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**Advancing Health and non-Health Security, Diplomacy and  
International Relations through the Enlightened Design and  
Delivery of Smart Global Health Programs**

**Kevany, S.**

A PhD by Published Work awarded by the University of Westminster.

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*Advancing Health and non-Health Security, Diplomacy and International Relations  
through the Enlightened Design and Delivery of Smart Global Health Programs.*

In partial fulfilment of requirements for the Doctorate by Past Work

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## Table of Contents

<b>Declarations</b>	<b>4</b>
<b>Foreword</b>	<b>5</b>
<b>Part One – Background and Introduction</b>	<b>6</b>
1. Original Contributions and Key Terms	6
i. Global Health Diplomacy	8
ii. Smart Global Health	9
iii. Cool Wars	10
2. Structural Overview	11
3. Personal Statement	12
<b>Part Two – Original Findings and Contributions to Knowledge</b>	<b>16</b>
1. That smart global health efforts can contribute to conflict prevention	16
2. That global health programs facilitate counterterrorism efforts	20
3. That smart approaches are effective in resolving tensions in conflict settings	24
4. That global health has become a national and international security issue	28
5. That approaches to program design, delivery and evaluation can be further optimized	32
6. That parameters and tools to optimize global health program design can be generated	35
7. That innovative diplomatic approaches to program design can be identified	39
<b>Part Three – Conclusion</b>	<b>44</b>
Original Contributions Redux	44

<b>Afterword</b>	<b>46</b>
<b>Annex 1 – Publications Submitted for Consideration</b>	<b>47</b>

## **Declarations**

I declare that all the material contained in this thesis is my own work.

The submission as a whole or in part is not substantially the same as any that I have previously made or am currently making, whether in published or unpublished form, for a degree, diploma or similar qualification at any university or similar institution.

Until the outcome of the current application to the University is known, the work or works submitted will not be submitted for any such qualification at another university or similar institution.

## **Foreword**

We live in an era of blurred lines – between disciplines, professions, pursuits. Phones are no longer phones, but are camera and diaries, entertainment systems and work stations. Engineers have become environmental engineers – considering the environmental impact of their work, just as much as its structural integrity. Similarly, ecological modernizers attempt to unify development and industrialization with environmental protection and advancement in a synergistic, mutually supportive manner. In the realms of global health, diplomacy, security and international relations, as addressed in the following, such synergistic, interdigitated and smart approaches are also in play. In all such cases, such enlightened approaches are the hallmark of enlightened human evolution.

## Part One – Background and Introduction

### 1. Original Contributions and Key Terms

Amongst other original contributions to knowledge, my past work has shown that the pursuit of global strategic or stability goals, previously the remit of humanitarian interventions and broader hard power initiatives, are no longer limited to military purviews.<sup>1</sup> In this context, post the Iraq and Afghanistan conflicts, we live in an era which has seen challenges to the cost-effectiveness of traditional means of conflict prevention, resolution, and counter-terrorism.<sup>2</sup> In my research, I have focused on the original advancement of ‘smart’ (defined here as the multifarious use of non-military resources to achieve bilateral or multilateral strategic ends)<sup>3</sup> and soft power efforts via global health programs – defined here as the provision of treatment, prevention and care services for HIV/AIDS, tuberculosis, malaria (as well as broader health system strengthening initiatives) by related donor countries and organizations – with reference to (1) diplomatic, strategic, or foreign policy considerations and (2) the development of innovative systems to optimize their effectiveness in resolving civil conflict, regime change, and challenging human rights abuses as well as advancing health and non-health security.<sup>4</sup> Under the *Cool Wars*<sup>5</sup> paradigm, I have also advanced understanding of ways in which military and non-military initiatives may employ global health efforts as strategic tools, yet without compromising the health goals for which they were originally designed.<sup>6</sup> In *The Lancet Global Health*, I characterized this need for greater disciplinary interdigitation, exchangeability and multifariousness (which echoes historical precedents) as follows:

*“Global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President’s Emergency Plan for AIDS Relief (PEPFAR) have, at present, no explicit or formal internal capacity to respond to the overarching diplomatic or foreign policy concerns of either their donors or the broader*

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<sup>1</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.921211 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>2</sup> Center for Strategic and International Studies (2010). Final report of the CSIS Commission on smart global health policy. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>

<sup>3</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.921211 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>4</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.921211 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>5</sup> Feldman, N. (2013). *Cool Wars: The Future of Global Competition*. Random House: New York.

<sup>6</sup> Kevany, S. and Baker, M. (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016; Kevany S (2015). The United States’ Response to Ebola. *The New York Times*, Letters to the Editor. Retrieved from [http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?\\_r=0](http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?_r=0)

*global community.7 To the utilitarian, this respect for professional boundaries is to be welcomed. To the cosmopolitan, the increasingly connected nature of both the causes of, and solutions to, poverty, disease, ill health, and health security—in the context of associated considerations of world peace, non-health security, conflict prevention, and international stability—implies that all entities, individuals, and policies are interconnected, and cannot operate in isolation of each other.<sup>8</sup> As former President of the USA John Fitzgerald Kennedy remarked to the UN during its early idealism: “the long labor of peace is an undertaking for every nation—in this effort, none of us can remain unaligned. To this goal, none can be uncommitted”.<sup>9</sup>*

The same may be said for global health initiatives: while for example the principles of the responsibility to protect<sup>10</sup> may be combined with programs for HIV/AIDS treatment and prevention, to have a dual effect on both health and humanitarian levels the appropriate international relations design considerations must be borne in mind. If not, foreign assistance will struggle to achieve these objectives. In this regard, my published research has advanced the theoretical development and practical application of such smart (or holistic) approaches to program design and delivery by presenting (1) a cohesive series of arguments in favour of the integration of global health, foreign policy, international relations, and diplomacy and (2) innovative practical and policy strategies for the use of such programs in the humanitarian intervention context.

This overview commentary has therefore been designed to (1) explain the links and draw out interconnections between my past published papers, (2) highlight original contributions to knowledge, and (3) demonstrate the potential for further optimization of synergies between global health, security, conflict resolution, counter terrorism, and diplomacy. This approach unites my seven key findings presented below into a single, coherent statement of the latent and potential role of global health and other international development and foreign assistance programs in the strategic, security, international relations, humanitarian intervention, and global stability contexts.

My past publications thus represent original contributions to the fields of both global health and international relations. In particular, and for the first time, my development of a

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<sup>7</sup> Michaud, J., Kates J. (2013). Global health diplomacy: advancing foreign policy and global health interests. *Glob Health Sci Pract* 2013; 1: 24–28.

<sup>8</sup> Brown, G. (2008) Moving from cosmopolitan legal theory to legal practice: Models of cosmopolitan law. *Leg Stud* 2008; 28: 430–51.

<sup>9</sup> Kennedy, J. (1963) Address to the United Nations Security Council, 1963. <http://www.jfklibrary.org/Research/Research-Aids/Ready-Reference/JFK-Quotations.aspx>

<sup>10</sup> Hehir, A (2013). *the Responsibility to Protect*. Hampshire: Palgrave Macmillan; Davies, S. (2010). What contribution can International Relations make to the evolving global health agenda? *International Affairs*, 86(5), 1167-1190.



comprehensive set of evaluation criteria has enabled the value of global health programs to be determined not just from medical or economic but also from diplomatic, security, conflict resolution and political perspectives. My associated findings have also demonstrated, building on prior research and literature, that (1) global health programs may generate both diplomatic and conflict resolution effects beyond primary programmatic goals<sup>11</sup> and (2) that through the appropriate redesign of implementation processes, diplomatic (as well as health) gains to both donors and recipients may be further optimized.<sup>12</sup>

Perhaps most importantly, my past work makes original contributions to arguments for the avoidance or limitation of hard power international interventions, where possible, by their substitution with smart power initiatives. These smart global health approaches (see following definitions) are based on the development of original modifications to the use and design of global health programs to optimize their joint health and strategic impact. In turn, my work has built on arguments for (1) transfers of funding from defense to development budgets (in both donor and recipient countries)<sup>13</sup> and (2) the development of new, strategically-driven roles for military forces in global health efforts.<sup>14</sup>

#### **i. Global Health Diplomacy**

Prior research and literature on the global health diplomacy paradigm has synthesized the rubrics of international relations and development, making each mutually reinforcing and synergistic in achieving their objectives:<sup>15</sup> global health programs, if designed with appropriate principles in mind, may be just as effective in diplomatic realms as the reverse in our multifarious, interdisciplinary era. Separately but simultaneously, and advancing past efforts to look beyond conventional metrics of program performance<sup>16</sup> – almost always, in

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<sup>11</sup> Kevany, S. et al (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival*, 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>

<sup>12</sup> Kevany S (2014). Global health diplomacy, 'Smart Power', and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.92121 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>13</sup> Burkle, S. (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*, 28(3), 1–3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591>

<sup>14</sup> American Foundation for AIDS Research. (2013). U.S. global health investments: The evidence on health, diplomatic and economic impact. *AMFAR Issue Brief*. Retrieved from <http://www.amrefusa.org/silo/files/amfar-global-health-investment-impact-june-2011.pdf>

<sup>15</sup> Kickbusch, I., Novotny, T., Drager, N., Silberschmidt, G., & Alcazar, S. (2007). Global health diplomacy: training across disciplines. *Bulletin of the World Health Organization*, 85, 82–91. Retrieved from [http://www.scielo.org/scielo.php?pid=S0042-96862007001200027&script=sci\\_arttext&tlng=es](http://www.scielo.org/scielo.php?pid=S0042-96862007001200027&script=sci_arttext&tlng=es)

<sup>16</sup> Brown, G. (2012). Distributing who gets what and why: four normative approaches to global health. *Global Policy*, 3(3), 292-302.

prior research and literature, viewed strictly from medico-economic perspectives such as cost-effectiveness analyses – my original global health diplomacy approaches also take into account (for example) considerations of sustainability, local ownership, cultural sensitivity, and responsiveness to local health and non-health needs in program design. In an extension of the McNamara Fallacy (which posits that ostensibly positive quantitative assessments of success such as those employed by the United States' Secretary of Defense Robert S. McNamara during the Vietnam War may be damagingly misleading),<sup>17</sup> simply because global health's diplomatic effects are unmeasured, that does not mean they don't exist.

## ii. Smart Global Health

A crossover hybrid – smart power<sup>18</sup> – has recently been added to the foreign policy toolkit of diplomacy, soft power, and hard power. Within the definition provided above, smart power also embraces the tactical use of global health interventions by military forces,<sup>19</sup> and my past work has further defined and articulated this crossover by reviewing the strengths and weaknesses of international military responses to Ebola crises in West Africa<sup>20</sup> as well as contributions by bilateral and multilateral health programs to international access, peace-keeping, and nation-building in conflict and post-conflict settings such as Iraq,<sup>21</sup> Afghanistan,<sup>22</sup> Sudan,<sup>23</sup> and South Sudan.<sup>24</sup> While prior research and literature has shown that the inherent multifariousness of smart global health offers alternatives to hard or coercive interventions<sup>25</sup> – thereby saving lives through the avoidance or mitigation of

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<sup>17</sup> Basler, M. (2009). Utility of the McNamara fallacy. *British Medical Journal*, 339, b3141.23

<sup>18</sup> Kevany, S. (2014). Global health diplomacy, 'Smart Power', and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.92121 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>19</sup> Center for Strategic and International Studies. (2007). CSIS commission on smart power. Retrieved from [http://csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)

<sup>20</sup> Kevany, S. (2015). The United States' Response to Ebola. *The New York Times*, Letters to the Editor. [http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?\\_r=0](http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?_r=0)

<sup>21</sup> Kevany, S. et al (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival*, 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>

<sup>22</sup> Kevany, S., Sahak, O., Workneh, N. & Saeedzai, A. (2014). Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs. *Medicine, Conflict and Survival*, 30:1, 37-55. <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>

<sup>23</sup> Kevany, S. (2014). International Access and Global Health Diplomacy in Sudan. *The Lancet Global Health*, <http://globalhealth.thelancet.com/2014/05/02/international-access-and-global-health-diplomacy-sudan>

<sup>24</sup> Kevany, S. et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Medicine, Conflict and Survival*, July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>25</sup> Center for Strategic and International Studies. (2010). Final report of the CSIS Commission on smart global health policy. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>

conflict<sup>26</sup> – my original research found that its benign potency does not end there. Equally importantly, my work has generated new evidence that smart global health stands to benefit donor, as well as recipient, countries via the theory of enlightened self-interest,<sup>27</sup> winning support for ostensibly altruistic<sup>28</sup> efforts across the political spectrum.

### iii. Cool Wars

Even the most intelligently designed, multifarious global health programs may struggle to perform without acceptance by local communities. In remote villages or overcrowded urban centers in the world's poorest countries, my past research has shown that acceptance of global health programs – even by the poorest of the poor – is far from a *fait accompli*.<sup>29</sup> Yet if programs are considered appropriate and attractive by locals, that can make all the difference. Building on the ideas developed by the *Cool Wars* paradigm,<sup>30</sup> as well as exposure to the zeitgeist-driven San Francisco model of HIV/AIDS care,<sup>31</sup> such acceptance is in turn vital for donor countries seeking to improve diplomacy and international relations. This approach is of particular importance in the health security context. In epidemic outbreak situations which are managed by combined civilian and military forces (as was the case in the 2014 East Africa Ebola outbreak), both in-country and international responses were considered in my past work successful or unsuccessful not just on the basis of their curtailment of the outbreak (health security outcomes)<sup>32</sup> but also through the way they were managed from a combined health security and health diplomacy outcome perspective.<sup>33</sup>

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<sup>26</sup> Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4). Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000226>

<sup>27</sup> Kevany, S. (2014). Global Health Diplomacy: A 'Deus ex Machina' for International Development and Relations. *International Journal of Health Policy and Management*, 3(2): 111–112. [www.ijhpm.com/pdf/2867\\_7dfa3b1a8850ce1070ef08fb0d0204be.html](http://www.ijhpm.com/pdf/2867_7dfa3b1a8850ce1070ef08fb0d0204be.html)

<sup>28</sup> Altruism is defined here as the contribution of individuals, organizations or nations -- charitable and financial or otherwise -- to the advancement of the health and development of developing countries without expectations of returns on such investments. However, altruism is not considered to necessarily exclude acts of 'enlightened self-interest'.

<sup>29</sup> Kevany, S. et al (2012). Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. *BMC Public Health*, 12: (459): 1-11. <http://www.biomedcentral.com/1471-2458/12/459/abstract>

<sup>30</sup> Feldman, N. (2013). *Cool Wars: The Future of Global Competition*. London: Random House.

<sup>31</sup> Kevany, S. (2016). HIV/AIDS, Global Health Diplomacy, and "San Francisco Values": From the Local to the Global. *Annals of Global Health*, Sep-Oct; 81(5):611-7. <http://www.ncbi.nlm.nih.gov/pubmed/27036717>

<sup>32</sup> Kevany, S. (2015). The United States' Response to Ebola. *The New York Times*, Letters to the Editor. [http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?\\_r=0](http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?_r=0)

<sup>33</sup> Larkan F, Ryan C\*, Kevany S. (2015). The Geopolitics of Ebola and Global Health Security: Why Anthropology Matters. *Irish Journal of Anthropology*, Vol, 18, 1.

My related work attempts to illustrate that, in the 21<sup>st</sup> century, international political or ideological allegiances (however futile or illusory they may ultimately be) are no longer necessarily won by arms supply or *coup d'états*. Instead, it is the most diplomatically altruistic – rather than most militarily-generous – benefactors that now advance spheres of influence. References to such approaches in the global health context is therefore applied throughout this review to (1) capture professional experiences (and related research papers) in key combined strategic and epidemiological settings such as North Africa<sup>34</sup> and the Middle East<sup>35</sup> and also (2) build on prior research, literature and policy statements demonstrating that it is those health programs that are most in tune with local cultures, values, societies, and norms that are both best-utilized<sup>36</sup> and stand to more effectively win, from a diplomatic perspective, ‘hearts and minds’.<sup>37</sup>

## 2. Structural Overview

This overview of my past work and demonstration of my original contribution is divided in to seven sub-sections. Therein, I present four sets of original academic contributions to knowledge on the current relevance and remedial qualities of global health to four realms of conflict: prevention, resolution, counter terrorism, and security. These sections focus on my observational academic and professional experience in countries such as Iraq, Afghanistan, and South Sudan. Although reviewing and analyzing actual events, the success of selected global health programs in each of these realms is also contrasted with the broader *status quo*: as well as their health benefits, such HIV/AIDS, tuberculosis, and malaria treatment and prevention initiatives have implications for peace building and keeping but currently only - given the lack of appropriate parameters and structures - on an *ad hoc* basis.

This is followed by an exploration of three further combined academic and practical findings that link my original contributions to knowledge throughout my past work, namely that (1)

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<sup>34</sup> Kevany, S. et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Medicine, Conflict and Survival*, July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>35</sup> Kevany, S. (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival*, 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>

<sup>36</sup> Global Health Initiative. (2012). US government interagency paper on country ownership. Retrieved from <http://www.ghi.gov/documents/organization/195554.pdf>

<sup>37</sup> Obama, B. (2014, May 29). Full transcript of President Obama's commencement address at West Point. *The Washington Post*. Retrieved from [http://www.washingtonpost.com/politics/full-text-of-president-obamas-commencement-address-at-west-point/2014/05/28/cfbcdcaa-e670-11e3-afc6-a1dd9407abcf\\_story.html](http://www.washingtonpost.com/politics/full-text-of-president-obamas-commencement-address-at-west-point/2014/05/28/cfbcdcaa-e670-11e3-afc6-a1dd9407abcf_story.html)

contemporary approaches to global health program design, selection, delivery and evaluation - when viewed from the security and diplomatic perspectives - can be improved; (2) parameters of smart or diplomatic approaches to global health program design can be generated and applied; and (3) appropriate means by which smart or diplomatic approaches to global health program design, selection and delivery can be identified and implemented.

Throughout, I also demonstrate how my original contributions have built on past and current research in the fields of international relations, diplomacy, and global health and development. This includes, for example, (1) explorations at the institutional level of the diplomatic value of humanitarian programs by the Royal Institute for International Affairs<sup>38</sup> and the Center for Strategic and International Studies<sup>39</sup>; (2) bilateral<sup>40</sup> and multilateral<sup>41</sup> policy initiatives in the field of international relations, diplomacy, and global health; and (3) my collaborations with leaders in the field of global health diplomacy.<sup>42</sup> In particular, my research has advanced many of the nascent arguments presented in these and other publications and research initiatives related to optimizing synergies between health and diplomatic efforts. My work has also synthesized, in an original and innovative manner, many of the competing definitions of terms such as global health diplomacy and smart global health currently in use academically,<sup>43</sup> politically,<sup>44</sup> and in the broader policy context.<sup>45</sup>

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<sup>38</sup> Royal Institute for International Affairs. (2010). Global health diplomacy: A way forward in international affairs. *Chatham House*, meeting summary document. Retrieved from <http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/280611summary.pdf>

<sup>39</sup> Center for Strategic and International Studies. (2010). Final report of the CSIS Commission on smart global health policy. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>

<sup>40</sup> Walensky, R. & Kuritzkes, D. (2010). The impact of the President's Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and why it remains essential. *Clinical Infectious Diseases*, 50(2), 272–275. doi:10.1086/649214

<sup>41</sup> Rodriguez-Garcia, R. (2001). How can health serve as a bridge for peace? *George Washington University Medical School Research Paper*. Retrieved from <http://www.certi.org/publications/policy/gwc-12a.pdf>

<sup>42</sup> Novotny, T. & Kevany, S. (2013). The way forward in global health diplomacy: Definitions, research, and training. In T. Novotny, I. Kickbusch, & M. Told (Eds.), *21st century health diplomacy* (pp. 203–225). Geneva: World Scientific; Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocations for health and HIV in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570–587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>

<sup>43</sup> Lee, K., & Gomez, E. (2012). Brazil's ascendance: The soft power role of global health diplomacy. *The World Financial Review*. Retrieved from <http://www.worldfinancialreview.com/?p=414>

<sup>44</sup> Feldbaum, H. (2010). Global health and foreign policy. *Epidemiological Review*, 32, 82–92. Retrieved from [www.epirev.oxfordjournals.org/content/32/1/82.full](http://www.epirev.oxfordjournals.org/content/32/1/82.full)

<sup>45</sup> Michaud, J., & Kates, J. (2013). Global health diplomacy: Advancing foreign policy and global health interests. *Global Health: Science & Practice*, 1(1), 24–28. Retrieved from <http://www.ghspjournal.org/content/1/1/24.full>

### 3. Personal Statement

Herein, I have also reviewed my published efforts in the context of my academic and professional experience, which (in brief) has included over one hundred field missions, many to conflict or post-conflict settings such as Sudan,<sup>46</sup> South Sudan,<sup>47</sup> Afghanistan,<sup>48</sup> Iraq,<sup>49</sup> Egypt and Sierra Leone. These have been performed as part of global health consulting or academic duties covering monitoring and evaluation, health diplomacy, program evaluation, and strategic assessments for a range of bilateral and multilateral institutions including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Irish Department of Foreign Affairs, the United Nations Development Program, the University of California, and the Australian Department of Foreign Affairs.

My development of original diplomatic evaluation and program design perspectives for global health, humanitarian and other development programs was, however, initially based on the exploration of the downstream, non-health effects of large-scale HIV/AIDS treatment programs in South Africa.<sup>50</sup> This concept was further developed based on extensive field work on health and humanitarian programs in Zimbabwe, Tanzania, and Thailand, which highlighted positive synergies between smart health programs, diplomacy, security, and political stability.<sup>52</sup> In all of these countries, and in each of the early stages of

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<sup>46</sup> Kevany S (2014). International Access and Global Health Diplomacy in Sudan. *The Lancet Global Health*. <http://globalhealth.thelancet.com/2014/05/02/international-access-and-global-health-diplomacy-sudan>

<sup>47</sup> Kevany, S et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Medicine, Conflict and Survival*, July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>48</sup> Kevany, S., Sahak, O., Workneh, N. & Saeedzai, A. (2014). Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs. *Medicine, Conflict and Survival*, 30:1, 37-55. <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>

<sup>49</sup> Kevany, S. et al (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival*, 30 (2). <http://dx.doi.org/10.1080/13623699.2014.890827>

<sup>50</sup> Kevany, S., Meintjes, G., Rebe, K., Maartens, G., & Cleary, S. (2010). Clinical and financial burdens of secondary level care in a public sector antiretroviral roll-out setting (G. F. Jooste Hospital). *South African Medical Journal*, 99(5): 320-5. <http://www.ncbi.nlm.nih.gov/pubmed/19588792>

<sup>51</sup> Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocations for health and HIV in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570–587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>

<sup>52</sup> Kevany, S., Khumalo-Sakutukwa, G., Singh, B., Chingono, A., Morin, S., & NIMH Project Accept Study Team. (2016). Global Health Diplomacy, Monitoring & Evaluation, and the Importance of Quality Assurance & Control: Findings from NIMH Project Accept (HPTN 043): A Phase III Randomized Controlled Trial of Community Mobilization, Mobile Testing, Same-Day Results, and Post-Test Support for HIV in Sub-Saharan Africa and Thailand. *PloS one*, 11(2), e0149335; Kevany, S et al (2012). Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. *BMC Public Health*, 12: (459): 1-11. <http://www.biomedcentral.com/1471-2458/12/459/abstract>

my work, I built on and advanced prior research findings related to the unintended consequences of humanitarian assistance<sup>53</sup> and the integration of the theory and practice of diplomacy into global health programs.<sup>54</sup>

In turn, and based on field experience in conflict and post-conflict settings, I sought to build on prior literature on the actual and potential role of appropriately selected, designed and delivered humanitarian aid programs to peace keeping<sup>55</sup> and nation building.<sup>56</sup> My associated research outputs and professional experience led to a list of principles – collated from related research efforts<sup>57</sup> and unified, for the first time, to optimize the collateral benefits of global health programs without compromising (instead, enhancing) primary programmatic goals<sup>58</sup> – as well as my development of an original tool for program evaluation.<sup>59</sup> My key conclusions were then summarized in short commentary pieces in the United Kingdom,<sup>60</sup> the United States,<sup>61</sup> and Ireland.<sup>62</sup> I have also demonstrated the applicability of these approaches in the military<sup>63</sup> and counter-terrorism<sup>64</sup> contexts.

The methods I employed to achieve this included observational research, semi-structured or informal interviews, and operational research findings based on the overlaps, where they

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<sup>53</sup> Jan, S. (1998). A holistic approach to the economic evaluation of health programs using institutionalist methodology. *Social Science & Medicine*, 47, 1565–1572. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0277953698002287>

<sup>54</sup> Kickbusch, I., & Buss, P. (2011). Global health diplomacy and peace. *Infectious Disease Clinics of North America*, 25, 601–610. doi:10.1016/j.idc.2011.05.006

<sup>55</sup> Kickbusch, I., & Buss, P. (2011). Global health diplomacy and peace. *Infectious Disease Clinics of North America*, 25, 601–610. doi:10.1016/j.idc.2011.05.006

<sup>56</sup> Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4). Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000226>

<sup>57</sup> Jaffe, S. (2013). The USA and global health diplomacy: Goals and challenges. *The Lancet*, 381, 1087. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60746-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60746-1/fulltext)

<sup>58</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.92121 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>59</sup> Kevany S (2015). Diplomatic advantages and threats in global health program selection, design, delivery and implementation: development and application of the Kevany Riposte. *Globalization and Health*, 11(1):22. [www.globalizationandhealth.com/content/11/1/22](http://www.globalizationandhealth.com/content/11/1/22)

<sup>60</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84.

<sup>61</sup> Kevany S. (2016). HIV/AIDS, Global Health Diplomacy, and “San Francisco Values”: From the Local to the Global. *Annals of Global Health*, Sep-Oct; 81(5):611-7. <http://www.ncbi.nlm.nih.gov/pubmed/27036717>

<sup>62</sup> Kevany, S., & Brugha, R. (2015). Irish Aid and Diplomacy in the Twenty-first Century: Optimising Enlightened Self-Interest, Supranational Priorities and Foreign Policy Impact. *Irish Studies in International Affairs*, 26, 207-225.

<sup>63</sup> Kevany, S. and Baker, M. (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016.

<sup>64</sup> Kevany, S. (2016). Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards. *Journal of Policing, Intelligence and Counter Terrorism*, 11(1), 84-92. <http://www.tandfonline.com/doi/full/10.1080/18335330.2016.1161225>

existed, with consulting or academic duties for organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria or the University of California, San Francisco (UCSF) respectively. In all cases, and particularly where my findings synergized with consultancy or other duties, all necessary publication permissions were sought from the respective organization(s). Similarly, in many cases, consultancy employers or academic colleagues were co-authors on the associated publications.<sup>65</sup>

As a result of this approach, my publications were designed to add to and advance not only academic investigation (as presented in Findings 1 to 4 below) but also the practical, policy and operational understanding of the design and delivery of smart global health programs (as presented in Findings 5 to 7). This distinction is also broadly representative of the chronological sequence of my published work, which evolved from academic analyses to the generation of more practical and policy-oriented efforts, though there is not a direct or exact correlation between this evolution and date of related publication.

Finally, throughout my academic and professional experience, I have sought to support and advance prior research findings that international health, aid, humanitarian and development funding is increasingly reliant on demonstrating diplomatic and other collateral value.<sup>66</sup> In turn, where possible, such programs have also been increasingly required to demonstrate their capacity to advance strategic,<sup>67</sup> political,<sup>68</sup> and diplomatic<sup>69</sup> (as well as altruistic) objectives.<sup>70</sup> I therefore sought throughout my research both to unify and add to these arguments in order to create a more compelling case, accepted across the political spectrum, for investment by affluent countries in the health of the world's poorest people.<sup>71</sup>

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<sup>65</sup> A full list of co-authors, combined with their approximate percentage contribution, is provided in Annex 1. These levels of contribution were confirmed by subsequent correspondence, and formed part of my application to the University of Westminster for this doctorate by past work.

<sup>66</sup> American Foundation for AIDS Research. (2013). U.S. global health investments: The evidence on health, diplomatic and economic impact. *AMFAR Issue Brief*, Retrieved from <http://www.amrefusa.org/silo/files/amfar-global-health-investment-impact-june-2011.pdf>

<sup>67</sup> Burkle, S. (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*, 28(3), 1-3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591>

<sup>68</sup> Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4). Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000226>

<sup>69</sup> Michaud, J., & Kates, J. (2013). Global health diplomacy: Advancing foreign policy and global health interests. *Global Health: Science & Practice*, 1(1), 24-28. Retrieved from <http://www.ghspjournal.org/content/1/1/24.full>

<sup>70</sup> Lords Select Committee. (2011). Does UK aid make the right difference? Retrieved from <http://www.parliament.uk/business/committees/committees-a-z/lords-select/economic-affairscommittee/news/aidinquiry—evidence-session-5-july/>

<sup>71</sup> Despite the orientation of my past work towards the design and delivery of global health programs, the philosophical tradition I attempt to originally contribute to and advance is focused on political



## Part Two – Original Findings and Contributions to Knowledge

**Finding 1: That smart global health efforts contribute to conflict prevention by removing sources of civil or international tension, thereby functioning on both altruistic and ‘world peace’ levels.**

Global health programs for communicable diseases such as HIV/AIDS, tuberculosis and malaria, as well as health system strengthening operations, are now nearly universal in scope and reach: in almost every nation, some form of bilateral or multilateral donor or recipient assistance program is in place.<sup>72</sup> The primary objective of these programs is to alleviate illness and disease amongst the world’s poorest people.<sup>73</sup> In order to achieve this, two key elements are required: (1) international support for such altruistic efforts, and (2) delivery of well-designed intervention response programs.<sup>74</sup> Over the past ten years, I have been extensively involved with the design, delivery, monitoring, evaluation and documentation of such initiatives in a wide range of settings, from Afghanistan to Zimbabwe. My objective, in this section, is to demonstrate my contributions to knowledge in documenting programmatic value in not just the health, but also the non-health political, stability, and strategic realms.

Throughout my field and research experience, it became clear that – in both stable and unstable settings, though magnified in the latter – there was scope for further original contributions to prior findings on the benign (and occasionally malign) downstream impact of humanitarian efforts beyond the medical: their unintended consequences,<sup>75</sup> collateral or downstream effects,<sup>76</sup> and positive or negative externalities.<sup>77</sup> For example, my work focused

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economy (e.g. Rawlsian theories of social justice ) and economic theory (e.g. post-utilitarianism ). In addition, the theories of Emanuel Kant, including the potential contributions of health and development programs to world security, stability and cooperation, represent a key influence: in this regard, I have sought both to modernize, and find contemporary applications for, his ‘philosophical sketch’ of perpetual world peace in the fields of smart global health and global health diplomacy.

<sup>72</sup> Chattu, V. (2017). The rise of global health diplomacy: An interdisciplinary concept linking health and international relations. *Indian Journal of Public Health*, 61(2), 134.

<sup>73</sup> World Health Organization. (2012, November). The right to health. Fact sheet 323. Retrieved from <http://www.who.int/mediacentre/factsheets/fs323/en/index.html>

<sup>74</sup> Walensky, R., & Kuritzkes, D. (2010). The impact of the President’s Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and why it remains essential. *Clinical Infectious Diseases*, 50(2), 272–275. doi:10.1086/649214

<sup>75</sup> Lyman, N. & Wittels, S. (2010). No good deed goes unpunished: The unintended consequences of Washington’s HIV/AIDS programs. *Foreign Affairs*, July–August 2010. Retrieved from <http://www.foreignaffairs.com/articles/66464/princeton-n-lyman-and-stephen-bwittels/no-good-deed-goes-unpunished>

<sup>76</sup> McInnes, C., & Lee, K. (2006). Health, security and foreign policy. *Review of International Studies*, 32, 5–23. doi:10.1017/S0260210506006905

on advancing prior related research findings that some global health efforts related to HIV/AIDS in Tanzania, Thailand and elsewhere may inadvertently challenge local cultural or religious norms,<sup>78</sup> while other efforts (also often inadvertently) may have positive implications for political stability, nation-building, and security.<sup>79</sup>

In addition to advancing understanding of the indirect effects of global health programs as conflict prevention mechanisms,<sup>80</sup> my past work also recognized the importance of building on prior academic and applied efforts to develop new systems for international cooperation and stability – in many ways, synonyms for conflict prevention – under the auspices of the smart power paradigm.<sup>81</sup> Prior literature has shown that such traditional and distinct – if not siloed – international relations, aid and diplomacy paradigms and techniques continue to be critical elements of both bilateral and multilateral efforts to prevent international conflict,<sup>82</sup> as do (as a last resort) hard power humanitarian intervention efforts.<sup>83</sup>

Yet, my academic and professional experience also found that the *status quo* has not met with unqualified or even consistent success: at both national and international levels, there is an ongoing need for innovative and interdisciplinary systems of preventing conflict. At the intersection of these dual research agendas, my original contributions to knowledge focused on the review, analysis and evaluation of health programs that had demonstrated – when appropriately selected, designed and delivered – their potential impact beyond health in the realms of international relations, domestic and international security, and conflict prevention.<sup>84</sup>

My past work has sought to demonstrate that those global health programs designed with smart or diplomatic considerations in mind may hold the key to ensuring the consistent

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<sup>77</sup> Jan, S. (1998). A holistic approach to the economic evaluation of health programs using institutionalist methodology. *Social Science & Medicine*, 47, 1565–1572. Retrieved from [www.sciencedirect.com/science/article/pii/S0277953698002287](http://www.sciencedirect.com/science/article/pii/S0277953698002287)

<sup>78</sup> Katz, R. and, Kornblat, S. (2011). Defining health diplomacy: Changing demands in the era of globalization. *The Milbank Quarterly*, 89, 503–523. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00637.x/abstract>

<sup>79</sup> Katz, R., & Singer, D. (2007). Health and security in foreign policy. *Bulletin of the World Health Organization*, 85, 233–234. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/>

<sup>80</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.921211 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>81</sup> Center for Strategic and International Studies. (2007). CSIS commission on smart power. Retrieved from [http://csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)

<sup>82</sup> Brainard, L. (2006). *Security by other means*. Washington, DC: Brookings Institution Press.

<sup>83</sup> Hehir, A (2009). *Humanitarian Intervention: An Introduction*. London: Palgrave.

<sup>84</sup> Kevany, S. (2014). Global Health Diplomacy: A ‘Deus ex Machina’ for International Development and Relations. *International Journal of Health Policy and Management*, 3(2): 111–112. [www.ijhpm.com/pdf/2867\\_7dfa3b1a8850ce1070ef08fb0d0204be.html](http://www.ijhpm.com/pdf/2867_7dfa3b1a8850ce1070ef08fb0d0204be.html)

effectiveness of HIV/AIDS, tuberculosis, or malaria efforts in the non-health context, and – critically – without such interdigitation reducing impact of primary programmatic health goals. Building on the *Cool Wars* paradigm,<sup>85</sup> which suggests that global spheres of influence will no longer be dominated by military or ideological allegiances, such approaches also function to prevent conflict (at both national and international levels) through the inculcation of broader strategic and security awarenesses in previously narrow areas of development focus.<sup>86</sup>

I found that, to enhance the capacity and influence of global health efforts in the realm of conflict prevention (in, for example, the context of Southern Sudan’s civil and successional wars), key programmatic design features included adaptability,<sup>87</sup> sustainability,<sup>88</sup> the advancement of local ownership and involvement in service delivery,<sup>89</sup> and the selection of cost-effective responses to disease threats,<sup>90</sup> as well as responsiveness in program design to all forms of cultural, social, political, economic and religious sensitivities.<sup>91</sup> When mindful of these considerations, the functionality of global health was found to have the power to operate simultaneously on health, altruistic, and national and international stability levels.<sup>92</sup> While prior research and literature has identified these features on an *ad hoc* or piecemeal basis (e.g. Feldbaum<sup>93</sup> [2010] in the context of American foreign policy and Michaud et al<sup>94</sup>

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<sup>85</sup> Feldman, N (2013). *Cool Wars: The Future of Global Competition*. New York: Penguin

<sup>86</sup> Center for Strategic and International Studies. (2010). Final report of the CSIS Commission on smart global health policy. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>

<sup>87</sup> Kevany, S. et al (2012). Health diplomacy and adapting global health interventions to local needs. *BMC Public Health*, 12, 459. Retrieved from <http://www.biomedcentral.com/1471-2458/12/459/abstract>

<sup>88</sup> Kevany, S. (2014). Global Health Diplomacy: A ‘Deus ex Machina’ for International Development and Relations. *International Journal of Health Policy and Management*, 3(2): 111–112. [www.ijhpm.com/pdf/2867\\_7dfa3b1a8850ce1070ef08fb0d0204be.html](http://www.ijhpm.com/pdf/2867_7dfa3b1a8850ce1070ef08fb0d0204be.html)

<sup>89</sup> Kevany S. (2016). HIV/AIDS, Global Health Diplomacy, and “San Francisco Values”: From the Local to the Global. *Annals of Global Health*, Sep-Oct; 81(5):611-7. <http://www.ncbi.nlm.nih.gov/pubmed/27036717>

<sup>90</sup> Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocations for health and HIV in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570–587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>

<sup>91</sup> Kevany, S. et al (2012). Health diplomacy and adapting global health interventions to local needs. *BMC Public Health*, 12, 459. Retrieved from <http://www.biomedcentral.com/1471-2458/12/459/abstract>

<sup>92</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84. [http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)00245-4/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00245-4/fulltext)

<sup>93</sup> Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4). Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000226>

<sup>94</sup> Michaud, J., Moss, K., & Kates, J. (2012). U.S. global health policy: The U.S. Department of Defense and global health. Kaiser Family Foundation Policy Review Document.

[2012] regarding international security), my original contribution to knowledge in this regard has been the synthesis, collation, and formalization of such criteria.

Based on my field experience in the South Sudan<sup>95</sup> and the Republic of the Sudan<sup>96</sup> settings, I observed that many global health programs were – either by accident or design – already partially yet successfully functioning in this holistic manner. Although subsequent conflict has taken place in South Sudan, I observed and documented efforts to develop and implement smarter (or cooler, acknowledging the *Cool Wars*<sup>97</sup> paradigm) programs that indirectly advanced internal, tribal and regional cooperation in the Western Equatoria and Bhar el-Ghazaal provinces. This included improvements in governance and coordination across the new country (and in the immediate pre-secession era) via the health sector, as well as improved communication and harmonization of health initiatives at local, national and international levels.<sup>98</sup>

Of key importance in achieving such synergies was, as documented in my research,<sup>99</sup> the adaptation of health programs to align with political, security and diplomatic considerations. With my recognition that fragile states such as South Sudan and Zimbabwe required extensive changes to service delivery efforts based on local conditions, the primacy of broader strategic and stability considerations versus achievement of narrow programmatic goals in limited timeframes was also established. Through the enlightened,<sup>100</sup> holistic approach to global health program design, evaluation and delivery that my work has posited, potential sources of national and international conflict and tension in both countries may have been, however fractionally, reduced.

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<sup>95</sup> Kevany, S. et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: Contributions of monitoring and evaluation systems to ‘nation-building’ in South Sudan. *Medicine, Conflict and Survival*, 28, 247–262. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>96</sup> Kevany, S. (2014). International Access and Global Health Diplomacy in Sudan. *The Lancet Global Health*, <http://globalhealth.thelancet.com/2014/05/02/international-access-and-global-health-diplomacy-sudan>

<sup>97</sup> Feldman, N. (2013). *Cool Wars: The Future of Global Competition*. Random House: New York.

<sup>98</sup> Kevany, S. et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: Contributions of monitoring and evaluation systems to ‘nation-building’ in South Sudan. *Medicine, Conflict and Survival*, 28, 247–262. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>99</sup> Kevany, S. et al (2012). Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. *BMC Public Health*, 12: (459): 1-11. <http://www.biomedcentral.com/1471-2458/12/459/abstract>

<sup>100</sup> Kevany, S., Fleischer, T., & Benatar, S. (2013). Improving resource allocation decisions for health and HIV programmes in South Africa: bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8 (5): 570-87. <http://www.ncbi.nlm.nih.gov/pubmed/23651436>

Similarly, in North Sudan, my field experience indicated that investment in global health efforts improved both international communications and cooperation as well as access to otherwise ‘off-limits’ areas.<sup>101</sup> My work has built on, and attempted to prove, this assertion by articulating that optimization of the dual role of diplomatic global health programs represents an innovative, practical – and, to date, underutilized – element of the 21<sup>st</sup> century foreign policy tool kit. In order to further advance the impact of HIV/AIDS, tuberculosis, malaria and health system strengthening efforts in the realms of conflict prevention and national and international cooperation) described in prior research and literature as ‘Health as a Bridge for Peace’<sup>102</sup>) the need for a system of design that inculcated diplomatic awareness in to altruistic efforts was therefore found to be of key importance. My past work has helped to fill this gap in contemporary knowledge on a situation-specific basis, including the contribution of global health programs to counter-terrorism efforts.

**Finding 2: That global health programs facilitate counterterrorism efforts by removing sources of grievance.**

National and international terrorism is one of the greatest security threats of the 21st century.<sup>103</sup> Rather than pursue ideological or strategic agendas through conventional warfare, for which many states or population groups are ill-equipped, terrorist attacks represent a highly effective alternative to open conflict. In many cases, prior research has found that these attacks may also be precipitated by the accumulation of economic, developmental, or other grievances<sup>104</sup> including low levels of health service provision in resource-poor settings.<sup>105</sup> No contemporary examination of national and international security is therefore complete without reference to the potential impact and effect of international health programs as a counter terrorism measure,<sup>106</sup> the theory and practice of which I have originally contributed to in my past work.

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<sup>101</sup> Kevany, S. (2014). International Access and Global Health Diplomacy in Sudan. *The Lancet Global Health*, <http://globalhealth.thelancet.com/2014/05/02/international-access-and-global-health-diplomacy-sudan>

<sup>102</sup> Rodriguez-Garcia, R. (2001). How can health serve as a bridge for peace? George Washington University Medical School Research Paper. Retrieved from <http://www.certi.org/publications/policy/gwc-12a.pdf>

<sup>103</sup> Burkle, S. (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*, 28(3), 1–3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591>

<sup>104</sup> Eckenwiler, L., & Hunt, M. (2014). Counterterrorism, ethics, and global health .Hastings Center Report. doi:10.1002/hast.308

<sup>105</sup> Center for Strategic and International Studies. (2010). Final report of the CSIS Commission on smart global health policy. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>

<sup>106</sup> Williams, P. (Ed.). (2012). Security studies: an introduction. Routledge.

Based on my field experience in many countries associated with terrorism (e.g. Iraq, North Sudan, and Afghanistan), global health programs emerged as a possible counter terrorism measure via mitigating a key source of international resentment. This observation is in keeping with related prior research findings:<sup>107</sup> by acting to redress global inequalities in health care funding, provision, and quality via efforts to reduce levels of HIV/AIDS, malaria or tuberculosis, one of the key motives for terrorist outrages – resentment against perceptions of exploitation or inequality – was removed,<sup>108</sup> thereby undermining support for (and the attraction of) extremism.

My work also built on prior research findings demonstrating that global health efforts, particularly if characterized by sensitivity to recipient community needs, could be highly effective in both health and non-health realms -- including as effective counter terrorism initiatives.<sup>109</sup> This finding was based on evaluation and analysis of the activities of bilateral and multilateral actors with whom I worked, as well as the use of health and development programs by military forces.<sup>110</sup> Of note, the latter were in many cases already in place in counter-terrorism settings, and were therefore (in keeping with prior research) often ideally positioned to engage in smart global health initiatives.<sup>111</sup>

In order for global health efforts to act as both counter terrorism and humanitarian endeavors, my professional experiences also supported prior research findings that it was first necessary to ensure that the programs themselves do not become targets of extremism.<sup>112</sup> Prior research had shown that – if identified as direct or even proxy actors against terrorism, or suspected of advancing ideological or counter-ideological agendas – program buildings and staff may quickly become targets.<sup>113</sup> The maintenance of

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<sup>107</sup> Michaud, J., Moss, K., & Kates, J. (2012). U.S. global health policy: The U.S. Department of Defense and global health. Kaiser Family Foundation Policy Review Document.

<sup>108</sup> Eckenwiler, L., & Hunt, M. (2014). Counterterrorism, ethics, and global health. *Hastings Center Report*, 44(3), 12-13.

<sup>109</sup> Kevany, S. (2016). Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards. *Journal of Policing, Intelligence and Counter Terrorism*, 11(1), 84-92. <http://www.tandfonline.com/doi/full/10.1080/18335330.2016.1161225>

<sup>110</sup> Kevany S and Baker M (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016.

<sup>111</sup> Eckenwiler, L., & Hunt, M. (2017). Health and security: ethical principles for counter-terror policy and practice in protection crises and beyond. *Medicine, conflict and survival*, 14 (3): 1-14.

<sup>112</sup> Kevany, S. (2016). Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards. *Journal of Policing, Intelligence and Counter Terrorism*, 11(1), 84-92. <http://www.tandfonline.com/doi/full/10.1080/18335330.2016.1161225>

<sup>113</sup> Al-Hawdrawi, H. H., Sadeq, A. F., Diener, E., Wright, V., & Alobaidi, W. (2017). The Lived Experience of Iraqi Nurses who Live and Work in Communities Impacted by War or Terrorist Threat. *Research Journal of Pharmacy and Technology*, 10(7), 2058-2062.

organizational and operational independence of global health efforts from the work of official counter terrorist organizations was therefore identified as paramount.

Yet global health programs were also observed, based on my academic and professional experience, to act against terrorism in other (less explicit) ways, and without compromising disciplinary integrity. In Afghanistan, for example, malaria programs run by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United Nations Development Program, amongst other organizations, operated in provinces inaccessible to the military<sup>114</sup> with only the urgency of local health needs allowing for the establishment of any form of international presence. Through such efforts, and for the first time, my work demonstrated that (for example) malaria programs were able to provide services in a way that respected local cultures, religions, politics and society. In this way, and building on prior research,<sup>115</sup> secure international access to and presence in ever more remote and hostile regions was achieved in an increasingly cooperative way.

Although my research found that gains in counter terrorism in South Sudan, Iraq and Afghanistan (amongst other settings) made through such efforts were unquantifiable, the research and field evidence presented in my portfolio taken collectively suggests that there has been a significant impact in reducing negative perceptions of donor countries and organizations through global health. Specifically, this synergy occurred when health programs were also designed in a way that inculcated awareness of both local and international security imperatives -- yet without advancing such a purview in to the realm of suspected military or espionage collaboration, for which global health workers have in the past been targeted.<sup>116</sup> Such findings were (1) both supported by prior research, which had previously documented the opportunities and risks of such 'hearts and minds' efforts, and (2) built on these findings by articulating the specific processes (e.g. the interdisciplinary and collaborative design of global health programs, including expertise in the fields of international relations and diplomacy) and design criteria (e.g. those aspects of program design that produced diplomatic as well as altruistic dividends) that led to these enhanced effects.

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<sup>114</sup> Kevany, S., Sahak, O., Workneh, N. & Saeedzai, A. (2014). Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs. *Medicine, Conflict and Survival*, 30:1, 37-55. <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>

<sup>115</sup> Howard, N., A. Shafi, C. Jones, and M. Rowland. 2010. Malaria Control under the Taliban Regime: Insecticide-treated Net Purchasing, Coverage, and Usage among Men and Women in Eastern Afghanistan. *Malaria Journal* 9: 7.

<sup>116</sup> Gostin, L. (2014). Global polio eradication: espionage, disinformation, and the politics of vaccination. *The Milbank Quarterly*, 92(3), 413-417.

Other original opportunities to improve the capacity of global health to act as counter terrorism operations at both policy and service delivery levels presented in my past research include (1) the allocation of health resources across regions, programs and population groups based on the dual consideration of both strategic and medical goals (as opposed to the past acceptance of the primacy of cost-effectiveness analyses in such decisions<sup>117</sup>) and (2) improved consciousness amongst previously siloed global health organizations (and their staff) of the latent benign strategic and security implications of their activities.<sup>118</sup>

Similarly – and while, again, maintaining operational independence – my research supported the established and accepted concept that smarter or more diplomatic global health programs improve staff safety by reducing past tendencies to operate in isolation from military, intelligence and security organizations.<sup>119</sup> Without compromising programmatic integrity, the development of joint liaisons, initiatives and operations to identify, align and coordinate common objectives formed a key element of my original interpretation of the global health diplomacy paradigm.<sup>120</sup>

In particular, the seemingly irreconcilable attempt to ensure that global health programs and institutions maintain operational independence while also contributing to non-health strategic or counter-terrorism goals was found, in my work, to be dependent on the medical and health community's willingness to control the governance of such collaborations.<sup>121</sup> Without such effort, there is the risk that global health programs will, once again, be commandeered for such purposes without appropriate consultation and collaboration.<sup>122</sup> I

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<sup>117</sup> Kevany, S., Fleischer, T., & Benatar, S. (2013). Improving resource allocation decisions for health and HIV programmes in South Africa: bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8 (5): 570-87. <http://www.ncbi.nlm.nih.gov/pubmed/23651436>

<sup>118</sup> Kevany, S. (2015). James Bond and Global Health Diplomacy. *International Journal of Health Policy & Management*. Editorial commentary. 4 (x): 1-4. [http://www.ijhpm.com/article\\_3098\\_0.html](http://www.ijhpm.com/article_3098_0.html)

<sup>119</sup> Burkle, S. (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*, 28(3), 1-3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591>

<sup>120</sup> Novotny, T. & Kevany, S. (2012). The Way Forward in Global Health Diplomacy: Definitions, Research, and Training. Book chapter in: *21st Century Health Diplomacy*. <http://www.worldscientific.com/worldscibooks/10.1142/8178>

<sup>121</sup> Kevany S (2015). James Bond and Global Health Diplomacy. *International Journal of Health Policy & Management*, Editorial commentary. 4 (x): 1-4. [http://www.ijhpm.com/article\\_3098\\_0.html](http://www.ijhpm.com/article_3098_0.html)

<sup>122</sup> Gostin, L. (2014). Global polio eradication: espionage, disinformation, and the politics of vaccination. *The Milbank Quarterly*, 92(3), pp.413-417.



suggest that the onus, even today, may therefore still remain on the global health community and its governing organizations (e.g. the World Health Organization) in this regard.<sup>123</sup>

Other opportunities for global health to counter terrorism – identified in past research and further documented and demonstrated in my work – were found to include conscious efforts by global health programs to (1) win ‘hearts and minds’ in remote or isolated regions otherwise susceptible to extremist doctrine<sup>124</sup> and (2) avoid implementation of interventions (however cost-effective they may be) likely to incite religious, social or cultural sensitivities among recipient populations.<sup>125</sup> These considerations were, however, rarely (if ever) found to have been part of the scientific protocols that governed service design and delivery. It was this gap that this element of my past research was designed to fill.

In this regard, my (and other prior<sup>126</sup>) work also highlighted the need to review global health programs and activities from the perspective of their capacity to aid, abet, or facilitate extremist organizations by (either consciously or inadvertently) providing health care to terrorists, extremists, or their support networks and organizations. However, rather than advocating for selected denial of care, such awareness was instead designed to ensure that health efforts were sensitive to both the potential negative *and* positive consequences they may make to local and international security.<sup>127</sup> In my examination of the prior literature, no formal mechanisms for generating such awareness amongst the global health community were found to exist.<sup>128</sup>

I concede that the latter findings are to some extent subjective: alternate interpretations of global health provision to terrorist groups (identified in both my past and other prior

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<sup>123</sup> Kevany S. (2016). Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards. *Journal of Policing, Intelligence and Counter Terrorism*, 11(1), 84-92. <http://www.tandfonline.com/doi/full/10.1080/18335330.2016.1161225>

<sup>124</sup> Kevany S, Sahak O, Workneh N & Saeedzai A (2014). Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs. *Medicine, Conflict and Survival*, 30:1, 37-55. <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>

<sup>125</sup> Kevany, S. et al (2012). Health diplomacy and adapting global health interventions to local needs. *BMC Public Health*, 12, 459. Retrieved from <http://www.biomedcentral.com/1471-2458/12/459/abstract>

<sup>126</sup> Stephan, M., & Beyerle, S. (2015). How to stop extremism before it starts. *Foreign Policy*. Retrieved from <http://foreignpolicy.com/2015/03/17/how-to-stop-extremism-before-it-starts/>

<sup>127</sup> Eckenwiler, L., & Hunt, M. (2014). Counterterrorism, ethics, and global health. Hastings Center Report. doi:10.1002/hast.308

<sup>128</sup> Kevany, S. (2015). James Bond and Global Health Diplomacy. *International Journal of Health Policy & Management, Editorial commentary*. 4 (x): 1-4. [http://www.ijhpm.com/article\\_3098\\_0.html](http://www.ijhpm.com/article_3098_0.html)

research) consider such services as reducing negative perceptions of donor countries.<sup>129</sup> In either scenario, however, my research reached the original conclusion that global health agencies and actors should attempt to both independently (and collaboratively) control and optimize the leveraging of their geostrategic access to off-limits regions for both strategic and altruistic ends, rather than cede control of these choices to security institutions.<sup>130</sup>

### **Finding 3: That smart global health approaches are effective in resolving tensions in conflict settings.**

Original efforts to resolve national and international tensions in conflict and post-conflict countries and regions, as well as contribute to both health and national reconstruction, have been documented in my work in settings such as Iraq,<sup>131</sup> South Sudan,<sup>132</sup> Afghanistan,<sup>133</sup> Papua New Guinea,<sup>134</sup> and Sierra Leone.<sup>135</sup> In all cases – while health programs that respond effectively and efficiently to epidemic threats in such settings are of key importance in their own right – my research supported prior findings that their value is exponentially increased in (synergistically) both health and non-health realms when more abstract concepts such as sustainability and local ownership are taken in to account.<sup>136</sup> The aim of this section is therefore to summarize my original findings on ways of optimizing global health program effectiveness in the conflict resolution realm.

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<sup>129</sup> Kevany, S. (2014). Global health diplomacy, 'Smart Power', and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.921219 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>130</sup> Kevany, S. (2016). Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards. *Journal of Policing, Intelligence and Counter Terrorism*, 11(1), 84-92. <http://www.tandfonline.com/doi/full/10.1080/18335330.2016.1161225>

<sup>131</sup> Kevany S, Jaf P, Workneh N, Abu Dalo M, Tabena M, Rashid S & Al Hilfii T (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival* 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>

<sup>132</sup> Kevany, S. et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Medicine, Conflict and Survival* July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>133</sup> Kevany, S. et al (2014). Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs. *Medicine, Conflict and Survival*, 30:1, 37-55. <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>

<sup>134</sup> Kevany, S. et al (2015). Global health diplomacy, national integration, and regional development through the monitoring and evaluation of HIV/ AIDS programs in Papua New Guinea, Vanuatu, and Samoa. *Int J Health Policy Manag.* 2015; 4(6):337-41. [www.ncbi.nlm.nih.gov/pubmed/26029892](http://www.ncbi.nlm.nih.gov/pubmed/26029892)

<sup>135</sup> Kevany, S. (2015). The United States' Response to Ebola. *The New York Times*, Letters to the Editor. [http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?\\_r=0](http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?_r=0)

<sup>136</sup> Royal Institute for International Affairs. (2010). Global health diplomacy: A way forward in international affairs. Chatham House: meeting summary document. Retrieved from <http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/280611summary.pdf>

In my experience, global health programs were observed, either accidentally or when intentionally holistically designed, to also contribute to abstract concepts such as peace-keeping and nation-building<sup>137</sup> in situations where national, international and community relations were effectively integrated in to program design and delivery.<sup>138</sup> In turn, my past work also supported and further demonstrated the established argument that such downstream non-health effects – in cases where they could be planned and guaranteed – provided compelling rationales for continued and enhanced funding of global health by bilateral and multilateral donors.<sup>139</sup>

For example, in professionally assisting in the redesign of HIV/AIDS and tuberculosis services by the Global Fund to Fight AIDS, Tuberculosis and Malaria in Iraq, I observed a range of such collateral conflict resolution effects. In turn, these were found to be the result – both directly and indirectly – of a combined constellation of planned and serendipitous programmatic features. For example, and beyond the links I established between improved relations between donor and recipient states and the provision of cost-effective global health services,<sup>140</sup> attention to geostrategic accessibility and coverage were also found to be of key importance.

My work also supported the assertion that program visibility played a key role in the dual effectiveness of global health efforts, particularly in Iraq.<sup>141</sup> While communicating donor contributions to local populations had been previously established as being of key importance,<sup>142</sup> I found that appropriate branding was also dependent on the documentation of effective and diplomatically-managed partnerships with local actors such as the Ministry of Health. In addition, I also found that high-profile events supported by both national and international partners attracted significant benign media coverage for international actors.<sup>143</sup>

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<sup>137</sup> Kevany, S. et al(2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Medicine, Conflict and Survival*, July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>138</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84.

<sup>139</sup> Walensky, R., & Kuritzkes, D. (2010). The impact of the President's Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and why it remains essential. *Clinical Infectious Diseases*, 50(2), 272-275. doi:10.1086/649214

<sup>140</sup> Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocations for health and HIV in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570-587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>

<sup>141</sup> Lane, R. 2013. "Thamer Kadum Al Hilfi: Looking Ahead to a Healthier Iraq." *The Lancet* 381: 897.

<sup>142</sup> Alesina, A., & Dollar, D. (2000). Who gives foreign aid to whom and why? *Journal of Economic Growth*, 5(1), 33-63.

<sup>143</sup> These included tuberculosis conferences, the launch of tuberculosis partnerships, and the hand-over of the country's first specialized tuberculosis hospital to the Iraqi National Tuberculosis

In Iraq, my work also demonstrated for the first time that intervention selection was a key element of the integration of health and diplomatic considerations. For example, such diplomatic (or smart) tuberculosis treatment, prevention and broader health systems strengthening efforts consciously avoided the use of any potentially culturally, religiously, or socially sensitive programs. In addition, all such programs were explicitly non-ideological, avoiding the use of confrontational religious or cultural messaging. Similarly, awareness of program sustainability and alignment with local needs represented key diplomatic considerations that were found to change local perspectives on donor countries, building further on prior related research findings and hypotheses.<sup>144</sup> In this way, also, intervention transferability (i.e. the capacity for programs to transition to local ownership and control) was also found to be an essential element of diplomatic program design and delivery.<sup>145</sup>

However, the most significant contribution to the nation-building and peace-keeping effects of smart global health efforts that I observed in Iraq was, perhaps, in terms of conflict resolution. This included the previously-identified contribution of international health actors to the maintenance of an established non-military international peace-keeping presence.<sup>146</sup> Although it is impossible to state categorically that smart or diplomatic health programs contributed to the augmentation of peace and stability, during my field visits discussions with local stakeholders revealed that local hostility and conflict were consistently allayed through provision of equally accessible services independent of local factionalism.<sup>147</sup>

Anti-corruption efforts through international partnerships, as well as direct and indirect economic benefits of health programs, were also found to play key roles in the dual functionality of global health efforts in Iraq. In regard the former, my work demonstrated that – in addition to supporting prior research findings that monitoring and evaluation systems play a valuable role in both improvement of program accountability and evidencing

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Program (NTP). See also Touma, J. 2012. UNDP and WHO Hand Over First Specialized Tuberculosis Hospital to the Government of Iraq. *UNDP Iraq Office Press Release*. [http://www.iq.undp.org/Publications\\_View.aspx?q=SUQ9NTQm-QC%2Bil4uoBos%3D](http://www.iq.undp.org/Publications_View.aspx?q=SUQ9NTQm-QC%2Bil4uoBos%3D)

<sup>144</sup> Yang, A., Farmer, P., and McGahan, A. (2010). Sustainability' in Global Health. *Global Public Health* 5 (2): 129–135. doi:10.1080/17441690903418977.

<sup>145</sup> Kevany, S. et al (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival* 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>

<sup>146</sup> Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4). Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000226>

<sup>147</sup> Kevany, S. et al (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival* 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>

program effectiveness<sup>148</sup> –such systems were also observed to generate national and international partnerships and communications mediums in otherwise inaccessible settings. For example, in personal communiqués during field visits (referenced in my related publication<sup>149</sup>), National Tuberculosis Program (NTP) representatives recognized that a key feature of the redesigned global health efforts was their capacity to tacitly improve financial accountability, thereby mitigating the risk of donor or recipient concerns (with inevitable international relations consequences) related to the inappropriate use of funds.

Other original diplomatic effects of smart health programs evinced during my work in Iraq included innovative collaborative mechanisms between international actors, local communities, the Ministry of Health, the NTP, and other departments of the Iraqi government. These were in turn found to produce downstream socio-economic effects such as (1) increased equity and accessibility in service delivery and (2) reducing stigma towards – and thereby employability of – tuberculosis patients. More broadly, a donor commitment to high profile conditions of immediate national importance – the responses to which stood to make a tangible national impact in terms of both economic and population health – such as tuberculosis was found to represent a key element of smart, global health program design paradigms, in keeping with prior research and literature.<sup>150</sup>

Finally, while prior research had shown that the inclusion of security or clandestine agendas as part of global health programs risks potentially negative diplomatic and inter-state relations consequences between recipient and donor countries<sup>151</sup> as well as security risks to program staff,<sup>152</sup> my research found that both explicit and implicit collaboration between armed forces and development programs had the potential to advance both peace-keeping and altruistic agendas in tandem.<sup>153</sup> As a result, I concluded (in agreement with and building

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<sup>148</sup> The Lancet (2010). Evaluation: The top priority for global health. *The Lancet*, 375, 526. Retrieved from <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610600566.pdf>

<sup>149</sup> Kevany, S. et al (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival* 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>

<sup>150</sup> Lyman, N., and Wittels. S. (2010). No Good Deed Goes Unpunished: The Unintended Consequences of Washington's HIV/AIDS Programs. *Foreign Affairs*. Accessed December 1, 2012. <http://www.foreignaffairs.com/articles/66464/princeton-lyman-and-stephen-b-wittels/>

<sup>151</sup> Eckenwiler, L., & Hunt, M. (2014, May–June). Counterterrorism, ethics, and global health. *Hastings Center Report*. doi:10.1002/hast.308

<sup>152</sup> Gostin, L (2014). Global polio eradication: espionage, disinformation, and the politics of vaccination. *The Milbank Quarterly*, 92(3), pp.413-417.

<sup>153</sup> Kevany, S. and Baker, M. (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016.

on the work of other researchers<sup>154</sup>) that investment in global health efforts – through consideration of their combined direct, strategic, altruistic, security, and peacekeeping effects (not to mention a complementary reduction in the cost of hard power interventions through their substitution with smart power) provided a significantly higher return on investment than that captured by traditional systems of performance reporting.<sup>155</sup>

**Finding 4: That global health and associated responses have become national and international, health and non-health security issues.**

Prior research has shown that global health responses are increasingly important in terms of both health<sup>156</sup> and non-health<sup>157</sup> security. In terms of the former, efforts to contain epidemic outbreaks such as Ebola or HIV/AIDS often have an international security component: responses are designed as much to protect the health of donor countries and allay risks of the spread of disease across borders as they are to treat and protect affected regions and populations.<sup>158</sup> In such cases, the rationale for international bilateral or multilateral HIV/AIDS, tuberculosis, malaria or other programs is therefore based on a form of enlightened self-interest.<sup>159</sup>

Ways in which disease outbreaks may affect broader security concerns, including the stability of developing countries, have been addressed in prior research.<sup>160</sup> For example, a key element of international health responses such as the United States' President's Emergency Plan for AIDS Relief (PEPFAR) has been the health of the armed forces of developing countries.<sup>161</sup> The potential of epidemic diseases to destabilize states or regional balances of power through effects on the health of armies or other national structures has prompted

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<sup>154</sup> Davies, S. (2010). What contribution can International Relations make to the evolving global health agenda? *International Affairs*, 86(5), 1167-1190.

<sup>155</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84

<sup>156</sup> Gostin, L. (2013). *Global health law*. Cambridge: Harvard University Press. ISBN 9780674728844.

<sup>157</sup> Centers for Disease Control and Prevention (2015). *Global Health—Global Health Security Agenda*. Retrieved from <http://www.cdc.gov/globalhealth/security/>

<sup>158</sup> Dietrich, J. (2007). The politics of PEPFAR: The President's emergency plan for AIDS relief. *Ethics & International Affairs*, 21(3). Retrieved from [http://www.carnegiecouncil.org/publications/journal/21\\_3/essay/001.html#:pf\\_printable](http://www.carnegiecouncil.org/publications/journal/21_3/essay/001.html#:pf_printable)

<sup>159</sup> White, B. (2001). *The globalization of world politics: An introduction to international relations*. New York, NY: Oxford University Press.

<sup>160</sup> Kevany, S., & Brugha, R\*. (2015). Irish Aid and Diplomacy in the Twenty-first Century: Optimising Enlightened Self-Interest, Supranational Priorities and Foreign Policy Impact. *Irish Studies in International Affairs*, 26, 207-225.

<sup>161</sup> Walensky, R., & Kuritzkes, D. (2010). The impact of the President's Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and why it remains essential. *Clinical Infectious Diseases*, 50(2), 272–275. doi:10.1086/649214

extensive international donor investment in the military health of resource-poor settings,<sup>162</sup> with the added benefit to donors of creating military and strategic *ententes*.<sup>163</sup>

Thirdly, prior research has paid increased attention to the overlap between health and human security, raising the profile of health as a security issue within and among organizations such as the European Union<sup>164</sup> and the United Nations.<sup>165</sup> The correlation of epidemic diseases such as HIV/AIDS, tuberculosis and malaria with low levels of human security through, for example, economic deprivation (as identified in prior literature<sup>166</sup>) has promoted an associated examination of links between communicable health threats and broader societal concerns.

In response to this network of connections between global health and international health and non-health security, my work has further explored opportunities for HIV/AIDS, tuberculosis, and malaria programs to address, through smart design parameters, both health and non-health security threats in unison.<sup>167</sup> Such concepts also extend to broader realms of international stability: its maintenance is, by nature, connected with (and an extension of) national and international security.<sup>168</sup> Conversely, any efforts that help to improve global stability through global health<sup>169</sup> (which has represented one of the key overarching contributions of my past work) may therefore also be said to also improve global security.

The original connections my past work identified between global health efforts and international security have also been driven by, and based on, exposure to the safety of

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<sup>162</sup> Larkan F, Ryan C\*, Kevany S. (2015). The Geopolitics of Ebola and Global Health Security: Why Anthropology Matters. *Irish Journal of Anthropology*, Vol, 18, 1.

<sup>163</sup> The Lancet (2014). National Armies for Global Health? Editorial, October 25, 2014, 1477, Retrieved from [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61923-1/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61923-1/fulltext?rss=yes)

<sup>164</sup> Rehn, O. (2005). Europe's smart power in its region and the world. *Speech at the European Studies Centre, St Antony's College, University of Oxford, 1 May 2008*. Retrieved from [www.europa.eu/rapid/pressReleasesAction.do?reference=SPEECH](http://www.europa.eu/rapid/pressReleasesAction.do?reference=SPEECH)

<sup>165</sup> Ki-Moon, B. (2013). With \$3 billion annual shortfall in controlling malaria, replenishing Global Fund should be a priority to prevent resurgence [Press release]. United Nations, NY: The Global Fund to Fight AIDS, Tuberculosis and Malaria. Retrieved from <http://www.theglobalfund.org/en/blog/32053/>

<sup>166</sup> Benatar, S. (2015). Explaining and responding to the Ebola epidemic. *Philosophy, Ethics, and Humanities in Medicine* 10(5). doi:10.1186/s13010-015-0027-8. Retrieved from <http://www.pehmed.com/content/10/1/5>

<sup>167</sup> Kevany, S. (2014). Global health diplomacy, 'Smart Power', and the New World Order. *Global Public Health*. DOI:10.1080/17441692.2014.92121 DOI:10.1080/17441692.2014.921219 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>168</sup> Novotny, T. & Kevany, S. (2012). The Way Forward in Global Health Diplomacy: Definitions, Research, and Training. Book chapter in: *21st Century Health Diplomacy*. <http://www.worldscientific.com/worldscibooks/10.1142/8178>

<sup>169</sup> Council on Foreign Relations. (2013). The global health regime [Policy paper]. New York: Author. Retrieved from <http://www.cfr.org/health-science-and-technology/global-health-regime/p22763>

health program staff working in high-risk conflict or post-conflict environments.<sup>170</sup> This led to my examination of partnerships between health and military organizations,<sup>171</sup> framed in a manner that did not compromise the perceived or actual independence of altruistic efforts (which can, paradoxically, increase risks to program staff).<sup>172</sup> Similarly, my academic and professional experience posited the original concept that the selection of those global health programs that are most suitable – culturally, economically, socially, politically and religiously – to recipient country and community conditions also significantly improves staff security.<sup>173</sup> In a complementary manner, and building on prior research,<sup>174</sup> my work demonstrated that international security efforts such as the deployment of military forces in international humanitarian interventions were also presented with opportunities to advance strategic, diplomatic or foreign policy agendas through improved engagement with, and use of, health efforts.<sup>175</sup> In both cases, such approaches adhere closely to the smarter, more interdigitated and interdepartmental styles of government and governance identified as emerging in the 21<sup>st</sup> century.<sup>176</sup>

The innovative efforts to advance health and security synergies between diplomatic, health, security and defense that I both articulate and envision are, however, dependent on the careful management and coordination of associated responses, as identified in prior communiqués.<sup>177</sup> Just as global health efforts that ignore local cultural, social, political or religious considerations may cause resentment and threaten international relations, my work has demonstrated that military or security-driven global health efforts may compromise both health and diplomacy outcomes if strategy neglects this dual diplomatic imperative.

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<sup>170</sup> Burkle, S. (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*, 28(3), 1–3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591>

<sup>171</sup> Kevany, S. (2015). James Bond and Global Health Diplomacy. *International Journal of Health Policy & Management*. Editorial commentary. 4 (x): 1-4. [http://www.ijhpm.com/article\\_3098\\_0.html](http://www.ijhpm.com/article_3098_0.html)

<sup>172</sup> Kevany, S. and Baker, M. (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016.

<sup>173</sup> Kleinman, A. (2010). Four social theories for global health. *The Lancet*, 375, 1518–1519. doi:10.1016/S0140-6736(10)60646-0

<sup>174</sup> Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4), e1000226.

<sup>175</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83–e84. [http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)00245-4/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00245-4/fulltext)

<sup>176</sup> Brown, M. et al (2014). Bridging public health and foreign affairs: the tradecraft of global health diplomacy and the role of health attachés. *Science & Diplomacy*, 3(3); Greenwood, D (2016). Governance, Coordination, and Evaluation: The Case for an Epistemological Focus and a Return to C. E. Lindblom *Political Research Quarterly* 2016, Vol. 69(1) 30– 42.

<sup>177</sup> Buekens, P. (2013). Medical school deans' letter to President Obama. Retrieved from <http://www.jhsph.edu/news/newsreleases/2013/Klag%20letter%20to%20President%20Obama.pdf>



Ultimately, my work and experience has supported and advanced the concept that it is only through interdisciplinary management – by, amongst others, military forces, bilateral agencies, donor and recipient country governments, and multilateral actors – that both global health and global security can be advanced in unison.<sup>178</sup> More specifically, my research found that such improved collaboration and coordination between aid and national and international security agencies requires innovate and interdisciplinary joint expertise training in international politics, security, and health. Such efforts, while still nascent, are gaining momentum via efforts such as (1) the Office of Global Health Diplomacy<sup>179</sup> situated within the United States’ State Department, (2) the Global Health Security Agenda,<sup>180</sup> and (3) a range of other contemporary research and practitioner initiatives.<sup>181</sup> Nonetheless, as the following review of the first of my combined academic and practical findings in the next section demonstrates, current systems of deploying global health for security, diplomatic, or strategic ends remain *ad hoc* and sub-optimal.

**Finding 5: That contemporary approaches to global health program design, selection, delivery and evaluation – when viewed from security, international relations and diplomatic perspectives – can be further optimized.**

My research has shown that the impact of global health’s actual and potential scope for further contributions to international relations and diplomacy – and therefore world peace, stability and security – is increasingly demonstrable.<sup>182</sup> In many cases, humanitarian aid and development operations have succeeded where the use of military force or humanitarian intervention has failed.<sup>183</sup> The classification of such efforts as soft power<sup>184</sup> has evolved into

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<sup>178</sup> The Lancet (2014). National Armies for Global Health? Editorial, October 25, 2014, 1477, available at [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61923-1/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61923-1/fulltext?rss=yes)

<sup>179</sup> Kerry, J. (2013). Remarks at a global health event with partner countries. Retrieved from <http://www.state.gov/secretary/remarks/2013/09/214733.htm>

<sup>180</sup> Connolly, J. (2014). Governing Towards ‘One Health’: Establishing Knowledge Integration in Global Health Security Governance. *Global Policy*.

