COVID-19 vaccines and global health diplomacy: Canada and France compared

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Abstract

This chapter compares Canada's and France's policies and practices regarding COVID-19 vaccines. It asks to what extent they advance domestic interests versus international ones and what the impact is on their influence in the world. The two countries both have a history of global health diplomacy and share a desire to play an important role on the world stage. The COVID pandemic provided them with an opportunity to exercise that commitment. Both countries quickly embraced, at the rhetorical level, the need to address the global crisis via multilateral channels, including to ensure an equitable distribution of vaccines. How they acted, however, differed considerably. The Canadian government took a strong "Canada First" position, in spite of verbal and some financial support for multilateral responses, and impeded patent waivers that would increase global vaccine production. By taking actions that would prolong the pandemic at the global level, Canada also behaved to the detriment of its global "soft power". France, on the other hand, acted more multilaterally and strategically from the perspective of soft power, and reversed its initial self-interested position on intellectual property rights. We argue that Canada's and, to a lesser extent, France's domestic policy objectives undermined their global health diplomacy efforts and ultimately acted against their own interests, both in terms of health outcomes and being able to exercise influence in global affairs, especially in the Global South. By emphasizing approaches characterized by selfishness and charity, rather than equity and justice, they are also, along with their counterparts in the Global North, undermining the credibility of Northern aid donors more generally and the legitimacy of the aid regime.

Keywords: Canada, COVID-19, foreign aid, France, global health, health diplomacy, multilateralism, self-interest, soft power, vaccines

Introduction

The COVID-19 pandemic has disrupted the delivery of foreign aid, while increasing the need for international assistance. However, the extent to which the crisis is truly transforming the foreign aid *regime* remains an open question. Other than a renewed emphasis on social services and well-being, most trends associated with the pandemic are actually accelerations of processes that were already in place, such as a growing proportion of aid being directed to humanitarian assistance and the increased reliance on local partners in the Global South (Brown, 2021b). Despite the universal recognition of the need for a concerted global effort to fight the novel coronavirus, one of the most significant reinforced trends has been the growth of self-interest in foreign aid, not only in the rationale for aid but also in how short-term national interests have eclipsed medium- and long-term national and common interests. This contradiction is especially apparent in donor countries' acquisition and distribution of COVID-19 vaccines.

This chapter compares Canada's and France's policies and practices regarding COVID vaccines. It asks to what extent they advance domestic interests versus international ones and what the impact is on their influence in the world. The two countries are especially interesting case studies among "traditional" aid donors as they both have a history of global health diplomacy and their respective leaders during the first years of the pandemic, Prime Minister Justin Trudeau and President Emmanuel Macron, shared a dynamic leadership style and a desire to play an increasingly important role on the world stage. As such, the pandemic provided them with an opportunity to exercise that commitment, predisposing Canada and France to be potential champions of multilateral cooperation to fight COVID-19. Indeed, both countries quickly embraced, at the rhetorical level, the need to address the global crisis via multilateral channels, including to ensure an equitable distribution of vaccines.

How they acted, however, differed considerably. The Canadian government took a strong "Canada First" position, in spite of verbal and financial support for multilateral responses, and impeded patent waivers that would increase global vaccine production. By taking actions that would prolong the pandemic at the global level, Canada also behaved to the detriment of its global "soft power". France, on the other hand, acted more multilaterally and strategically, and reversed its initial self-interested position on intellectual property rights. We argue that Canada's and, to a lesser extent, France's domestic policy objectives undermined their global health diplomacy efforts and ultimately acted against their own interests, both in terms of health outcomes and being able to exercise influence in global affairs, especially in the Global South. By emphasizing approaches characterized by selfishness and charity, rather than equity and justice, they also, along with their counterparts in the Global North, undermined the credibility of Northern aid donors more generally and the legitimacy of the aid regime.

To make this argument, we begin by presenting an overview of the concepts of soft power and public health diplomacy. We then analyse in turn the cases of Canada and France, based on publicly available documentation, including government statements, media reports, and analysis by scholars and practitioners. When examining the governments' actions, we draw on Harman et al.'s (2021) normative hierarchy of the three means of fighting vaccine inequity: Most ethical is the "pooling, temporary waivers, or suspension of IP [intellectual property]" (Harman et al., 2021, p. 2). Second is multilateral charity, epitomized by the flawed COVAX initiative. The most problematic is bilateral (country-to-country) charity, because "it is unclear if this will be done for free, at a lower cost, tied to diplomacy or conditionality, or crucially, when these vaccines will be made available, where they will go, or how many will be delivered. The bilateral charity approach has little to do with equity and more to do with geopolitics, wealth and aid dependency" (Harman et al., 2021, p. 1).

Taking into account that analytical framework, we structure our comparison of Canada and France via five related questions. First, mainly as background, what was each country's experience in support to the health sector in the Global South and in global health diplomacy? Second, what was its discourse on global COVID vaccination? Third, how did it conduct its domestic vaccine procurement? Fourth, how did

it proceed in international vaccine donations and how did it support multilateral initiatives? Fifth, what was its position on vaccine-related intellectual property rights? The coherence and inconsistencies in Canada's and France's rhetoric and actions, as well as the similarities and differences between the two countries, help us trace a nuanced picture and tease out its implications.

