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Global Health Diplomacy, ‘Smart Power’, and the New World Order

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Both the theory and practice of foreign policy and diplomacy, including systems of hard and soft power, are undergoing paradigm shifts, with an increasing number of innovative actors and strategies contributing to international relations outcomes in the ‘New World Order’. Concurrently, global health programmes continue to ascend the political spectrum in scale, scope and influence. This concatenation of circumstances has demanded a re-examination of the existing and potential effectiveness of global health programmes in the ‘smart power’ context, based on adherence to a range of design, implementation and assessment criteria, which may simultaneously optimise their humanitarian, foreign policy and diplomatic effectiveness. A synthesis of contemporary characteristics of ‘global health diplomacy’ and ‘global health as foreign policy’, grouped by common themes and generated in the context of related field experiences, are presented in the form of ‘Top Ten’ criteria lists for optimising both diplomatic and foreign policy effectiveness of global health programmes, and criteria are presented in concert with an examination of implications for programme design and delivery. Key criteria for global health programmes that are sensitised to both diplomatic and foreign policy goals include visibility, sustainability, geostrategic considerations, accountability, effectiveness and alignment with broader policy objectives. Though diplomacy is a component of foreign policy, criteria for ‘diplomatically-sensitised’ versus ‘foreign policy-sensitised’ global health programmes were not always consistent, and were occasionally in conflict, with each other. The desirability of making diplomatic and foreign policy criteria explicit, rather than implicit, in the context of global health programme design, delivery and evaluation are reflected in the identified implications for (1) international security, (2) programme evaluation, (3) funding and resource allocation decisions, (4) approval systems and (5) training. On this basis, global health programmes are shown to provide a valuable, yet underutilised, tool for diplomacy and foreign policy purposes, including their role in the pursuit of benign international influence. A corresponding alignment of resources between ‘hard’ and ‘smart’ power options is encouraged.

Keywords: smart power; global health diplomacy; foreign policy; international relations

Background

A renaissance in diplomacy and foreign policy

Foreign policy is designed to create and maintain cordial relations between countries while simultaneously pursuing objectives such as security, international development, cooperation and conflict resolution, and domestic economic growth (Smith, 2008), under the auspices of the ‘enlightened self-interest’ of nation states (de Tocqueville, 1865;
White, 2001). Associated principles include advancement of human rights, promotion of democracy, good governance, prevention of violent conflicts, collective security, dispute arbitration, abolition of aggressive war, free trade and interstate cooperation (Nolan, 1998). As both a subset and a tool of the foreign policy métier, principles of diplomacy include negotiation (and, specifically, skill in handling international negotiations without hostility), conflict resolution, dialogue, and communications (United States Department of State, 2010). Among other countries and interstate organisations, the European Union, the United Kingdom and the United States all include the encouragement of regional cooperation, the advancement of human rights, the promotion of democracy and good governance, and the prevention of violent conflicts as joint diplomatic and foreign policy priorities (Frist, 2007; Smith, 2008; United Kingdom Foreign & Commonwealth Office, 2013; United States Department of State, 2010).

In the twenty-first century ‘New World Order’ (see, e.g. Etzioni, 2013), traditional foreign policy and diplomacy practices are undergoing a dramatic transition (Horton, 2007). Contemporary international initiatives are no longer exclusively under the auspices of narrow professional divisions, but include a range of less formal, ‘non-state’ actors (Kickbusch, 2012). Katz, Kornblut, Arnold, Lief, and Fischer (2011) define these ‘multi-stakeholder’ diplomatic and foreign policy approaches as encompassing a ‘larger sphere of interactions’ among participants who have not, traditionally, been involved in international politics. Separately, but simultaneously, foreign assistance investment has reached unprecedented levels of growth, while also increasing dramatically in scale, scope and political prestige in recent years (Center for Strategic and International Studies [CSIS], 2011). Within international development, dramatic recent increases in funding for global health programmes (Fidler, 2011; Ravishnakar et al., 2007) – represented by a quadrupling in expenditure between 1990 and 2007 (Institute for Health Metrics, 2010) – has driven a strengthening of previously tenuous links between global health, diplomacy and foreign policy (Garrett, 2012). In this context, the role, content, structure and importance of global health programmes are being reappraised and reframed as alternative tools of both foreign policy and diplomacy (Burkle, 2013; CSIS, 2010; Feldbaum, 2010; Fidler, 2007; Nye, 2004), in turn driving a dramatically increased demand for optimisation of these ‘collateral’ outputs (The Lancet, 2010).

The unique role of global health

There is a growing appreciation of the preeminent effectiveness of global health programmes in achieving both diplomatic and foreign policy goals as compared to other forms of international development (Vanderwagen, 2006), including leveraging health initiatives to improve the security, influence and image of donor countries or organisations (Feldbaum, 2010; Feldbaum & Michaud, 2010), or, more simply, ‘using health-related cooperation to pursue non-health objectives’ in the foreign policy context (Fidler, 2011). The contemporary political status of global health (Fidler, 2007), as well as its future trajectory within the current ideology that underpins the global economy (Benatar, Gill, & Bakker, 2011), is therefore unprecedented. Although there are occasions when health programmes maintain independent and nonaligned targets, in most cases, the medical, the economic and the political are increasingly inseparable (Farmer, Kleinman, Kim, & Basilico, 2013; Kleinman, 2010), forming a compelling basis for bridging international barriers ‘because health transcends traditional, and more emotional, concerns’ (Bourne, 1978). This alignment presents valuable opportunities for stronger international alliances through global health, as defined by the constellation of interests in what has become known as ‘global health diplomacy’ (Fidler, 2007; Kickbusch, Novotny, Drager,
Silberschmidt, & Alcazar, 2007; Stewart, Keusch, & Kleinman, 2010). Global health programmes, therefore, ‘have political ramifications that cannot be ignored’ (CSIS, 2011). Concurrently, the global health community has successfully begun to leverage these links to influence associated political and economic resource allocation decisions (Lee, 2007). However, such integration of roles and objectives, at both the bilateral and multilateral donor levels, requires astute, informed and practical judgement to be successful in optimising both direct and indirect programmatic goals (Kickbusch, Lister, Told, & Drager, 2012).

