northern provinces. Unfortunately, these growth rates do not seem to benefit the population as a whole (De Bruyn, 2014). Mozambique's position on the Human Development Index is around the 180th position. Inequalities exist between rich and poor and rural and urban regions (UNDP, 2013 and previous reports). The poor socio-economic situation is also visible in the health situation, for instance the high prevalence of HIV/AIDS cases, the relatively low life expectancy, the high number of tuberculosis patients and malaria victims, as well as the very limited access to potable water and sanitation. Notwithstanding progress in the last decade, health indicators remain problematic: Life expectancy

<sup>11</sup> Cox (1981) actually "identified three 'categories of forces' that combine to constitute a particular historical structure or framework" of action in time.

<sup>12</sup> The interviews were either taped with prior permission or notes were taken and transcribed directly afterwards. With most interviewees it was agreed to not link their citations directly to their names. The semi-structured interviews dealt with the following topics: knowledge about the emerging powers presence (material, ideational, institutional), existing cooperation and coordination with one or more of emerging powers, involvement in initiatives of the emerging powers, perception of the emerging powers approaches.

at birth stands at 56.5 for women and 53.3 for men (2014), mortality due to malaria stands at 71.4 per 100,000 people (2012), maternal mortality rate at 480 per 100,000 births, 10.8% of 18-49 years old has HIV/AIDS, there are 0.4 physicians per 10,000 people (2013) (Timmermans & Vinyals, 2012; UNDP, 2013). These health problems can be explained by the low quality (esp. volume and predictability) of international external financing, the lack of formally trained health personnel and community workers, inadequate health infrastructure, the epidemiological vulnerability to life threatening diseases, malnutrition and inadequate nutritional habits, unequal access to health care, limited alignment and coordination amongst donors, and complexity of the sector of sexual and reproductive health and rights (Vlaamse Regering, 2009).

The Health Strategic Plan (or *Plano Estratégico do Sector da Saúde* – PESS), drawn up by the Ministry of Health (MISAU), is the main guiding document for the health sector. Within the PESS 2009-2012, the government has prioritized the need for strengthening the health system, the development of human resource capacity, the improvement of health care infrastructure, increased community engagement and the expansion of training and deployment of community health workers. In December 2013, the Ministry of Health approved the PESS for the period 2014-2019. This plan lists a number of reforms congruent with the on-going decentralization process. Among other issues, there is a focus on increasing access to and improving quality of primary health care, and reducing maternal mortality and chronic malnutrition.

Despite decreasing donor dependency ratios, Mozambique is a heavily donor dependent country. Between 2008 and 2012 the donor dependency ratio fluctuated between 41 and 52% (representing around US\$ 3 to 4 billion, excluding the exceptionally high figure of US\$ 8 billion in 2012), while in 2013 and 2014 the dependency decreased to 20 to 25%. In the period 2008-2015 the total health budget increased from US\$ 7.1 to 19.1 billion (UNICEF, 2014; Ministério da Saúde, 2008-2014). The most important donors in terms of financial contribution include the US Group (including USAID, PEPFAR, CDC), and a group of nine bilateral donors and two multilateral partners (the ProSaúde) which have pooled resources in a common fund. Foreign donors support the health sector via general and/or budget support, direct project support and off-budget funds. The development partners meet once in the Health Partners Group (HPG). In addition there are a number of global financial institutions, notably the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI) that have entered the scene relatively recently. Besides these donors, there are a number of civil society organizations which are impor-

tant development actors. These include the Clinton Foundation and the network of international NGOs working in the areas of HIV/AIDS and health, that are represented by the organization NAIMA+.

## Emerging powers in the Mozambican health sector

The emerging powers do hardly appear in the above mentioned discussion or documents, including in the annual financial reports. This picture may be misleading, since at least three of the four countries are deploying health assistance activities in Mozambique, as table 1 shows and is discussed in this section.

### China

The most recent and comprehensive attempts to map Chinese health assistance are provided by Liu et al. (2014) and Grépin et al. (2014). The former analysed available Chinese sources (529 in total) and the latter complemented this by analysing the information provided by AidData. Both research teams admit that data are still incomplete and further research and verification is necessary. One of the main reasons for this is the absence of a single official source of data for global health assistance. Their analyses show that the overall pledged health aid to Africa ranges annually between US\$ 150 million (Liu et al., 2014) and US\$ 231 million (Grépin et al., 2014). According to Grépin et al. (2014) this would make China the ninth donor in health assistance to Africa. The aid is mainly project based and in-kind and targets five broad areas: medical teams, construction of hospitals, donation of drugs and equipment, training of health personnel and malaria control (Liu et al., 2014). The framework of Chinese health (and general) assistance is agreed upon at the High Level Forums on China-Africa Cooperation (FOCAC) and published within its Action Plans (FOCAC, 2012; Bräutigam, 2009). Although Mozambique would not rank among the first ten countries of China's health assistance, as will be demonstrated below, it hosts initiatives representing these main components.

In 2009, Jansson and Kiala (2009) identified the Chinese cooperation projects since Mozambican independence<sup>13</sup>. These included mainly grants and concessional loans for emergency relief, the construction of factories, housing and public buildings, agricultural infrastructure and some health projects (see below).

<sup>13</sup> See Alden & Chichava (2014) for an overview of Mozambique-China relationships.



Table 1  
*Overview of development cooperation initiatives of Brazil, India, China and South Africa  
 in the health sector in Mozambique*

Project	Type of cooperation	Leading Mozambican institutions	Leading BRICS institutions	Other partners	Estimated budget from Brazilian gov't (US\$ - rounded figures)	Time period	Source of information
<b>Brazil</b> ARV, construction and other medicines factory	Grant, technical cooperation	MISAU	Ministry of Health & Fiocruz & Farmanguinhos	-	Around 23 million on about 34.6 million investment (excl. technical assistance)	Ideas presented in 2003 and ongoing	Business year 2013, Russo et al. 2014
Strengthening the pharmaceutical department's regulatory agency	Technical cooperation	MISAU	ANVISA	-	395,00 and 483,000 (2011 amount)	Committed 2008 and 2010 and ongoing	AidData, Russo et al. 2013, Stolte 2012, interviews Fiocruz
Human milk banks	Technical cooperation	MISAU	Ministry of Health & Fiocruz	-	553,000 (2011 amount)	Committed 2010 and ongoing	AidData and interviews Fiocruz and gov't officials Mozambique
Strengthening of National Institute of Health	Technical cooperation	MISAU, National Institute of Health	Ministry of Health & Fiocruz	-	Total cost 301,000, committed 2014 (2011 amount)	2007 and ongoing	AidData, Russo et al. 2013, interviews Fiocruz & Gov't official Mozambique
Master programme in health sciences	Technical cooperation	University of Mondlane	University of Brasilia	-		Ongoing	Interviews Gov't of Mozambique, Fiocruz
Strengthening of prevention and cancer control	Technical cooperation	MISAU	Ministry of Health	-	420,000 (amount 2011)	Committed 2010	AidData, Russo et al. 2013
Provision of nutrients	Loan/grant	Gov't of Mozambique	Gov't of Brazil		1.3 million total amount, 994 committed (2011 amount)	Committed 2008	AidData
Dental health projects	Research, technical cooperation	MISAU	Ministry of Health	-	268,000 and 351,000 (2011 amount)	Committed in 2008 and 2010	AidData, Russo et al. 2013
Community care project	Technical cooperation	Gov't of Mozambique	Gov't of Brazil	-	US\$ 553,000 (2011 amount)	Committed 2010	AidData
Tele-health system and support to the medical library		Gov't Mozambique	Gov't of Brazil	-	160,000 (2011 amount)	Committed 2010	AidData