Soft Power, Global Health Diplomacy and Multilateral Responses

Soft power is generally understood as "the ability to get what you want through attraction rather than coercion or payments" (Nye, 2004, p. x), as opposed to hard power, which refers to the use by states of material resources as a means of pressure, in particular military force. Soft power rests on more intangible attributes, particularly cultural and political, on which a country's reputation and thus its influence on the global stage depends (Chung, 2011). It allows for more peaceful solutions, as well as considerable savings in terms of human, material and financial resources when compared to coercive initiatives. The notion of soft power thus makes it possible to conceive of state discourses and initiatives through a reputational lens and the construction and maintenance of a positive image on the world stage.

COVID-19 constituted an opportunity for states to boost their image by demonstrating leadership in responding to this global health and economic crisis in an equitable way. At the global level, while some countries had long been strongly involved in what is known as global health diplomacy, others jumped on the bandwagon and "emerging" countries became more active. Global health diplomacy refers to "multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health" (Kickbusch, Silberschmidt & Buss, 2007, p. 230). According to Kickbush (2011), "foreign policy can be used to promote health goals", but it can also "endanger health" (p. 1). For instance, international trade and patent laws restrict the possibility of producing affordable medicines, prioritising the profits of pharmaceutical companies and national interests over the health of millions (Brunet-Jailly, 2016; Gopakumar, 2016; Sharun & Dhama, 2021).

Increasing the supply of vaccines is urgently required to save lives and prevent further spread of the coronavirus. Reducing the global case load would also decrease the odds of dangerous new variants emerging, which is in all countries' best interest. Many companies have been expanding their manufacturing capacity, but it is nowhere near sufficient – and they have proven extremely reluctant to voluntarily licence other companies to manufacture them on their behalf. Despite characterizations of COVID vaccines as a "global public good", something with the potential to benefit everyone, everywhere, most remain very much *private* goods, under the control of powerful profit-seeking companies whose interests do not necessarily align with principles of equity, solidarity, justice or in fact global public health. As a result, the only remaining option to increase manufacturing is "to move towards involuntary production upscaling" (Meijer et al., 2021, p. 1).

In the interest of global well-being, international agreements and domestic laws already allowed states to individually and collectively authorize the manufacturing of generic vaccines without the patent holders' permission, for which they would nonetheless be compensated, known as compulsory licencing. Under certain circumstances, including during a public health emergency such as a pandemic, the World Trade Organization's Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement permits such a process to take place without first attempting to obtain the patent-holder's permission, i.e., without seeking voluntary licencing. The majority of the world's countries, including China, Russia and the United States, expressed support for a temporary TRIPS waiver that would further weaken intellectual property rights to facilitate the expansion of manufacturing of generic COVID vaccines. Initially proposed by India and South Africa in October 2020, such a waiver can only be granted under WTO rules if there is a consensus among member states.

The manufacturing and distribution of prophylactic medical products are subject to a subcategory of global health diplomacy, namely vaccine diplomacy, which "refers to almost any aspect of global health diplomacy that relies on the use or delivery of vaccines" (Hotez, 2014, p. 2). Vaccines are a precious instrument of soft power, even "national security assets", used to pursue political and diplomatic objectives in an uneven playing field in which poorer countries generally have access to vaccines last (Pannu & Barry, 2021, p. 744).

The COVID-19 pandemic quickly led to the creation of an international solidarity mechanism: the Access to COVID-19 Tools Accelerator (ACT-A), co-coordinated by Gavi, the Vaccine Alliance (Gavi), the Coalition for Epidemic Preparedness Innovations (CEPI) and the World Health Organization (WHO). Invoking principles of equity and justice, wealthier countries committed to funding this mechanism designed to ensure "equitable access to COVID-19 tests, treatments, and vaccines" for all countries regardless of their purchasing power, because "no-one is safe until everyone is safe" (WHO, n.d., para. 1 and 4). In particular, access to vaccines is a major challenge for low-income countries as "[t]he endgame is no longer simply how to make the best vaccine in the laboratory, but rather how vaccines will be purchased and used appropriately" (Hotez, 2001, p. 863).

ACT-A includes the COVAX initiative for COVID-19 vaccines. In particular, the COVAX Advanced Market Mechanism (AMC), financed mainly through wealthy countries' official development assistance, was created to ensure low- and middle-income countries could have equitable access to vaccines. To do so, COVAX was meant to pool vaccine resources, either bought by COVAX or donated by countries, and distribute them according to need, determined according to a country's population size, target vaccination rate and possible acute outbreaks (Berkley, 2021). COVAX aimed to vaccinate only 20% of poor countries' inhabitants, far below wealthier countries' own targets, a disparity that Zimbabwean philanthropist Strive Masiyiwa called "a deliberate global architecture of unfairness" (quoted in Merelli, 2021).