<sup>181</sup> Kickbusch, I. et al (2012). Global health diplomacy: Concepts, issues, actors, instruments, and cases. New York, NY: Springer.

<sup>182</sup> Nunes, J. (2017). Disease Diplomacy: International Norms and Global Health Security *Ethics & International Affairs*, 31(3), 385-388.

<sup>183</sup> The Lancet (2014). National Armies for Global Health? Editorial, October 25, 2014, 1477, available at [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61923-1/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61923-1/fulltext?rss=yes)

<sup>184</sup> Nye, J. (2004, May and June). The decline of America’s soft power. *Foreign Affairs*. Retrieved from <http://www.foreignaffairs.com/articles/59888/joseph-s-nye-jr/the-decline-of-americas-soft-power>

the use of terms such as smart power:<sup>185</sup> international health initiatives that, functioning in multifarious ways, both explicitly and implicitly advance diplomatic or international relations agendas. The aim of this section is to present those aspects of my past work which suggest that contemporary program design approaches, while occasionally effective on an *ad hoc* basis, remain sub-optimal from the diplomatic perspective.

In order to provide a comprehensive review of past dually-effective efforts, my research cited a range of development programs from the 20<sup>th</sup> century that have been successful in this regard, beginning with the involvement of the World Health Organization (WHO) in colonial and post-colonial settings through to the hearts and minds programs of the Second World and Vietnam Wars<sup>186</sup> by the United States. Prior research has also shown that the creation of health corridors to provide essential supplies and services has limited the spread of civil war conflicts in Latin America,<sup>187</sup> while the use of ‘Health as a Bridge for Peace’<sup>188</sup> systems have specifically and effectively targeted areas of ethnic or other forms of tension worldwide. My original efforts to synthesize these findings found that this dual focus did not represent a misallocation of health resources, even from medical or epidemiological perspectives: rather, such smart efforts resulted in both fewer lives lost through conflict<sup>189</sup> and an augmentation of funding for global health (thereby saving yet more lives) when such dual effects could be articulated and demonstrated to politicians and policymakers *‘in a language they really understand’*.<sup>190</sup>

However, despite these successes, my research found that such effects, to date, have been promulgated on a largely extemporaneous basis, with their roots in the (often emergency) international responses described above. As a result, in many cases prior research has demonstrated that global health programs had little or no impact beyond health:<sup>191</sup> in such situations, the argument for global health as enhancing international stability (and therefore

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<sup>185</sup> Center for Strategic and International Studies. (2007). CSIS commission on smart power. Retrieved from [http://csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)

<sup>186</sup> Kevany, S. and Baker, M. (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016.

<sup>187</sup> Marcus, L.J., Dorn, B.C. and McNulty, E.J., (2011). Renegotiating health care: resolving conflict to build collaboration. John Wiley & Sons.

<sup>188</sup> Chan Boegli, L., & Arcadu, M. G. (2017). Healing under fire—medical peace work in the field. *Medicine, conflict and survival*, 33(2), 131-140.

<sup>189</sup> Kevany, S. and Baker, M. (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016.

<sup>190</sup> Kevany S (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*. DOI:10.1080/17441692.2014.92121 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>191</sup> Marseille, E., & Khan, J. (2002). HIV prevention before HAART in sub-Saharan Africa. *The Lancet*, 359, 1851–1856. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(02\)08705-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)08705-6/abstract)

security) lost force. Further, my research generated the original finding that global health programs may even have a negative effect on international relations: in situations where they were externally, didactically imposed – with only, for example, donor health security in mind – local sensitivities and considerations were frequently ignored, thereby alienating local populations.<sup>192</sup>

I both critiqued and supported the response of the United States and other countries to the 2014 Ebola outbreak in Sierra Leone in this regard;<sup>193</sup> in some cases, military (or militarized) responses (possibly mistakenly) treated the disease vector as a conventional enemy.<sup>194</sup> In other situations, such as the use of male circumcision interventions (despite their cost-effectiveness when viewed from purely health economic perspectives) to stop the spread of HIV/AIDS,<sup>195</sup> my research supported the established finding that there is too often little consideration of local cultural, social or religious practices in program selection and design, leading to increased suspicion and hostility towards donor countries.<sup>196</sup> Similarly, both my academic and professional experience<sup>197</sup> supported and affirmed the (also established) finding that the use of some reproductive health interventions, when interpreted by recipient communities as a population control effort, risked alienation between donor and recipient countries.<sup>198</sup>

My research also reached the original conclusion that the utility of global health programs in the security, stability and diplomatic contexts is, in fact, potentially weakened by these types of interventions. While traditional global health program selection, design and delivery

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<sup>192</sup> Kevany, S. et al (2016). Global Health Diplomacy, Monitoring & Evaluation, and the Importance of Quality Assurance & Control: Findings from NIMH Project Accept (HPTN 043): A Phase III Randomized Controlled Trial of Community Mobilization, Mobile Testing, Same-Day Results, and Post-Test Support for HIV in Sub-Saharan Africa and Thailand. *PloS one*, 11(2), e0149335.

<sup>193</sup> Kevany, S. (2015). The United States' Response to Ebola. *The New York Times*, Letters to the Editor. Retrieved from [http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?\\_r=0](http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?_r=0)

<sup>194</sup> Larkan, F., Ryan, C., Kevany, S. (2015). The Geopolitics of Ebola and Global Health Security: Why Anthropology Matters. *Irish Journal of Anthropology* Vol, 18, 1.

<sup>195</sup> Novotny, T. & Kevany, S. (2012). The Way Forward in Global Health Diplomacy: Definitions, Research, and Training. Book chapter in: *21st Century Health Diplomacy*. <http://www.worldscientific.com/worldscibooks/10.1142/8178>

<sup>196</sup> Downs, J. (2013). 'The body we leave behind': a qualitative study of obstacles and opportunities for increasing uptake of male circumcision among Tanzanian Christians. *BMJ Open*, 3(5), e002802.

<sup>197</sup> Shade, S., Kevany, S. et al (2013). Cost, cost-efficiency and cost-effectiveness of integrated family planning and HIV services. *AIDS*. 2013 Oct; 27 Suppl 1:S87-92. <http://www.ncbi.nlm.nih.gov/pubmed/24088688>

<sup>198</sup> Uche, C. (2011). Population problems and family planning in Africa. *Sociologia Ruralis*, 12(3/4), 419–430. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12259218>

systems may therefore function highly when based on narrow performance metrics,<sup>199</sup> I concluded that such utilitarian approaches are (at worst) flawed or (at best) incomplete when viewed from broader, more holistic perspectives.<sup>200</sup> My research then investigated original ways in which dually-effective global health efforts that were successful on both health and diplomatic levels could be consistently guaranteed.

Based on my review of global health programs that had been successful on both levels, I identified a range of common features that formed the key elements of smart diplomatic health responses.<sup>201</sup> Although these have (as noted above) been articulated individually, my original contribution has been to collate and present these criteria in a unified manner. As a result of my efforts, HIV/AIDS, tuberculosis, malaria or health systems strengthening programs in resource-poor settings could, both theoretically and practically, for the first time (1) be observationally evaluated from a holistic perspective and (2) complement traditional measures of cost-effectiveness. In order for this process to occur consistently and effectively, however, I found that (1) new tools and procedures to review global health program design from the diplomatic (as well as altruistic or epidemiological) perspective as well as (2) significant advances in levels of collaboration and consultation between health and diplomatic actors at the policy level would be required.<sup>202</sup>

In supporting the need for such holistic, interdisciplinary, and interdepartmental decision making tools and systems, I also advanced the politico-economic philosophical case that considerations of cost-effectiveness in program selection, using narrow metrics to judge program success, should be significant but not paramount considerations.<sup>203</sup> Conversely, with the more holistic consideration of international relations prerogatives in global health program design, such investments gained bipartisan support across the political spectrum<sup>204</sup> (thereby indirectly unifying the increasingly polarized government factions of the developed

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<sup>199</sup> Marseille, E., & Khan, J. (2002). HIV prevention before HAART in sub-Saharan Africa. *The Lancet*, 359, 1851–1856. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(02\)08705-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)08705-6/abstract)

<sup>200</sup> Kevany S, Matthews M. (2016). Diplomacy and health: the end of the utilitarian era. *Int J Health Policy Manag.* 2017;6(x):x-x. doi:10.15171/ijhpm.2016.155

<sup>201</sup> Kevany S (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*, DOI:10.1080/17441692.2014.92121 <http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>202</sup> Kevany, S., & Brugha, R. (2015). Irish Aid and Diplomacy in the Twenty-first Century: Optimising Enlightened Self-Interest, Supranational Priorities and Foreign Policy Impact. *Irish Studies in International Affairs*, 26, 207-225. <http://www.jstor.org/stable/10.3318/isia.2015.26.12>

<sup>203</sup> Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocations for health and HIV in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570–587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>

<sup>204</sup> Kevany S. (2016). HIV/AIDS, Global Health Diplomacy, and “San Francisco Values”: From the Local to the Global. *Annals of Global Health*. Sep-Oct; 81(5):611-7. <http://www.ncbi.nlm.nih.gov/pubmed/27036717>

world).<sup>205</sup> Similarly, by proving their multifariousness in the defense or strategic realms, my findings suggested that funds previously devoted to the latter efforts may be meaningfully transferred to global health in order to achieve, less destructively, the same foreign policy ends<sup>206</sup> – thereby challenging accepted rationales for investment in the military-industrial complex.

With such a transfer of budgets from military-industrial to development budgets based on global health's newly-demonstrated effectiveness in (1) security and strategy, (2) international *ententes* and alliances, and (3) conflict prevention and resolution, I have suggested that smarter global health may therefore meaningfully be said to have the potential to advance abstract concepts such as world peace and cooperation.<sup>207</sup> However, I concluded that such dual effectiveness was also critically dependent on the identification of practically-applicable parameters for diplomatic program design, selection and delivery.

**Finding 6: That parameters and tools to optimize smarter approaches to global health program design can be generated and applied.**

For global health to be an effective contributor to national and international stability and security, particularly in conflict or post conflict regions, my academic and professional experience suggested that a range of parameters that could inform program design, selection and delivery from the diplomatic perspective needed to be developed. These included the above-referenced considerations of sustainability, transferability, visibility, effectiveness, adaptability, and coordination, as well as mindfulness of the significant scope to optimize relevant health program's contributions (or non-contributions) to synergistic concerns such as human rights advancement.<sup>208</sup> My aims in this aspect of my past research were therefore

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<sup>205</sup> Kevany, S., Matthews, M. (2016). Diplomacy and health: the end of the utilitarian era. *Int J Health Policy Manag.* 2017;6(x):x-x. doi:10.15171/ijhpm.2016.155

<sup>206</sup> Kevany, S. (2014). Global health diplomacy, 'Smart Power', and the New World Order. *Global Public Health*. DOI:10.1080/17441692.2014.921211  
<http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>207</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84.

<sup>208</sup> Kevany, S., Fleischer, T., & Benatar, S. (2013). Improving resource allocation decisions for health and HIV programmes in South Africa: bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health* 8 (5): 570-87.  
<http://www.ncbi.nlm.nih.gov/pubmed/23651436>

(1) to identify an original ‘top ten’ list of such characteristics<sup>209</sup> and (2) to develop a system for their practical application in the evaluative context.<sup>210</sup>

Of note, I found that none of the above considerations were represented in contemporary systems of either global health program monitoring and evaluation or cost-effectiveness analyses. On occasions when considered or mentioned, I also found (in keeping with prior research) that such holistic evaluation was deemed to be unfeasible due to the lack of quantitative measurements for seemingly abstract concepts such as sustainability.<sup>211</sup> In most cases, such considerations were found to be at best either an afterthought or referred to in generic terms in related policy documents.<sup>212</sup> Other relevant parameters which faced similar constraints in terms of implementation and measurability were found to include awareness of the environmental impact of global health programs,<sup>213</sup> the establishment of local and international institutional partnerships,<sup>214</sup> accountability,<sup>215</sup> neutrality,<sup>216</sup> and geo-strategic location.<sup>217</sup> In all cases, the diplomatic effectiveness and dividends of global health programs on which the fulfilment of these criteria depended was, at best, extemporaneous.<sup>218</sup>

With my original identification, definition, and peer-reviewed publication of the top ten criteria for global health advancement of (1) diplomatic and (2) broader foreign policy agendas, such parameters were for the first time established.<sup>219</sup> This also represented a first documented attempt to ensure that, to the greatest extent possible, all relevant non-health

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<sup>209</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*. DOI:10.1080/17441692.2014.921211  
<http://dx.doi.org/10.1080/17441692.2014.921219>

<sup>210</sup> Kevany, S. (2015). Diplomatic advantages and threats in global health program selection, design, delivery and implementation: development and application of the Kevany Riposte. *Global Public Health*. 2015; 11(1):22. [www.globalizationandhealth.com/content/11/1/22](http://www.globalizationandhealth.com/content/11/1/22)

<sup>211</sup> Basler, M. (2009). Utility of the McNamara fallacy. *British Medical Journal*, 339, b3141.23

<sup>212</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria. (2011). Our identity: The Global Fund identity guidelines for external partners. *The Global Fund*. Retrieved from [www.theglobalfund.org/Core\\_GlobalFundIdentity\\_Guidelines\\_en/](http://www.theglobalfund.org/Core_GlobalFundIdentity_Guidelines_en/)

<sup>213</sup> Marseille, E. and Kevany, S. (2011). Case management to improve adherence for HIV-infected patients receiving antiretroviral therapy in Ethiopia: a micro-costing study. *Cost Effectiveness and Resource Allocation*, 2011; 9:18. <http://www.ncbi.nlm.nih.gov/pubmed/22185656>

<sup>214</sup> Kickbusch, I., & Buss, P. (2011). Global health diplomacy and peace. *Infectious Disease Clinics of North America*, 25, 601–610. doi:10.1016/j.idc.2011.05.006

<sup>215</sup> Adams, V. (2008). Global health diplomacy. *Medical Anthropology*. Oct-Dec; 27(4), 315–323.

<sup>216</sup> Kickbusch, I., & Buss, P. (2011). Global health diplomacy and peace. *Infectious Disease Clinics of North America*, 25, 601–610. doi:10.1016/j.idc.2011.05.006

<sup>217</sup> Center for Strategic and International Studies. (2010). Final report of the CSIS Commission on smart global health policy. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>

<sup>218</sup> Bonventre, E. (2008, January). Monitoring and evaluation of Department of Defense humanitarian assistance programs. *Military Review*, pp. 66–72.

<sup>219</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*. DOI:10.1080/17441692.2014.921211  
<http://dx.doi.org/10.1080/17441692.2014.921219>

considerations were simultaneously considered (along with and without sacrificing traditional epidemiological aims) in global health program design and delivery.

From the diplomatic perspective, and building on both my own and other prior research for each criterion, I defined the parameters as follows: (1) neutrality<sup>220</sup> (selection of culturally, religiously and socially appropriate interventions); (2) visibility<sup>221</sup> (appropriate branding to generate positive associations between international presence, health outcomes, and donor prestige); (3) sustainability<sup>222</sup> (provisions to mitigate risks of international relations tensions consequent on program termination); (4) adaptability<sup>223</sup> (delivery of programs that are responsive to locally-identified or emerging health or non-health priorities); (5) effectiveness<sup>224</sup> (selection of interventions with proven primary health outcomes); (6) accountability<sup>225</sup> (program contributions to monitoring and evaluation systems through the production of verifiable results); (7) partnership generation<sup>226</sup> (contributions to the development of sub-national, national, and international partnerships within and beyond health); (8) design and implementation-level awareness of other economic, political, environmental, and social program effects<sup>227</sup>; (9) interdependence<sup>228</sup> (program involvement with non health-related organizations); and (10) training<sup>229</sup> (appropriate selection and recognition of program staff from the diplomatic perspective, including education on prevailing political and strategic themes). In each case, the parameter represented either an

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<sup>220</sup> Adams, V. (2008). Global health diplomacy. *Medical Anthropology*. Oct-Dec; 27(4), 315–323.

<sup>221</sup> Alesina, A., & Dollar, D. (2000). Who gives foreign aid to whom and why? *Journal of Economic Growth*, 5(1), 33–63.

<sup>222</sup> Lyman, N. & Wittels, S. (2010). No good deed goes unpunished: The unintended consequences of Washington's HIV/AIDS programs. *Foreign Affairs*. July–August 2010. Retrieved from <http://www.foreignaffairs.com/articles/66464/princeton-n-lyman-and-stephen-bwittels/no-good-deed-goes-unpunished>

<sup>223</sup> Kevany, S. et al (2012). Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. *BMC Public Health* 12: (459): 1-11. <http://www.biomedcentral.com/1471-2458/12/459/abstract>

<sup>224</sup> Marseille, E., & Kevany, S. (2010). The cost of providing case management services to antiretroviral patients in Ethiopia. *Cost Effectiveness and Resource Allocation*, 9, 113–120. Retrieved from <http://www.resource-allocation.com/content/9/1/18>

<sup>225</sup> Kevany, S. et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Medicine, Conflict and Survival* July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>226</sup> Kickbusch, I., & Buss, P. (2011). Global health diplomacy and peace. *Infectious Disease Clinics of North America*, 25, 601–610. doi:10.1016/j.idc.2011.05.006

<sup>227</sup> American Foundation for AIDS Research. (2013). U.S. global health investments: The evidence on health, diplomatic and economic impact. *AMFAR Issue Brief*. Retrieved from <http://www.amrefusa.org/silo/files/amfar-global-health-investment-impact-june-2011.pdf>

<sup>228</sup> Kolaczinski, J. et al. (2005). Malaria control in Afghanistan: Progress and challenges. *The Lancet*, 365(9469), 1506–1512.

<sup>229</sup> Katz, R. et al (2011). Defining health diplomacy: Changing demands in the era of globalization. *The Milbank Quarterly*, 89, 503–523. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00637.x/abstract>

original contribution or an extension, distillation, or unification of previously disparate prior research.

In order to advance practical efforts to improve global health's diplomatic impact, I then converted these top ten lists into original questionnaire-style data collection and program review tools. For each of the main diplomatic criteria, a series of sub-parameters were also identified. For example, for program adaptability, interview and observational (or evaluative) research questions included enquiries on levels of (1) responsiveness to health needs, (2) responsiveness to non-health needs, (3) recipient-led program design, and (4) recipient-led resource allocation decisions. In South Africa, I then undertook a field-level pilot of the diplomatic assessment questionnaires with the assistance of an interview guide<sup>230</sup> (thereby adding a qualitative component) which was complemented, where necessary, by follow-up questions via e-mail exchanges and teleconferences with key managerial and field staff. Further on-site and desk research (e.g. reviews of intervention protocols and standard operating procedures) was also conducted to inform questionnaire responses, as necessary.

My completion of this pilot evaluation resulted in the creation of an original performance metric for global health programs - the 'K-Score'. Each parameter and sub-parameter was scored according to its performance in the diplomatic realm (e.g. 'highly advantageous', 'moderately advantageous', 'neutral, not relevant, or not considered', 'not applicable', 'potential moderate threat', or 'potential significant threat'), in accordance with the intervention's identified level of alignment with associated diplomatic goals and principles. For the purpose of simplicity, I associated the response categories with scores of +2, +1, 0 (zero) (for both 'neutral, not relevant, or not considered' and 'not applicable'), -1, and -2, respectively, which allowed sub-classification and classification scores to be aggregated and averaged (with equal weightings) in order to provide an overall program diplomatic performance score.

This innovative system of program evaluation represented, for the first time, an effort to specify – quantitatively and qualitatively – the performance of a global health program on the diplomatic level. Based on these results, I then generated a series of recommendations to troubleshoot areas of diplomatic deficiency, with a view to enabling the program under

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<sup>230</sup> Kevany S (2015). Diplomatic advantages and threats in global health program selection, design, delivery and implementation: development and application of the Kevany Riposte. *Globalization and Health*. 2015; 11(1):22. [www.globalizationandhealth.com/content/11/1/22](http://www.globalizationandhealth.com/content/11/1/22)



review (in this case, a multilevel HIV/AIDS prevention intervention)<sup>231</sup> to perform optimally on both diplomatic and altruistic levels in the future.

Following my establishment of diplomatic parameters for global health program review (as well as a separate list of parameters for broader foreign policy considerations) and the development of associated tools, I sought to ensure (by their publication and open access) that all global health efforts now had the potential to be delivered in a smarter, more multifarious, and more holistic manner.<sup>232</sup> My work recognized, however, that the widespread use and application of such efforts also required the development of other policy level systems to ensure that diplomatic considerations could be integrated into program design on an *ex ante* as well as *ex post* basis.

**Finding 7: That innovative policy processes for the advancement of smart approaches to global health program design, selection and delivery can be implemented.**

Prior research has shown that efforts to develop policy coherence and harmonization – including optimizing synergies between governmental, international, and supranational initiatives – involve challenging accepted structures and purviews, not least through advancing knowledge transfer and communication.<sup>233</sup> There is, as a result, an ongoing need for the evolution of policy processes – defined here as the evolution of, for example, ministerial concerns from agendas to provisionally approved and then official government policy<sup>234</sup> -- particularly through greater interdigitation between siloed departmental purviews and associated areas of expertise.<sup>235</sup> Such enabling environments are dependent upon innovative systems of both collaboration and coordination (collectively referred to here as coherence) in governance: Metcalfe (1994) notes that, in extreme cases, government ministries or departments may make significant decisions independently of either (1) central executive authority or (2) consideration of possible positive or negative externalities on other

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<sup>231</sup> Lippman, S. et al (2016). Attrition and opportunities along the HIV care continuum: findings from a population-based sample, North West Province, South Africa. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 73(1), pp.91-99.

<sup>232</sup> Kevany, S. (2014). Global Health Diplomacy: A 'Deus ex Machina' for International Development and Relations. *International Journal of Health Policy and Management* 3(2): 111-112. [www.ijhpm.com/pdf/2867\\_7dfa3b1a8850ce1070ef08fb0d0204be.html](http://www.ijhpm.com/pdf/2867_7dfa3b1a8850ce1070ef08fb0d0204be.html)

<sup>233</sup> Greenwood, D. (2016). Governance, Coordination, and Evaluation: The Case for an Epistemological Focus and a Return to C. E. Lindblom *Political Research Quarterly* 2016, Vol. 69(1) 30- 42.

<sup>234</sup> Sabatier, P.A. and Weible, C.M. (2014). *Theories of the policy process*. Westview Press.

<sup>235</sup> Brown, M. et al (2014). Bridging public health and foreign affairs: the tradecraft of global health diplomacy and the role of health attachés. *Science & Diplomacy*, 3(3).

departmental priorities.<sup>236</sup> In many cases, existing structures of governance and policymaking (such as, for example, between health, development and foreign policies) are inherently restricted by implicitly or explicitly demarcated spheres of influence.<sup>237</sup> Though greater policy coherence is not universally supported because of the complexities of interaction and decision-making it demands (of previously independently-operating government ministries, agencies or departments<sup>238</sup>), in the context of global health diplomacy my original contributions in this context were to advance such cohesion via (1) a review of gaps in policy coherence between departments of international development, diplomacy, and foreign policy and (2) the advancement of suggestions for practical, consultative and joint decision-making systems to fill them.

As noted above, my academic and professional experience found that coherent (also referred to as ‘joined-up’ or holistic<sup>239</sup>) initiatives between global health, security, and diplomacy were primarily dependent on awareness amongst non-health policymakers of the diplomatic and strategic importance of global health programs.<sup>240</sup> In order for this to take place, I also found that continued advocacy efforts to articulate the diplomatic dividends of global health efforts (e.g. through interdepartmental bodies such as the United States’ State Department Office of Global Health Diplomacy, to whom I presented these findings in November 2015, as well as via both my own and other prior research in the enlightened self-interest<sup>241</sup> and foreign policy<sup>242</sup> contexts) were necessary and effective -- yet insufficient to address the significant gaps and missed opportunities to develop interdigitated global health programs that functioned in synergistic, mutually beneficial ways. This finding was consistent with the extensive prior research findings of others on coordination, collaboration and coherence in governance and policymaking referenced above; my original contribution has, in this context, been to highlight the need for greater coherence in the specific realms of defense, diplomacy and development, with each leveraging the other field’s strengths to advance mutual agendas.

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<sup>236</sup> Metcalfe, L. (1994). International Policy Co-ordination and Public Management Reform. *International Review of Administrative Sciences* 60 (2): 271–90. doi:10.1177/002085239406000208.

<sup>237</sup> Brown, G., & Harman, S. (2011). Risk, Perceptions of Risk and Global Health Governance. *Political Studies*, 59(4), 773-778.

<sup>238</sup> Kickert, W. J., Klijn, E. H., & Koppenjan, J. F. (Eds.). (1997). *Managing complex networks: Strategies for the public sector*. Sage.

<sup>239</sup> Pollitt, C., 2003. Joined-up government: a survey. *Political studies review*, 1(1), pp.34-49.

<sup>240</sup> Novotny, T. & Kevany, S. (2012). The Way Forward in Global Health Diplomacy: Definitions, Research, and Training. Book chapter in: *21st Century Health Diplomacy*. <http://www.worldscientific.com/worldscibooks/10.1142/8178>

<sup>241</sup> White, B. (2001). *The globalization of world politics: An introduction to international relations*. New York, NY: Oxford University Press.

<sup>242</sup> Europa. (2010). Foreign and security policy: speaking with one voice. *European Union policy document*. Retrieved from [www.europa.eu/pol/cfsp/index\\_en.htm](http://www.europa.eu/pol/cfsp/index_en.htm)

Both my research and professional experience found that the conversion of either advocacy or scientific efforts in to routine policymaking decisions, which would represent a key basis of such improved coherence, would require innovative structural changes at the policy level.<sup>243</sup> Similarly, both Ansell (2008)<sup>244</sup> and Sørensen & Torfing (2009)<sup>245</sup> advocate greater inclusiveness and collaboration in the policy process via the related concepts of network and meta governance -- both of which are designed to streamline operations, optimize interdepartmental synergies, and reduce purview-based disconnects. Related conclusions have been reached in the research of Kickert (1997) in the context of the smart management of complex networks such as those between national, departmental, governmental and policymaking bodies.<sup>246</sup> In challenging traditional siloed vertical public sector hierarchies, the original suggestions for collaborative diplomatic and aid policymaking that I have developed are aligned with these approaches: for example, currently (and in most cases only then on an *ad hoc* basis) my research demonstrated that international diplomacy and development efforts are rarely deployed in combination with each other,<sup>247</sup> and that few policy or governance mechanisms for coherence currently exist.<sup>248</sup>

Yet both my academic and professional experience observed and documented that the nascent interdigitation and coherence of previously distinct health and non-health governance policy processes<sup>249</sup> continues to grow. For example, and as described above, in the security realm my research supported established findings that both the effectiveness and acceptability of demarcated foreign policy response strategies – traditionally reliant on independent (and often non-collaborative and uncoordinated) efforts by, for example, departments or ministries of defense, development and diplomacy -- are under scrutiny.<sup>250</sup>

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<sup>243</sup> Kevany, S., & Brughna, R. (2015). Irish Aid and Diplomacy in the Twenty-first Century: Optimising Enlightened Self-Interest, Supranational Priorities and Foreign Policy Impact. *Irish Studies in International Affairs*, 26, 207-225

<sup>244</sup> Ansell, C. and Gash, A., 2008. Collaborative governance in theory and practice. *Journal of public administration research and theory*, 18(4), pp.543-571.

<sup>245</sup> Sørensen, E. and Torfing, J., 2009. Making governance networks effective and democratic through metagovernance. *Public administration*, 87(2), pp.234-258.

<sup>246</sup> Kickert, W. J., Klijn, E. H., & Koppenjan, J. F. (Eds.). (1997). *Managing complex networks: Strategies for the public sector*. Sage.

<sup>247</sup> Novotny, T. & Kevany, S. (2012). The Way Forward in Global Health Diplomacy: Definitions, Research, and Training. Book chapter in: *21st Century Health Diplomacy*. <http://www.worldscientific.com/worldscibooks/10.1142/8178>

<sup>248</sup> Feldbaum, H. (2010). Global health and foreign policy. *Epidemiological Review*, 32, 82-92. Retrieved from [www.epirev.oxfordjournals.org/content/32/1/82.full](http://www.epirev.oxfordjournals.org/content/32/1/82.full)

<sup>249</sup> Brown, M. et al (2014). Bridging public health and foreign affairs: the tradecraft of global health diplomacy and the role of health attachés. *Science & Diplomacy*, 3(3).

<sup>250</sup> Europa. (2010). Foreign and security policy: speaking with one voice. *European Union policy document*. Retrieved from [www.europa.eu/pol/cfsp/index\\_en.htm](http://www.europa.eu/pol/cfsp/index_en.htm)

Not least, this shortcoming is reflected in the challenges of modern conflict and security environments which conventional methods of intervention have struggled to successfully resolve,<sup>251</sup> including the limited range and availability of effective responses to contemporary threats to world stability such as international terrorism<sup>252</sup> and the Syrian civil war.<sup>253</sup>

From both the security and the humanitarian ends of the governmental spectrum, therefore, my academic and professional experience has supported the previously-advanced hypothesis that a smart convergence of skills, responsibilities and interests is currently taking place -- even if in a manner which national political or policy systems are as yet not equipped to leverage to full effect.<sup>254</sup> Related gaps identified in my research included (1) the lack of formal or informal policy processes for consideration of how (if at all) global health efforts might advance strategic interests; (2) how such processes can be adapted (in the both short and long terms) to respond to foreign, development and diplomatic policy priorities, crises and emergencies simultaneously;<sup>255</sup> (3) how such efforts might simultaneously advance the alignment of global health efforts with international security or defense priorities;<sup>256</sup> and (4) whether such an advanced role in the broader foreign policy realm for global health would, on a routine policymaking basis, be feasible and operationalizable.<sup>257</sup>

In line with Ansell (2008)<sup>258</sup> and Sørensen & Torfing (2009),<sup>259</sup> my work supported the finding that the establishment of direct lines of communication and consultation between disparate policymaking and political stakeholders represents a key first step in this regard.<sup>260</sup>

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<sup>251</sup> Burkle, S., & Garfield, R. (2013). Civilian mortality after the 2003 invasion of Iraq. *The Lancet*, 381, 879. Retrieved from <http://press.thelancet.com/mortality.pdf>

<sup>252</sup> Eckenwiler, L., & Hunt, M. (2014, May–June). Counterterrorism, ethics, and global health *Hastings Center Report*. doi:10.1002/hast.308

<sup>253</sup> Birdsall, N. (2013). Try something new in Syria [Commentary]. Washington, DC: Center for Global Development. Retrieved from [www.cgdev.org/blog/try-something-new-syria](http://www.cgdev.org/blog/try-something-new-syria)

<sup>254</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83–e84. [http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)00245-4/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00245-4/fulltext)

<sup>255</sup> Kevany, S. et al (2012). Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. *BMC Public Health* 12: (459): 1-11. <http://www.biomedcentral.com/1471-2458/12/459/abstract>

<sup>256</sup> Kevany, S. and Baker, M. (2016). Applying Smart Power via Global Health Engagement. *Joint Forces Quarterly*, 83: 4th Quarter, 2016.

<sup>257</sup> Kevany, S. (2016). Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards. *Journal of Policing, Intelligence and Counter Terrorism*, 11(1), 84-92. <http://www.tandfonline.com/doi/full/10.1080/18335330.2016.1161225>

<sup>258</sup> Ansell, C. and Gash, A., 2008. Collaborative governance in theory and practice. *Journal of public administration research and theory*, 18(4), pp.543-571.

<sup>259</sup> Sørensen, E. and Torfing, J., 2009. Making governance networks effective and democratic through metagovernance. *Public administration*, 87(2), pp.234-258.

<sup>260</sup> Kevany, S. (2014). Global health diplomacy, 'Smart Power', and the New World Order. *Global Public Health*. DOI:10.1080/17441692.2014.921212 <http://dx.doi.org/10.1080/17441692.2014.921212>

Yet the capacity of a new, cross-sectoral breed of global health diplomats to advise on global health inputs in the foreign policy context was also found, in keeping with prior research, to require (1) increased funding;<sup>261</sup> (2) a clearer and broader mission statement, mandate, and purview;<sup>262</sup> and (3) collaborative governmental platforms and fora (as represented in this context by the innovative location of the United States' Office of Global Health Diplomacy within the State Department apparatus<sup>263</sup>).

I concluded that, in keeping with prior research on collaborative governance systems,<sup>264</sup> an original model for smart global health policy process restructuring would also require the direct involvement of global health representatives and relevant experts in the highest political and foreign policy discussions in order to articulate the possible contributions that adaptations to contemporary program efforts might make in resolving both pressing and longer-term foreign policy concerns. In some countries, albeit to a limited extent, this process had already begun with global health experts sitting on national security councils;<sup>265</sup> to date, however, these efforts have focused on global health security issues related to pandemic control and preparedness rather than the proactive use of smart global health in the foreign policy, strategic, security, or diplomatic contexts.

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<sup>261</sup> Brown, M. et al (2014). Bridging public health and foreign affairs: the tradecraft of global health diplomacy and the role of health attachés. *Science & Diplomacy*, 3(3).

<sup>262</sup> Brown, M. et al (2014). Bridging public health and foreign affairs: the tradecraft of global health diplomacy and the role of health attachés. *Science & Diplomacy*, 3(3).

<sup>263</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84; Kevany S (2015).

<sup>264</sup> Emerson, K., Nabatchi, T., & Balogh, S. (2012). An integrative framework for collaborative governance. *Journal of public administration research and theory*, 22(1), 1-29.

<sup>265</sup> United States Department of State. (2011). Leading through civilian power: The first quadrennial diplomacy and development review. Retrieved from <http://www.state.gov/documents/organization/153108.pdf>

## Part Three – Conclusion

### Original Contributions Redux

I believe that the research papers and publications I present here have originally contributed to the understanding (and therefore optimization) of how global health programs have advanced, and have the potential to further advance, conflict prevention, conflict resolution, and counter-terrorism efforts as well as boarder concepts such as diplomacy, foreign policy, and international relations. In each of the earlier (1 to 4) findings above, the examples I provide of academic and professional experience are, both individually and collectively, designed to demonstrate the vast actual and potential contributions of smart global health programs to broader, perhaps more abstract goals such as world peace and stability.<sup>266</sup> These benefits also bring 21<sup>st</sup> century global health program design full circle, ensuring that an equally (if not more) important result – the health and well-being of the world’s poorest people – is enhanced by conflict prevention, conflict resolution, and the associated generation of compelling arguments for greater bipartisan funding and support for international development efforts.

In terms of my latter findings (5 to 7) -- that contemporary approaches to global health program design, selection, delivery and evaluation, when viewed from the security and diplomatic perspectives, can be further optimized; that innovative parameters of smart or diplomatic approaches to global health program design can be applied; and that appropriate policy and political processes for the routine design and implementation of smart or diplomatic global health programs can be implemented -- the links between global health and national and international security and stability issues identified in my research were summarized in a series of editorial commentaries.<sup>267</sup> Similarly, recommendations to address the shortcomings of past approaches (e.g. PEPFAR activities in Uganda<sup>268</sup> or bilateral efforts by organizations such as Irish Aid<sup>269</sup>) have been presented in peer-reviewed publications.

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<sup>266</sup> Kevany, S. (2014). Global health diplomacy, ‘Smart Power’, and the New World Order. *Global Public Health*. DOI:10.1080/17441692.2014.921211  
<http://dx.doi.org/10.1080/17441692.2014.921211>

<sup>267</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84; Kevany S (2015).

<sup>268</sup> Kevany, S. (2014). Global Health Diplomacy: A ‘Deus ex Machina’ for International Development and Relations. *International Journal of Health Policy and Management* 3(2): 111–112.  
[www.ijhpm.com/pdf/2867\\_7dfa3b1a8850ce1070ef08fb0d0204be.html](http://www.ijhpm.com/pdf/2867_7dfa3b1a8850ce1070ef08fb0d0204be.html)

<sup>269</sup> Kevany, S., & Brugha, R\*. (2015). Irish Aid and Diplomacy in the Twenty-first Century: Optimising Enlightened Self-Interest, Supranational Priorities and Foreign Policy Impact. *Irish Studies in International Affairs*, 26, 207-225. (80%) [www.jstor.org/stable/10.3318/isia.2015.26.12](http://www.jstor.org/stable/10.3318/isia.2015.26.12)

Similarly, I have demonstrated how my past work makes other original contributions to prior research and literature via (1) the generation of formal parameters for smart or diplomatic program design and (2) the articulation of models by which such efforts can be implemented. In regards the former, my development and publication of a set of criteria for global health program design in the diplomatic, foreign policy and security realms may in this context represent the culmination of my original research findings over the past ten years.<sup>270</sup> I concede however that this is not an exhaustive system: future research may for example need to include more qualitative components beyond field staff interviews and questionnaires, as well as generating comparative K-Score results from different global health programs and interventions (and across diverse populations and settings) in order to further inform understanding of which global health initiatives have the greatest combined diplomatic, enlightened self-interest, and altruistic impact – as well as the inclusion of systems to ensure that diplomatic gains do not come at the cost of primary programmatic goals, and the trade-offs therein.

Nonetheless, my past work has reflected extensive field experience (on consultancy, academic and other levels) in the adaptation, design, delivery and evaluation of global health programs in settings in which non-health considerations may occasionally take primacy over narrow medical performance metrics. The articulation of these observations and experiences has thence collectively created the basis -- through exposure to observed links and synergies between global health programs and non-health concerns -- for this presentation of my original contributions to knowledge and academic literature. Rewardingly, these efforts have subsequently been applied to niche groups as diverse as soldiers<sup>271</sup> and surfers.<sup>272</sup> This reach illustrates that (in a modified echo of Kennedy's 1963 proclamation in the introduction to this work) the advancement of international relations, security, cooperation, peace and diplomacy is both the responsibility of, and accessible to, us all.

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<sup>270</sup> Kevany, S. (2015). Diplomatic advantages and threats in global health program selection, design, delivery and implementation: development and application of the Kevany Riposte. *Globalization and Health*. 2015; 11(1):22. [www.globalizationandhealth.com/content/11/1/22](http://www.globalizationandhealth.com/content/11/1/22)

<sup>271</sup> Kevany, S. (2016). New roles for global health: diplomatic, security, and foreign policy responsiveness. *The Lancet Global Health*, 4(2), e83-e84; Kevany S (2015).

<sup>272</sup> Kevany, S. (2016). Act Locally: How Low Profile Surf Travel can be Combined with Global Health. *The Surfer's Journal*, 25 (4).

## **Afterword**

For global health to perform optimally, in terms of both health and non-health outcomes, its programs and practitioners must also be willing to blur lines and look beyond the narrow confines of protocols and job descriptions. Willing, also, to take on new responsibilities: to act, when necessary, as international security or diplomatic liaisons or (sometimes literally) barefoot diplomats. Only then will all members of society – as well as all dimensions of the political spectrum – understand the critical value of global health investments to world development, stability, cooperation, and – ultimately – peace.



## Annex 1 – Publications Submitted for Consideration

The publications included for consideration are listed below; the percentage figures following each article are representative of my personal contribution to collaborative papers. Conformations from coauthors were requested to support these percentages, and responses successfully received are marked by an asterisk after the coauthor name. In addition, a full portfolio of my publications (from which these have been selected) has been submitted to the University of Westminster under separate cover. Publications are listed in order of appearance and relevance to the preceding findings, and full copies of each are then listed in the same order.

Of note, the journals in which my research has been published are internationally-recognized and of high academic impact. These include publications in South Africa (*the South African Medical Journal*), the United Kingdom (*The Lancet Global Health and Medicine, Conflict and Survival*), and the United States of America (*Global Public Health*). The range of these journals illustrates the international nature of my research, and may also demonstrate the international applicability of the principles and practices of global health diplomacy.

The work presented in this portfolio is also the product of a range of my past professional and academic international affiliations, including collaborations with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United Nations Development Program, the United States' Office of Global Health Diplomacy, the World Health Organization, the Office of Global Health Diplomacy, and the United States' President's Emergency Plan for AIDS Relief. My research has also been conducted under a variety of institutional affiliations, including the University of California, San Francisco, the University of Cape Town, and Trinity College Dublin.

Lectures delivered on the basis of these publications have included a seven-module global health diplomacy elective course on the Trinity College Dublin Master of Global Health course, as well as annual guest lectures have also included the master's in global health and clinical scholars programs (UCSF) and the University of California, Berkeley School of Public Health. In addition, my research has led to the listing of a publication in the Nobel Institute Publications List.<sup>273</sup> Formal Letters of Commendation from the Ministries of

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<sup>273</sup> Kevany, S. et al (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South

Health of the Governments of Iraq and Egypt, as well as the Egyptian Ministry of Health Medal, have also been awarded.<sup>274</sup> A list of other presentations and commendations based on these publications are listed on my attached curriculum vitae and on [www.diplomatichealth.com](http://www.diplomatichealth.com).

Finally, these publications have led to an H-Index score of 10, 245 citations, and an i10-Index of 10.<sup>275</sup> These are considered to be high scores, given (1) the unique and nascent nature of the global health diplomacy discipline and (2) the range of subjects and journals across which this work has been published.

1. Kevany S, Sahak O\*, Workneh N\* & Saeedzai A\* (2014). *Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs*. *Medicine, Conflict and Survival*, 30:1, 37-55. <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187> (80%)
2. Kevany S, Hatfield A\*, Workneh N\*, Aurang Zeb Durrani B\*, Bekele Y, White K\* (2012). *Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan*. *Medicine, Conflict and Survival* July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590> (80%)
3. Kevany S, Jaf P, Workneh N\*, Abu Dalo M\*, Tabena M, Rashid S & Al Hilfi T\* (2014). *Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes*. *Medicine, Conflict and Survival* 30 (2). (80%) <http://dx.doi.org/10.1080/13623699.2014.890827>
4. Kevany S. (2016). *Global health engagement in diplomacy, intelligence and counterterrorism: a system of standards*. *Journal of Policing, Intelligence and Counter Terrorism*, 11(1), 84-92. (100%). <http://www.tandfonline.com/doi/full/10.1080/18335330.2016.1161225>
5. Kevany S (2014). *Global health diplomacy, 'Smart Power', and the New World Order*. *Global Public Health*. (100%) DOI:10.1080/17441692.2014.92121 <http://dx.doi.org/10.1080/17441692.2014.921219>

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Sudan. *Medicine, Conflict and Survival* July-September; 28 (3): 247-62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>

<sup>274</sup> Please see [www.diplomatichealth.com/commendations](http://www.diplomatichealth.com/commendations)

<sup>275</sup> Google Scholar search for "Sebastian Kevany": [https://scholar.google.com/scholar?hl=en&as\\_sdt=0%2C3&q=sebastian+keваны&btnG=](https://scholar.google.com/scholar?hl=en&as_sdt=0%2C3&q=sebastian+keваны&btnG=)

6. Kevany S (2015). *Diplomatic advantages and threats in global health program selection, design, delivery and implementation: development and application of the Kevany Riposte*. (100%)  
Globalization and Health. 2015; 11(1):22.  
[www.globalizationandhealth.com/content/11/1/22](http://www.globalizationandhealth.com/content/11/1/22)
7. Kevany S and Baker M\* (2016). *Applying Smart Power via Global Health Engagement*.  
Joint Forces Quarterly, 83: 4th Quarter, 2016.  
[www.ndupress.ndu.edu/JFQ/Joint.../applying-smart-power-via-global-health-engagement/](http://www.ndupress.ndu.edu/JFQ/Joint.../applying-smart-power-via-global-health-engagement/) (80%).
8. Kevany S (2015). *James Bond and Global Health Diplomacy*. International Journal of Health Policy & Management. Editorial commentary. 4 (x): 1-4.  
[http://www.ijhpm.com/article\\_3098\\_0.html](http://www.ijhpm.com/article_3098_0.html) (100%)
9. Kevany, S. (2016). *New roles for global health: diplomatic, security, and foreign policy responsiveness*. The Lancet Global Health, 4(2), e83-e84. (100%)  
[www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)00245-4/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00245-4/fulltext)
10. Kevany S (2014). *Global Health Diplomacy: A 'Deus ex Machina' for International Development and Relations*. International Journal of Health Policy and Management 3(2): 111–112.  
[www.ijhpm.com/pdf\\_2867\\_7dfa3b1a8850ce1070ef08fb0d0204be.html](http://www.ijhpm.com/pdf_2867_7dfa3b1a8850ce1070ef08fb0d0204be.html) (100%)
11. Kevany S, Matthews M. (2016). *Diplomacy and health: the end of the utilitarian era*. Int J Health Policy Manag. 2017;6(x):x–x. doi:10.15171/ijhpm.2016.155 (90%)  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5384981/>
12. Kevany S, Gildea A, Garae C, Moa S, Lautusi A (2015). *Global health diplomacy, national integration, and regional development through the monitoring and evaluation of HIV/AIDS programs in Papua New Guinea, Vanuatu, and Samoa*. Int J Health Policy Manag. 2015; 4(6):337-41. [www.ncbi.nlm.nih.gov/pubmed/26029892](http://www.ncbi.nlm.nih.gov/pubmed/26029892) (90%)
13. Kevany, S., & Brugha, R\*. (2015). *Irish Aid and Diplomacy in the Twenty-first Century: Optimising Enlightened Self-Interest, Supranational Priorities and Foreign Policy Impact*. Irish Studies in International Affairs, 26, 207-225. (80%)  
[www.jstor.org/stable/10.3318/isia.2015.26.12](http://www.jstor.org/stable/10.3318/isia.2015.26.12)
14. Kevany, S., Khumalo-Sakutukwa, G., Singh, B., & NIMH Project Accept Study Team. (2016). *Global Health Diplomacy, Monitoring & Evaluation, and the Importance of Quality Assurance & Control: Findings from NIMH Project Accept (HPTN 043): A Phase III Randomized Controlled Trial of Community Mobilization, Mobile Testing, Same-Day Results, and Post-Test Support for HIV in Sub-Saharan Africa and Thailand*. PloS one, 11(2), e0149335. (90%)  
<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0149335>

15. Kevany S, Fleischer T\*, & Benatar S\* (2013). *Improving resource allocation decisions for health and HIV programmes in South Africa: bioethical, cost-effectiveness and health diplomacy considerations.* Global Public Health 8 (5): 570-87. <http://www.ncbi.nlm.nih.gov/pubmed/23651436> (80%)
16. Kevany S, Chingono A\*, Mulawa M\*, & NIMH Project Accept Study Team (2012). *Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept.* BMC Public Health 12: (459): 1-11. <http://www.biomedcentral.com/1471-2458/12/459/abstract> (90%)
17. Larkan F, Ryan C\*, Kevany S. (2015). *The Geopolitics of Ebola and Global Health Security: Why Anthropology Matters.* Irish Journal of Anthropology Vol, 18, 1. (30%) [https://www.researchgate.net/publication/288831843\\_The\\_Geopolitics\\_of\\_Ebola\\_and\\_Global\\_Health\\_Security\\_Why\\_Anthropology\\_Matters](https://www.researchgate.net/publication/288831843_The_Geopolitics_of_Ebola_and_Global_Health_Security_Why_Anthropology_Matters)
18. Novotny T & Kevany S (2012). *The Way Forward in Global Health Diplomacy: Definitions, Research, and Training.* Book chapter in: 21st Century Health Diplomacy. <http://www.worldscientific.com/worldscibooks/10.1142/8178> (50%)
19. Kevany S. (2016). *HIV/AIDS, Global Health Diplomacy, and "San Francisco Values": From the Local to the Global.* Annals of Global Health. Sep-Oct; 81(5):611-7. <http://www.ncbi.nlm.nih.gov/pubmed/27036717> (100%)
20. Kevany S (2016). *Act Locally: How Low Profile Surf Travel can be Combined with Global Health.* The Surfer's Journal: 25 (4). (100%) [https://www.surfersjournal.com/pa\\_author/sebastian-kevany/](https://www.surfersjournal.com/pa_author/sebastian-kevany/)

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### Global Health Diplomacy Investments in Afghanistan: Adaptations and Outcomes of Global Fund Malaria Programs

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## Global Health Diplomacy Investments in Afghanistan: Adaptations and Outcomes of Global Fund Malaria Programs

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*Background:* Global health programmes require extensive adaptation for implementation in conflict and post-conflict settings. Without such adaptations, both implementation success and diplomatic, international relations and other indirect outcomes may be threatened. Conversely, diplomatic successes may be made through flexible and responsive programmes. We examine adaptations and associated outcomes for malaria treatment and prevention programmes in Afghanistan. *Methods:* In conjunction with the completion of monitoring and evaluation activities for the Global Fund to Fight AIDS, Tuberculosis and Malaria, we reviewed adaptations to the structure, design, selection, content and delivery of malaria-related interventions in Afghanistan. Interviews were conducted with programme implementers, service delivery providers, government representatives and local stakeholders, and site visits to service delivery points were completed. *Findings:* Programmes for malaria treatment and prevention require a range of adaptations for successful implementation in Afghanistan. These include (1) amendment of educational materials for rural populations, (2) religious awareness in gender groupings for health educational interventions, (3) recruitment of local staff, educated in languages and customs, for both quality assurance and service delivery, (4) alignment with diplomatic principles and, thereby, avoidance of confusion with broader strategic and military initiatives and (5) amendments to programme 'branding' procedures. The absence of provision for these adaptations made service delivery excessively challenging and increased the risk of tension between narrow programmatic and broader diplomatic goals. Conversely, adapted global health programmes displayed a unique capacity to access potentially extremist populations and groups in remote regions otherwise isolated from international activities. *Conclusions:* A range of diplomatic considerations when delivering global health programmes in conflict and post-conflict settings are required in order to ensure that health gains are not offset by broader international relations losses through challenges to local cultural, religious and social norms, as well as in order to ensure the security of

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programme staff. Conversely, when global health programmes are delivered with international relations considerations in mind, they have the potential to generate unquantified diplomatic outcomes.

**Keywords:** adaptations; global health diplomacy; malaria; The Global Fund; conflict

## Background

Public health issues, including malaria, are particularly problematic in conflict settings as a result of breakdowns in health systems, displacement of vulnerable populations and increased risk of epidemics (Rowland et al. 2002). Malaria prevalence, for many years, has been tied to conflict in Afghanistan; during the Soviet invasion, rates of malaria increased faster than any other disease (Johnson 1998). An estimated 5–10-fold rise in malaria prevalence is estimated to have occurred as a result of the current Afghanistan conflict, with war considered to have been a key driver of the growth of *Plasmodium falciparum* (PF) malaria in particular (Kolaczinski et al. 2005). Both malaria prevalence and incidence is particularly high in rural areas, with cattle-owning individuals at substantially higher risk (Bouma and Rowland 1995); of the 31 million population of Afghanistan, an estimated 10 million or 31% of the population, live in high-transmission areas (World Health Organization 2012a) – which are, in many cases, also those regions most affected by insecurity. Children and teenagers are considered to carry most of the burden of disease (Kolaczinski et al. 2005), though reliable demographic distribution figures are not currently available.

Throughout the current conflict in Afghanistan, delivery of most basic health care services has been the responsibility of international non-governmental organisations (NGOs) due to the progressive breakdown in the delivery of Afghanistan national and public health services during the war (Kolaczinski et al. 2005). In recent years, the Global Fund to Fight AIDS, Tuberculosis and Malaria ('The Global Fund') has played an increasingly prominent role in financing malaria treatment and prevention programmes around the world, accounting for approximately US\$8 billion of the US\$9 billion that comprised both national and international financing for malaria control in 2010 (World Malaria Report 2011). Malaria grant recipients include the Afghanistan Ministry of Health through the National Malaria and Leishmaniasis Control Programme (NMLCP), the HealthNet Trans-Cultural Psychosocial Organisation (HNTPO) and the Bangladesh Rural Advancement Committee (BRAC) (Global Fund 2011). HNTPO and BRAC hold primary responsibility for preventive programmes through insecticide-treated bed net (ITN) and long-lasting insect net (LLIN) distribution, while the NMLCP is responsible for malaria treatment. Through the NMLCP, Global Fund grants support (1) supply of medications for PF malaria and (2) investments in expanding diagnostic capacity at the community level (Global Fund personal communication 2013). Cross-cutting



interventions employed by all implementing organisations include LLIN and ITN distribution, rapid diagnostic tests and the provision of artemisinin combined therapy and oral artemisinin (Kolaczinski et al. 2005; World Malaria Report 2011), and are, for the purposes of this paper, collectively and defined as ‘global health programmes’ or ‘global health initiatives’. Since 2006, the Global Fund has allocated over \$68 million for malaria programmes in Afghanistan, and over 7.3 million LLINs and ITNs have been distributed in the country as a result of Global Fund support (Global Fund 2013).

Gaining access to populations in high-transmission malaria areas has become extremely difficult as a result of security and logistical considerations (Kolaczinski et al. 2005; World Health Organization 2012b). In addition, highly conservative forms of Islamic beliefs make it hard to reach much of the female population, and access to a public health facility in under one hour of walking is possible for only 57% of the population (Ministry of Health 2008). As a result of such logistical and environmental constraints, international collaborations, such as the Afghanistan Health Initiative between the United States Office of Global Health Affairs and the Afghanistan Ministry of Public Health, are often limited in their focus to (1) the development of high-level leadership and management skills and (2) focus on centralised treatment and care centres such as the Rabia Balkhi Hospital in Kabul, the southern and eastern regions of Kandahar and Jalalabad and districts around the northern city of Mazar-e-Sharif (Office of Global Health Affairs 2010). In spite of these circumstances, the provision of a ‘basic package of health services’ (BPHS) has been contracted out to NGO in 31 out of the country’s 34 provinces (Ameli and Newbrander 2008). For Global Fund grants in Afghanistan, specific challenges to service delivery have included (1) difficulties in travelling to service delivery points to conduct monitoring and evaluation (M&E) exercises (restricted to the Balkh, Herat, Nangarhar and Kabul provinces) and (2) difficulty with primary and sub-grant recipients adhering to procedures and practices under grant agreements (Global Fund 2011).

Confusion between political, military and development objectives presents dramatic and serious threats both to the safety of global health programme staff (Center for Global Development 2013; Goniewicz and Goniewicz 2013) and to their ‘diplomatic effectiveness’ (Buekens et al. 2013), while attempts to pursue broader strategic or security-related goals through global health programmes have been critiqued as attempts to ‘hijack’ primary programmatic objectives (Woods 2005). Nonetheless, most overseas development assistance is focused on strategically significant recipient countries, including Afghanistan (Gostin and Mok 2009). In this way, both bilateral and multilateral global health programmes have become, implicitly or explicitly, increasingly intertwined with broader foreign policy, diplomatic and international relations objectives (Feldbaum 2010). Such foreign policy perspectives are both multilevel and multi-causal (Rosenau 1966), and involve the synthesis of information from a wide variety of knowledge bases. Failure to consider such principles and

objectives when designing, selecting and implementing global health programmes and therefore runs the risk of creating a ‘tense and confusing duality’ (CSIS 2010a). For example, 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 outcomes, may also constitute potential liabilities from the diplomatic perspective. Although it is critically important for global health programmes to attempt to optimise primary outcomes such as quality-adjusted life years, both their design and content needs to be carefully assessed in order to ensure that (1) they are not being achieved at the cost of diplomatic or international relations objectives and (2) where they have the capacity to achieve such collateral objectives, these are leveraged appropriately (Thompson 2008). In the case of Afghanistan, as with other conflict and post-conflict settings, the need to both sensitise and adapt all aspects of global health programme delivery to avoid diplomatic and staff security risks consequent upon these potentially damaging links (CSIS 2010b) may also be leveraged to generate positive diplomatic outcomes (Bonventre 2008). More specifically, as Novotny notes, global health programmes ‘attract a diverse and pluralistic world to better opportunities and a sense of dignity. We can appeal to these values, and inoculate against extremism’ (Novotny and Adams 2007).

The adaptation of global health interventions is essential to successful service delivery in politically unstable settings Kevany, Khumalo-Sakutukwa et al. (2012), and may be broadly divided into diplomatic and operational types (Kevany, Hatfield et al. 2012). Deciding which intervention components to include, and which may be inappropriate on cultural, religious, economic or social grounds, has become an essential part of health care planning in Afghanistan (Kolaczinski et al. 2005; Chowdhury, Alam, and Ahmed 2006; Thompson 2008; Wickford, Hultberg, and Rosberg 2008; Howard et al. 2010). The *Afghanistan National Strategy for Improving Quality in Health Care 2011–2015* notes the importance of adapting international standards and health interventions to local conditions, including service assessment tools, M&E systems, and ‘the science of health care improvement’ (Ministry of Public Health 2010). Global Fund-supported organisations such as HNTPO, BRAC and the NMLCP have been amongst the first to attempt to pilot alternative techniques for malaria treatment and prevention (Kolaczinski et al. 2005; Chowdhury, Alam, and Ahmed 2006), improving access to remote rural populations while also increasing geographical coverage. HNTPO was the first organisation to pilot insecticide-treated bed nets in Afghanistan in both refugee camps and the eastern Afghanistan province of Nangarhar, and amongst refugee communities in particular, malaria interventions have been extensively adapted to better serve environmental, social and economic conditions (Hewitt et al. 1996; Rowland and Nosten 2001). However, continuing operational research to successfully adapt health care delivery mechanisms in order to facilitate the scale up of prevention, diagnosis and treatment capacity in insecure regions is still needed

(Ahmad 2004). In this paper, using Global Fund-supported malaria programmes in Afghanistan as an example, we examine (1) the intervention-specific, logistical and environmental adaptations that have succeeded in improving programmatic access and coverage in insecure or unstable regions of Afghanistan and (2) potential indirect-associated gains in international relations and ‘global health diplomacy’.

## **Methods**

Using Global Fund-supported malaria programmes as a sampling frame, we reviewed the service delivery adaptations developed by implementing field and central office staff in order to facilitate intervention delivery in insecure regions. Data were collected through (1) desk reviews, (2) correspondence and interviews with in-country staff and (3) site visits to HNTPO, NMLPC and BRAC central offices and service delivery points. Associated identified adaptations were categorised as (1) intervention-specific, (2) logistical or (3) environmental. Such categorizations were derived on an iterative basis, with broad groups of adaptation types emerging during the review process, as well as through reference to prior groupings of global health intervention adaptations (e.g. Kevany, Khumalo-Sakutukwa et al. 2012).

In conjunction with the completion of on-site data verification and M&E periodic assessment reports for the Global Fund, a desk review of the structure, design, selection, content and delivery of related malaria interventions in Afghanistan was conducted in order to identify key programmatic adaptations. This process included review of all publicly available documentation related to Global Fund programme design and delivery, as provided on the Global Fund website for Afghanistan (Global Fund 2013) including (1) portfolio reviews of the Global Fund malaria grants, (2) associated information on the Country Coordinating Mechanism, Principal Recipient (PR) and Local Fund Agent (LFA) and (3) data on grant disbursements, financial statistics and key results. In addition, programmatic assessments of service utilisation and other related and relevant documentation used for this paper such as derived from grant recipient background portfolios (e.g. maps and charts of health centre location and performance) were reviewed in collaboration with PR and sub-recipient teams during site visits in order to identify site-specific adaptations to facilitate service delivery in insecure regions.

Collaborative document and activity reviews were conducted with primary- and sub-recipient Global Fund programme implementers, service delivery providers, government representatives, local stakeholders and the Global Fund’s LFA during site visits to HNTPO, BRAC, Ministry of Health and NMLCP offices. Reviews focused on discussion of (1) the intervention adaptations identified during the desk review and (2) identification of possible successes and challenges of adapted service delivery from the diplomatic perspective. Subsequent correspondence with the Global Fund, implementing organisations and in-coun-

try representatives via email and conference calls also contributed to an enhanced understanding of identified adaptations and associated diplomatic effects.

Site visits to primary and sub-recipient central offices were completed in October 2011 as part of the Global Fund's periodic review process. Site visits to service delivery points were also completed throughout 2011 and 2012 in order to gain a fuller understanding of intervention adaptations. These visits are routinely conducted by the in-country LFA team as part of the Global Fund's M&E quality assurance process, whereupon the LFA team includes reports on the success of intervention implementation, in terms of uptake and acceptability to local communities, through the identification of local service delivery adaptations. Site visits also present LFA staff with a rare opportunity to meet with, and gain feedback from service delivery providers for Global Fund-supported programmes based in insecure regions.

## **Results**

Global health programmes for malaria treatment and prevention required a range of adaptations for successful implementation in Afghanistan. These were developed (1) to ensure the security of service delivery staff, (2) to improve local acceptability of interventions, (3) to improve geographical and population coverage, (4) to improve service utilisation and (5) in order to ensure that programmes were diplomatically sensitised. The following types of adaptations were identified.

### ***Intervention adaptations***

#### *Information, education and communication campaigns*

Information, education and communication interventions are particularly important in conflict settings (Spiegel 2004). In particular, the use of appropriate language, careful efforts to avoid cultural or religious references, the appropriate use of local dialects and languages, as well as the elimination of content that may be perceived by local populations as inflammatory, ideological or propagandist, are all essential to successful roll-out (Schuftan 2009). For example, the use of military metaphors (e.g. global health 'campaigns') may need to be avoided under these circumstances, as well as moderation of language that confronts regional social or religious norms related to sexual activity, which is frequently the case with HIV/AIDS programmes (see, for e.g. Calderon 1997). In addition, adaptation of the medium itself has, in the past, been a critical consideration in Afghanistan, with education for malaria delivered through mosques, local newspapers and radio (Kolaczinski et al. 2005). In order to successfully promote health education messages in insecure areas, all educational materials used in Global Fund-supported programmes are routinely screened by implementers to ensure the exclusion of any phrases, language or terminology that might be misinterpreted by militant or hostile elements in recipient communities.

### *Intervention selection*

The selection of the most appropriate interventions from a diplomatic and international relations perspective, in order to ensure that interventions are restricted to those that do not conflict with local community, social, cultural or religious norms, is essential to successful implementation (Castro, Barrera, and Martinez 2004). For example, those interventions that may challenge social, behavioural or even (in the case of HIV/AIDS) sexual norms are necessarily excluded in the Afghanistan context (see below), while intervention design and delivery is necessarily mindful of location, delivery and content in the religious context. Similarly, Kolaczinski et al. (2005) note that relatively complex interventions such as indoor residual spraying, which require advanced planning, smooth logistics, reliable health information, and accurate timing of the campaigns, are unfeasible in conflict settings. In Afghanistan, Global Fund-supported programme staff routinely screen potential interventions to ensure that no logistical, operational, cultural, religious, social or economic challenges would be consequent on their implementation. This results in a focus on the delivery of simple and easily implemented interventions such as ITN and LLIN distribution that carry no risk of offending local sensibilities.

### *Service delivery adaptations*

LLINs and ITNs constitute one of the few feasible options for protection against malaria in chronic emergencies (Rowland et al. 2002; Howard et al. 2010), but their utilisation has required a range of adaptations to social marketing techniques (Howard, Chandramohan, and Freeman 2003). During the OSDV process, LFA staff noted that, although LLINs and ITNs were being distributed to households in accordance with Global Fund targets (thereby meeting distribution targets at the *de jure* level), most recipients did not subsequently unpack and hang the nets. Distribution teams also observed confusion amongst recipients related to the use of LLINs and ITNs, often characterised as simply reducing the risk of mosquito bites rather than as malaria prevention devices. In response, distribution teams expanded their responsibilities in order to better orient household members on both (1) installation and (2) specific uses and benefits of ITN and LLIN use in the context of malaria prevention.

### *Gender sensitivities*

The use of combined male and female information sessions for malaria has a successful record as a prevention mechanism (Atkinson and Fitzgerald 2010). In Afghanistan, however, the use of mixed-gender interventions is considered to be unacceptable on cultural, religious and social grounds, whereby male and female group or social activities are traditionally strongly separated and delineated (Moghadam 1989; Zulfacar 2006). Such practices are more pronounced

in rural areas, where the majority of the population reside, as well as amongst those with low educational attainment throughout the country (Manganaro and Alozie 2011). In keeping with local customs, the Global Fund's implementing partners established separate male and female discussion groups in order to ensure that women were able to access services without risk of social exclusion or gender bias, as well as separate and distinct protocols to reflect different social standards in urban and rural settings. In the former, implementers assigned female staff members to conduct health education activities and convey associated messages to community members during intervention implementation, while in rural areas, where such levels of female involvement were not considered to be culturally appropriate, 'female-only' health fora, in which no male participants were permitted to attend or take part, were provided. Finally, gender issues were also considered in staff selection. In particular, female staff were found to more easily gain entry to the household to monitor intervention uptake and adherence.

### ***Logistical adaptations***

#### *Community preparedness and enlisting community support*

In keeping with successful efforts by the Ministry of Health to enlist support and approval of groups such as the Taliban for public health campaigns in insecure regions (Rubenstein 2013), community preparedness is an essential aspect of global health intervention implementation (Kevany, Khumalo-Sakutukwa et al. 2010). In order to improve local acceptability in insecure regions, including clear descriptions of the roles and organisational parameters of international NGOs, extensive community preparedness for malaria intervention introduction was conducted by implementing partners. These measures helped to 'sensitise' remote or isolated communities for international involvement in health services provision. Specific community preparedness measures included (1) meetings with senior community and religious leaders, (2) enlisting support of local health and political stakeholders, and (3) holding community fora to seek the advice and input of community members on malaria intervention design and delivery. In particular, the involvement of both religious and community leaders was considered to be essential in the successful implementation of malaria interventions, verification of distribution reports, and in establishing reliable lines of communication with remote or rural areas. This method is not unlike that which is utilised by other successful public health programmes in Afghanistan, (e.g. BRAC) (Chowdhury, Alam, and Ahmed 2006).

#### *Staff selection adaptations*

The selection of appropriately skilled staff is critical to successful global health intervention delivery (Thompson 2008; World Health Organization 2010). In addition to standard reference to professional requirements and qualifications,

Global Fund-supported programmes in Afghanistan were found to make extensive adaptations to staffing and hiring procedures, across both quality assurance and service delivery functions, in order to successfully deliver services in insecure regions. In areas such as the Helmand province, efforts were focused on the recruitment of local, rather than international or inter-regional staff, in keeping with negative connotations surrounding international activities in these regions. Regional social, cultural and religious norms were strictly observed, including the deliberate limitation and restriction of recruitment practices to (1) personnel of regional ethnic origin, (2) personnel adhering to regional religious beliefs, and, where possible, (3) personnel with authority and credibility in rural communities. Notably, local recruitment was also associated with a reported reduction in inaccurate service delivery and improved utilisation statistics, though only anecdotal evidence from programme officers and coordinators is currently available in this regard.

#### *Adaptations to M&E systems*

M&E activities require extensive adaptations to function successfully in insecure areas (Kevany, Hatfield et al. 2012). Of note, the importance of a clear distinction between public health reporting and intelligence gathering related to non-project activities must be made in order to explicitly avoid life-threatening dangers both to project staff and public health workers (Center for Global Development 2013). Global Fund-supported M&E activities were adapted in the Afghanistan setting by (1) ensuring additional security for M&E and QA visits throughout accessible regions (i.e. the Balkh, Herat, Kabul and Nangarhar provinces) and (2) modified QA visit schedules, increased use of electronic communications and amendments to reporting system flow in insecure or inaccessible regions. For the latter, service delivery utilisation reports were provided both directly to regional offices and also to the central office in order to ensure that data flow was consistently maintained. In addition, heightened collaboration between the Global Fund's partners in Afghanistan (including BRAC and the NMLCP) helped to ensure that, when necessary, alternative M&E reporting systems were available.

#### *Integration and alignment of services*

Of particular importance to the diplomatic delivery of global health interventions in insecure settings is responsiveness to local needs (Chowdhury, Alam, and Ahmed 2006; Ameli and Newbrander 2008; Thompson 2008; Global Health Initiative 2012). In this context, the integration of malaria interventions with activities addressing other community health and disease priorities has become a key feature of adaptable and effective malaria programmes (Atkinson and Fitzgerald 2010). Similarly, in Afghanistan, any notion of vertical programming was abandoned in the absence of political stability (Johnson 1998). The integration process was facilitated through the Global Fund's support (in concert with

USAID, the European Union and the World Bank) of health facilities under the health systems strengthening programme of the BPHS. Through previously vertical service delivery points, Global Fund-supported malaria interventions are delivered in conjunction with safe motherhood and neonatal care programmes, child health and immunisation, public nutrition and other communicable disease control (Afghanistan Ministry of Public Health 2010). Perhaps most importantly, malaria treatment and prevention activities are also fully integrated with the Afghanistan national primary health care programme through the BPHS, which is comparatively well accepted in insecure areas. More broadly, integrated and aligned collaborations form an essential component of international global health programme success (Thompson 2008; Ng and Ruger 2011), and, in Afghanistan, often the only way for successful international global health service delivery to be maintained is through a network of well-established partners across government departments (Kolaczinski et al. 2005). In this regard, the work of the Global Fund's in-country LFA team included the generation of recommendations on (1) locally acceptable funding structures and (2) building relationships with national government actors.

#### *Accessibility adaptations*

Adaptations to global health programme schedules and procedures are amongst the most essential elements in increasing intervention uptake (Howard et al. 2010; Khumalo-Sakutukwa et al. 2010). Without appropriate consideration of local customs, including working hours and times at which local communities are able to access health services, successful intervention delivery is unlikely, and may even increase the risk of hostility to global health programmes if not carefully considered (Kevany, Khumalo-Sakutukwa et al. 2012). In the case of Afghanistan, changes to service delivery schedules and procedures developed by the Global Fund's implementing partners included the adaptation of working hours to local conditions, increased use of community health care workers, and the delivery of malaria 'outreach' services, including mobile treatment and LLIN distribution units, in order to improve service accessibility to remote populations in mountainous regions. For example, service delivery timetables included consideration of local professional and agricultural cycles in order to ensure that intervention availability did not conflict with other day-to-day engagements amongst recipient populations. In addition, the support of 'health posts', comprised of two volunteer community health workers with flexible 'working hours', have also been jointly developed as an innovative system to improve accessibility in remote areas.

#### *Environmental adaptations*

##### *Security considerations*

Though global health initiatives are separate and distinct from security and political considerations, it is often essential to ensure alignment in order to avoid



potential dualities or inadvertent pursuit of conflicting regional goals (Thompson 2008; Feldbaum 2010) as well as ensuring the security of programme staff (Burkle 2013; Goniewicz and Goniewicz 2013). This includes the sensitization of global health programme service delivery to regional security considerations (Bonventre 2008). In Afghanistan, insecure conditions have meant that coordination between health and security operations are critically important, not just for the safety of the staff, but in the cohesive pursuit of broader national stability (Rubenstein 2012). To this end, in Afghanistan, programme staff are routinely advised on the importance of impartiality in service delivery (i.e. the non-aligned provision of health services to all recipient populations, regardless of belief or political alignment) in politically sensitive areas (especially those rural areas which remain beyond the direct or effective control of the government), including specific directives requiring avoidance of the use of any phrase or action that might be interpreted as alignment either with domestic or international political groupings, as well as reviewing routine security briefings from both international agencies and the Afghanistan government in order to inform associated resource allocation decisions. For example, in regions where anti-Western sentiment continues to prevail, references to bilateral (rather than multilateral) funding sources may create security tensions if not explicitly accompanied by (1) dis-association with armed activities or (2) *specific* statements and demonstrations of political neutrality (Mogelson 2012).

#### *Economic adaptations*

In order to ensure successful utilisation of health services, interventions must consider the economic needs and capacity of both service delivery providers and recipients (Howard et al. 2010; Kevany, Murima et al. 2012) as conformity with stated national economic strategies such as rural development and micro-finance (Chowdhury, Alam, and Ahmed 2006). In many cases, labour-intensive but capital-cheap interventions are considered most appropriate to conflict settings (Kolaczinski et al. 2005), and subsidised sales through NGO clinics and mobile sales teams have, in the past, quickly increased malaria intervention coverage in Afghanistan (Kolaczinski et al. 2005). However, legal considerations also act as prohibitive barriers to the purchase of malaria prevention mechanisms such as LLINs and ITNs in Afghanistan (Howard, Chandramohan, and Freeman 2003). These include provisions in the Afghanistan constitution guaranteeing free primary-level health care to all citizens, thereby effectively prohibiting the sale of LLINs and ITNs at any price (Government of Afghanistan 2013). In response, all related Global Fund-supported malaria interventions are provided free of charge.