‘Policy coherence’ versus ‘stove-piping’

In recognition of the complex mixture of motivations that guide contemporary international development policies (Lumsdaine, 1993), as well as the ‘myriad newer uses’ of foreign assistance programmes (Lancaster, 2007), the European Union explicitly advocates the strategic use of global health to achieve diplomatic goals (Europa, 2010; European Commission, 2010; Rehn, 2005), which has, in turn, become a defining feature of pan-European foreign policy in recent years (Kagan, 2002). In the United States, increasing levels of integration between the State Department and US Agency for International Development (USAID) are indicative of their increasingly interchangeable roles (Shah, 2011; United States Department of State, 2008), reflected, in this context, by the groundbreaking creation of the Office of Health Diplomacy within the State Department (Morrison, 2013) as well as an enhanced role for US ambassadors in health diplomacy (Michaud & Kates, 2013). In the United Kingdom, the Department for International Development (DFID) has been assigned an explicit foreign policy role (Lords Select Committee, 2011; Rushton & McInnes, 2006) under the stated goal of ‘policy coherence’ between global health and foreign affairs (Kickbusch et al., 2007), and in a manner evocative of the traditional foreign policy practices of smaller countries (see, e.g. Irish Department of Foreign Affairs, 2014). Similarly, nations such as Russia and China have made foreign policy goals an explicit objective of their international health and development programmes (see, e.g. The Guardian, 2013a, 2013b), while from a ‘South-South’ perspective, the global health diplomacy efforts of countries such as Cuba and Brazil have both won international acclaim as well as generating significant political capital for donors (Keck, 2007; Lee & Gomez, 2012). At the supra-national level, the United Nations has shown an increased propensity to combine conflict resolution and humanitarian activities (Associated Press, 2011; Burkle, 2013), while the World Bank has recommended that global health programmes should respond, wherever possible, to policy issues beyond their primary goals (The World Bank, 2011). Such ‘mainstreaming’ of responsibilities and shared values blurs the line between previously ‘siloed’, disciplinary, and ‘stovepiped’ ministerial or departmental responsibilities (Sundberg & Sandberg, 2013) in recognition of ‘spill-over effects’ (Kickbusch & Buss, 2011) that have, since the dawn of international initiatives, made it inevitable that no aspect of foreign policy operates in isolation (Hagel, 2004). In the academic context, such realpolitik is represented by a ‘post-functionalist’ or ‘statist’ (Brown, 1992) diplomacy and foreign policy framework, under which the success of global health programmes is judged by both their direct and indirect outcomes.

A revolution in defence and security

The deployment of ‘hard power’ or the use of military coercion to influence the behaviour and interests of political bodies to achieve diplomatic goals such as
international conflict prevention and resolution, is in a period of rapid evolution (Nye, 2004). Traditional forms of international military interventions are declining both in public support (Keeter, 2007; Shackle, 2011) and in judicial legitimacy (Gallup News Service, 2002), in light of revelations that conflicts such as the Iraq War resulted up to half a million civilian deaths (Burkle & Garfield, 2013), while their cost-effectiveness – including spiralling medical costs for returning veterans (Baker, 2014) – is also under increasing levels of scrutiny (Scully, 2011). The ongoing reluctance of the international community to intervene in conflicts such as Syria is at least in part due to the echo of these interventions (British Broadcasting Corporation, 2013) and has resulted in the ‘taxonomy of conflict’ (Burkle, 2013) undergoing dramatic transitions, including calls for the greater integration of global health programmes into security operations (Burkle, 2013). This has also been illustrated, not just by the effects of global health programmes during political uprisings in Bahrain, Turkey, and Egypt in recent years (Rubenstein, 2013), but through initiatives such as the World Health Organization (WHO)–mandated ‘Health as a Bridge for Peace’ programme, which leverage global health initiatives in support of political, structural, and social peace-building (Rodriguez-Garcia, 2001). Contemporary foreign policy trends therefore suggest that the ‘Cold Wars’ of the past will be increasingly supplanted in the twenty-first century by ‘Soft Wars’, ‘Smart Wars’ (Simons, 2012), or even ‘Cool Wars’ (Feldman, 2013), creating and pursuing combined aid-related and military-based international alliances. This vision has drawn heightened attention to innovative roles for global health programmes in achieving security, defence and conflict prevention or resolution goals (Birdsall, 2013; Feldbaum, 2010; Michaud & Kates, 2013), with particular reference to the selection, design and delivery of appropriate interventions for (1) military stability operations and (2) ‘partnership engagement’ (Michaud, Moss, & Kates, 2012). Recognition of associated ‘peace and stability’ dividends (Brainard, 2006; Novotny & Kevany, 2013) through appropriate adaptations to programme design, selection and delivery considerations have, in turn, inculcated an awareness that the transcendent goals of both foreign assistance and foreign policy include the pursuit of international cooperation, conflict resolution and peace-keeping (Kickbusch & Buss, 2011).