COVAX, however, did not live up to those initial goals. Although it allows all countries regardless of their revenue to request vaccine doses, in practice, while self-financing countries are guaranteed an access to vaccines in proportion to the amount they contribute, vaccine supplies for poorer countries depend on funding availability, as the head of Gavi has recognised (Berkley, 2021). The mechanism's fatal flaw is that it relies on charitable donations and market mechanisms. It has been unable to purchase the planned number of doses because wealthy countries displayed a tremendous degree of "vaccine nationalism" and locked in supplies via direct contracts with pharmaceutical companies, especially of the premium mRNA vaccines, buying enough to inoculate their population multiple times over. They resisted the loosening of intellectual property rights (Sharun and Dhama, 2021), which would have helped increase vaccine production and availability. COVAX's ability to purchase supplies on the global market was further limited by India's five-month moratorium in April 2021 on exports of its version of the AstraZeneca vaccine, enacted to deal with an escalating case rate at home, revealing the problem with COVAX's overreliance on a single country as its main supplier. With a limited ability to buy doses on its own, for most of 2021 COVAX had to rely on in-kind donations of mainly surplus vaccines. However, wealthy countries also failed to meet their pledges of vaccine donations and funding to permit COVAX to cover the needs of poorer countries, while authorizing booster shots for their populations before even health workers and vulnerable populations could be vaccinated in the Global South (Ghebreyesus, 2021a, 2021b).

So-called "emerging countries" and "rivals" China, India and Russia undertook their own COVID vaccine diplomacy, which had the potential to disrupt Western countries' selfish dynamics. Prior to the pandemic, India produced more than half of the world's vaccines and had a long track record of providing affordable medicines across the world (Brunet-Jailly, 2016; Sharun and Dhama, 2021). However, after initially being a major source of COVAX's vaccines and donating millions of doses to neighbouring countries even before vaccinating a significant proportion of its own population, India temporarily banned

COVID vaccine exports. Despite China's early use of vaccines as a diplomatic tool to the benefit of poorer countries, the country encountered supply problems, there were suspicions that China would withhold the provision of vaccines to countries criticizing its human rights records, and doubts persisted on the efficacy of Chinese vaccines against variants (Wee, 2021; Mashal and Yee, 2021; Keaten, 2021). In August 2020, Russia was the first country to approve a vaccine against COVID-19. However, concerns rapidly spread regarding Sputnik V's quality, including the conduct of its trials and transparency on results (Mahase, 2020). Moreover, stepping up production proved very challenging, and Russia faced delivery delays due to a lack of technical capacity and experienced personnel, as well as shortages in supplies (Ivanova and Nikolskaya, 2021). Moreover, not all of those countries' vaccines received WHO approval.

The hope of a widely available and highly effective vaccine coming from China, India or Russia proved disappointing, stymying their efforts to conduct global public health diplomacy. We now turn to the cases of Canada and France to analyse to what extent these "traditional" Western donors acted from the perspective of soft power and used vaccine diplomacy to further their own interests or, instead, to promote solidarity and justice through fair and equitable access to COVID vaccines.

Canada: Not Walking the Talk

For this first case study, we examine in turn the five issue areas identified in our analytical framework as applied to Canada.

Global Health Diplomacy

Health had been an explicit area of focus of Canadian foreign aid since at least 2000 (Canada, 2002). Most prominently, the Conservative government of Stephen Harper strongly promoted its Muskoka Initiative for Maternal, Newborn and Child Health, launched in 2010. By 2014, it had committed Cdn$8.5 billion (US$6.8 billion) to the initiative, a sizeable investment. Despite this generosity, it was criticized for a number of shortcomings, notably its exclusion of abortion services even where legal in order to please the Conservative Party's base, which tarnished the Initiative's reputation internationally (Brown, 2018). Under the Justin Trudeau Liberal government, Canada expanded the focus to "sexual and reproductive health and rights".

While many analysts praise Canada's development assistance and global influence in the area of health since the late 1990s, especially when delivered via multilateral channels (Ruckert, Labonté & Lencucha, 2019; Weldon & Hoffman 2021), most are also quite critical of the distance between rhetoric and reality. A common refrain is that Canada could do much more, not only or even primarily by increasing its budget allocations, but rather by spending its funds better. Authors have variously found assistance to the health sector to have been too stingy, too narrow, too short term and ad hoc, too self-interested and/or overemphasizing services, while paying insufficient attention to the social determinants of health and health care infrastructure (Huish, 2021; Huish & Spiegel, 2012; Spiegel & Huish, 2009). Several sources highlight contradictions between global health objectives and other dimensions of Canadian foreign policy, as well as the lack of greater global leadership (Nixon et al., 2018; Percival, 2018; Weldon and Hoffman, 2021). COVID presented Canada with a new leadership opportunity, but the government failed to seize it and, moreover, took other steps that were detrimental to its global reputation, even as it espoused valiant rhetoric.