#### *Branding adaptations*

The 'branding' of interventions often has to be modified in conflict settings in order (1) to ensure the safety of staff, (2) to ensure that interventions are not

deliberately avoided due to their international connotations (Global Fund 2011; Goniwicz and Goniwicz 2013) and (3) to ensure that services are readily understood by often poorly educated populations who may have been cut-off from international exposure (Kevany, Khumalo-Sakutukwa et al. 2012). Independence in programme branding and identity has also been identified as being essential to service utilisation and uptake (InterAction 2012). At the same time, programme branding of some kind is essential in promoting the benign role of international actors in the region, contributing to changing perceptions around their role and presence (USAID 2012). A health care organisation for civilian war victims, Emergency, has succeeded in having its brand recognised as a neutral entity amidst conflicts between warring factions. However, maintaining this reputation has met with recent challenges, and the organisation has recently been a target of local authorities – ostensibly due to corruption charges, though many accusatory anti-war messages have also been an issue (Mogelson 2012). In the case of Afghanistan, a number of changes to Global Fund-supported programme branding were introduced in order to ensure that associated interventions did not attract hostile attention from extremist groups. This included (1) the avoidance of the use of bilateral (rather than multilateral) international insignia or logos and (2) an exclusive focus on health-related issues in malaria community mobilisation messaging. As a result of such adaptations to global health programme branding, with particular regard to avoiding specific brands that suggested national or political affiliations, international insignia such as those used by the Global Fund were successfully maintained in service delivery.

## Discussion

### *Direct adaptation benefits: changes in service utilisation*

Perhaps, the most important measure of successful adaptations to global health programme delivery is in terms of service utilisation (Kevany, Khumalo-Sakutukwa et al. 2012). In the Afghanistan setting, ongoing introduction of the above adaptations was observed by the study team to result in a wide range of service utilisation improvements, most closely related to the successful distribution of ITNs and LLINs, in accordance with Global Fund targets. While these gains cannot be solely attributable to the adaptations process, both central and field office staff noted the temporal association between intervention introduction and improvements in uptake.

### *Collateral adaptation benefits: ‘Global Health Diplomacy’*

More broadly, the evaluation of global health intervention effectiveness in conflict settings also needs to make explicit humanitarian principles (Banatvala and Zwi 2000). In this context, we propose a number of collateral diplomatic benefits unique to conflict settings, that are consequent on these successful

adaptations, and that are not captured by conventional measures of evaluation. A range of diplomatic considerations when delivering global health programmes in conflict and post-conflict settings are required in order to ensure that health gains are not offset by broader international relations losses through challenges to local cultural, religious and social norms (Labonte and Gagnon 2010). Conversely, when global health programmes are delivered with international relations considerations in mind, they have the potential to generate unquantified diplomatic outcomes through access to potentially hostile regions and populations (Fidler 2007; Novotny 2007; Feldbaum 2010). In this context, global health diplomacy therefore primarily represents the dual goals of improving global health and bettering international relations, particularly in conflict areas and resource-poor environments (Novotny 2007; Thompson 2008; Feldbaum 2010). In the case of Afghanistan, three sets of key collateral, or indirect, outcomes, as a result of the intervention adaptations process, with both diplomatic and international relations dividends, were observed and are hereby proposed.

*Access to extremist populations and insecure regions*

As a result of the careful design of programmes for insecure settings in Afghanistan, access of service delivery in insecure regions was dramatically improved, most notably in the provinces of Faryab, Khost and Kunar, in which both intervention implementation and safe passage for programme staff were facilitated by negotiations with community elders. While this may be perceived by some critics as serving the health needs of hostile and extremist groups, an alternative interpretation views these efforts as helping allay political extremism in susceptible populations who have not yet become hostile to donor countries (Novotny 2007), or to entice populations away from terrorist groups and militants as well as improving community health (Thompson 2008; Rubenstein 2013). In many cases, this is a matter of providing an alternative means of access to health-related resources for local populations, whose only other option may often be to align with terrorist groups that can provide for individual and community needs (Burkle 2005). Such collateral benefits are, however, only conceivable with the most careful selection, design, delivery and adaptation of services in politically and socially unstable regions (Kevany, Khumalo-Sakutukwa et al. 2012) – and require an explicit separation between health service delivery and political or strategic agendas in order to ensure the safety of programme staff (Buekens et al. 2013).

*Enhancing donor prestige and acceptability*

Both the prestige and acceptability of international donor activities were observed to improve as a result of the adaptations process. The careful consideration of recipient population sensitivities and needs may, therefore, have

resulted in significant increases in service utilisation in insecure regions, a key indicator of intervention (and therefore donor) acceptability. This is aligned with a diplomatic approach to global health programme selection, design and delivery, which takes into account a range of associated considerations beyond primary programmatic goals, including the promotion, where possible, of more benign perceptions of donor organisations (CSIS 2007). This has also been made possible by BRAC, who contain the name of their nation (Bangladesh) in their organisation title, yet maintain strong approval from local populations by (1) following a thorough intervention adaptations process and (2) maintaining a lack of perceived national strategic interest in Afghanistan (Chowdhury, Alam, and Ahmed 2006).

### *Building an acceptable international presence*

Perhaps, most importantly, the successful adaptation of global health interventions to insecure regions, as noted above, may help to build up an international presence in otherwise-inaccessible provinces of Afghanistan, which would, in turn, be impossible without appropriate adjustments to programme design, selection and delivery. Health interventions have, in the past, been proposed as a key aspect of ‘nation-building’ and ‘peace-keeping’ in insecure regions, not least due to their capacity to safely access insecure areas as well as accomplishing their primary programmatic goals (Centre for Strategic and International Studies 2010; Pearson 2012). The successful adaptation of global health interventions to local needs and sensitivities means that these processes are facilitated and supported, and produce associated (but again unquantified, and possibly unquantifiable) outcomes not least the added peace-keeping effects that come with the location of neutral and benign international actors in hostile regions, as exemplified by the presence of the Italian organisation Emergency’s surgical centre in the conflict zone of Lashkar Gah in the Helmand province since 2004 (Bush 1998; Mogelson 2012).

### **Conclusions**

The absence of provision for global health programme adaptations may make service delivery excessively challenging in conflict and post-conflict environments, as well as increasing the risk of tension between narrow, programmatic, broader and diplomatic goals (Feldbaum 2010). Conversely, in Afghanistan, appropriately adapted global health programmes displayed a unique capacity to generate a range of collateral benefits when viewed as a method of diplomacy (Fidler 2007; Novotny 2007; Thompson 2008), including the enhancement of donor prestige and trust, as well as the development and maintenance of a benign and non-adversarial international presence. This process may also help to improve programme effectiveness, accessibility and even cost-effectiveness, all of which are essential components of ‘diplomatic’ health interventions

(Novotny 2007). The authors wish to note that the assessment of global health programmes from a diplomatic perspective is a very new, potentially groundbreaking, element of global health research and one in which little or no work has been done to date. In the early twenty-first century, diplomatic outcomes remain unplanned, and therefore unquantified aspect of the intervention process at this stage of history, and can therefore only be discussed in an ad hoc, observational and retrospective fashion. It is to be hoped that with the future development of explicit criteria, guidelines and even methods of outcome measurement related to diplomacy that these effects may, in the future, become more easily recognised and described. Nonetheless, it remains critically important, both (1) to maintain clear and explicit distinctions between development, military and political agendas (Buekens et al. 2013) and (2) to ensure the safety and security of programmatic staff through appropriate security liaisons (Burkle 2013). Only with such distinctions and with the inclusion of such considerations in programme selection, design and delivery can global health successfully fulfil its potential to achieve both diplomatic and life-saving goals.

### **Disclaimer**

N.G.W., co-author, currently works at The Global Fund to Fight AIDS, Tuberculosis and Malaria. The views expressed in this article are those of the named author and do not necessarily reflect the decisions or stated policy of these organisations.

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### **References**

- Afghanistan Ministry of Public Health. 2008. *National Risk and Vulnerability Assessment*. [http://www.enrecahealth.dk/news/e-learning/Improving\\_Health\\_Service\\_Delivery.pdf](http://www.enrecahealth.dk/news/e-learning/Improving_Health_Service_Delivery.pdf).
- Afghanistan Ministry of Public Health. 2010. *The Afghanistan National Strategy for Improving Quality in Health Care 2011–2015*. <http://www.gfmer.ch/SRH-Course->

- 2012/country-coordinators/pdf/National-Strategy-Improving-Quality-Health-Care-2011-Afghanistan.pdf.
- Ahmad, K. 2004. "Insecurity and Lack of Funds Hamper Progress on Afghan Health Service." *Bulletin of the World Health Organization* 82 (9): 712–713. <http://www.who.int/bulletin/volumes/82/9/news.pdf>.
- Ameli, O., and W. Newbrander. 2008. "Contracting for Health Services: Effects of Utilization and Quality on the Costs of the Basic Package of Health Services in Afghanistan." *Bulletin of the World Health Organization* 86: 920–928.
- Atkinson, J., and L. Fitzgerald. 2010. "Community Participation for Malaria Elimination in Tafea Province, Vanuatu: Part I. Maintaining Motivation for Prevention Practices in the Context of Disappearing Disease." *Malaria Journal* 9: 1–16. doi:10.1186/1475-2875-9-93.
- Banatvala, N., and A. Zwi. 2000. "Conflict and Health: Public Health and Humanitarian Interventions: Developing the Evidence Base." *BMJ* 321: 101–105.
- Bonventre, E. (2008). "Monitoring and Evaluation of Department of Defense Humanitarian Assistance Programs." *Military Review* 88 (Jan.): 66–72.
- Bouma, M., and M. Rowland. 1995. "Failure of Passive Zooprophylaxis: Cattle Ownership in Pakistan is Associated with a Higher Prevalence of Malaria." *Transactions of the Royal Society of Tropical Medicine and Hygiene* 89: 351–353.
- Buckens, P. M., et al. 2013. *Medical School Deans' Letter to President Obama*. <http://www.jhsph.edu/news/newsreleases/2013/Klag%20letter%20to%20President%20Obama.pdf>.
- Burkle, F. M., Jr. 2005. "Anatomy of an ambush: Security Risks Facing International Humanitarian Assistance." *Disasters* 29: 26–37.
- Burkle, S. 2013. "Throwing the Baby Out With the Bathwater: Can the Military's Role in Global Health Crises be Redeemed?" *Prehospital and Disaster Medicine* 1–3. Accessed February 14, 2013. <http://www.ncbi.nlm.nih.gov/pubmed/23406945>
- Bush, K. 1998. *A Measure of Peace: Peace and Conflict Impact Assessment (PICA) of Development Projects in Conflict Zones*. Working Paper No. 1 of The Peace Building and Reconstruction Program Initiative & The Evaluation Unit. [www.conflictsensitivity.org/node/58](http://www.conflictsensitivity.org/node/58).
- Calderon, M. R. 1997. "HIV/AIDS Prevention and Control Series: Religious-Based Initiatives." *The AIDS Control and Prevention (AIDSCAP) Project, Family Health International, and the United States Agency for International Development*. <http://visionmundial.org/sv/wp-content/uploads/2012/03/103.pdf>.
- Castro, F. G., M. Barrera, Jr., and C. R. Martinez, Jr. 2004. "The Cultural Adaptation of Prevention Interventions: Resolving Tensions between Fidelity and Fit." *Prevention Science* 5 (1): 41–45.
- Center for Global Development. 2013. "White House Should Explicitly Ban Intelligence Involvement in Public Health Campaigns." *Center for Global Development Policy Brief*. <http://www.cgdev.org/content/publications/detail/1426835>.
- Chowdhury, Mushtaque R, M. A. Alam, and J. Ahmed. 2006. "Development Knowledge and Experience – From Bangladesh to Afghanistan and Beyond." *Bulletin of the World Health Organization* 84: 677–681.
- CSIS (Center for Strategic and International Studies). (2007). *CSIS Commission on Smart Power*. [http://csis.org/files/media/isis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/isis/pubs/071106_csissmartpowerreport.pdf).
- CSIS (Center for Strategic and International Studies). 2010a. *From Conflict to Pandemics: Three Papers from the CSIS Global Health and Security Working Group*. [http://csis.org/files/publication/100506\\_Bonventre\\_FromConflictToPandemics\\_Web.pdf](http://csis.org/files/publication/100506_Bonventre_FromConflictToPandemics_Web.pdf).
- CSIS (Center for Strategic and International Studies). 2010b. *Final Report of the CSIS Commission on Smart Global Health Policy*. <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>.

- Feldbaum, H. (2010). "Health Diplomacy and the Enduring Relevance of Foreign Policy Interests." *Plos Medicine* 7.
- Fidler, D. 2007. "Reflections on the Revolution in Health and Foreign Policy." *Bulletin of the World Health Organization* 85 (3).
- Global Health Initiative. 2012. "The United States Government Global Health Strategy." *Centers for Disease Control & Prevention Strategy Document*. <http://www.cdc.gov/globalhealth/ghi/pdf/GHIstrategy.pdf>.
- Goniewicz, M., and K. Goniewicz. 2013. "Protection of Medical Personnel in Armed Conflicts – Case Study: Afghanistan." *European Journal of Trauma and Emergency Surgery* 39: 107–112.
- Gostin, L., and E. A. Mok. 2009. "Grand Challenges in Global Health Governance." *British Medical Bulletin* 90: 7–18.
- Government of Afghanistan. 2013. *Constitution of the Government of Afghanistan*. [http://www.afghan-web.com/politics/current\\_constitution.html](http://www.afghan-web.com/politics/current_constitution.html).
- Hewitt, S. E., M. Farhan, H. Urhaman, N. Muhammad, M. Kamal, and M. W. Rowland. 1996. "Self-protection from Malaria Vectors in Pakistan: An Evaluation of Popular Existing Methods and Appropriate New Techniques in Afghan Refugee Communities." *Annals of Tropical Medicine and Parasitology* 1996 (90): 337–344.
- Howard, N., D. Chandramohan, and T. Freeman. 2003. "Socio-economic Factors Associated with the Purchasing of Insecticide-treated Nets in Afghanistan and their Implications for Social Marketing." *Tropical Medicine and International Health* 8: 1043–1050.
- Howard, N., A. Shafi, C. Jones, and M. Rowland. 2010. "Malaria Control under the Taliban Regime: Insecticide-treated Net Purchasing, Coverage, and Usage among Men and Women in Eastern Afghanistan." *Malaria Journal* 9: 7.
- InterAction. 2012. *Open Letter to the Director of the Central Intelligence Agency*. <http://www.interaction.org/document/interaction-letter-cia>.
- Johnson, C. 1998. *Afghanistan: A Land in Shadow. An Oxfam Country Profile*. Oxford: Oxfam.
- Kevany, S. A. Hatfield, N. Workneh, K. White, Y. Bekele, and B. Az. (2012). "Diplomatic and Operational Adaptations to Global Health Programs in Post-Conflict Settings: Contributions of Monitoring and Evaluation Systems to 'Nation-Building' in South Sudan." *Medicine, Conflict and Survival July-September* 28 (3): 247–62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>.
- Kevany, S., G. Khumalo-Sakutukwa, O. Murima, A. Chingono, P. Modiba, G. Gray, H. Van Rooyen, et al. June 20, 2012. "Health Diplomacy the Adaptation of Global Health Interventions to Local Needs in Sub-Saharan Africa and Thailand: Evaluating Findings from Project Accept (HPTN 043)." *BMC Public Health* 12: 459. doi:10.1186/1471-2458-12-459. <http://www.ncbi.nlm.nih.gov/pubmed/22716131>.
- Kevany, S., O. Murima, B. Singh, D. Hlubinka, M. Kulich, S. F. Morin, and M. Sweat. March 7, 2012. "Socio-economic Status and Health Care Utilization in Rural Zimbabwe: Findings from Project Accept (HPTN 043)." *Journal of Public Health Africa* 3 (1): 46–51. <https://www.ncbi.nlm.nih.gov/m/pubmed/22962629/?i=7&from=/1469676/related&filter=loattrfree%20full%20text>.
- Kolaczinski, J., K. Graham, A. Fahim, S. Brooker, and M. Rowland. 2005. "Malaria Control in Afghanistan: Progress and Challenges." *The Lancet* 365 (9469): 1506–1512.
- Labonte, R., and M. Gagnon. 2010. "Framing Health and Foreign Policy: Lessons for Global Health Diplomacy." *Globalization and Health* 6 (14). doi:10.1186/1744-8603-6-14.
- Manganaro, L. L., and N. O. Alozie. 2011. "Gender Role Attitudes: Who Supports Expanded Rights for Women in Afghanistan?" *Sex Roles* 64 (7–8): 516–529.

- Mogelson, L. 2012. "Pacifists in the Cross-Fire: The Kabul Hospital that Treats all Sides." *New York Times Magazine*. [http://www.nytimes.com/2012/05/20/magazine/the-kabul-hospital-that-treats-all-comers.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2012/05/20/magazine/the-kabul-hospital-that-treats-all-comers.html?pagewanted=all&_r=0).
- Moghadam, V. 1989. "Revolution, the State, Islam, and Women: Gender Politics in Iran and Afghanistan." *Social Text* 22: 40–61.
- Ng, N., and Ruger, J. 2011. "Global Health Governance at a Crossroads." *Global Health Governance* 3 (2). <http://www.ghg.org/Ng&Ruger.pdf>.
- Novotny, T., and V. Adams. (2007). "Global Health Diplomacy: A Call for a New Field of Teaching and Research." *San Francisco Medicine* 80 (3): 22–23.
- Office of Global Health Affairs. 2010. *Online Performance Appendix Fiscal Year 2010*. [www.hhs.gov/about/budget/fy2011/2011oghaopa.pdf](http://www.hhs.gov/about/budget/fy2011/2011oghaopa.pdf).
- Pearson, N. 2012. "The Role of the Health Sector in Wider State-Building: A Discussion Paper." *Health and Fragile States Network*. [http://www.healthandfragilestates.org/index2.php?option=com\\_docman&task=doc\\_view&gid=61&Itemid=3](http://www.healthandfragilestates.org/index2.php?option=com_docman&task=doc_view&gid=61&Itemid=3).
- Rosenau J. N. (1966). "Pre-Theories and Theories of Foreign Policy." In *Approaches in Comparative and International Politics*, edited by R. Barry Farrell, 27–92. Evanston: Northwestern University Press.
- Rowland, M., and F. Nosten. 2001. "Malaria Epidemiology and Control in Refugee Camps and Complex Emergencies." *Annals of Tropical Medicine and Parasitology* 95: 741–754.
- Rowland, M., J. Webster, P. Saleh, and D. Chandramohan. 2002. "Prevention of Malaria in Afghanistan through Social Marketing of Insecticide-Treated Nets: Evaluation of Coverage and Effectiveness by Cross-Sectional Surveys and Passive Surveillance." *Tropical Medicine & International Health* 7 (10): 813–822.
- Rubenstein, L. 2012. "Protection of Health Care in Armed and Civil Conflict." *Center for Strategic & International Studies Report*. [http://csis.org/files/publication/120125\\_Rubenstein\\_ProtectionOfHealth\\_Web.pdf](http://csis.org/files/publication/120125_Rubenstein_ProtectionOfHealth_Web.pdf).
- Rubenstein, L. April, 2013. "Unhealthy Practice: Medical Work in Conflict Zones is Compromised." *Foreign Affairs*. <http://www.foreignaffairs.com/articles/139344/leonardsrubenstein/unhealthypractice?page=show>.
- Schuftan, C. 2009. "The Role of Ethics and Ideology in Our Contribution to Global Health." *Glob Health Action* 2. doi:10.3402/gha.v2i0.2033. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2802366/>.
- Spiegel, P. 2004. "HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action." *Disasters* 28 (3): 322–339.
- The Global Fund. 2011a. "Our Identity: The Global Fund Identity Guidelines for External Partners." *The Global Fund*. [www.theglobalfund.org/.../Core\\_GlobalFundIdentity\\_Guidelines\\_en/](http://www.theglobalfund.org/.../Core_GlobalFundIdentity_Guidelines_en/).
- The Global Fund. 2011b. *The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria*. Accessed September 19, 2011. [www.theglobalfund.org/en/highlevelpanel/](http://www.theglobalfund.org/en/highlevelpanel/)
- The Global Fund. 2013. *Portfolio Search: Afghanistan Malaria Program*. Accessed May 11, 2013. <http://portfolio.theglobalfund.org/en/Search/PortfolioSearch#>
- Thompson, D. F. 2008. *The Role of Medical Diplomacy in Stabilizing Afghanistan*. Washington, DC: Center for Technology and National Security Policy, National Security Policy, National Defense University, 63.
- USAID. 2012. *Working in Crises and Conflict*. <http://www.usaid.gov/what-we-do/working-crises-and-conflict>.
- Wickford, J., J. Hultberg, and S. Rosberg. 2008. "Physiotherapy in Afghanistan – Needs and Challenges for Development." *Disability and Rehabilitation* 30 (4): 305–313.



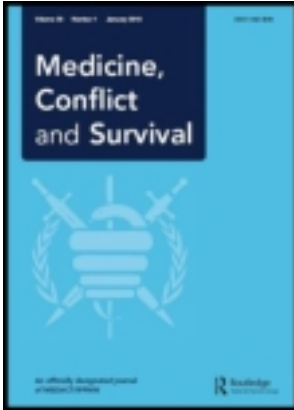
- Woods, N. 2005. "The Shifting Politics of Foreign Aid." *International Affairs* 81 (2): 393–409.
- World Health Organization. 2010. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. [www.who.int/workforcealliance/knowledge/resources/.../index.html](http://www.who.int/workforcealliance/knowledge/resources/.../index.html).
- World Health Organization. 2012a. World Malaria Report 2012. [http://www.who.int/malaria/publications/world\\_malaria\\_report\\_2012/en/](http://www.who.int/malaria/publications/world_malaria_report_2012/en/).
- World Health Organization. 2012b. "Afghanistan: Public Health Issues and Concerns." *Humanitarian Health Section: Programs and Projects*. <http://www.who.int/hac/donorinfo/afg/en/index1.html>.
- World Malaria Report. 2011. *Afghanistan Country Profile*. [www.who.int/malaria/publications/country-profiles/profile\\_afg\\_en.pdf](http://www.who.int/malaria/publications/country-profiles/profile_afg_en.pdf).
- Zulfacar, M. 2006. "The Pendulum of Gender Politics in Afghanistan." *Central Asian Survey* 25: 27–59.

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### Diplomatic and operational adaptations to global health programmes in post-conflict settings: contributions of monitoring and evaluation systems to health sector development and 'nation-building' in South Sudan

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## **Diplomatic and operational adaptations to global health programmes in post-conflict settings: contributions of monitoring and evaluation systems to health sector development and ‘nation-building’ in South Sudan**

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Monitoring and evaluation (M&E) systems are an essential element of functioning and accountable global health programmes. In post-conflict settings, the role of M&E systems is also critical to ensure that health services are being delivered to those populations and regions most in need. Given the inherent challenges of health service delivery in such environments, a range of both diplomatic and operational adaptations to M&E procedures are necessary. Using the ‘12 components’ of a functioning M&E system as a conceptual and analytical framework, we observed and reviewed the key challenges to M&E systems in South Sudan as part of a broader review of United Nations Development Programme (UNDP) activities supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Based on additional interview-based reviews and analyses of M&E activities, a list of adaptations to standardized M&E procedures in response to post-conflict environmental challenges was developed. The study concludes that development and implementation of M&E systems in post-conflict environments requires extensive adaptations to conventional procedures. Flexible and adaptable as well as ‘diplomatically sensitized’ M&E systems are considered to be essential to the successful completion of M&E-related activities, and may also contribute to broader international relations, ‘nation-building’, and peace-keeping goals.

**Keywords:** Global Fund; global health diplomacy; monitoring and evaluation; post-conflict; South Sudan

### **Introduction**

Taking South Sudan as a specific case, the purpose of this paper is to share information on M&E challenges in post-conflict settings, and to highlight

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associated diplomatic and operational adaptations, based on recent field experiences.

### ***Implementing global health programmes in resource-poor settings***

Global health programmes make up a large and increasing share of overseas development assistance (ODA) (McCoy 2009), making their successful implementation all the more important, from both 'value for money' (Global Fund 2010) and cost-effectiveness (Gold 1996) perspectives. However, implementing interventions for diseases of public health importance such as HIV, tuberculosis and malaria in resource-poor settings presents a range of both specific and cross-cutting challenges to in-country health ministries, project directors, health care providers and donors. These include, amongst others, the procurement of goods and services, recruitment and retention of skilled health personnel, supply chains, funding flows, and working within a limited health systems infrastructure (Fleischer *et al.* 2008). In particular, monitoring and evaluating the performance of global health programmes in resource-limited settings can raise a wide range of challenges, including adequacy of funding, accessibility of sites, regularity of data reporting, and the effective completion of quality assurance and quality control activities (UNAIDS 2009).

### ***Additional challenges of post-conflict environments***

Delivery of global health programmes is especially important in post-conflict settings. Populations in post-conflict environments may be disproportionately vulnerable to infectious diseases (Ghobarah 2004), and in even greater need of health services than is normally the case in resource-poor settings. In addition, the delivery of health services and the effective functioning of the health system may continue to be affected by on-going civil, social, military and political tensions in the post-conflict period, especially in geographical areas still considered 'insecure' (*ibid.*). Similarly, there may also be reluctance amongst implementers and donors to conduct global health programmes in areas that may place their staff, project partners and other resources (e.g., vehicles and medical equipment) at risk. These conditions present significant challenges to the implementation of modern M&E systems, in the context of the '12 components' of a functioning M&E system (UNAIDS 2009).

### **M&E systems**

Monitoring and evaluation systems for health are made up of 12 'components', representing the full spectrum of M&E-related activities (UNAIDS 2009), and providing a conceptual and analytical framework for

the review and adaptation of M&E systems. These components are: organizational structures for M&E; human capacity for M&E; M&E partnerships; an M&E plan; a costed M&E work plan; M&E advocacy, communications and culture; routine programme monitoring; surveys and surveillance; M&E databases; supervision and data auditing; evaluation and research; and data dissemination and use. In post-conflict settings, many (or all) of these components will need to be adapted to local conditions. In the descriptions below, the adaptation of each of these components to post-conflict settings is described.

### ***Monitoring and evaluation in post-conflict environments***

Monitoring and evaluation (M&E) is an increasingly important dimension of global health programmes (Feachem 2007). In the absence of monitoring and evaluation activities, effective implementation of performance-based funding models, such as those adopted by innovative financing mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the 'Global Fund') and the World Bank (Center for Global Development; World Bank 2010) is difficult or impossible to achieve. M&E systems also improve the quality of decision-making, enhance efficiency, serve as an anti-corruption mechanism, and build capacity for understanding programme success (The Lancet 2010). Producing consistent, verifiable and measurable programme results is all the more important in both resource-poor and post-conflict environments, where there is often a more immediate need for funds to be used to maximum effect (Management Systems International 2006). More specifically, effective monitoring and evaluation of activities in these settings helps to:

- determine if health services are being delivered to those most in need;
- devise adaptations to strengthen or enhance the service delivery process;
- contribute, wherever possible, to both the strengthening of the health sector as well as the broader, system-wide rebuilding process that is frequently required in post-conflict settings;
- perhaps most importantly, ensure accountability in the appropriate flow and use of donor funds (Global Fund 2011b).

### ***Challenges to monitoring and evaluation in post-conflict environments***

M&E systems face significant challenges in post-conflict settings. Reporting systems are frequently underdeveloped, and the timely reporting of reliable information from facilities to districts (and upwards, to the national level) faces both logistical and operational challenges (USAID/BASICS 2006). These include:

- local capacity to capture adequately or document key data points and for the secure transmission of data;
- site accessibility for quality assurance purposes;
- lack of existing M&E infrastructure; and
- difficulties in recruiting and training local staff in M&E procedures.

Both conflict and resource limitations impact upon the capacity to document the data, and illiteracy levels are often extremely high. Perhaps most importantly, post-conflict settings place significant additional professional burdens on health services staff, including higher demands on personal and professional capacity in the effective delivery of health services. In this way, M&E activities are often relegated to the category of ‘optional extras’ compared to the more immediate challenge of delivering health care, and to which all available resources must often be devoted.

### **Results-based financing and global health diplomacy in post-conflict environments**

More broadly, both the ethos and requirements of results-based financing faces a range of challenges in post-conflict settings. Perhaps most significantly, target-based performance evaluation systems, when under fixed terms of engagement, may not always have the capacity to respond to broader environmental considerations, placing donors, implementers and evaluators in challenging positions as they attempt to reconcile a need to set feasible and realistic program goals under complex (and often unpredictable) broader economic, political, social and security conditions (Winderl 2006). These concatenations of circumstances may often place significant strain on relations between stakeholders (Eyben 2006). Although no metrics are currently available to measure the contributions (or threats) to international relations ideals affected by development programmes, ignoring their effects from a diplomatic perspective risks creating a ‘tense and confusing duality’ between foreign policy and foreign assistance (CSIS 2010). There is, therefore, a constant need to ensure that the principles of ‘global health diplomacy’ (Fidler 2007, Feldbaum 2010) underpin all aspects of results-based financing – including the development and implementation of M&E systems.

### **Methodology**

In this paper, we present a case study of M&E activities of the Global Fund to Fight AIDS, Tuberculosis and Malaria (‘The Global Fund’) in South Sudan, including key challenges, lessons learned, and recommendations for conducting future M&E activities in similar resource-poor, post-conflict environments. Between May 2010 and May 2012, the authors conducted seven field visits to Southern Sudan (or, since July 2011, the independent

nation of South Sudan) to evaluate the M&E systems used by the principal grant recipient. Field visits ranged from one week to five weeks, involving extensive travel throughout the country, in order to:

- assess M&E capacity for grant reviews;
- complete on-site data verification (OSDV) quality assurance activities.

Through a series of interviews with key stakeholders, including the M&E, HIV, tuberculosis, and malaria departments of the Ministry of Health of the Government of South Sudan, combined with site visits and the composition of technical reports for the Global Fund's local funding agent (LFA), KPMG Kenya, the authors gained a detailed understanding of the challenges and associated adaptations required for a functioning M&E system in this environment. Data collection was, therefore, largely qualitative in nature, and combined aspects of both operational and observational research. Based on these experiences, a series of 'lessons learned' from the field were agreed upon with key stakeholders including national M&E and health representatives, donor organizations, the LFA team, and programme implementers.

## **Setting**

### ***Environmental challenges***

Covering an area of over 2.5 million square kilometres, and with a total population of 45 million, the Sudan is one of the largest – and poorest – regions in the world, with per capita GNP of just over US\$1000 (World Bank 2010). In South Sudan, which formally seceded from the North in January 2011, and was recognized by the United Nations as the independent Republic of South Sudan in July 2011, conflict between rival tribal, political, religious and ideological factions has been on-going since the 1950s (Prunier 2004). This environment has created a range of challenges to the effective functioning of a public health system. In many regions, no health facilities are available, with only the most basic health outposts servicing rural areas, while on-going political and military insecurity has meant that the country's health infrastructure, including referral, reporting and supply systems, is significantly underdeveloped. This is reflected in the very high maternal mortality rates of 2054 per 100,000 live births and a mortality rate for children under five years of age of 135 per 1000 live births (Southern Sudan Ministry of Health 2011).

### ***Monitoring and evaluation systems in South Sudan***

The Sudanese national M&E system was established in 2003. M&E units were established at the federal level and in six states (Sid Ahmed 2010). Since secession, the Directorate of Research, Planning and Health System



Development (DRPHSD), under the Ministry of Health of the Government of South Sudan has been responsible for coordinating M&E functions of the national public health system (Ministry of Health 2010). Other partners supporting monitoring and evaluation system development in South Sudan include the World Bank, the United Nations International Children's Emergency Fund (UNICEF), the Global Alliance for Vaccine Initiative (GAVI), the United States Agency for International Development (USAID), and the World Health Organization (WHO) (Government of South Sudan 2009). Monitoring and evaluation activities of Global Fund-supported programmes in South Sudan are jointly managed by the provisional Government of South Sudan Ministry of Health and the United Nations Development Programme (UNDP) as principal grant recipient (PR). In addition, the local funding agent (LFA) for the Global Fund, KPMG Kenya, contributes to this process via oversight, verification and validation of programmatic M&E data. Together with international technical assistance, these groups are responsible for undertaking performance reviews, quality assurance, and on-site data verification activities in the South Sudan region, and, in this way, have attained a unique understanding of the associated challenges to global health programme implementation.

### ***Global Fund activities in South Sudan***

Global Fund support for South Sudan includes grants for HIV (US\$27 million), tuberculosis (US\$47 million), and malaria (US\$90 million), as well as separate initiatives for health systems strengthening programmes (US\$20 million) (Global Fund 2011a). Across all grants, the Global Fund guidelines recommend between five to ten per cent of funds to be used for M&E functions (Global Fund 2011c): of the US\$184 million Global Fund investment in South Sudan, between US\$9 million and US\$18 million is set aside for M&E activities (Global Fund 2011a). Cross-cutting M&E activities, including national M&E system strengthening are all grant-funded with a special focus on associated training and database and reporting systems development under the health systems strengthening grant.

### ***Key challenges to monitoring and evaluation in South Sudan***

Capacity for M&E of global health programmes across all of the '12 components' faces a range of challenges in South Sudan (Ministry of Health 2010). Some of the most significant challenges include:

- the absence of standardized tools for use at service delivery points (e.g. the health facility level);

- the lack of a common understanding of indicator measurement (leading to the use of different systems of measurement, across different health facilities, for the same indicators);
- lack of clear mapping of health facilities supported by various partners;
- an inadequate archiving system for source documents and registers;
- limited supportive supervision; and
- underutilization of available M&E resources.

Other important challenges include: geographical barriers to access; political insecurity; and lack of qualified local human resources (including high levels of staff attrition and limited availability of staff with basic data skills) (United Nations Development Programme 2010). Specific challenges and weaknesses of the M&E system in South Sudan may therefore be divided into ‘operational’ and ‘diplomatic’ challenges.

### **Operational challenges**

#### ***Organizational structures***

The Ministry of Health of South Sudan has developed a comprehensive national M&E framework for the health sector (Ministry of Health 2010). This includes plans for the development of appropriate indicators, supportive supervision, organizational structures, M&E advocacy capacity, and M&E work plans (Ministry of Health 2011) under the auspices of the Directorate of Research, Planning and Health System Development (DRPHSD). However, day-to-day functioning of the national M&E system faces numerous challenges, including availability of human resources, technical capacity, and appropriate infrastructure. At present, state and local Ministry of Health M&E systems are extremely limited, with one M&E officer per governorate.

#### ***Data collection***

Infectious diseases amongst displaced persons and refugees are a common feature of post-conflict settings (Spiegel 2004). This presents a specific challenge to data collection for M&E, including the accurate completion of M&E records at the service delivery point level as well as additional provision in the design of registers (e.g., community of origin vs. community of residence and capacity to address or prevent high levels of loss-to-follow-up), as a result of difficulties in identifying transient patients, combined with associated challenges related to loss to treatment follow up for both HIV and tuberculosis programmes. The diversity of cultures and languages associated with such displacements also has important implications for the efficiency and effectiveness of M&E-related data collection activities.

### ***Data reporting and flow***

M&E reporting systems face particular challenges in post-conflict settings, including regularity of data flows from health facilities or service delivery points upwards to state and national levels. Supply chains, for both goods and data, may be difficult or impossible to maintain, while communications with health facilities outside the main urban areas is often sporadic. Such systems are also frequently disrupted due to ongoing regional conflicts, leading to difficulties in demand forecasting and inventory management and transmitting data or goods to or from regional and central levels, making the M&E of drugs and equipment very difficult. In the context of South Sudan, geography and weather patterns also impact supply chains and reporting (United Nations Development Programme 2010).

### ***Human resources for M&E***

Human resources capacity for M&E presents specific challenges in post-conflict environments. M&E staff training and retention is a continuous challenge, including the loss of trained staff through conflict, the unwillingness of trained staff to risk working in unstable environments, and unpredictable payment systems. In the setting of South Sudan, training and retention of skilled staff present a unique set of challenges from an M&E perspective, including completion of register data; frequency of data transmission; analytical capacity and capacity for information use; and establishment of professional relationships (United Nations Development Programme 2010).

### ***Surveys and surveillance***

In post-conflict settings, the limited availability of recent epidemiological data presents a particular challenge to the setting of indicator targets and associated resource allocation decisions, and anecdotal evidence is frequently used as a last resort to determine disease incidence and prevalence levels in the absence of effective surveillance systems (United Nations Development Programme 2010). In the case of South Sudan, very little data on the HIV, tuberculosis or malaria epidemics was collected during the most intensive years of conflict (Wakabi 2010), making both the effectiveness and appropriateness of Global Fund programmes hard to measure. Despite this, there have been efforts to strengthen local capacity for data generation and utilization, including the successful recent completion of a national Malaria Indicator Survey (MIS) and Sudan 'Household Surveys' (The Global Fund 2011a).

### ***Data quality and verification challenges***

A range of challenges related to data quality and verification are unique to post-conflict settings. These include transport (e.g., damaged roads, limited air travel, and irregularity of scheduling), and complex security clearance systems. In the case of South Sudan, verification of performance-related data (e.g., inventories, review of treatment registers, site visits) is frequently difficult to achieve due to these logistical challenges related to site visits.

### **Diplomatic challenges**

#### ***M&E advocacy, communications and culture***

M&E advocacy, communications and culture across all levels of the health system are often limited in post-conflict environments, creating obstacles to regular monitoring and evaluation activities. In particular, opportunities for data dissemination and feedback of results are often severely affected by regional and national conflict. This issue is compounded in resource-poor settings, where existing communications systems may already be inadequate. In the case of South Sudan, where there are only 70 internet hosting organizations, there are no email and only limited telephone services in place in most rural areas, and related key communications tools are virtually non-existent (CIA World Factbook 2010). Similarly, the lack of ground transport routes, including paved roads, between regions presents additional communications challenges from an M&E perspective.

#### ***M&E partnerships***

A limited range of service delivery providers are in place in South Sudan. Many organizations and staff are reluctant to deliver services in post-conflict settings, for the reasons outlined above. As a result, the opportunities for M&E partnerships between national bodies and international or other non-governmental organizations, leveraging the latter's strength and experience, are very limited in these settings.

### **Lessons learned**

#### ***Conducting monitoring and evaluation activities***

In response to these challenges, the effective implementation of M&E activities for global health programmes in South Sudan has required the development of a unique set of skills and strategies by key stakeholders and associated adaptations to the '12 components'. To this end, and in collaboration with these groups, the following checklist of considerations for the adaptation of M&E activities has been developed for the South Sudan region, according to 'diplomatic' and 'operational' needs.

## **Operational adaptations**

### ***Organizational structures***

One of the main challenges of M&E systems in post-conflict environments is their institutionalization at all levels of reporting (Sid Ahmed 2010). In the case of South Sudan, M&E plans make explicit reference to the development of M&E systems at all reporting levels (UNDP 2010), with the goal of furthering the 'institutionalization' of M&E throughout the health system. Similarly, the implementation of donor-specific M&E organizational structures should, wherever possible, contribute to the development of national M&E systems. In South Sudan, where national monitoring and evaluation systems are not yet fully developed, donors and implementers are routinely asked, by the Global Fund, to consider the value of their models in forming the basis of national systems (UNDP 2010) in order to ensure that these broader programme sustainability considerations are successfully taken into account.

### ***Data collection***

Wherever possible, standardized M&E database systems should be adaptable to post-conflict environments. This includes development of contingency plans for missing data; changes in the minimum requirements for data reporting (as opposed to the development of completely new M&E systems); more flexible M&E-related standard operating procedures; and a higher degree of collaboration with local actors (e.g., health facility M&E staff) than might usually be the case. This is reflected in the development of M&E databases by Global Fund principal recipients in South Sudan, which makes specific provision for the development of advanced capacity in these areas (UNDP 2010).

### ***Data reporting and flow***

Timelines for M&E data submission should be developed with the challenges of a resource-poor, post-conflict environment in mind. If possible, reporting may need to take place at a less frequent rate than in stable settings, in recognition of infrastructural and resource challenges. These considerations are reflected in M&E activities in South Sudan, where flexibility in responding to reporting requirements is frequently required (UNDP, personal communication, 2010).

### ***Data quality and verification challenges***

Without the availability of additional time to conduct M&E activities, the risk that scheduling, logistical or security concerns will disrupt the timely

completion of quality assurance activities is significantly heightened. If necessary, adapted timelines may be required to complete monitoring and evaluation activities such as on-site data verifications (OSDVs). In addition, it may be necessary to commence activities in advance of deadlines, to allow for disruptions.

### **Diplomatic adaptations**

#### ***M&E advocacy, communications and culture***

The M&E process requires a specific focus on diplomatic procedures in post-conflict settings, including awareness of possible cultural and religious differences between the M&E team and regional staff, especially in rural areas. Clarity in communications during the M&E process is also of particular importance, and includes use of appropriate, non-sectarian terminology. In South Sudan, this approach is an integral part of M&E activities (UNDP, personal communication, 2010).

#### ***M&E partnerships***

The activities of a large number of donors and non-governmental organizations, all operating small- to medium-sized projects, as is often the case in post-conflict settings, makes the harmonization of M&E activities among partners all the more important. This includes regular meetings among partners to ensure that no duplication of M&E effort is taking place. In South Sudan, the establishment of an intersectoral M&E working group meant that M&E activities are increasingly coordinated across donor and national organizations, with quarterly meetings established to facilitate the exchange of experiences and developments among stakeholders (Government of Southern Sudan 2010).

#### ***Planning, coordination and security***

Additional planning and coordination are required for site visits, including advance notice of planned site visits. In addition, where possible, all partners (e.g., Ministry of Health and PR representatives) should attempt to coordinate their activities rather than conducting individual assessments. Security measures are also central to the safety of the monitoring and evaluation team. For international staff working in the region, it is advisable to complete appropriate security clearances; schedule a 'Plan B' in order to avoid potential 'flash points' or insecure areas; carefully observe local political developments; and maintain close contact with security, NGO and other organizations who can provide timely information on security situations.

### ***Contributions to peace-keeping and nation-building***

Although development initiatives have had some effect in de-escalating post-conflict tensions in South Sudan, in many cases they have been unable to address broader social, economic and political issues due to a lack of coordination with broader international strategic planning initiatives (MacRae 1997). Ideally, and wherever possible, M&E activities, which may leverage international communications links, should contribute to both the peace-keeping and nation-building processes in conflict and post-conflict settings (Church and Rogers 2006). This includes awareness of the potential collateral contributions of M&E systems (e.g., improved national and international communications and health systems strengthening), to the broader conflict resolution process, as well as the interaction of local and national priorities and their role in de-escalating tensions (Anten 2010). Feldbaum (2010) notes that such health system strengthening activities in post-conflict settings and their role in counter insurgency and nation-building efforts 'has further intertwined health and national security objectives'. However, while the nexus between health sector development and specific aspects of global health programmes have been widely recognized (Biemsa *et al.* 2009), the causal mechanism with the 'nation-building' process remains unclear (Eldon *et al.* 2008). This remains an area of on-going research, for which specific metrics and outcome measures have yet to be developed (Bonventre 2008), and which may represent a key shortcoming of existing M&E systems.

### **Conclusions**

#### ***Results***

A range of challenges to M&E activities in post-conflict environments has been identified, as well as associated adaptations. These included modifications to standardized procedures for reporting timeframes, communications, planning coordination and security, and contributions to broader peace-keeping activities in response to the post-conflict challenges of limited regional accessibility, epidemiological data, supply chain and reporting systems, and the M&E of displaced persons and refugees.

#### ***Achievements to date***

A number of achievements in the strengthening of M&E activities specific to post-conflict settings have already taken place in South Sudan. These include the introduction of a number of initiatives designed to implement the 'lessons learned' described above, which relate to the development of national M&E tools, a common understanding on indicators and data collection procedures, and improved harmonization of M&E activities

across partners. In particular, the Ministry of Health has developed a National M&E Framework for the health sector (Ministry of Health 2010), and a National Health sector M&E Technical Working Group has been created in order to provide closer coordination and technical support to the national M&E system. In addition, UNDP M&E staff are located in close proximity to the Ministry of Health to ensure closer collaboration between government and donors.

The Global Fund has also made significant contributions to building on specific 'lessons learned' for M&E in the South Sudan context. These include support for national M&E system strengthening, through contributions to the conduct of the 2009 national malaria indicator survey; the strengthening of state level M&E systems through renovation of transportation, equipment and internet connections; and completion of the antenatal clinic sentinel surveillance survey for HIV (The Global Fund 2011a). In addition, the process of health facility mapping – a major challenge to date in South Sudan – is currently being finalized in order to provide information on location and tracking of services, human resources, infrastructure and equipment. Mapping has now been completed in nine out of the ten states of South Sudan. More broadly, such development of M&E systems in South Sudan looks likely to continue to increase after the comprehensive peace agreement (Sin Ahmed 2010).

### *Next steps*

Global health programmes are in high demand in post-conflict, resource-poor settings, where the need for public health services is both immediate and on-going. In few other environments is the need for healthcare as urgently required. While the delivery of urgently-required health services should not be constrained by the presence or absence of an M&E system, in order for these programmes to function efficiently and effectively, and to validate and maintain performance-based funding streams, functioning M&E systems must be in place. In this article, we have attempted to describe both the challenges to and achievements of M&E systems development and adaptation in post-conflict settings. However, a number of the above 'lessons learned' still need to be operationalized in the conduct of M&E activities in South Sudan – not least the development of appropriate metrics to determine the contributions of global health and other development programmes to more abstract goals including international relations, 'nation-building', and peace-keeping activities. In addition, while this is based on experiences on South Sudan, it is to be assumed that these are, in many cases, also common to other conflict and post-conflict, resource-poor settings. Based on consideration of the above guidelines, programme managers may take heart that an appropriately-adapted M&E system in such a setting is not only feasible, but may have the potential to make a



significant contribution, not just to national health systems strengthening, but also to the broader 'nation building' process.

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### References

- Anten, L., 2010. *Strengthening governance in a post-conflict district of the Democratic Republic of Congo: a study of Ituri*. Conflict Research Unit, Netherlands Institute for International Relations. Available from: [http://www.clingendael.nl/publications/2010/20100802\\_cru\\_publicatie\\_lanten.pdf](http://www.clingendael.nl/publications/2010/20100802_cru_publicatie_lanten.pdf) [Accessed 9 July 2012].
- Biemsa, R., et al., 2009. The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control. *Health Policy and Planning*, 24 (4), 239–252.
- Bonventre, E., 2008. Monitoring and evaluation of Department of Defense humanitarian assistance programs. *Military Review*, January, 66–72.
- Center for Strategic and International Studies, 2010. *Final report of the CSIS Commission on Smart Global Health Policy*. Available from: <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy> [Accessed 9 July 2012].
- Church, C., and Rogers, M., 2006. *Designing for results: integrating monitoring and evaluation in conflict transformation programs*. Washington, DC: Search for Common Ground.
- CIA World Factbook, 2011. *Sudan country profile*. Available from: <https://www.cia.gov/library/publications/the-world-factbook/geos/su.html> [Accessed 7 July 2012].
- Eldon, J., Waddington, C., and Hadi, Y., 2008. *Health system reconstruction: can it contribute to state-building?* London: Health & Fragile States Network, HLSP Institute.
- Eyben, R., 2006. Making relationships matter for aid bureaucracies. In: R. Eyben, ed. *Relationships for aid*. London: Earthscan.

- Feachem, R., 2007. The US President's malaria initiative: two years on. *The Lancet*, 370 (9603), 1893–1894.
- Feldbaum, H., 2010. Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7 (4), e1000226.
- Fidler, D., 2007. Reflections on the revolution in health and foreign policy. *Bulletin of the World Health Organization*, 85 (3). Available from: <http://www.who.int/bulletin/volumes/85/3/07-041087/en/index.html> [Accessed 9 July 2012].
- Fleischer, T., Kevany, S., and Benatar, S., 2008. Will escalating spending on HIV treatment displace funding for treatment of other diseases? *South African Medical Journal*, 100 (1), 32–34.
- Ghobarah, H., 2004. The post-war public health effects of civil conflict. *Social Science and Medicine*, 59 (4), 869–884.
- Global Fund, 2010. *Improving value for money in Global Fund-supported programs*. Global Fund Report for Third Replenishment Meeting, March. Available from: <http://www.theglobalfund.org/en/performance/effectiveness/value/improving/>. [Accessed 1 March 2012].
- Global Fund, 2011a. *Sudan: grant profile*. Available from: <http://portfolio.the-globalfund.org/Country/Index/SUD?lang=en> [Accessed 1 December 2011].
- Global Fund, 2011b. *Results with integrity: the Global Fund's response to fraud*. Available from: [http://www.theglobalfund.org/documents/core/whitepapers/Core\\_ResultsWithIntegrityResponseToFraud\\_WhitePaper\\_en.pdf](http://www.theglobalfund.org/documents/core/whitepapers/Core_ResultsWithIntegrityResponseToFraud_WhitePaper_en.pdf) [Accessed 9 July 2012].
- Global Fund, 2011c. *The Global Fund operations policy manual*. Available from: [http://www.google.ie/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CE0QFjAA&url=http%3A%2F%2Fwww.theglobalfund.org%2Fdocuments%2Fcore%2Fmanuals%2FCore\\_OperationalPolicy\\_Manual\\_en%2F&ei=8m0AUPSWF4bs6gG847XSBg&usq=AFQjCNGHsQ7BHhOb1KFz2BIP3oAWSNjabQ](http://www.google.ie/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CE0QFjAA&url=http%3A%2F%2Fwww.theglobalfund.org%2Fdocuments%2Fcore%2Fmanuals%2FCore_OperationalPolicy_Manual_en%2F&ei=8m0AUPSWF4bs6gG847XSBg&usq=AFQjCNGHsQ7BHhOb1KFz2BIP3oAWSNjabQ) [Accessed 15 April 2012].
- Gold, M., 1996. *Cost-effectiveness in health and medicine*. New York: Oxford University Press.
- Government of South Sudan. 2009. *Round 9 proposal: health system strengthening component*. Available at: [http://www.theglobalfund.org/grantdocuments/9SU\\_DH\\_1920\\_0\\_full.pdf](http://www.theglobalfund.org/grantdocuments/9SU_DH_1920_0_full.pdf) [Accessed 30 September 2011].
- Macrae, J., 1997. Conflict, the continuum and chronic emergencies: a critical analysis of the scope for linking relief, rehabilitation and development planning in Sudan. *Disasters*, 21 (3), 223–243.
- Management Systems International, 2006. *Monitoring and evaluation in post-conflict settings*. Washington, DC: USAID.
- McCoy, D., 2009. Global health funding: how much, where it comes from, and where it goes. *Health Policy and Planning*, 24 (6), 407–417.
- Ministry of Health, 2010. *Health policy of the Government of South Sudan 2007–2011*. Government of South Sudan, Ministry of Health.
- Ministry of Health, Government of Southern Sudan and the Southern Sudan Commission for Census, Statistics and Evaluation, 2006. *South Sudan household health survey*. Government of South Sudan, Ministry of Health.
- Prunier, G., 2004. Rebel movements and proxy warfare: Uganda, Sudan and the Congo (1986–99). *African Affairs*, 103 (412), 359–383.
- Sin Ahmed, H., 2010. Monitoring and evaluation system of the Federal Ministry of Health: the current situation and future perspective. *Sudanese Journal of Public Health*, 3 (1), 39–40. Available from: <http://www.sjph.net.sd/files/vol3i1p39-40.pdf> [Accessed 9 July 2012].

- Spiegel, P., 2004. HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action. *Disasters*, 28 (3), 322–339.
- The Lancet, 2010. Editorial. Evaluation: the top priority for global health. *The Lancet*, 375 (9714), 526.
- USAID/BASICS, 2006. Health management capacity assessment tool for post-conflict states. In: *Basic support for institutionalizing child survival (USAID/BASICS) for the United States Agency for International Development (USAID)*. Available from: <http://www.msh.org/global-presence/BASICS.cfm> [Accessed on 10 February 2012].
- UNAIDS, 2009. *Monitoring and evaluation system assessment guidelines to support preparation, implementation and follow-up activities: 12 components monitoring and evaluation system strengthening tool*. Geneva: UNAIDS.
- United Nations Development Programme, 2010. *Costed M&E work plans for HIV, tuberculosis and malaria for Global Fund grants*. UNDP Planning Documents.
- Wakabi, W., 2010. Health situation remains grave in South Sudan. *The Lancet*, 372 (9633), 101–102.
- Winderl, T., 2006. *Conflict-sensitive monitoring and evaluation manual*. Kathmandu: UNDP Nepal, M&E Unit.
- World Bank, 2010. *Country profile: demographic and geographical data for Sudan*. Available from: <http://data.worldbank.org/country/sudan> [Accessed 9 July 2012].

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### Global health diplomacy in Iraq: International relations outcomes of multilateral tuberculosis programmes

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## Global health diplomacy in Iraq: International relations outcomes of multilateral tuberculosis programmes

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*Background:* International development programmes, including global health interventions, have the capacity to make important implicit and explicit benefits to diplomatic and international relations outcomes. Conversely, in the absence of awareness of these implications, such programmes may generate associated threats. Due to heightened international tensions in conflict and post-conflict settings, greater attention to diplomatic outcomes may therefore be necessary. We examine related ‘collateral’ effects of Global Fund-supported tuberculosis programmes in Iraq. *Methods:* During site visits to Iraq conducted during 2012 and 2013 on behalf of the Global Fund to Fight AIDS, Tuberculosis and Malaria, on-site service delivery evaluations, unstructured interviews with clinical and operational staff, and programme documentary review of Global Fund-supported tuberculosis treatment and care programmes were conducted. During this process, a range of possible external or collateral international relations and diplomatic effects of global health programmes were assessed according to predetermined criteria. *Results:* A range of positive diplomatic and international relations effects of Global Fund-supported programmes were observed in the Iraq setting. These included (1) geo-strategic accessibility and coverage; (2) provisions for programme sustainability and alignment; (3) contributions to nation-building and peace-keeping initiatives; (4) consistent observation of social, cultural and religious norms in intervention selection; and (5) selection of the most effective and cost-effective tuberculosis treatment and care interventions. *Conclusions:* Investments in global health programmes have valuable diplomatic, as well as health-related, outcomes, associated with their potential to prevent, mitigate or reverse international tension and hostility in conflict and post-conflict settings, provided that they adhere to appropriate criteria. The associated international presence in such regions may also contribute to peace-keeping efforts. Global health programmes may frequently produce a wider range of ‘collateral benefits’ that conventional monitoring and

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evaluation systems should be expanded to assess, in keeping with contemporary efforts to leverage development programmes from a 'global health diplomacy' perspective.

**Keywords:** global health diplomacy; Iraq; conflict; tuberculosis; international relations

## **Background**

### ***Tuberculosis and Global Fund-supported tuberculosis programmes in Iraq***

Iraq has an estimated population of 32 million, and, in 2011, was ranked 44th out of 212 countries and territories by estimated number of tuberculosis cases (WHO 2012). Iraq is also amongst the nine 'high tuberculosis burden' countries in the World Health Organization Eastern Mediterranean Regional Office (WHO-EMRO) Region, contributing 3% of total tuberculosis cases worldwide (WHO 2012). Total tuberculosis caseload was 24,000 in 2011, of which 15,000 were new cases detected that year (WHO 2012). In response, the Global Fund to Fight AIDS, Tuberculosis and Malaria, in collaboration with the United Nations Development Program (UNDP), began providing support to the Iraqi National Tuberculosis Program (NTP) in 2007, with total investments to date of approximately US\$29.7 million (Global Fund 2012). Key focus areas include (1) support to the delivery of services for quality Direct Observation Treatment Strategy (DOTS) tuberculosis care for poor and vulnerable populations; (2) programmatic expansion to include the three northern governorates within the Kurdistan Region (Erbil, Sulimaniya and Duhok); (3) increasing the NTP's management capacity; (4) increasing case detection rates of smear-positive tuberculosis cases to 70% by 2014 and positive treatment outcomes amongst smear positive cases to 85% and the treatment success rate for incident cases (all new cases plus relapses) to 89%; and (5) improving universal access to diagnosis, treatment and care for Multi Drug-Resistant tuberculosis (MDR-TB) (UNDP 2010a), for which 84 cases existed in 2011 (WHO 2012). At least in part as a result of these initiatives, notifications of smear positive cases in Iraq increased from 38% in 2006 to almost 57% in 2011 (WHO 2011), while estimated mortality from TB per 100,000 population has declined from 4.1 in 2005 to 3.2 in 2011 (WHO 2012).

### ***Challenges to tuberculosis programmes in Iraq***

High levels of stigma surrounding tuberculosis (including, for example the reluctance of infected persons to approach health care providers due to social pressures) have resulted in significant challenges to treatment and care in Iraq. In addition, the prolonged recent conflict has resulted in significant reductions in the infrastructural and human capital capacity of the NTP, operating under the auspices of the national Ministry of Health, to deliver effective diagnosis, treatment and prevention campaigns in many parts of the country (Al-Hilfi,

Lafta, and Burnham 2013). Governorates across Iraq also vary immensely in terms of security, geography and cultural diversity, with a wide range of differing languages and dialects (e.g. Arabic, Sorani, Kurmanji, Azeri, Aramaic); religions (including Shia, Sunni, Yezidi, Zoroastrian, Christian, Jewish); and ethnicities (such as Kurdish, Arabic, Assyrian, Turkmen, Feyli), presenting challenges to standardized, equitable and consistent intervention implementation. In addition, current epidemiological data for tuberculosis, as well as other health conditions, is limited by the lack of any recent national census or survey data in the country beyond the landmark collaborative NTP and WHO 'capture-recapture' study (Huseynova et al. 2013). Above all, the current security situation is a major limitation for global health and other international development projects (Lane 2013), as a result of both ongoing high levels of terrorism as well as continuing political and religious tensions throughout the country (Fawcett 2013). In this context, there have been calls for the more explicit use of global health programmes as a tool of international relations and diplomacy in the Iraq setting as a meaningful alternative to the pursuit of 'hard power' interventions (Horton 2006).

### *The development of a 'global health diplomacy' perspective*

A number of articles have outlined the rationale for the pursuit of broader diplomatic objectives through foreign assistance programmes (see, for example CSIS 2010; Feldbaum 2010; Feldbaum and Michaud 2010; Katz et al. 2012; Novotny and Adams 2007). As well as achieving their direct and planned programmatic goals, global health initiatives also have the capacity to make significant collateral contributions to the diplomatic and international relations goals of donor countries, including conflict resolution, nation-building and regional peace-keeping activities (Feldbaum 2010). Simultaneously, dramatic recent increases in funding for global health programmes under programmes such as the Global Fund and the USA's President's Emergency Plan for AIDS Relief mean that there is increased demand for the evaluation of both direct (Bendavid and Bhattacharya 2009) and indirect (or 'collateral') programme impacts, outcomes and outputs (Walensky and Kuritzkes 2010). In this context, Fidler (2007), in advancing the concept of 'global health diplomacy', defined here as the dual goals of improving global health and bettering international relations in conflict areas and resource-poor environments (Novotny and Adams 2007), notes that the traditional political hierarchy (in which foreign assistance programmes, including health initiatives, are traditionally consigned to the field of 'low politics') is, increasingly, informed by development activities. As a result of this paradigm shift, the role, design and implementation of global health programmes is being reexamined in the light of their potential contribution to the 'high political' aims of diplomacy and international relations.



### ***Diplomacy and global health***

Global health programmes are, therefore, increasingly visible in conflict and post-conflict settings around the world (United States Institute of Peace 2009), leveraged, where possible, by donor countries, in a strategic capacity, both (1) to win ‘hearts and minds’ in lieu of ‘hard power’ options in a ‘smart power’ international relations framework (CSIS 2007, 2010); and (2) in keeping with a ‘statist’ approach which seeks to link health initiatives to a diplomatic remit (Alesina and Dollar 1998; Davies 2011). In order to achieve these broader goals, global health programmes are increasingly aligned with the principles of international relations, helping to inform the selection, design, structure and delivery of associated interventions (Chatham House 2011), while the fundamental guiding principles of diplomacy are increasingly integrated into their design and delivery (McInnes and Lee 2012; Novotny and Adams 2007). Although these principles have not been exhaustively defined, and measurement of related programmatic performance lies well outside the range of conventional monitoring & evaluation systems (Bonventre 2008), the evaluation of global health’s contributions to international relations outcomes is increasingly of interest (Novotny and Kevany 2013).

### ***The Global Fund and global health diplomacy***

While the Global Fund is a non-aligned, apolitical organization (Global Fund 2013a), all global health activities may, deliberately or inadvertently, produce diplomatic and international relations dividends as well as health gains (Feldbaum and Michaud 2010). In addition, the Global Fund is guided in resource allocation decisions across and within recipient countries by the strategic preferences of donor countries, specifically those related to (1) donor bilateral development objectives and priorities (Aidspan 2013a) and (2) capacity-building activities in countries of specific interest to donors (Aidspan 2013b). In the Iraq context, though none of the Global Fund’s programmes are intentionally, consciously or explicitly designed to address international relations or diplomatic issues, related outcomes may therefore nonetheless occur on an unplanned, ad hoc basis. Significantly, multilateral and non-aligned initiatives such as the Global Fund are uniquely positioned to deliver health services, with appropriate diplomatic gains, in areas and regions where bilateral donors may fear to tread.

### ***Developing and conducting a global health diplomacy evaluation***

Given the importance of cultural and social considerations in conflict and post-conflict settings, the Global Fund attempts to take into consideration ‘program appropriateness’ as well as programme effectiveness and efficiency (Global Fund 2010), at least in part as a result of close attention to communications

protocols and joint decision-making with the NTP (Lane 2013). In this context, and in order to attempt to evaluate the achievement of both the implicit and explicit international relations outcomes by foreign assistance programmes in post-conflict settings, we applied a range of criteria outlining the key features of diplomatically ‘sensitized’ global health programmes to tuberculosis prevention, treatment and care programmes supported by the Global Fund in Iraq.

## Methods

### *Global health diplomacy evaluation criteria development*

Proposed possible criteria for the development of ‘diplomatically effective’ foreign assistance programmes were developed based on a review of the literature and in conjunction with a parallel book chapter (Novotny and Kevany 2013). Through this review of publications related to (1) health diplomacy; (2) global health and international relations; and (3) global health and foreign policy, we extracted those diplomatic principles and characteristics considered desirable, appropriate and effective in global health programmes in order to form the basis of a ‘global health diplomacy’ perspective for programme evaluation, as articulated in the recent book *Twenty-First Century Global Health Diplomacy* (Novotny and Kickbusch 2009). Briefly, these include questions such as ‘does the global health programme assist access to strategic resources or markets’; ‘is the donor’s regional or international influence and prestige enhanced’; and, perhaps most importantly, ‘has this program contributed to regional stability, nation-building, international relations, helping us move towards world peace.’ This suggested principles for (1) the pursuit of diplomatic objectives in the global health context (e.g. Feldbaum 2010); (2) requirements for the achievement of ‘global health diplomacy’ outcomes (e.g. Kickbusch and Buss 2011); and (3) international relations, security and ‘smart power’ considerations (e.g. CSIS 2010). For each criterion, associated contributions and achievements from Global Fund-supported tuberculosis programmes in Iraq were assessed and described.

### *Site visits*

In April and May 2012, and in September and October 2013, the authors conducted a series of field visits to tuberculosis diagnosis, treatment and prevention service delivery points (SDPs) supported by the Global Fund in the Kurdistan Regional Governorate (KRG) of Iraq, including the Sulimaniya, Duhok and Erbil governorates. These visits were organized in concert with the Global Fund’s Local Fund Agent, KPMG LLP, the NTP and the grant principal recipient (UNDP), for the Global Fund’s on-site data verification (OSDV) and routine service quality assessment (RSQA) review purposes. SDPs included specialized tuberculosis clinics, general hospitals with tuberculosis coordination

units, primary health care centres and regional tuberculosis offices throughout the KRG.

### ***Interviews***

Programme implementation and challenges were reviewed and evaluated through direct observation of service capacity and delivery, as well as through (1) a series of semi-structured interviews with clinical and operational representatives at the SDP level; (2) meetings with representatives of the UNDP and grant sub-recipients (including representatives of the International Medical Corps); (3) during meetings and discussions with NTP officials; and (4) as a part of discussions with recipients of tuberculosis services. During SDP site visits, interviews with stakeholders and service delivery providers were also conducted. This process was complemented by observational data collection on the alignment of tuberculosis programme design with the principles of international relations and diplomacy.

### ***Document review***

Site visits and associated interviews were complemented and supplemented by desk reviews of the interventions, targets and implementation structure of associated Global Fund tuberculosis grants for Iraq, including the review of (1) grant principal recipients' and sub-recipients' performance frameworks; (2) associated monitoring and evaluation work plans; and (3) progress update and disbursement request reports. In addition, all other available records related to service delivery, geographical coverage and programme achievements at the SDP level were reviewed during, and subsequent to, each site visit. This included review of (1) programme structure and design; (2) staffing; (3) geographical coverage; (4) target populations; and (5) interactions with national and donor institutions. Finally, additional data on the content of UNDP programmes, including specific provisions for considerations around the potential collateral intervention outcomes of diplomacy, peace-keeping, nation building and conflict prevention were sourced from subsequent correspondence with UNDP in-country representatives.

## **Results**

### ***Geo-strategic accessibility and coverage***

Geo-strategic considerations of global health and other international development programmes relate to assessments of their location from a political, security or even counter-terrorism perspective (Christ and Daniel 2013). Global Fund and UNDP-supported sites in Iraq range from a 60-bed federal hospital, for treating drug-resistant cases of tuberculosis, to the smallest

'Category-C' primary health care centres in remote and rural areas, representing a broad range of both geographical coverage and service delivery options (Al-Hilfi, Lafta, and Burnham 2013). In addition, the initiation of health volunteer activities in the marshlands of southern Iraq through the training of women health volunteers has also taken place as a direct result of Global Fund support (resulting in both increased case detection among household contacts and improved follow-up on treatment). More broadly, the 18 governorates in which Global Fund-supported interventions are currently available in Iraq include all 124 national health districts, the three northern governorates of the KRG and all disputed areas between the KRG and Iraq (Kirkuk and Ninewa), in addition to current conflict areas including the Baghdad, Salaheldeen, Anbar, Basra and Diyala Governorates. Global Fund and UNDP activity in these areas represents rare cases in which international, UN-mandated presences are permitted, which otherwise remain, to a great extent, inaccessible to most multinational or multilateral organizations.

### ***Intervention selection***

The selection of culturally, religiously and socially appropriate global health interventions is particularly important in conflict and post-conflict settings (Rubenstein 2011), where sensitivities both to the nature and goals of donor involvement and, as a result, utilization of the interventions themselves, may be significantly affected (Kevany 2013). With these considerations in mind, Global Fund tuberculosis programmes in Iraq maintain strict fidelity to internationally approved interventions for tuberculosis treatment, prevention and care (Global Fund 2011), focusing on (1) expansion of quality assured tuberculosis diagnostic and treatment services; (2) tuberculosis interventions for high risk population groups; (3) engagement of the private sector in tuberculosis control; (4) operational research and impact measurement; (5) provision of quality-assured laboratory services for MDR-TB; (6) developing human resources specific to MDR-TB; (7) M&E; and (8) tuberculosis drug and case management (UNDP 2012). In addition, Global Fund-supported interventions were selected based on the domestic needs such as strengthening the capacity of diagnostic laboratories and infrastructure of the TB care facilities. For the Round 6 and Round 9 (Phase I) Global Fund grants, the UNDP-NTP partnership has focused on the provision of first- and second-line tuberculosis treatment, as well as developing human resources to provide associated services including DOTs training, smear sputum microscopy and MDR-TB drug and case management. Tuberculosis treatment, prevention and broader health systems strengthening efforts, therefore, consciously avoid the use of any potentially culturally, religiously, or socially sensitive interventions. In addition, all Global Fund-supported programmes for tuberculosis treatment and prevention in Iraq are explicitly non-ideological, avoiding the use of religious, cultural or other influences (Partners in Health 2012).

***Visibility and branding***

Appropriate branding of global health interventions may help to improve perceptions of donor countries and organizations amongst recipient populations (Leonzon 2010). At a number of SDPs visited during site visits, international branding, both for the Global Fund and the UNDP, was observed in the form of (1) Global Fund annotations on key diagnostic instruments; (2) presence of Global Fund logos and plaques outside health care provider sites; and (3) branding of programme vehicles and other equipment. In addition, throughout the grant, a number of high-profile events, supported by both the Global Fund and the UNDP, and attracting significant media coverage (e.g. tuberculosis conferences; the launch of tuberculosis partnerships; the hand-over of the country's first specialized tuberculosis hospital to the NTP), took place (Touma 2012; WHO 2012). In addition, the logos of all multilateral partners, including the Global Fund, the UNDP and the WHO are found on most health registers, guidelines and equipment (UNDP, personal communication). The use of Global Fund branding and logos should be distinguished from bilateral branding, which may cause tensions and hostility in conflict and post-conflict settings (see, for example Kolaczinski et al. 2005). Programme branding was, therefore, observed to avoid the use of references to specific donor countries, focusing specifically on descriptions of the forms of treatment and support available.

***Programme sustainability and alignment***

Limitations on, or threats to, programme sustainability present one of the greatest threats to both health and diplomatic outcomes of global health programmes (Lyman and Wittels 2010). Conversely, sustainable global health programmes designed in a manner closely aligned with, and transferrable to, recipient country priorities and capacities have the potential to produce significant diplomatic dividends (McInnes and Lee 2012). In this context, Global Fund-supported programmes in Iraq have built on close relationships with both the NTP and the national Ministry of Health throughout the grant process, with both priority alignment and intervention transferability forming essential elements of programme design and delivery (Al-Hilfi, Lafta, and Burnham 2013; Lane 2013; Touma 2012): since the beginning of Global Fund grant activity in Iraq, related objectives have consistently been derived from the goals of NTP. As part of the UNDP mandate and the mission priorities of the Global Fund, the NTP and the Iraq Anti-Tuberculosis Association (of which the latter are the only two national stakeholders in the Global Fund project in Iraq) are currently undergoing capacity development in both administrative and financial aspects, in addition to the technical strengthening that the NTP has received from the Global Fund since 2008 (UNDP, personal communication). In particular, national health system capacity-building through training of health workers and management staff has become a key element of broader efforts to ensure

programme sustainability (Yang, Farmer, and McGahan 2010). Similarly, all Global Fund-supported SDPs visited during site visits were found to be operating under the auspices of nationally approved tuberculosis care providers at the governorate, regional and district levels, rather than through independent or external providers, with a view to eventual funding and administrative transition. Programme sustainability has also been promoted through investment in capital good that simultaneously contributes to the pursuit of health systems strengthening goals. This includes (1) strengthening the infrastructure of the NTP through renovation of tuberculosis clinics and MDR-TB in-patient hospitals; (2) procurement of diagnostic equipment designed to extend programme services to reach the most vulnerable populations (e.g. X-ray machines and microscopes for tuberculosis clinics in prisons; provision of molecular diagnostic equipment to TB coordination units at the district level); and (3) fully equipping five culture laboratories and two mobile clinics to provide tuberculosis services to internally displaced populations (UNDP 2012).

### *Contributions to 'nation-building' and peace-keeping initiatives*

Given the location of Global Fund-supported initiatives in a number of conflict and post-conflict regions, potential contributions to peace-keeping and 'nation-building' (and rebuilding) exercises are often regarded as hidden 'collateral' programme outputs (Kevany 2012; Novotny and Kevany 2013). These include the contribution of international actors to the maintenance of an established, non-military international peace-keeping presence. Nonetheless, the causal mechanism between improved security and the presence of international development programmes is unclear (Eldon, Waddington, and Hadi 2008). Although it is impossible to state categorically that global health programmes contribute to the augmentation of peace and stability, local stakeholders noted that the provision of such services has helped to allay hostility and conflict in certain settings, not least through the common provision of equally accessible tuberculosis services, independent of local factionalism. Similarly, the Global Fund currently supports a number of refugee initiatives in Iraq, through the NTP, for the treatment of TB as a result of the current Syrian refugee crisis. Above all, the neutral stance of the Global Fund towards sensitive international political issues has provided a healthy ground for proper cooperation with national authorities (NTP, personal communication).