Project	Type of cooperation	Leading Mozambican institutions	Leading BRICS institutions	Other partners	Estimated budget from Brazilian gov't (US\$ - rounded figures)	Time period	Source of information
Trilateral cooperation in slum rehabilitation		Municipality of Maputo	Brazilian Ministry of Cities and the Federal Savings Bank of Brazil	Italian development cooperation	3 million	2011 and ongoing	Ministero degli Affari Esteri, website Citesalliance, interviews Italian cooperation
Trilateral cooperation in HIV/AIDS	Technical cooperation		Ministry of Health & Fioacruz	CDC & USAID	Exploration trips of 11,000 total cost, of which 9,000 committed	In negotiation	AidData, interviews Fioacruz, CDC and Mozambican officials
School Feeding and Food Purchase Programme	Technical cooperation	Ministry of Education, Ministry of Agriculture	ABC	WFP, FAO	1.8 million (2011 amount)	Committed 2010 Ongoing	AidData, interviews Mozambican officials, Brazilian government, WFP
Exchange of experiences in HR	Technical cooperation	MISAU	State of Bahia	-	-	Negotiations	Interview 'traditional donor' representative
Technical Support for Implementation of the Institute of Women, Children and Adolescents	Technical cooperation	Gov't of Mozambique	ABC/Brazilian gov't		45,000 (2011 amount)	Committed 2011	AidData
<b>India</b> Pan-African – Network: tele-health equipment	Equipment, technical cooperation?	MISAU	Indian government	African Union	3 million (very rough estimate for total Pan-African e-project in Mozambique)	2010 - 2014	Interviews representatives of Indian cooperation
<b>China</b> Medical equipment for Maputo central hospital	Equipment, grant	Government of Mozambique	Government of China	-	1,6 million	Committed 2013	AidData, Xinhua 2014
Pediatric ward in Beta central hospital	Infrastructure grant				23 million	Committed 2013	Aiddata
Construction of residence for doctors	Infrastructure loan	Gov't of Mozambique	Government of China				AidData, interview Chinese cooperation
Brightness Action Campaign		MISAU	Government of China			2011	Interview Mozambican officials

Project	Type of cooperation	Leading Mozambican institutions	Leading BRICS institutions	Other partners	Estimated budget from Brazilian gov't (US\$ - rounded figures)	Time period	Source of information
Medical teams (17 in total, of about 12 people each)	Technical cooperation	MISAU	Chinese government & Sichuan province	-		1976 and ongoing	AidData, Li 2011, interviews Mozambican officials
Anti-malaria centre	Grant, technical cooperation	Government of Mozambique	Government of China	-		Committed 2009	AidData, interviews Chinese academics
Cooperation agreement to grant malaria medicines		Government of Mozambique	Government of China			Agreement 2010	AidData
Medical equipment	Equipment grant	Government of Mozambique	Government of China		9.3 million (for at least 5 countries, incl. Mozambique)	Committed 2010	Aiddata
Package of interest-free loans for Mozambique's agriculture, health and education sectors	loans	Government of Mozambique	Government of China	-	184.8 million (2009 amount)	Committed 2007	Aiddata
<b>South Africa</b> Agreement in health matters on collaboration on different fields		Government of Mozambique	Government of South Africa		2005		Department of Health SA 2005)

Five years later, the emphasis on infrastructure and agriculture is still valid and according to Zhou & He (2014), citing Xinhua China, has become in 2012 Mozambique's main financial creditor. A technical and economic cooperation agreement between Mozambique and China of 2004 provides the bilateral framework for health cooperation.

Probably the most known and oldest feature of Chinese health assistance, the medical teams, are also present in Mozambique. These are a responsibility of the Chinese provinces (Shen & Fan, 2014). Between 1976 and 2013 the province of Sichuan has sent 17 teams of about 12 to 14 doctors specialized in different areas, accompanied by a team leader and one interpreter and a cook, each for a two year period. In Mozambique they operate mainly in the Central Hospital of Maputo<sup>14</sup>. Another, though separate medical team is part of the so-called 'Brightness Action' campaign. This refers to a delegation of Chinese medical experts that carry out cataract operations in African countries. In September 2011 Mozambique welcomed the team to carry out about 300 cataract operations in the Central Hospital of Maputo in a period of ten days. No decision has been made yet about a possible repetition of this project<sup>15</sup>. The second component, infrastructure provision, consists in Mozambique of the rehabilitation of the main hospital of Beira – including the construction of an extra wing, which will add an additional 250 beds to the existent 800 beds. In addition an accommodation residence for the Chinese medical teams is constructed in Maputo. The construction is funded by the Chinese government and carried out by Chinese construction firms<sup>16</sup>. Thirdly, in terms of the provision of medicines, the AidData website mentions that China agreed to donate anti-malaria drugs in 2010, but there is no information "on the amount of medicine provided, dates the medicine reached the country, and the completion status". According to the Centre for Chinese Studies (2010), at the FOCAC meeting of 2006, the Chinese ambassador to Mozambique pledged to donate US\$ 700,000 worth of medication for the period 2008/2010. The Centre argues that this donation also acts as a subsidy to China's own pharmaceutical companies. About the fourth component little information is known. Although several officials mentioned in interviews that Mozambican doctors are travelling to China to attend specialised courses, no data were available about the number of beneficiaries or courses attended. Also about the last component, the malaria control centre, information is not readily available. Since China has made

<sup>14</sup> Personal interview with official of Mozambican Ministry of Health, 2015, Maputo.

<sup>15</sup> Personal interview with official of Mozambican Ministry of Health, 2013, Maputo.