Vaccine Distribution Rhetoric

From the outbreak of the pandemic, the Canadian government emphasized the importance of multilateral vaccination efforts and of the fundamental principles of solidarity, equity and justice with regard to access to vaccines – at least when addressing international audiences. For example, in July 2020, before any vaccines had been approved, Trudeau was the lead author of a statement signed by nine heads of state and heads of government that argued that:

> [We] must urgently ensure that vaccines will be distributed according to a set of transparent, equitable and scientifically sound principles. […] A fair and effective vaccine allocation mechanism, guided by WHO advice and based on needs rather than means, should focus on saving lives and protecting health systems. We call on global leaders to commit to contributing to an equitable distribution of the covid-19 vaccine […]. (Trudeau et al., 2020)

In a similar vein, in September 2020, Minister of International Development Karina Gould declared that Canada was working to create a mechanism that would provide "a fair, equitable, accessible and affordable vaccine" at the global level (quoted in Blanchfield, 2020).

When addressing primarily domestic audiences, the Canadian government infused its rhetoric with more self-interest. For example, on different occasions, Gould made the case that "we will not be safe from COVID-19 in Canada until everyone, everywhere is" (quoted in GAC, 2020), "Our health here depends on the health of the other 'over there'" (Gould, 2020) and "supporting other countries in their fight against COVID-19 is crucial to protect Canadians at home" (quoted in PMO, 2020). In May 2020, Trudeau (2020) invoked Canadian economic interests, arguing that "Canadian jobs and businesses depend on stable and productive economies in other countries – so it matters to us how everyone weathers this storm". These statements, despite the injection of self-interest, remained compatible with the principles of justice, equity and solidarity at the global level.

Vaccine Procurement

Less compatible with the enlightened dimension of the self-interested rhetoric was Canada's actual domestic procurement. Widely criticized at home for an initially slow acquisition and rollout of vaccines when compared to the United States and the United Kingdom, the government overcompensated by aggressively signing contracts with a wide range of potential suppliers, sometimes paying a premium price to leapfrog over other purchasers in delivery timetables. Procurement Minister Anita Anand explained that the government wanted to make sure that "Canadians are at the front of the line" (quoted in Jones and Harris, 2020). Prioritizing its own citizens is to be expected of any government. However, in so doing, Canada became a record-breaking vaccine stockpiler. A *British Medical Journal* blog awarded Canada the "gold medal for top hoarder" for having purchased enough doses to fully vaccinate its entire population more than five times over (Benton, Majumder & Yamey, 2021).

Given the finite global supply of doses, Canada's excessive deals with pharmaceutical companies – including purchases from the Serum Institute of India – meant that fewer doses were available on the market for other countries or COVAX to purchase. Moreover, Canada decided to access 1.9 million doses of the AstraZeneca vaccine from COVAX AMC. Although Canada was entitled to do so, exercising that option opened up Canada to additional criticism, as those doses would have otherwise gone to low- and middle-income countries that had not already secured sufficient or indeed any supplies for their populations (Usher, 2021). The government eventually decided to forego any further deliveries from COVAX, but only after it had more AstraZeneca doses that it could possibly need, given that its use had

been almost entirely suspended in Canada over concerns regarding side effects and the newly widespread availability of the "more desirable" Pfizer and Moderna mRNA vaccines.

Canada's international reputation suffered from its patently selfish "Canada First" behaviour in its domestic vaccine acquisition and the indirect harm that such vaccine nationalism does to other countries (Brown, 2021a). Canada could, however, have redeemed itself through vaccine donations and measures to increase global vaccine manufacturing, but it failed to be sufficiently proactive in those areas as well.

Vaccine Assistance

For a long time, the Canadian government refused to explain what it would do with its surplus doses once it had enough to vaccinate fully the Canadian population, even calling the scenario "hypothetical" (Lum, 2020). This reluctance was confusing, as the outcome was virtually certain, given the oversupply, and, moreover, governments must plan for multiple scenarios. In March 2021, the government stated that it would wait until vaccines had been made available to all Canadians before donating any doses to countries in need (Zimonjic & Cullen, 2021), unlike other donor countries such as France, New Zealand and Norway. The Liberal government was presumably worried about voters objecting to altruism, even though polls suggest that the public in Canada and other high-income countries was broadly supportive of donating a proportion of national vaccine supplies (Clarke et al., 2021, p. 935).

In the meantime, Canada did make relatively generous financial contributions to the multilateral COVAX AMC initiative. In particular, Canada announced in September 2020 a donation of Cdn$220 million (about US$175 million) to buy vaccines for low- and middle-income countries, and also contributed over Cdn$1 billion (US$800 million) for other forms of support to "equitable access to vaccines, tests and treatments" (Canada, 2021).

In August 2021, the month after receiving enough doses to vaccinate its entire adult population, Canada announced that it would donate "up to" 10 million doses of the Janssen/Johnson and Johnson vaccine (GAC, 2021a), which had been approved for use in Canada, but never actually distributed, presumably because of its inferior effectiveness compared to other options and the perceived risk of side effects, as well as the fact that the first shipment of doses from the United States to Canada had to be destroyed because they were contaminated. That commitment brought promised total to over 40 million doses to COVAX, but the government did not provide a timetable or deadline, nor a breakdown of which vaccines it would be contributing. It has only rolled them out slowly and sometimes close to their expiry dates, which needlessly complicated logistics and ultimately risked them having to be destroyed (York, 2021). As of October 22, 2021, out of the 40 million committed to COVAX, it had donated only 3.7 million doses and actually delivered only 1.4 million doses (WHO, 2021a). At the end of October, Trudeau announced that Canada would donate "up to" 10 million doses of the Moderna vaccine (PMO, 2021).

