GLOBAL PUBLIC HEALTH
2019, VOL. 14, NO. 1, 147–151
https://doi.org/10.1080/17441692.2018.1471147

Routledge
Taylor & Francis Group

COMMENTARY

A vision for global heath diplomacy in the foreign policy process: using smart power to prevent and resolve international conflict

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ABSTRACT

In the twenty-first Century, the developed world attempts to provide global health assistance, to poorer countries – at least in part in the pursuit and maintenance of world order and stability. Rarely, however – and in most cases, then on an ad hoc basis – are related foreign policy tools deployed in combination with each other. Nonetheless, there is currently greater openness than ever before to such interdigitation. Not least this reflects the unprecedented challenges of modern political and security conditions – struggling to operate amidst a broader culture of global adverserialism, and conflict which conventional systems of intervention have struggled to successfully resolve. The problems presented in this regard by the Iraq and Afghanistan conflicts have evolved into, and been magnified by, the limited range and availability of effective responses to contemporary threats such as the Islamic State, international terrorism, jihadism, and the Syrian civil war. The risk of further contagion to even more severe world stability concerns that these situations present calls for an urgent restructuring of the way in which foreign policy processes and initiatives work, including systems of coordination and consultation between national and international agencies of defense, diplomacy, and development.

ARTICLE HISTORY
Received 7 January 2017
Accepted 8 April 2018

KEYWORDS
Global health; policy process; security; foreign policy; diplomacy

Twenty-first century foreign policy

In the twenty-first Century, the developed world attempts to provide development aid services and support, including global health, to poorer countries – at least in part, in the pursuit and maintenance of world order and stability. In the same way, diplomacy and defense efforts are, ideally, delivered with the same principles of enlightened self-interest in mind. Rarely, however, and in most cases then on an *ad hoc* basis, are related foreign policy tools deployed in combination with each other (Burkle, 2013). Nonetheless, there is currently greater openness than ever before to such interdigitation.

Not least, this reflects the challenges of modern political and security conditions combined with a broader culture of global adverserialism and conflict which conventional systems of intervention have struggled to successfully resolve (Shackle, 2011). The problems presented in this regard by the Iraq and Afghanistan conflicts have evolved into, and been magnified by, the limited range and availability of effective responses to contemporary threats such as the Islamic State, international terrorism, jihadism, and the Syrian civil war (Carrion & Eaton, 2015). The risk of further contagion to even more severe world stability concerns that these situations represent, combined with the current wave of right-wing threats to health, development and diplomacy efforts (Wodak, 2015) calls for an urgent restructuring of the way in which foreign policy toolkits work.

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In parallel, increasing attention is being paid to both the definitions (Koplan et al., 2009) and importance of global health efforts in terms of their latent political and diplomatic effects (Fidler, 2007; Horton, 2017). While HIV/AIDS and the Ebola outbreak (Kevany, 2015a) have obvious and vital relevance to the enlightened self-interest of the western world, health security considerations represent only one aspect of the heightened contemporary awareness of global health as a tool of diplomacy: that the design, delivery, location, and even population focus of tuberculosis, malaria or other programmes often has the potential for dual and transformative effects on international relations (Kevany et al., 2012).

Yet such synergies, while laudable, stand to complicate rather than simplify the range of options available to politicians and policymakers when faced with pressing or long-term foreign policy concerns: from both the security and humanitarian (or high and low) ends of the political spectrum (McInnes & Roemer-Mahler, 2017) – in the global south, as much as in developed countries – a dynamic and synergistic convergence of skills, responsibilities, and interests is taking place in a manner which political processes and policy systems are not yet equipped to leverage to full effect.

A need for evolving national structures & strategies

In a nascent effort to bridge these gaps, the United States' Office of Global Health Diplomacy (OGHD) was created in 2012 in response to a range of budgetary and political pressures. As an overarching mission, the office was given a key role to play in the development of country ownership systems in response to concerns about the sustainability of the United States' President's Emergency Plan for AIDS Relief (PEPFAR) under conditions of global economic contraction (Walensky & Kuritzkes, 2010). In recent years, however, the OGHD has been responsible for a range of additional mandates, more closely connected with the State Department apparatus. This includes whether the diplomatic design and delivery of international endeavours, including health and development programmes, can help (even to a limited degree) in neutralising or counteracting non-health security, political, or terror threats (Kevany, 2015b) at their source – thereby creating compelling bipartisan rationales for their support (Feldbaum, Lee, & Michaud, 2010).

Yet such smart global health (Kevany, 2014) approaches also demand innovative political decision-making systems, as well as examination of the ways in which the (often divergent) principles and goals of diplomacy, defense and development interact with each other. Few global health efforts, until recently, have been proactively reviewed in this regard (Kevany, 2015b): while the scientific, medical and health economic integrity of such interventions should never be undermined by the pursuit of non-health concerns, an absence of related awarenesses risks overlooking international relations considerations and dividends between donor and recipient countries.

In contrast, the joint governance of global health's interactions and collaborations with intelligence, security, diplomatic and military agencies by OGHDs in donor countries worldwide would harmonise foreign policy efforts in mutually supportive ways. Critically, such a system would represent the apogee of recent demands to fold the United Kingdom's Department for International Development (DFID) in to the Foreign Office – representing, instead, a chance for the global health community to define and control its own diplomatic role (Eckenwiler & Hunt, 2017). But how, in terms of policy process and practice, might this be achieved?