<sup>16</sup> Personal interview with official of Mozambican Ministry of Health, 2015, Maputo, and Permanent Secretariat, 2016 and Club of Mozambique, 2016.

significant progress in fighting malaria in the last 40 years and is one of the main providers and developers of an important anti-malaria medicine, the Chinese government decided to share Chinese knowledge about the treatment of malaria with African counterparts. In essence, this is done through the construction of centres set up by Chinese experts and the provision of facilities and drugs for free for the first three years (Zhi-Gui et al., 2014). In Mozambique the equipment and support are mainly integrated within a malaria centre in Maputo<sup>17</sup>. Besides this existing assistance, the Mozambican and Chinese governments are exploring cooperation in traditional medicine, an expansion of the medical teams and technical and physical infrastructure support in the North of Mozambique<sup>18</sup>.

### India

In comparison to China, India's general and health assistance has received less attention – although the number of publications is increasing. Efforts to have an overview of India's approaches and figures are rendered difficult due to the absence of an overarching policy document. The available research shows that India's bilateral commitments in health to African and Asian countries would amount to about US\$ 100 million in the period 2009-2012 – which makes it a relatively modest part of India's general development cooperation (GHSi, 2012)<sup>19</sup>. Main areas of assistance include the provision of equipment and medicines, infrastructure, capacity development and support in areas in which it has considerable expertise, especially information and communication technology (GHSi, 2012; Huang, 2011). However, some authors argue that rather than state driven, India's cooperation model is driven by the market. Rather than the government, private companies, and more specifically those providing generic medicines or service delivery, are the main representatives – with the government playing a facilitating role – of India's development cooperation model (EADI, 2013).

Health is not among the priorities of India's governmental cooperation with Mozambique. According to the Indian High Commission<sup>20</sup> up until 2010 the country extended large lines of credit up to US\$ 640 million for infrastructural,

<sup>17</sup> Curiously it was rather difficult to obtain information about the location and the state of affairs of the centre with Mozambican policy makers, organizations and donors working in the domain of malaria. Actually, some of the interviewees even doubted its existence. The scarce media and academic material did not correspond with current reality. Representatives of the Ministry of Health of Mozambique elucidated that most of the equipment and support was located and 'used effectively' in the centre in Polana Caniço, an area of Maputo.

<sup>18</sup> Personal interviews with officials of Mozambican Ministry of Health, 2015, Maputo, and Permanent Secretariat, 2017 and Zhuhai China, 2016.

<sup>19</sup> Estimates about the total development cooperation of India range from about US\$ 600 million annually to about 1.5 billion annually. If credit lines are taken into account the figure could amount to a multitude of this figure (De Bruyn, 2013a; Mullen & Arora, 2016).

<sup>20</sup> See [hicominind-maputo.org](http://hicominind-maputo.org), accessed 5 January 2015, and personal interview with Mr. S. Balachandran, Second Secretary of Indian High Commission, Maputo, 28 March 2013 and 13 May 2015.

agricultural and energy projects and grants of US\$ 200,000 up to 5 million in research and training, equipment and infrastructure, mainly in the agricultural sector and for community development<sup>21</sup>. However, projects entailing general infrastructure provision and construction could not be identified in Mozambique. Nevertheless the country hosts one of India's flagship ICT projects: the Pan African e-Network. This project aims to connect hospitals and universities to similar institutions in India via a satellite and fibre optic network. It includes tele-medicine, i.e. Indian medical specialists assist their African counterparts in medical consultation via online networks (Carmody, 2011). In Mozambique, the Maputo central hospital has been singled out as the partnering institution for tele-medicine and hosts also some of the tele-education possibilities. Precise figures for Mozambique were not available, but Indian sources give a very rough estimate of US\$ 3 million for the total project (which also encompasses other aspects relating to education) (see De Bruyn, 2018 for more detailed analysis)<sup>22</sup>. A second area of cooperation – which might be expanded in the future – is the referral of patients (with illnesses which cannot be treated in Mozambique) to Indian hospitals. Thirdly, the Indian and Mozambican governments collaborate in the quality control and regulation of important Indian medicines – though institutional capacity building is not yet part of this cooperation. Other areas which are being explored are research and development with Indian institutes, institutional capacity building in traditional medicine and attracting Indian pharmaceutical companies to invest in Mozambique. It is worth mentioning that Indian private sector is becoming increasingly active in Mozambique. Besides the Indian pharmaceutical companies exporting generic medicines to Mozambique, there are a few private Indian hospitals, or hospitals employing Indian practitioners in Maputo, providing mainly tertiary health services<sup>23</sup>. One of the new entrees is the Dr. Agarwal's Eye Hospital. This is one of the main chains of eye care centres and hospitals in India. The lack of eye services in large parts of the African continent made the company decide to expand its operations to Mauritius in 2010, and later on to Rwanda, Madagascar and Mozambique. In 2013 centres were opened in Maputo, Nampula and Matola, while the intention is to cover all provinces of Mozambique.

<sup>21</sup> Another and very well-known component of India's human resource capacity building assistance, the provision of long and short term training and scholarships in India via programs provided by institutions such as Indian Technical and Economic Cooperation (ITEC) are not a feature of India-Mozambican assistance. Some of these programmes exclude medicine, dentistry & nursing. While for other programmes the representative of the High Commission explains the lack of participation by referring to language problems.

<sup>22</sup> Personal interview with representative of Indian implementation agency, 2013.

<sup>23</sup> See also Xinhua (2014) for an agreement between the Indian Apollo Group and the Mozambican government.

## Brazil

Together with agriculture and education, health is one of the key sectors of Brazil's technical cooperation with other African countries, representing 22% of its technical assistance to Africa in the period 2003-2010 (ABC, 2010). However in absolute figures this is rather modest. For instance, estimates compiled by Russo et al. (2013) range from US\$ 12 million, to US\$ 14 million in the five Portuguese-speaking African countries alone between 2006 and 2009. When also taking into account other modalities, such as humanitarian assistance and export credits, the relative importance decreases further, since technical assistance represents only 3% of the total development cooperation budget (Cabral & Shankland, 2012). Nevertheless, the Brazilian health approach has attracted considerable attention in academic literature due to its characteristic approach (see below). Mozambique is arguably the country in which its effects are most prominently apparent, because it is the most important partner of Brazil's development cooperation (due to the common language, diplomatic bonds, and commercial interests). Most of Brazil's cooperation initiatives (in health and other sectors) are present (Alden, Alves, & Chichava, 2017; Cabral & Shankland, 2012; Chichava et al., 2013; Melo, 2016; Stolte, 2012).