In parallel, in August and September, the Canadian government donated 762,080 AstraZeneca doses bilaterally (government to government) in six countries in South America and the Caribbean (McGregor, 2021). The Canadian government presented only a vague rationale for distributing these vaccines bilaterally, as opposed to via the COVAX allocation and delivery mechanism. The choice can be presumed to be a desire to curry favour with the recipient government and the diaspora in Canada. If so, it was at best only partially successful, as observers noted the fact Canada only shipped the less desirable vaccine type. Trinidadian-Canadian Pundit Vijay Persad Seetahal, who played a role in brokering the donation to his country of origin, stated that "After I make that solemn thanks to her [Canadian Minister of International Development Karina Gould], I am going to beg and ask her very nicely for Pfizer vaccines" (quoted in Ramdass, 2021).

Oddly for a multilateral mechanism, even doses that COVAX distributes are linked to the country that donated the vials. Canada's first AstraZeneca donations to COVAX, for instance, were announced as

having been sent to Nigeria, Kenya and Niger (Gavi, 2021a), even though Canada actually played no role in selecting the recipients according to Global Affairs Canada (York, 2021). Even more confusingly, COVAX has identified shipments of the Chinese vaccine Sinopharm to Nicaragua and Zimbabwe as being Canadian-funded (McGregor, 2021).

Canada's vaccine donations were announced late, were delivered slowly and in an apparently ad hoc manner, and consisted only of doses that Canada has no intention of ever using. They were not especially numerous (given the size of Canada's stockpile) and the total commitment compared poorly with the 1 billion vaccines that the United States had pledged to donate. As such, the credit that Canada's vaccine diplomacy could earn remained limited. The final possibility for a strong contribution to global public health would be leadership in expanding vaccine manufacturing, but Canadian immobilism rendered that scenario moot as well.

Intellectual Property Rights

Whereas some European countries such as Germany and the United Kingdom opposed a TRIPS waiver, Canada remained officially undecided more than a year after the proposal was made. In this context, sitting on the fence is not the same as abstaining from a vote; when a consensus is required, indecision is a form of blocking the adoption of the decision.

The Canadian government stonewalled by repeatedly asking for more evidence that intellectual property rights are the main barrier to expanded vaccine production and argued that a waiver was unnecessary because existing mechanisms permitted compulsory licencing without one. However, its reasoning was demonstrably false (Labonté et al., 2021). For instance, Canada has its own compulsory licencing mechanism, known as Canada's Access to Medicines Regime (CAMR). In place since 2005, it has only been used once to date. The process is so cumbersome that the company in question, Apotex, decided never to engage with it again (Houston & Nickerson, 2021). Nonetheless, in March 2021, the Bolivian government signed a contract with Canadian company Biolyse to produce 15 million doses of the Janssen/Johnson and Johnson vaccine via compulsory licencing. The CAMR requires government approval before production can start. However, like for TRIPS, the Canadian government stalled. It neither approved nor rejected the request and refused to state when a decision would be made – to the dismay of the Bolivian government, which publicly criticised the gap between Canada's rhetoric and actions (Khan, 2021).

It is unclear why, given the global health emergency, the Canadian government was unwilling to support existing provisions for compulsory licencing, whether at home or internationally, based on apparently spurious and contradictory arguments. Such measures are of little or no threat to the profits of Canadian pharmaceutical companies and could in fact benefit Canadian generic drug manufacturers. It would also increase Canada's credibility as a supporter of global public health and thus contribute to Canada's soft power. Some sources speculate that the big COVID vaccine manufacturers pressured the Canadian government to block approval, using as leverage future access to vaccines and pharmaceutical company investment in manufacturing in Canada (Abbas, 2021, p. 14, 17; Khan, 2021; Moss, 2021, p. 13). Whatever the reason, Canada was unwilling to act in that area as well, let alone play a leadership role, to the detriment of its international reputation.

France: Strategic Posturing

We now turn to the case of France, once again examining the five issue areas outlined in the introduction.

Global Health Diplomacy

The French government defined health as one of the five sectoral priorities of its foreign assistance in 2018. In particular, it reaffirmed its commitment to fighting pandemics through contributions to multilateral organisations (Ministry of Economy, Finance and Recovery [MEFR], 2018). In 2021, it reiterated this focus on health in its law on inclusive development and the fight against global inequalities, which frames health as a global public good (Légifrance, 2021).

France has been a major actor in global health diplomacy for decades, albeit not always consistently. An enduring feature is France's focus on African countries with which it has long-lasting colonial ties, in line with its overall foreign assistance strategy (Ministry for Europe and Foreign Affairs [MEFA], 2021a). In the early 2000s, France shifted from mostly bilateral initiatives to allocating most of the aid dedicated to health to multilateral initiatives (Donor Tracker, n.d.; Goblé, 2011). Indeed, France in the last 20 years has led and participated in major multilateral endeavours dedicated to fight epidemics and pandemics: it is the second largest public donor to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund, n.d.; Canada is the seventh largest); it is a founding member of Unitaid, which is engaged in fighting epidemics in low- and middle-income countries; it had a role in the development of Gavi, and the International Finance Facility for Immunization in particular. However, several analysts found this shift to be detrimental to the support of health systems in the long term, despite France's rhetoric (Atlani-Duault et al., 2016; Kerouedan et al., 2011). Moreover, using only multilateral channels for global health diplomacy risks minimizing France's efforts in terms of visibility and "exposes it to political volatility" (Atlani-Duault et al., 2016, p. 2259).