‘Smart global health’: aligning the principles of global health, foreign policy and diplomacy

Foreign policy and diplomatic perspectives are both multilevel and multicausal (Rosenau, 1966), involving synthesis of information from a wide variety of knowledge bases. The failure to consider such a range of criteria when designing, selecting and implementing global health programmes therefore runs the risk of creating a ‘tense and confusing duality’ (CSIS, 2010), whereby the implications of delivering global health programmes without diplomatic or foreign policy considerations are just as dangerous to human dignity as the reverse (Fidler, 2007). For example, global health programmes that challenge cultural, religious, ideological, social and behavioural norms in recipient countries and communities, while compelling in terms of their capacity to achieve primary ‘target’ outcomes, may also constitute potential liabilities from the diplomatic or foreign policy perspectives ‘as public health experts act without awareness of larger diplomatic strategies or tensions that may be at play’ (Katz et al., 2011). On this basis, diplomatic, international development and foreign policy trends are increasingly aligned with the theory of ‘smart power’ (Ferrero-Waldener, 2007): the strategic use of persuasion, capacity building and the projection of influence, in ways that are both cost-effective and have political and social legitimacy, based on an integrated strategy and
resource base across national actors (CSIS, 2010). ‘Smart global health’, in turn, leverages global health programmes for epidemiological, economic, political and international relations and a range of other international concerns (CSIS, 2010). Although traditionally associated with bilateral agendas, ‘smart global health’ approaches also apply to the initiatives of multilateral organisations such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, which often have highly significant diplomatic and foreign policy effects (see, e.g. Kevany et al., 2014; Kevany, Sahak, Workneh, & Saeedzai, 2014; Michaud & Kates, 2013) but which, in the absence of appropriate systems of recognition, have achieved only limited attention (Kickbusch et al., 2012).

**Diplomatic triumphs – and failures – of global health**

The indirect, collateral or ‘downstream’ effects of global health programmes have, to date, led to a number of unanticipated, and often inadvertent, diplomatic and foreign policy triumphs for donors. Similarly, a lack of awareness of the diplomatic and foreign policy ramifications of global health programmes has, on occasion, led to a corresponding decline in donor prestige and international relations. The former include the documented diplomatic and foreign policy gains consequent upon the President’s Emergency Plan for AIDS Relief (PEPfAR) (Walensky & Kuritzkes, 2010); polio eradication campaigns (Kaufmann & Feldbaum, 2009); health-related ceasefires in conflict regions (Kickbusch & Buss, 2011); and partnerships between the United Nations Development Program and The Global Fund to Fight AIDS, Tuberculosis and Malaria in conflict and post-conflict settings (Kevany, Benatar, & Fleischer, 2013; Kevany et al., 2012; Kevany, Jaf, et al., 2014; Kevany, Sahak, et al., 2014). Conversely, the latter includes poorly designed penetration of vaccination campaigns in Pakistan by clandestine agencies, jeopardising both primary programmatic goals and the lives of global health programme workers (Buekens, 2013); fiscal threats to the sustainability of PEPfAR’s HIV treatment programmes (Lyman & Wittels, 2010); negative environmental consequences of health interventions (WHO, 2013) and notwithstanding the widespread, long-standing suspicion in recipient communities of hidden agendas embedded within controversial global health interventions such as male circumcision (Quigley, Weiss, & Hayes, 2001) and family planning (Uche, 2011). Strategic global health interventions, therefore, must be both ‘productive and useful from a health perspective’, yet ‘vigilant about the unanticipated consequences they produce’ (Katz et al., 2011).

**Optimising collateral diplomatic and foreign policy effects**

Although it is critically important for global health programmes to pursue primary outcomes such as gains in quality-adjusted life years, their selection, design, content and delivery should, *ceteris paribus*, be carefully assessed in order to ensure that (1) these outcomes are not being achieved at the expense of foreign policy, diplomatic or international relations objectives (Royal Institute for International Affairs, 2010) and (2) where interventions have the capacity to achieve benign collateral or ‘spill-over’ (Kickbusch & Buss, 2011) objectives, these are recognised, recorded and rewarded (Royal Institute for International Affairs, 2010). The rise of a utilitarian approach to international development and foreign assistance evaluation, however, as represented by the ascendancy of decision-making tools such as cost-effectiveness analysis, has resulted in the predominant use of narrow, single-metric assessment measures as exclusive barometers of global health programme worth or value – the ‘ruthless winnowing of complex problems into defined tasks with measurable
targets’ (Fidler, 2011). Under what has been described as the ‘precautionary principle’ in global health, contemporary practices dictate that the moral worth of an action is determined only by its quantified outcome, without regard to unintended consequences (Martuzzi & Tickner, 2004). Such approaches are, necessarily, restricted in their capacity to reflect values or outcomes beyond those of predetermined interest to the medical profession (Jan, 1998): in a variation on the McNamara Fallacy (Basler, 2009), global health programmes may produce a range of unquantified, and often unquantifiable, diplomatic and foreign policy outcomes, impacts or outputs, which are, therefore, considered to be nonexistent. There is, however, a ‘lack of ability’ to demonstrate effectiveness in this context, particularly in the absence of related programme assessment criteria (Bonventre, 2008), which would help to ensure that global health programmes attain even the minimum acceptable standards required in the diplomatic or foreign policy spheres. Policymakers have, therefore, called for a system of assessment that reflects these broader considerations (Royal Institute for International Affairs, 2010) both (1) in order to portray international development and foreign assistance expenditures as ‘return-producing investments’ (Jaffe, 2013) rather than costs; (2) to ‘speak a language that people with power really understand’ (Nye, 2004); while also (3) taking into account the realpolitik of a broader range of international affairs (Novotny & Kevany, 2013). Without the articulation of these benefits, global health programmes run the risk of being viewed as ‘misplaced priorities’ (Transcript of House Foreign Affairs Committee, 2011). In turn, the establishment of (1) a ‘taxonomy’ for the integration of diplomatic and foreign policy values into global health (Katz et al., 2011), (2) ‘diplomatically-sensitised’ quantitative and qualitative outcome measures (Royal Institute for International Affairs, 2010) and (3) systems of measurement for global health programme impact on non-health outcomes and values (CSIS, 2011) have been called for. Current research questions around the coherence, effectiveness and legitimacy of global health diplomacy (Kickbusch & Buss, 2011) therefore include (1) how current and potential, explicit and implicit, national and international benefits of foreign assistance may more meaningfully serve foreign policy objectives when ‘diplomatically-sensitised’; (2) how policymakers can determine if global health programmes are diplomatically effective (or harmful), contributing to or hindering foreign policy goals and (3) how to recognise, quantify and reward the value of these contributions (Novotny & Kevany, 2013).