As everywhere else in Africa, Brazil's development cooperation with Mozambique intensified with the accession of Luiz Inácio Lula da Silva, and was geared in first instance at agriculture, followed by education and health (Chichava et al., 2013). As the only country in southern Africa, Brazil opened an office of Fiocruz in Maputo, employing two people. The framework for Brazil's cooperation with Mozambique is not only provided by its bilateral agreements, but is also framed within international agreements, in particular with Lusophone countries. The Strategic Plan for Cooperation in Health of the Community of Portuguese-speaking Countries (the PECS/CPLP) aims to create and develop universal access to quality health services in the member states (Buss & Ferreira, 2010). Exact figures about the development cooperation of Brazil in health in Mozambique are difficult to find. As the representatives of the Embassy of Brazil asserted<sup>24</sup>: "The cooperation of Brazil does not have a value, because it consists only of salaries of technicians, flight tickets, accommodation and so on. There is no overarching budget – there are only projects". As table 1 shows, the Brazilian cooperation encompasses considerably more projects in health than the other three emerging powers in this study. This does not only reflect the importance of

<sup>24</sup> Interview with Mr Paulo Joppert, ministro-conselheiro, Brazilian Embassy, Maputo, 14 November 2013.

Mozambique as a partner in Brazil's development cooperation, but also its focus on health.

From the interviews with the Brazilian representatives can be concluded that in discourse and intention the cooperation with Mozambique reflects the Brazilian horizontal structuring approach (Russo et al., 2013) of building the institutional and human resources capacities of the public health system via peer-to-peer cooperation projects and programmes applying recipes which supposedly have proved to be successful in Brazil:

The Brazilian cooperation is a structuring cooperation. Brazil does not only support and assist in the areas in which it is needed, but also offers structural support to allow the system to be sustainable on its own. [...] The principal objective of the cooperation [...] is the development of a public, autonomous and self-managing system. This allows Mozambique to take its own decisions<sup>25</sup>.

Without doubt the project which has received the most attention is the development of a pharmaceutical production factory (Abdenur & Marcondes, 2017). Though an exception in the country's cooperation with Africa, it also demonstrates the characteristics of the structuring and institutional strengthening approach. The initial objective of the plant is to produce a number of antiretroviral and other types of drugs, making Mozambique less dependent on the import of medicines to address its HIV/AIDS problem, and ultimately even be able to export to other countries. This represents a health investment of US\$ 34.6 million over 10 years (which also includes private sector contributions) (Russo et al., 2014). To control the safety, quality and the pricing of the medicines, the National Sanitary Surveillance Agency (ANVISA) and the Ministry of Health of Brazil supported the creation of a Drug Regulatory Authority (Stolte, 2012).

Despite the attention for the factory, the largest part of the Brazilian health assistance encompasses institutional capacity building between Fiocruz and the Ministry of Health. This includes firstly, the organization of small training courses, masters courses and PhDs in amongst other biomedical sciences and public health in Brazil and Mozambique. About 50 to 60 students have already spent time in Brazil within this programme. Secondly, Fiocruz and the Mozambican National Health Institute (INS) cooperate within the development of strategic plans and policies. Thirdly, the assistance includes a range of specific technical assistance in various areas, such as oncology, dentistry and HIV/AIDS. An example is the human milk bank programme. This programme promotes breastfeed-

<sup>25</sup> Interview with Mr Paulo Joppert, ministro-conselheiro, Brazilian Embassy, Maputo, 14 November 2013.



ing and collects mother milk to provide to children without access to this source of nutrition. It also aims to prevent mother-to-child transmission of HIV/AIDS. The intention is to install it in the Central Hospital of Maputo<sup>26</sup>. However, due to organizational and financial constraints, the implementation of the programme is delayed, and in 2015 DfID agreed to offer financial and organizational support<sup>27</sup>.

The latter also demonstrates Brazil's interest in trilateral cooperation. There have also been negotiations between Brazil, Mozambique and the US government to set up a trilateral agreement in health. The three governments signed a declaration intent in the beginning of 2012 to collaborate in food security, health and agriculture. Despite several negotiations with USAID and the US Centre for Disease Control and Prevention (CDC) to set up a program on HIV/AIDS, no concrete decisions have been decided upon yet, although there is cooperation on an ad hoc basis<sup>28</sup>. Other examples include a cooperation between the Italian Development Cooperation, the Brazilian Ministry of Cities and the Federal Savings Bank of Brazil, and the Municipality of Maputo for the rehabilitation and sanitation of slums in Maputo<sup>29</sup>, as well as a school feeding program to address, amongst other issues, malnutrition, which involves the World Food Programme, the Food and Agricultural Organization, the ABC and the Mozambican Ministry of Education<sup>30</sup>.

### South Africa

As in other countries, South Africa's governmental cooperation with Mozambique focuses mainly on conflict prevention, economic issues and investments. The foreign policy of South Africa is framed, on the one hand, by the Southern African Development Community (SADC), which main objective includes regional integration, and on the other hand the New Partnership for Africa's Development (NEPAD), the economic development programme of the African Union<sup>31</sup>. Health features but marginally in the cooperation between both countries, although they signed an agreement in health matters in 2005. This agreement stipulates collaboration on joint surveillance, control and management of communicable and non-communicable diseases, strengthening of immunization programmes, human resources planning and development and patient

<sup>26</sup> Personal interviews with officials of Mozambican Ministry of Health, 2015, Maputo.

<sup>27</sup> Personal interviews with officials of DfID, May 2015, Maputo.

<sup>28</sup> Personal interviews with representatives of USAID and CDC and the Brazilian Embassy and Fiocruz, Maputo, 2013 and 2015.

<sup>29</sup> Personal interviews with representatives of Italian Cooperation and of the Brazilian Embassy, Maputo, 2013.

<sup>30</sup> Personal interviews with officials of Mozambican Ministry of Education, the WFP and the Brazilian Embassy, 2013 and 2015, Maputo.

<sup>31</sup> Personal communication with South Africa High Commission in Lilongwe, 2013.

referral systems. Mozambique and South Africa agreed to exchange health professionals for purposes of sharing new techniques and technologies, including training and education programmes; exchange and dissemination of information on health issues; creating partnerships with South Africa's health institutions and organisations; exchange in biomedical and health system research; and exchanging information and sharing experience in human resources management in the context of decentralisation to local facilities (Department of Health of South Africa, 2005). According to officials of the Mozambican Health Ministry<sup>32</sup>, these intentions have been but partially implemented. Concrete cooperation with the South African government is limited to exchange of information on border control and common regulations and referral of patients.

## **Perception and knowledge about rising powers of main governmental actors**

Before embarking on the analysis of the anatomy of influence framework, it is useful to present what kind of knowledge exists about the rising powers' health assistance within the traditional donor community and governmental officials. This gives a first indication of the presence and the influence of the rising powers in health assistance. Within the traditional donor community little was known about the presence of China, South Africa, Brazil and India. For China only medical teams and some infrastructure provision were regularly mentioned in the interviews and for Brazil the creation of a pharmaceutical factory had caught the eye.