### *Programme effectiveness and cost-effectiveness*

Global health programmes are more likely to be diplomatically effective if they can be associated with proven results (CSIS 2010). Similarly, global health programmes are more likely to advance diplomatic goals if they can be demonstrated to save more lives than alternative investments (Marseille and Hofmann 2002). All of the tuberculosis treatment, care and prevention activities in the

Iraq setting were selected, wherever possible, to be both effective and cost-effective in health economics terms. This is in keeping with the stated policies of the Global Fund, to ensure that, wherever possible, optimal 'value for money' is attained (The Global Fund 2010), and illustrated by a focus on the provision of large-scale, low-cost, diagnostic and treatment interventions for tuberculosis such as those described above. For example, the Iraq National Reference Laboratory, with support from the Global Fund, passed drug proficiency susceptibility panel tests that decreased the cost of MDR diagnosis which was previously done abroad in Egypt, Iran, Jordan and India (NTP, personal communication), while declines in the percentage of unfavourable treatment outcomes (e.g. died, treatment failure, default or transfer) from 16% (2007) to 11% (2012) due to good drug adherence reflects the success of proven cost-effective community-based advocacy, communication and social mobilization programmes (NTP, personal communication).

### ***M&E and anti-corruption systems***

Improved international communications are increasingly recognized by both bilateral and multilateral donors as an essential feature of international cooperation (Dahinden 2011), including the development of links to isolated populations through which global health initiatives can build networks and relationships (Kevany, Hatfield et al. 2012). In this context, the establishment of national and international M&E systems has formed a key component of the Global Fund's programmes in Iraq. In 2012, a national M&E database was piloted in nine governorates by the UNDP, and, once launched online in 2013, will become the Iraqi Ministry of Health's first official M&E database. To complement this initiative, both computers and Internet services have been provided to all tuberculosis clinics by the UNDP as part of a strategy to strengthen M&E capacity at the regional level. More broadly, updated M&E registers, treatment and identity cards, sheets and using an electronic nominal recording system have now been introduced in all governorates (NTP, personal communication). These advancements improve the development of timely and standardized reporting systems, both internally and internationally, on programme performance. In addition to playing a valuable role in both improvement of programme accountability and evidencing programme effectiveness, and also in terms of anti-corruption (Global Fund 2012), these M&E systems also provide valuable national and international communications mediums in otherwise-inaccessible settings. Similarly, and as part of the site visits, both Global Fund OSDV and RSQA activities by international actors were conducted successfully, for the first time, in 2012, and subsequently in 2013, generating further M&E communications advances between local stakeholders and international actors. NTP representatives recognized that a key feature of the Global Fund's performance-based funding model is its capacity to improve financial accountability, thereby mitigating the risk of donor (or recipient)

concerns related to inappropriate use of funds (Al-Hilfi, personal communication).

### ***International partnerships***

Global health programmes may contribute to the development of sub-national, national and international partnerships with reference to appropriate standards for how donor and multilateral organizations should interact with governments in recipient countries (Adams, Novotny, and Leslie 2008; CSIS 2010), coordinate initiatives (CSIS 2010), and build international alliances beyond health (Kickbusch and Buss 2011). International partnerships between the Global Fund and in-country stakeholders in Iraq are mediated by the UNDP (UNDP 2012) and include a range of innovative collaborative mechanisms between the grant principal recipient, the Global Fund, the National Ministry of Health, the NTP and other departments of the Iraqi government. For example, the Iraq Global Fund country coordinating mechanism (CCM) has been chaired throughout the grant process by the Iraqi Minister for Health, while the Global Fund-supported ‘Stop Tuberculosis Partnership’ is under the joint patronage of the First Lady of Iraq and the WHO-EMRO (WHO-EMRO 2012). In addition, both the Global Fund and the UNDP have advanced regional partnerships (e.g. with the KRG) for programme implementation purposes, helping to build both national and international partnerships through global health initiatives.

### ***Economic benefits***

International health programmes may generate economic benefits at both the macro- and microeconomic levels (Bhargava et al. 2010; Kevany, Murima et al. 2012), which, in turn, broaden global health intervention effectiveness from a diplomatic perspective (Feldbaum 2010; Fidler 2007). In Iraq, related economic benefits of Global Fund-supported programmes were observed to include (1) the presence of a significant number of patients of working age undergoing tuberculosis treatment, thereby contributing to the labour force; (2) the generation of links between healthcare and other social services (e.g. referral of tuberculosis patients to social services at both SDP and regional levels); and (3) the ‘up-skilling’ and associated increased earning potential of tuberculosis training programmes for health professionals. For example, both case notifications and successfully treated TB patients in Iraq are consistently highest amongst persons of working age (NTP, personal communication). At the patient level, UNDP planning documents (see below) also make explicit their programmatic focus on both (1) increasing social equity for tuberculosis patients; and (2) reducing stigma towards, and thereby employability of, tuberculosis patients (UNDP 2013).



***Policy alignment***

The failure to align global health activities, and related policies, with broader strategic and diplomatic considerations may create a ‘tense and confusing duality’ for both donor and recipient organizations (CSIS 2010). Unless carefully designed in this context, global health programmes run the risk of unintentionally obstructing, or even opposing, international relations and diplomatic considerations. In the case of Iraq, political instability and tensions within the central government of Baghdad are ongoing, challenging both the ease with which international donors can provide assistance while also affecting their willingness towards involvement with global health programmes (Al-Hilfi, personal communication). In Iraq, Global Fund and UNDP-supported tuberculosis interventions have, since their introduction, adhered to broader, strategic country policies as jointly generated by the UNDP and the Government of Iraq, including the *National Development Plan for the Government of Iraq 2011 to 2014* (Iraq National Ministry of Planning 2010) and the *United Nations Development Assistance Framework for Iraq 2011–2014* (UNDP 2010b). Equally importantly, tuberculosis treatment and care programmes in Iraq are directly linked to the Millennium Development Goals (specifically, to Goal 6: ‘*Combat HIV/AIDS, Malaria and Other Diseases*’ and Target 6C: ‘*To have halted and begun to reverse by 2015 the incidence of malaria and other major diseases*’) (United Nations 2013).

***Commitment to ‘high-profile’ conditions***

Tuberculosis remains one of the most ‘high profile’ diseases in Iraq and throughout the Middle East, both due to historical links with the region and ongoing high caseloads in global terms (WHO 2012). In this context, the capacity of Global Fund-supported programmes to focus on conditions widespread in the general population, rather than limiting interventions to specific regions or population groups, in turn results in more visible, high-profile, high-impact and ‘popularized’ global health programmes, which are, in turn, more likely to attract benign national and international attention (Feldbaum, Lee and Michaud 2010). Such enhanced coverage provides, in itself, a compelling medium for diplomatic effects of global health programmes. As is the case with HIV in other contexts (e.g. Lyman and Wittels 2010), the introduction of health campaigns for conditions whose neglect may otherwise constitute threats to economic, political or social stability may also be associated with such programmes. In the Iraq setting, TB remains one of the most ‘high-profile’ and epidemiologically significant diseases, with recent evidence indicating that, of the 14,500 TB cases in Iraq in 2011, up to 31% (95% CI 24–42) were unreported (Huseynova et al. 2013). In this context, Global Fund support of the NTP has expanded involvement of primary health care centres (PHCCs)

throughout the country to 1186 sites (62% of all PHCCs) (NTP, personal communication), representing significant population and geographical coverage.

### ***Global health and clandestine activities***

Clandestine interaction between political and military intelligence-gathering activities and global health programmes has been shown to increase the security risk of both programme staff and programme recipients (Wood-Wright 2013). In addition, the inclusion of clandestine agendas as part of global health programmes risks potentially negative diplomatic and international relations consequences between recipient and donor countries (ibid). Nonetheless, the more explicit collaboration between armed forces and development programmes has become an increased prerogative in many parts of the world, designed to protect non-military program staff (Burkle 2013). In a recent open letter, the Deans of the major medical schools in the USA called on the incumbent US political administration to strengthen efforts to make more explicit the interaction between global health and clandestine (as well as explicit) military and strategic intelligence activities (Bueken et al. 2013). In the case of Iraq, improving personnel security whilst also ensuring that the risk of diplomatic incidents occurring on this basis is minimized is of central importance to the achievement of both health and non-health goals.

## **Discussion**

### ***Limitations on the role and applicability of cost-effectiveness analysis in resource allocation***

The rise of a utilitarian approach to international development programme evaluation, as represented by tools such as cost-effectiveness analysis, has resulted in the predominant use of single-metric measures as exclusive barometers of worth or value, or the ‘ruthless winnowing of complex problems into narrowly-defined tasks with measurable targets’ (Fidler 2011). In a variation on the McNamara Fallacy (Basler 2009), global health programmes, as demonstrated above, may have a range of downstream, collateral or indirect outcomes, impacts or outputs that are not currently quantified – and are therefore considered to be non-existent. Before global health resource allocation decisions across alternative interventions are made based on criteria such as cost-effectiveness, therefore, the relative and absolute strengths of interventions according to broader diplomatic and strategic criteria should, wherever possible, be considered and included in the associated calculus (Kevany, Benatar, and Fleischer 2013). For foreign assistance programmes to be of optimal effectiveness, they should be evaluated, qualitatively, observationally and quantitatively, according to the most complete range of outcomes which they stand to deliver.

***Metrics to measure global health diplomacy achievements and effectiveness***

The current USA Secretary of State called, in his inaugural speech, for health and development programmes to enhance their diplomatic role in order to negate the need for ‘hard power’ interventions, wherever possible (United States State Department 2013). However, the development of formal metrics to evaluate the international relations and diplomatic effectiveness of foreign assistance programmes has not, to date, been achieved, although attempts have been made to articulate these dividends (e.g. Bush 2011; CSIS 2010). Given the fundamentally unquantifiable nature of many of these related outcomes, including the winning of ‘hearts and minds’, the generation of good will towards donors, and the furthering of international cooperation and partnerships, further assessments on the basis of the criteria and approach outlined above, to be further developed in line with advances at the theoretical level, are encouraged. In the future, these outcomes might be more formally evaluated through their inclusion in routine service assessments, complementary to the health outcome-focused instruments currently in use (e.g. Global Fund 2013b), and based on those tools currently employed by the Global Fund and related organizations.

***Broader diplomatic sensitization of health and development programmes and staff***

The advanced training of international health personnel in the principles of diplomacy and international relations has been proposed as a key feature of global health diplomacy (Katz 2012). In regions such as Iraq, the potential significance of such training is heightened, especially when viewed from the international relations perspective. Wherever possible, the sensitization of global health personnel to the diplomatic importance of their work and associated interactions should be included as a key part of their training, most particularly in conflict and post-conflict settings. Only in such circumstances can the diplomatic dividends of such initiatives be optimized. More broadly, these findings indicate the potentially significant contributions that the design, content and implementation of global health programmes can make to diplomacy. Adherence to the assessment criteria proposed elsewhere (Novotny and Kevany 2013) has the potential to make foreign assistance programmes both less contentious and more effective in their simultaneous pursuit of development and diplomatic goals. In this way, the use of foreign assistance programmes to contribute to broader international relations goals may also be monitored and evaluated. Ultimately, recognition of these accomplishments has the potential to focus the attention of developed nations on the use of global health programmes as both a practical and effective way of pursuing the goals of international relations and diplomacy, particularly amidst sharply decreasing public support for other forms of ‘hard power’ interventions in recent years.

### **Conclusion: the diplomatic effectiveness of global health programmes**

These findings suggest that global health programmes in Iraq are already well advanced in their diplomatic and international relations effectiveness, fulfilling all four of the identified advantages of leveraging global health programmes for conflict resolution in the country – in turn, helping to reframe the *modus operandi* of twenty-first century diplomacy (Horton 2006). SDPs and other stakeholders observed during this review produced a wide range of examples of the potential diplomatic effectiveness of appropriately designed global health programmes in conflict and post-conflict settings. Beyond their direct, primary and explicit public health effects, Global Fund-supported tuberculosis programmes in Iraq were also shown to have an implicit effectiveness in the context of (1) reducing hostility towards international programmes through appropriate modifications to interventions and based on the non-aligned, multilateral nature of programme branding; (2) inclusive attention and care towards potentially peripheral and extremist groups and individuals, winning ‘hearts and minds’; (3) transcending traditional social, cultural and religious barriers through the equitable and unbiased provision of services; (4) engendering community support through health care provision; and (5) augmenting peace-keeping activities through the establishment of communications networks and the development of an international, but non-hostile, presence in conflict regions. Provided associated considerations are taken into account at the programme design, resource allocation and implementation phases, global health initiatives may therefore improve accessibility to, and stability in, remote and inaccessible regions.

### **Disclaimer**

N.G.W., co-author, currently works at The Global Fund to Fight AIDS, Tuberculosis and Malaria. P.J., co-author, currently works at the United Nations Development Programme. M.A.D., co-author, currently works at KPMG Jordan. The views expressed in this article are those of the named authors, and do not necessarily reflect the decisions or stated policy of these organizations.

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## References

- Adams, V., T. Novotny, and H. Leslie. 2008. "Global Health Diplomacy." *Medical Anthropology* 27 (4): 315–323.
- Aidspan. 2013a. *France Undertakes an Evaluation of Its 'Contribution' to the Global Fund*. [http://www.aidspan.org/gfo\\_article/france-undertakes-evaluation-its-%E2%80%9Ccontribution%E2%80%9D-global-fund](http://www.aidspan.org/gfo_article/france-undertakes-evaluation-its-%E2%80%9Ccontribution%E2%80%9D-global-fund).
- Aidspan. 2013b. *France Pledges \$1.4 billion for Global Fund's Fourth Replenishment*. [http://www.aidspan.org/gfo\\_article/france-pledges-14-billion-global-fund%E2%80%99s-fourth-replenishment](http://www.aidspan.org/gfo_article/france-pledges-14-billion-global-fund%E2%80%99s-fourth-replenishment).
- Al Hilfi, T., R. Lafta, and G. Burnham. 2013. "Health Services in Iraq." *The Lancet* 381: 939–948. [www.thelancet.com/journals/lancet/article/PIIS0140...7/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140...7/abstract).
- Alesina, A., and D. Dollar. 1998. *Who Gives Foreign Aid to Whom and Why?* National Bureau of Economic Research Working Paper No. 6612. Accessed November 15, 2012. <http://www.nber.org/papers/w6612>
- Basler, M. 2009. "Utility of the McNamara Fallacy." *British Medical Journal* 339: b3141.23.
- Bendavid, E., and J. Bhattacharya. 2009. "The President's Emergency Plan for AIDS Relief in Africa: An Evaluation of Outcomes." *Annals of Internal Medicine* 150 (10): 688–695.
- Bhargava, A., D. Jamison, L. Lau, and C. L. Murray. 2010. *Modeling the Effects of Health on Economic Growth*. GPE Discussion Paper Series: No. 33. Evidence and Information for Policy World Health Organization. <http://www.who.int/healthinfo/paper33.pdf>.
- Bonventre, E. 2008. "Monitoring and Evaluation of Department of Defense Humanitarian Assistance Programs." *Military Review* 88: 66–72.
- Bueken, P., J. Curran, J. Finnegan, and J. Frenck. 2013. *Open Letter to President Obama Regarding Polio Worker Assassinations in Pakistan*. <http://www.jhsph.edu/news/newsreleases/2013/Klag%20letter%20to%20President%20Obama.pdf>.

- Burkle, F. M. 2013. "Throwing the Baby Out With the Bathwater: Can the Military's Role in Global Health Crises be Redeemed?" *Prehosp Disaster Med.* 14: 1–3. <http://www.ncbi.nlm.nih.gov/pubmed/23406945>.
- Bush, K. 2011. *A Measure of Peace: Peace and Conflict Impact Assessment (PCIA) of Development Projects in Conflict Zones*. Working Paper No. 1. The Peace-building and Reconstruction Program Initiative & The Evaluation Unit. [www.conflictsensitivity.org/node/58](http://www.conflictsensitivity.org/node/58).
- Chatham House. 2011. "Global Health Diplomacy: A Way Forward in International Affairs." *Meeting Summary: Centre on Global Health Security*. Accessed November 1, 2012. <http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/280611summary.pdf>
- Christ, E., and L. Daniel. 2013. *Doctor Outlines Global Health's Tie to Security Operations*. <http://www.geostrategicforecasting.com/doctor-outlines-global-healths-tie-to-security-operations/#sthash.Vb43jw2F.dpuf>.
- (CSIS) Center for Strategic and International Studies. 2007. *Final Report of the CSIS Commission on Smart Power*. Accessed October 1, 2012. [www.csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://www.csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)
- (CSIS) Center for Strategic and International Studies. 2010. *Final Report of the CSIS Commission on Smart Global Health Policy*. Accessed November 1, 2012. <http://www.csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>
- Dahinden, M. 2011. "Communication in International Cooperation." Swiss Agency for Development and Cooperation presentation at the University of Lugano, Lugano, September 5.
- Davies, S. E. 2011. "What Contribution can International Relations make to the Evolving Global Health Agenda?" *International Affairs* 86 (5): 1167–1190.
- Eldon, J., C. Waddington, and Y. Hadi. 2008. *Health System Reconstruction: Can it Contribute to State-building?* London: Health & Fragile States Network, HLSP Institute.
- Fawcett, L. 2013. "The Iraq War Ten Years on: Assessing the Fallout." *International Affairs*. <http://www.chathamhouse.org/publications/ia>.
- Feldbaum, H. 2010. "Health Diplomacy and the Enduring Relevance of Foreign Policy Interests." *PLoS Medicine* 7 (4).
- Feldbaum, H., and J. Michaud. 2010. "Health Diplomacy and the Enduring Relevance of Foreign Policy Interests." *PLoS Medicine* 7 (4): e1000226.
- Feldbaum, H., K. Lee, and J. Michaud. 2010. "Global Health and Foreign Policy." *Epidemiologic Reviews* 32 (1): 82–92.
- Fidler, D. 2007. "Reflections on the Revolution in Health and Foreign Policy." *Bulletin of the World Health Organization* 85 (3): 243–244.
- Fidler, D. 2011. "Rise and Fall of Global Health as a Foreign Policy Issue." *Global Health Governance* IV (2). <http://ghgj.org/DavidFidler.pdf>.
- Global Fund. 2010. "Improving Value for Money in Global Fund-Supported Programs." *Global Fund Report for Third Replenishment Meeting*. Accessed March 1, 2012. <http://www.theglobalfund.org/en/performance/effectiveness/value/improving/>
- Global Fund. 2011a. *Iraq Grant Portfolio*. <http://portfolio.theglobalfund.org/en/Country/Index/IRQ>.
- Global Fund. 2012. *Iraq Portfolio Overview*. <http://portfolio.theglobalfund.org/en/Country/Index/IRQ>.
- Global Fund. 2013a. *About the Global Fund*. <http://www.theglobalfund.org/en/about/>.
- Global Fund. 2013b. *Routine Service Quality Assessment and On-Site Data Verification Tools*. <http://www.theglobalfund.org/en/me/documents/dataquality/>.

- Horton. 2006. "Iraq: Time to Signal a New Era for Health in Foreign Policy." *The Lancet* 368: 1395–1397. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)69492-0/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69492-0/fulltext).
- Huseynova, S., D. S. Hashim, M. R. Tbena, R. Harris, A. Bassili, I. Abubakar, P. Glaziou, and K. Floyd. 2013. "Estimating Tuberculosis Burden and Reporting in Resource-limited Countries: A Capture-recapture Study in Iraq." *The International Journal of Tuberculosis and Lung Disease* 17 (4): 462–467.
- Iraq National Ministry of Planning. 2010. "The National Development Plan for the Government of Iraq 2011 to 2014." *Ministry of Planning Document*. <http://www.iauiraq.org/documents/1159/ndp24th.pdf>.
- Katz, R., S. Kornblet, G. Arnold, E. Lief, and J. E. Fischer. 2012. "Defining Health Diplomacy: Changing Demands in the Era of Globalization." *The Milbank Quarterly* 89 (3): 503–523.
- Kevany, S. 2012. "Diplomatic and Operational Adaptations to Global Health Programmes in Post-conflict Settings: Contributions of Monitoring and Evaluation Systems to Health Sector Development and 'Nation-building' in South Sudan." *Medicine, Conflict and Survival* 28 (3): 247–262. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>.
- Kevany, S. 2013. "Health Diplomacy and the Adaptation of Global Health Interventions to Local Needs in Sub-Saharan Africa and Thailand: Findings from Project Accept (HPTN 043)." *BMC Public Health* 12: 459.
- Kevany, S., A. Hatfield, N. Workneh, K. White, Y. Bekele, and B. Az. 2012. "Diplomatic and Operational Adaptations to Global Health Programs in Post-Conflict Settings: Contributions of Monitoring and Evaluation Systems to 'Nation-Building' in South Sudan." *Medicine, Conflict and Survival* 28 (3): 247–62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>.
- Kevany, S., O. Murima, B. Singh, D. Hlubinka, M. Kulich, S. F. Morin, and M. Sweat. 2012. "Socio-Economic Status and Health Care Utilization in Rural Zimbabwe: Findings from Project Accept (HPTN 043)." *Journal of Public Health Africa* 3 (1): 46–51. <https://www.ncbi.nlm.nih.gov/m/pubmed/22962629/?i=7&from=1/1469676/related&filter=loattrfree%20full%20text>.
- Kevany, S., S. R. Benatar, and T. Fleischer. 2013. "Improving Resource Allocation Decisions for Health and HIV Programmes in South Africa: Bioethical, Cost-Effectiveness and Health Diplomacy Considerations." *Global Public Health* 8 (5): 570–587.
- Kickbusch, I., and P. Buss. 2011. "Global Health Diplomacy and Peace." *Infectious Disease Clinics of North America* 25 (3): 601–610, ix. doi:10.1016/j.idc.2011.05.006.
- Kolaczinski, J., K. Graham, A. Fahim, S. Brooker, and M. Rowland. 2005. "Malaria Control in Afghanistan: Progress and Challenges." *The Lancet* 365 (9469): 1506–1512.
- Lane, R. 2013. "Thamer Kadum Al Hilfi: Looking Ahead to a Healthier Iraq." *The Lancet* 381: 897.
- Leonzon, R. 2010. "Rajiv Shah Defends USAID Branding Policy." *DevEx Newswire*. <https://www.devex.com/en/news/shah-us-aid-branding-policy-a-matter-of/70489>.
- Lyman, N. P., and S. B. Wittels. 2010. "No Good Deed Goes Unpunished: The Unintended Consequences of Washington's HIV/AIDS Programs." *Foreign Affairs*. Accessed December 1, 2012. <http://www.foreignaffairs.com/articles/66464/princeton-lyman-and-stephen-b-wittels/no-good-deed-goes-unpunished>
- Marseille, E., and Paul B Hofmann. 2002. "HIV Prevention before HAART in Sub-Saharan Africa." *The Lancet* 359: 1851–1856.
- McInnes, C., and K. Lee. 2012. *Global Health and International Relations*. London: Polity Press.

- Novotny, T., and V. Adams. 2007. "Global Health Diplomacy – A Call for a New Field of Teaching and Research." *San Francisco Medicine* 80 (3): 22–23.
- Novotny, T., and S. Kevany. 2013. "The Way Forward in Global Health Diplomacy: Definitions, Research, and Training." In *21st Century Global Health Diplomacy*. World Scientific Press. <http://www.worldscientific.com/worldscibooks/10.1142/8178>.
- Novotny, T., and I. Kickbusch. 2009. "Global Health Diplomacy – A Bridge to Innovative Collaborative Action." *Global Forum Update on Research for Health* 5: 41–45.
- Partners in Health. 2012. *Institute for Health and Social Justice Issues: Funding for Global Health*. <http://www.pih.org/pages/ihsj-issue-funding-for-global-health>.
- Rubenstein, L. 2011. *Health in Conflict-Affected States: Valuable Lessons and Unanswered Questions*. Center for Strategic and International Studies Smart Global Health Program. <http://www.smartglobalhealth.org/blog/entry/health-in-conflict-affected-states-valuable-lessons-and-unanswered-question/>.
- Touma, J. 2012. *UNDP and WHO Hand Over First Specialized Tuberculosis Hospital to the Government of Iraq*. UNDP Iraq Office Press Release. [http://www.iq.undp.org/Publications\\_View.aspx?q=SUQ9NTQm-QC%2Bil4uoBos%3D](http://www.iq.undp.org/Publications_View.aspx?q=SUQ9NTQm-QC%2Bil4uoBos%3D).
- United Nations. 2013. *The Millennium Development Goals*. [www.un.org/millenniumgoals/](http://www.un.org/millenniumgoals/).
- UNDP (United Nations Development Program). 2010a. *GFATM UNDP-Iraq Project Document 2010*. (Phase I-SSF grant, Round 9).
- UNDP (United Nations Development Program). 2010b. *United Nations Development Assistance Framework for Iraq 2011 to 2014*. United Nations Country Team in Iraq document. <http://iq.one.un.org/cca-undaf.asp>.
- UNDP (United Nations Development Program). 2012. *Our Work: What the United Nations Development Program Does in Iraq*. <http://www.iq.undp.org/OurWork.aspx>.
- UNDP (United Nations Development Program). 2013. *Fast Facts: Support to the National Tuberculosis and HIV/AIDS Programmes in Iraq*. UNDP Fact Sheet. [www.undp.org/hiv/](http://www.undp.org/hiv/).
- United States Institute of Peace. 2009. *Post-conflict Health Reconstruction: New Foundations for US Policy*. United States Institute of Peace Working Paper. Accessed December 1, 2012. [http://www.usip.org/files/resources/post-conflict\\_health\\_reconstruction.pdf](http://www.usip.org/files/resources/post-conflict_health_reconstruction.pdf).
- United States State Department. 2013. *John Kerry's Address at the University of Virginia*. Secretary of State. Accessed February 20, 2013. <http://www.state.gov/secretary/remarks/2013/02/205021.htm>.
- Walensky, R. P., and D. R. Kuritzkes. 2010. "The Impact of the President's Emergency Plan for AIDS Relief (PEPFAR) Beyond HIV and Why it Remains Essential." *Clinical Infectious Diseases* 50 (2): 272–275. doi:10.1086/649214.
- Wood-Wright, N. 2013. *CIA Vaccination Cover in Pakistan*. Johns Hopkins School of Public Health News. <http://www.jhsph.edu/news/news-releases/2013/klag-CIA-vaccination-cover-pakistan.html>.
- World Health Organization. 2011. *WHO Global Tuberculosis Report 2011*. [www.who.int/tb/publications/global\\_report/2011/gtbr11\\_full.pdf](http://www.who.int/tb/publications/global_report/2011/gtbr11_full.pdf).
- World Health Organization. 2012. *Global Tuberculosis Report 2012*. Accessed January 15, 2013. [http://apps.who.int/iris/bitstream/10665/75938/1/9789241564502\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75938/1/9789241564502_eng.pdf).
- World Health Organization Eastern Mediterranean Regional Office. 2012. *Iraq joins the Global Stop Tuberculosis Partnership*. WHO-EMRO Media Centre. <http://www.emro.who.int/media/news/stop-tb-partnership-iraq.html>.
- Yang, A., P. E. Farmer, and A. M. McGahan. 2010. "'Sustainability' in Global Health." *Global Public Health* 5 (2): 129–135. doi:10.1080/17441690903418977.





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

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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 Health' (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 (Yeresskovsky, 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 prosequi* (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 roll-out 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 outweigh 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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## References

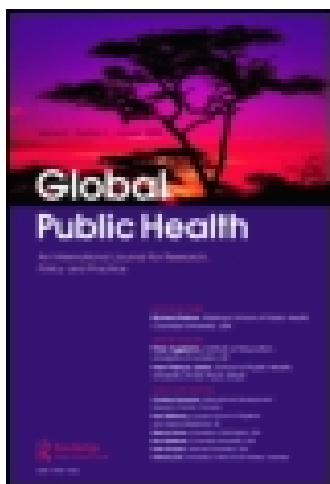
- Adams, D. (1987). *Dirk gently's holistic detective agency*. London: Picador.
- American Foundation for AIDS Research (2013). *U.S. global health investments: The evidence on health, diplomatic and economic impact*. AMFAR issue brief. Retrieved from <http://www.amrefusa.org/silo/files/amfar-global-health-investment-impact-june-2011.pdf>
- Basler, M. (2009). Utility of the McNamara fallacy. *British Medical Journal*, 339, b3141.23.
- Benatar, S. (2015). Explaining and responding to the Ebola epidemic. *Philosophy, Ethics, and Humanities in Medicine* 10(5). doi:10.1186/s13010-015-0027-8. Retrieved from <http://www.peh-med.com/content/10/1/5>
- Bhattacharya, G. (2004). Sociocultural and behavioral contexts of condom use in heterosexual married couples in India: Challenges to the HIV prevention program. *Health Education & Behavior*, 31(1), 101–117. Retrieved from <http://heb.sagepub.com/content/31/1/101.short>
- Bräutigam, D., & Knack, S. (2004). Foreign aid, institutions, and governance in Sub-Saharan Africa. *Economic Development and Cultural Change*, 52(2), 255–285. Retrieved from <http://www.jstor.org/stable/10.1086/380592>
- Buekens, P. (2013). *Medical school deans' letter to President Obama*. Retrieved from <http://www.jhsph.edu/news/newsreleases/2013/Klag%20letter%20to%20President%20Obama.pdf>
- Burkle, S. (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*, 28(3), 1–3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&id=8921591>
- Center for Strategic and International Studies (2010). *Final report of the CSIS Commission on smart global health policy*. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>
- Centers for Disease Control and Prevention (2015). *Global Health—Global Health Security Agenda*. Retrieved from <http://www.cdc.gov/globalhealth/security/>
- Critchlow, D. (1995). Birth control, population control, and family planning: an overview. *Journal of Policy History*, 7(1), 1–21. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12346341>
- Dewachi, O., Skelton, M., Nguyen, V., Fouad, F., Abu Sitta, G., Maasri, Z., & Giacaman, R. (2014). *Changing therapeutic geographies of the Iraqi and Syrian wars*. doi:10.1016/S0140-6736(13)62299-0
- Dietrich, J. (2007). The politics of PEPFAR: The President's emergency plan for AIDS relief. *Ethics & International Affairs*, 21(3). Retrieved from [http://www.carnegiecouncil.org/publications/journal/21\\_3/essay/001.html:pf\\_printable](http://www.carnegiecouncil.org/publications/journal/21_3/essay/001.html:pf_printable)
- Eckenwiler, L., & Hunt, M. (2014, May–June). *Counterterrorism, ethics, and global health* (Hastings Center Report). doi:10.1002/hast.308
- Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4), e1000226. Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000226>
- Gardham, D. (2015). Islamic State creates jihadi health service. *BMJ*, 350. doi:10.1136/bmj.h3487
- Gostin, L. (2013). *Global health law*. Cambridge: Harvard University Press. ISBN 9780674728844.
- Gostin, L. (2014). Global polio eradication: Espionage, disinformation, and the politics of vaccination. *Milbank Quarterly*, 92(3), 413–417. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12065/abstract;jsessionid=AFBBBD06790EF5F3BEDF2C9AE6EF9588.f03t02?deniedAccessCustomisedMessage=&userIsAuthenticated=false>



- Katz, R., Kornblet, S., Arnold, G., Lief, E., & Fischer, J. (2011). Defining health diplomacy: Changing demands in the era of globalization. *Milbank Quarterly*, 89, 503–523. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.14680009.2011.00637.x/abstract>
- Kerry, J. (2013). *Remarks at a global health event with partner countries*. Retrieved from <http://www.state.gov/secretary/remarks/2013/09/214733.htm>
- Kevany, S. (2014). Global health diplomacy, 'smart power', and the new world order. *Global Public Health: An International Journal for Research, Policy and Practice*. doi:10.1080/17441692.2014.921219
- Kevany, S. (2015, April 20). The American response to Ebola. *The New York Times Letters to the Editor*. Retrieved from [http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?\\_r=0](http://www.nytimes.com/2015/04/20/opinion/the-american-response-to-ebola.html?_r=0)
- Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocation decisions for health and HIV programmes in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570–587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>
- Kevany, S., Jaf, P., Workneh, N. G., Dalo, M. A., Tabena, M., Rashid, S., & Al Hilfi, T. K. Y. (2014). Global health diplomacy in Iraq: International relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival*. doi:10.1080/13623699.2014.890827
- Kevany, S., Khumalo-Sakutukwa, G., Murima, O., Chingono, A., Modiba, P., Gray, G., ... Morin, S. (2012). Health diplomacy the adaptation of global health interventions to local needs in sub-Saharan Africa and Thailand: Evaluating findings from project accept (HPTN 043). *BMC Public Health*, 12, 459. Retrieved from <http://www.biomedcentral.com/14712458/12/459/abstract>
- Kevany, S., Sahak, O., Workneh, N. G., & Saeedzai, S. A. (2014). Global health diplomacy investments in Afghanistan: Adaptations and outcomes of global fund malaria programs. *Medicine, Conflict and Survival*, 30(1), 37–55. Retrieved from <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>
- Kickbusch, I., Orbinski, J., Winkler, T., Schnabel, A. (2015). We need a sustainable development goal 18 on global health security. *The Lancet*, 385(9973), 1069. Retrieved from <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2960593-1/fulltext?rss=yes>
- Kleinman, A. (2010). Four social theories for global health. *The Lancet*, 375, 1518–1519. doi:10.1016/S0140-6736(10)60646-0
- Koplan, J., Bond, T., Merson, M. (2009). Towards a common definition of global health. *Lancet*, 373, 1993–1995. Retrieved from <http://www.ianphi.org/documents/articlesArchives/2009Koplan%20Lancet.pdf>
- Mackey, T., & Strathdee, S. (2015). Responding to the public health consequences of the Ukraine crisis: an opportunity for global health diplomacy. *Journal of the International AIDS Society*. Retrieved from <http://www.jiasociety.org/index.php/jias/article/view/19410>
- Mackey, T., Liang, B. (2011). The global counterfeit drug trade: patient safety and public health risks. *Journal of Pharmaceutical Sciences*, 100(11), 4571–4579. doi:10.1002/jps.22679.
- Pledge Peace Union (2015). *Geneva convention: Introduction and historical background*. Retrieved from [http://www.ppu.org.uk/learn/texts/doc\\_geneva\\_con.html](http://www.ppu.org.uk/learn/texts/doc_geneva_con.html)
- Rehn, O. (2005). *Europe's smart power in its region and the world*. Speech at the European Studies Centre, St Antony's College, University of Oxford, 1 May 2008. Retrieved from [www.europa.eu/rapid/pressReleasesAction.do?reference=SPEECH](http://www.europa.eu/rapid/pressReleasesAction.do?reference=SPEECH)
- Rogin, J. (2012). NATO chief: Intervention just won't work in Syria. *Foreign Policy*. Retrieved from <http://foreignpolicy.com/2012/02/29/nato-chief-intervention-just-wont-work-in-syria/>
- Schwartz, S., & Dunkel, C. (2009). Terrorism: An identity theory perspective. *Studies in Conflict & Terrorism*, 32, 537–559, 2009. Retrieved from [http://www.researchgate.net/profile/Seth\\_Schwartz/publication/225029149\\_Terrorism\\_An\\_Identity\\_Theory\\_Perspective/links/0fcfd4fbbd2e19a2e6000000.pdf](http://www.researchgate.net/profile/Seth_Schwartz/publication/225029149_Terrorism_An_Identity_Theory_Perspective/links/0fcfd4fbbd2e19a2e6000000.pdf)
- Stephan, M., & Beyerle, S. (2015). How to stop extremism before it starts. *Foreign Policy*. Retrieved from <http://foreignpolicy.com/2015/03/17/how-to-stop-extremism-before-it-starts/>
- The Guardian (2014). *Pakistan polio vaccinator's murder by militants raises health workers' fears*. Retrieved from <http://www.theguardian.com/society/2014/mar/25/pakistan-polo-vaccinators-murder-militants-salma-farooqi>

- The Lancet* (2015). *Global health security*. Retrieved from <http://www.thelancet.com/infographics/global-health-security>
- The Lancet Editorial (2015). National armies for global health? *The Lancet*, 384, 1477. Retrieved March 1, 2015, from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61923-1/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61923-1/fulltext?rss=yes)
- United Nations International Children's Emergency Fund (2001). *No Guns, Please!* UNICEF Division of Communication. Retrieved from [http://www.unicef.org/emerg/files/Emergencies\\_No\\_guns\\_please\\_leaflet.pdf](http://www.unicef.org/emerg/files/Emergencies_No_guns_please_leaflet.pdf)
- United Nations Office on Drugs and Crime (2015). *Background of the United Nations Convention against corruption*. Retrieved from <https://www.unodc.org/unodc/en/treaties/CAC/>
- Yereskovsky, A. (2000). *The Global Security Environment and U.S.-Russian Strategic Relations in the 21st Century: Partners or rivals?* Discussion Paper 2000-13, Center for Science and International Affairs, John F. Kennedy School of Government, Harvard University. Retrieved from [http://belfercenter.ksg.harvard.edu/publication/2956/global\\_security\\_environment\\_and\\_usrussian\\_strategic\\_relations\\_in\\_the\\_21st\\_century.html](http://belfercenter.ksg.harvard.edu/publication/2956/global_security_environment_and_usrussian_strategic_relations_in_the_21st_century.html)

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### Global Health Diplomacy, 'Smart Power', and the New World Order

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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;

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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, Kornblat, 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, & Basilio, 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 ‘siloes’, 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 synthesis 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.

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- 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, Brooker, & 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)
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Table 2. Foreign policy criteria for global health programmes.

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- 1 *Geo-political location*: Reference to strategic locational considerations (CSIS, 2010), including capacity to access geographic areas hostile to international actors (Feldbaum, 2010); positively influencing areas prone to insurgent manipulation (Bonventre, 2008); enticing populations away from terrorist groups (Rubenstein, 2013); working in regions which may contribute to regime change (Birdsall, 2013, AMFAR, 2013); and decreasing opportunities for opponents with destructive agendas (Jaffe, 2013)
  - 2 *Nation-building and peace-keeping initiatives*: Contributions to nation-building (Kevany et al., 2012a) and peace-keeping processes (Eldon, Waddington, & Hadi, 2008; Kevany, 2012), including resolution of conflict (Novotny & Adams, 2007); regional stability (Feldbaum, 2010); integration of peace-building concerns into global health programmes (Novotny & Adams, 2007; Macrae, 1997; Kickbusch & Buss, 2011); and advancing democratisation in the developing world (AMFAR, 2013)
  - 3 *Strategic alignment*: Harmonisation between bilateral and multilateral global health and foreign policies (CSIS, 2007; Feldbaum, 2010) and inculcation of strategic awareness of relationships between global health and foreign policy goals (CSIS, 2010), including recognition of the capacity of global health programmes to advance or obstruct international relations objectives (Katz et al., 2011)
  - 4 *'High-profile' conditions*: Responding to health needs that may have significant implications for donor security, health or economic well-being (CSIS, 2010; Feldbaum, 2010), including transnational epidemic diseases such as HIV/AIDS, tuberculosis and malaria (Michaud & Kates, 2013)
  - 5 *Human rights*: Alignment between global health service delivery and the defence and advancement of human rights, including the abolition of slavery, freedom from tyranny, and access to health services, thereby contributing to the advancement of human dignity, both within and beyond health (WHO, 2012)
  - 6 *Accessing strategic markets and resources*: Optimising the extent to which global health programmes assist, in a manner that is fair and transparent to recipients, in gaining access to strategic resources or markets (Feldbaum, 2010), including commodity resources from low- and middle-income countries (AMFAR, 2013; Novotny & Kevany, 2013), which, in turn, generate economic gains for both donors and recipients (Jaffe, 2013)
  - 7 *Inclusiveness*: Leveraging global health programmes to unite opposing political factions, promoting reconciliation and peace (Rubenstein, 2013), including negotiation, mediation and 'public health persuasion' initiatives, through integration of former adversaries within the same health service (Kickbusch, 2012) regardless of affiliation (Rubenstein, 2013)
  - 8 *Prestige*: Leveraging global health programmes to revise negative donor stereotypes (Katz et al., 2011), including (1) altering perceptions of donor countries and organisations in recipient communities (Bonventre, 2008), (2) winning the 'hearts and minds' of actual or potential extremist populations (Feldbaum, 2010; Novotny & Adams, 2007) and (3) elevating 'donor image' (AMFAR, 2013)
  - 9 *Smart power*: Delivery of global health programmes in terms of 'armed social work' (Feldbaum, 2010), 'civilian power' (United States Department of State, 2010) and 'militarised aid' (Burkle, 2013), aligned with the support and protection of armed forces (Rubenstein, 2013) in conflict and post-conflict settings (Burkle, 2013)
  - 10 *Communications*: Development of communications links to isolated populations through which bilateral and multinational initiatives may build networks and relationships, gather strategic information and intelligence related to health and non-health issues, in pursuit of overarching political objectives and build a platform for environmental, security and development initiatives (Kevany, 2012)
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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, Zaidie, & 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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### References

- Adams, V., Novotny, T. E., & Leslie, H. (2008). Global health diplomacy. *Medical Anthropology*, Oct–Dec; 27(4), 315–323.
- Alden, C., & Amnon, A. (2011). *Foreign policy analysis—New approaches*. Abingdon: Routledge.
- Alesina, A., & Dollar, D. (2000). Who gives foreign aid to whom and why?. *Journal of Economic Growth*, 5(1), 33–63.
- American Foundation for AIDS Research. (2013). *U.S. global health investments: The evidence on health, diplomatic and economic impact*. AMFAR Issue Brief. Retrieved from <http://www.amrefusa.org/silo/files/amfar-global-health-investment-impact-june-2011.pdf>
- Associated Press. (2011). *UN military forces retaliate in Ivory Coast*. Retrieved from <http://www.cbsnews.com/stories/2011/04/10/501364/main20052584.shtml>
- Atwood, J. (2010). Elevating development assistance. *PRISM Report*, 1(3), 3–11. Retrieved from <http://www.isn.ethz.ch/Digital-Library/Publications/Detail/?ots591=0c54e3b3-1e9c-be1e-2c24-a6a8c7060233&lng=en&id=134152>
- Baker M. (2014). Casualties of the global war on terror and their future impact on health care and society: A looming public health crisis. *Military Medicine*, 179 (4), 348. doi:10.7205/MILMED-D-13-00471
- Basler, M. (2009). Utility of the McNamara fallacy. *British Medical Journal*, 339, b3141.23
- Benatar, S. R., Gill, S., & Bakker, I. (2011). Global health and the global economic crisis. *American Journal of Public Health*, 101, 646–653. doi:10.2105/AJPH.2009.188458
- Birdsall, N. (2013). *Try something new in Syria* [Commentary]. Washington, DC: Center for Global Development. Retrieved from [www.cgdev.org/blog/try-something-new-syria](http://www.cgdev.org/blog/try-something-new-syria)
- Bonventre, E. (2008, January). Monitoring and evaluation of Department of Defense humanitarian assistance programs. *Military Review*, pp. 66–72.
- Bourne, P. (1978). A partnership for international health care. *Public Health Reports*, 93(2), 114–123.
- Brainard, L. (2006). *Security by other means*. Washington, DC: Brookings Institution Press.
- British Broadcasting Corporation. (2013). *Cameron fears Iraq effect holding West back in Syria*. Retrieved from <http://www.bbc.co.uk/news/uk-politics-22316517>
- Brown, C. (1992). *International relations theory: New normative approaches*. New York, NY: Columbia University Press. Retrieved from <http://books.google.com/books?hl=en&lr=&id=vp eGPvu97CsC&oi=fnd&pg=PP9&dq=statist+international+relations+theory&ots=a3cVem0lh&sig=ScgWHL0wd7ctzAxImipk78dbYeY#v=onepage&q=statist%20international%20relations%20theory&f=false>
- Buekens, P. (2013). *Medical school deans’ letter to President Obama*. Retrieved from <http://www.jhsph.edu/news/newsreleases/2013/Klag%20letter%20to%20President%20Obama.pdf>

- Burkle, S. (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*, 28(3), 1–3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591>
- Burkle, S., & Garfield, R. (2013). Civilian mortality after the 2003 invasion of Iraq. *The Lancet*, 381, 879. Retrieved from <http://press.thelancet.com/mortality.pdf>
- Center for Strategic and International Studies. (2007). *CSIS commission on smart power*. Retrieved from [http://csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)
- Center for Strategic and International Studies. (2010). *Final report of the CSIS Commission on smart global health policy*. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>
- Center for Strategic and International Studies. (2011). *Is the era of big funding for global health over?* Retrieved from [http://csis.org/files/attachments/110110\\_BaezaPPT.pdf](http://csis.org/files/attachments/110110_BaezaPPT.pdf)
- Clinton, H. R. (2012). *Saving more lives than ever* [Commentary]. Washington, DC: Centre for Global Health and Diplomacy. Retrieved from <http://www.ghdnews.com/index.php/global-health-challenges/feature/74-saving-more-lives-than-ever-hillary-rodham-clinton>
- Cookson, R., McCabe, A., & Tsuchiya, A. (2007). Public healthcare resource allocation and the rule of rescue. *Journal of Medical Ethics*, 34, 540–544. doi:10.1136/jme.2007.021790
- Council on Foreign Relations. (2013). *The global health regime [Policy paper]*. New York: Author. Retrieved from <http://www.cfr.org/health-science-and-technology/global-health-regime/p22763>
- de Tocqueville, A. (1865). *Democracy in America*. Retrieved from <http://xroads.virginia.edu/~HYPER/DETOC/>
- Disease Control Priorities Project. (2008). *Using cost-effectiveness analysis for setting health priorities*. Washington, DC: Fogarty International Center of the U.S. National Institutes of Health. Retrieved from <http://www.dcp2.org/file/150/>
- Eldon, J., Waddington, C., & Hadi, Y. (2008). *Health system reconstruction: Can it contribute to state-building?*. London: Health & Fragile States Network, HLSP Institute.
- Etzioni, A. (2013). A liberal, rule-based order? *International Journal of Contemporary Sociology*, 50(1), 46. Retrieved from <http://icps.gwu.edu/files/2013/07/IJCS.pdf>
- Europa. (2010). *Foreign and security policy: speaking with one voice*. European Union policy document. Retrieved from [www.europa.eu/pol/cfsp/index\\_en.htm](http://www.europa.eu/pol/cfsp/index_en.htm)
- European Commission. (2010). *The EU role in global health*. Brussels: COM (2010)128 final.
- Farmer, P., Kleinman, A., Kim, J., & Basilio, M. (2013). *Reimagining global health: An introduction*. Oakland: University of California Press.
- Feldbaum, H. (2010). Global health and foreign policy. *Epidemiological Review*, 32, 82–92. Retrieved from [www.epirev.oxfordjournals.org/content/32/1/82.full](http://www.epirev.oxfordjournals.org/content/32/1/82.full)
- Feldman, N. (2013). *Cool war: The future of global competition*. New York, NY: Random House.
- Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4). Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000226>
- Ferrero-Waldener, B. (2007, 24 September). *The European Union and the world: A hard look at soft power*. Speech presented at the Columbia University, New York, NY.
- Fidler, D. (2007). Reflections on the revolution in health and foreign policy. *Bulletin of the World Health Organization*, 85(3). Retrieved from [www.who.int/bulletin/volumes/85/3/07-041087/en/](http://www.who.int/bulletin/volumes/85/3/07-041087/en/) doi:10.2471/BLT.07.041087
- Fidler, D. (2011). Rise and fall of global health as a foreign policy issue. *Global Health Governance*, 4(2), 1–12. Retrieved from <http://web.ebscohost.com/abstract?direct=true&profile=ehost&scope=site&authtype=crawler&jml=19392389&AN=64305228&h=q%2fBxoZzfMru3d0OR0qtEozp2jMwTvoDHF10NE4HzHVA42zmSzfMfGA6cNwnas9k1k8HWrMkhA6tvCOKt1EBoKA%3d%3d&crl=c>
- Fleischer, T., Kevany, S., & Benatar, S. (2010). Will escalating spending on HIV treatment displace funding for other diseases? *South African Medical Journal*, 100(1), 32–34. Retrieved from <http://www.samj.org.za/index.php/samj/article/viewFile/3588/2650>
- Frist, W. (2007). Medicine as a currency for peace through global health diplomacy. *Yale Law Policy Review*, 26, 209–229.
- Gahr Stor, J. (2007). Health is a foreign policy concern. *Bulletin of the World Health Organization*, 85(3), 161–244. Retrieved from <http://www.who.int/bulletin/volumes/85/3/07-100307/en/>

- Gallup News Service. (2002). *Support for invasion of Iraq remains contingent on U.N. approval*. Retrieved from <http://www.gallup.com/poll/7195/support-invasion-iraq-remains-contingent-unaapproval.aspx>
- Garrett, L. (2012, March). Money or die. A watershed moment for global public health. *Foreign Affairs*. Retrieved from <http://www.foreignaffairs.com/articles/137312/laurie-garrett/money-or-die>
- The Global Fund to Fight AIDS, Tuberculosis and Malaria. (2011). Our identity: The Global Fund identity guidelines for external partners. *The Global Fund*. Retrieved from [www.theglobalfund.org/.../Core\\_GlobalFundIdentity\\_Guidelines\\_en/](http://www.theglobalfund.org/.../Core_GlobalFundIdentity_Guidelines_en/)
- The Global Fund to Fight AIDS, Tuberculosis and Malaria. (2013). *Data quality tools and mechanisms*. Retrieved from <http://www.theglobalfund.org/en/me/documents/dataquality/>
- Global Health Initiative. (2012). *US government interagency paper on country ownership*. Retrieved from <http://www.ghi.gov/documents/organization/195554.pdf>
- The Guardian*. (2013a). China commits billions in aid to Africa as part of charm offensive. Accessed through <http://www.theguardian.com/global-development/interactive/2013/apr/29/china-commits-billions-aid-africa-interactive>
- The Guardian*. (2013b). The rebirth of Russian foreign aid. Accessed through <http://www.theguardian.com/global-development/2011/may/25/russia-foreign-aid-report-influence-image>
- Hagel, C. (2004, July and August). A republican foreign policy. *Foreign Affairs*. Retrieved from <http://www.foreignaffairs.com/articles/59921/chuck-hagel/a-republican-foreign-policy>
- Horton, R. (2007). Health as an instrument of foreign policy. *The Lancet*, 369, 806–807. Retrieved from <http://scholar.google.com/scholar?cluster=14964748696365445822&hl=en&oi=scholar>
- Institute for Health Metrics. (2010). *Financing of global health: Tracking development assistance for health from 1990 to 2007*. Retrieved from <http://www.healthmetricsandevaluation.org/publications/summaries/financing-global-health-tracking-development-assistance-health-1990-2007>
- Irish Department of Foreign Affairs. (2014). *Review of Ireland's foreign policy and external relations*. Department of Foreign Affairs White Paper. Retrieved from <https://www.dfa.ie/about-us/what-we-do/our-strategy-and-guiding-principles/foreign-policy-review/>
- Jaffe, S. (2013). The USA and global health diplomacy: Goals and challenges. *The Lancet*, 381, 1087. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60746-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60746-1/fulltext)
- Jan, S. (1998). A holistic approach to the economic evaluation of health programs using institutionalist methodology. *Social Science & Medicine*, 47, 1565–1572. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0277953698002287>
- Kagan, R. (2002). Power and weakness. *Policy Review*, 113, 208–221. Retrieved from <https://www.mtholyoke.edu/acad/intrel/bush/kagan.htm>
- Kassalow, J. (2001). *Why health is important to U.S. foreign policy*. New York: Council of Foreign Relations. Retrieved from <http://www.cfr.org/us-strategy-and-politics/why-health-important-us-foreign-policy/p8315>
- Katz, R., Kornblat, S., Arnold, G., Lief, E., & Fischer, J. (2011). Defining health diplomacy: Changing demands in the era of globalization. *The Milbank Quarterly*, 89, 503–523. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00637.x/abstract>
- Katz, R., & Singer, D. (2007). Health and security in foreign policy. *Bulletin of the World Health Organization*, 85, 233–234. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636232/>
- Kaufmann, J. R. & Feldbaum, H. (2009). Diplomacy and the polio immunization boycott in Northern Nigeria. *Health Affairs*, 28, 1091–1101. doi:10.1377/hlthaff.28.4.1091
- Keck, C. (2007). *Cuba's contribution to global health diplomacy*. Global Health Diplomacy Workshop, University of California, San Diego, 2007. Retrieved from <http://igcc3.ucsd.edu/research/globalhealth/presentations/keck.pdf>
- Keeter, S. (2007). *Trends in public opinion about the war in Iraq, 2003–2007*. Washington, DC: Pew Research Center. Retrieved from <http://pewresearch.org/pubs/431/trends-in-public-opinion-about-the-war-in-iraq-2003-2007>
- Kennedy, J. (1963). *Address to the UN General Assembly, September 20, 1963*. Retrieved from <http://millercenter.org/president/speeches/detail/5764>
- Kevany, S. (2012). Socio-economic status and health care utilization in rural Zimbabwe. *Journal of Public Health in Africa*, 3, e13. Retrieved from <http://www.publichealthinafrica.org/index.php/jphia/article/view/jphia.2012.e13>

- Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocations for health and HIV in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570–587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>
- Kevany, S., Hatfield, A., Beleke, Y., Aurang Zeb, B., White, K., & Workneh, N. (2012). Diplomatic and operational adaptations to global health programs in post-conflict settings: Contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Medicine, Conflict and Survival*, 28, 247–262. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23189590>
- Kevany, S., Khumalo-Sakutukwa, G., Murima, O., Chingono, A., Modiba, P., Gray, G., ... Morin, S. (2012). Health diplomacy and adapting global health interventions to local needs. *BMC Public Health*, 12, 459. Retrieved from <http://www.biomedcentral.com/1471-2458/12/459/abstract>
- Kevany, S., Jaf, P., Workneh, N. G., Dalo, M. A., Tabena, M., Rashid, S., & Al Hilfi, T. K. Y. (2014). Global health diplomacy in Iraq: International relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival*. Retrieved from <http://dx.doi.org/10.1080/13623699.2014.890827>
- Kevany, S., Sahak, O., Workneh, N. G., & Saeedzai, S. A. (2014). Global health diplomacy investments in Afghanistan: Adaptations and outcomes of global fund malaria programs. *Medicine, Conflict and Survival*, 30(1), 37–55. Retrieved from <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>
- Khumalo-Sakutukwa, G., Morin, S. F., Fritz, K., Charlebois, E. D., Van Rooyen, H., Chingono, A., ... Coates, T. J. (2008). Project Accept (HPTN 043): A community-based intervention to reduce HIV incidence in populations at risk for HIV in sub-Saharan Africa and Thailand. *JAIDS – Journal of Acquired Immune Deficiency Syndromes*, 49(4), 422–431.
- Kickbusch, I. (2012). Global health diplomacy: How foreign policy can influence health. *British Medical Journal*, 2011, 342, d3154. Retrieved from <http://www.bmj.com/content/342/bmj.d3154>
- Kickbusch, I., & Buss, P. (2011). Global health diplomacy and peace. *Infectious Disease Clinics of North America*, 25, 601–610. doi:10.1016/j.idc.2011.05.006
- Kickbusch, I., Lister, G., Told, M., Drager, N. (2012). *Global health diplomacy: Concepts, issues, actors, instruments, for and cases*. New York, NY: Springer.
- Kickbusch, I., Novotny, T., Drager, N., Silberschmidt, G., & Alcazar, S. (2007). Global health diplomacy: Raining across disciplines. *Bulletin of the World Health Organization*, 85, 82–91. Retrieved from [http://www.scielosp.org/scielo.php?pid=S0042-96862007001200027&script=sci\\_arttext&tlng=es](http://www.scielosp.org/scielo.php?pid=S0042-96862007001200027&script=sci_arttext&tlng=es)
- Ki-Moon, B. (2013). *With \$3 billion annual shortfall in controlling malaria, replenishing Global Fund should be a priority to prevent resurgence* [Press release]. United Nations, NY: The Global Fund to Fight AIDS, Tuberculosis and Malaria. Retrieved from <http://www.theglobalfund.org/en/blog/32053/>
- Kleinman, A. (2010). Four social theories for global health. *The Lancet*, 375, 1518–1519. doi:10.1016/S0140-6736(10)60646-0
- Kolaczinski, J., Graham, K., Fahim, A., Brooker, S., & Rowland, M. (2005). Malaria control in Afghanistan: Progress and challenges. *The Lancet*, 365(9469), 1506–1512.
- Kreps, S., & Zenko, M. (2014, March & April). The Next Drone Wars. *Foreign Affairs*. Retrieved from <http://www.foreignaffairs.com/articles/140746/sarah-kreps-and-micah-zenko/the-next-drone-wars>
- Krugman, P. (2013, September 11). Toxic inequality. *The New York Times*. Retrieved from [http://krugman.blogs.nytimes.com/2013/09/11/toxic-inequality/?\\_r=0](http://krugman.blogs.nytimes.com/2013/09/11/toxic-inequality/?_r=0)
- Labonte, R., & Gagnon, L. (2010). Framing health and foreign policy: Lessons for global health diplomacy. *Globalization and Health*, 6, 65–76. Retrieved from <http://www.globalizationandhealth.com/content/6/1/14>
- Lancaster, C. (2007). *Foreign aid: Diplomacy, development, domestic politics*. Chicago, IL: University of Chicago Press. Retrieved from [http://www.grips.ac.jp/teacher/oono/hp/course/lec12\\_devcoop/JForeign%20Aid\\_chapter%204.pdf](http://www.grips.ac.jp/teacher/oono/hp/course/lec12_devcoop/JForeign%20Aid_chapter%204.pdf)
- The Lancet. (2010). Evaluation: The top priority for global health. *The Lancet*, 375, 526. Retrieved from <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610600566.pdf>
- Lee, K. (2007). Bridging health and foreign policy: The role of health impact assessments. *Bulletin of the World Health Organization*, 85, 207–211. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17486212>
- Lee, K., & Gomez, E. (2012). Brazil's ascendance: The soft power role of global health diplomacy. *The World Financial Review*. Retrieved from <http://www.worldfinancialreview.com/?p=414>

- Lords Select Committee. (2011). *Does UK aid make the right difference?* Retrieved from <http://www.parliament.uk/business/committees/committees-a-z/lords-select/economic-affairs-committee/news/aid-inquiry—evidence-session-5-july/>
- Lumsdaine, D. (1993). *Moral vision in international politics: The foreign aid regime 1949–1989*. Princeton, NJ: Princeton University Press.
- Lyman, N. P., & Wittels, S. B. (2010). *No good deed goes unpunished: The unintended consequences of Washington's HIV/AIDS programs*. Foreign Affairs. July–August 2010. Retrieved from <http://www.foreignaffairs.com/articles/66464/princeton-n-lyman-and-stephen-b-wittels/no-good-deed-goes-unpunished>
- Macrae, J. (1997). Conflict, the continuum and chronic emergencies: A critical analysis of the scope for linking relief, rehabilitation and development planning in Sudan. *Disasters*, 21(3), 223–243.
- Marseille, E., & Kevany, S. (2010). The cost of providing case management services to antiretroviral patients in Ethiopia. *Cost Effectiveness and Resource Allocation*, 9, 113–120. Retrieved from <http://www.resource-allocation.com/content/9/1/18>
- Marseille, E., & Khan, J. (2002). HIV prevention before HAART in sub-Saharan Africa. *The Lancet*, 359, 1851–1856. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(02\)08705-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)08705-6/abstract)
- Martuzzi, M., & Tickner, J. (2004). *The precautionary principle: Protecting public health, the environment, and the future of our children*. Geneva: World Health Organization. Retrieved from [http://www.euro.who.int/\\_data/assets/pdf\\_file/0003/91173/E83079.pdf](http://www.euro.who.int/_data/assets/pdf_file/0003/91173/E83079.pdf)
- McInnes, C., & Lee, K. (2006). Health, security and foreign policy. *Review of International Studies*, 32, 5–23. doi:10.1017/S0260210506006905
- Mercy Corps. (2011). *Mission metrics: One agency's effort to capture mission level results*. Presentation to the America Evaluation Association. Retrieved from <http://comm.eval.org/Resources/ViewDocument?DocumentKey=1c34aa46-b6f3-4ec3-ac1f-3261e8838ce3>
- Michaud, J., & Kates, J. (2013). Global health diplomacy: Advancing foreign policy and global health interests. *Global Health: Science & Practice*, 1(1), 24–28. Retrieved from <http://www.ghspjournal.org/content/1/1/24.full>
- Michaud, J., Moss, K., & Kates, J. (2012). U.S. global health policy: The U.S. Department of Defense and global health. *Kaiser Family Foundation Policy Review Document*.
- Morrison, J. (2013). *The New State Department Office of Global Health Diplomacy: A second chance to get things right*. Center for Strategic & International Studies Smart Global Health Blog. Retrieved from <http://www.smartglobalhealth.org/blog/entry/the-new-state-department-office-of-global-health-diplomacy-a-second-chance/>
- Mulley, S. (2010). *Donor aid: New frontiers in transparency and accountability*. United Kingdom Transparency and Accountability Initiative. Retrieved from [http://www.transparency-initiative.org/wp-content/uploads/2011/05/donor\\_aid\\_finall.pdf](http://www.transparency-initiative.org/wp-content/uploads/2011/05/donor_aid_finall.pdf)
- Nolan, C. (1998). *Norms and principles that govern international relations*. Boston University International Forum Series. Retrieved from <http://kenedy.byu.edu/papers/NolanWS.pdf>
- Novotny, T., & Adams, V. (2007). Global health diplomacy—A call for a new field of teaching and research. *San Francisco Medicine*, 80(3), 22–23.
- Novotny, T., & Kevany, S. (2013). The way forward in global health diplomacy: Definitions, research, and training. In T. Novotny, I. Kickbusch, & M. Told (Eds.), *21st century health diplomacy* (pp. 203–225). Geneva: World Scientific.
- Nye, J. (2004, May and June). The decline of America's soft power. *Foreign Affairs*. Retrieved from <http://www.foreignaffairs.com/articles/59888/joseph-s-nye-jr/the-decline-of-americas-soft-power>
- Obama, B. (2014, May 29). Full transcript of President Obama's commencement address at West Point. *The Washington Post*. Retrieved from [http://www.washingtonpost.com/politics/full-text-of-president-obamas-commencement-address-at-west-point/2014/05/28/cfbcdcaa-e670-11e3-afc6-a1dd9407abcf\\_story.html](http://www.washingtonpost.com/politics/full-text-of-president-obamas-commencement-address-at-west-point/2014/05/28/cfbcdcaa-e670-11e3-afc6-a1dd9407abcf_story.html)
- Ord, R. (2013). *The moral imperative toward cost-effectiveness in global health*. Center for Global Development Policy Document. Retrieved from [www.cgdev.org/content/publications/detail/1427016](http://www.cgdev.org/content/publications/detail/1427016)
- Paulson, H. (2010). *Global health as smart power*. Retrieved from <http://www.humanosphere.org/2010/08/global-health-as-smart-power/>
- Piot, P., Zewdie, D., & Turmen, T. (2002). *HIV/AIDS prevention and treatment*. Retrieved from <http://download.thelancet.com/pdfs/journals/lancet/PIIS014067360209342X.pdf?id=a02f57d1811fcb77:-460f17de:13e5822e1d3:69301367284614093>

- Quigley, M., Weiss, H., & Hayes, R. (2001). Male circumcision as a measure to control HIV infection and other sexually transmitted diseases. *Current Opinion in Infectious Diseases*, 14(1), 71–75. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11979118>
- Ravishnakar, N., Gubbins, P., Cooley, R., Leach-Kemon, K., Michaud, C., Jamison, D., and Murray, C. (2007). Financing for global health: Tracking development assistance for health from 1990 to 2007. *The Lancet*, 373, 2113–2124. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60881-3/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60881-3/abstract)
- Rawls, J. (1971). *A theory of justice*. Cambridge, MA: Belknap Press of Harvard University Press, 1999.
- Rehn, O. (2005). *Europe's smart power in its region and the world*. Speech at the European Studies Centre, St Antony's College, University of Oxford, 1 May 2008. Retrieved from [www.europa.eu/rapid/pressReleasesAction.do?reference=SPEECH](http://www.europa.eu/rapid/pressReleasesAction.do?reference=SPEECH)
- Reuters. (2011). *Pfizer accused of strong-arm tactics to cover up deaths of innocent children*. Retrieved from <http://articles.mercola.com/sites/articles/archive/2011/01/18/pfizer-accused-of-massive-corruption-in-killing-african-children.aspx>
- Rodriguez-Garcia, R. (2001). *How can health serve as a bridge for peace?* George Washington University Medical School Research Paper. Retrieved from <http://www.certi.org/publications/policy/gwc-12a.pdf>
- Rosenau, J. N. (1966). Pre-theories and theories of foreign policy. In *Approaches in comparative and international politics*. Evanston, IL: Northwestern University Press.
- Royal Institute for International Affairs. (2010). *Global health diplomacy: A way forward in international affairs*. Chatham House: meeting summary document. Retrieved from <http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/280611summary.pdf>
- Rubenstein, L. (2013, April 24). Unhealthy practice: Medical work in conflict zones is compromised. *Foreign Affairs*. Retrieved from <http://www.foreignaffairs.com/articles/139344/leonard-s-rubenstein/unhealthy-practice>
- Rushton, S., & McInnes, C. (2006). The UK, health and peace-building: The mysterious disappearance of health as a bridge for peace. *Medicine, Conflict and Survival*, 22(2), 94–109. doi:10.1080/13623690600620940
- Scully, M. (2011, March 21). *Costs of Libya operation already piling up*. Retrieved from <http://www.nationaljournal.com/nationalsecurity/costs-of-libya-operation-already-piling-up-20110321?page=1>
- Shackle, S. (2011, March 22). Libya polls show that British public is divided. *The New Statesman*. Retrieved from <http://www.newstatesman.com/blogs/the-staggers/2011/03/british-public-support-action>
- Shah, R. (2011). *Statement by Dr. Rajiv Shah, Administrator, United States Agency for International Development, before the Senate Foreign Relations Committee*. Wednesday, April 13, 2011.
- Simons, A. (2012, April). Soft war equals smart war? Think again. Foreign Policy Research Institute. Retrieved from <http://www.fpri.org/enotes/2012/201204.simons.soft-war-smart-war.html>
- Skinner, H., & Sriharnan, S. (2007). Building cooperation through health initiatives: An Arab and Israeli case study. *Conflict and Health*, 1. doi:10.1186/1752-1505-1-8
- Smith, K. (2008). *European Union foreign policy in a changing world*. Cambridge: Polity Press.
- Sridhar, L., & Woods, P. (2007). Are there simple conclusions on how to channel health funding? *The Lancet*, 375, 1326–1328. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/20381855>
- Stewart, K., Keusch, G., & Kleinman, A. (2010). Values and moral experience in global health: Bridging the local and the global. *Global Public Health*, 5(2): 115–121. doi:10.1080/17441690903484201
- Straziuso, J. (2013). *New push against polio and new vaccines in Somalia*. Retrieved from [http://article.wn.com/view/2013/04/25/New\\_push\\_against\\_polio\\_and\\_new\\_vaccines\\_in\\_Somalia/#/related\\_news](http://article.wn.com/view/2013/04/25/New_push_against_polio_and_new_vaccines_in_Somalia/#/related_news)
- Sundberg, H., & Sandberg, K. (2013). Managing stovepiped organisations—A comparison of public and private organisations. *International Journal of Public Information Systems*, 2(1), 39–54. Retrieved from <http://www.diva-portal.org/smash/record.jsf?pid=diva2:26299>
- Transcript of House Foreign Affairs Committee Hearing on U.S. Foreign Policy Priorities. (2011). *Hearing held on March 1, 2011*. Retrieved from [http://www.micevhill.com/attachments/immigration\\_documents/hosted\\_documents/112th\\_congress/TranscriptOfHouseForeignAffairsCommitteeHearingOnFY12BudgetRequestForForeignAffairs.pdf](http://www.micevhill.com/attachments/immigration_documents/hosted_documents/112th_congress/TranscriptOfHouseForeignAffairsCommitteeHearingOnFY12BudgetRequestForForeignAffairs.pdf)
- Uche, C. (2011). Population problems and family planning in Africa. *Sociologia Ruralis*, 12(3/4), 419–430. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12259218>

- United Kingdom Foreign and Commonwealth Office. (2013). *What we do*. Retrieved from <https://www.gov.uk/government/organisations/foreign-commonwealth-office/about>
- United States Agency for International Development. (2013). *USAID strategy on democracy, human rights and governance*. Retrieved from [http://www.usaid.gov/sites/default/files/documents/1866/USAID%20DRG\\_%20final%20final%206-24%203%20\(1\).pdf](http://www.usaid.gov/sites/default/files/documents/1866/USAID%20DRG_%20final%20final%206-24%203%20(1).pdf)
- United States Department of State. (2008). *Joint department of state, USAID enterprise architecture transition strategy for FY2009*. Retrieved from <http://www.state.gov/m/irm/rls/110469.htm>
- United States Department of State. (2010). *Why foreign policy is important*. Retrieved from <http://future.state.gov/why/44560.htm>
- United States Department of State. (2011). *Leading through civilian power: The first quadrennial diplomacy and development review*. Retrieved from <http://www.state.gov/documents/organization/153108.pdf>
- United States Global Leadership Coalition. (2012). *Smart power 2.0: America's global strategy*. Retrieved from <http://www.usglc.org/downloads/2012/12/USGLC-Smart-Power-Brochure.pdf>
- Valentino, B. (2011, November/December). The true costs of humanitarian intervention. *Foreign Affairs*. Retrieved from <http://www.foreignaffairs.com/articles/136542/benjamin-a-valentino/the-true-costs-of-humanitarian-intervention>
- Vanderwagen, W. (2006). Health diplomacy: Winning hearts and minds through the use of health interventions. *Military Medicine*, 171, 3–4. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17447611>
- Walensky, R. P., & Kuritzkes, D. R. (2010). The impact of the President's Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and why it remains essential. *Clinical Infectious Diseases*, 50(2), 272–275. doi:10.1086/649214
- White, B. (2001). *The globalization of world politics: An introduction to international relations*. New York, NY: Oxford University Press.
- The World Bank. (2011). *The world development report 2011: Conflict, security, and development*. Washington, DC: Author. Retrieved from <http://wdr2011.worldbank.org/fulltext>
- World Health Organization. (2012, November). *The right to health*. Fact sheet 323. Retrieved from <http://www.who.int/mediacentre/factsheets/fs323/en/index.html>
- World Health Organization. (2013). *Medical waste*. Retrieved from [http://www.who.int/topics/medical\\_waste/en/](http://www.who.int/topics/medical_waste/en/)
- World Medical Association. (2008). *WMA Declaration of Helsinki – Ethical principles for medical research involving human subjects*. Retrieved from <http://www.wma.net/en/30publications/10policies/b3/index.html>



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# Diplomatic advantages and threats in global health program selection, design, delivery and implementation: development and application of the Kevany Riposte

Sebastian Kevany

## Abstract

**Background:** Global health programs, as supported by organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Emergency Plan for AIDS Relief (PEPFAR), stand to make significant contributions to international medical outcomes. Traditional systems of monitoring and evaluation, however, fail to capture downstream, indirect, or collateral advantages (and threats) of intervention selection, design, and implementation from broader donor perspectives, including those of the diplomatic and foreign policy communities, which these programs also generate. This paper describes the development a new *métier* under which assessment systems designed to consider the diplomatic value of global health initiatives are described and applied based on previously-identified "Top Ten" criteria.

**Methods:** The "Kevany Riposte" and the "K-Score" were conceptualized based on a retrospective and collective assessment of the author's participation in the design, implementation and delivery of a range of global health interventions related to the HIV/AIDS epidemic. Responses and associated scores reframe intervention worth or value in terms of global health diplomacy criteria such as "adaptability", "interdependence", "training," and "neutrality". Response options ranged from "highly advantageous" to "significant potential threat".

**Results:** Global health initiatives under review were found to generate significant advantages from the diplomatic perspective. These included (1) intervention visibility and associations with donor altruism and prestige, (2) development of international non-health collaborations and partnerships, (3) adaptability and responsiveness of service delivery to local needs, and (4) advancement of broader strategic goals of the international community. Corresponding threats included (1) an absence of formal training of project staff on broader political and international relations roles and responsibilities, (2) challenges to recipient cultural and religious practices, (3) intervention-related environmental concerns, and (4) a lack of *prima facie* consideration of intervention diplomatic and foreign policy consequences.

**Conclusions:** Global health interventions stand to generate significant diplomatic advantages for donor and recipient countries and organizations when appropriately selected, designed, targeted, and delivered. Conversely, in the absence of the application of standards such as those developed under the Kevany Riposte, threats to diplomacy and international relations may occur. With the application of related systems to other global health programmes and settings, comparative results on the relative worth of alternate approaches from the diplomatic perspective may be generated to better inform political, strategic, and global health policy and programmatic decisions.