Criteria development

**Philosophical basis**

A wide range of definitions for ‘global health diplomacy’ and ‘global health as foreign policy’ have been proposed in recent years (see, e.g. Feldbaum, 2010; Kickbusch et al., 2007; McInnes & Lee, 2006; Novotny & Adams, 2007), helping to identify key criteria for ‘diplomatic’ or ‘foreign policy–sensitised’ global health programmes. In many cases, these definitions relate to a range of philosophical perspectives and conceptual frameworks, including Rawlsian, Machiavellian and Kantian approaches (see, e.g. Rawls, 1971) to international development, all of which (1) reflect a ‘neo-utilitarian’ philosophy and (2) consider contributions to such abstract concepts as world peace (Kickbusch & Buss, 2011). On this basis, a synthesis of contemporary global health programme design, delivery and evaluation criteria, grouped by common themes and keywords, and which pay specific attention to optimising the strategic use of global health interventions, are presented in Tables 1 and 2. Alternate definitions based on competing interpretations of ‘global health diplomacy’, including (1) the use of foreign policy to pursue global health objectives (e.g. Gahr Stor, 2007; McInnes & Lee, 2006) and (2) ‘negotiation-based
health diplomacy’ through multilateral organisations such as the WHO (see, e.g. Kickbusch et al., 2007) though beyond the scope of this paper, are also borne in mind – not least in the context of the significant potential contributions of ‘health-sensitised foreign policy’ to global health outcomes (see, e.g. Kickbusch et al., 2012).

Field experience

The identification of both diplomatic and foreign policy criteria also draws on the retrospective overview and synthesisation of the author’s experience of global health programme implementation and evaluation in Iraq, Afghanistan, Sudan, South Sudan, Ethiopia, Zimbabwe, South Africa, Egypt and Kenya; settings in which the integration of global health programmes with diplomatic and foreign policy considerations is often both indispensable and unavoidable. This experience includes examination of the international relations effects of Global Fund–supported malaria programmes in Afghanistan and Iraq (Kevany, Jaf, et al., 2014; Kevany, Sahak, et al., 2014); the development of ‘diplomatically-sensitised’ monitoring and evaluation systems in South Sudan (Kevany, Hatfield, et al., 2012), the implementation of transferable and sustainable innovative antiretroviral adherence programmes in Ethiopia (Marseille & Kevany, 2010); the responsiveness and adaptability of voluntary counselling and testing services to prevailing political, social and economic conditions in Zimbabwe (Kevany, Khumalo-Sakutukwa, 2012; Kevany et al., 2013) and the alignment of global health programmes with diplomatic priorities (Fleischer, Kevany, & Benatar, 2010) in South Africa (Kevany et al., 2013).

Refining the distinctions between diplomacy and foreign policy in the global health context

As noted above, diplomacy is a ‘subset’ of the broader foreign policy toolkit (Royal Institute for International Affairs, 2010), and associated evaluation criteria tend to be inherently explicit, responding to the needs of both donors and recipients. By contrast, ‘foreign policy values’ of global health programmes tend to be characterised on a more implicit basis, responding to a broader agenda related to the ‘enlightened self-interest’ of donors and international organisations (Kassalow, 2001). This agenda includes strategic, political, and security considerations beyond the realm of diplomacy (Alden & Amnon, 2011) and is often in pursuit of ostensibly distinct objectives such as conflict resolution, conflict prevention, or trade and economic considerations. While ‘diplomatically-sensitised’ global health programmes address the dual goals of improving both global health and international relations (Novotny & Adams, 2007), global health programmes that respond to foreign policy needs both support foreign policy objectives (CSIS, 2010) and make global health decisions on the basis of ‘high politics’ (Labonte & Gagnon, 2010; see also distinctions proposed to this effect in Kickbusch & Buss, 2011). At the most fundamental level, diplomatic criteria may therefore be viewed as enhancing the value or worth of global health programmes to recipients both donors and, while foreign policy (or ‘smart power’) criteria relate more specifically to the corresponding goals and needs of donors. Both diplomatic and foreign policy perspectives, despite these distinctions, respond to the overarching needs of the international community. Identified ‘strategic global health’ criteria have therefore been divided into ‘diplomatic’ and ‘foreign policy’ categories. Nonetheless, this distinction does not preclude conflicts between diplomatic and foreign policy criteria.
Criteria for ‘diplomatically-sensitised’ and ‘foreign policy-sensitised’ global health programmes