India and South Africa were only mentioned with regards to the involvement of their private sector (such as import of pharmaceuticals and patients attending hospitals in South Africa). Interestingly, also within the Mozambican government information was hard to come by: information was very dispersed over different individuals, and even the Department of Planning and Cooperation of the Ministry of Health could only provide partial information.

None of the rising powers was thus identified as a major development actor within the health assistance with Mozambique. These findings are also supported by an unpublished study commissioned by the Dutch cooperation agency of 2010 on the main stakeholders in the agricultural sector, in which none of the emerging powers was mentioned. The findings below provide a more nuanced picture about the rising powers' influence and presence in the Mozambican health assistance.

<sup>32</sup> Personal interviews with officials of Mozambican Ministry of Health, 2015, Maputo.

Representatives of the traditional donors as well as the Mozambican government were asked to identify the bilateral or multilateral actors which exerted most influence on the policy development in the health sector of the Mozambican government on the one hand, and those who possessed most valuable expertise on the other<sup>33</sup>. Figures 1 and 2 show that the relative influence of the emerging powers on the policy making process as well as provider of expertise is very limited to non-existent. The few results within the Mozambican government's survey make only reference to Brazil.

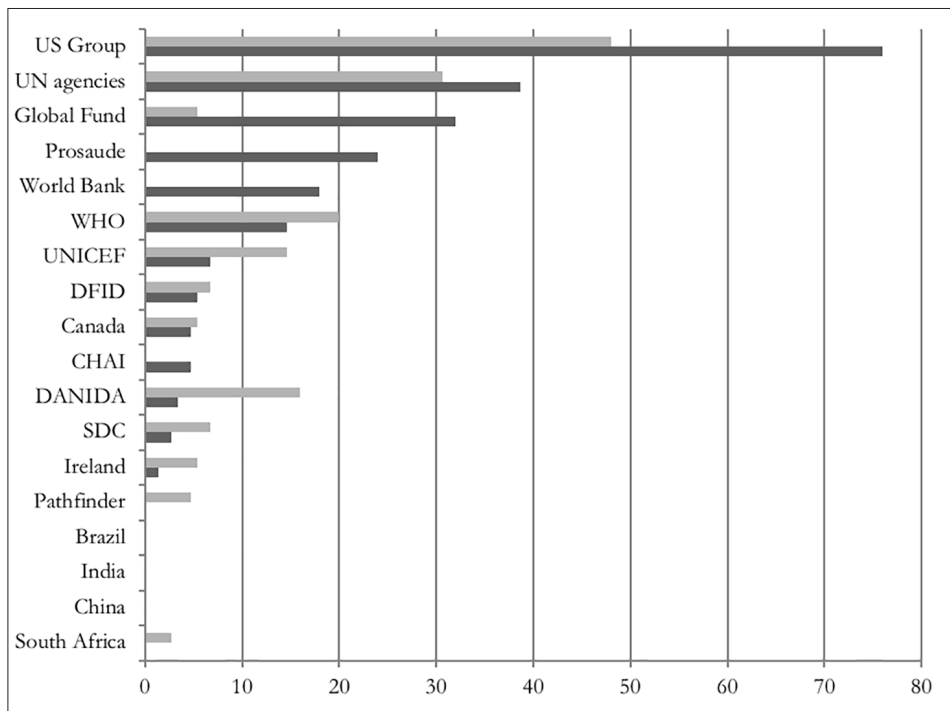


Figure 1: Traditional development partners view in 2015 on which actors influence most the policy making process and possess most relevant expertise and know-how to address the challenges in health in Mozambique<sup>34</sup>

<sup>33</sup> For the traditional donors, all of the 15 heads of cooperation or health experts were willing to answer the first question and 14 the second. Unfortunately only 5 of the 15 Mozambican officials wanted to address the question. Reasons for refusal included first of all that the respondents did not feel well-positioned to answer the question (the minister or president should do this). Other reasons referred to having only partial view on the health sector, and the diversity of the expertise areas. Given the absence of similar survey studies within the Mozambican government, the results of this perception survey are given as an illustration.

<sup>34</sup> See note 17 for more info on the survey. The figures show the percentage of total points that each actor received on the maximum amount of points that could have been received (if every respondent, including those that refused to answer, in a group had given 5 points to that actor) in the group of traditional donors and UN agencies (table 1), and in the group of Mozambican government officials (table 2).

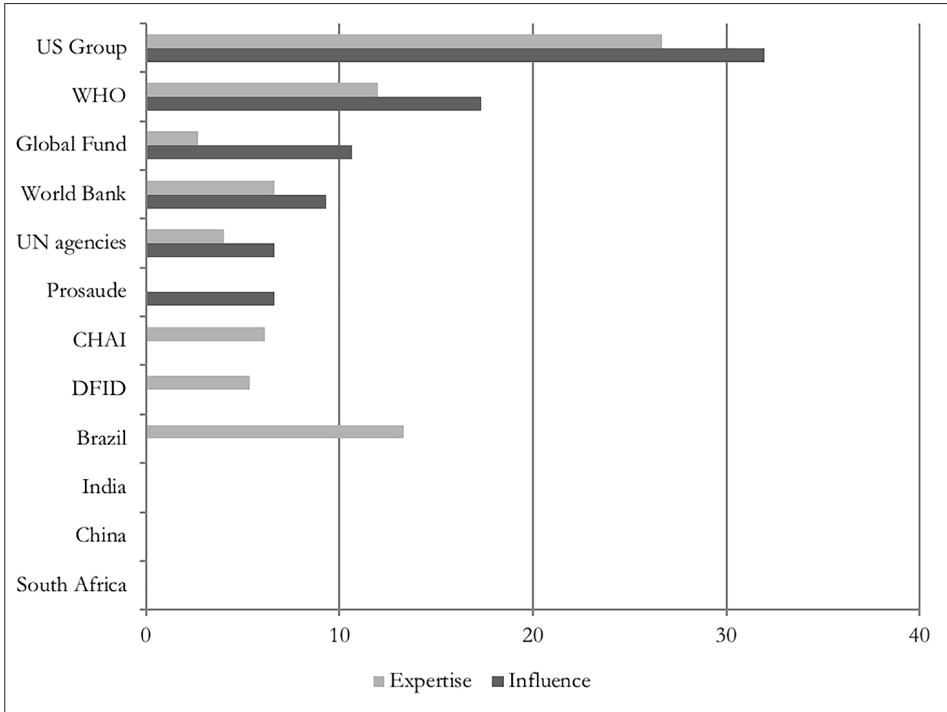


Figure 2: Mozambican governments’ view in 2015 on which actors influence most the policy making process and possess most relevant expertise and know-how to address the challenges in health in Mozambique