**Keywords:** Global health diplomacy, foreign policy, PEPFAR, HIV/AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, 'smart power'

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## Theoretical & philosophical basis

### Global health, diplomacy, and foreign policy

Foreign policy trends in both the European Union and the United States are increasingly aligned with “smart power” [1] approaches, in recognition of the “myriad newer uses” of global health and development initiatives [2]. The European Union advocates strategic use of foreign assistance, combined with diplomacy and arbitration, to pursue foreign policy goals under the Common Foreign & Security Policy [3,4] via a specific focus on global health [5]. Similarly, in the United States, increasing levels of alignment between the State Department, the United States Agency for International Development, the Department of Defense and the Department of Health and Human Services is indicative of their increasingly interchangeable roles [6]. In the United Kingdom, foreign assistance now forms an integral component of foreign affairs [7] under the stated goal of “policy coherence” [8]. Conversely but convergently, both the United Nations and international military forces have displayed an increased propensity to combine conflict resolution and humanitarian activities [9], whilst the World Bank has recommended that international development focus on security issues beyond primary programmatic goals [10]. These trends are of increasing importance to the design, delivery and evaluation of global health intervention programs under initiatives such as the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) [11] particularly in the context of the recent creation of the Office of Global Health Diplomacy [12] and related programs supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (“The Global Fund”) [13].

### Aligning & sensitizing global health programs to international affairs

Unlike the medically-dominated ethos of global health, diplomatic and foreign policy perspectives are both multi-level and multicausal, involving the synthesis of information from a variety of social science knowledge systems [14]. Failure to consider foreign policy and international relations principles and objectives when designing, selecting and implementing global health programs such as PEPFAR and the Global Fund’s related HIV/AIDS initiatives may, therefore, create a “tense and confusing duality” [15]. For example, while global health programs that challenge cultural, religious, ideological, social and behavioral norms are often compelling in terms of their capacity to achieve primary health outcomes, they may also create unquantified downstream benefits, or constitute potential liabilities, from the diplomatic and foreign policy perspectives. Although it is critically important for such initiatives to attempt to optimize outcomes such as quality-adjusted life years (QALYs), their design and delivery needs to be carefully evaluated in order to ensure that (1) these goals

are not being achieved at the cost of foreign policy, diplomatic, international relations, or broader global strategic objectives, and (2) their potential to achieve such collateral objectives is optimized [16].

### Ranking global health programs from the foreign policy and diplomatic perspectives

The rise of a utilitarian approach to global health evaluation, as represented by tools such as cost-effectiveness analysis, has resulted in the predominant use of narrow, single-metric measures as exclusive barometers of global health program worth or value [17]. No international initiative, however, operates in isolation or without epistemic consequences [18]. In a variation on the McNamara Fallacy [19], such programs produce a range of downstream, collateral or indirect outcomes that are not adequately quantified – and, therefore, considered to be non-existent. In the 21<sup>st</sup> century, both foreign policy-makers and global health professionals require an innovative *métier* that reflects these broader considerations, both (1) in order to portray global health expenditures as investments rather than costs, and (2) to “speak a language that people with power really understand” [20]; foreign assistance priorities and associated resource allocation decisions should, where possible, include consideration of the universal and fundamental aspirations of global political, security, and strategic affairs [21]. The recent emergence of the smart power paradigm [22] has, at least in part, been a product of this increased integration between foreign policy and global health initiatives [23], elevating global health to the status of a powerful diplomatic and foreign policy tool, rather than merely a humanitarian effort. There has been, to date, a “lack of ability” to demonstrate the effectiveness of foreign assistance programs in this context [24]. This paper outlines the development and application of just such a “diplomatic assessment” approach for global health programmes, adopting a term from the art of fencing, and eponymously entitled the Kevany Riposte, due to its conceptual basis as an innovative and interdisciplinary approach that challenges “siloes” [13] or “stovepiped” [25] perspectives. These efforts are based on the author’s prior identification of “Top Ten” lists for diplomatic effectiveness [25], and as applied to a retrospective and collective assessment of PEPFAR and Global Fund-supported HIV/AIDS initiatives in South Africa, Sudan, Kenya, South Sudan, Zimbabwe, Tanzania, Iraq, Afghanistan, Egypt, and elsewhere, in order, for the first time, to assess intervention program threats and advantages from this broader perspective.

## Methods

### Defining “HIV/AIDS initiatives”

Community-based behavioral, educational, and diagnostic initiatives form an innovative and essential part of

both the Global Fund and PEPFAR's HIV/AIDS response paradigms [26,27]. Such programs provide, amongst other features, technical assistance to strengthen prevention programming; community support mechanisms; referral systems; and other behavioral and community-based health promotion and educational initiatives [28]. Within this broader operational context, HIV Counseling & Testing (HCT) based around "wellness days", "community mobilization", and "post-test support services", amongst other forms of service delivery, are provided in community venues in order to increase, for example, numbers of persons tested for HIV/AIDS provided with personalized support and guidance regarding behavioral risk-reduction, as well as raising community awareness and engagement. In the health systems strengthening context, related interventions also contribute to capacity building (e.g. the provision of district-level trainers to implement "Prevention with Positives" programs) [29]. For the purposes of this paper, "HIV/AIDS interventions", "HIV/AIDS programmes", and "HIV/AIDS initiatives" therefore refer to such community-based, multi-level HIV/AIDS responses, including *combined* diagnostic, prevention, behavioural, and health system strengthening programs under the auspices of Project Accept [30], the Global Fund, and PEPFAR South Africa [31], whilst excluding therapeutic programs such as antiretroviral treatment and surgical interventions such as voluntary adult male circumcision.

#### **Kevany Riposte and K-Score development**

Systems by which to quantify the latent and potential global health diplomacy and foreign policy value of global health programmes were developed based on previously-identified criteria for "global health diplomacy" and "global health and foreign policy" appropriateness and effectiveness in global health program design, delivery and evaluation [32]. Originally presented in the form of two "Top Ten" tables – representative of those features or characteristics of global health programs identified as effective in the foreign policy or diplomatic contexts, respectively, in the related literature – classifications were adapted to Excel-based questionnaire and scoring formats (see Additional file 1 Annex 1: Diplomatic Assessment Questionnaire and Scoring Tool). Development of the Kevany Riposte and K-Score also drew on the author's prior contributions to the development and utilization of related designs, in particular the Global Fund's Routine Service Quality Assessment (RSQA) and On-Site Data Verification (OSDV) tools [33]. The results presented in this paper relate specifically to "diplomatic", rather than "foreign policy", considerations.

#### **Implementation & utilization**

Diplomatic assessments of HIV/AIDS initiatives were based on the retrospective and collective assessment of

the author's field deployments for diplomatic monitoring & evaluation, cost-effectiveness, and quality assurance purposes on behalf of the Global Fund, the United Nations Development Program, PEPFAR implementing organizations (e.g. the International Training and Education Center for Health), the University of California, San Francisco, and the Project Accept community-based voluntary counseling and testing intervention (as implemented under the United States' National Institutes for Mental Health) between 2007 and 2014. Related on-site engagements included field missions to service delivery points (e.g. mobile HIV/AIDS counseling and testing centers in the Northwest Province of South Africa for PEPFAR and in Sudan and South Sudan for the Global Fund) and engagements and liaisons with key governmental and non-governmental organizations and individuals (e.g. the South African, Sudanese and South Sudanese Ministries of Health on behalf of the Global Fund). Field-level and on-site observations conducted to inform assessment responses were undertaken, where possible, with the assistance of an interview guide (see Additional file 2 Annex 2: Interview and Assessment Guide for Diplomatic and Foreign Policy Assessments) and were complemented, where necessary, by follow-up questions via e-mail exchanges and teleconferences with key managerial and field staff. Further on-site and desk research (e.g. review of intervention protocols and standard operating procedures) was also conducted to complete remaining questionnaire responses, as necessary.

#### **Defining assessment classifications & sub-classifications**

The primary classifications employed in the Kevany Riposte and K-Score were based directly on previously-identified "Top Ten" criteria keywords (e.g. "communications"; "adaptability"), as described above. Related sub-classifications were based on interpretations and descriptions of each primary classification in the literature (e.g. the "adaptability" classification was associated with themes of "responsiveness to health needs", "responsiveness to non-health needs", "recipient-led program design", and "recipient-led resource allocation"). For purposes of both detail and consistency, four such sub-classifications were developed for each classification, resulting in 40 assessment questions. In turn, these sub-classifications were expanded and articulated in the form of specific thematic questions to be addressed to relevant project staff, including program managers, field officers, and other project personnel, designed to be relevant to project activities at the individual, intervention and policy levels (see below).

#### **Policy, intervention and individual level assessment dimensions**

As a result of the broad range of issues related to the diplomatically-effective delivery of global health programs,

the above assessment procedures included implicit consideration of three main evaluation dimensions: (1) policy level (e.g. whether donor organization guidelines addressed relevant practices & procedures), (2) intervention level (e.g. whether intervention protocol and standard operating procedures were appropriately designed from the diplomatic perspective), and (3) individual level performance and responsibilities (e.g. sensitization of national and international project staff to consideration of broader local, national, and international strategic environments). Sub-classification questions were designed to be informed by, and completed based on consideration of, these three constructs.

**Responses, scoring and comments**

Response options to sub-classification questions were divided into six categories: “highly advantageous”, “moderately advantageous”, “neutral, not relevant, or not considered”, “not applicable”, “potential moderate threat”, and “potential significant threat”, in accordance with level of alignment with associated diplomatic goals and principles (Table 1). These response categories were associated with scores of +2, +1, zero (for both “neutral, not relevant, or not considered” and “not applicable”), -1, and -2, respectively. Sub-classification scores were then aggregated and averaged in order to provide an overall classification score. No weighting was attached to different classifications or sub-classifications, based on the assumption that all classifications were of equal value or importance from the diplomatic perspective. Scope for additional comments, narrative descriptions, and categorization justification was also included at the assessment and evaluation stage in order to provide further explanation, as necessary, for scoring decisions. Finally, all classification scores were aggregated and averaged in order to determine an overall intervention-specific diplomatic assessment rating, representative of the collective programs under review, in the diplomatic context (the “K-Score”).

**Program performance from the diplomatic perspective**

**Overall diplomatic assessment results**

Diplomatic assessment ratings at the classification and sub-classification levels are presented in Table 2 and

Additional file 1 Annex 1. The HIV/AIDS initiatives under review were collectively found to be “moderately advantageous” from the diplomatic perspective, attaining an overall average score of +1 across diplomatic assessment classifications. This included three “highly advantageous”, three “moderately advantageous”, one “neutral”, and three “potential moderate threat” classification scores (Fig. 1).

**“Highly advantageous” classifications**

HIV/AIDS initiatives were considered to be “highly advantageous” under the diplomatic assessment classifications of “visibility”, “adaptability”, and “partnerships”. These results are in keeping with prior findings related to both the structure and “unintended consequences” of HIV/AIDS intervention programs [18]. For example, the extensive intervention adaptability of related HIV/AIDS interventions has been documented elsewhere [34], including the importance of intervention visibility and communications through revisions to key practices (e.g. evolving intervention “branding” and terminology to fit with local cultures and social norms) and community mobilization activities. Similarly, the generation of international partnerships through collaborations based on international HIV/AIDS initiatives is in keeping with prior findings related to the documented success of academic and inter-governmental collaborations under both the Global Fund and PEPFAR [35].

**“Moderately advantageous” classifications**

HIV/AIDS initiatives under review were found to be “moderately advantageous”, from the diplomatic perspective, in terms of “sustainability”, “accountability”, and “economic, political, environmental and social effects”. These findings are also supported by reference to related studies. For example, positive assessments for sustainability were driven by intervention strengths in the context of “country ownership” [36] and transferability to local actors, while diplomatic advantages in the “accountability” context are aligned with previously-documented strengths of PEPFAR and the Global Fund in monitoring and evaluation and other quality assurance and control systems [37]. Similarly, positive economic, political, and social outcomes were driven by the

**Table 1** Scoring and Results Classifications for “Top Ten” Criteria

Classification	Interpretation	Score
Highly advantageous	<i>Intervention program displays clear and significant value from the diplomatic or foreign policy perspective.</i>	<b>+2</b>
Moderately advantageous	<i>Intervention program displays some strengths in advancing diplomatic or foreign policy goals.</i>	<b>+1</b>
Acceptable, neutral, or not relevant	<i>Intervention attains diplomatic or foreign policy minimum standards.</i>	<b>0</b>
Not applicable	<i>Intervention program does not operate in the context of this classification (or sub-classification).</i>	<b>0</b>
Potential moderate threat	<i>Intervention program may constitute a threat to diplomatic or foreign policy goals.</i>	<b>-1</b>
Potential significant treat	<i>Intervention program constitutes a clear and significant threat from the diplomatic or foreign policy perspective.</i>	<b>-2</b>

**Table 2** Diplomatic Assessment Results

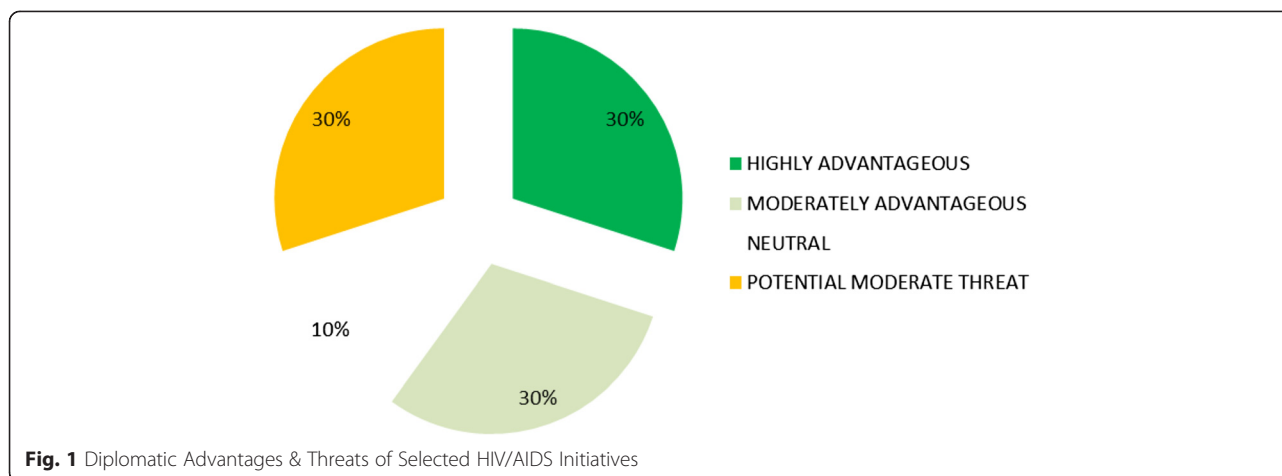
Classification	Sub-classification 1	Sub-classification 2	Sub-classification 3	Sub-classification 4	Score	Rating
Neutrality	<i>Cultural</i>	<i>Social</i>	<i>Religious</i>	<i>Other</i>		
Neutrality Score	-1	-1	-2	2	-1	POTENTIAL MODERATE THREAT
Visibility	<i>Appropriate Branding</i>	<i>Safety &amp; Security</i>	<i>National Linkages</i>	<i>Visibility through Communications</i>		
Visibility Score	2	1	1	2	2	HIGHLY ADVANTAGEOUS
Sustainability	<i>Sustainability</i>	<i>Transferability</i>	<i>Intervention Type</i>	<i>Forward-Looking Commitments</i>		
Sustainability Score	-2	1	2	2	1	MODERATELY ADVANTAGEOUS
Effectiveness	<i>Effectiveness</i>	<i>Constrained Budgets</i>	<i>Cost-Effectiveness</i>	<i>Academic Evidence</i>		
Effectiveness Score	2	-1	-2	2	0	NEUTRAL
Adaptability	<i>Responsiveness to Health Needs</i>	<i>Responsiveness to Non-Health Needs</i>	<i>Recipient-Led Program Design</i>	<i>Recipient-Led Resource Allocation</i>		
Adaptability Score	1	2	2	2	2	HIGHLY ADVANTAGEOUS
Accountability	<i>Contributions to M&amp;E Systems</i>	<i>Production of Verifiable Results</i>	<i>Presentation of Health &amp; Non-Health Achievements</i>	<i>Combating Corruption and Increasing Transparency</i>		
Accountability Score	2	2	1	-1	1	MODERATELY ADVANTAGEOUS
Partnerships	<i>Reference to Standards of International Interaction</i>	<i>Building International Alliances</i>	<i>Interaction Coordinating Initiatives</i>	<i>Sub-National Partnerships</i>		
Partnerships Score	0	2	2	2	2	HIGHLY ADVANTAGEOUS
Economic, Political, Environmental and Social (EPES) Effects	<i>Economic Growth</i>	<i>Political Stability</i>	<i>Social Evolution</i>	<i>Environmental Impact</i>		
EPES Effects Score	2	1	2	-2	1	MODERATELY ADVANTAGEOUS
Interdependence	<i>Organizational Relationships</i>	<i>Staff Safety</i>	<i>Mission Statements</i>	<i>Joint Agenda Accomplishment</i>		
Interdependence Score	-1	0	-1	-1	-1	POTENTIAL MODERATE THREAT
Training	<i>Staff Selection</i>	<i>Staff Recognition</i>	<i>Education on Strategic Themes</i>	<i>Diplomatic Risks and Benefits</i>		
Training Score	-2	1	-1	-1	-1	POTENTIAL MODERATE THREAT
Overall K-Score & Assessment					1	MODERATELY ADVANTAGEOUS

widespread provision of social and economic support services (such as “Back to Work” or income-generating horticultural schemes), which were frequently attached to those primary service delivery components under review [30].

#### “Neutral” classifications

HIV/AIDS interventions were classified as “neutral” from the diplomatic perspective in the context of “effectiveness”. The limited consideration of budgetary constraints

after the intervention or programmatic support period, combined with the high demand for affordable and cost-effective health care delivery and financing strategies in recipient countries, are current causes of concern throughout both the global health and international development contexts [38], most particularly in the current global recession era. In this context, the increased use of both health and non-health effectiveness and cost-effectiveness information as a key component of intervention design



and delivery on a *prima facie* rather than a *post-hoc* basis may significantly strengthen intervention design and delivery [39] in this regard.

**“Potential moderate threat” classifications**

Potential moderate threats to diplomatic considerations, interests and outcomes at both recipient and donor levels related to “neutrality”, “interdependence”, and “training”. These findings are, once again, in keeping with a range of contemporary recommendations on the design and delivery of global health intervention programs. For example, in the context of neutrality, the imposition of international cultural, social and religious standards and norms on recipient societies, often without appropriate levels of consultation at the local and community levels, may represent a threat both to successful program implementation *and* to international relations [34]. Conversely, a lack of awareness of the strategic implications of global health’s resource allocation decisions may mean that foreign assistance can unintentionally support extremist organizations [40]. Similarly, in the context of “interdependence”, a lack of organizational and operational coordination and alignment between health and non-health initiatives related to broader strategic and international affairs considerations has been identified as a possible source of conflict between health and diplomatic goals [41]. Finally, in the context of “training”, limited levels of broader political education and awareness in global health practitioners operating in international environments has been identified as a key gap at the individual capacity level [42,43].

**Potential significant threats at the sub-classification level**

Although no classifications were rated as a “potential significant threat” from the diplomatic perspective, specific sub-classifications recording this result are highlighted here. These include programmatic threats to religious neutrality (under the “neutrality” classification), limited

assurances and planning regarding funding sustainability (under the “sustainability” classification), limited or no *prima facie* use of health and non-health cost-effectiveness findings (under the “effectiveness” classification, and as described above), limited or no consideration of environmental impact (under the “economic, political, environmental and social effects” classification), and inadequate provision of broader diplomatic training, awareness, and formalization of related roles and responsibilities (under the “training” classification). Strategies to address these potentially significant diplomatic threats have been presented, in recent years, via innovative recommendations on the 21<sup>st</sup> century design and delivery of global health service delivery [13].

**Interpretation & conclusions**

**Key findings**

For the first time, a global health intervention has been assessed through the lens, and from the perspective, of diplomatic appropriateness, sensitivity and effectiveness. HIV/AIDS initiatives were found to score positively in terms of diplomatic effectiveness, whilst also evincing both (1) potential areas of improvement and (2) a limited number of potential diplomatic threats. These findings may represent significant considerations for policymakers both within and beyond global health, who are now equipped to determine the value, worth or risk of global health investments beyond the narrow metrics employed by traditional monitoring and evaluation or cost-effectiveness analyses associated with a narrow (and often exclusively medical) selection of outcomes, outputs and impact assessments [44]. These results should, nonetheless, still be considered in conjunction with traditional measures of program effectiveness or efficiency in order to determine associated resource allocation and implementation decisions: low levels of intervention cost-effectiveness, for example, may be

offset by significant intervention returns or value at the diplomatic level [35].

#### **Enlightened strategic & resource allocation decisions: beyond cost-effectiveness**

The results presented here are designed for use and reference at both the global health policy level and across the broader *milieu* of bilateral and multilateral foreign policymaking and practice. For example, within global health and development, these results may help to inform “enlightened” resource allocation decisions beyond the “potentially flawed” [35] reliance on cost-effectiveness analyses as the exclusive determinant of global health program worth or value. Perhaps even more importantly, the interpretation and use of these results at the diplomatic and foreign policy level presents a range of opportunities for policymakers to leverage, design, and refine global health and other development initiatives for the purposes of foreign policy and diplomacy [45].

#### **“Smart power” and “smart global health”**

At its most optimal, the Kevany Riposte and the K-Score may help both health and non-health, bilateral and multilateral organizations to manipulate aid in order to substitute for, offset, complement, or support the use of hard power in favour of smart power options, via the creation of a new “stage” in the escalation of international engagements, in keeping with 21<sup>st</sup> Century standards of acceptability for, and effectiveness of, international military interventions [46,47]. A new step in the “escalation hierarchy” amongst traditional and accepted stratifications such as neutrality, diplomacy, soft power and hard power [48] would be epitomized by such smart global health initiatives [45]. This may, in turn, bring about (1) a transfer or collaboration of resources from hard to smart international initiatives operating under “military umbrellas” [46] and, where feasible and appropriate, (2) the increased or enhanced use by military forces and related organizations of smart global health systems to pursue foreign policy and strategic prerogatives [49].

#### **Utilization in the international intelligence context**

The employment of global health programs for strategic political ends in an unstructured manner has, in the past, put global health workers at a security risk by association, regardless of whether or not individual- or organizational-level activities are in fact related to such ostensibly extraneous objectives [50]. At the same time, Western powers are increasingly open to the use of innovative, collaborative and interdisciplinary efforts to resolve contemporary international affairs and security challenges [51], against which conventional response

systems have faced significant challenges. In this highly nuanced, complex, and occasionally clandestine context, non-health dividends may be attained if global health programs are selected, designed and delivered in a manner that bears in mind potential international conflict resolution, cooperation, and security goals *as well as* primary health and development outcomes [52]; past research has suggested that locating highly-diplomatic global health projects in extremist regions, as informed by the “geo-strategic considerations” classification, provides meaningful alternatives to political or other forms of extremism [53]. In this context, the Kevany Riposte and the K-Score may offer standards by which international agencies such as the United Kingdom’s Security Service, (MI5), the European Union’s Intelligence Analysis Centre [54], and the United States’ Central Intelligence Agency (CIA) liaise with both donor, supranational, and recipient departments of international development and health in a fashion that both (1) reduces threats to aid workers and (2) integrates multifarious dimensions to global health programs which are, in turn, (3) conducted in a style acceptable and transparent to recipient country governments. Such innovative collaborations, instead of acquiescing to demands that global health funding be transferred to defense [55], stand to achieve both altruistic, intelligence, and security goals simultaneously. Perhaps most importantly, employment of assessment systems under the Kevany Riposte in this context will also help to ensure that global health programs do not inadvertently *harm* international security by providing aid, health, or other financial support to extremist organizations [56]. Notwithstanding these other potential gains, traditional (and possibly flawed) approaches to intelligence gathering through international development initiatives [57] stand to be both improved and made more effective by the application of relevant criteria, models, procedures and standards to both organizational and individual-level activities and liaisons in this context.

#### **Limitations**

The absence of comparator results from other global health intervention programs is a key limitation of this work. The generation of relevant comparable “K-Scores” in different settings (e.g. the diplomatic effectiveness of tuberculosis treatment programs in Iraq or malaria prevention initiatives in Afghanistan, as described elsewhere by the author) [17,52] may, as with the results of cost-effectiveness analyses, generate opportunities for intervention ranking or league tables [58] from the diplomatic or foreign policy perspective. For example, comparisons with HIV/AIDS interventions excluded from this review (e.g. antiretroviral treatment or male circumcision) might provide useful information to

policymakers regarding related resources allocation decisions. This review should, therefore, be characterized and interpreted as a pilot initiative, based on which, in future, Kevany Riposte systems, scope, and results may be further refined and applied by larger teams. In addition, future efforts might also (1) consider dividing the system's structure and results across the three major evaluation dimensions outlined above (i.e. individual, policy and intervention levels) in a more explicit fashion, (2) correlate health and diplomatic outcomes (see below), and (3) attempt to further describe the political and operational mechanisms by which the results of diplomatic and foreign policy evaluations may be translated from findings such as those presented here into policy, and thence into practice [59–61] (see below).

#### Plotting health effectiveness against intervention effectiveness

A related area of potential interest and inquiry to organizations such as the United States' Centers for Disease Control and Prevention (CDC) is consideration of the effects of diplomatically "highly advantageous" global health interventions on health outcomes. Do "more diplomatic" global health interventions relate to improved health outcomes – or vice versa – or both? Such findings, though beyond the scope of this paper, might be determined through cross-referencing intervention medical efficacy and effectiveness against diplomatic assessment values. Though direction of causality may be challenging to prove, the establishment of such relationships may help to further explain the manifold connections between diplomatically and medically successful global health interventions [62].

#### Recommendations

Global health interventions and related Global Fund and PEPFAR-supported programs have the potential to be of significant importance in alleviating developing countries from the worst effects of communicable and non-communicable disease and ill-health. More broadly, such interventions may also have the potential to advance diplomatic considerations related to the interests of both donor and recipient countries, as well as national and international, health and non-health, goals and initiatives, such as strategic and security concerns. In order to optimize the potential future impact of these latter dimensions, and based on the results presented here, related recommendations include (1) consideration of the redesign of HIV/AIDS initiatives in the context of training, organizational interdependence, and neutrality, whilst also addressing the specific "potential significant threats" at the sub-classification level described above; (2) the further development of intervention sustainability, accountability, and latent political, economic, social and

environmental potential; (3) the development and *prima facie* integration of intervention health and non-health effectiveness findings into intervention program design and delivery; (4) building on the successes and diplomatic advantages associated with intervention visibility, adaptability, and partnership development; and (5) leveraging these latent diplomatic assets, at the individual, intervention and policy levels, in order to address broader national and international strategic concerns.

#### Next steps: utilization of results and "evidence into policy & practice"

The identification of five main opportunities and mechanisms for utilization of the results of the Kevany Riposte and K-Score have previously been identified by the author as (1) training, (2) evaluation, (3) resource allocation, (4) funding, and (5) military and international security considerations [25]. A range of *realpolitik* scenarios for such applications are conceivable. In one possible example, widespread diplomatic reviews conducted under the auspices of organizations such as the Office of Global Health Diplomacy, the United Kingdom's Royal Institute for International Affairs, or the European Union's External Action Service, might provide a detailed picture of the comparative worth of global health interventions, from the diplomatic and foreign policy perspectives, across a range of key settings, population groups, and regions around the world. These results might then be overlaid, with the assistance of donor and recipient country foreign policymakers or professional diplomats, with global diplomatic, political, foreign policy or strategic needs and threats in order to determine both (1) overall and targeted global health investments, (2) geo-strategic and demographic focus, and (3) intervention program selection, whilst (4) better aligning interventions with broader strategic considerations and the work of non-health international initiatives and organizations. In this way, the smart use of global health initiatives may provide a meaningful and effective alternative or complement to other forms of international intervention on the world stage, advancing both health and non-health goals [63].

#### Additional files

**Additional file 1: Annex 1 Diplomatic Assessment Questionnaire and Scoring Tool.**

**Additional file 2: Annex 2 Interview and assessment guide for diplomatic and foreign policy assessments.**

#### Competing interests

The author declares that he has no competing interests.

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## References

- Ferrero-Waldener B (2007). The European Union and the World: A Hard Look at Soft Power. New York: Columbia University. September 24<sup>th</sup>, 2007.
- Lancaster C. Foreign Aid: Diplomacy, Development. Domestic Politics: University of Chicago Press; 2007.
- Europa (2010). Foreign and Security Policy: Speaking with One Voice. Accessed through: [www.europa.eu/pol/cfsp/index\\_en.htm](http://www.europa.eu/pol/cfsp/index_en.htm)
- Kagan R. Power and Weakness. Policy Review. 2002;113:208–21. Retrieved from <https://www.mtholyoke.edu/acad/intrel/bush/kagan.htm>.
- European Commission (2010). The EU Role in Global Health. European Commission consultation document. Brussels: March 2010 Accessible through: [https://ec.europa.eu/europeaid/eu-role-global-health\\_en](https://ec.europa.eu/europeaid/eu-role-global-health_en)
- Department of State (2008). Joint Department of State, USAID Enterprise Architecture Transition Strategy for FY2009. Accessed through: <http://www.state.gov/m/irm/rls/110469.htm>
- Tran M (2012). The Politics of UK Aid Explained. The Guardian. September 26<sup>th</sup>, 2012. Accessible through: <http://www.theguardian.com/global-development/2012/sep/26/the-politics-uk-aid-explained>
- Kitchen N (2010). The Future of UK Foreign Policy: Executive Summary. IDEAS reports - special reports, Kitchen, Nicholas (ed.) SR006. LSE IDEAS, London School of Economics and Political Science, London, UK. Accessed through: [http://eprints.lse.ac.uk/43547/1/The%20future%20of%20UK%20foreign%20policy\\_executive%20summary](http://eprints.lse.ac.uk/43547/1/The%20future%20of%20UK%20foreign%20policy_executive%20summary) (lsero).pdf
- The Lancet (2015). National Allies for Global Health? The Lancet 384: 1477. Retrieved from: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61923-1/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61923-1/fulltext?rss=yes)
- The World Bank (2011). The World Development Report 2011: Conflict, Security, and Development. Accessed through: <http://wdr2011.worldbank.org/fulltext>
- O'Neill J & Pappas G (2007). Health Diplomacy: Lessons for Global Health from PEPFAR. The International Journal of World Health and Societal Politics. 7: 1. Accessed through: <https://ispub.com/IJWH/7/1/3801>.
- United States Department of State (2014). About the Office of Global Health Diplomacy. Accessible through: <http://www.state.gov/s/ghd/about/>
- Novotny T, Kevany S. The way forward in global health diplomacy: Definitions, research, and training. In: Novotny T, Kickbusch I, Told M, editors. 21st century health diplomacy. Geneva: World Scientific; 2013. p. 203–25.
- Hudson V, Vore C (1995). Foreign policy Analysis: Yesterday, Today and Tomorrow. Mershon Int Stud Rev. 39 (2): 209–38. Accessible through: <http://bev.berkeley.edu/fp/readings/ForeignPolicyAnalysisDomesticPolitics.pdf>.
- Center for Strategic and International Studies (2010). Final Report of the CSIS Commission on Smart Global Health Policy. Accessed through: <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>
- Feldbaum H. Global Health & Foreign Policy. Epidemiological Review. 2010;32:82–92.
- Kevany S, Jaf P, Workneh N, Abu Dalo M, Tabena M, Rashid S & Al Hilfi T (2014). Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. Medicine, Conflict and Survival 30 (2): <http://dx.doi.org/10.1080/13623699.2014.890827>
- Lyman N & Wittels S (2010). No Good Deed goes Unpunished: The Unintended Consequences of Washington's HIV/AIDS programs. Foreign Affairs. July–August 2010. Retrieved from <http://www.foreignaffairs.com/articles/66464/princeton-n-lyman-and-stephen-bwittels/no-good-deed-goes-unpunished>
- Basler M. Utility of the McNamara Fallacy. Br Med J. 2009;339:b3141–23.
- Nye J (2004). The Decline of America's Soft Power. Foreign Affairs: May & June 2004 Issue. Accessible through: <https://www.foreignaffairs.com/articles/2004-05-01/decline-americas-soft-power>
- Warmerdam W & de Haan A (2011). The Roles of Aid in Politics. International Institute for Social Studies. Accessible through: [www.iss.nl/Bibliography/The\\_Roles\\_of\\_Aid\\_in\\_Politics\\_February\\_](http://www.iss.nl/Bibliography/The_Roles_of_Aid_in_Politics_February_)
- Center for Strategic & International Studies (2007). The CSIS Commission on Smart Power. Accessible through: [http://csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)
- Feldbaum H, Michaud J. Health Diplomacy and the Enduring Relevance of Foreign Policy Interests. PLoS Med. 2010;7(4), e1000226. doi:10.1371/journal.pmed.1000226.
- Bonventre E. Monitoring and Evaluation of Department of Defense Humanitarian Assistance Programs. Military Review. 2008;88(1):66–72.
- Garrett L (2007). The Challenge of Global Health. Foreign Affairs. January & February 2007 Issue. Accessible through: <https://www.foreignaffairs.com/articles/2007-01-01/challenge-global-health>
- PEPFAR (2014). PEPFAR Prevention Guidance. Accessible through: <http://www.PEPFAR.gov/reports/guidance/171094.htm>
- The Global Fund (2012). The Global Fund Strategy 2012–2016. Accessible through: [www.theglobalfund.org/Core\\_GlobalFundStrategy01\\_Attachment\\_en/](http://www.theglobalfund.org/Core_GlobalFundStrategy01_Attachment_en/)
- United States Global Health Initiative (2011). Global Health Initiative Strategy 2011–2016. Accessible through: <http://www.ghi.gov/whereWeWork/docs/SouthAfricaStrategy.pdf>
- PEPFAR (2010). Kenya Country Operational Plan 2010. Accessible through: [www.PEPFAR.gov/documents/organization/228466.doc](http://www.PEPFAR.gov/documents/organization/228466.doc)
- Khumalo-Sakutukwa G, Morin S, Fritz K, Charlebois E, Van Rooyen H, Chingono A, et al. The NIMH Project Accept Study Team (2010). Project Accept (HPTN 043): A Community-Based Intervention to Reduce HIV Incidence in Populations at Risk for HIV in Sub-Saharan Africa and Thailand. J Acquir Immune Defic Syndr. 2008;49(4):422–31. [http://www.academia.edu/8166578/Project\\_Accept\\_HPTN\\_043\\_A\\_Community-Based\\_Intervention\\_to\\_Reduce\\_HIV\\_Incidence\\_in\\_Populations\\_at\\_Risk\\_for\\_HIV\\_in\\_Sub-Saharan](http://www.academia.edu/8166578/Project_Accept_HPTN_043_A_Community-Based_Intervention_to_Reduce_HIV_Incidence_in_Populations_at_Risk_for_HIV_in_Sub-Saharan)
- International Teaching and Education Center for Health (2014). South Africa: I-TECH Launches Re Mmogo Pholong [Together In Wellness] Program. Accessible through: <http://news.go2itech.org/2012/10/south-africa-wellness-program/>
- Kevany S (2014). Global Health Diplomacy, 'Smart Power', and the New World Order. Global Public Health: An International Journal for Research, Policy and Practice. 2014. doi:10.1080/17441692.2014.921219.
- The Global Fund (2014). Data and Service Quality Assessment. Accessible through: <http://www.theglobalfund.org/en/me/documents/dataquality/>
- Kevany S, Khumalo-Sakutukwa G, Murima O, Chingono A, Modiba P, Gray G, et al (2013). Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. BMC Public Health. 2012;12(459):1–11. <http://www.biomedcentral.com/1471-2458/12/459/abstract>.
- Walensky R, Kurtzkes G (2011). The Impact of The President's Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and Why It Remains Essential. Clin Infect Dis. 50 (2): 272–5. Accessible through: <http://cid.oxfordjournals.org/content/50/2/272.abstract>.
- United States Agency for International Development (2013). Issue Brief: Country Ownership. Accessible through: <http://www.usaid.gov/sites/default/files/documents/1864/CountryOwnershipIssueBrief.pdf>
- Kevany S, Hatfield A, Workneh N, Aurang Zeb Durrani B, Bekele Y, Khan U, et al. Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. Med, Confl Surviv July–September; 2012;28(3):247–62. <http://www.ncbi.nlm.nih.gov/pubmed/23189590>.
- Yang A, Farmer P. Sustainability: in Global health. Glob Public Health. 2010;5(2):129–35. Accessible through: <http://www.ncbi.nlm.nih.gov/pubmed/20213563>.
- United Kingdom Medical Research Council (2007). Developing and evaluating complex interventions: new guidance. Accessible through: <http://www.mrc.ac.uk/documents/pdf/complex-interventions-guidance/>
- Eckenwieler L, Hunt M. Counterterrorism, Ethics, and Global Health. Hastings Cent Rep. 2014;44(3):12–3. Accessible through: <http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=6885>.
- Royal Institute for International Affairs (2011). Global Health Diplomacy: A Way Forward in International Affairs. Accessible through: <https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/280611summary.pdf>
- Katz R, Komblet S, Arnold G, Lief E, Fischer J. Defining health diplomacy: Changing demands in the era of globalization. Milbank Q. 2011;89:503–23.

- Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00637.x/abstract>.
43. Kickbusch I, Novotny T, Drager N, Silberschmidt G, Alcazar S. Global health diplomacy: Training across disciplines. *Bulletin of the World Health Organization*. 2007;85:82–91. Retrieved from [http://www.scielosp.org/scielo.php?pid=S004296862007001200027&script=sci\\_arttext&tlng=es](http://www.scielosp.org/scielo.php?pid=S004296862007001200027&script=sci_arttext&tlng=es).
  44. Marseille, E., & Khan, J. (2002). HIV prevention before HAART in sub-Saharan Africa. *The Lancet*, 359, 1851–1856. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(02\)08705-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)08705-6/abstract)
  45. Center for Strategic and International Studies. (2010). Final report of the CSIS Commission on smart global health policy. Retrieved from <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>
  46. Burkle S (2013). Throwing the baby out with the bathwater. *Prehosp Disaster Med*. (3):1–3. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=892159>
  47. Burkle S, Garfield R. Civilian mortality after the 2003 invasion of Iraq. *The Lancet*. 2013;381:879. Retrieved from <http://press.thelancet.com/mortality.pdf>.
  48. Copeland D, Potter E. Public Diplomacy in Conflict Zones: Military Information Operations Meet Political Counter-Insurgency. *The Hague J Diplomacy*. 2008;3(3):277–97. Accessible through: <http://booksandjournals-brillonline.com/content/journals/10.1163/187119108x367161?crawler=true>
  49. Center for Strategic & International Studies (2014). Global Health Engagement: Sharpening a Key Tool for the Department of Defense. Accessible through: [http://csis.org/files/publication/140930\\_Daniel\\_DODGlobalHealth\\_Web.pdf](http://csis.org/files/publication/140930_Daniel_DODGlobalHealth_Web.pdf)
  50. United States Agency for International Development (2009). Development Assistance and Counter-Extremism. USAID Policy Document. Accessible through: <https://dec.usaid.gov/dec/content/GetDoc.axd?>
  51. Vanderwagen W (2006). Health Diplomacy: Winning Hearts and Minds thorough the use of Health Interventions. *Military medicine* 171: 3-4. White B (2001). *The Globalization of World Politics: An Introduction to International Relations*. New York: Oxford University Press
  52. Kevany S, Sahak O, Workneh N, Saeedzai A. Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs. *Med Confl Surviv*. 2014;30(1):37–55. <http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187>.
  53. Novotny T, Adams V. Global health diplomacy—A call for a new field of teaching and research. *San Francisco Medicine*. 2007;80(3):22–3.
  54. Europa (2015). Factsheet on EU Intelligence Analyses Center (INTCEN). Accessible through: [http://eu-un.europa.eu/articles/en/article\\_16050\\_en.htm](http://eu-un.europa.eu/articles/en/article_16050_en.htm)
  55. Norton-Smith R (2015). MI5, 'Jihadi John', terrorism, UK defense, budgets— all connected. *The Guardian*. Defense and Security Blog, March 2nd, 2015. Accessible through: <http://www.theguardian.com/news/defence-and-security-blog/2015/mar/02/mi5-jihadi-john-terrorism-uk-defence-budgets-all-connected>
  56. Williams J (2015). Countering violent extremism: improving U.S. strategy for the future. Brookings Institution: Middle East Politics & Policy Department. Accessed through: <http://www.brookings.edu/blogs/markaz/posts/2015/02/06-countering-violent-extremism>
  57. Hider J (2014). US sent fake aid workers to spy on Cuba. *The Times*, US & Americas. August 5<sup>th</sup>, 2014. Accessible through: <http://www.thetimes.co.uk/tto/news/world/americas/article4166629.ece>
  58. Using cost-effectiveness league tables to compare interventions to prevent sexual transmission of HIV. Pinkerton S (2001). *AIDS* 215(7): 917-28. Accessible through: <http://www.ncbi.nlm.nih.gov/pubmed/11399964>
  59. Yamey G. Evidence-Based policymaking in Global health: The Payoffs & Pitfalls. *Evid Based Med*. 2011;16:97–9. Accessible through: <http://ebm.bmj.com/content/16/4/97>.
  60. Brown M, Mackey T, Shapiro C, Kolker J, Novotny T (2014). Bridging Public Health and Foreign Affairs: The Tradecraft of Global Health Diplomacy and the Role of Health Attachés. *Science & Diplomacy* 3: 3. Accessed through: <http://www.sciencediplomacy.org/article/2014/bridging-public-health-and-foreign-affairs>
  61. Kevany, S., Benatar, S., & Fleischer, T. (2013). Improving resource allocations for health and HIV in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Global Public Health*, 8, 570–587. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23651436>
  62. Kleinman A (2010). The art of medicine: Four social theories for global health. Vol 375 May 1, 2010. Accessible through: <http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673610606460.pdf>
  63. Michaud J, Kates J. Global health diplomacy: Advancing foreign policy and global health interests. *Global Health: Science & Practice*. 2013;1(1):24–8. Retrieved from <http://www.ghspjournal.org/content/1/1/24.full>.

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U.S. Navy Hospital Corpsman talks with students from Andalas Primary School during subject matter expert exchange held at Andalas Social Health Clinic, during Pacific Partnership 2016, August 26, 2016 (Royal Australian Air Force/David Cotton)

# Applying Smart Power via Global Health Engagement

By Sebastian Kevany and Michael Baker

The U.S. military is entering a period of dramatic redirection and restructuring at a time of broader international upheaval, from Ukraine to Syria.<sup>1</sup> The past decade of global conflict has emphasized the predominant hard power focus of the Armed Forces, often with limited success. The emergence of a new mission—smart power—offers

opportunities to shift toward innovative forms of international intervention and conflict resolution by the U.S. military through coordination with national security strategies such as global health diplomacy (GHD).<sup>2</sup> Recently articulated doubts over the wisdom of supplying health, development, and other forms of economic support to those countries that support Islamic

fundamentalism highlight an increasing need for the United States and other world powers to harmonize and align development, altruistic, and security initiatives.<sup>3</sup>

Military forces could be deployed and used to contribute to foreign policy, global health, and the strengthening of key local actors in related sectors.<sup>4</sup> Doing so could maintain strategic regional and international goals and advance international stability and development through strategies such as *global health engagement* (GHE). GHE is defined as “health

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activities which the DOD [Department of Defense] conducts in support of the national security policy and military strategy of the United States.”<sup>5</sup> While a range of tensions exists around expanded military engagement in humanitarianism, we can attempt to guide this process toward a mutually acceptable engagement on both altruistic and strategic levels via the GHD paradigm.

Considerable damage to the international prestige of the armed forces of the United States and United Kingdom has resulted from the Iraq and Afghanistan wars and associated events.<sup>6</sup> Combined with questions of strategic gains, cost-effectiveness (consideration of the “opportunity costs” of the combat and postcombat periods, including care of returning veterans), long-term regional stability, and lack of global social, political, and cultural acceptability, there is increasing speculation regarding the use of combined military, health, and development initiatives as some of the possible effective substitutes for, or complements to, hard power interventions. For example, strengthening host-nation healthcare systems is one path to achieving strategic goals, through accessing and stabilizing regimes opposed to extremism.<sup>7</sup>

Opponents of smart power strategies point to the fact that there is no proven correlation between international development programs and the capacity of donors to positively influence geopolitical events, yet medical initiatives are increasingly recognized as an effective and efficient method of supporting the global community’s dual-health and non-health priorities in tandem.<sup>8</sup> These include threat reduction from epidemics, enhanced security (including health security), and political and diplomatic alliances—pursued in concert with each other, rather than in isolation, via DOD initiatives such as medical stability operations and partner engagement and force health protection and readiness.<sup>9</sup> Thus GHE is specifically designed to support both national security and international engagement.<sup>10</sup>

The modern international security environment has undergone significant changes since the end of the Cold War.

One significant driver of this change is the failed state, an environment that provides little hope for a better future among young populations and is “susceptible to exploitation by terrorists, tyrants, and international criminals.”<sup>11</sup> Concurrently, the nature of the physical battlefield has changed via an increasing number of tribal and ethnic clashes that involve non-state, guerrilla, or other irregular players rather than uniformed forces.<sup>12</sup> This evolution of the conflict environment has had a corresponding impact on approaches used by security instruments to implement and influence foreign policy objectives.

The U.S. Marine Corps first identified related models in the latter half of the 1990s, describing its vision of future warfare in this context as the “Three Block War” under which hypothesis individual soldiers are required to simultaneously conduct military, peacekeeping, and aid operations in combination with, and in close geographical proximity to, each other.<sup>13</sup> The essence of this innovative concept is that modern militaries, to be effective, must be trained to operate in all three operating environments simultaneously—and that to do so, leadership training in related noncombat skills, including health care and diplomacy, must be conducted at all levels of command.

Military technology has advanced significantly in recent years, including remote imaging that can be leveraged to gain immediate information regarding needs on the ground through overflight by satellites and unmanned aerial vehicles (UAVs). This ascendancy of technological warfare has led to a reevaluation of the role of traditional or conventional armed forces as ground troops.<sup>14</sup> Apart from growing public intolerance of military and civilian “body counts” associated with the pre-UAV era, the increased range of options offered by related technological advances has meant that the threat neutralization roles formerly the responsibility of the foot soldier are increasingly delegated to unmanned interventions.<sup>15</sup> As described in the Three Block War paradigm, the role of individual soldiers is evolving beyond mere combatants. To adapt to these new and

diverse roles, as well as proving purposeful activity for the residual manpower surplus associated with technological warfare, the Armed Forces require increased training in, and awareness of, their role as international representatives, global health workers, and diplomats, as well as their traditional battlefield roles.

Soldiers will continue to function according to the rules of engagement and take orders and procedures from their officers, while demonstrating an *explicit* awareness and recognition of their *implicit* role as benign liberators and agents of international relations and development that stands to significantly enhance their prestige, value, functionality, and self-esteem. Such aspirations mirror the North Atlantic Treaty Organization’s longstanding Peace Support Operations doctrine, which includes the provision of humanitarian assistance to civilian populations as one of its six guiding principles.<sup>16</sup>

Since the end of the Cold War, international economic crises and domestic budgetary pressures have generated tremendous pressure on Western military establishments to adapt and streamline operations via a diversification of roles and responsibilities. Military and political leaders’ recognition of international health emergencies and climate change as threats to national security is notable.<sup>17</sup> The *Policy Guidance for DOD Global Health Engagement*, released in May 2013, made important first steps in related diversification processes.<sup>18</sup> All of these vectors have come to be important elements in the strategies and tactics used by the military in current and recent conflicts—as well as in the context of the debate about the appropriate role, structure, and composition of the U.S. military. These broader global developments have contributed in a critical way to a rapidly evolving conflict environment in which traditional interventions have struggled to achieve success.

### **GHD as a Strategic Military Tool**

The discussion thus far suggests that the increased use of tools such as GHE by the Armed Forces should be examined more closely in the diplomatic context as well as in its primary health security



People's Liberation Army Navy hospital ship *Peace Ark* Senior Captain Sun Tao shares medical experiences during group activity during Fundamentals of Global Health Engagement Course at Makalapa Clinic as part of Rim of the Pacific 2016, Joint Base Pearl Harbor–Hickam, July 11, 2016 (U.S. Navy/ Katarzyna Kobiljak)

role (for example, the 2014 response to West Africa's Ebola outbreak) of protecting vital national health security interests.<sup>19</sup> This is particularly relevant in the context of DOD guidance that promulgates the use of global health programs to achieve strategic endstates or to support other national and international objectives. *Global health*, in this context, is defined as the alleviation of those health challenges that affect the world's poorest and most marginalized populations, with an emphasis on communicable diseases such as HIV/AIDS, tuberculosis, and malaria, as well as specific reference to health concerns that require global cooperation due to transcendence of territorial boundaries.<sup>20</sup> GHD in this context is therefore best described as a foreign policy tool that blurs the line between altruism and enlightened self-interest. It leverages military and political assets in response

to both human or natural disaster emergencies and longer term nation-building and stabilization through infectious diseases control and support in order to achieve specific goals for the global community.<sup>21</sup>

Western military forces hold a distinguished tradition of providing emergency health and aid assistance to civilian populations overwhelmed by natural disasters or civil strife.<sup>22</sup> The military is unique in providing immediate response using transportation assets, surveillance, monitoring and evaluation, and other intelligence tools—particularly important in both epidemiological and security contexts.<sup>23</sup> The Armed Forces also have a built-in logistics supply system that can put relief anywhere in the world in a short time. This represents a unique set of capabilities that often make the military the best “first responder” for GHE.<sup>24</sup> Opportunities for those fields of endeavor

related to GHE (for example, emergency medical care, provision of drugs or treatments, rapid mobilization of people or resources) and those generally associated with GHD (polio eradication, HIV/AIDS prevention or treatment, and anti-malarial campaigns) are increasingly evident.

Medical “hearts and minds” operations were also initially highly successful as an alternative to military force during the Vietnam War, and it remains a regret of the conflict's high-level planners that such approaches were not maintained and employed more extensively.<sup>25</sup> Modern GHE doctrine, encompassing longer term global health interventions, appears to have assimilated related lessons on the need for different configurations, supplies, and training for appropriate, sustainable, and effective responses, in both medical and strategic contexts. For example, after more than 13 years



Co-founder and CEO of Seed Global Health speaks on “Improving Developing Country Health Systems Through the Spirit of Volunteerism,” part of Secretary’s Office of Global Health Diplomacy Speaker Series, at State Department, April 22, 2014 (State Department)

of operations according to traditional military roles, U.S. involvements and interventions in Southeast Asia are now increasingly characterized as soft power missions, while DOD policy guidance for GHE stipulates parameters to “ensure legality, appropriateness, and effectiveness” as well as building the trust and confidence of partner nations and communities.<sup>26</sup> The United States is not alone in pursuing such innovative strategies; other international actors such as Venezuela and Cuba, through sustainable initiatives such as community based clinics and hospitals that provide long-term and affordable health care to recipient populations, have been “particularly adept at parlaying provision of medical services to nationals of other countries into support in international forums” as well as advancing strategic donor self-interest.<sup>27</sup>

The military has proved its nascent capacity in settings such as Iraq and Afghanistan to provide longer term GHE support operations. This is evident in programs that mitigate infectious diseases such as HIV/AIDS, tuberculosis and malaria, as well as making healthcare systems stronger.<sup>28</sup> There has been no evidence to

date of the maintenance of these activities after military withdrawal, while related GHE initiatives have both demonstrated the potential capacity of the military in this regard and produced significant yet unmeasured strategic gains that were potentially as effective in achieving strategic goals as combat and ballistic efforts.<sup>29</sup> While combined tactical and altruistic successes have occurred throughout military history, no formal framework and set of standards for their delivery, along with a set of operational principles governing such engagements that optimize smart power effectiveness, have been developed and applied.

### Issues of Primacy, Alignment, and Harmonization

In a recent editorial, *The Lancet* examines the risks and benefits of the inevitable augmentation of the military’s role in global health in the 21<sup>st</sup> century.<sup>30</sup> We must ask to what extent GHE and other altruistic endeavors could be used by the United States and others as a convenient rationale for expanding international military presence—arguments that Russia has employed to justify its occupation of eastern parts

of Ukraine.<sup>31</sup> Interagency coordination and governance of combined GHE and GHD activities as well as public and media transparency are therefore key concerns.<sup>32</sup>

Enhanced alignment between DOD and the U.S. Agency for International Development (USAID), for example, inevitably raises questions around alignment between civilian and military doctrines. Would DOD, in a joint GHD/GHE operation scenario, subordinate itself to the governing principles and authority of USAID? Or, under a GHD paradigm, would USAID become increasingly aware of strategic considerations, with specific regard to settings in which conflict is currently taking place or recipient populations that pose a proven threat to donor security? DOD is at present subordinated to USAID through its Office of Foreign Disaster Assistance in every foreign disaster response that DOD is asked to support. For nondisaster engagements, such as partner-nation capacity-building, while not subordinate to USAID, DOD policy guidance directs that “GHE activities should be consistent with the relevant U.S. Embassy’s integrated country strategy

and complementary to USAID's country development cooperation strategy" to avoid redundancy—or even conflict—between individual agency efforts.<sup>33</sup> The development of coherent, consistent, and broadly applicable GHE approaches may be informed, enhanced, and made practicable by reference to relevant criteria, standards, and guidelines for smart global health.<sup>34</sup>

### Developing a Frame of Reference

If the U.S. military chooses to devote greater levels of resources and effort to GHE in order to achieve joint strategic and altruistic ends under a GHD paradigm, adherence to appropriate program and intervention design, delivery, and selection criteria will be of critical importance. As a recent RAND report notes, "A focus on the higher-order objective of enhancing legitimacy of local leaders would cause planners to carry out global health programs in a different way."<sup>35</sup> This demonstrates the importance of adapting focus to optimize multilevel gains. Equally important, interventions should not threaten the structure or integrity of local healthcare systems by significantly exceeding local standards of care.<sup>36</sup> Smart intervention categories in this regard, and as described in recent DOD guidance, also include educational and training exercises. These are endeavors to which, for example, the plans, operations, and military intelligence division of organizations such as the U.S. Navy and Naval Reserve might meaningfully contribute.

Civil affairs units of the United States and other militaries traditionally conduct civil-military operations, including initiatives such as Civil Information Management, Foreign Humanitarian Assistance, and Nation Assistance. The remit of such units also extends to the preservation and restoration of protected targets such as healthcare facilities in war zones, facilitating links between military commanders and civil society. Civil affairs personnel have become increasingly integral to U.S. (and United Nations) peacekeeping operations in Iraq,

Afghanistan, Somalia, and the former Yugoslavia, while also contributing via short- and long-term aid efforts in countries such as Cambodia and Honduras.<sup>37</sup> Civil affairs units do not focus primarily on health issues, but, via the GHE paradigm, the U.S. military continues to develop international health and global health capacity in this context.

The development of systems by which the military can operate in closer cohesion with global health initiatives is central to the success of smart power strategies. These include consideration of the delivery of health assistance programs under *military umbrellas*, defined (in this context) as military support, advisement, protection, and coordination for health, development, and foreign assistance activities in unstable or insecure environments. While successful strategic outcomes may have been at least partially achieved in recent conflicts through global health roles in "armed social work," the dangers posed to non-military international development and diplomatic representatives have never been greater.<sup>38</sup> These include the increased incidence of violent deaths, abductions, and hostage situations involving formally and informally deployed personnel in regions as diverse as Sudan, Somalia, and Syria. To counter this threat, military intelligence, surveillance, and communications can provide support to assist a humanitarian response, allowing, for example, transportation and logistics to be fine-tuned for maximum impact and staff security. Careful and detailed advance liaison with local stakeholders, including health, military, and political representatives, can also help to ensure both health and strategic successes via a "hand off" to local personnel or organizations as the military departs.<sup>39</sup>

DOD policy guidance suggests that GHE initiatives should target activities on locations or regions "where there is humanitarian need balanced with operational and strategic significance."<sup>40</sup> Accessing unstable or ungoverned areas is a critical aspect of 21<sup>st</sup>-century U.S. military and diplomatic policy.<sup>41</sup> Two of the major smart power questions—"What are the positions and preferences

of the targets to be influenced?" and "What forms of power behavior are most likely to succeed?"—are linked to the objective of enhanced geographical influence and coverage by international actors.<sup>42</sup> Access to and development of an international presence in otherwise non-permissive areas provide opportunities for communications and education to populations whose only other alternative is often exposure to extremist propaganda, doctrine, and inculcation. Appropriately designed, selected, and adapted global health initiatives, operating in concert with the military umbrellas to provide protection and support, have been demonstrated in such circumstances to enhance both international influence and relations in remote geographical regions of countries such as Afghanistan and Iraq.<sup>43</sup>

International development and health programs have traditionally assisted with or been employed as tools of international lines of strategic intelligence and communication.<sup>44</sup> The recent outcry over the use of vaccination programs as a cover for intelligence-gathering activities in Pakistan elicited a range of dissociating responses from medical leaders, the White House, and other key actors at the State Department.<sup>45</sup> Arguments that objectives such as international security transcend those of international development suggest that such condemnations should be tempered by broader historical and contextual considerations.<sup>46</sup> The use of GHE surveillance from both the national and health security perspectives forms an explicit element of related DOD policy guidance.<sup>47</sup> The access granted to global health and development programs in insecure environments cannot be systematically leveraged or exploited in this ad hoc manner, both risking safety and security of program staff and jeopardizing future target population approval of any forms of international involvement. Rather, a compelling case for structures governing the use of strategic communications and observations, in either an explicit or an implicit manner, is made based on the tragic lessons learned from such experiences.<sup>48</sup>

## Training

GHD in the context of military personnel training will include the development of enhanced diplomatic and humanitarian skill sets, with a specific focus on improving strategic capacity within GHE staff and improving diplomatic and humanitarian capacity within combat staff. The Three Block War paradigm illustrates the complex spectrum of challenges and responsibilities likely to be faced during deployment or on the modern battlefield, including stability operations. The essence of such approaches is that both military and foreign assistance personnel must be trained to operate coherently in diplomatic, humanitarian, and combat capacities simultaneously rather than in a stovepiped fashion. Adaptations to the related “strategic corporal” approach build on the increasingly global consensus that leadership in complex, rapidly evolving, and potentially hostile health and security environments requires a much broader range of skills and training than previously considered necessary.

To achieve joint strategic and altruistic goals, the U.S. military may wish to invest further in the application of smart power and GHD contributions to GHE. This would include enhancing specialist diplomatic input on the choice of GHE interventions, the manner in which they are delivered, as well as their duration, sustainability, and alignment between medical and strategic considerations. These are of critical importance to “the evaluation of DOD GHE projects as a means to determine whether strategic theater objectives are satisfied,” with particular reference to unexpected health or non-health outcomes and consequences.<sup>49</sup> To date, in the United States and elsewhere, diplomatic, development, and military forces, when acting independently of each other, “may lack either the appropriate authority or resources to employ smart power,” risking “tense and confusing dualities” between agency agendas.<sup>50</sup> Such increased levels of interdepartmental cooperation are desirable yet have been exceedingly difficult to accomplish in practice.<sup>51</sup> The use of GHD

specialists, building on the development of GHE coordinators at DOD, will help to ensure the greatest possible strategic impact and alignment. Complementary inputs include advising on host-nation capacity for GHE project appropriateness and country ownership.<sup>52</sup>

## Conclusions

What do these recommendations imply for the future acceptability, prestige, and success of international interventions by the U.S. military and its allies? As the 21<sup>st</sup> century progresses, DOD is presented with a unique opportunity to establish itself not only as eminently capable of power projection but also as an altruistic and humanitarian organization. To achieve these noble goals, which echo the national and international respect and admiration for the Armed Forces in the immediate aftermath of World War II as exemplified by the Marshall Plan, decisionmakers may choose to support strategic plans using GHE as a key role for the Armed Forces, addressing contemporary “asymmetries of perception” surrounding the military’s role in international affairs.<sup>53</sup> It may be unrealistic to propose that significantly expanding the scope of GHE informed by GHD operating principles would single-handedly counter the doubts that have been generated by more recent armed conflicts in which the United States has engaged.

It is nonetheless hoped that such an enhanced role in both diplomatic and medical endeavors would augment the successful and simultaneous pursuit of development *and* strategic goals. Related initiatives such as Operation *United Assistance* have cast the U.S. military in a new light—as a highly responsive, effective, rapid response organization that has the capacity to contribute to national and also global health and non-health security.

A range of concerns and critiques related to U.S. military involvement in global health and broader international development programs deserves recognition. For example, the visible role that the military has played in recent disaster relief efforts from Haiti to Monrovia to Fukushima, and, most recently, the

response to the Ebola epidemic in West Africa, has elicited an abundance of commentary both supportive and questioning of the military’s role. The latter has been driven by events such as attacks on healthcare workers in Pakistan as a result of associations with security activities in pursuit of Osama bin Laden and more general concerns around the implications of military GHE “occupations.”<sup>54</sup> Such agendas, though potentially justifiable on the international and health security levels, cast doubt upon the viability of expanded collaborations between global health and geopolitical or geostrategic concerns.<sup>55</sup> Until these ambiguities are resolved, DOD GHE efforts will continue to be critiqued for “an ad hoc, short-term focus, poor appreciation of local cultural norms, inadequate high-level involvement, and a failure to properly assess effectiveness.”<sup>56</sup>

Issues of political and social legitimacy surrounding armed interventions are at least partially addressed through the integration of hard and soft power operations, helping to rebuild American military preeminence as an agent of good.<sup>57</sup> As a counterpoint, the pursuit of armed interventions that either ignore the health and well-being of civilian and other populations is increasingly unacceptable on social, political, and legislative bases—as well as being fraught with negative strategic consequences.<sup>58</sup> Global public opinion appears united in believing that the reported 100,000 civilian deaths during the Iraq conflict should never be allowed to happen again.<sup>59</sup> To limit the extent of such casualties and to improve military legitimacy, smart power efforts require critical funding decisions related to the military-industrial complex, including, where feasible and appropriate, advocacy for GHE in lieu of or complementary to ballistic alternatives. The past 3 to 5 years have already seen a dramatic evolution of the way GHE is designed, planned, and executed in many combatant commands. We advocate for the continuation, diplomatization, and acceleration of this process.

Former Chairman of the Joint Chiefs of Staff Admiral Mike Mullen has stated that “we have been leading with the military for far too long. We



need to get diplomacy, development, fiscal, economic, financial, and educational tools out in front. We cannot kill our way to victory. It's not going to work."<sup>60</sup> The limited effectiveness of the Transformational Diplomacy Doctrine under the George W. Bush administration is in direct contrast to the role of military GHE under a smart power system proposed in this article.<sup>61</sup> As the United States faces expansionism from a more aggressive China, a newly emboldened Russia, and the dangerous Islamic State of Iraq and the Levant, the pressure to maintain and develop international stability and balance of power has never been greater. The declining social, cultural, economic, and political thresholds of public tolerance for violently contested international conflicts that do not relate directly to national security indicate that with each passing decade, the U.S. military is becoming more wary of becoming embroiled in less-than-vital engagements.<sup>62</sup>

Given the rapidly changing and increasingly non-human or technological nature of combat, serving Soldiers, Marines, Sailors, and Airmen need to be gainfully occupied in meaningful ways during both peace and war. An enhanced role for GHD-based GHE would address this issue in an enlightened and also a self-interested fashion. Otherwise, as Sun Tzu teaches us, an unoccupied army quickly becomes restless—and may, ultimately, end up provoking the very conflicts it seeks to resolve. JFQ

## Notes

<sup>1</sup> Frederick M. Burkle, Jr., "Throwing the Baby Out with the Bathwater," *Prehospital and Disaster Medicine* 28, no. 3 (June 2013), available at <<http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591>>.

<sup>2</sup> CSIS *Commission on Smart Power: A Smarter, More Secure America* (Washington, DC: Center for Strategic and International Studies [CSIS], 2007), available at <[http://csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)>; Ronald Labonté and Michelle L. Gagnon, "Framing Health and Foreign Policy: Lessons for Global Health Diplomacy," *Globalization and Health* 6, no. 14

(August 2010), 65–76, available at <[www.globalizationandhealth.com/content/6/1/14](http://www.globalizationandhealth.com/content/6/1/14)>.

<sup>3</sup> Matthew Levitt, *Better Late than Never: Keeping USAID Funds Out of Terrorist Hands*, PolicyWatch 1277 (Washington, DC: The Washington Institute, August 2007), available at <[www.washingtoninstitute.org/policy-analysis/view/better-late-than-never-keeping-usaid-funds-out-of-terrorist-hands](http://www.washingtoninstitute.org/policy-analysis/view/better-late-than-never-keeping-usaid-funds-out-of-terrorist-hands)>.

<sup>4</sup> Nathan Finney, "A Culture of Inclusion: Defense, Diplomacy, and Development as a Modern American Foreign Policy," *Small Wars Journal*, September 26, 2010, available at <<http://smallwarsjournal.com/blog/journal/docs-temp/553-finney.pdf>>; J. Christopher Daniel with Kathleen H. Hicks, *Global Health Engagement: Sharpening a Key Tool for the Department of Defense* (Washington, DC: CSIS, October 2014), available at <[http://csis.org/files/publication/140930\\_Daniel\\_DODGlobalHealth\\_Web.pdf](http://csis.org/files/publication/140930_Daniel_DODGlobalHealth_Web.pdf)>.

<sup>5</sup> Office of the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict (OASD SO/LIC), *Policy Guidance for DOD Global Health Engagement* (Washington, DC: Office of the Secretary of Defense, May 15, 2013), available at <<http://docz.io/doc/1738598/2013-policy-guidance-fo-dod-global-health-engagement>>.

<sup>6</sup> Phillip C. Saunders, "The United States and East Asia after Iraq," *Survival* 49, no. 1 (Spring 2007), available at <[www.cfr.org/content/meetings/Iraq-Impact/49-1\\_09\\_Saunders.pdf](http://www.cfr.org/content/meetings/Iraq-Impact/49-1_09_Saunders.pdf)>.

<sup>7</sup> Sebastian Kevany et al., "Global Health Diplomacy Investments in Afghanistan: Adaptations and Outcomes of Global Fund Malaria Programs," *Medicine, Conflict and Survival* 30, no. 1 (January–March 2014), 37–55, available at <[www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187](http://www.tandfonline.com/doi/pdf/10.1080/13623699.2014.874187)>.

<sup>8</sup> Ken Adelman, "Not-So-Smart' Power: Go Ahead, Congress, Cut Away at U.S. Foreign Aid," *Foreign Policy*, April 18, 2011, available at <[www.foreignpolicy.com/articles/2011/04/18/not\\_so\\_smart\\_power](http://www.foreignpolicy.com/articles/2011/04/18/not_so_smart_power)>; Kellie Moss and Josh Michaud, *The U.S. Department of Defense and Global Health: Infectious Disease Efforts* (Washington, DC: The Henry J. Kaiser Family Foundation, October 2013), available at <<http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8504-the-u-s-department-of-defense-and-global-health-infectious-disease-efforts.pdf>>.

<sup>9</sup> Josh Michaud and Jennifer Kates, "Global Health Diplomacy: Advancing Foreign Policy and Global Health Interests," *Global Health: Science and Practice* 1, no. 1 (March 2013), available at <[www.ghspjournal.org/content/1/1/24.full](http://www.ghspjournal.org/content/1/1/24.full)>.

<sup>10</sup> OASD SO/LIC.

<sup>11</sup> Steward Patrick, "'Failed States' and Global Security: Empirical Questions and Policy Dilemmas," *International Studies Review* 9, no. 4 (Winter 2007), 644–662.

<sup>12</sup> James R. Clapper, Director of National

Intelligence, Statement for the Record, Worldwide Threat Assessment of the U.S. Intelligence Community, Senate Select Committee on Intelligence, March 12, 2013.

<sup>13</sup> James E. Szepesy, "The Strategic Corporal and the Emerging Battlefield: The Nexus Between the USMC's Three Block War Concept and Network Centric Warfare" (MALD thesis, 2005); Charles Krulak, "The Strategic Corporal: Leadership in the Three Block War," *Marines Magazine*, January 1999.

<sup>14</sup> Sarah Kreps and Micah Zenko, "The Next Drone Wars: Preparing for Proliferation," *Foreign Affairs*, March/April 2014, available at <[www.foreignaffairs.com/articles/140746/sarah-kreps-and-micah-zenko/the-next-drone-wars](http://www.foreignaffairs.com/articles/140746/sarah-kreps-and-micah-zenko/the-next-drone-wars)>.

<sup>15</sup> Moss and Michaud.

<sup>16</sup> Allied Joint Publication–3.4.1, *Peace Support Operations* (Brussels: North Atlantic Treaty Organization, July 2001), available at <<http://publicintelligence.net/nato-peace-support-operations-doctrine/>>.

<sup>17</sup> Harley Feldbaum, "Global Health and Foreign Policy," *Epidemiological Review* 32, no. 1 (April 2010), 82–92, available at <[www.epirev.oxfordjournals.org/content/32/1/82.full](http://www.epirev.oxfordjournals.org/content/32/1/82.full)>.

<sup>18</sup> OASD SO/LIC.

<sup>19</sup> "National Armies for Global Health?" Editorial, *The Lancet*, October 25, 2014, 1477, available at <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61923-1/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61923-1/fulltext?rss=yes)>.

<sup>20</sup> OASD SO/LIC.

<sup>21</sup> Thomas E. Novotny and Vincanne Adams, "Global Health Diplomacy: A Call for a New Field of Teaching and Research," *San Francisco Medicine* 80, no. 3 (April 2007), 22–23.

<sup>22</sup> Michaud and Kates.

<sup>23</sup> Kevany et al., "Global Health Diplomacy Investments in Afghanistan."

<sup>24</sup> "National Armies for Global Health?"

<sup>25</sup> Robert S. McNamara, *In Retrospect: The Tragedy and Lessons of Vietnam* (New York: Vintage Books, 1996).

<sup>26</sup> Gary J. Schmitt, "A Hard Look at Soft Power in East Asia," AEI Research (Washington, DC: American Enterprise Institute, June 19, 2014), available at <[www.aei.org/publication/a-hard-look-at-soft-power-in-east-asia/](http://www.aei.org/publication/a-hard-look-at-soft-power-in-east-asia/)>; OASD SO/LIC.

<sup>27</sup> Robert Huish, "Why Does Cuba 'Care' So Much? Understanding the Epistemology of Solidarity in Global Health Outreach," *Public Health Ethics* (October 2014), available at <<http://phe.oxfordjournals.org/content/early/2014/10/15/phe.phu033.full>>; "Stimulus to Aid Fogarty Grantees," *Global Health Matters* 8, no. 1 (January/February 2009), available at <[www.fic.nih.gov/News/Global-HealthMatters/Documents/ghmjan-feb2009.pdf](http://www.fic.nih.gov/News/Global-HealthMatters/Documents/ghmjan-feb2009.pdf)>.

<sup>28</sup> Moss and Michaud.

<sup>29</sup> Michael H. Basler, "Utility of the

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McNamara Fallacy,” *British Medical Journal*, vol. 339, b3141 (August 4, 2009), available at <[www.bmj.com/content/339/bmj.b3141](http://www.bmj.com/content/339/bmj.b3141)>.

<sup>30</sup> “National Armies for Global Health?”

<sup>31</sup> Ibid.; Uri Friedman, “Putin’s Playbook: The Strategy Behind Russia’s Takeover of Crimea,” *The Atlantic*, March 2, 2014, available at <[www.theatlantic.com/international/archive/2014/03/putins-playbook-the-strategy-behind-russias-takeover-of-crimea/284154/](http://www.theatlantic.com/international/archive/2014/03/putins-playbook-the-strategy-behind-russias-takeover-of-crimea/284154/)>.

<sup>32</sup> Burkle.

<sup>33</sup> OASD SO/LIC.

<sup>34</sup> Eugene V. Bonventre, “Monitoring and Evaluation of Department of Defense Humanitarian Assistance Programs,” *Military Review* (January–February 2008), 66–72; CSIS, “Final Report of the CSIS Commission on Smart Global Health Policy,” Washington, DC, March 2010, transcript available at <<http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>>.