Global health programmes that have been sensitised to achieve diplomatic goals, supplementary to primary programmatic objectives, adhere to a common set of design, implementation and outcome criteria for optimising diplomatic effectiveness (see Table 1). Key characteristics include unbiased delivery of services, across population groups; the development of linkages and partnerships between host and donor countries; training, involvement and employment of local communities, including entrepreneurship and employment generation; ideological and cultural neutrality, sensitivity and adaptability; the choice, where possible, of the most effective and cost-effective interventions; sustainability, and appropriate programme visibility and branding. Global health programmes designed to pursue foreign policy goals were found not only to overlap, but also to conflict, with the above diplomatic criteria, due at least in part to their separate and distinct philosophical basis (Table 2). Related criteria include geostrategic and geopolitical location, including the provision of an international stabilising presence; a focus on ‘high-profile’ conditions such as HIV/AIDS, tuberculosis and malaria; alignment with donor foreign policy goals, strategies and organisations; consideration of ‘nation-building’ and peace-keeping roles of global health programmes in recipient countries, including contributions to national and international security agendas; collaboration with military interventions under appropriate ‘security umbrellas’; responsiveness to economic incentives of donor countries and funders; inclusiveness in service delivery, and contributions to international networks and regime change in unstable states. In summary, for both foreign policy–sensitised and diplomatically-sensitised global health programmes, all identified criteria, themes and keywords reflect consideration of five key issues of interest to the pursuit of cohesive and enhanced international engagements: who (e.g. programme staff background and training); what (e.g. selection of appropriate interventions); when (e.g. consideration of prevailing political issues); where (e.g. geopolitical and recipient population considerations) and how (e.g. programme adaptability and sensitivity).

Implications

The military, global health, and international security

The lack of alignment between the military, foreign policy, and global health programmes has led to recent decades being the most dangerous ever for global health workers (Rubenstein, 2013) and for which risks more formal recognitions of valour have been suggested (Burkle, 2013), lending special significance to the diplomatic and foreign policy implications of global health programmes in conflict and post-conflict settings. Concurrently, with the formal adoption and adaptation of global health programmes as a tool of diplomacy and foreign policy (Obama, 2014), the use of hard power as a system of international conflict resolution has been increasingly complemented by less intrusive, invasive and destructive systems of intervention, variously described as ‘armed social work’ (Feldbaum, 2010) or ‘civilian power’ (United States Department of State, 2010). By demonstrating the effectiveness of global health programmes in achieving military goals, the transfer of responsibilities and associated resources from ‘hard’ to ‘smart’ power options, based on the recognition and measurement of the latter’s diplomatic and foreign policy impact, is increasingly a la mode (Bonventre, 2008; Burkle, 2013). This paradigm involves new and innovative roles for the military in concert with global health programmes, including (1) providing ‘umbrella support’ and logistics for ‘health-led
Table 1. Diplomatic criteria for global health programmes.

1 **Neutrality**: The selection of culturally, religiously and socially appropriate interventions (Kevany, 2012; Kevany, Hatfield, et al., 2012; Kevany, Khumalo-Sakutukwa, et al., 2012), encompassing vigilance around possible unanticipated consequences of global health programmes on recipient societies, cultures and religions (Adams, Novotny, & Leslie, 2008).

2 **Visibility**: Appropriate programmatic branding to generate positive associations between international presence, health outcomes, and donor prestige (Alesina & Dollar, 1998), thereby ensuring that (1) international contributions are clearly visible (CSIS, 2010; The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011) and (2) programmatic achievements are conveyed to both local and national leaders (CSIS, 2010).

3 **Sustainability**: Provision for programme sustainability (Jaffe, 2013) or (as a minimum acceptable standard) transferability (Lyman & Wittels, 2010) in order (1) to mitigate risks of international relations tensions consequent on programme termination and (2) to ensure a ‘forward-looking commitment’ in programme design, selection and implementation (CSIS, 2011).

4 **Adaptability**: Delivery of global health programmes that are responsive to locally identified health and non-health priorities, in a manner adaptable to circumstantial demands beyond the intervention protocol (Kevany, 2012), including, where appropriate, recipient-led programme design and resource allocation decisions (Global Health Initiative, 2012).

5 **Effectiveness**: The selection, wherever possible, of global health interventions with proven primary health outcome effectiveness and cost-effectiveness in order to ensure recipient countries, communities and individuals are provided with optimal health benefits under constrained budgets (Kevany et al., 2013; Marseille & Khan, 2002; Ord, 2013).

6 **Accountability**: Contributions to monitoring and evaluation systems, through the production of verified programmatic results, to (1) reduce corruption and increase transparency (Kevany, Hatfield, et al., 2012; Mulley, 2010), (2) generate a stronger rationale for support to donor stakeholders (The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011) and (3) support new notions of programmatic responsibility (Adams et al., 2008; CSIS, 2010).

7 **Partnerships**: Contributions of global health programmes to the development of sub-national, national, and international partnerships, with reference to appropriate standards by which donor and multilateral representatives interact with governments in recipient countries (Adams et al., 2008; CSIS, 2010), coordinate initiatives (CSIS, 2011), and build international alliances beyond health (Kickbusch & Buss, 2011).

8 **Economic, political, environmental, and social effects**: (1) Optimising contributions of global health programmes to economic growth at the micro- (Kevany, Hatfield, et al., 2012) and macro-economic levels through the creation of improved economic climates (AMFAR, 2013), (2) generating social and political benefits that promote stable nations (Novotny & Adams, 2007), social justice and equity (ibid), social stabilisation (Jaffe, 2013) and (4) the promotion of productivity, dignity and self-worth among recipients (USAID, 2013), and (4) minimising negative environmental impacts of medical supplies (WHO, 2013).

9 **Interdependence**: Articulating, where possible, the parameters of global health programme involvement with non–health-related organisations, in order to (1) protect the well-being of programme staff through adherence to well-defined mission statements (Kolaczinski, Graham, Fahim, Brook, & Rowland, 2005) and (2) preserve recipient community trust (Michaud & Kates, 2013).

10 **Training**: Appropriate selection, training and recognition of global health programme staff from the diplomatic perspective, including education on (1) prevailing political and strategic themes and (2) systems by which intervention activities may stand to contribute to, or exacerbate, broader diplomatic strategies (Katz et al., 2011).
Table 2. Foreign policy criteria for global health programmes.