In 2012, France adopted for the first time a strategy for international health cooperation, followed in 2017 by a more detailed strategy for global health. Both emphasize the fight against infectious diseases and the strengthening of health systems as priorities, and both place the geographical focus on Francophone Africa (MEFA, 2012, 2017). However, the latest strategy puts greater emphasis on international health security, including to "promote the fight against emerging diseases and guarantee access to essential public health products", notably vaccines for poorer countries (MEFA, 2017, p. 24).

Hence, France has significant experience in global health diplomacy and has made health a priority sector of its foreign policy over the last 20 years, preferring multilateral instances but making sure to maintain its influence in French-speaking Africa. The challenge for France is to continue (re)building its influence on the global stage by showing financial but above all political leadership for global health solidarity (Atlani-Duault et al., 2016; Kerouedan et al., 2011). France seized the opportunity presented by the COVID crisis to defend equitable access to vaccines through multilateralism both rhetorically and by leading key initiatives such as ACT-A and vaccine donations. However, it undermined its efforts by "bilateralizing" its multilateral support to serve its own interests.

Vaccine Distribution Rhetoric

Since the beginning of the COVID-19 pandemic, France has consistently appealed to values and principles of multilateralism, solidarity, justice and cooperation. As early as March 2020, France, as part of the G7 alongside Canada, co-published a statement asserting the crisis needs "a strongly coordinated international approach" (Élysée, 2020a, para. 2). In May 2020, leaders of France and three other European countries and top representatives of the European Union (EU) shared their "determination to work together, with all those who share our commitment to international cooperation. We are ready to lead and support the global response" and committed to "[make the vaccine] available, accessible and affordable to all" (Michel et al., para. 8 and 11). In July 2020, France reiterated its commitment along with 18 representatives from European, Latin American and Caribbean countries. They declared their support for "the [ACT-A] initiative, which aims to speed up the development, production and fair and universal

access to […] vaccines against COVID-19 and strengthen health systems, especially in the most vulnerable countries and most disadvantaged sectors in our societies" (MEFA, 2020a, para. 6).

On its own, France has also advocated global solidarity and cooperation on multiple occasions, with the Minister for Europe and Foreign Affairs Jean-Yves le Drian calling for "international cooperation", "effective multilateralism" and "universal access to vaccines" (MEFA, 2020b, para. 1; MEFA, 2021b, para. 5). From the start, President Emmanuel Macron called for an international response to the multifaceted crisis and the involvement of all stakeholders, and took part in the launch of ACT-A. He announced "France's commitments to this inclusive, comprehensive and cooperative vision of health" (Élysée, 2020b). In April 2021, after vaccines were approved and vaccination progressed rapidly in rich countries, he stated that "the time has come to share" because "our health also depends on what is happening in poorest countries" (Élysée, 2021). Albeit characterized by some self-interest, these stances are nonetheless in line with principles of solidarity and justice. France partly followed them for vaccine procurement, even though the EU's vaccine nationalism somewhat tarnished the idealistic rhetoric.

Vaccine Procurement

France sources its COVID vaccines solely through multilateral channels, namely the EU. Contrary to Canada, it decided not to acquire any doses from COVAX, which can be considered in line with France's commitment to solidarity. As the EU secured almost three doses per person bilaterally even before any vaccine was approved (Overseas Development Institute [ODI], 2020), tapping into COVAX vaccine reserves would have further hindered poorer countries' access. Indeed, the EU negotiated opaque deals with pharmaceutical companies early on to ensure it would have enough vaccines for its own citizens, committing billions of dollars and indirectly excluding citizens in poorer countries from timely vaccination (European Commission, n.d.; Guéguen, 2021).

France thus showed solidarity, but only after it knew the EU had secured deals with vaccine manufacturers. In contrast, the French government demonstrated some leadership in providing vaccine assistance, looking to boost its reputation on the global stage and to affirm its position as a key actor in global health. Still, by instrumentalizing multilateral mechanisms, France appeared to resemble Harman et al.'s (2021) least desirable scenario of bilateral charity.

Vaccine Assistance

When it became clear that COVAX could not secure enough doses directly from manufacturers, France was the first country to donate doses through this mechanism – even before its domestic vaccination was complete (Gavi, 2021b). As of October 2021, it has pledged to donate 120 million doses to COVAX (France 24, 2021a). France thus became second most generous country regarding dose-sharing commitments through COVAX after the United States, albeit a distant second (WHO, 2021a). However, only 13.5 million doses had been delivered out of the 44.7 million that were officially considered donated as of October 22, 2021 (WHO, 2021a). Moreover, France provided mainly AstraZeneca vaccines shunned by the French population, as was primarily the case in Canada (France 24, 2021b; *Le Matin*, 2021).