<sup>35</sup> Maria C. Haims et al., *Developing a Prototype Handbook for Monitoring and Evaluating Department of Defense Humanitarian Assistance Projects* (Santa Monica, CA: RAND, 2011), available at <[www.rand.org/pubs/technical\\_reports/TR784.html](http://www.rand.org/pubs/technical_reports/TR784.html)>.

<sup>36</sup> OASD SO/LIC.

<sup>37</sup> M. Baker, “History-Making MEDCAP Mission to Cambodia,” *Naval Reserve Association News* 44, no. 9 (September 1997), 29.

<sup>38</sup> Feldbaum; Burkle.

<sup>39</sup> Sebastian Kevany et al., “Diplomatic and Operational Adaptations to Global Health Programs in Post-Conflict Settings: Contributions of Monitoring and Evaluation Systems to ‘Nation-Building’ in South Sudan,” *Medicine, Conflict and Survival* 28, no. 3 (July–September 2012), 247–262, available at <[www.ncbi.nlm.nih.gov/pubmed/23189590](http://www.ncbi.nlm.nih.gov/pubmed/23189590)>.

<sup>40</sup> OASD SO/LIC.

<sup>41</sup> Roberts.

<sup>42</sup> Joseph S. Nye, Jr., “The Decline of America’s Soft Power,” *Foreign Affairs*, May/June 2004, available at <[www.foreignaffairs.com/articles/59888/joseph-s-nye-jr/the-decline-of-americas-soft-power](http://www.foreignaffairs.com/articles/59888/joseph-s-nye-jr/the-decline-of-americas-soft-power)>.

<sup>43</sup> Kevany et al., “Global Health Diplomacy Investments in Afghanistan”; Sebastian Kevany et al., “Global Health Diplomacy in Iraq: International Relations Outcomes of Multilateral Tuberculosis Programmes,” *Medicine, Conflict and Survival* 30, no. 2 (April–June 2014), available at <<http://dx.doi.org/10.1080/13623699.2014.890827>>.

<sup>44</sup> National Intelligence Council, *Strategic Implications of Global Health*, ICA 2008-10D (Washington, DC: Department of State, December 2008), available at <[www.state.gov/documents/organization/113592.pdf](http://www.state.gov/documents/organization/113592.pdf)>.

<sup>45</sup> Pierre M. Buekens et al., Medical School Deans’ Letter to President Barack Obama, January 6, 2013, available at <[www.jhsph.edu/news/news-releases/2013/Klag%20letter%20to%20President%20Obama.pdf](http://www.jhsph.edu/news/news-releases/2013/Klag%20letter%20to%20President%20Obama.pdf)>.

<sup>46</sup> W. Michael Reisman and James E. Baker,

*Regulating Covert Action: Practices, Contexts, and Policies of Covert Coercion Abroad in American Law* (New Haven: Yale University Press, 2011).

<sup>47</sup> OASD SO/LIC.

<sup>48</sup> Frederick Burkle, Jr., and Richard Garfield, “Civilian Mortality after the 2003 Invasion of Iraq,” *The Lancet*, March 16, 2013, available at <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)62196-5/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)62196-5/fulltext?rss=yes)>.

<sup>49</sup> OASD SO/LIC.

<sup>50</sup> Nye.

<sup>51</sup> Joint Publication 3-08, *Interorganizational Coordination During Joint Operations* (Washington, DC: The Joint Staff, June 24, 2011), available at <[www.dtic.mil/doctrine/new\\_pubs/jp3\\_08.pdf](http://www.dtic.mil/doctrine/new_pubs/jp3_08.pdf)>.

<sup>52</sup> OASD SO/LIC.

<sup>53</sup> Steven Metz and Douglas V. Johnson II, “Asymmetry and U.S. Military Strategy: Definition, Background, and Strategic Concepts,” January 2001, available at <[www.strategic-studiesinstitute.army.mil/pubs/summary.cfm?q=223](http://www.strategic-studiesinstitute.army.mil/pubs/summary.cfm?q=223)>.

<sup>54</sup> Daniel Tiefengraber, *Non-State Actors & Global Health: Eradicating Polio in Pakistan*, Case Study 15 (Barcelona: Barcelona Institute for Global Health, November 2013), available at <[www.is-global.org/documents/10179/25254/15.Eradicating+Polio+in+Pakistan.pdf/639c1179-2694-4e39-82ab-f978631141ea](http://www.is-global.org/documents/10179/25254/15.Eradicating+Polio+in+Pakistan.pdf/639c1179-2694-4e39-82ab-f978631141ea)>.

<sup>55</sup> Declan Walsh, “Polio Crisis Deepens in Pakistan, With New Cases and Killings,” *New York Times*, November 26, 2014.

<sup>56</sup> “National Armies for Global Health?”

<sup>57</sup> Jarat Chopra and Tanja Hohe, “Participatory Intervention,” *Global Governance* 10, no. 3 (July–September 2004), 289–305, available at <<http://siteresources.worldbank.org/INTJUSFORPOOR/Resources/ParticipatoryIntervention.pdf>>.

<sup>58</sup> Burkle.

<sup>59</sup> Burkle and Garfield.

<sup>60</sup> U.S. Global Leadership Coalition, “Military Leaders,” available at <[www.usglc.org/budget-center/on-the-record/military-leaders/#LetterM](http://www.usglc.org/budget-center/on-the-record/military-leaders/#LetterM)>.

<sup>61</sup> Justin Vaisse, “The Rise and Fall of the Bush Doctrine: The Impact on Transatlantic Relations,” presentation at the Institute of European Studies, University of California at Berkeley, April 6, 2006, available at <<http://econpapers.repec.org/paper/cdlbneur/qt5qg2v2d8.htm>>.

<sup>62</sup> Andrew J. Bacevich, “A Less-than-Splendid Little War,” *Wilson Quarterly* 38, no. 1 (Winter 2014), 52–67, available at <<http://wilsonquarterly.com/stories/a-less-than-splendid-little-war/>>.



## James Bond and Global Health Diplomacy

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### Abstract

In the 21st Century, distinctions and boundaries between global health, international politics, and the broader interests of the global community are harder to define and enforce than ever before. As a result, global health workers, leaders, and institutions face pressing questions around the nature and extent of their involvement with non-health endeavors, including international conflict resolution, counter-terrorism, and peace-keeping, under the global health diplomacy (GHD) paradigm.

**Keywords:** Global Health, Counter-Terrorism, Security, Foreign Policy, Diplomacy

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### Oddly Familiar?

Images of the *beau sabreur* continue to evolve in the 21st Century. In an era, when pursuit of — or opposition to — ideological goals through violent conflict is increasingly regarded with a jaundiced eye by society,<sup>1</sup> the world is looking for new benign (and malign) points of reference. Enter the “James Bond” *motif*: worldly, humanitarian, concerned with the global public good, a seasoned “international,” a natural diplomat who eschews violence except as a last resort, coupled with a willingness, for part of one’s professional life, to forsake conventional lifestyles; possessed of cultural awareness, sophistication, diplomacy, and a physical capacity to survive in often uncomfortable surroundings — 007 is one of the few benign 20th Century paradigms to have endured recent cultural, historical and societal shifts.<sup>2</sup> Does this sound oddly familiar to some of those inhabiting the world of global health? And, if so, where might this continuing convergence between the pursuit of world peace, international development, conflict resolution, and international cooperation — the evolution of a history of international health closely connected with both colonialism and commerce — ultimately lead? Without trivializing or misrepresenting the very serious nature of global health work by drawing flippant parallels, this commentary examines possible ways in which the remit of both the organization and the individual within the *métier* may be expanded to address non-health issues — related to international security, diplomacy, and foreign policy — on a more formal, structured, and explicit (rather than *ad-hoc* or implicit) basis under the “global health diplomacy” (GHD) framework, while also commenting on (1) the limits to such integration, and (2) ways in which synergies may be achieved successfully.

### New Standards of Style

Global health, though encompassing a highly diverse group of individuals and organizations with varied motives, specialties, and *modus operandi*, is not, historically, a glamorous

profession. Often indifferently rewarded, and without those formal systems of disciplinary recognition that distinguish other walks of life, honours are more often internal and nebulous rather than external and quantifiable. In the past, society has shown limited interest in recognizing associated individual-level altruism and hardships. This, however, may be changing. “Generation Z,” we are told, places greater value on doing good for humanity than on achievements such as wealth accumulation.<sup>3</sup> In what Douglas Adams calls the “Fundamental Interconnectedness of All Things,”<sup>4</sup> disciplinary boundaries — which can be both inefficient and artificial — in both global health and other professions, are increasingly being tested and expanded,<sup>5</sup> — akin to the multi-functionality and convenience of the modern “smart phone.” Professional contributions to resolving the world’s problems, are, in the multifarious “smart” era, now hailed as realistic and achievable personal goals. Engineers, for example, are increasingly becoming environmentalists<sup>6</sup>; conversely, is it only a matter of time before we see Bond fighting the real enemies of the 21st Century — less Cold War politics and megalomania, and greater attention to social and economic inequality, the excesses of the military-industrial complex, environmental degradation, prejudices, poverty, racism, disease, corruption, human rights violations, and improving global health, that drive so many of our world’s more fundamental problems? Combating such ills, whether natural, cultural, historical or man-made, may represent a more compelling *raison d’être* to the next generation than fighting stereotypical and traditional global “bads.” The global health remit, under the GHD paradigm, therefore becomes increasingly integrated with that of the diplomat or the *attaché* in order to advance the global community’s health and non-health goals.

### Professional Parallels

Global health workers, who conduct vital and important international medical work as well as de facto “barefoot” international relations,<sup>7</sup> do not sign up to be diplomats — let

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alone intelligence operatives — and should not be exposed, voluntarily or involuntarily, to risks which may affect their colleagues as much as themselves.<sup>8</sup> However, those doctors, nurses, project managers, field staff, epidemiologists, and other specialists within the global health community traveling to countries such as Afghanistan, Sudan, South Sudan, and Iraq do so with the knowledge that they are placing themselves in potentially perilous situations — and that, directly or indirectly, their endeavours are inexorably tied to concerns of conflict resolution, “smart power,” diplomacy, foreign policy, and international relations.<sup>9</sup> Implicitly, if not explicitly, it is not uncommon for global health professionals — particularly those politically appointed, or representative of national governments — to undertake duties far beyond their brief related to foreign policy, and international relations,<sup>5</sup> even if these pursuits are not always directly related to the advancement of health goals, but instead operate in parallel with them. Similarly, bilateral aid programs have consistently combined political goals with healthcare agendas in an implicit manner<sup>10</sup>; GHD approaches merely make these implicit mechanisms explicit, and therefore both clearer, and better optimized, by both donors and recipients. The historical parallel of global health workers doubling as missionaries, or *vice versa*, is a compelling representation of the medical community’s capacity to pursue broader, “downstream” goals. In parallel, at the personal level, anecdotal evidence suggests that global health work often demands an inherent courage and awareness of environmental and situational risks — dangers which may not necessarily increase in direct proportion to the addition of diplomatic duties and responsibilities.<sup>11</sup>

### The Wrong Way

The assassination of community health workers in Pakistan<sup>12</sup> as an indirect result of associations with clandestine activities in the search for Osama Bin Laden, though possibly a one-off catastrophic event, may have damaged the credibility of immunization programs throughout the developing world for years to come.<sup>13</sup> Such tragedies have, in recent years, raised serious questions around the acceptability of implicitly combining global health with foreign policy initiatives.<sup>14</sup> This was not an isolated event: Germany’s foreign spy agency “routinely camouflages its agents as development aid workers, even in war zones,”<sup>15</sup> while other countries have allegedly made use of aid personnel for intelligence purposes in locations such as Cuba.<sup>16</sup> Further examples abound: In March 2009, Sudan expelled several major foreign aid agencies, including Oxfam and Save the Children, from the Darfur region in response to accusations by President al-Bashir of foreign aid workers being “spies” and “thieves.”<sup>17</sup> Global health personnel, due to their location and activities, may therefore face ethical and moral dilemmas around their implicit role and function, including situations such as vaccination or family planning programs being used as plots for “western control,”<sup>18</sup> or the training of health workers manifesting as a threat to the military-government apparatus. Even more critically, many personnel also remain hopelessly naïve about how both donor governance and recipients of aid interpret their work in political terms.<sup>19</sup> The unplanned, unstructured, and *ad-hoc* combination of global health and foreign policy initiatives

will, therefore, inevitably lead to further tragedies and failures of the kind described above — with correspondingly greater threats to global health workers’ safety and security — while the discrediting of associated agencies threatens both diplomatic and broader international relations between donors and recipients.

### Opportunity Points

Within the global health architecture, opportunity points for the involvement of global health in foreign policy can only be identified through an understanding of the actors, contexts and challenges of both fields. Medicine and health are, to a far greater extent than other forms of international development, involved in situations of conflict, terrorism, warfare, and humanitarian emergency and catastrophe, making the integration of diplomacy into related projects and interventions of critical importance.<sup>20</sup> The advancement of foreign policy goals by national governments through health and development programs is, thus, a natural evolution of this association. Actors such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the President’s Emergency Plan for AIDS Relief (PEPFAR), and the United Nations Development Program (UNDP) frequently (though on an *ad-hoc* basis) advance both health and non-health agendas in unison, such as the secession of South Sudan from the Republic of Sudan,<sup>21</sup> challenging extremism in Afghanistan,<sup>22</sup> or contributing to conflict resolution in Iraq.<sup>23</sup> Even players such as *Medicins sans Frontières* (MSF) and the World Health Organization (WHO), despite their exclusively apolitical manifestoes, cannot hope to avoid some form of non-health influence, partisanship, or even (in the case of MSF) potentially offensive elitism.<sup>24</sup> At the individual level, even non-political global health representatives are frequently presented with opportunities to design and deliver recommendations and programmatic adaptations that address or report on both health and non-health (eg, political, social or economic) goals in concert with each other.<sup>25</sup> Even more fundamentally, such personnel are implicitly responsible for North-South relations in their comportment, behaviours and personal diplomacy when operating overseas.<sup>5</sup> To date, however, no standards, trainings, operating procedures, evaluation tools or guidelines, though now available,<sup>26</sup> have been routinely employed this regard.<sup>27</sup>

### The Right Way?

Rather than advocating for greater delineation on this basis, fields such as GHD, under certain interpretations,<sup>28</sup> attempt to resolve these tensions by encouraging, leveraging and making explicit such overlaps from the “smart power” perspective, employing altruistic operations to pursue broader non-health goals including international security.<sup>24</sup> GHD can therefore be leveraged to pursue global “goods” unrelated to health programs — a benign force, as long as it is not manipulated into pursuing global “bads” via rapacious foreign policies — and, even then, remains a better route than violent conflict. Is there, then, a “right” way for global health to interact with international politics, intelligence and diplomacy? Or, conversely, can non-health professions such as the clandestine services also help to advance global health? In spite of the threats, dangers, and blanket opposition to such proposals

from the medical community,<sup>13</sup> if appropriately structured, delivered and monitored, there may yet be a place for diplomatic, security, and political activities embedded within the global health *milieu*. Those shocked and appalled by the scale and scope of civilian casualties in recent conflicts<sup>29</sup> have called for alternatives to engagements such as the Iraq War through the implementation of global health programs working in collaboration with intelligence services and operating under “military umbrellas.”<sup>30</sup> Such approaches seek to exploit synergies between health and non-health organizations such as the advancement of humanitarian causes, conflict resolution, and international cooperation, as well as via operational overlaps: both groups are embedded, often for long periods, in remote and potentially hostile cultures; both operate under the aegis of international agencies; and both play a (conscious or unconscious) part in broader international strategic initiatives which may be unrelated to their primary programmatic responsibilities.<sup>20</sup> Examples such as the highly political nature of the polio immunization boycott in Northern Nigeria and related diplomatic efforts to overcome challenges to uptake, are representative of potential future successes of disciplinary integration based on GHD approaches.<sup>31</sup> However, successful collaborations are equally dependent on adherence to a set of standards and operating principles that recognize and respect both mutual and distinct goals, operating procedures, and standards of conduct between health and non-health organizations.<sup>32</sup>

#### Building Mutually Acceptable and Appropriate Collaborations

Such approaches represent the antithesis of contemporary thought in this regard, and will inevitably provoke controversy. Innovative and interdisciplinary combinations, most frequently designed to involve health in broader global agendas but also, conversely, to integrate and pursue foreign policy concerns via international development, if ever to occur successfully, must be carefully and meticulously planned – not least to protect the health, safety, prestige and operational independence of the global health community. If this is possible, on the basis, perhaps, of adherence to and application of appropriate criteria for the “diplomatic” and “foreign policy” sensitization of global health interventions,<sup>11</sup> opportunities for mutually acceptable associations may exist. These might include, for example: (1) Leveraging the location and presence of international health programs in unstable regions for international security and conflict resolution purposes; (2) enhancing and engaging with information gathered through monitoring and evaluation systems to better understand local communities, cultures, and preferences; (3) exploiting the extensive collaborations that global health efforts develop with community, district, regional, and international bodies; and (4) eraming such associations as an explicit *quid pro quo* with recipient countries, whereby vital intelligence efforts related to national and international security are, formally or informally, exchanged for, or combined with, the provision of altruistic development programs.

#### Uneasy Allies

As health and politics become increasingly and inexorably intertwined, the risk of “cross-contamination” across previously-distinct professional and disciplinary challenges

increases exponentially; associations between clandestine organizations such as the Central Intelligence Agency (CIA), world politics, and global health initiatives have never before been so much in the public eye.<sup>33</sup> Similarly, the involvement of military organizations as potential actors in in global health operations — such as under Operation United Assistance in response to the Ebola outbreak<sup>33</sup> — are the subject of intense contemporary media interest, scrutiny, and even alarm. Such reflection is both welcome and necessary, and has both the safety of global health workers and the advancement of international cooperation and diplomacy as its goal. Nonetheless, with the decreased stature, cost-effectiveness, international social and cultural acceptability, and even relevance of “hard power” operations in the 21st Century, opportunities for such collaborations in the interests, not just of global health, but also of broader international security, are both of increasing importance and increasingly unavoidable. In the context of contemporary crises such as Syria and the Islamic State, both strategic and altruistic initiatives have either failed, or faced unacceptable security challenges — at both the individual and organizational levels — when operating independently of each other. Structured liaisons and collaborations may be the only alternative left. Success, in turn, relies on intelligence, military, global health, and development organizations working together in unprecedented ways, as characterized by the recent creation of the United States’ Office of Global Health Diplomacy (OGHD) embedded within increasingly political divisions of the State Department.<sup>34</sup> The involvement, in such cases, of essentially political and foreign policy departments into the very mechanics of global health program design and delivery should be welcomed and endorsed by the global health community – not just for the added global health funding this dual agenda may generate, but because of the essential and urgent need to integrate diplomatic principles and practices into a profession that has, for too long, been dominated by the narrow (and often culturally, politically and diplomatically insensitive) nature of interventions designed exclusively by the medical and economic professions.<sup>35</sup> Those involved will likely resent and resist such encroachments of their purview – but both shaking and stirring such boundaries will, in the 21st Century, continue to be an essential part of global health’s evolution.

#### Ethical issues

Not applicable.

#### Competing interests

Author declares that he has no competing interests.

#### Author’s contribution

SK is the single author of the manuscript.

#### References

1. Shackle S. Libya polls show that British public is divided. The New Statesman. <http://www.newstatesman.com/blogs/the-staggers/2011/03/british-public-supportaction>. Published March 22, 2011.
2. Comentale E, Watt S, Willman S. *Ian Fleming & James Bond: the cultural politics of 007*. Indiana University Press; 2005.
3. Turpin T. Making the world a better place tops Generation Z’s

- list for best employer. Financial Post, March 25, 2015. <http://business.financialpost.com/executive/careers/making-the-world-a-better-place-tops-generation-zs-list-for-best-employer>.
4. Adams D. *Dirk Gently's Holistic Detective Agency*. London: Picador; 1987.
  5. Katz R, Kornblat S, Arnold G, Lief E, Fischer J. Defining health diplomacy: changing demands in the era of globalization. *Milbank Q* 2011;89:503–523. doi:10.1111/j.1468-0009.2011.00637.x
  6. Sulieman S. Building the bridge of engineers and environmentalists. University of California Research Report. <http://research.universityofcalifornia.edu/stories/2011/08/merced-sustainability-engineers.html>. Published 2011.
  7. Brown M, Mackey T, Shapiro C, Kolker J, Novotny T. Bridging Public Health and Foreign Affairs: The Tradecraft of Global Health Diplomacy and the Role of Health Attachés. *Science & Diplomacy* 2011;3(3). <http://www.sciencediplomacy.org/article/2014/bridging-public-health-and-foreign-affairs>.
  8. Sridhar D, Clinton C. Overseeing Global Health. *Finance & Development*. December 2014. <http://www.imf.org/external/pubs/ft/fandd/2014/12/sridhar.htm>
  9. Center for Strategic and International Studies (CSIS). Final report of the CSIS Commission on smart global health policy. <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>. Published 2010.
  10. Lancaster C. *Foreign aid: Diplomacy, development, domestic politics*. University of Chicago Press; 2008.
  11. Kevany S. International access and global health diplomacy in Sudan. *The Lancet Global Health*. May 2, 2014 <http://globalhealth.thelancet.com/2014/05/02/international-access-and-global-health-diplomacy-sudan>
  12. Boone J. Pakistan polio vaccinator's murder by militants raises health workers' fears. *The Guardian*. March 25, 2014. <http://www.theguardian.com/society/2014/mar/25/pakistan-polo-vaccinators-murder-militants-salma-farooqi>
  13. Buekens, P. Medical school deans' letter to President Obama. Retrieved from <http://www.jhsph.edu/news/newsreleases/2013/Klag%20letter%20to%20President%20Obama.pdf>. Published 2013.
  14. Mackey T, Strathdee S. Responding to the public health consequences of the Ukraine crisis: an opportunity for global health diplomacy. *Journal of the International AIDS Society*. Accessible through: <http://www.jiasociety.org/index.php/jias/article/view/19410/html>
  15. German Foreign Policy Agents Posing as Development Workers. <http://www.german-foreign-policy.com/en/fulltext/57990>. Published 2012.
  16. The Guardian. USAID programme used young Latin Americans to incite Cuba rebellion. <http://www.theguardian.com/world/2014/aug/04/usaid-latin-americans-cuba-rebellion-hiv-workshops>. Published August 4, 2014.
  17. Rice X. Sudan's president orders all foreign aid groups to leave country within a year. *The Guardian*. March 16, 2014. <http://www.theguardian.com/world/2009/mar/16/sudan-aid-agencies-expelled>.
  18. PATH Organization. Combatting Anti-Vaccination Rumours: Lessons Learned from Case Studies in East Africa. [http://www.path.org/vaccineresources/files/Combatting\\_Antivac\\_Rumors\\_UNICEF.pdf](http://www.path.org/vaccineresources/files/Combatting_Antivac_Rumors_UNICEF.pdf). Published 2015.
  19. Carr S, MacLachlan M, McAuliffe E. *Psychology of aid (vol. 10)*. Routledge; 2005.
  20. Feldbaum H, Michaud J (2010). Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Med*. 2010;7(4):e1000226. doi:10.1371/journal.pmed.1000226
  21. Kevany S, Hatfield A, Beleke Y, Aurang Zeb B, White K, Workneh N. Diplomatic and operational adaptations to global health programs in post-conflict settings: Contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Med Confl Surviv*. 2012;28(3):247-262.
  22. Kevany S, Sahak O, Workneh NG, Saeedzai SA. Global health diplomacy investments in Afghanistan: Adaptations and outcomes of global fund malaria programs. *Medicine, Conflict and Survival*. 2014;30(1):37-55.
  23. Kevany S, Jaf P, Workneh NG, et al. Global health diplomacy in Iraq: International relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival*. 2014;30(2):91-109. doi:10.1080/13623699.2014.890827
  24. Redfield P. The Unbearable Lightness of Expats: Double Binds of Humanitarian Mobility. *Cult Anthropol*. 2012;27(2):358–382.
  25. Kevany S, Khumalo-Sakutukwa G, Murima O, et al. Health diplomacy and adapting global health interventions to local needs. *BMC Public Health*. 2012;12:459. doi:10.1186/1471-2458-12-459
  26. Kevany S Diplomatic advantages and threats in global health program selection, design, delivery and implementation: development and application of the Kevany Riposte. *Global Health*. 2015;11:22. doi:10.1186/s12992-015-0108-x
  27. Cole J. Global health diplomacy at the Global Fund. The Global Fund to Fight AIDS, Tuberculosis and Malaria: Personal Communication; 2013.
  28. Novotny T, Kevany S. The way forward in global health diplomacy: Definitions, research, and training. In: Novotny T, Kickbusch I, Told M, eds. *21st Century Health Diplomacy*. Geneva: World Scientific; 2013:203-225.
  29. Burkle S, Garfield R. Civilian mortality after the 2003 invasion of Iraq. *Lancet*. 2013;381:877-879. doi:10.1016/S0140-6736(12)62196-5
  30. Burkle F (2013). Throwing the baby out with the bathwater. *Prehospital and Disaster Medicine*. 2013;28(3):1-3.
  31. Kaufmann JR, Feldbaum H. Diplomacy and the polio immunization boycott in Northern Nigeria. *Health Aff (Millwood)*. 2009;28(4):1091-1101. doi:10.1377/hlthaff.28.4.1091
  32. National armies for global health? *Lancet*. 2014;384(9953):1477. doi:10.1016/S0140-6736(14)61923-1.
  33. Gostin L Global Polio Eradication: Espionage, Disinformation, and the Politics of Vaccination. *Milbank Q*. 2014;92(3):413-417.
  34. Morrison J. The New State Department Office of Global Health Diplomacy: A second chance to get things right. Center for Strategic & International Studies Smart Global Health Blog. Retrieved from <http://www.smartglobalhealth.org/blog/entry/the-new-state-department-office-of-global-health-diplomacy-a-second-chance/>. Published 2013.
  35. Basler M. Utility of the McNamara fallacy. *BMJ*. 2009;339:b3141.23.

## New roles for global health: diplomatic, security, and foreign policy responsiveness



Global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (PEPFAR) have, at present, no explicit or formal internal capacity to respond to the overarching diplomatic or foreign policy concerns of either their donors or the broader global community.<sup>1</sup> To the utilitarian, this respect for professional boundaries is to be welcomed. To the cosmopolitan, the increasingly connected nature of both the causes of, and solutions to, poverty, disease, ill health, and health security—in the context of associated considerations of world peace, non-health security, conflict prevention, and international stability—implies that all entities, individuals, and policies are interconnected, and cannot operate in isolation of each other.<sup>2</sup> As former President of the USA John Fitzgerald Kennedy remarked to the UN during its early idealism: “the long labor of peace is an undertaking for every nation—in this effort, none of us can remain unaligned. To this goal, none can be uncommitted”.<sup>3</sup>

Most recently, the blurring of the line of institutional responsibilities to advance and protect global and international health has been shown by an expansion of military purviews in response to such emergencies as the west African Ebola outbreak.<sup>4</sup> Correspondingly, and in parallel, rationales exist for global health professionals and organisations to work, wherever possible, to resolve diplomatic and foreign policy issues beyond health—with the *sine qua non* that health outcomes, access to services, and “health for all” remain primary operational goals.<sup>5</sup> Where collateral or downstream effects—of, for example, health systems strengthening initiatives—can advance non-health international affairs to the benefit and satisfaction of both donor and recipient countries, as well as the broader global community, there seems to be no reason why such an expanded *de jure* and *de facto* remit should not be encouraged.

This has, of course, been happening since the very beginning of global health and international development efforts.<sup>6</sup> What distinguishes a 21st century approach—an era of increasing levels of transparency, technology, education, interdigitation, and accountability—is the evolution of the implicit to

the explicit; of a shift away from the covert use of aid to advance foreign policy and diplomacy (often in suboptimal ways) to an overt system of programme design, delivery, and evaluation that optimises both health and non-health goals in tandem with each other, in the mutual interests of both donors and recipients, and leveraging all available synergies. These considerations inevitably have implications for the type of interventions that are used; if in no other way than by ensuring that cost-effective approaches are also adaptable and responsive to local needs, cultures, religions,<sup>7</sup> and other country ownership considerations.<sup>8</sup>

Consider international terrorism; a growing threat to which conventional “hard power” responses have had limited success in addressing. What could, or should, global health do about it? Dissociate (as advocated by the Deans of the US medical schools),<sup>9</sup> isolate, establish boundaries, and “stove-pipe”? Or accept the possibility that such disciplinary overlaps, and associated consideration of both health and non-health considerations in programme design, delivery, and location, are both benign and inevitable under “smart”,<sup>10</sup> multifarious, and interrelated approaches? To focus efforts only on health outcomes risks, as one report puts it, creating “tense and confusing dualities”<sup>11</sup> when measured against political, diplomatic, or other foreign policy metrics and benchmarks. It could therefore be both appropriate and timely for global health leaders to take the initiative in establishing mutually acceptable parameters for such interdisciplinary engagements before it is too late, and the chance for such inputs has passed.

Two recent pieces—one developing an instrument for the establishment and evaluation of diplomatic and foreign policy principles and standards within global health programmes,<sup>7</sup> the other proposing a set of codes or soft laws by which global health governance can control and calibrate its inputs to international security and the broader, non-health interests of the global community<sup>12</sup>—might help to provide the basis for such an approach. For so long reliant on resource allocation instruments such as cost-effectiveness, making narrow metrics the only consideration in assessing programmatic

worth or value,<sup>13</sup> policy makers now have the option of expanded, holistic assessments of the effects of global health programmes across both health and non-health outcomes.

To return to the original example, for how long can the Global Fund—an organisation with growing international influence—attempt to transcend the non-health political, security, and international relation concerns of the global community, which will continue to be implicitly affected by its interventions? Is the illusory virtue of apolitical aid—the very existence of which is highly questionable—worth the cost of avoiding (often minor) modifications to programme design and delivery that enable the harmonised achievement of benign health and non-health objectives?

With the ascendancy of the global health diplomacy paradigm,<sup>1</sup> both bilateral and multilateral donors now have a powerful and unique opportunity to pursue and support noble humanitarian and international relations goals that are closely linked to the high ideals of global health. The development of diplomatic, political, and security, and foreign policy liaison offices—in the manner of the US Office of Global Health Diplomacy—would help to ensure that criteria for positive diplomatic and foreign policy effects are advanced in tandem with world health.

By elaborating and making explicit to donors the benign collateral effects of health programmes, global health diplomacy approaches also present an important message to funders: that their investments, as well as pursuing altruistic ideals, also achieve even more “enlightened self-interest”<sup>10</sup> ends such as national security, international relations, conflict resolution, world peace, and the prevention or mitigation of armed conflict—through, for example, improved communications or the establishment of an international presence.<sup>14</sup> At a time when arguments against the augmentation of hard power budgets have

become increasingly compelling, if the same aims can be achieved through soft or smart power,<sup>15</sup> we stand on the brink of an era in which global health will become firmly established in the high political pantheon.

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I declare no competing interests.

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- 1 Michaud J, Kates J. Global health diplomacy: advancing foreign policy and global health interests. *Glob Health Sci Pract* 2013; **1**: 24–28.
- 2 Brown GW. Moving from cosmopolitan legal theory to legal practice: Models of cosmopolitan law. *Leg Stud* 2008; **28**: 430–51.
- 3 Kennedy JF. Address to the United Nations Security Council, 1963. <http://www.jfklibrary.org/Research/Research-Aids/Ready-Reference/JFK-Quotations.aspx> (accessed July 8, 2015).
- 4 The Lancet. National armies for global health? *Lancet* 2014; **384**: 1477.
- 5 WHO. Constitution of the World Health Organization. Geneva: World Health Organization, 1989.
- 6 Alesina A, Dollar D. Who gives foreign aid to whom and why? *J Econ Growth* 2000; **5**: 33–63.
- 7 Kevany S, Khumalo-Sakutukwa G, Murima O, et al. Health diplomacy and the adaptation of global health interventions to local needs in sub-Saharan Africa and Thailand: Evaluating findings from Project Accept (HPTN 043). *BMC Public Health* 2012; **12**: 459.
- 8 Goosby E, Dybul M, Fauci A, et al. The United States President’s Emergency Plan for AIDS Relief: a story of partnerships and smart investments to turn the tide of the global AIDS pandemic. *J Acquir Immune Defic Syndr* 2012; **60**: 551–56.
- 9 Buekens P. Medical school deans’ letter to President Obama, 2013. <http://www.jhsph.edu/news/news-releases/2013/Klag%20letter%20to%20President%20Obama.pdf> (accessed Aug 29, 2015).
- 10 Kevany S. Global health diplomacy, ‘smart power’, and the new world order. *Glob Public Health* 2014; **9**: 787–807.
- 11 Center for Strategic and International Studies. Final report of the CSIS Commission on smart global health policy. <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy> (accessed Sept 27, 2015).
- 12 Kevany S. Diplomatic advantages & threats in global health program selection, design, delivery and implementation: the development and application of the Kevany Riposte. *Global Health* 2015; **11**: 22.
- 13 Kevany S. Global health engagement in diplomacy, intelligence and counter-terrorism: a system of standards. *JPICT* (in press).
- 14 Kevany S, Sahak O, Workneh N, Saeedzai S. Global health diplomacy investments in Afghanistan: adaptations and outcomes of global fund malaria programs. *Med Confl Surviv* 2014; **30**: 37–55.
- 15 Bipartisan Policy Center. The Case for Strategic Health Diplomacy: a Study of PEPFAR. <http://bipartisanpolicy.org/library/the-case-for-strategic-health-diplomacy-a-study-of-pepfar/> (accessed Nov 11, 2015).





# Global health diplomacy: a ‘Deus ex Machina’ for international development and relations

## Comment on “A Ghost in the Machine? Politics in Global Health Policy”

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Brugha and Bruen (1) raise a number of compelling issues related to the interaction between politics and policy in the global health context. The first question that their views invite is whether this is, at heart, best characterized as a benign or malign influence. Many commentators have suggested that this overlap should be discouraged (2–4), while others advocate a decrease in ‘stove-piped’ or ‘siloed’ approaches to government, politics, and academia (5,6). To use a parallel example, the world of sport has indirectly contributed a number of notable political advances, not least the end of apartheid in South Africa as a partial result of the ban imposed on their international teams (7). In spite of this, organizations such as FIFA refuse to be drawn into supporting sanctions against international football teams on non-sporting grounds (8). The future scope and role of global health will, inevitably, face corresponding challenges. In this context—and in terms of the sustainability of global health funding in a time of fiscal austerity—an enhanced role for political considerations may be just the “Deus ex Machina” that global health needs.

### Diplomacy in global health leadership

The authors point to global health leaders such as Sir Richard Feachem as necessarily being adept at both political machinations as well as the more altruistic goals of international health and development. Organizations such as the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Health Organization (WHO), and their leaders, are increasingly aware of their responsibilities in this context (9,10); for example, the damage done to international relations through deeply unpopular structural adjustment policies of the late 20<sup>th</sup> Century (11) are, fortunately, now a thing of the past. In the 21<sup>st</sup> Century, global health leaders will be drawn from a more dynamic, interdisciplinary and, above all, diplomatic generation (12).

### The formalization of political considerations in global health

Bruen and Brugha refer to the ‘ghost in the machine’ of politics in global health. This reflects the traditionally implicit, yet

undefined, role of political considerations in this context. Institutions such as the WHO have been implicitly politicised since their inception (13), and contemporary global health initiatives find their roots in colonial and post-colonial political and economic considerations (13). Increasingly, in the 21<sup>st</sup> Century, such influences are formalised and explicit. This evolution has been led by the creation of the Office of Health Diplomacy in the United States Department of State, which has been mandated with an official agenda to optimise the diplomatic and foreign policy impact of global health programmes (14). The European Union has enshrined the use of global health programmes as part of its external relations ‘soft power’ strategy (15), while the United Kingdom has recognised the pursuit of international affairs goals as a central responsibility—even *raison d’être*—of the Department for International Development (16).

### Tempering extremist donor approaches

In the recent Ugandan parliament ruling outlawing homosexuality (17), both sides of the political spectrum in donor countries such as the United States considered each other culpable. Proponents of liberal and progressive sexual policies in the global health context accused the evangelical right of a focus on abstinence-only programmes, to the detriment of health services for “most at risk populations”, (18); in response, conservative commentators countered with suggestions that policies acceptable in places such as San Francisco, driven by the ‘unruly melange’ of a highly effective local civil society (19), were imposed upon recipient countries without appropriate recognition of contemporary social, political, and cultural norms (20). In reality, the truth most likely lies somewhere between these two viewpoints. What is clear in both cases is that global health programmes, driven by either conservative or progressive political agendas, increasingly need to be monitored and vetted based on transcendent ideals that resonate with all elements of the political spectrum; the ‘post-partisan’ criteria of global health diplomacy. To paraphrase Rudyard Kipling, this will allow policy-makers to legislate and plan for the inevitable triumphs and disasters of programme implementation – but, ensured of diplomatic sensitivity, to treat these two imposters just the same.

### Global health diplomacy and the Global Fund

Specific mention of the roles, aspirations, and responsibilities of the Global Fund in this context recognizes the innovative

style of the organisation highlighted by Bruen and Brugha. The hidden, unmeasured, and collateral effects of Global Fund programmes in contexts such as Iraq and Afghanistan have been documented by this author elsewhere (21,22). As the Global Fund may therefore help to bring much more than just good health to recipients, especially in conflict and post-conflict settings, should not such achievements be measured, documented, and brought to the attention of the Fund's (often sceptical) donors? In parallel, on the micro level, the responsibilities of local funding agents and fund portfolio managers in the international relations context are increasingly under scrutiny (23). The adversarial culture by which it has been suggested the Global Fund was initially driven (24) has been tempered by such 'neo-utilitarian' approaches" (25).

### Conclusion: formalizing the God in the machine

In times of fiscal austerity, illustrating that political, foreign policy, diplomatic, or international relations ends can be achieved through global health, provides a "miraculous" (or "Deus ex Machina") added incentive to funders to maintain (or increase) their support of related bilateral and multilateral initiatives. The enhanced role of diplomacy and foreign policy in global health, therefore, has benign implications for global health funding, but also for world peace, for a new and less destructive role of military forces, and for both the theory and practise of international relations (21,22). To date, the integration of such principles has been a largely ad-hoc process; *terra incognita* for both diplomats and global health practitioners. The development and application of explicit criteria for global health programme design, evaluation, and delivery from the diplomatic and foreign policy perspectives, both to optimise benign effects and to eliminate interdisciplinary threats (26), will help to usher in a new era for both global health and international relations—one in which the two disciplines will become inextricably linked.

### Ethical issues

Not applicable.

### Competing interests

Author declares that he has no competing interests.

### Author's contribution

SK is the single author of the manuscript.

### References

- Bruen C, Brugha R. A Ghost in the Machine? Politics in Global Health Policy. *Int J Health Policy Manag* 2014; 3: 1–4. doi: [10.15171/ijhpm.2014.59](https://doi.org/10.15171/ijhpm.2014.59)
- Thomas C, Weber M. The Politics of Global Health Governance: Whatever Happened to "Health for All by the Year 2000"? *Global Governance: A Review of Multilateralism and International Organizations* 2004; 10: 187–205.
- Marseille E, Khan J. HIV prevention before HAART in sub-Saharan Africa. *Lancet* 2002; 359: 1851–6. doi: [10.1016/S0140-6736\(02\)08705-6](https://doi.org/10.1016/S0140-6736(02)08705-6)
- Fidler D. The Rise and Fall of Global Health as a Foreign Policy Issue. *Global Health Governance* 2011; 4: 10–8.
- Lee K, Novotny T. Brazil and the Framework Convention on Tobacco Control: Global Health Diplomacy as Soft Power. *PLoS Med* 2011; 7: e1000232. doi: [10.1371/journal.pmed.1000232](https://doi.org/10.1371/journal.pmed.1000232)
- Feldbaum H, Michaud J. Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Med* 2010; 7: e1000226. doi: [10.1371/journal.pmed.1000226](https://doi.org/10.1371/journal.pmed.1000226)
- Nixon R. Apartheid on the Run: The South African Sports Boycott. *Transition* 2002; 58: 68–88.
- Sobolev I, Gazeta R. FIFA turns down U.S. request to ban Russia from hosting the 2018 World Cup. Russia Beyond the Headlines News Website [internet]. 2014. Available from: [http://rbth.com/news/2014/04/06/fifa\\_turns\\_down\\_us\\_request\\_to\\_ban\\_russia\\_from\\_hosting\\_the\\_2018\\_world\\_cup\\_35703.html](http://rbth.com/news/2014/04/06/fifa_turns_down_us_request_to_ban_russia_from_hosting_the_2018_world_cup_35703.html)
- World Health Organization (WHO). Global Health Diplomacy [internet]. 2014. Available from: <http://www.who.int/trade/diplomacy/en/>
- Kevany S. International access and global health diplomacy in Sudan. The Lancet Global Health Blog [internet]. 2014. Available from: <http://globalhealth.thelancet.com/2014/05/02/international-access-and-global-health-diplomacy-sudan>
- Abouharb M, Cingranelli D. The Human Rights Effects of World Bank Structural Adjustment, 1981–2000. *Int Stud Q* 2006; 50: 233–62. doi: [10.1111/j.1468-2478.2006.00401.x](https://doi.org/10.1111/j.1468-2478.2006.00401.x)
- Katz R, Kornblet S, Arnold G, Lief E, Fischer J. Defining health diplomacy: Changing demands in the era of globalization. *Milbank Q* 2011; 89: 503–23. doi: [10.1111/j.1468-0009.2011.00637.x](https://doi.org/10.1111/j.1468-0009.2011.00637.x)
- Farmer P. Colonial Roots of Global Health. Harvard College Global Health Review [internet]. 2009. Available from: <http://hcghr.wordpress.com/2009/09/19/colonial-roots-of-global-health/>
- United States Department of State. About the Office of Global Health Diplomacy [internet]. 2014. Available from: <http://www.state.gov/s/ghd/about/>
- Europa. Foreign and security policy: speaking with one voice. European Union policy document [internet]. 2010. Available from: [http://www.europa.eu/pol/cfsp/index\\_en.htm](http://www.europa.eu/pol/cfsp/index_en.htm)
- United Kingdom Foreign and Commonwealth Office. What we do [internet]. 2013. Available from: <https://www.gov.uk/government/organisations/foreign-commonwealth-office/about>
- The Guardian News Service. Ugandan MPs rush through draconian laws against homosexuality. *The Guardian* [serial on the internet]. 2013. Available from: <http://www.theguardian.com/world/2013/dec/20/uganda-mps-laws-homosexuality>
- Bailey S. U.S. Evangelicals Forced On The Defensive Following Uganda's Anti-Gay Laws [internet]. 2013. Available from: [http://www.huffingtonpost.com/2014/03/07/us-evangelicals-gay-laws\\_n\\_4899418.html](http://www.huffingtonpost.com/2014/03/07/us-evangelicals-gay-laws_n_4899418.html)
- Buse K, Walt G. An unruly mélange? Coordinating external resources to the health sector: A review. *Soc Sci Med* 1997; 45: 449–63.
- Weigratz J. Rejecting the West on policy: Uganda, neoliberalism and the Anti-Homosexuality Bill [internet]. 2014. Available from: <http://africanarguments.org/2014/04/30/rejecting-the-west-on-policy-uganda-neoliberalism-and-the-anti-homosexuality-bill-by-jorg-wiegratz/>
- Kevany S, Jaf P, Workneh NG, Dalo MA, Tabena M, Rashid S, Al Hilfi TKY. Global health diplomacy in Iraq: International relations outcomes of multilateral tuberculosis programmes. *Medicine, Conflict and Survival* 2014; 30: 91–109. doi: [10.1080/13623699.2014.890827](https://doi.org/10.1080/13623699.2014.890827)
- Kevany S, Sahak O, Workneh NG, Saeedzai SA. Global health diplomacy investments in Afghanistan: Adaptations and outcomes of global fund malaria programs. *Medicine, Conflict and Survival* 2014; 30: 37–55. doi: [10.1080/13623699.2014.874187](https://doi.org/10.1080/13623699.2014.874187)
- Garmaise D. Global Fund Takes Steps to Improve LFA Performance. *AIDSPAN Newsletter* [serial on the internet]. 2011. Available from: [http://www.aidspace.org/gfo\\_article/global-fund-takes-steps-improve-lfa-performance](http://www.aidspace.org/gfo_article/global-fund-takes-steps-improve-lfa-performance)
- Macro International. The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria Synthesis of Study Areas 1, 2 and 3. 2009. Available from: <http://www.theglobalfund.org/en/terg/evaluations/5year/>
- Ryan L. Evaluation of the Organizational Effectiveness of the Global Fund. Macro International Review Document [internet]. 2007. Available from: [www.theglobalfund.org/documents/terg/TERG\\_SA1\\_Report\\_en/](http://www.theglobalfund.org/documents/terg/TERG_SA1_Report_en/)
- Kevany S. Global Health Diplomacy, 'Smart Power', and the New World Order. *Glob Public Health* 2014; 1–21. doi: [10.1080/17441692.2014.921219](https://doi.org/10.1080/17441692.2014.921219)



## Diplomacy and Health: The End of the Utilitarian Era

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### Abstract

Cost-effectiveness analysis (CEA), as a system of allocative efficiency for global health programs, is an influential criterion for resource allocation in the context of diplomacy and inherent foreign policy decisions therein. This is because such programs have diplomatic benefits and costs that can be uploaded from the recipient and affect the broader foreign policy interests of the donor and the diplomacy landscape between both parties. These diplomatic implications are vital to the long-term success of both the immediate program and any subsequent programs; hence it is important to articulate them alongside program performance, in terms of how well their interrelated interventions were perceived by the communities served. Consequently, the exclusive focus of cost-effectiveness on medical outcomes ignores (1) the potential non-health benefits of less cost-effective interventions and (2) the potential of these collateral gains to form compelling cases across the interdisciplinary spectrum to increase the overall resource envelope for global health. The assessment utilizes the Kevany Riposte's "K-Scores" methodology, which has been previously applied as a replicable evaluation tool<sup>1</sup> and assesses the trade-offs of highly cost-effective but potentially "undiplomatic" global health interventions. Ultimately, we apply this approach to selected HIV/AIDS interventions to determine their wider benefits and demonstrate the value alternative evaluation and decision-making methodologies. Interventions with high "K-Scores" should be seriously considered for resource allocation independent of their cost-effectiveness. "Oregon Plan" thresholds<sup>2</sup> are neither appropriate nor enforceable in this regard while "K-Score" results provide contextual information to policy-makers who may have, to date, considered only cost-effectiveness data. While CEA is a valuable tool for resource allocation, its use as a utilitarian focus should be approached with caution. Policy-makers and global health program managers should take into account a wide range of outcomes before agreeing upon selection and implementation.

**Keywords:** Diplomacy, Cost-Effectiveness, Threshold, Resource Allocation

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### Background

#### A Challenge to Cost-Effectiveness Analysis

In recent decades, cost-effectiveness analysis (CEA) has become increasingly important in both technical and allocative resource allocation decisions for global health interventions.<sup>3</sup> This includes, but is not limited to, the determination of which programs to support, in which places and focusing on which populations, based on cost per unit of currency involved against outcomes such as HIV/AIDS infections averted, quality-adjusted life years gained, or disability-adjusted life years lost.<sup>4</sup> Such utilitarian approaches, while valuable in the technical efficiency realm, have been considered short-sighted and narrow in "real-world" scenarios, especially those in which cultural, social, religious, diplomatic, equity, accessibility, and political considerations have to be taken into account.<sup>5</sup> How does CEA decision-maker respond, for example, to situations in which tides of popular support for less cost-effective interventions, such as antiretroviral therapy for HIV/AIDS, result in an increase in funding for global health,<sup>6</sup> and thereby potentially saving more lives than if optimal utilitarian interventions were exclusively used?

#### Global Health Intervention Value

Assessing the relative value or worth of global health interventions begins with the development of hypothetical

comparisons. A range of highly cost-effective interventions for HIV/AIDS are, of course, already in existence.<sup>7</sup> To date, few of these have been formally assessed from a foreign policy perspective.<sup>8</sup> However, certain features of contemporary interventions suggest possible foreign policy advantages or threats.<sup>1</sup> In the case of HIV/AIDS, behavioral or surgical interventions are frequently in conflict with local traditions and societal norms; from the social, religious or cultural viewpoints.<sup>9</sup> While such interventions may be highly cost-effective, how much attention from their advocates has gone in to the challenges to local health traditions — notwithstanding possible downstream health effects — in the developing world's primary healthcare context? Similarly, the promotion of other HIV/AIDS interventions has, to date, paid little heed to the challenges that this brings about on the non-health level.<sup>10</sup>

#### Diplomatic Versus Economic Value

To assess the total utility of global health interventions and capture the wider interrelated community health and non-health benefits, which is of real interest to program donors; it is necessary to consider a quantitative model that is designed to capture the broader socio-economic implications. The "Kevany Riposte" is a recently-developed and published CEA tool that assigns numerical values to the diplomatic worth (or

threats) of global health interventions.<sup>1</sup> The Kevany Riposte incorporates the following 10 assessment criteria when a particular intervention's inherent design is being analyzed (Table 1).

In each instance, the specific criterion is graded on a mathematical benefit-threat spectrum, which results in a "K-Score" that quantifies the potential risks and rewards of the criteria that constitute a particular intervention. When the K-Scores are summated, they are contextualized against the "Kevany Threshold" (KT), which is an effectiveness quorum that can be optimized depending upon the donor's effectiveness tolerance. The K-Score's inherent threat-benefit calculations are, therefore, mathematically rated accordingly (Table 2).

The result from the application of the Kevany Riposte is an overall clearer understanding of an intervention's cost-effectiveness and potential externalities. Thus, the Kevany Riposte and the resulting positioning with respect to the KT can offer a much better understanding of a particular intervention's diplomatic value to a donor's philosophy, national values, and overall foreign policy agenda.

### Balancing Diplomatic and Economic Value With the Kevany Riposte

The assessment of global health interventions that fail to achieve the KT results in a hypothetical model that (1) forces an intervention's rejection from the resource allocation pantheon or (2) necessitates the intervention's modification

to adhere to the diplomatic criteria listed above. In practice, this would involve the application of a KT to a selection, or the entire range, of HIV/AIDS interventions currently in use. Such a process would take place both via desk reviews and at the field level, focusing on those classifications and sub-classifications under which the intervention registered potential, moderate or severe diplomatic threats. For example, intervention timelines and the feasibility of long-term handover to local actors would be guaranteed, in advance of intervention implementation, to be within the capacity of local actors in the long-term.<sup>11</sup> Similarly, there is an increasing consensus that global health interventions which stand to challenge local healthcare as well as other traditions or practices should be designed and delivered on a highly collaborative and interactive basis with recipient countries, local communities and other stakeholders.

The result of such diplomatic "screening" procedures for global health programs will be to ensure that, on a *prima facie* basis, all interventions are both cost-effective and diplomatically-effective – ideally, without sacrificing either health or non-health gains, but nonetheless providing analytical tools to respond to ethical dilemmas related to situations in which such trade-offs have to occur. The combination of such considerations stands to improve program implementation, uptake, utilization, donor support, and recipient recognition and appreciation of donor efforts.<sup>12</sup> Let us consider a concrete worked example showing a plausible (not clearly unethical) cost-effective intervention that can be rejected (or severely

**Table 1.** Criteria and Non-exhaustive Outline of Themes Assessed and Questions Evaluated

Criterion	Description of Themes (Not Exhaustive)
Neutrality	How tailored is the intervention to the recipient's society, religious practices, cultural values?
Visibility	How visible are the source funding organizations?
Sustainability	Can the intervention be financially supported by the recipient after the funding period? Can the intervention be transferred?
Effectiveness	Has the intervention and its results been scientifically validated? Are there measures in place to deal with constrained budgets?
Adaptability	Can the intervention respond to unforeseen health needs? Does the intervention have positive externalities? Have communities had an input?
Accountability	Does the intervention produce regular results from communities that are verifiable? Is an M&E philosophy prevalent and is corruption combatted?
Partnerships	Does the intervention promote institutional partnerships: national and regional? Do intervention staff receive guidance on international standards?
Economic, Political, Environmental and Social Effects	Does the intervention contribute to wider economic growth? Does the intervention promote political stability? Does the intervention increase dignity and self-worth amongst recipients? Does the intervention utilize public space appropriately? Does the intervention damage the environment?
Interdependence	Is the intervention coordinated with the aims of other programs? Does the intervention complement or operate in tandem with other interventions?
Training	Have intervention staff been trained? Is the training qualification recognized? Have staff received training to deal with cultural and religious customs?

Abbreviation: M&E, Metaphysics and Epistemology.

**Table 2.** Scoring and Results for K-Score Classifications

Classification	Explanation	Score
Highly advantageous	Intervention program displays clear and significant value from the diplomatic or foreign policy perspective.	+2
Moderately advantageous	Intervention program displays some strengths in advancing diplomatic or foreign policy goals.	+1
Acceptable, neutral, or not relevant	Intervention attains diplomatic or foreign policy minimum standards.	0
Not applicable	Intervention program does not operate in the context of this classification (or sub-classification).	0
Potential moderate threat	Intervention program may constitute a threat to diplomatic or foreign policy goals.	-1
Potential significant threat	Intervention program constitutes a clear and significant threat from the diplomatic or foreign policy perspective.	-2

modified) and swapped out based on diplomatic criteria.

## Methods

### Comparing Diplomatically and Economically-Effective Choices

Our example focuses on, firstly, a global health intervention for HIV/AIDS that is effective, efficacious and cost-effective; in both the controlled (trial) and applied (field) contexts (“Intervention A”), and that is implemented based on surgical procedures (eg, voluntary adult male circumcision). The context is a low-income, developing country setting with limited educational opportunities and high levels of religious practices and awareness, as well as a significant focus on traditional (even tribal) values related to sexual health and gender norms. These norms are not considered damaging from western perspectives; rather, they are neutral in terms of social progressiveness, recognizing the multifarious global health interventions that address, in concert with each other, both health and (for example) oppressive gender practices that are to be welcomed and supported. Our cost-effectiveness ratio for this intervention is approximately US\$3000 per HIV infection averted, both with a “K-Score” of 5 out of a possible 10, with 3 criteria classified as “significant diplomatic threats”: namely, sustainability, adaptability, and neutrality.

Our comparator intervention (“Intervention B”) is implemented via a combination of voluntary counseling and testing, post-test support services, antiretroviral treatment, and community mobilization, as well as utilizing strategies such as; “abstinence, be faithful, and condomize” (ABC), which represent interventions with both health and non-health agendas,<sup>13</sup> and scores highly on the K-Score (9 out of 10, with 3 criteria classified as “significant diplomatic advantages”) but is less cost-effective (US\$5000 per HIV infection averted). Such an intervention has been initially evaluated from the outset of study design for effect on diplomatic and foreign policy outcomes, as well as standard health and medical metrics.<sup>1</sup> More specifically, challenges to (non-damaging) local customs have been mitigated, sustainability has been ensured; downstream and side-effects have all been considered as part of the original assessment plan. Effects on local perceptions of donors, cultural, and religious acceptability, and the anticipation of long-term intervention issues have also been considered on a *prima facie* basis.

## Results

Finally, we take the United Nations (UN) international statistical standard for population health metrics of 100 000 susceptible persons suffering from a generalized HIV epidemic (prevalence 10% and incidence 2%). Total number of HIV infections, therefore, currently stand at 10 000 and increase (excluding annual HIV-related deaths) at a rate of 2000 per year. The implementation of intervention A, under a fixed budget of US\$1 000 000, would, in this theoretical framework, avert 333 HIV infections in the first year of implementation or 16.6% of new infections. Conversely, intervention B<sup>[1]</sup> would avert 200 infections or 10%. Our question then becomes: is the difference in the number of HIV infections averted (133 infections or 6.6% of new infections) offset by diplomatic gains, including but not limited to; (1) their

potential to attract additional funds to intervention B, thereby increasing the funding envelope (eg, increases in support for antiretroviral and other global health interventions at the turn of the century),<sup>14</sup> (2) the possible health gains consequent on increased long-term utilization via the performance of the sustainability, visibility, and cultural acceptability criteria<sup>15</sup> for intervention B, and (3) at the most abstract level, the (nebulous and possibly unquantifiable) health gains and lives saved as a result of improved international relations between donor and recipient countries.<sup>16</sup>

If these possible benefits can be shown to equal or exceed the 133 HIV infections that the original choice of intervention B failed to avert, the case for preferring investment in intervention B is strengthened. Let us assume that, for example, the diplomatic success of the intervention resulted in a doubling of funding for intervention B (from US\$1 000 000 to US\$2 000 000), thereby also doubling the number of HIV infections averted (from 200 to 400). This means that, in comparison to the choice of staying with the “less diplomatic” intervention A, an additional 67 HIV/AIDS infections (or 20% of all new infections) are averted in the first year of implementation. Such increases in funding and support for interventions that capture both donor and recipient imaginations, as well as “hearts and minds,” is not unprecedented (witness the dramatic mobilization of funding for antiretroviral treatment during the 1990s and early 2000s, for example<sup>17</sup>).

## Discussion

### K-Scores and Cost-Effectiveness Ratios

An additional assumption is the effect of improvements in K-Scores on cost-effectiveness ratios. Improved K-Scores are not connected to the cost of the intervention (either absolute cost or cost per unit of output or outcome). Rather, these scores are linked to outcomes. For example, if we accept an increase in funding for the intervention by a factor of 20% — as a possibly conservative estimate in the context of the quadrupling of funding for global health interventions in recent years — for each additional K-Score point, outcomes or outputs improve in a directly corresponding manner. In this example, a differential in K-Scores of 4 implies an increase in funding for intervention B of 80%. Based on our initial budget of \$1 000 000 for intervention B, this would, therefore, increase to \$1 800 000. This improved budget would, therefore, generate a total of 360 HIV infections averted.

### Advantages and Disadvantages

As an alternative or complement to traditional CEA for global health, the development and application of diplomatic thresholds has both advantages and disadvantages. Positives include the development and selection of more sensitive, sustainable and “diplomatic” global health interventions that advance, for example, international relations, cooperation stability, security and conflict resolution – the broader interests of the global community – without sacrificing the primary altruistic, humanitarian, and development goals of international medical assistance measures. Possible disadvantages include the need for additional design considerations for global health interventions that integrate these concerns, rather than, as in the past, simply

developing an effective or cost-effective intervention and proceeding directly to implementation. The feasibility of these pre-implementation checks should also be considered – is it realistic for bilateral and multilateral donors, as well as non-governmental organizations (NGOs), to undertake “diplomatic evaluation” checks, via a checklist or electronic app, on their efforts on both a *pre-hoc* and *post-hoc* basis? Many would, however, consider these added bureaucratic and administrative hurdles a small price to pay for the dual advancement of diplomatic and development goals in a synergistic fashion.

## Conclusions

In this example, the KT is based on an increase in funding envelopes contingent on the fulfillment of diplomatic criteria. It is hard, but not impossible, to support this assertion. It is also, perhaps, no coincidence that the ascendancy of global health interventions which are likely to score highly in terms of K-Scores (eg, antiretroviral treatment and voluntary counseling and testing) coincided with a period of dramatic growth in global health funding.<sup>18</sup> Conversely, in latter years, the focus towards less emotive efforts was linked, again perhaps coincidentally, with more cost-effective but potentially less diplomatic efforts.<sup>19,20</sup> The “threshold” is, therefore, based on considerations such as the capacity to attract funding. In practice, the KT can, therefore, be defined as “the point at which diplomatic outcomes, including sustainability, cultural awareness and other considerations, increase intervention funding, momentum, utilization and support to such an extent that the total number of HIV infections averted equals or exceeds those of alternative HIV infections, with better cost-effectiveness in controlled, rather than ‘real world,’ long-term settings.” The consideration of the KT in resource allocation decisions and global health intervention selection, therefore, stands to simultaneously advance diplomatic and health goals, at the expense of neither.

## Ethical issues

Not applicable.

## Competing interests

The authors declare they have no competing interests.

## Authors' contributions

Conception and design, acquisition of data, analysis and interpretation of data, drafting of the manuscript, statistical analysis: SK and MM. Critical revision of the manuscript for important intellectual content; Administrative, technical, or material support: MM. Supervision: SK.

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## Endnote

[1] The “lifetime cost savings” for Interventions A and B are assumed, for the purposes of this model, to be the same.

## References

1. Kevany S. Diplomatic advantages & threats in global health program selection, design, delivery and implementation: the development and application of the Kevany Riposte. *Global Health*. 2015;11: 22. doi:10.1186/s12992-015-0108-x
2. Oberlander J, Marmor T, Jacobs L. Rationing medical care: rhetoric and reality in the Oregon Health Plan. *CMAJ*. 2001;164(11):1583-1587.
3. Marseille E, Hofmann PB, Kahn JG. HIV prevention before HAART in sub-Saharan Africa. *Lancet*. 2002;359(9320):1851-1856.
4. Weinstein MC, Siegel JE, Gold MR, Kamlet MS, Russell LB. Recommendations of the Panel on Cost-effectiveness in Health and Medicine. *JAMA*. 1996;276(15):1253-1258.
5. Kevany S, Benatar SR, Fleischer T. Improving resource allocation decisions for health and HIV programmes in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations. *Glob Public Health*. 2013;8(5):570-587. doi:10.1080/17441692.2013.790461
6. Heywood M. South Africa's treatment action campaign: combining law and social mobilization to realize the right to health. *J Hum Rights Pract*. 2009;1(1):14-36.
7. Creese A, Floyd K, Alban A, Guinness L. Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence. *Lancet*. 2002;359(9318):1635-1643
8. Collins C, Isbell M, Sohn A, Klindera K. Four principles for expanding PEPFAR's role as a vital force in US health diplomacy abroad. *Health Aff (Millwood)*. 2012;31(7):1578-1584. doi:10.1377/hlthaff.2012.0204
9. Miller GP. Circumcision: a cultural-legal analysis. *Virginia Journal of Social Policy and the Law*. 2002;7:497-537.
10. Kevany S. Global health diplomacy, 'smart power', and the new world order. *Glob Public Health*. 2014;9(7):787-807. doi:10.1080/17441692.2014.921219
11. Goosby E, Dybul M, Fauci AS, et al. The United States President's Emergency Plan for AIDS Relief: a story of partnerships and smart investments to turn the tide of the global AIDS pandemic. *J Acquir Immune Defic Syndr*. 2012;60 Suppl 3:S51-S56. doi:10.1097/QAI.0b013e31825ca721
12. Khumalo-Sakutukwa G, Morin SF, Fritz K, et al. Project Accept (HPTN 043): a community-based intervention to reduce HIV incidence in populations at risk for HIV in sub-Saharan Africa and Thailand. *J Acquir Immune Defic Syndr*. 2008;49(4):422-431. doi:10.1097/QAI.0b013e31818a6cb5
13. Dietrich JW. The politics of PEPFAR: the president's emergency plan for AIDS relief. *Ethics Int Aff*. 2007;21(3):277-292. doi:10.1111/j.1747-7093.2007.00100.x
14. McCoy D, Chand S, Sridhar D. Global health funding: how much, where it comes from and where it goes. *Health Policy Plan*. 2009;24(6):407-417. doi:10.1093/heapol/czp026
15. Kevany S, Khumalo-Sakutukwa G, Murima O, et al. Health diplomacy and the adaptation of global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept (HPTN 043). *BMC Public Health*. 2012;12:459. doi:10.1186/1471-2458-12-459
16. Walensky RP, Kuritzkes DR. The impact of the President's Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and why it remains essential. *Clin Infect Dis*. 2010;50(2):272-275.
17. Piot P, Coll Seck AM. International response to the HIV/AIDS epidemic: planning for success. *Bull World Health Organ*. 2001;79(12):1106-1112.
18. Ravishankar N, Gubbins P, Cooley RJ, et al. Financing of global health: tracking development assistance for health from 1990 to 2007. *Lancet*. 2009;373(9681):2113-2124. doi:10.1016/s0140-6736(09)60881-3
19. Fidler DP. Rise and fall of global health as a foreign policy issue. *Glob Health Gov*. 2011;4(2):1-12.
20. Fidler DP. After the revolution: global health politics in a time of economic crisis and threatening future trends. *Glob Health Gov*. 2009;2(2):1-21.



# Global health diplomacy, national integration, and regional development through the monitoring and evaluation of HIV/AIDS programs in Papua New Guinea, Vanuatu, and Samoa

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## Abstract

The South Pacific countries of Vanuatu, Samoa, and Papua New Guinea have ascended rapidly up the development spectrum in recent years, refining an independent and post-colonial economic and political identity that enhances their recognition on the world stage. All three countries have overcome economic, political and public health challenges in order to stake their claim to sovereignty. In this regard, the contributions of national and international programs for the diagnosis, treatment and prevention of HIV/AIDS, with specific reference to their monitoring and evaluation (M&E) aspects, have contributed not just to public health, but also to broader political and diplomatic goals such as ‘nation-building’. This perspective describes the specific contributions of global health programs to the pursuit of national integration, development, and regional international relations, in Vanuatu, Samoa and Papua New Guinea, respectively, based on in-country M&E activities on behalf of the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria and the Australian Department of Foreign Affairs and Trade (DFAT) during 2014 and 2015. Key findings include: (1) that global health programs contribute to non-health goals; (2) that HIV/AIDS programs promote international relations, decentralized development, and internal unity; (3) that arguments in favour of the maintenance and augmentation of global health funding may be enhanced on this basis; and (4) that “smart” global health approaches have been successful in South Pacific countries.

**Keywords:** HIV/AIDS, Global Health Diplomacy, Monitoring and Evaluation ((M&E), Samoa, Vanuatu, Papua New Guinea

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## Background

The South Pacific countries of Vanuatu, Samoa, and Papua New Guinea have ascended rapidly up the development spectrum in recent years (1), refining an independent and post-colonial economic and political identity that enhances their recognition on the world stage. This process has not been an easy one, with all three countries having had to overcome economic, political and public health challenges in order to stake their claim to sovereignty, national identity, and internal cohesion (2). In this regard, national and international programs for HIV/AIDS, with specific reference to their Monitoring and Evaluation (M&E) aspects, have augmented not just public health, but also, as in other settings (3), broader political and diplomatic goals such as ‘nation-building’, defined here as the societal integration of diverse origins, histories, languages, cultures and religions within the boundaries of a sovereign state (4). This ‘perspective’ describes the specific contributions of global health programs to the pursuit of national integration, development, and regional international relations, in Vanuatu, Samoa, and Papua New Guinea, respectively, based on the authors’ in-country diplomatic and M&E activities, observations and experiences on behalf of the Global Fund to Fight AIDS, Tuberculosis (TB), and

Malaria (“The Global Fund”) and the Australian Department of Foreign Affairs and Trade (DFAT). These missions were conducted in response to a range of challenges that face many low- to middle-income countries from the M&E perspective, including deficiencies in appropriate equipment, skills, and communications systems (3).

## The challenge of regional integration in Vanuatu

The Republic of Vanuatu has faced considerable challenges in developing a ‘national identity’ as a result of location, geography and logistics. Covering more than 80 islands across more than 800 square miles, the advancement of regional integration and cohesion since national independence in 1980 has been achieved only through overcoming significant political and economic challenges (5). Since Vanuatu’s recognition as an independent state by the United Nations (UN), successive governments have grappled with the challenges posed by creating a unified leadership across a diverse range of settings, cultures and populations (6). Such efforts have demanded contributions from every facet of society (7) and every government department, including joint initiatives between international global health organizations such as the Global Fund and the World Health Organization

(WHO) with the Vanuatu Ministry of Health (8). Amongst other achievements, such collaborations have sought to advance the vertical, horizontal and diagonal integration of health programs; programmatic impact on local health services; government health ministerial restructuring; and the development of national healthcare strategies in a harmonized and aligned fashion across the island chain (WHO County Office Vanuatu, personal communication, 2014).

### **The role and resurgence of the Ministry of Health**

The Ministry of Health of Vanuatu has been of signal importance in these efforts. Throughout Vanuatu's history of independence, successive governments and ministers have made public health—with its broad reach and focus on accessibility, equity, and equality in service delivery—a lynchpin of national integration efforts (9), defined in this context as “the development and awareness of a common identity amongst the citizens of a country” (10). This ‘dual role’ of Vanuatu's public health programs was threatened, in recent years, via the pursuit of a highly contentious curative treatment strategy to the exclusion of funding for preventive medicine strategies (11). The subsequent restoration of the original public health paradigm in 2014 (12) has seen a resurgent role for the Ministry of Health, and public health in particular, in promoting both regional integration and preventive medicine.

### **Other contributions of global health efforts to national integration: monitoring and evaluation (M&E) of HIV/AIDS programmes**

Efforts made in the design, delivery and M&E of HIV/AIDS programs in Vanuatu have successfully adapted to this dual role of simultaneously promoting health and well-being whilst also contributing to the development of a national identity in a fashion that has been documented in other contexts (3). The national government has leveraged a range of opportunities to advance national integration, regional cooperation, and public health in concert with each other (13)—not just through the provision of health services, but also in parallel with culturally-appropriate health and education campaigns (14); inter-island supply chain and M&E activities; and joint national and regional training initiatives that focus on the application of M&E-driven decision-making in a coordinated and harmonious fashion within and across Secretariat of the Pacific Community (SPC) member countries (15). In particular, the socially, culturally, and economically ‘sensitized’ nature of HIV/AIDS programs, such as low-cost, inclusive, geographically widespread, and therefore accessible Voluntary Counseling and Testing (VCT) programs, supported by regionally—and linguistically adapted health education initiatives, has helped to ensure that intervention acceptability across Vanuatu's tribes, cultures and islands has led to improved uptake and utilization (16). In addition, the development and support of national M&E systems under the auspices of the Global Fund (amongst other donors) has been recognized as assisting successive governments in their efforts to both restore the broader public health system to previous standards of service delivery and improve inter-island communications, cooperation, and coordination via enhanced reporting systems (17). Specific examples include

the development of regional M&E capacity through trainings on remote islands such as Espirito Santo, the deployment of associated reporting equipment to rural healthcare facilities, and the establishment of harmonized donor and national health surveillance reporting systems (18). Finally, significant related efforts to pursue malaria eradication in Vanuatu (19) have given Vanuatu a unique place, and level of prestige, on the world stage via international publicization of such efforts (20). Through attempts to convince the global community that, via the right programs and international support, malaria eradication at the national level is possible in the 21st century, such efforts have also built and affirmed a positive national and international identity for target countries.

### **Public health amidst economic transition in Papua New Guinea**

Standing on the brink of potentially dramatic economic growth and social change associated with production from the Liquefied Natural Gas (LNG) project, the direction of resource revenues into improved and sustainable public health service delivery offers an opportune vehicle for Papua New Guinea to translate natural resources into human development outcomes (21). In this context, Papua New Guinea has the highest incidence of HIV/AIDS in the Pacific region, and has become the fourth country in the Asia Pacific region to be declared a ‘generalized epidemic’ (22). However, the lack of accurate and reliable surveillance and M&E data on the epidemic—particularly from remote areas—(i) significantly impacts the accuracy of health status indicators, which risk understating the extent of HIV/AIDS and other infectious diseases such as TB and malaria (23), (ii) limits coordination and harmonization between key stakeholders in healthcare delivery (24), and (iii) constrains both donor and recipient funding and decision-making through the absence of valid, reliable and up-to-date performance data (25).

### **Opportunities for international relations via enhanced monitoring and evaluation (M&E) systems**

The development of a functioning and cohesive M&E system in Papua New Guinea has, therefore, been a long-standing concern for donor organizations, focusing both on disease-specific systems (such as those for HIV/AIDS) (26) and broader health systems strengthening initiatives such as training, technical support, and key equipment provision (27). Amongst the donors currently operating in Papua New Guinea, perhaps the most significant, from an international relations perspective, is the Australian DFAT, formerly represented under the auspices of its development arm, AusAid. Given the increasingly significant regional, strategic and economic significance of close relations between Australia and Papua New Guinea, the development of effective and functional M&E systems fulfills a range of donor goals beyond ensuring quality assurance, transparency, and accountability in service delivery—such as the generation of reliable performance metrics with which to track funding—and as governed by policy initiatives such as the *Papua New Guinea and Australia Partnership for Development: Health and HIV Schedule* (28). Such collaborations recognize, both implicitly and explicitly, that supporting recipient governments to create an efficient health



system is both (i) an effective and sustainable approach to improving health service delivery and (ii) contributes to regional and international relations (29), including bridging political, economic, cultural and social differences to advance cooperation between nations.