## Analysis of influence of the emerging powers

### Material influence

Arguably one of the (and probably the) most important reason why none of the emerging powers features in the list of influential actors, is the relatively limited financial support provided by the governments of these countries to the health sector. Although some of the projects represent sizeable investments (i.e. the Brazilian pharmaceutical factory and the rehabilitation of the Beira hospital by the Chinese government) overall the four countries’ contribution to the Mozambican health sector is relatively limited. Official data also lack most of the contributions of the emerging powers (due to the faulty data communication and collection), making comparisons difficult. As some other traditional donors (USAID, JICA), they do not offer any budget or sector wide support – only project based support. Importantly, this aid is mostly tied. In addition, there are important differences between the four countries. South Africa’s governmental investments in health are almost non-existent; China’s policy focuses on infrastructure

and equipment provision and clinical support (treatment) and to a lesser extent on capacity building – mainly in the malaria sector; India’s governmental assistance is limited but expanding in certain areas, and while its general aid to Mozambique does include grants and loans, health is not a focal area; Brazil’s cooperation encompasses by far the most extensive number of projects of the four countries, but its regulatory framework does not allow to transfer financial resources abroad. Indirectly the emerging powers do provide additional financial resources to Mozambique via funding to multilateral organisations such as the Global Alliance for Vaccines and Immunization (GAVI), which are also active in Mozambique (Harmer et al., 2013). Notwithstanding the relatively limited number of projects (except Brazil) or financial support, from the emerging powers, some material influence is apparent. This can be concluded from the assertion that the Mozambican government is looking towards some of the emerging powers to finance specific projects.

Secondly, some of the emerging powers – esp. India – play an increasingly important role in addressing specific health problems for which there is no or inadequate equipment, know-how or human resources available in Mozambique. This is illustrated by the referral of patients to India (and South Africa), the virtual Pan-African e-Network, and the malaria centre and the medical teams and brightness action campaign of China. Besides the relevant expertise (see below), cost-effectiveness is an argument to turn to emerging powers and other South-South Cooperation partners for assistance. A Mozambican official asserted for instance<sup>35</sup>: “Every country can give doctors, training, research. But they’re less expensive than other doctors or countries. For one Western doctor we can employ eight Chinese ones”.

Thirdly, the projects of Brazil and China are characterized by a certain input of human resources – though the approaches and objectives differ. Brazil sends experts to Mozambique to build organizational and institutional capacities. Interestingly, though they are relatively limited in number and spend relatively short periods in Mozambique, they are increasingly solicited by traditional donors on an ad hoc basis or in trilateral projects. Chinese medical specialists, on the other hand, spend time in Mozambique to address specific health challenges. However, despite the attention received in media and promotion by the Chinese government, the medical teams are relatively modest in number and operate in a confined area (i.e. Maputo). Of course the lack of qualified medical personnel in Mozambique (about 930 general practitioners and 510 specialists in 2014) (Ministério da Saúde, 2013) implies that ten to twenty specialists do correspond

<sup>35</sup> Personal interview with official of Ministry of Health of Mozambique, May 2015, Maputo.

with a notable increase of personnel. As a comparison, Cuba deploys about 250 general practitioners and specialists in Mozambique of which more than half work outside Maputo<sup>36</sup>. An evaluation of the Centre for Chinese Studies of the Chinese medical teams in 2010 concluded that the language remains a barrier (Centre for Chinese Studies, 2010).

Fourthly, Brazil's material influence extends to long and short term training courses. While in other countries and sectors also China and India's cooperation is characterized by this type of support, this is not (yet?) part of the health cooperation with Mozambique. Exception is the virtual training component of the Pan-African e-Network – however, the available evaluation material hints that – due to organizational and language problems – very few students have benefitted from this<sup>37</sup>.

A fifth conclusion and important caveat to the material influence described above, is the lack of evaluation of the project based assistance. Although this is partly explained by the recent nature of the initiatives, and steps have been taken recently by the Chinese and Brazilian governments or academics to assess the implementation and effects<sup>38</sup>, there is still very little information about the state of affairs and effectivity of these projects. Consequently, the potential contribution to the amelioration of the health system or the specific health related problems of these approaches remains a question mark. Without intending to offer a profound assessment of the assistance – this would require indeed a very different methodological approach, and is beyond the scope of the research on which this article is based – the data collection did provide some very preliminary material about the state of some of the projects that nuance the very optimistic claims. For instance, in the case of the Indian tele-medicine project, all the infrastructure has been implemented and is operational, but it remains hardly used by Mozambican health personnel, according to the actors responsible for the implementation<sup>39</sup>. Interviews with several officials showed that though the support in the framework of the malaria support centres has been integrated within the health care system, it was not used as was intended initially. Russo et al. (2014) highlighted in their study of the Brazilian pharmaceutical factory that “traditional setbacks in project implementation such as changes in government, scarcity of skills, capital, services and raw materials in the local market have been overcome

<sup>36</sup> Personal interviews with Dr. Piloto, head of health cooperation of Cuba in Mozambique, 27 May 2015, and the Cuban Ambassador to Mozambique, 22 May 2015, Maputo.

<sup>37</sup> Personal interviews with officials of Ministry of Health, 2013 and 2015, Maputo.

<sup>38</sup> Personal interviews with representatives of Brazilian Embassy in Maputo, 2013, 2015; and with Chinese academics in Beijing, November 2014.

<sup>39</sup> Personal communication with officials of Ministry of Health, 2013 and 2015, Maputo.

by, respectively, training staff in Brazil, procuring products and services from neighbouring countries, and resorting to public-private support for extra funds". However, the authors also question the financial, technical and political sustainability, partly due to the underestimation of "the impact of government changes in political will, to the complexity of securing public sector's drugs purchases, and the conundrum of recruiting and retaining skilled personnel in Africa."

Lastly, although it is not part of governmental assistance, for the future context and possible development it is important to mention briefly the material influence of especially the Indian private sector. More than donations, the increased importance of import of medicines from India is apparent. India moved from the 14<sup>th</sup> to the 1<sup>st</sup> place of importers of medicinal and pharmaceutical products into Mozambique between 1995 and 2012. In 2012 India's share stood at 34%, representing more than 45 million US\$<sup>40</sup>. Interviewees of traditional donors as well as India and South Africa, also referred to the private hospital sector when asked about the presence of the rising powers in Mozambique. Noteworthy is Dr. Agarwal's Eye Hospital, one of the main chains of eye care centres and hospitals in India.

### **Ideational influence**

From the data collection and analysis can be concluded that ideational influence of the emerging powers on the Mozambican government and other development partners of donors is exerted in two different but related areas: in the general principles regarding development cooperation and in the nature of the expertise in health offered. An important caveat however is that – especially for the latter component – there are large differences between the four countries in this study.

