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COMMENTARY

Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards

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ABSTRACT

Distinctions between global health and other challenges to security and development, including counterterrorism initiatives, are becoming increasingly difficult to maintain in the twenty-first century. Indeed, it is increasingly unfeasible for global health organisations and initiatives, at both bilateral and multilateral levels, to claim that their work operates in isolation from non-health considerations. Intentionally or unintentionally, global health efforts have the potential to generate both benefits and threats to international security and counterterrorism efforts. Rather than advocate a complete dissociation between global health and intelligence, diplomacy and foreign policy, this article proposes a ‘Top 10’ ‘code of engagement’ between relevant professional communities to enable global health institutions and organisations to conduct their interactions, in conjunction with the broader interests of global community, on mutually acceptable terms.

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Philosophical approaches such as cosmopolitanism and epistemic uncertainty remind us of the ‘fundamental interconnectedness of all things’ (Adams, 1987). Never have such theories resonated so clearly as in the twenty-first century, where, under the auspices of the technological revolution, no global event can be said to occur in isolation. Such overlaps apply to politics, international security and global health, as articulated in the recent Lancet editorial ‘National Armies for Global Heath’ (2015); the advancement of the ‘smart global health’ paradigm (CSIS, 2010); the examination of global health’s overlap with counterterrorism efforts (Eckenwiler & Hunt, 2014); and the implications of the Ebola outbreak for global health security (The Lancet, 2015).

Enter the ethically fraught and much-opposed concept of interdisciplinary collaboration between global health, counterterrorism and international security initiatives. For all their differences, these efforts occupy much of the same space as one another. All require personnel working in often dangerous surroundings. All are active in regions where religious and political extremism is known to take place, such as Boko Haram’s and Al-Shabaab’s operations in countries with significant malaria, tuberculosis, HIV/AIDS and health system challenges. All are supported by wealthy and industrialised Western
societies and organisations. Trade in counterfeit medicines—vital to the provision of many global health programs—is increasingly of interest not just to organised crime, but to terrorist organisations (Mackey & Liang, 2011). And, perhaps most importantly, all are increasingly concerned with promoting world peace, economic development and political stability (Feldbaum & Michaud, 2010; Mackey & Strathdee, 2015).

The time has come for ‘global health’ to address the inevitability of these connections and associated responsibilities. It is increasingly unfeasible, as well as less and less credible, for global health organisations and initiatives, at both the bilateral and multilateral levels, to claim that their work operates in isolation from other considerations (Buekens, 2013). Intentionally or unintentionally, global health efforts have the potential to generate both benefits and threats to international security and counterterrorism; global health organisations and associated staff are increasingly becoming aware of the range of corresponding threats (e.g. the security of personnel) and benefits (e.g. increased funding and bipartisan support for health programs) (American Foundation for AIDS Research, 2013). Both health and non-health experts appear ambivalent about the ideal balance or structure of these collaborations, instead taking refuge in terms such as ‘uncertainty’, ‘beyond our scope’ or ‘a lack of expertise’ (Dewachi et al., 2014; Eckenwiler & Hunt, 2014). This calls for a formal system, acceptable across both health and non-health communities, that directs actual and latent synergies and tensions between development, diplomatic and security programs. In this context, the following ‘soft code’ for global health programs, organisations, initiatives, institutions and staff can help direct engagement in such non-health endeavours.

1. That global health respond to the declining political and social acceptability of hard power: In the wake of the devastating world wars of the twentieth century, succeeded with the disastrous and potentially cost-ineffective military efforts in Iraq and Afghanistan in this century, social approval for, and acceptability of, international interventions continues to decline. In an era when both the visual and the visceral consequences of conflict-related death and destruction are increasingly harder and harder to avoid, individuals, communities and societies have become increasingly intolerant of military action. This is similar to the mutually assured destruction paradigm of past generations, that diminished societal thresholds for the threat of nuclear war to such an extent as to make such forms of conflict politically impossible (Yereskovsky, 2000). The current and not unrelated reluctance of international alliances to engage in theatres such as Syria (Rogin, 2012) has created a vacuum of interventionism that has yet to be adequately addressed, while such conflicts continue to spiral out of control. World powers are thus increasingly being forced to consider non-military options, including smart global health, both to protect international stability and to project influence (Center for Strategic & International Studies, 2010).