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<td>1</td>
<td><strong>Geo-political location:</strong> Reference to strategic locational considerations (CSIS, 2010), including</td>
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<td></td>
<td>capacity to access geographic areas hostile to international actors (Feldbaum, 2010); positively</td>
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<td></td>
<td>influencing areas prone to insurgent manipulation (Bonventre, 2008); enticing populations</td>
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<td>away from terrorist groups (Rubenstein, 2013); working in regions which may contribute to</td>
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<td>regime change (Birdsall, 2013, AMFAR, 2013); and decreasing opportunities for opponents</td>
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<td>with destructive agendas (Jaffe, 2013)</td>
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<td>2</td>
<td><strong>Nation-building and peace-keeping initiatives:</strong> Contributions to nation-building (Kevany et al.,</td>
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<td>2012a) and peace-keeping processes (Eldon, Waddington, &amp; Hadi, 2008; Kevany, 2012), including</td>
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<td>resolution of conflict (Novotny &amp; Adams, 2007); regional stability (Feldbaum, 2010);</td>
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<td></td>
<td>integration of peace-building concerns into global health programmes (Novotny &amp; Adams, 2007; Macrae, 1997;</td>
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<td>Kickbusch &amp; Buss, 2011); and advancing democratisation in the developing world (AMFAR, 2013)</td>
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<td>3</td>
<td><strong>Strategic alignment:</strong> Harmonisation between bilateral and multilateral global health and</td>
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<td>foreign policies (CSIS, 2007; Feldbaum, 2010) and inculcation of strategic awareness of</td>
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<td>relationships between global health and foreign policy goals (CSIS, 2010), including</td>
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<td>recognition of the capacity of global health programmes to advance or obstruct international</td>
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<td>relations objectives (Katz et al., 2011)</td>
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<td>4</td>
<td><strong>‘High-profile’ conditions:</strong> Responding to health needs that may have significant implications</td>
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<td>for donor security, health or economic well-being (CSIS, 2010; Feldbaum, 2010), including</td>
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<td>transnational epidemic diseases such as HIV/AIDS, tuberculosis and malaria (Michaud &amp; Kates, 2013)</td>
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<td>5</td>
<td><strong>Human rights:</strong> Alignment between global health service delivery and the defence and</td>
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<td>advancement of human rights, including the abolition of slavery, freedom from tyranny, and access to</td>
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<td>health services, thereby contributing to the advancement of human dignity, both</td>
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<td>within and beyond health (WHO, 2012)</td>
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<td>6</td>
<td><strong>Accessing strategic markets and resources:</strong> Optimising the extent to which global health</td>
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<td>programmes assist, in a manner that is fair and transparent to recipients, in gaining access to</td>
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<td>strategic resources or markets (Feldbaum, 2010), including commodity resources from low-</td>
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<td></td>
<td>and middle-income countries (AMFAR, 2013; Novotny &amp; Kevany, 2013), which, in turn,</td>
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<td>generate economic gains for both donors and recipients (Jaffe, 2013)</td>
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<td>7</td>
<td><strong>Inclusiveness:</strong> Leveraging global health programmes to unite opposing political factions,</td>
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<td>promoting reconciliation and peace (Rubenstein, 2013), including negotiation, mediation and</td>
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<td>‘public health persuasion’ initiatives, through integration of former adversaries within the same</td>
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<td>health service (Kickbusch, 2012) regardless of affiliation (Rubenstein, 2013)</td>
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<td>8</td>
<td><strong>Prestige:</strong> Leveraging global health programmes to revise negative donor stereotypes (Katz et al.,</td>
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<td>2011), including (1) altering perceptions of donor countries and organisations in recipient</td>
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<td>communities (Bonventre, 2008), (2) winning the ‘hearts and minds’ of actual or potential</td>
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<td>extremist populations (Feldbaum, 2010; Novotny &amp; Adams, 2007) and (3) elevating</td>
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<td>‘donor image’ (AMFAR, 2013)</td>
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<td>9</td>
<td><strong>Smart power:</strong> Delivery of global health programmes in terms of ‘armed social work’ (Feldbaum, 2010),</td>
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<td>‘civilian power’ (United States Department of State, 2010) and ‘militarised aid’ (Burkle, 2013), aligned</td>
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<td>with the support and protection of armed forces (Rubenstein, 2013) in conflict and post-conflict</td>
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<td>settings (Burkle, 2013)</td>
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<td>10</td>
<td><strong>Communications:</strong> Development of communications links to isolated populations through</td>
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<td>which bilateral and multinational initiatives may build networks and relationships, gather</td>
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<td>strategic information and intelligence related to health and non-health issues, in pursuit of</td>
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<td>overarching political objectives and build a platform for environmental, security and</td>
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<td>development initiatives (Kevany, 2012)</td>
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interventions’ in conflict and post-conflict settings (Burkle, 2013), by which military protection for global health initiatives is provided with strategic goals in mind (Rubenstein, 2013) (2) ensuring that global health practitioners communicate and collaborate effectively and strategically with diplomatic and military personnel, and (3) refining the roles of soldiers to provide an increased proportion of health and humanitarian assistance in an era increasingly dominated by the use of unmanned drones to achieve combat objectives (Kreps & Zenko, 2014; Michaud & Kates, 2013). In this way, global health interventions, combined with military support, and delivered to inaccessible, persecuted or oppressed populations, may allow world powers to intervene more readily in settings such as Syria, with a greater likelihood of United Nations approval, less bloodshed, heightened effectiveness and cost-effectiveness and without the confrontational and reputational risks to Western powers consequent to recent conflicts in Iraq and Afghanistan. Recent examples of Africa Union forces operating in collaboration with global health initiatives in Somalia have shown how compelling such collaborations can be in combating political and religious extremism, illegitimate regimes, and tyranny (see, e.g. Straziuso, 2013), in the manner of successfully coordinated efforts between the United Nations’ armed missions and the United Nations Development Program in South Sudan (Kevany, Hatfield, et al., 2012).