### Translating global health reporting into global health diplomacy

How are enhanced HIV/AIDS M&E systems leveraged for diplomatic and international relations purposes (3)? Primarily, the production of valid, robust and reliable results of DFAT initiatives helps to strengthen the case for 'value for money' to both donor and recipient governments (23), demonstrating returns on investments and thereby building support for ongoing global health funding to the Australian Parliament (27,28). In this context, broader 'lessons learned' by DFAT in the implementation of Evaluation Capacity Building (ECB) programmes in Indonesia, Timor-Leste, Vanuatu, Fiji, and the Philippines are being accommodated to provide insight into local challenges and opportunities via the application of paradigms such as 'South-South' cooperation and 'triangular assistance' (30,31). Secondly, the production of such results may help to illustrate to the Papua New Guinean Ministry of Health, and the broader national government, that the interests of their country – and there are perhaps none more compelling than the provision of healthcare for infectious diseases (22) – are well-served by the ongoing involvement of external aid and development programs (3), as opposed to adopting 'aid skeptic' stances, as promoted by Zambian economist Dambisa Moyo (32). For this to be achieved, M&E strengthening has demanded a collaborative approach to capacity-building that appreciates the technical, conceptual and practical challenges faced by health sector implementing partners (33). Thirdly, the generation of M&E-based communications and reporting systems operating between donor and recipient countries may help to foster broader strategic collaborations, and closer international relations, in an era of heightened international activity and interest in the natural resources of the South Pacific region (34). Taken together, these considerations are of critical importance, not only to global health, but also to regional diplomatic and foreign policy priorities.

### Equitable national development through provincial capacity-building in Samoa

In a parallel fashion, though under contrasting circumstances, broader national development in Samoa has been enhanced through HIV/AIDS M&E systems via concerted efforts by the Global Fund, the World Bank, the United Nations Development Program (UNDP), the WHO, and other donors and international technical advisory bodies (35). The ongoing support by organizations such as the Global Fund for rural antenatal care clinics, for example, encompassing the training and equipping of local nurses to deal with both infectious diseases and associated reporting systems, has provided a vital impetus to both (i) the country's 'health security', in accordance with the WHO's identified regional priorities (36) such as the implementation of international health regulations (37); and (ii) provincial development through the decentralization of (previously-concentrated) health and

other public services outside of Apia, the national capital (38). The associated provision of health education to, and access to health services by, provincial populations in provinces such as Sanga, Tumasaga and Shefa therefore represents an advance, not just in the quality of healthcare, but also in the distribution of public services in an equitable fashion throughout the country (39).

### Social and cultural consequences of the pursuit of universal testing and coverage

Given the concentrated nature of the HIV/AIDS epidemic in Samoa (40), a unique opportunity exists to achieve two goals that are rarely-attained in developing (or indeed even in developed) countries: (i) universal HIV/AIDS status awareness, and, in conjunction, (ii) universal antiretroviral treatment for all persons diagnosed with HIV/AIDS (41). At present, through the efforts of the Samoan Ministry of Health, working in conjunction with donor organizations such as the Global Fund, all 12 persons who have been diagnosed with HIV/AIDS have been initiated on treatment (Samoa Ministry of Health, personal communication, 2014). Even when considered in the context of the very low reported HIV/AIDS incidence and prevalence in Samoa (a cumulative total of 23 cases since surveillance efforts began in 1990) (42,43), both universal coverage and Samoa's success in containing the HIV/AIDS epidemic are remarkable achievements. However, given the limited knowledge of HIV/AIDS status, especially in rural areas, resulting in a high probability of undiagnosed HIV-positives (Samoa Ministry of Health, personal communication, 2014), truly 'universal' diagnosis and coverage of HIV/AIDS patients through VCT cannot yet be said to have been substantively achieved. In response, attention to cultural, religious, and social norms in service delivery has formed a key element of improving uptake of HIV/AIDS testing in the country (44). In particular, both health education efforts to reduce stigma (45) and the development of 'youth-friendly' information centers (42) in response to the vulnerabilities of young people to HIV/AIDS (46) represent key initiatives by the Ministry of Health in this regard over recent years. In the context of the often conservative nature of Samoan society (47), the pursuit of national and post-colonial social and cultural development is therefore also supported by the development of such socially – and culturally – 'sensitized' (48) interventions.

### Conclusion: benefits of HIV/AIDS monitoring and evaluation (M&E) efforts beyond healthcare

Vanuatu, Papua New Guinea, and Samoa, in collaboration with organizations such as the Global Fund and the Australian DFAT have made consistent efforts to ensure that the broader, non-health outcomes of health, HIV/AIDS and related M&E activities are, either implicitly or explicitly, optimally realized. In these countries, such 'downstream effects' include, for example, regional centers being addressed with equal importance, from a health service delivery perspective, as regional capitals (41). Similarly, donor organizations' efforts to strengthen M&E through initiatives such as on-site data verifications and routine service quality assessments, as well as broader health system level M&E strengthening initiatives (27), have contributed to both

national and international links and communications at all levels of geographical and service delivery (49). In the most meaningful way, therefore, these 'enlightened self-interest' (50) or 'smart' (51) donor approaches have advanced altruistic and diplomatic goals simultaneously. Related initiatives have, in parallel, and through such multi-level funding rationales, made a profound impact on the control of communicable diseases such as HIV/AIDS and health system strengthening. In a similar fashion, the large-scale and rapid response of regional and other international partners to assist Vanuatu in the wake of the recent and devastating tropical cyclone has advanced, in parallel, regional solidarity, public health, and disaster relief (52). Other small post-colonial nations, in the South Pacific and elsewhere, may have much to learn from these 'smart' approaches to international health and development. In assessing the success of these programs, and in making the case for future donor support, it is therefore of paramount importance to recognize and attempt to optimize and quantify not just their health but also their broader 'non-health' outcomes (53).

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### Ethical issues

Not applicable.

### Competing interests

The authors declare that they have no competing interests.

### Authors' contributions

SK drafted and conceptualized the manuscript. AG provided key input and background on Papua New Guinea. CG provided key input and background on Vanuatu. SM and AL provided key input and background on Samoa.

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### References

- Asian Development Bank. Asian Development Outlook 2014: Fiscal Policy for Inclusive Growth. 2014. Available from: <http://www.adb.org/sites/default/files/publication/31241/ado2014-south-pacific-economies.pdf>
- Aldrich R. The Decolonisation of the Pacific Islands. *Itinerario* 2000; 24: 173-91.
- Kevany S, Hatfield A, Workneh N, Aurang Zeb Durrani B, Bekele Y, Khan U, *et al.* Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to 'nation-building' in South Sudan. *Med Confl Surviv* 2012; 28: 247-62. doi: [10.1080/13623699.2012.714654](https://doi.org/10.1080/13623699.2012.714654)
- Government of South Africa. *What is Social Cohesion and Nation-Building?* Department of Arts & Culture Discussion Document. 2014. Available from: [https://www.dac.gov.za/sites/default/files/WHAT%20IS%20SOCIAL%20COHESION%20AND%20NATION%20\(3\).pdf](https://www.dac.gov.za/sites/default/files/WHAT%20IS%20SOCIAL%20COHESION%20AND%20NATION%20(3).pdf)
- European Commission. Country Strategy and National Indicative Program: Vanuatu. 10th EDF Program of the European Commission (2008-2013). 2008. Available from: [http://ec.europa.eu/development/icenter/repository/scanned\\_vu\\_csp10\\_en.pdf](http://ec.europa.eu/development/icenter/repository/scanned_vu_csp10_en.pdf)
- Reuter T. *Sharing the Earth, Dividing the Land: Land and Territory in the Austronesian World*. Canberra: Australian National University Press; 2006. p. 326.
- Hess S. *Person and Place: Ideas, Ideals and the Practice of Sociality on Vanua Lava, Vanuatu*. Berghahn Books; 2009. p. 115.
- World Health Organization (WHO). *Health Service Delivery Profile Vanuatu: 2012*. WHO WPRO and Ministry of Health, Vanuatu Official Report. 2012. Available from: [http://www.wpro.who.int/health\\_services/service\\_delivery\\_profile\\_vanuatu.pdf](http://www.wpro.who.int/health_services/service_delivery_profile_vanuatu.pdf)
- Vanuatu Law Commission. *Review of the Dangerous Drugs Act [Cap 12] and the Penal Code [Cap 135]*. Issues Paper No. 01 of 2013. 2013. Available from: [http://www.lawcommission.gov.vu/images/pdf/dangerous\\_drugs.pdf](http://www.lawcommission.gov.vu/images/pdf/dangerous_drugs.pdf)
- National Institute of Open Schooling (NIOS). *National Integration and Secularism*. 2014. Available from: <http://www.nios.ac.in/media/documents/secsocscicour/english/lesson-24.pdf>
- Ligo G. Acting Health Director-General removed and replaced. *Vanuatu Daily Post*, June 27th, 2014. Available from: [http://www.dailypost.vu/article\\_52f059d2-d0db-5840-aeff-a13f78a2141d.html](http://www.dailypost.vu/article_52f059d2-d0db-5840-aeff-a13f78a2141d.html)
- Garae L. Prime Minister's Office confirms Tovu as Health's Acting Director-General. *Vanuatu Daily Post*, July 1st, 2014. Available from: [http://www.dailypost.vu/news/article\\_109dd656-6127-5a70-8347-632b06533ffc.html](http://www.dailypost.vu/news/article_109dd656-6127-5a70-8347-632b06533ffc.html)
- United Nations International Children's Emergency Fund. Leveraging ICT Effectively to Strengthen HIV/AIDS Treatment & Care. 2010. Available from: [http://www.unicef.org/eapro/Unicef\\_Asia-Pacific\\_ICT\\_Assessment\\_Report\\_Final\\_19Jan2011.pdf](http://www.unicef.org/eapro/Unicef_Asia-Pacific_ICT_Assessment_Report_Final_19Jan2011.pdf)
- Vanuatu Daily Post. A long-term solution for public health challenges [internet]. October 18th, 2014. Available from: [http://www.dailypost.vu/news/article\\_89029f41-a959-557b-a9ab-477125d7eaa1.html](http://www.dailypost.vu/news/article_89029f41-a959-557b-a9ab-477125d7eaa1.html)
- Prasad BC, Kausimae P. *Social Policies in Solomon Islands and Vanuatu*. Joint Commonwealth Secretariat and United Nations Research Institute for Social Development Report; 2012.
- Kalo J. Utilization of Adolescent Reproductive Health Services by Young People in Vanuatu. Ministry of Health and United Nations Population Fund Secretariat of the Pacific Community Joint Report; 2006. Available from: [http://countryoffice.unfpa.org/pacific/drive/AdRHS\\_Vanuatu.pdf](http://countryoffice.unfpa.org/pacific/drive/AdRHS_Vanuatu.pdf)
- The Global Fund. Pacific Islands Regional Coordinated Country Project on HIV/AIDS, TB and Malaria [internet]. 2014. Available from: <http://portfolio.theglobalfund.org/en/Country/Index/QMJ>
- Government of the Republic of Vanuatu. Health Sector Strategy 2010 -2016: Moving Health Forward. 2014. Available from: [http://www.wpro.who.int/health\\_services/vanuatu\\_nationalhealthplan.pdf](http://www.wpro.who.int/health_services/vanuatu_nationalhealthplan.pdf)
- Feachem R, Sabot O. A new global malaria eradication strategy. *Lancet* 2008; 371: 1633-5. doi: [10.1016/s0140-6736\(08\)60424-9](https://doi.org/10.1016/s0140-6736(08)60424-9)
- University of California San Francisco. Country Briefing: Eliminating malaria in Vanuatu; 2014.
- Australian Department of Foreign Affairs and Trade. Papua New Guinea country brief. 2014. Available from: [http://www.dfat.gov.au/geo/png/png\\_brief.html](http://www.dfat.gov.au/geo/png/png_brief.html)
- United Nations Programme on HIV/AIDS (UNAIDS). HIV/AIDS Stakeholder Mapping in Papua New Guinea. UNAIDS Report. 2004. Available from: <http://www.hivpolicy.org/Library/HPP000675.pdf>

23. Commonwealth of Australia. An Effective Aid Program for Australia: Making a real difference - Delivering real results [internet]. 2012. Available from: <http://dfat.gov.au/aid/Pages/australias-aid-program.aspx>
24. United Nations Development Program (UNDP). Human Development Report 2014. 2014. Available from: <http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf>
25. [No authors listed]. Evaluation: the top priority for global health. *Lancet* 2010; 375: 526. doi: [10.1016/S0140-6736\(10\)60056-6](https://doi.org/10.1016/S0140-6736(10)60056-6)
26. The Global Fund. Grant Portfolio: Papua New Guinea [internet]. 2014. Available from: <http://portfolio.theglobalfund.org/en/Country/Index/PNG>
27. Australian Department of Foreign Affairs and Trade (DFAT). Papua New Guinea Health System Capacity Development Program. 2014. Available from: [www.dfat.gov.au/about-us/.../hhsip-health-system-framework1.pdf](http://www.dfat.gov.au/about-us/.../hhsip-health-system-framework1.pdf)
28. Australian Department of Foreign Affairs and Trade (DFAT). Schedule to the Papua New Guinea–Australia Partnership for Development, Priority outcome 2: Health and HIV/AIDS [internet]. 2014. Available from: [http://aid.dfat.gov.au/Publications/Pages/2659\\_5398\\_4695\\_6862\\_4723.aspx](http://aid.dfat.gov.au/Publications/Pages/2659_5398_4695_6862_4723.aspx)
29. Michaud J, Kates J. Global health diplomacy: Advancing foreign policy and global health interests. *Glob Health Sci Pract* 2013; 1: 24-8. doi: [10.9745/GHSP-D-12-00048](https://doi.org/10.9745/GHSP-D-12-00048)
30. AusAid. Mid-Term Review (MTR) of Evaluation Capacity Building Program (Indonesia). 2013. Available from: <http://www.ode.dfat.gov.au/publications/documents/indonesia-evaluation-capacity-building-program-mtr-man-resp.pdf>
31. United Nations Economic and Social Council. Trends in South-South and Triangular Development Cooperation. Background Study for the Development Cooperation Forum. 2008. Available from: [http://www.un.org/en/ecosoc/docs/pdfs/south-south\\_cooperation.pdf](http://www.un.org/en/ecosoc/docs/pdfs/south-south_cooperation.pdf)
32. The Guardian. Bill Gates and Dambisa Moyo spat obscures the real aid debate [internet]. 2015. Available from: <http://www.theguardian.com/global-development/poverty-matters/2013/may/31/bill-gates-dambisa-moyo-aid>
33. Australian Government. Overview of Global Health Initiatives. 2014. Available from: <http://aid.dfat.gov.au/aidissues/health/Pages/home.aspx#initiatives>
34. Winning D. Japan Steps Up Interest in Papua New Guinea's Gas Riches [internet]. *The Wall Street Journal*; May 23rd, 2013. Available from: <http://blogs.wsj.com/moneybeat/2013/05/23/japan-steps-up-interest-in-papua-new-guineas-gas-riches/>
35. World Health Organization (WHO). *From Honiara to Apia: Report on Progress and Challenges*. 10th International Pacific Health Ministers Meeting. 2013. Available from: [http://www.wpro.who.int/southpacific/pic\\_meeting/2013/documents/PHMM\\_PIC10\\_4\\_Progress\\_Report.pdf](http://www.wpro.who.int/southpacific/pic_meeting/2013/documents/PHMM_PIC10_4_Progress_Report.pdf)
36. World Health Organization (WHO) Pacific Regional Office. Samoa National Health Plan - WHO Western Pacific Region. 2007. Available from: [http://www.wpro.who.int/health\\_services/samoa\\_nationalhealthplan.pdf](http://www.wpro.who.int/health_services/samoa_nationalhealthplan.pdf)
37. Scott A. Global Health Security Under Threat? Progress in implementing the International Health Regulations. *Health Diplomacy Monitor*; 2012. Available from: [http://www.academia.edu/1241479/Global\\_Health\\_Security\\_Under\\_Threat\\_Progress\\_in\\_implementing\\_the\\_International\\_Health\\_Regulations\\_2005\\_](http://www.academia.edu/1241479/Global_Health_Security_Under_Threat_Progress_in_implementing_the_International_Health_Regulations_2005_)
38. Leng D. A decentralized primary healthcare model based upon a cost-effective patient data system that includes remote districts and villages in Samoa. *Samoa Medical Journal* 2010; 2: 35-7.
39. The World Bank. Increasing access to effective, efficient and quality health services in Samoa [internet]. World Bank South Pacific Development Report. 2013. Available from: <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22517640~menuPK:141310~pagePK:34370~piPK:34424~theSitePK:4607,00.html>
40. World Health Organization (WHO). WHO Country Cooperation Strategy for Samoa 2013-2017. 2012. Available from: [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_wsm\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_wsm_en.pdf)
41. World Health Organization (WHO). CSU's Global Fund - related work. 2013. Available from: [http://www.wpro.who.int/entity/country\\_focus/global\\_health\\_initiatives/globalfund/en/](http://www.wpro.who.int/entity/country_focus/global_health_initiatives/globalfund/en/)
42. United Nations Programme on HIV/AIDS (UNAIDS). Oceania Fact Sheet. 2014. Available from: [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012\\_FS\\_regional\\_asia\\_pacific\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012_FS_regional_asia_pacific_en.pdf)
43. United Nations Programme on HIV/AIDS (UNAIDS). Samoan Global AIDS Reporting Progress Report 2013. Reporting Period: January – December 2013; Report submitted on 31st March 2014. Available from: [http://www.unaids.org/sites/default/files/en/dataanalysis/knownyourresponse/countryprogressreports/2014countries/WSM\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/en/dataanalysis/knownyourresponse/countryprogressreports/2014countries/WSM_narrative_report_2014.pdf)
44. United Nations Programme on HIV/AIDS (UNAIDS). Global AIDS Country Progress Report: Samoa. UNAIDS Report. 2012. Available from: [http://www.unaids.org/sites/default/files/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce\\_WS\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/sites/default/files/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_WS_Narrative_Report[1].pdf)
45. Samoan Red Cross Society. HIV/AIDS in Samoa [internet]. 2014. Available from: <http://www.redcross.org.ws/Whatwedo/Health/HIV/tabid/6588/language/en-US/Default.aspx>
46. Buchanan-Aruwafu H. Youth Vulnerability to HIV/AIDS in the Pacific. 2014. Available from: [http://www.apcom.org/tl\\_files/resources/HIV-Pacific%20YOUTH%20VULNERABILITY.pdf](http://www.apcom.org/tl_files/resources/HIV-Pacific%20YOUTH%20VULNERABILITY.pdf)
47. Cote JE. A social history of youth in Samoa: religion, capitalism, and cultural disenfranchisement. *Int J Comp Sociol* 1997; 38: 217-34.
48. Kevany S, Khumalo-Sakutukwa G, Murima O, Chingono A, Modiba P, Gray G, *et al.* Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. *BMC Public Health* 2012; 12: 459. doi: [10.1186/1471-2458-12-459](https://doi.org/10.1186/1471-2458-12-459)
49. Secretariat of the Pacific Community. Principal Recipient Annual Report: January to December 2009 [internet]. 2009 Available from: [https://www.spc.int/frp/index2.php?option=com\\_docman&task=doc\\_view&gid=173&Itemid=33](https://www.spc.int/frp/index2.php?option=com_docman&task=doc_view&gid=173&Itemid=33)
50. Fauci A. The expanding global health agenda: a welcome development. *Nature Med* 2007; 13: 1169-71. doi: [10.1038/nm1646](https://doi.org/10.1038/nm1646)
51. Center for Strategic and International Studies (CSIS). Final report of the CSIS Commission on smart global health policy. 2010. Available from: <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>
52. International Federation of Red Cross and Red Crescent Societies. Information Bulletin for the Pacific: Tropical Cyclone Pam. 2015. Available from: <https://www.ifrc.org/docs/Appeals/15/IBPacificTC130315.pdf>
53. Kevany S. Global Health Diplomacy, 'Smart Power', and the New World Order. *Glob Public Health* 2014; 9: 787-807. doi: [10.1080/17441692.2014.921219](https://doi.org/10.1080/17441692.2014.921219)

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# Irish Aid and Diplomacy in the Twenty-first Century: Optimising Enlightened Self-Interest, Supranational Priorities and Foreign Policy Impact

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## ABSTRACT

Irish Aid, Ireland's overseas representative and international development presence, is undergoing a period of rapid evolution, reflecting parallel changes in corresponding government ministries and aid agencies in Europe, the United States and other high-income donor countries. Common to this political, governmental and structural evolution is an increased integration between development and diplomacy, which forms a key cornerstone of twenty-first-century 'enlightened self-interest' approaches to foreign affairs. We propose that an 'enlightened self-interest' paradigm would not only enhance Ireland's capacity for the simultaneous pursuit of both diplomatic and development objectives, but also result in an 'enlightened *mutuality* of interests' benefitting both donors and recipients, in keeping with Ireland's distinguished history in this regard.

Using the 'enlightened self-interest' framework as a lens, we consider a range of contemporary themes related to the integration of development, diplomacy, trade and broader foreign affairs issues in the Irish context, such as security and international relations. These include (1) Ireland's past implicit 'diplomatic development' achievements and leadership, which provide a historical and current context for the 'global health diplomacy' paradigm; (2) measures for making integration of different dimensions of foreign policy a more explicit and transparent endeavour; and (3) efforts to identify where in Ireland's foreign affairs architecture such synergies may be found, developed and enhanced. Finally, (4) we consider those capacities required by governments, in Ireland and elsewhere, to operationalise 'diplomatic development' programmes.

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Ireland, via its overseas diplomatic and development presence, is presented with significant opportunities to design, and adapt, aid programmes to generate optimal impact on both donor and recipient strategic interests. Such ‘smart’ development approaches can help create a compelling case for maintenance and support of international foreign assistance funding across the political, economic and social spectrums; advance political, economic, development and security aspirations in unison; and promulgate an effective and innovative paradigm to be replicated by other small, high-income donor countries.

#### BACKGROUND: CONTEMPORARY NATIONAL AND INTERNATIONAL CONTEXTS

##### *Foreign affairs theory and practice in the twenty-first century*

International development, aid and foreign assistance programmes are increasingly leveraged by donor countries to pursue foreign policy, diplomacy, security, international relations and domestic and international economic growth—along with traditional objectives such as poverty alleviation and world health—through the strategic allocation of funding across recipient regions, countries, interventions and population groups.<sup>1</sup> This incorporation of disparate, and ostensibly unrelated, aspirations into a single, over-arching foreign policy strategy, has often been implicit in international initiatives throughout history.<sup>2</sup> More recently, however, it has been formally and explicitly enshrined in international initiatives, such as in efforts to define the European Union’s role in global health and ‘smart power’.<sup>3</sup> In the case of the United States of America, it has been formalised by the creation of departments such as the Office of Global Health Diplomacy.<sup>4</sup> This evolution, or revolution, in foreign policy theory and practice<sup>5</sup> is taking place in parallel with the identification of related synergies across foreign policy concerns.<sup>6</sup> In a complementary fashion, it is also occurring through the increased integration of both donor and recipient departments of foreign policy and assistance.<sup>7</sup>

<sup>1</sup>Harley Feldbaum, ‘Global health and foreign policy’, *Epidemiological Review* 32 (2010), 82–92, available online at: [www.epirev.oxfordjournals.org/content/32/1/82.full](http://www.epirev.oxfordjournals.org/content/32/1/82.full) (8 September 2015); William J. Fallon and Helene D. Gayle, *A healthier, safer and more prosperous world*, Final report of the Center for Strategic and International Studies Commission on smart global health policy (Washington, D.C., 2010), available at: <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy> (8 September 2015).

<sup>2</sup>Joshua Michaud and Jennifer Kates, ‘Global health diplomacy: advancing foreign policy and global health interests’, *Global Health: Science and Practice* 1 (1) (2013), 24–8; available at: <http://www.ghspjournal.org/content/1/1/24.full> (8 September 2015).

<sup>3</sup>European Commission, *The European Union’s role in global health*, COM (2010)128 final (Brussels, 2010); Oliver Rehn, ‘Europe’s smart power in its region and the world’, speech at the European Studies Centre, St Antony’s College, University of Oxford, 1 May 2008. Available at: [www.europa.eu/rapid/press-release\\_SPEECH-08-222\\_en.pdf](http://www.europa.eu/rapid/press-release_SPEECH-08-222_en.pdf) (8 September 2015).

<sup>4</sup>In the U.S., the Office of Health Diplomacy is located within the Department of State; further information about this office is available at: <http://www.state.gov/s/ghd/about/index.htm> (8 September 2015).

<sup>5</sup>Richard Horton, ‘Health as an instrument of foreign policy’, *The Lancet* 369 (2007), 806–7; available at: <http://scholar.google.com/scholar?cluster=14964748696365445822&hl=en&oi=scholar> (8 September 2015); David Fidler, ‘Reflections on the revolution in health and foreign policy’, *Bulletin of the World Health Organization* 85 (3) (2007), 243–4; available at: [www.ncbi.nlm.nih.gov/pubmed/17486221](http://www.ncbi.nlm.nih.gov/pubmed/17486221) (8 September 2015).

<sup>6</sup>David Fidler, ‘Rise and fall of global health as a foreign policy issue’, *Global Health Governance* 4 (2) (2011), 1–12.

<sup>7</sup>Sebastian Kevany, Solomon Benatar and Theodore Fleischer, ‘Improving resource allocations for health and HIV in South Africa: bioethical, cost-effectiveness and health diplomacy considerations’, *Global Public Health* 8 (2013), 570–87; available at: <http://www.ncbi.nlm.nih.gov/pubmed/23651436> (8 September 2015).

*Integration and post-partisanship*

The integrated, simultaneous pursuit of multiple foreign policy goals is both practically and conceptually distinct from ‘tied aid’ approaches, which attach a range of (often unpopular or ethically questionable) economic, political and structural conditions to the disbursement of donor funds.<sup>8</sup> To emphasise this distinction, in the United States, the location of the Office of Global Health Diplomacy within the State Department makes explicit the goal of leveraging global health programmes to promote and project a range of national values and international objectives, including both enhanced international relations and the pursuit of economic, political, security and strategic considerations.<sup>9</sup> In the United Kingdom, the Department for International Development (DfID) has, in recent years, become increasingly aligned with broader Whitehall priorities.<sup>10</sup> Such integration has, at least in part, been driven by (1) the post-partisan political ideal of making altruistic (and ostensibly charitable or ‘equity’ focused) foreign assistance funding more palatable to all elements of society, including the electorate and the media; as well as by (2) the generation of consensus-building and cross-party support for international initiatives such as the President’s Emergency Plan for AIDS Relief (PEPFAR) in the United States.<sup>11</sup> Thereby, diplomatic and development activities will, in theory, increasingly take place in a politically uncontested arena.<sup>12</sup>

*The pursuit of self-interest and foreign policy by small countries*

Concepts such as foreign policy and enlightened self-interest have specific applications to small, open economies such as Ireland. How, for example, might a small state, situated within the European Common Foreign and Security Policy (CFSP) still pursue its own interests in the bilateral foreign policy arena, or adequately and fairly project its views at the multilateral level? How is that self-interest (1) defined internally, and (2) projected externally? Examples of ‘internal’ challenges include the utilisation of economic assistance mechanisms such as the Common Agricultural Policy (CAP) in ways that benefit Ireland but may not always promote the interests of low-income countries.<sup>13</sup> Conversely, ‘external’ concerns encompass the projection of Ireland’s pro-development global image—even if this requires domestic fiscal and budgetary sacrifices. Historically, Irish national self-interest has been pursued through policies of diplomacy and negotiation, including ‘competitive bargaining’ related to trade, security and diplomatic issues—rather than by coercive or military measures—via multilateral institutions such as the United Nations, in order ‘successfully to

<sup>8</sup>Jon Temple, ‘Aid and conditionality’, in Dani Rodrik and Mark Rosenzweig (eds), *Handbook of development economics*, 4415–523 (Oxford and Amsterdam, 2010).

<sup>9</sup>See <http://www.state.gov/s/ghd/> for information on the Office of Global Health Diplomacy (8 September 2015).

<sup>10</sup>For information on the DfID, see the website of the Foreign and Commonwealth Office, <https://www.gov.uk/government/organisations/foreign-commonwealth-office/about> (8 September 2015).

<sup>11</sup>John Kerry, ‘Remarks at a global health event with partner countries’, New York, 25 September 2013; the text of these remarks is available at: <http://www.state.gov/secretary/remarks/2013/09/214733.htm> (8 September 2015).

<sup>12</sup>Rochelle Walensky and Daniel Kuritzkes, ‘The impact of the president’s emergency plan for AIDS relief (PEPFAR) beyond HIV and why it remains essential’, *Clinical Infectious Diseases* 50 (2) (2010), 272–5; doi:10.1086/649214.

<sup>13</sup>Conall O’Caoimh, ‘CAP system turns developing world’s farmers into beggars’, *Irish Times*, Debates, 17 July 2002; available at: <http://www.irishtimes.com/opinion/cap-system-turns-developing-world-s-farmers-into-beggars-1.1088840> (8 September 2015).

exert its will on the world'.<sup>14</sup> This approach has been further enhanced by Ireland's commitments to European Union systems such as the CFSP, under the aegis of which diplomatic and development considerations are increasingly intertwined.<sup>15</sup> The use of development aid, in this context, can therefore be seen as

not so much a claim of moral superiority but rather a conscious diplomatic strategy, in keeping with Ireland's political culture, which is designed to maximise the State's influence.<sup>16</sup>

Such approaches, perhaps not just coincidentally, mirror the development of global health diplomacy strategies by other 'like-minded countries' such as Norway.<sup>17</sup> Leveraging potential synergies between diplomacy and development in the Irish Aid context can build on Ireland's traditional approaches to both foreign policy and self-interest on the world stage. This stands to enhance Ireland's role in and leadership within related European institutions such as the CFSP and the European External Action Service (EEAS), both of which are in the process of exploring such synergies.<sup>18</sup> This will require careful balancing, and even occasional trade-offs, specifically in situations in which the interests of Ireland and those of its aid recipient countries are not synonymous, as may be the case where subsidised agricultural exports from Ireland undermine local food sustainability in low-income countries.<sup>19</sup> One of the most compelling means of achieving such a balance is through the significantly heightened interaction, harmonisation and coordination between, for example, Irish Aid and the Department of Foreign Affairs and Trade's political and economic divisions.

### *International development and foreign policy*

Within the Department of Foreign Affairs and Trade of countries such as Ireland and Australia, amongst others, there has been a corresponding move towards foreign policy integration as development objectives become more closely linked with broader diplomatic concerns.<sup>20</sup> Associated and formally articulated values and principles include the pursuit of good governance, the

<sup>14</sup>Daniel Thomas and Ben Tonra, 'To what ends EU foreign policy? Contending approaches to the Union's diplomatic objectives and representation', UCD Dublin European Institute Working Paper, 11–12 July 2011.

<sup>15</sup>Further information on Irish involvement with the CFSP is available from the Department of Foreign Affairs and Trade (DFAT); see 'Common security and defence policy', available at: <https://www.dfa.ie/our-role-policies/international-priorities/peace-and-security/common-security-and-defence-policy/> (8 October 2015).

<sup>16</sup>Ben Tonra, Michael Kennedy, John Doyle and Noel Dorr, 'Preface', in Tonra *et al.* (eds), *Irish foreign policy* (Dublin, 2012), xvii–xxii: xx.

<sup>17</sup>Kristin Sandberg and Steinar Andresen, *Health as foreign policy: the case of Norway* (Geneva, 2012), Graduate Institute of Geneva Paper Outline; available at: [http://graduateinstitute.ch/files/live/sites/iheid/files/sites/globalhealth/shared/Consortium/Cuba2009/Health%20as%20Foreign%20Policy%20paper%20outline%20Norway%2010.03.09\\_2\\_.pdf](http://graduateinstitute.ch/files/live/sites/iheid/files/sites/globalhealth/shared/Consortium/Cuba2009/Health%20as%20Foreign%20Policy%20paper%20outline%20Norway%2010.03.09_2_.pdf) (28 September 2015).

<sup>18</sup>Rehn, 'Europe's smart power in its region and the world'.

<sup>19</sup>Jean-Christophe Bureau and Alan Matthews, 'EU agricultural policy: what developing countries need to know', Trinity College Dublin, Institute for International Integration Studies, Discussion paper 91 (Dublin, 2005), available at: <https://www.tcd.ie/iis/documents/discussion/pdfs/iisdp91.pdf> (28 September 2015).

<sup>20</sup>Government of Ireland, *One world, one future: Ireland's policy for international development* (Dublin, 2013), available at: <https://www.irishaid.ie/media/irishaid/allwebsitemedia/20newsandpublications/publicationpdfsenglish/one-world-one-future-irelands-new-policy.pdf> (28 September 2014); Australian Department of Foreign Affairs and Trade, 'Overview of global health initiatives', (Barton, ACT, 2014), available at: <http://aid.dfat.gov.au/aidissues/health/Pages/home.aspx#initiatives> (29 September 2015).

protection and advancement of human rights and the pursuit of national and international economic growth and political stability, transcending a previously narrower development paradigm.<sup>21</sup> Such an approach is demonstrated in the multiplicity of non-health gains, such as regional integration, improved international relations and better provincial development, associated with successful regional global health disbursements.<sup>22</sup>

The incorporation of these themes in recent policy documents such as Ireland's *One world, one future: Ireland's policy for international development* implies that 'pro-poor' efforts, multilateral and bilateral diplomacy, and politically 'enlightened self-interest' are not merely compatible but, if appropriately framed, are more effectively pursued together.<sup>23</sup> The strategy envisages a multi-faceted and prominent role for Ireland in the alleviation of global poverty and hunger, as well as in tackling climate change, promoting gender equality, supporting fragile states, and facilitating ongoing efforts to address global health concerns such as the HIV/AIDS epidemic. This reflects a broad and diverse—but integrated—focus, combining efforts to tackle the underlying determinants of global inequity and under-development (poverty), contemporary and traditional sectoral priorities (hunger, climate change, global health, and HIV/AIDS), utilising cross-cutting and systemic approaches (gender- and rights-based approaches and efforts to assist fragile states). This ambitious combination of increased scope and greater specificity is reconciled through the articulation of 'whole of government' approaches, which identify common denominators and synergies between and across such thematic areas.<sup>24</sup>

To date, however, both in Ireland and elsewhere, this nascent search for synergies and organisational integration has taken place in a largely *ad-hoc* way. There has been no establishment or application of formal systems for determining the degree to which development programmes are being effectively employed to generate a broader range of envisaged benefits for both donors and recipients. The broader frame of reference encapsulated in Ireland's 2013 strategy has initiated a 'development diplomacy' process—combining the more traditional development objectives related to poverty and (sector-specific) Millennium Development Goals (MDGs) with a focus on reciprocal or mutual, global, public goods, such as economic growth and good governance. These bring development programmes into the sphere of diplomacy, and they require integrated ways of working across and within the Department of Foreign Affairs and Trade (DFAT).

### *Identifying 'diplomatic development' synergies*

A review of the 2006 White Paper on Irish Aid observed that the Development Cooperation Division generates 'a positive effect for Ireland, contributing to stability and security, enhancing our reputation, and deepening social and

<sup>21</sup>DFAT, *Statement of strategy, 2011 to 2014* (Dublin, 2011). The full text of this document is available at: <https://www.dfa.ie/media/dfa/alldfawebsitemedia/aboutus/dfat-statement-of-strategy-2011-2014.pdf> (29 September 2015).

<sup>22</sup>Sebastian Kevany, Caleb Garae, Serafi Moa, Av'aia Lautusi and Amy Gildea, 'Global health diplomacy, national integration, and regional development through the monitoring and evaluation of HIV/AIDS programs in Papua New Guinea, Vanuatu, and Samoa', *International Journal of Health Policy Management* 4 (2015), 337–41; doi: 10.15171/ijhpm.2015.89.

<sup>23</sup>Government of Ireland, *One world, one future*.

<sup>24</sup>Trocaire, 'Achieving policy coherence for development through a whole of government approach', Briefing paper, September 2013. The text of the paper is available at: <http://www.trocaire.org/resources/policyandadvocacy/achieving-policy-coherence-development-through-whole-government-approach> (29 September 2015).



economic ties elsewhere'.<sup>25</sup> Given this ambitious goal, which is an emerging feature in a number of high-income donor countries, this paper seeks to identify and begin to resolve some of the related political, economic and diplomatic challenges and opportunities facing Ireland. It does so by exploring the utility and applicability of 'enlightened self-interest' approaches to development, which build on synergies between national and international strategic objectives. Insofar as there is an assumption that such synergies exist, based on insights, precedents and examples from related literature, the paper then aims to identify the capacities required by donor governments to ensure that such theoretical 'compatibilities'—between sets of international principles and goals and national interests and objectives—can be achieved, operationalised, augmented, monitored and (perhaps most importantly) sustained. Based on a review of Ireland's past and current development achievements, we then point to where in the Irish Aid and broader DFAT institutional architecture such synergies may be found, developed and enhanced, including the further empowerment of the Irish Aid division in the political and diplomatic *milieu*. The paper ends with an identification of the types of capacities needed to ensure a sustainable 'mutuality of benefits' for Ireland as a donor country, its main aid recipient country partners and the broader international community.

### *Interdepartmentalism and the decline of 'siloed' government*

Prior to a major reorganisation in 2003, Ireland practiced a 'siloed' approach to development, based on demarcations and divisions across different arms of the DFAT, an approach that was strongly criticised internationally by the Organization for Economic Cooperation and Development (OECD) as well as raising concerns domestically.<sup>26</sup> The resultant reorganisation sought to integrate, rather than divide, the Irish government's foreign policy and development functions through 'cross-cutting approaches' and in line with a tradition of adherence to broader national and international policy trends.<sup>27</sup> It is no coincidence, then, that the principles and approaches of Irish Aid strategy in the period 2003 to 2013 were aligned with the multi-sectoral MDGs that set the global development agenda from 2000 to 2015.<sup>28</sup> Ireland's 2013 *One world, one future* policy therefore represents a significant advance: this 'whole of government' policy is not only informed by and aligned with the post-MDG policy landscape, it is also helping to shape that landscape, which will be

<sup>25</sup>Irish Development Education Association, 'Submission to review of the White Paper on Irish Aid: views on behalf of IDEA and its members' (March 2012); available at: [http://www.dochas.ie/Shared/Files/4/IDEA\\_White\\_paper\\_submission.pdf](http://www.dochas.ie/Shared/Files/4/IDEA_White_paper_submission.pdf) (29 September 2015).

<sup>26</sup>Organization for Economic Cooperation and Development, Development Assistance Committee, *DAC peer review: Ireland 2014* (Paris, 2014; hereafter cited as OECD/DAC, *Peer review: Ireland 2014*). The full text of the review is available at: <http://www.oecd.org/ireland/peer-review-ireland.htm> (30 September 2015); and Oireachtas Reports, 'Joint Committee on Foreign Affairs debate', 15 July 2004, available at: <http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/committeetakes/FOJ2004071500003> (8 October 2015).

<sup>27</sup>Government of Ireland, *One world, one future*; see also Helen O'Neill, 'The evolution of Ireland's foreign aid over the past 20 years: a 'review of ISIA reviews' since 1994', *Irish Studies in International Affairs* 24 (2013), 179–236; available at: <http://www.jstor.org/stable/42912420> (30 September 2015).

<sup>28</sup>Joe Costello, T.D., *Beyond 2015: where next for the Millennium Development Goals?* Minister of State's Keynote address, 16 August 2012; available at: <https://www.irishaid.ie/news-publications/speeches/speechesarchive/2012/august/beyond-2012-millennium-development-goals/> (8 October 2015).

characterised by new initiatives such as the Global Health Grand Convergence 2035.<sup>29</sup>

Irish Aid's 'Priority areas for action'—which include (1) promoting human rights and accountability, (2) provision of essential services, (3) promotion of trade and economic growth, (4) action on climate change, (5) a focus on fragile states, and (6) tackling 'global hunger'—represent a broad and potentially coherent focus for this 'post-MDG' era.<sup>30</sup> Such diversity and breadth of scope, incorporating as it does cross-cutting economic and political goals, will, however, require significant adaptability in, and responsiveness of, Irish Aid programmes in partner countries where the focus and budget has, in the past, been driven by those traditional 'sectoral' systems of engagement with which recipient governments were most familiar. Recent challenges, such as the Ebola outbreak in West Africa in 2014, have already demanded greater interdepartmentalism and interdisciplinary collaboration (between, for example, departments of foreign affairs and health), blurring the line between international development, security and foreign policy responsibilities.<sup>31</sup> In this context, the *One world, one future* approach looks to advance integration and policy coherence across Irish Aid and the DFAT's established diplomatic goals, epitomised by references to 'the centrality of international development cooperation to Irish foreign policy' as well as to 'bringing Ireland's contribution to the fight against global poverty and hunger to the centre of our foreign policy—where it rightly belongs'.<sup>32</sup>

*Aligning principles and practice: international development as 'high politics'*

At the heart of integrated political, foreign assistance and international relations approaches such as the 'global health diplomacy' paradigm lies the goal of harmonisation and alignment of diplomatic and development systems at the international, national and programmatic levels.<sup>33</sup> In Ireland, as elsewhere, without the application of formal coordination mechanisms that recognise the diverse (and occasionally conflicting) origins and goals of development and diplomacy, there remains the risk that these pursuits may not only fail to work synergistically but may also fall victim to 'tense and confusing dualities'.<sup>34</sup> Through the *One world, one future* vision, Ireland has already taken significant early steps to initiate this alignment—albeit in an implicit (and to some degree *ad-hoc*) manner:

by using a Whole-of-Government approach, we will ensure that our political and diplomatic engagement with [recipient] countries, as well as our engagement within the European Union and at the international level, particularly the United Nations, goes hand-in-hand with our humanitarian support.<sup>35</sup>

<sup>29</sup>Dean Jamison *et al.*, 'Global health 2035: a world converging within a generation', *The Lancet* 382 (9908) (2014), 1898–1955.

<sup>30</sup>Irish Aid, 'What we do: HIV and AIDS overview', information available at: <https://www.irishaid.ie/what-we-do/our-priority-areas/hiv-and-aids/hiv-and-aids-overview/> (7 October 2015).

<sup>31</sup>Tara Sonenshine, 'Ebola: an opportunity for public diplomacy', *The Globalist*, 4 August 2014; available at: <http://www.theglobalist.com/ebola-an-opportunity-for-public-diplomacy/> (8 October 2015).

<sup>32</sup>Government of Ireland, *One world, one future*.

<sup>33</sup>Thomas Novotny and Vincanne Adams, 'Global health diplomacy—a call for a new field of teaching and research', *San Francisco Medicine* 80 (3) (2007), 22–3.

<sup>34</sup>Fallon and Gayle, *A healthier, safer and more prosperous world*, Final report of the CSIS Commission.

<sup>35</sup>Government of Ireland, *One world, one future*.

For example, the inclusion as ‘Priority areas for action’ of horizontal or inter-sectoral approaches such as support to fragile states that simultaneously face complex development challenges—such as hunger and food insecurity—shows that Irish Aid initiatives no longer intend to operate in isolation, either from each other or from their broader environment.

Such approaches represent much more than grand aspirations that potential synergies will drive diplomatic dialogues between health and non-health actors at the highest levels of the political spectrum. A number of commentators predicted the rapid recent ascent, in an increasingly globalised world, of global health initiatives from a ‘low’ to a ‘high’ focus within the political *milieu*.<sup>36</sup> Examples include diplomatic dialogues around polio immunisation boycotts in Nigeria, whereby diplomats, politicians and medical professionals engaged in a collaborative ‘troubleshooting’ process to overcome cultural and policy obstacles to vaccination campaigns, in keeping with innovative systems of health policy decision-making.<sup>37</sup>

*From the implicit to the explicit: an incremental process*

Diplomatic and foreign policy perspectives on ‘global health and development’—henceforth used to denote all activities that advance the health of the world’s poorest people, including food security, poverty alleviation, agricultural and medical initiatives—fit closely with the central tenets of Irish Aid’s policy and philosophy in the twenty-first century. Approaches articulated in *One world, one future* are mirrored in the recent development of formal criteria for ‘diplomatically sensitised’ or ‘foreign policy sensitised’ development programmes, in the form of ‘Top Ten’ design, implementation and review recommendations.<sup>38</sup> These include cost-effectiveness (efficiency and value for money), international coordination (development as an essential element of foreign policy), alignment (coordination with the European Union’s Common Foreign and Security Policy), interdepartmentalism (drawing on the strengths of all government departments) and human-rights awareness (ensuring that associated principles and standards are promoted, protected and integrated).

They also encompass contemporary themes such as international conflict resolution and ‘smart power’ (support of efforts that recognise links between peace, security and development); enhancing connections with domestic economic opportunities (joint initiatives between, for example, DFAT and the Department of Agriculture, Food and the Marine); adaptability (programmatic responsiveness to a rapidly evolving global environment); and domestic and international communications (engaging with the Irish public about the impact of Irish Aid). Traditional foreign affairs principles are also included, such as political neutrality (a commitment to humanitarian principles of impartiality and operational independence), sustainability (partnership agreements that support long-term and inclusive economic growth), and accountability

<sup>36</sup>Horton, ‘Health as an instrument of foreign policy’; Fidler, ‘Reflections on the revolution in health and foreign policy’.

<sup>37</sup>Ruairi Brugha and Zsuzsa Varvazovszky, ‘Stakeholder analysis: a review’, *Health Policy and Planning* 15 (3) (2000), 239–46; Judith Kaufmann and Harley Feldbaum, ‘Diplomacy and the polio immunization boycott in Northern Nigeria’, *Health Affairs* 28 (4) (2009), 1091–1101, available at: [http://graduateinstitute.ch/files/live/sites/iheid/files/shared/summer/GHD%202011%20Summer%20Course/Kaufmann%20et%20al%202009%20Nigeria\\_Polio.pdf](http://graduateinstitute.ch/files/live/sites/iheid/files/shared/summer/GHD%202011%20Summer%20Course/Kaufmann%20et%20al%202009%20Nigeria_Polio.pdf) (7 October 2015).

<sup>38</sup>Sebastian Kevany, ‘Global health diplomacy, “smart power”, and the new world order’, *Global Public Health: An International Journal for Research, Policy and Practice* 9 (7) (2014), 787–807, DOI:10.1080/17441692.2014.921219.

(generating institutional change to strengthen relationships between policy-makers, service providers, citizens and taxpayers).

*One world, one future*, through these thematic areas and objectives, therefore develops a common and transferable set of principles that stand to contribute to both improving the quality of life of the world's poorest people and to Ireland's, and the global community's, diplomatic, economic, political and security ideals. This context also illustrates the manner in which approaches such as 'global health diplomacy' stand to enhance Ireland's international engagements in an increasingly structured fashion.

#### PRINCIPLES INTO PRACTICE: BUILDING ON IRISH AID'S TRADITIONS TO DEVELOP INNOVATIVE PARADIGMS

##### *Irish Aid's 'history of diplomacy'*

As a prelude to the current vogue for diplomatic development programmes, Ireland has, for many years, been designing, selecting, implementing and delivering international foreign assistance initiatives that are models of sensitive interventionism. Historically, Ireland has tended to avoid those programmes that risk causing religious, cultural or social confrontation in recipient countries.<sup>39</sup> This has been particularly evident in Ireland's support of international health programmes, via an established focus on initiatives that advance human dignity and well-being, whilst, where necessary and appropriate, challenging recipient community norms in a diplomatic fashion.<sup>40</sup> Other donors may have much to learn from Irish Aid's 'low-risk' approaches in this regard as they pursue highly 'cost-effective', yet socially uncertain, strategies.<sup>41</sup> The origins of Irish Aid's approach lie in Ireland's international position as a small but high-income country with an open economy; a belief in foreign assistance as a symbol of Ireland's place as an independent and prosperous state on the world stage;<sup>42</sup> and associations with a range of national and international organisations (including missionary religious congregations and the Holy See). Its commitment to neutrality via refraining from membership of international military organisations such as NATO has been complemented by a proven long-term commitment to United Nations peace-keeping and development missions around the world.<sup>43</sup> Taken together, the evolution of its development programme and Ireland's particular historical circumstances have ensured that Irish Aid has consistently remained aware not just of the ideals of development, but also of the associated political, security, national and international prestige, economic and religious contexts in which such programmes operate.

<sup>39</sup>Kevin O'Sullivan, 'Biafra to Lomé: the evolution of Irish government policy on official development assistance, 1969–75', *Irish Studies in International Affairs* 18 (2007), 91–107; available at: <http://www.jstor.org/stable/25469818> (7 October 2015).

<sup>40</sup>Irish Aid, *Irish Aid annual report 2013* (Dublin, 2013); available at: <https://www.irishaid.ie/news-publications/publications/publicationsarchive/2014/july/irish-aid-2013-annual-report/> (7 October 2015).

<sup>41</sup>Maria Quigley, Helen Weiss and Richard Hayes, 'Male circumcision as a measure to control HIV infection and other sexually transmitted diseases', *Current Opinion in Infectious Diseases* 14 (1) (2001), 71–5; available at: <http://www.ncbi.nlm.nih.gov/pubmed/11979118> (7 October 2015).

<sup>42</sup>Kevin O'Sullivan, 'History and the development aid debate in the Republic of Ireland', *Policy and Practice: A Development Education Review* 12 (2011), 110–23; available at: <http://www.developmenteducationreview.com/issue12-perspectives6> (30 September 2015).

<sup>43</sup>Government of Ireland, *One world, one future*.

*A tradition of diverse, sensitive and inclusive programmes*

Ireland's development partnerships and cooperation efforts over the last 20 years have taken place at two main levels of engagement: (1) at national (or bilateral) level with key partner countries and (2) at international (or multilateral) level encompassing broader global engagements. Both national cooperation, in the form of sector-wide approaches (SWAPs) and direct budgetary support to sectoral ministries, and international cooperation, via United Nations agencies such as the WHO, UNICEF and the World Food Programme (WFP), as well as the European Union and new multilateral initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, have been consistently scrutinised and vetted, to maintain Ireland's tradition of diverse, sensitive and inclusive programmes. Such diversity, sensitivity and inclusiveness finds its roots in Ireland's missionary tradition, in a shared colonial history with the developing world, and, since accession to the EEC in 1973, in a high level of responsiveness to development ideals at the pan-European level.<sup>44</sup> Today, this tradition is reflected in the range of development initiatives that Ireland is currently associated with—one of the broadest, and most ambitious, portfolios for a country of its size.<sup>45</sup> These programmes have consistently won plaudits from peer organisations amongst both donors and recipients, including the OECD's Development Assistance Committee, which as recently as 2014 described Irish Aid as an 'honest broker', 'innovative', 'punching above its weight', and 'excelling in delivering effective aid'.<sup>46</sup>

*Restoring Irish Aid funding to pre-recession levels: beyond 'pro bono' rationales*

Ireland has achieved high levels of international prestige based on the design and delivery of its aid programmes. In the eyes of some elements of the international community, however, this reputation has been tarnished by funding cuts such as those applied to the Global Fund to Fight AIDS, Tuberculosis, and Malaria in the wake of the 'Celtic Tiger' economic collapse.<sup>47</sup> The one-third reduction in the Irish Aid budget since 2008, even if understandable in view of the overall cuts in government expenditure resulting from the economic crisis,<sup>48</sup> remains unprecedented in Irish history. The case for the restoration of international development funding to pre-recession levels can, however, be strengthened through articulating a broader diplomatic and development strategy that brings benefits to both donors and recipients, and by designing, delivering and reviewing aid programmes accordingly. In countries such as the United States, a case for the augmentation of global health expenditure from other sectors—such as the highly funded defence budget—is being made, based on the argument that international hostility can be equally, or better, addressed via military- or non-military-led humanitarian

<sup>44</sup>See Justin Kilcullen, 'Introduction', in Brian Maye, *The search for justice—Trócaire: a history* (Dublin, 2010); O'Sullivan, 'History and the development aid debate'; and Europa, 'Foreign and security policy: speaking with one voice', European Union policy document; available at: [www.europa.eu/pol/cfsp/index\\_en.htm](http://www.europa.eu/pol/cfsp/index_en.htm) (30 September 2015).

<sup>45</sup>Government of Ireland, *One world, one future*.

<sup>46</sup>OECD/DAC, *Peer review: Ireland 2014*.

<sup>47</sup>Irish Forum for Global Health, 'Aid funding for health', Position paper, November 2010; available at: <http://www.globalhealth.ie/uploads/files/ifgh%20aid%20paper.pdf> (30 September 2015).

<sup>48</sup>Government of Ireland, *One world, one future*.

initiatives. The corollary of this argument is twofold. First, an enhanced coordination between ‘hard’ and ‘soft’ power efforts (witness both the recent efforts by international armed forces in response to the West African Ebola outbreak and the Irish navy’s actions in safeguarding refugee health).<sup>49</sup> And, second, an increased responsibility for aid agencies across this expanded, and integrated, range of political, strategic and diplomatic deliverables.<sup>50</sup>

Whether in Ireland or the United States, therefore, the capacity to demonstrate to ‘aid sceptics’ that development investments can bring tangible benefit to donors neutralises arguments against funding programmes of foreign assistance. The benefits to Ireland from investing in international development therefore extend far beyond enhancing an international reputation for the advancement of global equity, altruistic humanitarianism and disinterested support for related global goals and values, towards generating tangible benefits that directly or indirectly contribute to economic growth. Such benefits include, for example, domestic dividends such as increasing the supply of international health workers, which make up a significant and increasing proportion of Ireland’s health-care work force.<sup>51</sup> Similarly, recognition of the international partnerships developed as a result of Irish Aid programmes in recent years—which have resulted in political dividends, trade gains and the creation of jobs for Irish (and non-Irish) citizens domestically and internationally—have been cited as rationales for restored or at least enhanced development funding.<sup>52</sup> If Irish Aid were to adopt an international assistance paradigm that goes beyond that of simply the *pro bono* donor, and if it did so in a manner that complied with the values and principles enshrined in the *One word one future* strategy, this would not threaten areas of programme integrity, such as the advancement of global health and development. Rather, it would likely rebuff critics of foreign assistance, and perhaps even encourage their participation in aid and development, thereby strengthening bipartisan support for Ireland’s contributions and commitments to international development.<sup>53</sup>

<sup>49</sup>Editorial, ‘National armies for global health?’, *The Lancet* 384 (1477) (25 October 2014); available at: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61923-1/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61923-1/fulltext?rss=yes) (1 March 2015); and Lorna Siggins, ‘More than 350 migrants rescued by LE “Niamh” in Mediterranean’, *Irish Times*, 24 July 2015; available at: <http://www.irishtimes.com/news/ireland/irish-news/more-than-350-migrants-rescued-by-le-niamh-in-mediterranean-1.2296442> (1 October 2015).

<sup>50</sup>Frederick M. Burkle, Jr, ‘Throwing the baby out with the bathwater: can the military’s role in global health crises be redeemed?’, *Prehospital and Disaster Medicine* 28 (3) (2013), 1–3; available at: <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8921591> (30 September 2015).

<sup>51</sup>Emma Quinn, *Managed migration and the labour market—the health sector in Ireland* (Dublin, 20016), report for the European Migration Network, research supported by the European Commission Directorate-General Justice, Freedom and Security and the Department of Justice, Equality and Law Reform Ireland; available at: [http://www.emn.ie/files/p\\_20100715122609manges%20Migration%20and%20the%20Labour%20market\\_the%20health%20sector%20in%20Ireland.pdf](http://www.emn.ie/files/p_20100715122609manges%20Migration%20and%20the%20Labour%20market_the%20health%20sector%20in%20Ireland.pdf) (7 October 2015).

<sup>52</sup>Jessica O’Dowd, ‘A need for reciprocal partnerships, not aid’, Irish Forum for Global Health Conference 2014, ‘Partnerships Panorama’, available at: <http://globalhealth.ie/a-need-for-reciprocal-partnerships-not-aid/> (7 October 2015); Department of Public Expenditure and Reform, *Comprehensive expenditure report 2015–2017* (Dublin, October 2014), available at: [www.per.gov.ie/the-comprehensive-expenditure-report-2015–2017-2/](http://www.per.gov.ie/the-comprehensive-expenditure-report-2015–2017-2/) (7 October 2015).

<sup>53</sup>See Suerie Moon and Oluwatosin Omole, ‘Development assistance for health: critiques and proposals for change’, Centre on Global Health Security Working Group Papers, Working Group on Finance, Paper 1 (London, April 2013); available at: [http://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0413\\_devassistancehealth.pdf](http://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0413_devassistancehealth.pdf) (7 October 2015).

*Twenty-first century capitalism: domestic growth through international development*

Lessons from the mutually beneficial and ‘enlightened self-interest’ approaches of organisations such as Ireland’s Electricity Supply Board (ESB)—which has, in the past, both developed infrastructure and built capacity in developing countries while simultaneously generating new markets for Irish skills and expertise through highly regarded rural electrification projects<sup>54</sup>—may provide a basis for corresponding international opportunities for Irish services and agriculture in the future. Supported by organisations such as the World Bank, ESB’s ‘commercial development’ efforts have included collaborations in emerging markets such as Vietnam and South Africa, as well as in post-conflict settings such as Kosovo, to build or rebuild essential public infrastructure services.<sup>55</sup> ‘Tied aid’ approaches to development make foreign assistance dependent on the fulfilment of unilaterally determined economic and political deliverables from recipients. On the other hand, the creation of systems by which public sector commercial initiatives and altruistic aid ideals can formally be combined—to the benefit of both Ireland and the global community—is an indispensable element of ‘21st Century Capitalism’.<sup>56</sup> Under such a paradigm no international commercial initiative can be considered acceptable, at the social, political or cultural levels, without generation of some form of associated ‘public good’ dividend. Such programmes, and the manner in which they are delivered, have or can become elements of Ireland’s international contribution to the development assistance architecture, and can benefit its reputation. Such synergies and systems could thus be a compelling (and cost-effective) way of reversing the decline in Ireland’s international standing and its development budgets in the aftermath of the aforementioned ‘Celtic Tiger’ boom and bust.<sup>57</sup> Efforts to assess, in practical terms, Ireland’s performance in this context may, in turn, generate opportunities for ‘diplomatic’ deployment of combined international commercial and development engagements, from which both DFAT and Irish Aid may draw important lessons. At the broadest possible conceptual level, the explicit ‘diplomatising’ of both national and commercial development programmes can thereby provide benefits, not just to individual donors, but also for efforts to achieve international growth and stability and global cooperation.

*Looking beyond cost-effectiveness in international development resource allocation decisions*

The success and value of international development programmes has always been judged on direct programmatic performance in the achievement of ‘indicator targets’ in terms of outputs, impact and outcomes.<sup>58</sup> Increasingly,

<sup>54</sup>*Dáil Éireann Debates*, ‘Written answers—overseas development aid’, Wednesday, 27 January 1999; available at: <http://debates.oireachtas.ie/dail/1999/01/27/00135.asp> (7 October 2015).

<sup>55</sup>Electricity Supply Board International, *Engineering and consultancy around the world* (Dublin, 2014); available at: [http://www.esb.ie/img/esbi\\_corporate\\_profile.pdf](http://www.esb.ie/img/esbi_corporate_profile.pdf) (7 October 2015).

<sup>56</sup>David Audretsch and Roy Thurik, ‘Capitalism and democracy in the 21st century: from the managed to the entrepreneurial economy’, *Journal of Evolutionary Economics* 10 (2000), 17–34; available at: <http://people.few.eur.nl/thurik/Research/Articles/Capitalism%20and%20democracy%20in%20the%2021st%20century,%20from%20the%20managed%20to%20the%20entrepreneurial%20economy.pdf> (7 October 2015).

<sup>57</sup>Irish Forum for Global Health, ‘Aid funding for health’.

<sup>58</sup>The Global Fund, ‘Guidelines for completing the PR “ongoing progress update and disbursement request” and LFA “ongoing progress review and disbursement recommendation”’, March 2014; available at: [http://www.theglobalfund.org/documents/core/guidelines/Core\\_PUDR\\_Guidelines\\_en/](http://www.theglobalfund.org/documents/core/guidelines/Core_PUDR_Guidelines_en/) (7 October 2015).

however, success is also judged on their social, cultural and ethical acceptability, and on the downstream economic, political and social advancement the programmes may catalyse.<sup>59</sup> Compelling contemporary examples of the need to find the balance between these criteria are found in debates around the provision of cost-effective, but potentially culturally, religiously or politically sensitive interventions related to HIV/AIDS in developing countries. To what extent should the most economically-efficient programmes be selected at the cost of recipient country ‘social norms’? Conversely, to what extent should (potentially harmful) recipient beliefs and traditions be challenged in the pursuit of optimal health outcomes?<sup>60</sup> In the same way, innovative approaches to development programme design, selection and review raise demanding questions about supporting initiatives that may conflict with diplomatic principles; conversely, the use of global health approaches that are sensitised to these principles—even if less cost-effective—becomes more attractive when viewed through the diplomatic lens.<sup>61</sup> Such circumstances might include the support for HIV/AIDS treatment programmes—and associated international organisations such as the Global Fund—during times of fiscal austerity, in a manner that ensures that the long-term transfer of responsibility for such initiatives to in-country actors is achieved in a gradual, humane and sustainable manner.

The question for smaller donors, such as Irish Aid, is to consider if and how its *pro bono* aid programmes can, either explicitly or implicitly, contribute to broader, high-level and overarching goals such as ‘world peace’ without compromising their primary goals, or whether such high-level goals should such be left to larger donors such as the United States and the United Kingdom to pursue? Given Ireland’s long track-record in support of United Nations peace-keeping efforts, for example, such high-level goals can hardly be considered ‘foreign territory’, and working towards them would, in fact, represent a strengthening of connectedness between goals that are already pursued by DFAT through currently disparate and disconnected strategies. Moreover, Ireland’s history of leadership to and empathy for developing countries in the post-colonial era is well recognised among priority partners in Africa. Only through the integration of such broader considerations into debates on Irish Aid’s role and purview can these combined diplomatic and development goals be addressed meaningfully, and synergies identified.

### *Mitigating ethical dilemmas related to ‘diplomatic development’*

If recipient gains and traditional development targets are not the sole (or even the primary) goal of assistance programmes, it has been suggested that such

<sup>59</sup>Sebastian Kevany *et al.*, ‘Health diplomacy and the adaptation of global health interventions to local needs in sub-Saharan Africa and Thailand’, *BioMed Central Public Health* 12 (2012), 459; available at: <http://www.biomedcentral.com/1471-2458/12/459/abstract> (30 September 2015). Jeff Sheehy, ‘Progress against HIV thwarted by patients’ unmet needs: UCSF study shows poverty undercuts otherwise major gains in HIV treatment’, news release, 26 April 2012, available at: <http://www.ucsf.edu/news/2012/04/11949/progress-against-hiv-thwarted-patients-unmet-needs> (30 September 2015).

<sup>60</sup>Gertrude Khumalo-Sakutukwa *et al.*, ‘Project Accept (HPTN 043): a community-based intervention to reduce HIV incidence in populations at risk for HIV in sub-Saharan Africa and Thailand’, *Journal of Acquired Immune Deficiency Syndromes* 49 (4) (2008), 422–31.

<sup>61</sup>Royal Institute for International Affairs, ‘Global health diplomacy: a way forward in international affairs’, Chatham House meeting summary document (28–9 June 2011); available at: <http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/280611summary.pdf> (7 October 2015).



programmes will be corrupted through the loss of ‘pure altruism’.<sup>62</sup> However, a number of examples suggest that both recipients and donors benefit equally from the diplomatic and foreign policy ‘sensitisation’ of global health programmes.<sup>63</sup> In other words, from the adaptation and refinement of such programmes to support parallel development and international relations objectives. First, as noted above, if Irish Aid’s resource allocation decisions are made on purely utilitarian grounds, there would be no place for the support of more complex and nuanced ‘multi-level’ or ‘combination’ interventions.<sup>64</sup> The prioritisation of such utilitarianism in the policy realm in the past has been critiqued for overlooking the broader humanitarian benefits, to both donor and recipient countries, of, for example, the treatment of HIV/AIDS patients. Such benefits lie outside conventional, and narrow, performance metrics such as quality-adjusted life-years (QALYs).<sup>65</sup> Second, and equally importantly, the ‘diplomatisation’ of international development programmes can have positive effects *and* be ethically defensible: in Ireland, as elsewhere, evidence of achieving collateral domestic goals through international assistance programmes can help attract support from a broader range of stakeholders across the political, public and economic fields.<sup>66</sup> Doing so, as noted above, helps to widen support beyond those who see altruism and equity as the primary rationale for aid programmes, thereby enlisting essential domestic support from those who are not sympathetic to equity or altruistic rationales but who remain open to arguments around synergies, mutualities and ‘enlightened self-interest’ as justification for maintenance of development budgets.

#### *Case study: diplomacy and development in Kenya*

Kenya is an appropriate setting for the integration of development and diplomacy under the aegis of Irish Aid, in that Ireland, despite comparatively low-level trade links by European Union standards, has long-standing links with the country and has recently strengthened its diplomatic presence through the appointment of an ambassador.<sup>67</sup> In a country where political stability is increasingly under threat, and in which the national government faces both internal and regional security pressures, an enhanced role for donor diplomacy in the development context is of immediate importance.<sup>68</sup> In this regard, there is a

<sup>62</sup>James Andreoni, ‘Impure altruism and donations to public goods’, *Economic Journal* 100 (461): 466–77; available at: <http://econweb.ucsd.edu/~jandreoni/Publications/ej90.pdf> (7 October 2015).

<sup>63</sup>Ronald Labonte and Michell Gagnon, ‘Framing health and foreign policy: lessons for global health diplomacy’, *Globalization and Health* 6 (August 2010), 65–76; available at: <http://www.globalizationandhealth.com/content/6/1/14> (7 October 2015).

<sup>64</sup>Elliott Marseille and James Kahn, ‘HIV prevention before HAART in sub-Saharan Africa’, *The Lancet* 359 (9320) (2002), 1851–6; available at: [www.ncbi.nlm.nih.gov/pubmed/12044394](http://www.ncbi.nlm.nih.gov/pubmed/12044394) (1 October 2015); Thomas Coates, ‘Effect of community-based voluntary counselling and testing on HIV incidence and social and behavioural outcomes (NIMH Project Accept; HPTN 043): a cluster-randomised trial’, *The Lancet Global Health* 2 (5) (May 2014), e267–e277.

<sup>65</sup>Peter Piot, ‘HIV/AIDS prevention and treatment’, *The Lancet* 360 (9326) (6 July 2002), 86 (correspondence); available at: [www.ncbi.nlm.nih.gov/pubmed/12114063](http://www.ncbi.nlm.nih.gov/pubmed/12114063) (7 October 2015).

<sup>66</sup>American Foundation for AIDS Research, ‘U.S. global health investments: the evidence on health, diplomatic and economic impact’, Issue Brief (2011).

<sup>67</sup>Department of Foreign Affairs and Trade, ‘Diplomatic and consular information for Kenya’, available at: <https://www.dfa.ie/embassies/irish-embassies-abroad/sub-saharan-africa/kenya/> (2 May 2015).

<sup>68</sup>Francis Mwega, *A case study of aid effectiveness in Kenya: volatility and fragmentation of foreign aid, with a focus on health*, Wolfensohn Center for Development, Working paper 8 (Brookings Institution, 2009); available at: [http://www.brookings.edu/~media/research/files/papers/2009/1/kenya%20aid%20mwega/01\\_kenya\\_aid\\_mwega.pdf](http://www.brookings.edu/~media/research/files/papers/2009/1/kenya%20aid%20mwega/01_kenya_aid_mwega.pdf) (7 October 2009).

need to ensure that Irish Aid programmes in Kenya are culturally, religiously and socially inclusive, given the country's contentious ethnic, social and religious rifts. Further, there is a two-fold need to consider the political and security implications of Ireland's aid programmes in Kenya, given the need to both ensure the safety and security of field-workers and Irish citizens and to play a 'higher-level role' through working with Kenyan government and other partners to advance internal and regional stability.<sup>69</sup> The integration of development and diplomatic goals, strategies and activities is essential in such environments, and may be facilitated by the current Irish ambassador to Kenya, Dr Vincent O'Neill, coming from a global health and development background.<sup>70</sup> This suggests the possibility of an increasingly integrated, interdisciplinary and collaborative future in Kenya for both Irish Aid and DFAT, in collaboration with United Nations organisations (for which the country is increasingly regarded as a regional 'hub')—and, of course, with the government of Kenya itself. Such a 'brave new world' would be one in which global health and development programmes are employed, in parallel, as tools for international relations, diplomacy and humanitarianism. This would represent a benign alternative to many of the myriad other manifestations of foreign policy, or the equally perilous consequences of inaction, and could be a precursor to a century in which the boundary between foreign assistance and diplomacy is increasingly blurred.<sup>71</sup>

#### NEXT STEPS: RECOMMENDATIONS AND APPLICATION

##### *Optimising diplomatic and foreign policy benefits: who, what and where?*

Those aspects of Irish Aid's global health and development programmes that are compatible with, and may help to advance, Ireland's diplomatic 'enlightened self-interest' on the world stage are, at present, in a nascent form; the explicit consideration, measurement and assessment of associated diplomatic threats and benefits is needed.<sup>72</sup> While it is possible that Ireland's current *ad-hoc* and implicit system of combining diplomacy and development may be maximising gains in both spheres, the application of a formal and transparent structure by which such programmes may be designed, delivered and reviewed from the diplomatic and foreign policy perspectives will help to ensure that both Irish and aid-recipient-country interests are optimised. For example, the current distribution of resources across Irish Aid programmes by geographical region (the *where*), recipient population (the *who*), and intervention type (the *what*) may be reviewed, using specialist tools,<sup>73</sup> to inform resource allocation decisions and generate recommendations related to the optimisation of diplomatic and foreign policy goals. This may also result in greater clarity in regard to which regions, countries and population groups in Irish Aid's main partner countries

<sup>69</sup>Fallon and Gayle, *A healthier, safer and more prosperous world*, Final report of the CSIS Commission.

<sup>70</sup>Public Affairs Ireland, 'New ambassadors and consul-generals announced', news release, 7 May 2014, available at: <http://www.publicaffairsireland.com/news/1601-new-ambassadors-and-consul-generals-announced> (1 October 2015).

<sup>71</sup>Rebecca Katz *et al.*, 'Defining health diplomacy: changing demands in the era of globalization', *Milbank Quarterly* 89 (3) (September 2011), 503–23; available at: <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00637.x/abstract> (1 October 2015).

<sup>72</sup>Eugene V. Bonventre, 'Monitoring and evaluation of Department of Defence humanitarian assistance programs', *Military Review* 88 (1) (January–February 2008), 66–72.

<sup>73</sup>Sebastian Kevany, 'Diplomatic advantages and threats in global health program selection, design, delivery and implementation: the development and application of the "Kevany Riposte"', *Globalization and Health*, forthcoming, 2015.

require enhanced diplomatic activity and responsiveness from Ireland in order to advance strategic, economic, political or international relations objectives.

*Other considerations: the 'how' and the 'when'*

The explicit consideration, and even quantification, of diplomatic and development challenges and opportunities would represent an important initial step towards both optimising Ireland's latent diplomatic and foreign policy impact, and guaranteeing returns on investment to the Irish taxpayer—be it in pursuit of development goals or mutual economic and political benefits for the donor and recipient country—in a more explicit, effective and structured manner. Ensuring that Irish Aid's programmes are not only cost-effective, but also culturally, religiously and socially adaptable and acceptable, and revising resource allocations according to these criteria, could advance both the diplomatic *and* global social, economic and health equity or altruistic outcomes of Irish Aid's work (the *how*). Other considerations include, for example, the international health security implications of outbreaks of epidemics such as Ebola, and other 'health emergencies', whereby health threats in impoverished countries are, as a result of revolutions in global mobility, transport and communications, increasingly regarded as threats to the health of developed nations also.<sup>74</sup> Such unexpected global 'events' demand timely and rapid responses from countries such as Ireland (the *when*).