As described extensively in the literature (Kragelund, 2010; Mawdsley, 2012), the governments of the emerging powers frame their development cooperation in a so-called South-South Cooperation discourse which emphasizes the following principles: solidarity, mutual benefit, demand driven-ness, non-interference and absence of conditions, expertise based on addressing own development challenges<sup>41</sup>. Despite the scarcity of official documents and speeches about health cooperation between the governments of the emerging powers and Mozambique, the interviews with representatives of the countries demonstrate to a certain extent a similar discourse in Mozambique.

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<sup>40</sup> Data from <http://unctadstat.unctad.org>. For more information, see De Bruyn (2013b).

<sup>41</sup> See Mawdsley (2012) for a discussion on the origins of these principles.

For instance, the representative of the Brazilian Embassy<sup>42</sup> remarked: “We don’t want to be compared to donors, they have a different approach from ours. There is a lot of transfer of funding involved. So automatically you impose conditions.” The Indian representative of the High Commission<sup>43</sup> mentioned in the same vein: “With our cooperation: no strings attached”.

Some of the Mozambican officials share this idea<sup>44</sup>: “The emerging powers [i.e. Brazil, India, China, South Africa] don’t ask conditions, no reforms” and “In general the cooperation within South-South Cooperation is more equilibrated, few conditions. Negotiations are also very different, there is little interference. It might be different in other sectors, but I only say something about health.” Another official singled out Brazil:

Brazil is different from traditional donors in various aspects. Of course the common language is very positive. Brazil and Mozambique are more like a brothers and sisters relationship. We learn together, share of info, build capacities building, transfer technology, it is like a learning relation. With traditional donors it is more a donor-recipient relationship: I do this and you do this.

However, there are also some dissident voices about certain emerging powers, which illustrate that there is no single shared opinion within the Mozambican government<sup>45</sup>: “the three countries [India, Brazil and China] are not the same. India actually follows the *stilo britanico* – sometimes rigid. While Brazil and China are very flexible” and on the other hand “In the cooperation with Brazil, we feel that Brazil wants to be superior, they have all the knowledge supposedly” and “China and India are very different, they’re more acting like equals.”

The four countries claim that their cooperation is demand driven, but Mozambique has to file a request for cooperation or assistance to the government of the respective rising power through the diplomatic representation in Mozambique. At the same time however, the options for cooperation are given and decided upon by the rising powers themselves and presented via the high level meetings (such as FOCAC). Moreover, representatives of the different rising powers and the Mozambican government asserted that these meetings (sometimes at presidential level), in which representatives of the rising power present

<sup>42</sup> Personal interview with representative of Brazilian Embassy in Mozambique, 2015, Maputo.

<sup>43</sup> Personal interview with representative of Indian High Commission in Mozambique, 2013, Maputo.

<sup>44</sup> Personal interviews with officials of Ministry of Health, 2013 and 2015, Maputo.

<sup>45</sup> Personal interviews with officials of Ministry of Health, 2013 and 2015, Maputo.



the possibilities for cooperation, are instrumental in the decision making process for certain projects, such as the pharmaceutical factory of Brazil<sup>46</sup>.

Interestingly, the argument of win-win and mutual benefit was not seen as a key guiding principle of the health cooperation. For instance, India's representative – though admitting not possessing insights into the details of development cooperation policies – claimed that the Indian cooperation did “need to be reciprocated”<sup>47</sup>. Also within the Mozambican government no mention was made of direct economic or political gains that the governments of emerging powers could obtain within the Mozambican health sector. However, this does not mean that benefits (other than solidarity and altruism) for governments of emerging powers may exist (or hoped to be leveraged) at other levels, such as gaining political weight at the global health governance level, or expanding trade or other economic opportunities in other sectors in Mozambique.

The motivations why the four countries engage with Mozambique can be explained by a combination of factors governing the four countries overall (health) assistance policy in Africa and partner country specific factors. Another way to look at the engagement is provided by Watt et al. (2014) who analyse the BRICS's motivation in global health negotiation by looking at three different possible motivations: social security, economic interest and security reasons. Transposing this framework to the Mozambican case, the Brazilian initiatives with the emphasis on self-reliance and access to public health demonstrate the social justice angle. China's and India's projects also focus on providing access to clinical treatment, but their projects (especially in the case of India) show a lesser ambition in number of people treated. South Africa's motivations are rather of a security nature, given the border that both countries share. This is visible in the focus of South Africa's health collaboration agreement.

Besides the general principles to development cooperation, ideational influence might be exerted in the views on how the health system should address the health challenges in Mozambique. Within our limited survey, only Brazil was mentioned among the emerging powers as potentially providing relevant expertise. Within the interviews the importance of Brazilian expertise was confirmed, although also Indian and Chinese know-how were mentioned, especially in traditional medicine. South Africa hardly appeared in the discussions. A Mozambican official argued:

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<sup>46</sup> Personal interviews with representatives of the Mozambican and Brazilian governments, 2013 and 2015, Maputo.

<sup>47</sup> Personal interview with representative of Indian High Commission in Mozambique, 2013, Maputo.

Brazil understands our problems and limits better. They have the same problems and contexts, for instance the literacy rate, poverty, lack of access to safe water, health care and basic care; lot of similar diseases. They also see themselves faced with a similar epidemiological change.

And a representative of a traditional donor added<sup>48</sup>:

Brazil always comes forward in the health sector at the global level – esp. when it comes to global human resources for health and access to basic health services. Due to the language and the expertise of Brazil there is a lot of potential in the collaboration with Mozambique and it could be beneficial for Mozambique. We would probably promote this kind of collaboration.

There are signs that the demand for more technical support in issues in which the emerging powers are supposed to possess valuable expertise will probably increase in the future. This can be illustrated by the interest from the Mozambican government, as several interviewees mentioned, to collaborate on traditional medicine. One Mozambican official explained<sup>49</sup>:

The traditional medicine of India is a little bit different than that in Mozambique. The use of medicinal plants is the same. [...] Most of the medicinal plants that we saw in India are the same as in Mozambique, because of the climate which is the same. That is why it is easy to learn from them [...] Brazil, India and China are our main contacts – [although we] also [have contact] with South Africa. We prefer to work with India over China, because of the language. Brazil [is interesting] because [...] of the legislation.

### **Institutional influence**

Institutional influence may take different forms. On the one hand in the type of organisations or actors which are managing and governing development cooperation, and on the other hand in the rules and ways that different actors interact – which refers in this study to cooperation or coordination with other development partners. A third component, which has already been dealt with above, is the attention given in the (Brazilian) assistance to institutional strengthening or capacity building.

The first component refers to three separate but linked issues: the limited presence, the peer-to-peer cooperation, and the absence of civil society. The emerging

<sup>48</sup> Personal interview with representative OECD-DAC donor in Mozambique, 2013, Maputo.