2. That global health agencies control the leveraging of extensive geostrategic access to ‘off-limits’ regions, countries and communities for strategic and altruistic ends: Terrorist organisations such as Boko Haram and Al-Shabaab operate in regions with significant public health problems, while global health programs operate in geopolitical regions often affected by, or associated with, terrorism. A range of opportunities exists for global health programs to support strategic as well as humanitarian or altruistic goals, such as enhanced or shared monitoring and evaluation systems. Rather than
simply issue nolle prosequis (Buekens, 2013), global health leaders have the capacity to determine acceptable ways in which their organisations and programs respond to global security threats without compromising disciplinary integrity or primary medical goals. At the collaborative level, this might imply coordinating activities, reporting, strategies and tactics with international non-health organisations and initiating appropriate liaison structures at the organisational and group levels that are both acceptable to, and harmonised or aligned with, the domestic policies of recipient countries (Kevany, Sahak et al., 2014).

(3) That global health resources be allocated across regions, programs and population groups based on strategic and medical goals: In a variation of the McNamara Fallacy (Basler, 2009), the exclusive use of health outcomes as determinants of resource allocation decisions ignores the downstream, collateral, indirect or inadvertent consequences of global health efforts across target populations, geostrategic regions and international relations. For example, the intensification of health education campaigns, which include both medical and diplomatic messaging (or, at least, medical messaging presented in a diplomatic fashion), in regions or communities susceptible to radicalisation may meaningfully address both health and non-health considerations. Examples include modifying or amending community mobilisation and post-test support service promotion for voluntary counselling and testing in Zimbabwe; the re-branding of associated intervention names in Tanzania in response to contemporary political social and religious considerations (Kevany et al., 2012); and the no arms logos on United Nations Development Programme vehicles and facilities in South Sudan (UNICEF, 2001). More broadly, the US President’s Emergency Plan for AIDS Relief (PEPFAR) has been extensively associated with adapting health education messaging to support indirect or downstream non-health goals (Dietrich, 2007). Considering a broader set of holistic criteria or ‘values’ related to foreign policy, security and diplomatic outcomes of global health programs (Kevany, 2014) could, therefore, help simultaneously optimise both health and non-health gains.

(4) That global health organisations and initiatives develop awareness at the group and individual levels of the strategic and security implications of their activities: Global health personnel operate under a humanitarian aegis and training structure. This limited scope presents both advantages and threats. While practitioners are often highly trained in related disciplines and sub-disciplines such as epidemiology, health policy or health systems, the broader political, strategic and international relations consequences of their actions, decisions and modus operandi generally go unconsidered (Katz, Kornblet, Arnold, Lief, & Fischer, 2011). Education, as part of basic global health training, in international diplomacy represents a potentially vital element of a more enlightened, cosmopolitan and multifarious approach to global health efforts that can address both health and non-health goals. Similarly, global health programs are obliged to ensure the protection and security of their staff—both ‘local hires’ and international personnel—via collaborative awareness and education efforts. These collaborations should occur in advance of project rollout at the highest possible strategic and program design levels, to prevent potential threats on a prima facie basis.

(5) That global health programs do not operate in isolation from military, intelligence and security organisations, but develop joint liaisons, initiatives and operations to align and
coordinate objectives: There is currently limited or no explicit coordination between strategic concerns and health objectives among major donor groups and countries such as the European Union, the United Kingdom, the United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Nascent efforts to address this through the Office of Global Health Diplomacy in the US State Department or the integration of smart approaches to European health and development efforts (Kerry, 2013; Rehn, 2005) have, to date, been given only a low priority in associated organisational manifestoes. Practical solutions include providing political, security and economic risk reports to international personnel; the absence of concerted and explicit efforts raises the risk of a ‘tense and confusing duality’ (CSIS, 2010; The Lancet Editorial, 2015) in foreign policy. There is, therefore, an urgent and significant ‘unmet need’ to develop joint liaison capacity at all levels of policy and practice: from the highest echelons of international development and defence ministerial and departmental decision-making to individuals at the field level (Kevany, Jaf et al., 2014).