If COVAX's initial purpose was to pool resources and then allocate them to low- and middle-income countries based on needs, the way Gavi, the media and sometimes governments framed vaccine donations and distribution casts doubts on the impartiality of the mechanism and France's intentions. Indeed, the multilateral initiative resembles a bilateral one in many instances, serving French interests and visibility in Africa in particular. For example, the media reported: "[Rwanda] received additional 247,000 doses of AstraZeneca through the COVAX mechanism, including 117,600 doses donated by the French government" (*East African*, 2021, para. 2); "France has donated 184,000 doses of AstraZeneca's (AZN.L) COVID-19 vaccine to Senegal through the COVAX vaccine-sharing facility" (Reuters,

2021, para. 1). A vaccine shipment received by Kampala reads “Covid-19 Vaccine Donation From **FRENCH government** to the Republic of Uganda” (*Independent*, 2021, emphasis in original).

In the case of Tunisia, the French government stated that “[t]his support will involve the imminent arrival of an initial French donation of 324,000 AstraZeneca vaccine doses through the COVAX initiative, following the Prime Minister’s visit to Tunisia” (MEFA, 2021c, para. 3). Elsewhere, the French government referred to this donation without even mentioning COVAX (MEFR, 2021). However, the French government denied engaging in “’vaccine diplomacy or clientelism’” in favour of Francophone Africa: “It is Gavi’s choice, that we fully support as Africa is the continent where vaccination campaigns are least advanced. But dose-sharing is also intended to serve other regions” (Liabot, 2021, para. 9 and 10). Like in the Canadian case, it would be odd for France to decide where vaccines go, given that COVAX has an allocation mechanism based on need. The wording above suggests doses are not pooled and that donor countries can designate doses for certain recipient countries, as the initial US donation to COVAX, with detailed earmarks, seem to confirm (White House, 2021). France also donated vaccines bilaterally, for example to Slovakia, following Harman & al.’s worst scenario of bilateral charity (Le Parisien, 2021a).

Moreover, France supported and even initiated multilateral endeavours dedicated to the fight against COVID-19, such as ACT-A. It did so with in-kind and financial contributions, even if some commitments have yet to be honoured. Indeed, French vaccine donations are in addition to a pledge of €200 million (US$250 million) to COVAX AMC (Gavi, n.d.) and €500 million (US$580 million) to support research and vaccine distribution through ACT-A (Reuters, 2020). However, those commitments appear to be relatively modest and sometimes arrived late compared to the significant bilateral initiative launched as early as April 2020 by France “COVID-19 – Health in Common” led by the French Development Agency. With a budget of €1.2 billion (US$1.4 billion), it aims to support mainly French-speaking African countries to respond to the COVID crisis in the short and longer term by reinforcing health systems (MEFA, 2020c).

France paved the way for vaccine sharing and pledged to provide more financial and in-kind support, to the benefit of its global reputation. However, if France were more committed to leadership and solidarity, it would have engaged in global health diplomacy to promote a more ethical approach to fighting vaccine inequity. A key measure would be fully supporting a loosening of intellectual property rights to step up vaccine production.

Intellectual Property Rights

France was initially opposed to weakening intellectual property protection to improve access to vaccines, including the proposed TRIPS waiver, aligning itself with the EU’s stance. It argued that the priority should instead be vaccine-sharing, technology transfer, strengthening health systems and stepping up production (Élysée, 2021). However, in May 2021, the day after US President Joe Biden declared his support for a partial patent waiver (for vaccines only, not therapeutics or technology), Macron said he was “very favorable to a waiver of intellectual property […] to make this vaccine a global public good” (Bertrand, 2021, para. 1). Later that month, he declared being in favour of “waiving any constraints in terms of intellectual property” (La Presse, 2021, para. 2). It was as if France suddenly remembered that it is committed to universal access to health as France views health as a global public good (Fabius, 2016). By supporting Biden’s position, France acted from the perspective of soft power to promote global solidarity rather than charity and positioned itself as a leader alongside the US.

France nonetheless tempered this *volte-face* by downplaying the potential of patent waivers, still pointing at the lack of technical and production capacities in the Global South, by exhorting producing countries like the US to lift export bans on vaccines and components, and by stating it was in favour of a “circumscribed waiver” of patents (Le Parisien, 2021b; Rovan, 2021, para. 3). Indeed, showing its support for IP waivers seemed risk-free, as the EU has systematically opposed them (European Parliament, 2021;

Hiault and Turban, 2021; Hiault, 2021), a consistent position hindering poor countries' access to medicines throughout the years and protecting patents held by European firms (Bassilekin, 2016; Gopakumar, 2016). Yet, in 2010 the European Commission recommended coherence between the EU's aid policy and its commercial interests, as well as to support the effective use of TRIPS provisions for poorer countries (European Commission, 2010).

In sum, France was rather opportunistic by positioning itself in favour of patent waivers only after the US did and after more than enough vaccine doses were secured for its own citizens. It acted from the perspective of soft power to boost its image as a leader and an ally of the Global South, but still did not promote a fully ethical approach, especially at the EU level.