<sup>49</sup> Personal interview with an official of the Ministry of Health, 2013 and 2015, Maputo.

powers have limited human and organisational resources available to coordinate and oversee the implementation of the projects within Mozambique. This is partly a consequence of the fact that the institutional structure to govern development cooperation is in the process of being developed (India and South Africa) or re-structured (Brazil). In essence the diplomatic missions are given the responsibility to follow up the projects. However, not all of them possess a clear oversight of the policies and initiatives undertaken. For instance, though the Brazilian institutions provided ample information (but it had to be compiled from different sources), the South African High Commission was unaware of major projects and India's High Commission only possessed very general information.

Besides the diplomatic missions, sector specific ministries and agencies play an important role in coordination, management and certainly the implementation of the initiatives. This approach of peer-to-peer cooperation is in Mozambique especially apparent with Brazil. Brazil is the only rising power that has a specific agency in Mozambique to manage the projects in health assistance. The Oswaldo Cruz Foundation, or Fiocruz, is a re-known Brazilian public health institution specialised in training, research, management of health programmes and production of pharmaceuticals and is the main implementing agency of Brazil's foreign health assistance (Almeida, 2010). This agency – employing only two people in Mozambique – also oversees activities in other African countries and the employees cannot be permanently based in Mozambique. In addition there are two people in the country to oversee the pharmaceutical drug factory, and during short periods Brazilian specialists come over to follow up the other projects.

Lastly, the institutional influence is mainly exerted by governmental institutions working with their counterparts. Civil society – Mozambican or from the rising powers – is almost entirely absent in the programmes and projects. Especially for Brazil this might seem remarkable given the important role that civil society has played in the development of the social programmes as well as certain health policies, for example regarding HIV/AIDS (see for instance Parker, 2009).

Results for the second component, interaction with other actors, confirm in first instance the finding of the general literature (Harmer & Buse, 2014) that the influence is exerted through bilateral relations, although – esp. in the case of Brazil – trilateral cooperation is explored, as well as collaboration with specific multilateral health initiatives. For all four countries decisions are taken between representatives of the highest governmental levels – as could be gathered from the interviews with government officials –, and it is questionable to which extent or at what stage representatives of the Mozambican Ministry of Health

are involved. In certain projects, the Mozambican officials claimed in the interviews that they were only involved and consulted after the decision was made. Trilateral cooperation is being explored by Brazil in several projects. Also various traditional donors expressed their interest in setting up some kind of cooperation with Brazil in Mozambique to address the health challenges.

There is very little information sharing or coordination among the four rising powers themselves in Mozambique and they also act outside of the coordination initiatives of the other foreign development actors in general and of traditional donors in particular – only Brazil participates (but marginally) in traditional donor meetings. The traditional partners meet regularly in the Health Partners Group (HPG). Although this is open to all development partners, rising powers do not attend this meeting – bar sporadic appearances of Brazil. From the interviews with traditional donors and representatives of the emerging powers it could be concluded that this is not only due to the resistance of being associated with traditional donor practices, but also because of time constraints, limited knowledge about the objectives of the coordination meetings and the limited efforts of traditional donors to include the other countries in the meetings. Moreover, attendance of the partner group meeting made it possible to identify extra potential obstacles: i.e. the use of a specialized and specific “donor” language (including specific terminology including many abbreviations), and English as the main means of communication (which is remarkable given the fact that Mozambique is a Portuguese speaking country). The partial coordination between traditional and ‘non’ traditional development actors might result in a decrease of effectiveness of development efforts, as well as extra time and resources of the Mozambican government to manage and coordinate the different initiatives.

## Conclusion

This article analysed the influence of four of the most debated emerging powers on health cooperation in Mozambique by looking at three components: material, ideational and institutional. The Mozambican case allowed to confirm certain findings of the general literature, expand the knowledge about other issues, and question some discursive claims. In order to draw lessons for the emerging powers’ health or development cooperation as a whole, it is necessary to assess to what extent Mozambique is a representative case study. In the article’s third section I have demonstrated that Mozambique hosts most of types of modalities and activities of the health assistance of each of emerging powers – and that

there are even some projects which are not found elsewhere (e.g. the Brazilian ARV factory). Important nuances include that (1) the presence and influence of Brazil is arguably much higher than in other (non Lusophone) African countries; (2) South Africa's presence is very limited, and therefore other sectors might be better studied to make statements about the country's development approach; (3) each sector and country has its own contextual specificities – and it would therefore be advisable in a later stage to compare the findings of this research with other studies. In this conclusion I would like to draw attention to five issues.

Firstly, the difficulty of compiling comprehensive information about the emerging powers health assistance in Mozambique, a country which might be considered as one of the most important partners of international cooperation, supports the hypothesis that available conclusions on the rising powers influence on African health assistance is based on very partial insights in the reality of partner countries, and re-affirms the need for specific country studies.

Secondly, the results show that notwithstanding the attention given in some international academic and policy circles to the emerging powers' growing role in international health assistance, the presence of China, India and South Africa is still relatively limited in Mozambican health assistance in terms of cooperation activities. Even Brazilian assistance, which is substantial and growing, is not comparable to that of the material support of the traditional donors. Nevertheless, the emerging powers offer an alternative ideational discourse about the principles of development cooperation.

Thirdly, despite many similarities, the four countries in this study show marked differences in their approaches to health assistance. Brazil promotes structural cooperation and self-reliance, combining human resource, organizational and institutional capacity development assistance, and – exceptionally (or pioneering) for its cooperation in Africa – pharmaceutical production development. The Chinese approach is characterized by infrastructural and equipment support, together with clinical support through human resource development. India's cooperation on the other hand is geared towards clinical long distance assistance – and its private sector involvement might prove to be much more influential on the health system. South Africa's health assistance is embedded in regional and border cooperation. An important question that arises is about the complementarity of the different views and approaches to health systems and governance. For instance, the 'compartmentalised' approach to malaria control versus the more integrated health systems Brazilian approach; or the emphasis on being self-sustainable in the production of medicines and pharmaceutical products of Brazil, versus the import of Indian generic medicines.

Fourthly, these potentially conflicting approaches as well as the limited communication between the traditional donors and rising powers (and between the latter) call for more coordination, cooperation and information sharing between rising powers, traditional and other development actors and partner country governmental and non-governmental actors.

Fifthly, the very limited evaluation material about the different projects raises questions about their effectivity and sustainability. However, the main conclusion is that there is still inadequate profound evaluation and assessment of the projects and interventions available to confirm or refute the (promising) claims of South-South Cooperation. Consequently, assessment should also address the important question to what extent the Mozambican government can and will apply the experience and expertise of the emerging powers to fulfil its own policy objectives and health.

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