Expanding the purview of health diplomacy

One reason for the prior politically and diplomatically peripheral role of global health was a limited appreciation of the potentially dramatic role HIV/AIDS, malaria or tuberculosis programmes could have on broader world affairs (Valentino, 2011), coupled with a lack of capacity to bring these benign forces to bear on day-to-day foreign policy (Bonventre, 2008). There is, today, still no clear mechanism by which such latent diplomatic effectiveness can be optimised, or for relevant expertise to

be brought to bear on the pressing foreign policy concerns of either the developed or developing world.

Such systems might include governance of the consultation by foreign policymakers with global health diplomacy specialists via OGHD-style departments regarding the influence that global health efforts can bring to bear on international conflict concerns (Kevany, Jaf, et al., 2014; Kevany, Sahak, Workneh, & Saeedzai, 2014). Initial questions in such interactions might include (1) how, if at all, global health efforts may benignly advance national and international conflict resolution; (2) if so, how can or should existing programmes be adapted to respond to these demands; (3) whether such advanced roles are, on a situation-by-situation basis, feasible and operationalizable; and (4) the related exploration of synergistic collaborative opportunities with security or military initiatives.

The establishment of such direct lines of communication between executive, defense, intelligence, security and global health and development agencies would be reminiscent of the early days of PEPFAR, when the Office of the Global AIDS Coordinator had a direct line to the White House (Ingram, 2010). Such restructuring would also require involvement of OGHD representatives with other relevant experts in broader foreign policy; in turn, this would require leadership with joint expertise in health, diplomacy and foreign affairs, as well as a distinct OGHD physical location within Whitehall or State Department equivalents, forging a global health identity that would integrate activities more closely with traditional foreign policy institutions.

Under such a model, OGHDs would provide rapid assessments of ways in which appropriately designed, targeted and delivered global health programmes could help to resolve foreign policy or diplomatic crises. Recommendations on the way in which such efforts would operate – including which departments and agencies would be involved; coordination with military or even clandestine activities (Kevany, 2015b); funding and timelines; cultural, religious, social and political sensitivity in intervention, target population, and physical location selection; and the challenges and feasibility of different response scenarios – would then be provided to foreign policy decision-makers on both *ad hoc* and routine bases.

From policy to practice

Mission statements and models for advisory and decision-making powers for OGHDs are, of course, insufficient on their own. The implications of such enhanced roles and responsibilities – including applied efforts such as the dispatch of OGHD task forces to theatres of conflict to oversee the design and deployment of diplomatic global health efforts – are inherently practical and applied. Such missions would, in turn, be built on greater embassy and ambassadorial interactions with the global health apparatus: the health diplomats responsible for such efforts would examine, for example, whether health programmes targeted exclusively for maximum epidemiological impact are also effectively supporting long-term diplomatic goals.

In some cases, there may be a trade-off between the two: purely epidemiologically-driven approaches to global health may inadvertently take partisan stances – favouring certain districts, ethnicities, tribes or regions over others (Feldbaum, Michaud, & Lee, 2010) and thus engendering diplomatically-damaging local suspicion and animosity that donors support the interests of one political or population group over another: such considerations are not routinely considered by health economists (Walensky & Kuritzkes, 2010). Similarly, the selection and prioritisation of global health interventions on the basis of narrow performance metrics such as cost-effectiveness analysis or monitoring and evaluation metrics can overlook their potential to alienate recipient populations in the absence of routine diplomatic tests for social, cultural and religious acceptability, thereby overlooking the essential distinction between global and international health – that recipient countries maintain ownership, investment (both monetarily and politically) and a voice in selecting those interventions that are most suitable for their operating environment.

From a practical perspective, establishing the purview and authority of OGHDs in either developed or developing countries will not be easy. Restructuring lines of foreign policy decision-making

requires attention and effort, and the introduction of the principles and practice of health diplomacy into the activities of both health and non-health government departments will require a degree of comprehension that will, inevitably, take time to build. At present, most inter-sectoral global health engagement (United States Department of Defense, 2013) efforts are made on opportunistic or imperative bases, such as by military leaders in the field (Kevany & Baker, 2016). In such situations, the consideration of diplomatic procedures and protocols is, too often, secondary to overriding tactical or strategic considerations. Yet it is possible that it will be those countries that advance most rapidly with the implementation of such liaisons that stand to benefit most from the synergies between global health, international relations, and diplomacy.

Ultimately, the worth and effectiveness of such reforms can only be assessed on an experimental basis: it will require trial and error to get the level of involvement and formula for a formal global health role in foreign policy right. Yet by making explicit to foreign policymakers the collateral effects of health programmes, such efforts send an important message to aid skeptics in the developed and developing world: that diplomatically-designed global health investments – as well as pursuing noble ideals such as the health of the world's poorest people – also achieve enlightened self-interest goals such as advancement of international relations, security, and the prevention or mitigation of armed conflict (Kevany et al, 2012).

To a very limited extent, this process has already begun, with global health experts sitting on the United States' National Security Council (Michaud & Kates, 2013); to date, however, this has focused on global health security issues related to pandemic control and preparedness rather than the proactive use of smart global health programmes in the foreign policy context. At the level of supranational organisations (such as the United Nations, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Health Organization), the inclusion of such considerations in global health policy dialogues, as well as the establishment of associated departments and offices, has helped to advance and optimise such synergies. Combined, the deepening involvement of global health in diplomatic and defense processes can lead to even more significant interdigitation as health, foreign policy and more abstract ideals such as world peace and security are advanced in concert with each other.

Disclosure statement

No potential conflict of interest was reported by the author.

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