Comparing National Approaches

In many ways, Canada and France reacted rather differently to the COVID pandemic. The Canadian government took a strong "Canada First" position, in spite of verbal and financial support for multilateral responses, to the detriment of its global soft power. It stood out for its reluctance to share its vaccine stockpile, even after securing many times more doses than it could use, and also stonewalled efforts to facilitate the compulsory licencing of vaccines, which was essential – albeit not sufficient – to expand global vaccine production. The evident gap between rhetoric and actual practices laid bare a lack of strategic vision, leadership and commitment to equity.

The French government acted more multilaterally and strategically than Canada from the perspective of soft power. For instance, it procured its vaccines multilaterally (albeit regionally) and decided to support a TRIPS waiver. However, France acted only after the US government did and mainly from within the EU's strong "Europe First" position, remaining secure in the knowledge that the EU would protect the interests of French pharmaceutical companies. Thus, whereas Canada has erected obstacles to the lifting of vaccine patent protections, France fared slightly better in belatedly providing some rhetorical support for waivers but little leadership for what Harman et al. (2021, p. 1) describe as the superior approach to fighting vaccine inequity, which is to challenge "unethical intellectual property (IP) regimes".

Both countries contributed financially and in kind to the second-best approach, which is to say multilateral charity, via the COVAX initiative. However, their cash contributions were undermined by their purchase, alongside other wealthy countries, of vaccines directly from manufacturers, hampering COVAX's ability to buy the doses it needed to meet its distribution and vaccination targets. As a result, COVAX had to rely to a large extent on ad hoc donations of leftover doses, notably of vaccine types that Canada and France no longer wanted to use domestically.

Finally, France and Canada did partake in the most problematic approach to vaccine allocation, namely bilateral charity – although with a relatively small proportion of their in-kind donations. The quote above about the need to express gratitude and beg Canada for more vaccines, especially some of the more valued mRNA ones, starkly illustrates the neocolonial dimension of the bilateral charitable donation modality, as opposed to one based on equity or justice.

However, both countries' multilateral donations were "bilateralized", that is to say, COVAX allowed a specific number of physical doses to be identified as having been donated from them to specific recipient countries. This practice contradicted COVAX's foundational multilateral equity-based principles. Moreover, pairing donor and recipient countries reinforces the idea of national gratitude for bilateral charity in line with geostrategic self-interest and undermines universal and rights-based principles in global vaccine distribution and public health.

The controversial practice of earmarking multilateral donations raises questions regarding COVAX. If donor countries are using this multilateral mechanism to give bilaterally or at least seem to do

so, COVAX becomes an instrument of rich countries' soft power and global health diplomacy – to the detriment of fair and equitable access to vaccines. Officially, donor countries should not be able to earmark their cash or in-kind donations to COVAX for specific recipient countries. But if they do not, why has COVAX's Independent Allocation of Vaccines Group drawn attention to "the need for countries which are sharing doses with COVAX to reduce/remove all earmarking" (WHO, 2021b)?

Notwithstanding expressions of gratitude, countries in the Global South have strongly criticized wealthy countries for their vaccine nationalism (Psaledakis, 2021).[1] The increased emphasis on donor self-interest, even in the face of a global health emergency, is not new to the pandemic context. Rather, COVID has accelerated this pre-existing trend, observable since the 2008 global financial crisis (Mawdsley et al., 2018). A *British Medical Journal* opinion piece described COVID vaccines distribution as "crumbs from the rich person's table" and the broader charity model as "a catastrophic failure" (Benton, Majumder & Yamey, 2021, para. 1). Multilateral charity thus appears to share some of the flaws of the bilateral charity model, beyond what Harman et al. (2021) had foreseen.

Conclusion and Implications for the Foreign Aid Regime

By acting in line with their short-term mainly domestic political objectives, France and especially Canada undermined their global health diplomacy, which they had been unevenly building up for decades. Ultimately, their choices are likely to prove detrimental to their medium- and long-term interests, not only in soft-power terms, but because they slowed the global fight against COVID-19, which could have a boomerang effect by favouring the emergence of new variants and prolonging their own and global recovery. Although the two countries had some differences between them and other "traditional" donors will have their own particularities, the Canadian and French experiences do not appear to differ in any significant ways from those of their peers. Future research can confirm if that is indeed the case – or analyse any important differences.

Countries in the Global South are unlikely to forget how France and especially Canada shamelessly discarded their discourse of equity, justice and solidarity when it came to vaccine procurement, distribution and manufacturing. Inasmuch as these two countries' actions reflect a trend among "traditional" aid donors, they have further delegitimated the donors' altruistic and principled aid narrative and the broader foreign aid regime, already under strain.[2] It remains to be seen the extent to which Canada's and France's global health diplomacy and soft power will be able to recover in a post-pandemic context – and to what extent countries of the Global South will be able to ensure more equitable multilateral responses to future crises. If they cannot count on international cooperation, they will have no choice but to focus on self-reliance.

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[1] Potential reference to other chapters of the book, such as the ones on Tanzania and Venezuela?

[2] Potential reference to other chapters of the book, such as Chapter 5: The Rules-Based World Order and the Notion of Legitimacy Crisis?

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