(6) That global health programs consciously seek to win ‘hearts and minds’ in remote or isolated regions otherwise susceptible to extremist doctrine: Global health programs, through health education campaigns, community mobilisation, community working groups and other forms of stakeholder involvement, stand to generate not only health but also educational, diplomatic and international relations gains (Kevany, Benatar, & Fleischer, 2013). In many cases, related operating environments are isolated, with limited exposure to or interaction with, schools of thought and cultures beyond local religious organisations. Global health programs stand to generate acceptable alternatives to extremist ideology in these regions by designing and delivering interventions in a way that simultaneously improves recipient health while addressing the root causes of terror and extremism. Appropriate embedded themes may, therefore, not just improve health, but also combat militant or radical fundamentalism at its source (Kevany, Sahak et al., 2014).

(7) That global health programs do not implement interventions likely to incite religious, social or cultural sensitivities among recipient populations: Driven by narrow metrics such as quality-adjusted life years as used in conventional cost-effectiveness and monitoring and evaluation techniques, as well as in broader health agenda setting (Kleinman, 2010), the impact of global health interventions on social, cultural and religious norms (community and individual level) has never been greater. Such issues have become particularly relevant in the context of the HIV/AIDS epidemic, responses to which (such as birth control promotion and male circumcision intervention) have challenged traditional behaviours (see Bhattacharya, 2004) in a way that, for example, tuberculosis or malaria programs have never been required to. While it is often important to inculcate social progress in global health programs, such as exploiting the overlap between HIV/AIDS treatment and prevention and the advancement of human rights (Kevany et al., 2013), the risk that such interventions may be interpreted as challenging revered traditions and sensibilities, or the suspicion that programs are being designed for more sinister ends (e.g. birth versus population control) (Critchlow, 1995) can alienate, antagonise or offend recipient populations. Global health programs should, therefore, be carefully vetted based on global
health diplomacy criteria (Kevany, 2015) to ensure that diplomatic threats do not out-
weigh health gains.

(8) That global health programs continue to address the underlying causes of extremism, including poverty, alienation and disenfranchisement: The root causes, operating environments and goals of counterterrorism and ill health will remain closely linked in the foreseeable future. Poverty, lack of opportunity and employment, social and cultural isolation, limited educational options and issues related to social justice and the global distribution of wealth, corruption and global inequality—all contribute to both radicalisation and the scale and scope of communicable and non-communicable diseases. Similarly, extremism and fundamentalism are associated with social alienation, poverty, lack of personal opportunity and choice, limited diversity in educational perspectives and a sense of distress at being (actually or mistakenly) threatened or exploited by external forces beyond individual control (Schwartz & Dunkel, 2009). Global health efforts, when appropriately designed and delivered, address both the medical and structural inequalities that generate the conditions for terrorism to flourish—thereby short-circuiting the malign ‘Catch-22’ cycle under which humanitarian interventions fail due to broader economic, political and diplomatic challenges (Benatar, 2015).