**Global health funding**

The characterisation of global health as a diplomatic or foreign policy tool will ultimately bring with it greater visibility and, therefore, investment support (Katz & Singer, 2007). Even in the context of recent advances, global health funding currently represents a mere 0.0005% of worldwide health expenditure (Garrett, 2012). The more evidence that can be generated regarding the manifold outputs of global health programmes, the stronger the case for associated funding; success in engaging governments and other funders is more likely when altruistic efforts can also be shown to benefit the national interest (Council on Foreign Relations, 2013; United States Global Leadership Coalition, 2012) ‘as a recipe for increased attention and resources’ (Michaud & Kates, 2013). In parallel, this process may further entrench global health efforts in the political milieu, making them ‘less vulnerable to prevailing winds’ (Garrett, 2012) whereby the alleviation of suffering and ill-health in the developing world is seen as discretionary in times of fiscal crisis (Novotny & Kevany, 2013). Under these circumstances, and in the context of increasingly fierce battles for funding by organisations such as The Global Fund to Fight AIDS, Tuberculosis and Malaria (Ki-Moon, 2013), it is at best naive, and at worst irresponsible, not to leverage international relations outputs as a key incentive to augmented donor funding.

**Global health resource allocation decisions**

Expertise in the appropriate allocation of resources across global health programmes, from both the diplomatic and foreign policy perspectives, will be required if such programmes are to attain optimal effectiveness in these realms (Fidler, 2007). This has already been illustrated by proposals for the more formal inclusion of expert ‘global health diplomacy’ considerations in health and HIV/AIDS resource allocation decisions in South Africa (Kevany et al., 2013), and includes the development of specialist capacity for (1) the reprogramming of existing resource allocation decisions from the diplomatic and foreign policy perspectives as well as (2) consideration of the strategic application of appropriately-adapted global health programmes to respond to immediate political, social, or security-related situations and emergencies (Birdsall, 2013; Novotny & Kevany, 2013).
In turn, the development of such expertise also suggests value in the creation of diplomatic or foreign policy liaison units in organisations such as The Global Fund to Fight AIDS, Tuberculosis and Malaria and the European Union, designed to link the needs and objectives of international development and foreign affairs more explicitly, and as pioneered by both the US Office of Global Health Diplomacy, the US Department of Defense Humanitarian Assistance, Disaster Relief and Global Health Directorate, and the ‘transformational vision’ of global health under the DFID in the United Kingdom (Horton, 2007).

Global health programme evaluation
Concerns of global health programme implementers around the lack of capacity of existing systems of evaluation to reflect contributions such as the creation of secure, just, and productive communities in the context of broader ‘mission metrics’ (Mercy Corps, 2011) have led to calls to include ‘a more general appeal to concepts such as moral justice and compassion’ (Lee, 2007). Both statesmen and ‘health diplomats’ therefore require a holistic system of evaluation that reflects these broader, collateral considerations. Though extensive challenges persist in attempting to place values on the downstream effects of global health programmes, ‘merely attempting to quantify what has previously been thought unquantifiable will pay dividends’ (Bonventre, 2008) in the context of a ‘21st Century political investment’ (Novotny & Kevany, 2013). Further development and recognition of diplomatic and foreign policy assessment criteria will therefore require significant changes to existing monitoring and evaluation systems towards broader, more holistic methods (Kevany et al., 2012a; United States Department of State 2011) as well as associated investment in the expansion of responsibilities in the duties of related personnel to include diplomatic and strategic assessments. This may be achieved, at least in part, by the adaptation of existing tools such as the Global Fund’s on-site data verification and routine service quality assessment tools (see, e.g. The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2013; Novotny & Kevany, 2013) – though reliance on generic templates may, paradoxically, produce just the lack of inclusiveness that the development of more responsive and holistic evaluation systems is designed to avoid.

Global health training
Global health practitioner responsibilities may be divided into their de jure life-saving roles and their de facto international relations responsibilities (Katz et al., 2011). In a ‘New World Order’ in which the basis (even the very definition) of professional achievement is increasingly questioned by society (Krugman, 2013), such endeavours represent a compelling beau ideal of twenty-first century achievement. In this context, professional training for global health may need to more explicitly value individual and organisational representative capacity, beyond mere technical or epidemiological competence: To date, neither bilateral donors nor associated multilateral organisations such as the Global Fund have systematically given global health professionals a framework for understanding the political milieu in which they act (Katz et al., 2011). Such increasingly interdependent operating environments require understanding of both global health and international relations: ‘a capable health diplomat must have a sophisticated understanding of the structures, programmes, approaches, and pitfalls surrounding these relationships to achieve success, whether working in the clinical setting or at the policy-making table’ (Novotny & Adams, 2007). Such skills rely not just on an understanding of the principles of
international relations, diplomacy, and foreign policy, but also on contemporary national, supra-national, and global political, security and policy agendas. In the absence of such training components, global health professionals may, otherwise, struggle to develop and maintain effective international partnerships (Katz et al., 2011), at least in part due to a lack of appreciation of prevailing socio-cultural and political contexts.