(9) That global health programs do not aid, abet or facilitate extremist organisations by providing health care to terrorists, extremists or their support networks and organisations: The Geneva Convention agreements make clear the fundamental importance of neutral medical and health care provision to both antagonists and civilians in conflict zones (Pledge Peace Union, 2015). With the ostensible contemporary failure of conventional systems of terrorism control and containment, global health efforts may wish to re-examine their role in providing humanitarian and other medical support to extremist groups, at both individual and organisational levels (Stephan & Beyerle, 2015). In Syria, for example, distinctions between allies and foes are increasingly hard to recognise, making partisan support difficult, if not impossible, to achieve. Ethically, therefore, should global health programs adhere to a Hippocratic manifesto that accepts all-comers with impunity, equal access and respect? Conversely, how should global health and security communities respond to efforts by violent extremist groups such as Islamic State to use health initiatives to win the ‘hearts and minds’ of annexed populations (Gardham, 2015)? Or, is it possible to save more lives by preventing attacks and avoiding conflict if global health efforts more explicitly adapted traditional approaches based on unconditional altruism, within Geneva Convention standards, to pursue strategic as well as humanitarian objectives?

(10) That none of these steps be interpreted as donors engaging in ‘development bribery’: ‘Smart’ global health programs require a modus operandi which belies the myth that such efforts are forms of international bribery to pacify potentially troublesome regions (Bräutigam & Knack, 2004). For global health programs and practitioners to achieve broader non-health goals, an extensive ‘rebranding’ of image, style and approach is required. ‘Soft’ perceptions around donor health programs are no longer as easily practicable in an era when such perceived distinctions are becoming increasingly difficult to maintain. Global health programs may, ultimately, find broader public and political support when more explicitly presented as tools of national security and foreign policy, as well as altruistic efforts in the global public interest.
Organisations such as Al-Shabaab and Boko Haram continue to commit some of the most destructive and inhumane outrages of the modern era. Conventional response systems—particularly standing armies—even when combined with the latest military-industrial technologies can do little to prevent such attacks, and appear rigid and lumbering when faced with such nimble opponents, occasionally even causing more destruction than they resolve (Kevany, 2015). It is time, if not for an entirely new strategic and security paradigm, at least to explore every option that can be leveraged in opposition to such outrages, including the more explicit combination of health and security efforts—via, for example, new health security treaties within the sustainable development goal framework (Kickbusch, Orbinski, Winkler, & Schnabel, 2015), multilateral initiatives such as the Global Health Security Agenda (GHSA) (Centers for Disease Control and Prevention, 2015), under the auspices of the UN Office on Drugs and Crime (UNODC) Convention against Crime (2015), or as ‘soft law’ in the form of a widely accepted code of conduct.

These proposals, although in keeping with contemporary efforts to ‘codify’ global health’s remit (Gostin, 2013), will inevitably be controversial. Nonetheless, these inexorable connections bring global health efforts significantly closer to those of organisations concerned with international security than most other professions or disciplines, even within the international development métier. Global health programs have the power, scope and capacity to mitigate many of the environmental conditions threatening global cooperation and security by promoting health education, international collaborations and exchanges, access to health services and progressive ideals that frame donor activity as cosmopolitan collaboration, rather than neo-colonialism. This evolution is also relevant to the overlap between paradigms of global and international health and related conceptual frameworks (Koplan, Bond, & Merson, 2009). Global community efforts to address the root causes of global adversarialism, poverty and inequalities in wealth, status and access through foreign assistance (‘global health’) are rooted in responses to cross-border health security threats (‘international health’) and broader non-health structural challenges via a ‘sense of local and global social, economic, physical and moral interdependence in the face of ongoing natural, biological and human induced tragedies’ (Benatar, 2015).

Any such integration brings with it both risks and responsibilities. The prestige, role, perception and security of global health programs and staff will inevitably be affected. Yet the fact remains that such an evolution is already taking place. Would not the polio vaccination workers assassinated in Pakistan as a result of associations with foreign policy and international security considerations (Gostin, 2014; The Guardian, 2014) have been safer operating under appropriate and collaborative ‘security umbrellas’ (Burkle, 2013), making implicit connections explicit? Global health and broader development workers are increasingly involved in political and security endeavours, and their effectiveness, efforts and bravery in this regard are worthy of recognition (Kevany, 2014). However, only a careful and planned consideration of such synergies, governed by the global health as well as defence and intelligence communities, can address such international security threats while also pursuing the goals of better global health outcomes and world peace.

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