Approval procedures and cost-effectiveness analysis

The traditional role of clinical review boards has been as arbiters of global health programme acceptability from the medical, ethical (or ‘bioethical’) perspective, under the auspices of the Declaration of Helsinki (World Medical Association, 2008). With the recognition that global health programmes may pose critical threats, as well as potential gains, to foreign policy and diplomatic outcomes, such roles and responsibilities will need to be expanded accordingly. This has already been reflected, in recent years, by two major trends in the global health métier. Firstly, the range of approvals required for global health programme implementation continues to expand in response to unethical clinical practices, particularly those related to randomised controlled trials in Africa (Reuters, 2011; World Medical Association, 2008). Secondly, from an academic perspective, the recognition of diplomatic and foreign policy effects of global health programmes has directly challenged advocates of cost-effectiveness analysis as the overarching– even the sole – criterion in programme worth or value (see, e.g. Marseille & Khan, 2002; Ord, 2013). The dangers inherent in programme selection and approval decisions based solely on conventional or utilitarian cost-effectiveness criteria have already been reflected in the political and economic dilemmas of investment in HIV treatment versus prevention (Piot, Zavdie, & Turmen, 2002) and these risks are increasingly under scrutiny from both the bioethical and humanitarian perspectives (Cookson, McCabe, & Tsuchiya, 2007; Kevany et al., 2013). When attempting to optimise diplomacy and foreign policy, as well as primary programmatic outcomes of global health programmes, conventional measures of performance designed for use in programme selection are therefore necessarily relegated to discussions of technical (i.e. informing choices between interventions within the same programmatic area) rather than allocative (i.e. informing choices across programmatic areas) efficiency (Disease Control Priorities Project, 2008; Jan, 1998, Kevany et al., 2013; Piot et al., 2002). With the development of more holistic approval systems, global health programmes may, in turn, become more meaningfully, and therefore more strategically, selected.

Conclusions

A renaissance approach to global health

Both diplomatically and foreign policy–sensitised global health programmes may make international development more effective by building international trust and cooperation (Skinner & Sriharan, 2007); winning ‘hearts and minds’ (Feldbaum, 2010); working towards international conflict resolution and the pursuit of peace (Kickbusch & Buss, 2011); improving communication and terms of trade (CSIS, 2010); and bringing, with a benign international presence, greater stability to unstable areas (Kevany, Hatfield, et al., 2012; Kevany, Khumalo-Sakutukwa, et al., 2012). Such programmes also have the potential to directly improve health outcomes through changes in service utilisation and uptake; improved geographical accessibility; sustainability; adaptability; and equity (Khumalo-Sakutukwa et al., 2008). More broadly, global health actors stand to improve
in prestige (Fidler, 2007), donor countries to gain in terms of ‘international image building’ (CSIS, 2010) and recipient populations to benefit through associated increases in global health funding (Clinton, 2012), thereby potentially, and perhaps ironically, saving more lives than if global health programmes were ‘stovepiped’ within a narrow programmatic construct (Atwood, 2010). Conversely, when viewed as political choices, global health programme decisions are likely to be made badly if governed exclusively by philanthropic considerations that ignore this ‘two-in-one’ character of humanitarian aid (Valentino, 2011). Without consideration of related interdisciplinary principles, ‘the high expectations that global health will achieve diplomatic goals beyond technical objectives will be thwarted by these gaps’ (Katz et al., 2011). Any consequent augmentation of resources for global health would, if appropriately distributed, therefore ultimately contribute not just to global health outcomes, but also to more abstract and transcendent ideals (Kickbusch & Buss, 2011). In this context, future research may wish to consider (1) the further corroboration of the proposed criteria presented in this paper, with reference to specific historical and contemporary practices; (2) examples of diplomatic and foreign policy triumphs and threats of global health programmes; and (3) the applicability of diplomatic and foreign policy criteria to a more diverse range of development initiatives.

A renaissance in diplomacy and foreign policy – revisited

Concerns about the corruption of the high idealism of global health programmes, which have their primary mission diverted or compromised to serve more powerful or competing interests, are relevant to the promotion of ‘global health diplomacy’ approaches (Paulson, 2010). Many of these reservations may lie, however, not with the reframing of global health programmes as tools of foreign policy and diplomacy but with efforts to make both diplomatic and foreign policy criteria, for so long implicit in programme design and delivery, part of a more explicit system of assessment and service delivery (Labonte & Gagnon, 2010). Abstract goals such as world peace, international cooperation, and global prosperity and security may transcend even the high idealism of global health programmes themselves (Novotny & Kevany, 2013). More specifically, from a foreign policy perspective, while it is of course unacceptable for global health programmes not to achieve, to the greatest extent possible within diplomatic and foreign policy parameters, their health-related goals, the achievement of health outcomes at high (but possibly sub-optimal) levels may be preferable if under the auspices of the joint pursuit of broader strategic and security interests (Royal Institute for International Affairs, 2010), thereby saving additional lives through improvements in international relations and conflict prevention or resolution (Burkle, 2013). Concurrently, the development of global health diplomacy perspectives challenge traditional notions of foreign policy practice, which, in the ‘New World Order’, rather than simply promoting national interests, ‘have become more concerned with partnerships than rivalries, and alliances rather than enmities’ (Horton, 2007) – while also challenging traditional beliefs around who should decide, and who should take responsibility for, setting priorities in foreign policy, foreign assistance and international development (Sridhar & Woods, 2007). With military, global health and foreign policy practitioners working together more closely than ever to better achieve mutual goals (Michaud & Kates, 2013), and in a world in which both a reluctance to resort to twentieth-century-style ‘hard power’ interventions and a greater than ever variety of ‘barefoot diplomats’ are increasingly evident, the alignment of global health programmes with the principles of defence, diplomacy and foreign policy will ensure that the ‘greater good’ of harmonious international relations balances the ‘lesser evil’ of brave decisions to look beyond narrow
programme-specific targets. Global health diplomacy is, in essence, too valuable to neglect – not just for recipients, not just for donors, but also for the international community. In this regard, today, and as it was half a century ago: ‘The long labor of peace is an undertaking for every nation – and, in this effort, none of us can remain unaligned. To this goal, none can be uncommitted’ (Kennedy, 1963).

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