Finally, such a review would include considerations of international prestige; programme effectiveness; Irish Aid's unmeasured contributions to the resolution of civil and international conflict; improved international relations; and the promulgation of international trade partnerships as a result of better global health, food security and poverty alleviation. Contemporary models for such joint political and development initiatives as the 'First 1,000 days' campaign—under the joint stewardship of former United States secretary of state Hillary Clinton and the WHO, which has been championed by Irish Aid on the world stage—encompass both sectoral and broader development goals.<sup>75</sup>

*Interdisciplinary training models: educational exchanges*

Joint diplomatic and development initiatives require that diplomats and development professionals are equipped with interchangeable skills that befit their increasingly overlapping responsibilities.<sup>76</sup> This is an area where formal training may be required for the advancement of a new form of interdisciplinary *metier*. In the United States, for example, such capacity building is focused on the provision of short courses—covering two to three days on an annual or twice-annual basis—to both diplomats and global health professionals, designed to bring together personnel from diplomatic and development backgrounds before deployment. These courses encompass the development of skills covering not only epidemiology, outcome and impact evaluation, but also strategic analyses related to the goals of their missions, based on the synthesis of information from organisations such as the WHO, the Global Fund and the World Bank. In turn, these efforts provide an overview of the

<sup>74</sup>Harley Feldbaum, Kelley Lee and Joshua Michaud, 'Global health and foreign policy', *Epidemiological Reviews* 32 (1) (2010), 82–92.

<sup>75</sup>Lawrence Haddad, 'The first 1000 days: Hillary Clinton on undernutrition', speech to Development Horizons, 11 May 2010; available at: <http://www.developmenthorizons.com/2010/05/first-1000-days-hilary-clinton-on.html> (1 October 2015).

<sup>76</sup>Katz *et al.*, 'Defining health diplomacy'.

health situation in-country; of what the United States government is doing there (and, thereby, what the ambassador is now responsible for); and of opportunities for the ambassador to engage with key actors (such as finance and health ministries) at the beginning of his or her tenure. Representatives from organisations such as Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the United States Agency for International Development (USAID), and the President's Emergency Plan for AIDS Relief (PEPFAR) attend the briefings, as, occasionally, do representatives from the Department of Defence and the Peace Corps, depending on the country to which the diplomats and development professionals are being dispatched.<sup>77</sup>

European models for such capacity building include those of the Graduate Institute in Geneva and nascent efforts at the Trinity College Dublin Centre for Global Health.<sup>78</sup> Such induction and training processes also help to develop skills for understanding and engaging in high-level political negotiations on critical international political and strategic issues (at, for example, the ambassadorial level), which can then be conducted in the context of an awareness of a recipient country's and its regions' historical, political and cultural contexts and development needs.<sup>79</sup> This inculcation of an enhanced understanding of Ireland's (and the broader global community's) international political, trade and economic interests within the general experience of international development professionals would closely mirror 'education and training exchange' systems already underway elsewhere. Through the dual strengthening of its development aid and diplomatic corps programmes on this basis, Ireland has an opportunity to take a well-earned place at the vanguard of the 'global health diplomacy' movement.

### *The role of academic institutions and expertise*

Building Irish Aid's, and the broader DFAT's, capacity for bridging development and diplomacy skills will require the development of appropriate domestic training and advisory expertise—encompassing not just issues of global health, but also health policy and international relations. For example, in the United States, global health diplomacy specialists provide training and advisory services at third- and fourth-level educational institutions. Such specialists are also utilised by federal and government agencies to provide strategic guidance and advice (1) to diplomatic and development personnel, as described above; (2) on the development of political application of systems to optimise dual impact; and (3) to ensure that diplomatic representatives (including US ambassadors overseas) are closely informed about health and other development (and development aid) issues.<sup>80</sup> Acquiring such capacities, in turn can help

<sup>77</sup>United States Office of Global Health Diplomacy, Training and educational programs of the United States Office of Global Health Diplomacy, Personal communication, 2014.

<sup>78</sup>See Ilona Kickbusch, 'Executive course in global health diplomacy', Graduate Institute of Geneva course prospectus (2014); available at: [http://graduateinstitute.ch/files/live/sites/iheid/files/shared/executive\\_education/global-health-diplomacy/Course%20flyer\\_GHD.pdf](http://graduateinstitute.ch/files/live/sites/iheid/files/shared/executive_education/global-health-diplomacy/Course%20flyer_GHD.pdf) (1 October 2015); and Trinity College Dublin, Centre for Global Health, 'About the centre for global health', documentation available at: <https://global-health.tcd.ie/> (1 October 2015).

<sup>79</sup>Sebastian Kevany *et al.*, 'Health diplomacy and the adaptation of global health interventions to local needs'.

<sup>80</sup>Ilona Kickbusch, 'Global health diplomacy: the need for new perspectives, strategic approaches and skills in global health', *Bulletin of the World Health Organization* 85 (3) (March 2007), 230–2; available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636243/> (7 October 2015).

to inform broader international negotiations on development and trade issues. Such efforts would be closely aligned with Irish Aid's commitments to furthering both domestic development education and broader public awareness of development issues and achievements.<sup>81</sup> Such expertise also has significant potential to be employed in the operational context, beyond an academic or theoretical role; global health diplomacy initiatives, in the future, are anticipated to require the application of such skills at the field level. Core competencies might include skill sets such as the 'diplomatic' monitoring and evaluation of global health programmes; designing adaptable global health interventions; enhancing recipient country global health diplomacy capacity through the 'country ownership' paradigm; capacity building in 'barefoot diplomacy' for non-diplomats and for more formal diplomatic capacity within Irish Aid; recognising strategic opportunities for global health to advance international cooperation and trade; and an enhanced understanding of the trade-offs between ethics and economics in global health resource allocation decisions.

Such innovative roles for 'development diplomacy specialists' will also embrace a capacity to contribute, at the highest political levels, to discussions on ways in which Irish Aid programmes may respond to both short- and long-term diplomatic, strategic, political and economic imperatives. This is reflected, in the United States, by the presence of 'global health diplomacy' representatives on the National Security Council.<sup>82</sup> A stated long-term goal of Ireland's *One world, one future* strategy is to create an exit strategy from aid dependence; this closely mirrors the Office of Global Health Diplomacy's 'country ownership' initiatives, under which responsibility and funding for global health programmes is transferred, according to diplomatic principles, to in-country stakeholders.<sup>83</sup> In the context of the European Union, the harmonisation of Irish Aid's approaches with 'smart power' strategies explicitly employed as part of the CFSP represents another way in which more 'applied' and political interdisciplinary roles may be required, should Ireland contribute in this regard at the supra-national level through initiatives such as the European Union's Intelligence Analysis Centre (EU-INTCEN).<sup>84</sup> Finally, the need to ensure that Irish Aid may be in a position to learn from, contribute to and collaborate with the combined development and diplomacy initiatives of countries such as the United States and the United Kingdom represents yet another way in which such political, development and academic roles will inevitably overlap.

## CONCLUSIONS

### *Lessons to others, lessons from abroad*

Under the theme of 'coherence', *One world, one future* notes that 'development policies can best be achieved when government policies and actions complement each other'.<sup>85</sup> Countries such as the United States and the United Kingdom

<sup>81</sup>Government of Ireland, *One world, one future*.

<sup>82</sup>Harley Feldbaum, *U.S. global health and national security policy*, Center for Strategic and International Studies Report (Washington, DC, 2009); the text of the report is available online, at: [http://csis.org/files/media/isis/pubs/090420\\_feldbaum\\_usglobalhealth.pdf](http://csis.org/files/media/isis/pubs/090420_feldbaum_usglobalhealth.pdf) (7 October 2015).

<sup>83</sup>Kerry, 'Remarks at a global health event with partner countries'.

<sup>84</sup>Rehn, 'Europe's smart power in its region and the world'; Europa, 'Factsheet on EU Intelligence Analyses Center (INTCEN)', February 2015, available at: [http://eu-un.europa.eu/articles/en/article\\_16050\\_en.htm](http://eu-un.europa.eu/articles/en/article_16050_en.htm) (1 October 2015).

<sup>85</sup>Government of Ireland, *One world, one future*, 28.

may learn from Irish Aid's 'low-risk', culturally, socially and politically sensitive development programmes, which have traditionally been highly responsive both to recipient country needs and preferences and to international best practices. In the same way, Irish Aid can learn from how larger donors make resource allocation decisions—taking into account not only altruistic perspectives, such as the advancement of health and the development equity, but also the diplomatic, economic and other consequences for the donor country. The ability to analyse aid decisions according to these criteria does not require that the interests of recipient countries become subsumed to those of the donor country; nor does it result in the introduction of 'tied aid', which Irish Aid has, for so long, successfully avoided. It does, however, result in a better analysis of the development partner and of the diplomacy environments in those countries in which Irish Aid works.

Making optimal use of the opportunities and synergies that stem from coherent diplomacy and development approaches requires that both Irish Aid and the broader Department of Foreign Affairs and Trade monitor how they perform against a broader set of judgement criteria. Such an approach has the potential to produce significant collateral diplomatic, economic and political benefits for Ireland. It may also enhance the case for continuing to provide global health and development funding by presenting the broadest possible range of direct, indirect, downstream, collateral and hidden investment outcomes. In this way, Ireland will be in a position to take the lead—along with other forward-thinking countries—in pioneering the 'diplomatic development' programmes of the twenty-first century.<sup>86</sup> In the manner of the World Health Organization's landmark 'Health as a bridge for peace' initiative, the pursuit of combined diplomatic and development goals is one which, as American president John F. Kennedy noted 50 years ago, no nation can afford to ignore, and from which all stand to benefit.<sup>87</sup>

<sup>86</sup>Thomas Novotny and Sebastian Kevany, 'The way forward in global health diplomacy: definitions, research, and training', in T. Novotny, I. Kickbusch and M. Told (eds), *Twenty-first century health diplomacy*, 203–25 (Geneva, 2013).

<sup>87</sup>John FitzGerald Kennedy, 'Address to the United Nations Security Council', 1963; available at: <http://www.jfklibrary.org/Research/Research-Aids/Ready-Reference/JFK-Quotations.aspx> (10 May 2015).

RESEARCH ARTICLE

# Global Health Diplomacy, Monitoring & Evaluation, and the Importance of Quality Assurance & Control: Findings from NIMH Project Accept (HPTN 043): A Phase III Randomized Controlled Trial of Community Mobilization, Mobile Testing, Same-Day Results, and Post-Test Support for HIV in Sub-Saharan Africa and Thailand



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## Abstract

### Background

Provision and scale-up of high quality, evidence-based services is essential for successful international HIV prevention interventions in order to generate and maintain intervention uptake, study integrity and participant trust, from both health service delivery and diplomatic perspectives.

### Methods

We developed quality assurance (QAC) procedures to evaluate staff fidelity to a cluster-randomized trial of the NIMH Project Accept (HPTN 043) assessing the effectiveness of a community-based voluntary counseling and testing strategy. The intervention was comprised of three components—Mobile Voluntary Counseling and Testing (MVCT), Community Mobilization (CM) and Post-Test Support Services (PTSS). QAC procedures were based on standardized criteria, and were designed to assess both provider skills and adherence to the intervention protocol. Supervisors observed a random sample of 5% to 10% of sessions each month and evaluated staff against multiple criteria on scales of 1–5. A score of 5 indicated 100% adherence, 4 indicated 95% adherence, and 3 indicated 90% adherence. Scores below 3 were considered unsatisfactory, and protocol deviations were discussed with the respective staff.

U01MH066702 (University of California, San Francisco). In addition, this work was supported by the HIV Prevention Trials Network (HPTN Protocol 043) of the Division of AIDS of the U.S. National Institute of Allergy and Infectious Diseases, and by the Office of AIDS Research of the U.S. National Institutes of Health.

**Competing Interests:** The authors have declared that no competing interests exist.

## Results

During the first year of the intervention, the mean scores of MVCT and CM staff across the 5 study sites were 4 (95% adherence) or greater and continued to improve over time. Mean QAC scores for the PTSS component were lower and displayed greater fluctuations. Challenges to PTSS staff were identified as coping with the wide range of activities in the PTSS component and the novelty of the PTSS process. QAC fluctuations for PTSS were also associated with new staff hires or changes in staff responsibilities. Through constant staff monitoring and support, by Year 2, QAC scores for PTSS activities had reached those of MVCT and CM.

## Conclusions

The implementation of a large-scale, evidence based HIV intervention requires extensive QAC to ensure implementation effectiveness. Ongoing appraisal of study staff across sites ensures consistent and high quality delivery of all intervention components, in keeping with the goals of the study protocol, while also providing a forum for corrective feedback, additional supervision and retraining of staff. QAC ensures staff fidelity to study procedures and is critical to the successful delivery of multi-site HIV prevention interventions, as well as the delivery of services scaled up in programmatic situations.

## Background

The heightened profile of global health efforts in the international relations and political spheres in turn requires enhanced efforts to ensure that programs are delivered in the most adaptable, appropriate and diplomatic manner. In this context, there remains no more severe global health crisis in the world today than the HIV epidemic in sub-Saharan Africa. There are approximately 25 million people living with HIV in sub-Saharan Africa, with 1.6 million new infections occurring in 2012 alone.<sup>[1]</sup> In addition to the global death and disease burden, the epidemic has had an enormous impact on economies and life expectancies, and left a legacy of millions of orphans. Structural factors, such as economic, social, legal and cultural conditions also contribute to increased risk for HIV infection in sub-Saharan Africa.<sup>[1]</sup>

In response, with associated reference to concentrated HIV epidemics in countries such as Thailand, the global health community has mobilized unprecedented levels of resources in a concerted attempt to turn the tide of the epidemic.<sup>[1]</sup> This has elevated the role of global health to the realm of 'high politics, in which both diplomatic and health outcomes of interventions must be considered,<sup>[2]</sup> leading to the development of diplomatic perspectives on global health interventions, such as the ability of staff and programs to pursue international relations goals. In this context, the provision of Voluntary HIV Counseling and Testing (VCT) services, as part of the comprehensive approach to HIV prevention, has been established as a key response to the epidemic.<sup>[3]</sup> Such HIV testing is linked with clinical and community interventions, improved referrals to care, treatment, prevention, and post-test support services.

## Project Accept

Project Accept (HPTN 043) a cluster-randomized trial of community mobilization, mobile testing, same-day results, and post-test support for HIV was conducted in Sub-Saharan Africa and Thailand. The intervention, described in detail elsewhere<sup>[4]</sup> focused on the 'scaling-up' of



evidence based HIV treatment and prevention strategies on an unprecedentedly large scale, covering four countries with severe generalized or concentrated HIV epidemics. Briefly, 34 communities in Africa (in South Africa, Tanzania, and Zimbabwe) and 14 communities in Thailand were randomized to receive either a community-based voluntary HIV counseling and testing (CBVCT) intervention in addition to standard clinic-based VCT (SVCT) services, or SVCT services alone.

The CBVCT intervention had three major strategies: (1) To make VCT more available in community settings via mobile voluntary counseling and testing (VCT); (2) to engage the community through outreach via community mobilization (CM); and (3) to provide post-test support services (PTSS), irrespective of the participants' HIV status. For mobile VCT, mobile units providing HIV testing were available at a range of venues throughout intervention communities for the duration of the three-year intervention period. For CM and PTSS, specific aims were to (1) create awareness about and open dialogue around HIV/AIDS in communities, (2) enhance the communities' understanding of, participation in, and enthusiasm for MVCT, (3) foster understanding and acceptance of HIV positive members of the community (stigma reduction), and (4) promote HIV risk reduction among all community members. The intervention is designed to be evidence-based, cost-effective, and feasible for rapid scale up in resource-poor settings.<sup>[4, 5]</sup>

These strategies were designed to change community norms and reduce risk for HIV infection among all community members, irrespective of whether they participated directly in the intervention. In addition, given the broad range of cultural geographical, religious and social context in which these interventions were designed and delivered, these strategies were designed with close attention to diplomatic considerations, including the maintenance of appropriate standards of behavior and service delivery standards by project staff. The intervention lasted for three years in each site.

## A Multilevel Prevention Intervention

Project Accept is characterized as a multicomponent, multilevel prevention intervention. The multilevel prevention framework has roots in the "ecological model," understanding the individual as embedded in societal, community, familial, and peer contexts and posits that behavior is shaped by economic, political, and social structures; sociocultural contexts; and social relationships in which people negotiate behaviors. As a result, multilevel interventions aim to address the multiple structural or sociocultural factors that influence an individual; these include interpersonal processes, community factors, and institutional factors. In addition, given the broad range of cultural geographical, religious and social context in which these interventions were designed and delivered, these strategies were designed with close attention to diplomatic considerations, which included maintenance of partnerships with stakeholders at all levels within the community, administrative, and political structures, thereby facilitating scale-up across diverse settings and broader geographical areas. The intervention also ensured appropriate standards of behavior and high quality of service delivery by project staff. All participants in the PTSS and MVCT arms of the study provided written consent. Due to the community-based nature of the CM component, community-based acceptance was attained in advance of related activities by relevant social and political leaders.

## Quality Assurance for HIV Prevention Interventions

Provision of high quality, diplomatically-sensitive services is essential for successful HIV prevention interventions. The development of efficient and effective procedures designed to monitor the quality of service delivery is therefore central to study planning and implementation.

The treatment integrity of psychotherapy interventions, which describes the degree to which an intervention is delivered as intended, was found to be adequately addressed in only 3.5% of evaluated interventions, though no related work has been undertaken for HIV/AIDS interventions specifically.[6] A number of recommendations have been provided in the literature on the implementation of treatment integrity procedures.[7–11]

Quality Assurance (QAC) is defined as the steps taken in advance to increase the quality and consistency with which an intervention is conducted.[12] Quality Control (QC) consists of activities conducted when the intervention is in the field in order to quickly identify and correct deviations from protocol as well as identify, according to standard operating procedures, sub-optimal performance (e.g. errors in staff judgment; non-adherence to study process; participant problems) Both QAC and QC procedures (hereafter referred to as ‘QAC’) are designed to maintain the integrity of the components by assessing adherence and assisting staff in meeting these goals, and are essential components in ensuring maintenance of quality control for “scaled-up” evidence-based interventions. Perhaps most importantly, the most essential overarching goal of the QAC process, besides maintaining study integrity, is to generate and maintain intervention uptake, and participant trust.[13] In this paper, we describe the methodology, results and effects of QAC monitoring throughout three years of Project Accept activities in intervention communities.

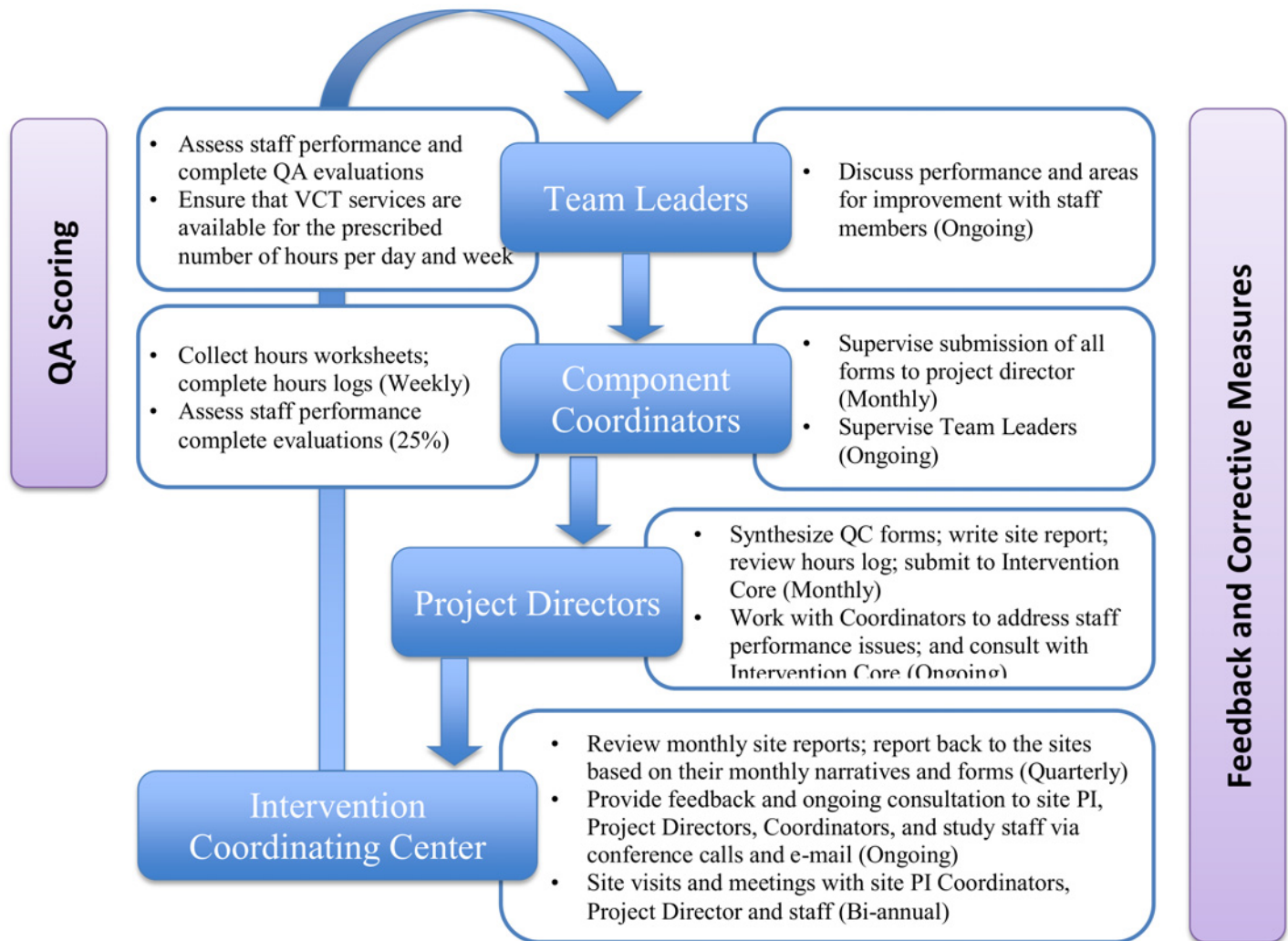
## Methods

### Ethics Statement

This research was approved by the U.S. National Institute of Mental Health as a cooperative agreement, through contracts U01MH066687 (Johns Hopkins University), U01MH066688 (Medical University of South Carolina), U01MH066701 (University of California, Los Angeles), and U01MH066702 (University of California, San Francisco). In addition, this work was supported by the HIV Prevention Trials Network (HPTN Protocol 043) of the Division of AIDS of the U.S. National Institute of Allergy and Infectious Diseases, and by the Office of AIDS Research of the U.S. National Institutes of Health. Institutional review board (IRB) approval was obtained from all US and international sites, including UCSF's Committee on Human Research and all other relevant ethics committees. All participants in the post-test support services (PTSS) and mobile voluntary counseling and testing (MVCT) arms of the study provided written consent. Due to the community-based nature of the community mobilization (CM) component, community-based acceptance was attained in advance of related activities by relevant social and political leaders.

The QAC reporting system and responsibilities are outlined in [Fig 1](#) (Quality Assurance & Control Reporting System and Responsibilities). In order to ensure that QAC criteria were applied consistently across sites, a comprehensive, centralized 8- day Training of Trainers (TOT) meeting was conducted for project managers and component coordinators at the outset of the intervention. The TOT included discussion of the theoretical underpinnings of the intervention, a detailed review of QAC procedures, review of the rating criteria and operational definitions, and practice QAC sessions and discussion. In addition, all relevant study staff were provided with extensive training on the importance of adapting the Project Accept intervention to local conditions, with appropriate awareness of local cultural, religious and social norms. All study staff (counselors, research nurses, outreach workers and team leaders) were subsequently trained by study coordinators at their respective study sites. All study staff were also trained in “Good Clinical Practice” (GCP), provided by the HIV Prevention Trials Network (HPTN).

Study coordinators were required to hold at least a master's degree in social sciences as well as supervision experience. All other study staff (counselors, research nurses and outreach



**Fig 1. Quality Assurance & Control Reporting System and Responsibilities.**

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workers) were required to have a minimum of a diploma in their professional area of expertise. In addition, they received Project Accept training in HIV counseling (study counselors); HIV counseling and testing and Rapid testing (research nurses); HIV counseling and group facilitation (PTSS staff); and community outreach and education techniques (CM outreach workers). Team leaders appointed for each of the study components received additional training in basic management, supervision and support skills. For each study component, training was standardized across sites using training manuals developed by Project Accept [<http://hivinsite.org/accept>]. [14] Efforts were made to ensure the trainings provided matched expected in-country and international standards and guidelines. From a diplomatic perspective, individuals who proved their ability to establish rapport, demonstrate good listening skills, and be supportive, respectful, and nonjudgmental, as well as demonstrating proficiency in basic counseling skills (active listening, reflection, and information gathering), and the basic facts of HIV transmission, were chosen as counselors. New staff were selected and trained by the site project director or a designated senior staff trainer. These procedures helped to ensure that identical procedures and content were delivered across study sites.

QAC roles and responsibilities at the site level are presented in [Fig 1](#). Consistent with recommendations for QAC review of behavioral and psychological interventions (Waltz et al, 1993), ratings were made for both (1) adherence to protocol and (2) competence at conducting the intervention. Standard operating procedures (SOP) manuals detailed QAC procedures for each intervention component and outlined step-by-step implementation procedures including goals, materials required, and timelines. Team leaders and coordinators monitored staff performance in the VCT, PTSS, and CM intervention components via (1) weekly supervision of field staff by team leaders and (2) independent review and rating of VCT, CM and PTSS sessions. Team leaders observed sessions conducted with participants in the field, and rated their fidelity to the protocol on multiple essential components using QAC evaluation forms scored with a 5-point scale. Supervisors observed a random sample of 5% to 10% of sessions each month and evaluated staff against multiple criteria on scales of 1–5. A score of 5 indicated 100% adherence, 4 indicated 95% adherence, and 3 indicated 90% adherence. Scores below 3 were considered unsatisfactory, and protocol deviations were discussed with the respective staff. Component coordinators were asked to evaluate at least 25% of sessions at their discretion to ensure both (1) inter-rater reliability and (2) that QAC activities were both timely and accurate.

### Reliability & Validity of QAC Measures

For project-specific QAC measures to be effectively interpreted and generalized, it is essential that reliability and validity of related scales be considered. In the case of Project Accept, measurement of key constructs (e.g. PTSS protocol adherence) was validated during QAC tool development, based on a collaborative process with both service delivery staff and the input and approval of clients [4]. For example, the use of specific scales (e.g. QAC scores of 1 to 5) was based on approvals and inputs from both QAC supervisors and project staff on the basis of comparability and user-friendliness. Of equal importance in this regard are the links between QAC scales and scores and primary intervention outcomes (e.g. number of HIV/AIDS infections averted). In order for QAC scores to be both valid and reliable in this regard, links between positive health outcomes and high QAC scores (allowing for relevant confounders) is critical. In this regard, though beyond the scope of this paper, comparison with the final outcomes and impact of the Project Accept intervention will allow for the establishment (if any) of such links.

### Sampling Strategy

Throughout the intervention, a random sample of VCT, CM and PTSS sessions were selected for QAC evaluation by team leaders. For VCT, during the first 6 months of the intervention 10% of counseling sessions were evaluated, with a minimum of 2 evaluations per counselor per month. Thereafter, 5% of sessions delivered per month were evaluated with a minimum of 1 evaluation per counselor per month. For CM, during the first six months 15% of outreach sessions were evaluated, with a minimum of 2 evaluations per CM staff member per month. Thereafter, 5% of outreach sessions were evaluated, with a minimum of 1 evaluation per CM staff member per month. For PTSS, during the first 6 months of the intervention all CET and stigma reduction sessions, 2 information sharing sessions, 20% of support sessions and 15% of crisis counseling sessions were evaluated. Thereafter, 1 CET session, 1 stigma reduction session, 4 information sharing sessions, 5% of support sessions and 5% of crisis counseling sessions were evaluated.

### Evaluating Intervention Components

For the VCT component, VCT team leaders assessed counselors' adherence and skill levels in 10 essential component areas, including (1) general counselor skills in keeping with the client-

centered, personalized risk reduction model recommended by the U.S. Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO)[15] and (2) adherence to counseling strategy. Each of these component areas were then assessed via approximately 10 required activity or skill criteria. General counselor skills included empathy, being non-judgmental, maintaining appropriate boundaries, and relaying the objectives of the VCT session. As with CM and PTSS, counseling staff were required to review component or session protocols, session checklists, and any other relevant information in advance of each session. From a diplomatic perspective, QAC procedures (1) helped to ensure that project staff completed the VCT process in a non-threatening and sensitive fashion and (2) in accordance with the expected international standards for the delivery of HIV counseling and testing.

For the CM component, CM team leaders assessed outreach workers' adherence and skill levels for 10 essential areas of community interaction and 6 areas of community referral and follow-up. These included (1) basic interaction skills, (2) provision of accurate information, and (3) referrals to further care. Interaction skills included empathy, being non-judgmental, maintaining appropriate boundaries, and maintaining session cohesion. In addition to adherence to manualized guidelines, CM activities were also rated, using the same scales, on the skill with which the staff member delivered the session. In particular, community mobilization staff were assessed on their success in adapting related activities to observe local social, cultural and religious norms,[16] thereby ensuring that the Project Accept intervention was delivered to recipient communities and individuals with appropriate attention to diplomatic considerations.

For PTSS, team leaders assessed facilitators' adherence and skill levels in individual crisis counseling, group information sessions, coping effectiveness training, and stigma reduction training (each with approximately 12 activity or skills criteria). Staff were evaluated on (1) basic support service delivery skills, (2) skills in guiding goal-setting, and (3) adherence to the PTSS curriculum. PTSS activities were evaluated and scored separately. As with CM and VCT assessment procedures, PTSS staff and service delivery was assessed with reference to acceptable standards of service delivery from the diplomatic perspective, including the provision of long-term, sustainable and effective coping strategies for patients diagnosed with HIV.

## QAC Scoring System

For each session, project staff were informed in advance of QAC assessment in advance. While this generated a risk that QAC scores would be higher when staff were aware that the specific sessions were being assessed, given staffing and spatial constraints, alternative blinded or covert assessment systems were considered unfeasible by the Intervention Core. Team leaders then recorded the relevant QAC score for each evaluation criterion on the appropriate QAC form. Evaluation criteria were thematically grouped by essential component area, and the average score for each group was recorded at the end of each section. Individual item scores within an area were averaged to create a summary score and those summary scores were again averaged for an overall QAC score. At the end of the form, a single overall score for the entire session was calculated based on an average of these scores. For each intervention component, these scores were then aggregated and averaged to generate a single QAC score for VCT, CM, and PTSS each month. At the end of each month, all QAC records for each intervention component across sites were transmitted to the intervention coordinating center via scanned, security-protected e-mail documents. These reports were accompanied by a narrative report from the site project director describing QAC activity over the reporting period. Receipt of QAC data was acknowledged, entered into a password-protected Microsoft Access database, and cross-checked through Microsoft Excel.

## Feedback and Corrective Measures

QAC performance charts across intervention components were produced for each study site by the intervention coordinating center and returned to site project directors with commentary and questions on performance on a monthly basis. Feedback reports also described emerging QAC issues across study sites in order to maintain communication and interactive learning between sites. Study sites were encouraged to use these reports as a training tool to focus attention on specific QAC issues, provide early feedback, and foster preventive measures. QAC data was also presented and examined on a monthly basis with US and site-based principal investigators via conference calls with the study steering committee.

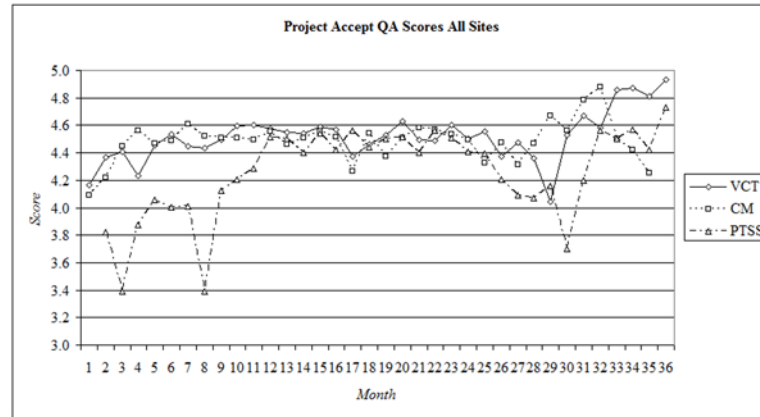
Also at the site level, feedback mechanisms included (1) weekly field staff meetings and (2) periodical written feedback to field staff by team leaders, component coordinators and project directors. QAC issues were also discussed at component-specific staff meetings, study-wide staff meetings, and in one-on-one meetings with project staff. The frequency and structure of these meetings was left to the discretion of the site team leaders and coordinators, who were judged to have the best assessment of staff needs. Team leaders and component coordinators used the QAC scores to (1) identify strengths and weaknesses of individual staff and overall areas and components of the intervention and (2) create action plans for improvement, retraining, or more frequent supervision and support. Staff failing to meet minimum QAC requirements were retrained and only allowed to resume their role after conducting 2 observed and evaluated sessions rated at 90% adherence or higher.

In addition, all study sites received support and monitoring visits from the intervention coordinating center at UCSF and designated National Institutes of Mental Health (NIMH) staff. In this context, monitors accessed and inspected study facilities and documentation, as well as observing the performance of study procedures. In addition, the intervention coordination director visited each study site bi-annually to evaluate the quality and consistency of the implementation of the intervention. These visits allowed firsthand observation of the intervention components and maintained open relations with field staff. Study site visits generally took one week to conduct and included: (1) Observing sessions and rating performance using the QC evaluation form; (2) reviewing files and forms for completeness and accuracy; (3) observing daily operations; (4) ensuring that the intervention was being implemented as prescribed in the Protocol and SOP guidelines; and (5) individual and group meetings with the site teams (site PI, project director, coordinators and staff) to provide direct supervision, feedback and answer questions. Study site visits were supported by monthly conference calls with each site.

## Results

### VCT

QAC scores across all components are presented in [Fig 2](#) (Quality Assurance & Control Scores for All Sites) and VCT QAC scores are presented in [Fig 3](#) (VCT Quality Assurance & Control Scores by Site). Periodic breaks in intervention delivery for holidays and rest periods are displayed as gaps in the chart data. All sites began the intervention with VCT QAC scores between 3.9 and 4.5. In Soweto, VCT QAC scores rose consistently throughout the first 6 months and remained at high levels throughout Year 1 and Year 2. In Year 3, scores declined sharply to 3.5, but recovered in succeeding months. In Tanzania, VCT QAC scores rose steadily during Year 1 of the intervention, and remained at a high level throughout Year 2. VCT QAC scores fell to 4.7 in Year 3. In Thailand, VCT QAC scores were consistently high during Year 1 and Year 2, although the cyclical nature of intervention service delivery there meant that VCT QAC data was not collected in all months. In Vulindlela, VCT QAC scores fell sharply during Year 1 (3.5)



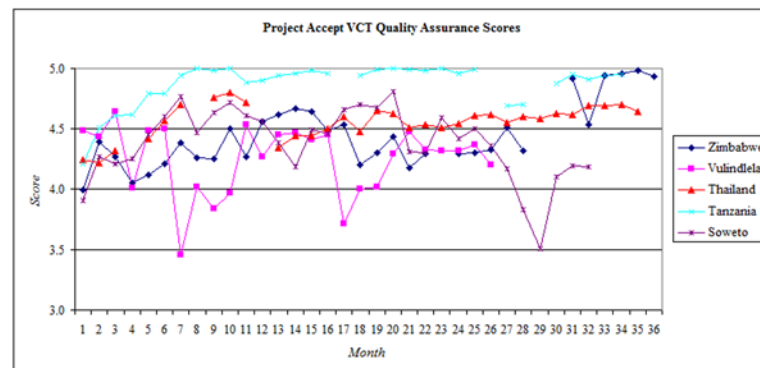
**Fig 2. Quality Assurance & Control Scores for All Sites.**

doi:10.1371/journal.pone.0149335.g002

and Year 2 (3.7). In Zimbabwe, VCT QAC scores remained between 4.0 and 4.7 throughout Year 1 and Year 2. In Year 3, after a prolonged absence from field work due to national elections, VCT QAC performance was above 4.5 and remained high throughout the remainder of the intervention. Overall, during Year 1 of the intervention the mean VCT QAC scores across the 5 study sites were 4 (95% adherence) or greater and remained consistently high during Year 2, with some fluctuations. During Year 3, VCT QAC scores fell to 4 and then recovered to levels above 4.5 throughout the final six months of the intervention.

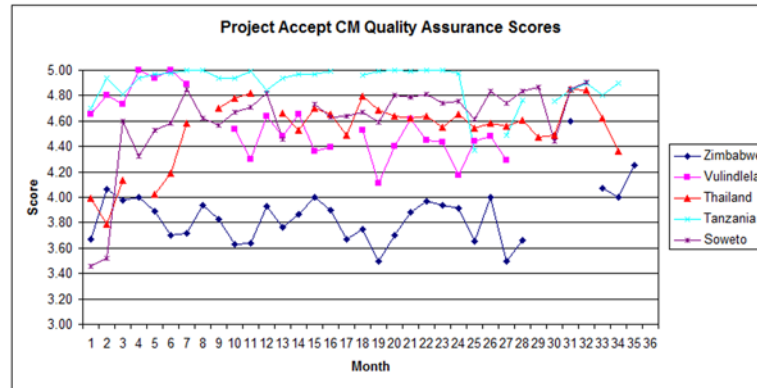
### CM

CM QAC scores are presented in Fig 4 (Community Mobilization Quality Assurance & Control Scores by Site). CM QAC scores began at between 3.4 (Soweto) and 4.7 (Tanzania). In Soweto, CM QAC scores rose quickly during the initial months of the intervention from 3.5 to 4.8, and only declined to 4.4 in Year 3. In Tanzania, CM QAC scores remained consistently high throughout Year 1 and Year 2 before declining to 4.4 in Year 3. CM QAC scores improved throughout the remainder of Year 3, and the site finished the intervention with average scores above 4.8. In Thailand, CM QAC scores rose from 4.0 to 4.8 throughout Year 1, and remained at high levels throughout Year 2 before declining to 4.5 in Year 3. In Vulindlela, CM QAC scores fell periodically during Year 1 (to 4.3) and Year 2 (to 4.1). The site’s CM QAC scores stabilized in Year 3. In Zimbabwe, CM QAC scores were lower than at other sites throughout



**Fig 3. VCT Quality Assurance & Control Scores by Site.**

doi:10.1371/journal.pone.0149335.g003



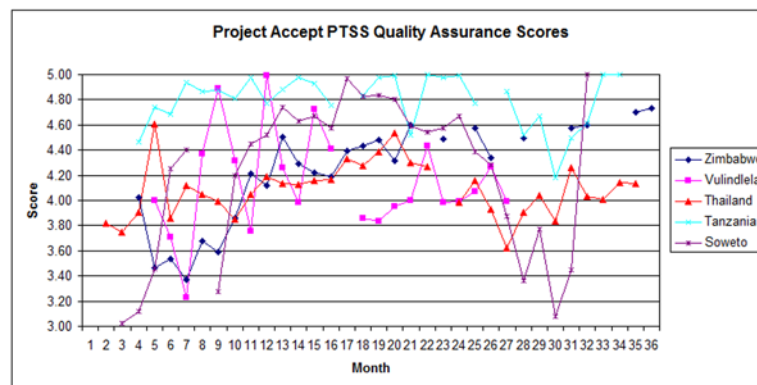
**Fig 4. Community Mobilization Quality Assurance & Control Scores by Site.**

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Year 1 and Year 2, with a range of 3.7 to 4.1, but remained at acceptable levels and, as with VCT QAC, improved during Year 3 (to 4.8) after an enforced absence from fieldwork. Overall, during Year 1 months of the intervention, the mean scores of CM staff across the 5 study sites were 4 (95% adherence) or greater and continued to improve over time. CM scores remained consistently high throughout Year 2 of the intervention and rose again during the first half of Year 3 to 4.8 before declining to 4.2 in the final months of the intervention.

### PTSS

PTSS QAC scores are presented in Fig 5 (Post-Test Support Services Quality Assurance & Control Scores by Site). In keeping with the intervention protocol, PTSS activities were not initiated in sites until between the second and fifth month of the intervention. As compared to VCT and CM, there was a wider range of initial QAC scores across sites, varying from 3.0 in Soweto to 4.5 in Tanzania. In Soweto, PTSS QAC scores rose rapidly during the first half of Year 1, from 3.0 to 4.4, before declining to 3.3. PTSS QAC scores then rose consistently throughout Year 2. In Year 3, PTSS QAC scores fell to 3.0 before recovering. In Tanzania, PTSS scores rose throughout Year 1, from 4.5 to 5.0, before declining briefly to 4.8 during Year 2. In Year 3, PTSS QAC scores fell again to 4.2, but recovered to levels above 4.8 by the end of the intervention. In Thailand, PTSS QAC scores improved rapidly during the first months of Year 1, from 3.8 to 4.6, before declining to 3.9. PTSS QAC scores remained at high levels throughout Year 2 before declining to 3.6 in Year 3. The site finished the intervention with a mean score of 4.0. In



**Fig 5. Post-Test Support Services Quality Assurance & Control Scores by Site.**

doi:10.1371/journal.pone.0149335.g005



Vulindlela, PTSS QAC scores fluctuated throughout Year 1 and Year 2, from a high of 5.0 to a low of 3.2. In Zimbabwe, after an initial decline from 4.0 to 3.4, PTSS QAC scores rose throughout Year 1 and remained consistently high during Year 2. PTSS QAC scores were only sporadically available during Year 3 owing to the reasons outlined above, but remained at acceptable levels (4.2 or above). Overall, combined QAC scores for the PTSS component were lower than VCT and CM during Year 1 of the intervention, and displayed greater fluctuations (Fig 2: Quality Assurance Scores for All Sites). Scores fell in the early months of the intervention to 3.4, and again towards the end of Year 1 to 3.4. Combined PTSS QAC scores were consistently high throughout Year 2. In Year 3, combined PTSS QAC scores fell to 3.7, but recovered to 4.7 by the end of the intervention. Across all sites, VCT and CM scores were higher than PTSS scores throughout Year 1. In Year 2, PTSS QAC scores had reached those of MVCT and CM, before falling below the other components again in the first half of Year 3. By the end of the intervention, PTSS QAC scores were again comparable to VCT and CM QAC scores.

## Discussion

Project Directors identified challenges experienced by study staff as (1) coping with the wide range of field activities and (2) the novelty of the CBVCT intervention. QAC score fluctuations were also associated with new staff hires or changes in staff responsibilities. The major effort put into developing and implementing the in-depth quality-assurance methodology has resulted in essential information on the successes and challenges of implementing this complex intervention. The overall 95% adherence to essential intervention delivery components indicates that the wide range of activities contained within the intervention can be successfully and faithfully implemented in resource limited settings. The QAC process has also been able to highlight challenges to implementation, especially around PTSS activities, and provided solutions to those challenges, primarily in the early identification of enhanced training needs. QAC data also serves an important purpose by monitoring consistency of component implementation. Of note, the application of feedback systems (e.g. site visits by the international intervention core team) were considered to be highly effective in remedying QAVC issues, though these could not be scientifically linked to changes in QAC results at the site level.

While the goal of QAC is to identify and correct non-adherence to the study protocol, it is also important to acknowledge elements that were performed particularly well and include these in the summaries as a way of motivating study staff. It is important that staff be given positive reinforcement in the areas where they are doing well and to be acknowledged for their valuable contribution to the project and to the team. These QAC procedures allow for the identification of skills training needs for VCT, PTSS, and CM staff, and relevant in-service skills trainings are discussed with the individual staff. In particular, VCT has been scaled up through-out African countries although very few report any attempts at QAC. Our experience in this large prevention trial is that such QAC is both (1) feasible and acceptable to both staff and participants and (2) associated with higher quality programmatic implementation.

The “diplomatic” QAC model presented under the Project Accept aegis is not without limitations. Given different social contexts, it may entirely appropriate to have greater flexibility across sites, as the present study did with permitting site team leaders and coordinators to set the frequency and structure of meetings to address QAC issues. However, this also introduces variability in how QAC issues are addressed, which could have some bearing on actual QAC across sites (as well as, for example, staff retention if some sites are better at this than others). Addressing some of these complexities and the need for additional research on how to assure QAC before implementing multi-site, multi-level interventions and assuring QAC once in the field remain key tasks for future related interventions. A further limitation to these results

relates to the presentation of mean fidelity scores across the sites without associated data on competencies and specific adherence challenges or that seemed to explain fluctuations over time and differences across contexts. Such information, given the range of components and geographical areas covered by the current manuscript, was considered to be beyond the scope of this paper. Finally, there are numerous factors in addition to QAC that influence fidelity and the ultimate success of interventions and implementation strategies: although QAC is likely a useful tool for supporting and promoting high fidelity when HIV prevention interventions are implemented, one cannot make definitive causal statements in this regard.

## Conclusions

The implementation of a large-scale, evidence based HIV intervention requires extensive QAC to ensure implementation effectiveness, building on a 'feedback loop' whereby improvements in service delivery become both an iterative and an intuitive process. During Project Accept, ongoing appraisal of study staff by intervention component across sites helped to ensure consistent and high quality delivery of all intervention components, in keeping with the goals of the study protocol. In addition, for the first time in any kind of global health intervention, attempts were made to assess standards of service delivery from a diplomatic perspective. The development of the field of global health diplomacy has helped to drive recognition of the importance of culturally appropriate and culturally sensitive global health interventions, which both international and domestic Project Accept QAC staff monitored on a routine basis throughout the intervention. The primary findings of Project Accept also suggest that a community-wide multicomponent intervention of mobilization, HIV testing and support services can be both safe and feasible[17] and can significantly increase testing, particularly in men. The study also shows that the routine monitoring and assessment of services through QAC is an essential component of public health practice. In this context, QAC ensures staff fidelity to study procedures and is critical to the delivery of multi-site HIV prevention interventions. Both the findings and the associated methods of QAC for the Project Accept intervention could, therefore, usefully inform other interventions being "moved to scale".

## Supporting Information

**S1 Fig. Zimbabwe Average Annual QAC Scores.**  
(XLS)

**S2 Fig. Tanzania Average Annual QAC Scores.**  
(XLS)

**S3 Fig. Vulindlela Average Annual QAC Scores.**  
(XLS)

**S4 Fig. Soweto Average Annual QAC Scores.**  
(XLS)

**S5 Fig. Thailand Average Annual QAC Scores.**  
(XLS)

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## Author Contributions

Conceived and designed the experiments: SK GKS SM BS AC. Performed the experiments: SK GKS SM BS AC. Analyzed the data: SK GKS SM BS AC. Contributed reagents/materials/analysis tools: SK GKS SM BS AC. Wrote the paper: SK GKS SM BS AC.

## References

1. UNAIDS: Core Slides: Global Summary of the AIDS Epidemic. Accessed through: [www.unaids.org/.../unaids/](http://www.unaids.org/.../unaids/) 2013.
2. Fidler D: Reflections on the Revolution in Global Health and Foreign Policy. Bulletin of the World Health Organization 2007.
3. PEPFAR: PEPFAR and Prevention, Care, and Treatment (December 2009). Available: <http://www.pepfar.gov/about/strategy/> 2009.
4. Khumalo-Sakutukwa G, Morin SF, Fritz K, Charlebois ED, van Rooyen H, Chingono A, et al: Project Accept (HPTN 043): a community-based intervention to reduce HIV incidence in populations at risk for HIV in sub-Saharan Africa and Thailand. *J Acquir Immune Defic Syndr* 2008, 49:422–431. doi: [10.1097/QAI.0b013e31818a6cb5](https://doi.org/10.1097/QAI.0b013e31818a6cb5) PMID: [18931624](https://pubmed.ncbi.nlm.nih.gov/18931624/)
5. Panel Discussion on Expanding and Diversifying HIV Testing and Counseling: Findings from the Field Sponsored by the Horizons Program March 14 2007: Washington, DC. Available: <http://www.popcouncil.org/uploads/pdfs/horizons/ctpanel/sangiwa.pdf>.
6. Perepletchikova F, Treat TA, Kazdin AE: Treatment integrity in psychotherapy research: analysis of the studies and examination of the associated factors. *J Consult Clin Psychol* 2007, 75:829–841. PMID: [18085901](https://pubmed.ncbi.nlm.nih.gov/18085901/)
7. Carroll KM, Nuro KF: One size cannot fit all: A stage model for psychotherapy manual development. *Clinical Psychology: Science and Practice* 2002, 9.
8. Gresham FM: Treatment integrity in single-subject research. In *Design and analysis of single-case research*. Edited by Franklin RD, Allison DB, Gorman BS; 1997: 93–117
9. Gresham FM, MacMillan DL, Beebe-Frankenberger ME, Bocian KM: Treatment integrity in learning disabilities intervention research: Do we really know how treatments are implemented? *Learning Disabilities Research & Practice* 2000, 15:198–205.
10. Schlosser RW: On the importance of being earnest about treatment integrity. *Augmentative and Alternative Communication* 2002, 18:36–44.
11. Waltz J, Addis ME, Koerner K, Jacobson NS: Testing the integrity of a psychotherapy protocol: assessment of adherence and competence. *J Consult Clin Psychol* 1993, 61:620–630. PMID: [8370857](https://pubmed.ncbi.nlm.nih.gov/8370857/)
12. CDC: Quality Assurance Guidelines for Testing Using Rapid HIV Antibody Tests Waived Under the Clinical Laboratory Improvement Amendments of 1988. 2007.
13. WHO: Scaling-up HIV testing and counselling services: a toolkit for programme managers. 2005.
14. National Institute of Mental Health Project Accept Study Materials. Available: <http://hivinsite.org/accept>.
15. CDC: Revised Guidelines for HIV Counseling, Testing, and Referral—Technical Expert Panel Review of CDC HIV Counseling, Testing, and Referral Guidelines, 2001. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>. 2001.
16. Kevany S, Hatfield A, Workneh NG, Durrani BA, Bekele Y, Khan U, et al: Diplomatic and operational adaptations to global health programmes in post-conflict settings: contributions of monitoring and evaluation systems to health sector development and 'nation-building' in South Sudan. *Med Confl Surviv* 2012, 28:247–262. PMID: [23189590](https://pubmed.ncbi.nlm.nih.gov/23189590/)
17. Coates TJ, Kulich M, Celentano DD, Zelaya CE, Chariyalertsak S, Chingono A, et al: Effect of community-based voluntary counselling and testing on HIV incidence and social and behavioural outcomes (NIMH Project Accept; HPTN 043): a cluster-randomised trial. *Lancet Glob Health* 2014, 2:e267–277. doi: [10.1016/S2214-109X\(14\)70032-4](https://doi.org/10.1016/S2214-109X(14)70032-4) PMID: [25103167](https://pubmed.ncbi.nlm.nih.gov/25103167/)

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### Improving resource allocation decisions for health and HIV programmes in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations

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## Improving resource allocation decisions for health and HIV programmes in South Africa: Bioethical, cost-effectiveness and health diplomacy considerations

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The escalating expenditure on patients with HIV/AIDS within an inadequately funded public health system is tending towards crowding out care for patients with non-HIV illnesses. Priority-setting decisions are thus required and should increasingly be based on an explicit, transparent and accountable process to facilitate sustainability. South Africa's public health system is eroding, even though the government has received extensive donor financing for specific conditions, such as HIV/AIDS. The South African government's 2007 HIV plan anticipated costs exceeding 20% of the annual health budget with a strong focus on treatment interventions, while the recently announced 2012–2016 National Strategic HIV plan could cost up to US\$16 billion. Conversely, the total non-HIV health budget has remained static in recent years, effectively reducing the supply of health care for other diseases. While the South African government cannot meet all demands for health care simultaneously, health funders should attempt to allocate health resources in a fair, efficient, transparent and accountable manner, in order to ensure that publicly funded health care is delivered in a reasonable and non-discriminatory fashion. We recommend a process for resource allocation that includes ethical, economic, legal and policy considerations. This process, adapted for use by South Africa's policy-makers, could bring health, political, economic and ethical gains, whilst allaying a social crisis as mounting treatment commitments generated by HIV have the potential to overwhelm the health system.

**Keywords:** HIV/AIDS; resource allocation; South Africa; policy; cost-effectiveness

### Introduction

The HIV pandemic is one of the greatest tragedies to afflict humankind. Sub-Saharan Africa, a highly impoverished region, has been the most severely affected, with devastating effects on the lives of individuals, families, whole population groups and society in general (UNAIDS, 2010). Starting from a very low incidence in the 1980s, the pandemic has spread rapidly across South Africa (a middle-income country) and infected over 6 million people, the largest population of HIV patients in any country. Although South Africa has the most highly developed infrastructure and health-care system in sub-Saharan Africa, economic growth has been slower than anticipated since the political transition in 1994, and social and economic inequality remain high and are getting worse (Organization for Economic Cooperation and Development,

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2011). For these reasons, the pandemic's impact on the health system and the related use of scarce health resources deserve special attention.

In this paper, we examine South Africa's response to the pandemic, which may have generated both positive and negative impacts on the public health system, provided by South Africa's Department of Health (DOH) and associated provincial governments. After an abysmally slow start, in 2003 the government introduced an ambitious programme to provide all HIV patients with antiretroviral drugs (ARVs). Spending on HIV significantly increased and rose at a higher rate than any other area of health expenditure (*vide infra*). Increased expenditure on HIV is both commendable and necessary. However, recent evidence indicates that as the government expands funding allocations for the urgent treatment demands of the HIV population on an unpredictable and ad hoc basis, the national public health sector's capacity to deal effectively with non-HIV diseases and traumatic injuries (which are also at virtually epidemic levels) may be undermined, in the context of what has been described as a rapidly deteriorating national public health system (Karim, 2009).

This is not a problem unique to South Africa (Gordon, 2008). Commentators elsewhere have raised the issue of dramatic increases in HIV treatment funding (as opposed to more cost-effective HIV prevention initiatives) 'squeezing out' other health-care services (Amico, Aran, & Avila, 2010; England, 2008). Unless tackled soon and effectively, the government's failure to allocate scarce health resources transparently and rationally will become an increasingly critical problem for South Africa's public health sector. We provide here a historical perspective on the HIV epidemic; review the government's pattern of spending on HIV and non-HIV health care; examine the present and possible future impact of these funding decisions on South Africa's public health sector; and recommend a process to allocate medical resources in an ethically and legally acceptable way as mounting health-care needs threaten to overwhelm the nation's public health services (Househam, 2010).

### **HIV and the changing burden of disease**

The scale of the HIV epidemic in Sub-Saharan Africa is unprecedented in modern medical history (UNAIDS, 2010), and has systematically undermined all health gains made in the post-apartheid era (Ijumba & Padarath, 2006). In 1996, the epidemic accounted for only 1.5% of male deaths and 2.5% of female deaths (Bradshaw et al., 2003). By 2000, HIV had been identified as the leading cause of death in South Africa, accounting for almost 30% of all deaths. By 2006, this had risen to 47% (Dorrington, Johnson, Bradshaw, & Daniel, 2006). This percentage may have been an underestimate as many HIV deaths continued to be attributed to other causes such as tuberculosis or pneumonia (Anderson & Phillips, 2006). In 2009, an estimated 390,000 new infections were reported in South Africa. Women were, and continue to be, most severely affected by the epidemic, with an estimated national prevalence of 30% amongst the 25- to 29-year-old age group (Karim, 2009). Of 4.6 million South Africans who were tested for HIV between April and November 2010, an astonishing 17% were HIV positive (Bodibe, 2011).

Although South Africa has only 0.7% of the world's population, it accounts for 17% of the global burden of HIV infection. The average time from HIV infection to death in South Africa is 8 to 10 years without ARVs (Anderson & Phillips, 2006), and the average life expectancy at birth in South Africa has fallen from 57 years in

1980 to 51 years in 2008 (World Bank Disease Control Priorities Project, 2008). It is not yet clear whether, or how soon, treatment with ARVs will mitigate this phenomenon. While the incidence of new HIV cases peaked in 1998, the annual number of deaths caused by HIV is not expected to plateau until 2015 (Dorrington et al., 2006).

The impact of the pandemic has been felt at all levels of the health system. In a study of a regional hospital in the Western Cape Province, 32.3% of patients were HIV positive, and a further 11% were clinically suspected to be positive (Burch & Benatar, 2006). This burden of infectious disease is markedly greater than it was in the past: a survey of patients in a major teaching hospital in the Western Cape showed that infectious diseases accounted for less than 10% of admissions from 1971 to 1982 (Benatar & Saven, 1995). Recent data are therefore representative of a changing burden of disease pattern that has dramatically altered demands made by patients on health-care services.

Simultaneously with the catastrophic impact of HIV on the burden of disease, non-HIV conditions, including stroke, ischaemic heart disease, violence and injuries, diabetes and chronic lung diseases continue to account for significant proportions of the total disease burden (Househam, 2010). Homicide, violence and accidents accounted for 15% of deaths in 2007, while one in five adult males admitted to being alcohol dependent (Barron, 2008). Death rates from cancer, stroke and diabetes rose by 12% between 1997 and 2004, while death rates from related conditions have risen by 35% for males and 18% for females in recent years (Anderson & Phillips, 2006). Tuberculosis continues to spread rapidly, placing an ever-increasing burden on health services (National Department of Health, 2004). Patients with multidrug-resistant (MDR) and extensively drug-resistant (XDR) tuberculosis are much more expensive to treat, and they present as yet unquantified health-care challenges (Singh, Upshur, & Padayatchi, 2007). Overall, health as reflected in a range of health indicators is in decline (Beresford, 2008a; Barron, 2008). Thus, while the public health sector must continue to find new internal and donor resources to treat a growing number of HIV patients, it must also continue to meet rising demands from patients with other chronic and acute diseases and traumatic injuries.

### **The South African government's evolving response to the HIV epidemic**

Despite the massive scale of the HIV pandemic, already clearly evident in the 1990s, the government's initial response was characterised by obfuscatory attitudes and denialism (Karim, 2009). Health service planners' lack of foresight and vision and inadequate resources hampered the public sector's ability to treat HIV patients. Until 2003, the government was unwilling to fund ARVs for hundreds of thousands of patients who needed them, having ignored the highly compelling evidence indicating the cost-effectiveness of ARV treatment available at that time (Baleta, 2003). Although the pandemic *ab initio* affected potentially productive members of society, the early government reaction of denial resulted in the failure to make long-term plans to cope with the looming public health crisis posed by the disease.

In the face of government apathy, local and international organisations played a key role in initiating treatment and care for AIDS patients (Baleta, 1999; Benatar, 2004; International Association of Physicians in AIDS Care, 2002; Rodriguez & La Salvia, 2004). In collaboration with the Provincial Administration of the Western



Cape and Médecins Sans Frontières, the Treatment Action Campaign (TAC), South Africa's largest and most effective HIV activist group, mobilised powerful segments of civil society to challenge the government's refusal to provide affordable and cost-effective treatment for HIV patients (Baleta, 2003). Only in 2003 did the government succumb to intense societal pressure to address the epidemic. The change in orientation, funding and policy was both dramatic and reactive, lurching from negligible to unprecedentedly high levels of funding for a specific disease. The *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* ('2003 plan') (National Department of Health, 2003), represented an ambitious policy response to be implemented over the 5 ensuing years. The government proposed to provide treatment to HIV patients pursuant to the 'highest international standards' through a countrywide continuum of care including home care, adherence support and nutritional support.

In March 2007, the DOH announced its *National Strategic Plan (NSP) on HIV and AIDS, 2007–2011* ('2007 Plan') (National Department of Health, 2007). This plan was even more ambitious than its predecessor. The DOH aimed to achieve the following by 2011: (1) to halve the rate of new HIV infections through prevention strategies and (2) to treat with ARVs 80% of those already living with HIV and their families. By 2009, over 730,000 HIV patients had been provided ARVs, with a target of 1.4 million on ARVs by 2012 (Mooney & Gilson, 2009).

In December 2011, the government launched the *NSP for HIV and AIDS, Sexually Transmitted Infections (STIs) and Tuberculosis 2012–2016* (2011 plan) (National Department of Health, 2011). The 2011 plan builds on both the 2003 and 2007 Plans, but focuses more attention on (1) the immediate provision of lifelong antiretroviral treatment to all HIV-positive mothers and TB patients, as well as (2) a significantly increased focus on prevention. The plan also stipulates that the government and its implementation partners should prepare to roll out new biomedical prevention strategies as soon as they have passed regulatory approval. The goals of the 2011 plan remain broadly similar to the 2003 and 2007 versions, and they promise 'universal access' to HIV prevention interventions (Cullinan, 2011). By the end of 2016, this new plan aims to: (1) enrol 3 million people for ARV treatment, (2) circumcise 4.3 million men and (3) reduce mother-to-child HIV transmission to 2% (currently at 4%) (Cullinan 2011). While these steps are overdue and welcome, the cost of these newly implemented programmes needs to be evaluated and reviewed in the context of limited resources.

### **Health expenditure in South Africa**

Although the South African government devotes a substantial portion of its national budget to health care, government health expenditure has remained at a steady level of between 8.4% and 8.9% of the budget in recent years (Health Systems Trust, 2010). Annual per capita government health expenditure has also remained virtually constant in recent years, rising from US\$135 during 1998–1999 to US\$139 during 2005–2006 (inflation-adjusted). These small increases have not kept pace with the changing burden of disease, and the projected annual increases of 7% in national health expenditure between 2004 and 2011 were expected to barely keep pace with inflation (Barron, 2008), and they have indeed not done so. It must be remembered that the national public health sector, staffed by about 30% of the country's doctors,

remains the sole provider of health care for 36 to 40 million people who are uninsured and who constitute approximately 80% of the nation's population (Benatar, 2004; Blecher & Thomas, 2005). Less than 20% of South Africans have private health insurance that provides access to health care from almost 70% of the country's doctors, with an annual per capita health expenditure of about \$1400 (South African National Treasury, 2010).

### ***Mounting HIV spending poses a challenge to the government***

Until the late 1990s, spending on HIV programmes was negligible, and it was only with the adoption of the 2003 plan that funding was substantially increased. Expenditure then grew at an extraordinarily high average annual rate of 48.2% between 1999 and 2005 (Blecher & Thomas, 2005). This was a significantly and consistently higher rate of growth than in any other area of national health expenditure. This level of growth has continued at an annual rate of approximately 24.8%, and dedicated HIV funding was recently estimated at US\$400 million per annum (Karim, 2009), of which approximately 40% comes from international donors (Ndlovu, 2010).

The 2007 plan was estimated to cost anywhere from US\$669.3 million in 2007 to US\$1.6 billion in 2011, with one estimate putting the overall cost over 5 years at US\$6.4 billion (National Department of Health, 2007). The 2011 Plan is projected to cost an extraordinary US\$16 billion over the ensuing 5-year period (National Department of Health, 2011). Overall HIV expenditure may eventually exceed 20% of the entire national health budget (National Department of Health, 2007), and treatment costs for HIV are anticipated to rise to 33% of total health expenditure by 2012 (Chopra et al., 2009), to be funded from a combination of donor and national sources.

These rapidly escalating expenditures on HIV combined with a range of competing public health commitments pose a potential crisis for a national public health-care system committed to serving the needs of all South Africans. Assuming both donor and national HIV expenditure will continue to amount to an ever-increasing proportion of the expenditure on health, this will, in all probability, increase tension between competing sectors within South Africa's public health-care system. In 2009, HIV accounted for R3359 million (US\$486.9 million) or 21.7% of the total R15.4 billion (US\$2.2 billion) national health budget (South African National Treasury, 2010). In the 2010 budget, an additional R8400 million (US\$1.2 billion) was allocated to HIV expenditure over the coming 3 years (South African National Treasury, 2010). This falls far short of the estimated \$16 billion that will be needed to implement the 2011 plan over the ensuing 5 years (National Department of Health, 2011). It should be noted that official estimates of prospective HIV expenditure have varied widely over recent years, and are frequently revised. As estimated amounts are not always budgeted and appropriated, it is often difficult to determine exactly what the South African government intends to spend on HIV in the medium- or long-term.

Although the current pattern of government health expenditure reflects a needed increase in HIV funding over earlier periods of neglect, these increases raise troubling questions from a resource-allocation perspective. Even before the latest increases, the government had spent over twice as much to care for each HIV patient

than it did to provide medical services for each patient with non-HIV conditions (Blecher & Thomas, 2005). In addition to providing health care to all HIV and non-HIV patients; the health-care infrastructure in the public sector needs to be improved; academic centres need to be sustained so that new generations of health-care professionals can be trained to address anticipated health-care needs in South Africa (Benatar, 2004); many more health-care workers need to be trained, employed and retained; and working conditions need to be augmented in order to diminish the 'push' factors that contribute to the health-care provider 'brain drain' (Benatar, 2007).

Although prevention has been widely accepted as a significantly more cost-effective strategy to curtail the epidemic (Marseille, Hofmann, & Kahn, 2002), a mere 11% (US\$694.6 million) of the planned expenditure on HIV from 2011 to 2016 is allocated to prevention, as opposed to significantly more expensive treatment initiatives in the 2007 and 2011 plans (National Department of Health, 2007, 2011). In view of this evidence, it is likely that the government will have to further increase spending on HIV prevention, thus compounding the long-term, national HIV-related cost burdens relative to other health conditions. These projected costs, though already astronomically high, have not taken into account the significant downstream costs of treating patients with ARV complications at the secondary level (Kevany, Meintjes, Rebe, Maartens, & Cleary, 2009).

### **Has spending on HIV 'crowded out' funding for non-HIV care?**

South Africa faces dramatic resource shortages across its publicly funded health system. As the overall national health budget grows at less than the inflation rate, expenditures for HIV continue to grow at a disproportionate rate to general health expenditure. In this context, and in the absence of any explicit systems to govern or restrain health-resource-allocation patterns, there is an increasing risk that the ability to treat other diseases will diminish, as has occurred elsewhere (Houston, 2002).

When Kenya introduced widespread HIV treatment, health services for non-HIV patients were curtailed against a backdrop of rising mortality rates (Guinness et al., 2002). Similarly, HIV programmes in the West Indies have been criticised for drawing providers towards well-funded HIV programmes via preferential funding, with consequent deleterious effects on the broader health system (Amico et al., 2010; England, 2008). Increased HIV expenditure has also been shown to be associated with reduced expenditure on immunisations and reproductive health interventions (Grépin, 2009). In view of this evidence, it is important to ask whether the same risk exists in South Africa as elsewhere (i.e., whether spiralling expenditures on HIV will 'crowd out' treatment of non-HIV conditions) (Beresford, 2008b), causing distortions across the rest of the health system (Chopra et al., 2009). For example, it is of concern in this regard that maternal mortality in South Africa increased from 150 per 100,000 pregnancies in 1998 to 650 per 100,000 in 2007 (Human Rights Watch, 2011).

There is some evidence that South Africa's health system has been significantly impacted by the HIV epidemic in terms of health-care professional workloads (Dohrn, Nzama, & Murrman, 2009). For example, in 2003, 94% of primary-level public health clinics provided sexually transmitted infection (STI) services in South Africa, including HIV services. By 2004, only two-thirds (67%) of all primary

health-care facilities provided immunisation services, and only 55% of such facilities provided antenatal care – two basic and critical elements of primary health care (Day, 2004). The prevention and treatment of non-communicable diseases has also been marginalised in South Africa, in part as a result of the overwhelming presence of communicable diseases that must be treated (Mayosi, 2009). Following substantial downsizing of hospital beds and medical and support staff across the country (Blecher, 2002; Benatar, 2004), in 2007, the government again reduced the budgets for the two major tertiary hospitals in the Western Cape (Cairncross, 2007). In addition to reducing tertiary services to the vast population served by these two major academic teaching hospitals, current trends are threatening postgraduate training, maintenance of surgical skills and research in established medical schools that must be sustained in order to serve broad national health goals (Benatar, 2004).

The government has suggested that increased spending on HIV treatment will improve services both to HIV patients and to non-HIV patients by strengthening the overall treatment and care capacity of the national public health infrastructure (National Department of Health, 2004). For example, the DOH estimated that 36% of all HIV plan expenditure would be used to benefit not only HIV patients, but also many others suffering from other conditions (National Department of Health, 2003). Some commentators have suggested that there is evidence that HIV spending has a positive impact on (1) both the broader health system generally (Biesma, Brugha, & Harmer, 2009) and (2) the treatment of other diseases that contribute to HIV co-infections, such as tuberculosis (Conseil, Mounier-Jack, & Coker, 2010). In addition, HIV expenditure may have leveraged a far higher level of expenditure on health than would otherwise have been the case (El-Sadr, 2009). However, such synergies between HIV scale-up and health system strengthening remain largely unproven (Rabkin, 2009). Furthermore, a study examining the impact of international aid for HIV/AIDS on other health issues argues that, conversely, substantial increases in donor funding for HIV/AIDS may have actually limited the funding available for other health needs in developing countries (Shiffman, 2009).

While some of the current expenditure on HIV treatment care may provide benefits for other users of the national public health system in the long-term, these dramatic increases in spending on HIV also threaten to diminish the resources available to provide services for patients with non-HIV conditions and for health care in general. Although the ‘crowding out’ of other health services by HIV expenditures remains unproven, we have asserted elsewhere that it would be morally, politically and probably legally unacceptable for expanded treatment of the HIV population to come at an unacceptable cost to patients who bear the burden of other chronic diseases and health conditions. We recommended, therefore, that the South African government urgently find the means to rationally and efficiently allocate its limited health resources among the many patient populations who need and can benefit from treatment (Fleischer, Kevany, & Benatar, 2010).

### **Charting a course for change: transparent, rational and ethical resource-allocation decisions for health and HIV funding**

Given the public health crisis caused by HIV and the dramatic effectiveness of treatment, the epidemic surely deserves special attention and increased funding. However, if such prioritisation systematically undermines adequate services for other

diseases, the national public health sector will have failed in its goal of providing equity in access to health care for citizens, an outcome which has already been observed in other settings (England, 2008). To cope with the dual challenges of the HIV pandemic, as well as maintaining a basic standard of care for all non-HIV patients, the government must rationally plan for the short-, medium- and long-term future of the health system, based on explicit and transparent processes (Chopra et al., 2009).

Any solution to the problem of making an arbitrary resource-allocation process more rational and evidence-based must begin with recognition of harsh realities. The government already commits 3.6% of GDP (almost 9% of the total national government budget) to funding health care (Hofman & Tollman, 2010), and there are limits to how much more the government could contribute to enhancing health care. There is no scenario under which all demands for health care could be met. Yet, policy-makers and politicians rarely admit that health resources are being rationed in a way that will, inexorably, deny some patients essential, life-saving treatment and sometimes excludes patients altogether. It might be argued that the government should divert additional resources from those allocated to other public services to fix a dysfunctional public health sector. Reducing excessive expenditure on defence is always a popular suggestion, but, without a compelling case for the substitution of health for military expenditure according to internationally recognised criteria (such as those proposed by Novotny & Kevany, 2013), it is unlikely to be heeded by most governments. Further, South Africa faces multiple crises that demand increased resources for underfunded public services: for example, education, policing, municipal services, land restitution and even basic services such as sanitation and clean water. While it is important to continue to advocate for health services to receive more resources, it would be politically unfeasible for the government to divert funds from other vital public services in order to expand national health services to an ideal level.

Despite bureaucratic resistance to admitting that the country must ration its limited resources, the need for making resource-allocation decisions is a relentless fact of life in South Africa, as it is in countries with much greater access to public resources. South Africa cannot avoid rationing its inadequate health resources, and indeed health administrators routinely engage in implicit rationing decisions, albeit on an ad hoc basis, and pursuant to no formal, explicit and transparent process that would ensure a rational outcome. The goal must be to design a process that would ensure rational, accountable and transparent allocation of resources that would take into account the views of diverse interest groups, and that the public, clinicians and administration could accept as fair.

### ***Improved public and stakeholder participation***

Traditionally, health budget priorities are set covertly by ‘insiders’ (usually government administrators), without involving ‘outsiders’ (such as clinicians, patients, ethicists and advocacy groups) in the decision-making (Coulter & Ham, 2000). South Africa’s policy-making processes are no different. For example, none of the HIV plans that require extraordinary expenditures for HIV made provision for a transparent process by which health budgets would be allocated, either at national or provincial levels. Nor do any of the plans require that budgets ensure fair, rational allocation of scarce resources, much less that this be done with public participation.

Despite the pressure on the government to meet multiple demands for diverse disease populations, and the controversy that erupts when the government hands down budget allocations made in secret, there is not yet an established institutional culture of making resource-allocation decisions in a rational, accountable and transparent manner.

While little is known about how national health resource-allocation decisions are made in most countries, some countries (e.g., the Netherlands, Sweden, New Zealand and the United Kingdom, as well as the state of Oregon in the United States) have moved towards explicit rationing processes (Donaldson, 2008). Although we do not recommend that South Africa simply take over a method of allocation used elsewhere, we believe that there are many advantages to using an explicit process for allocating health resources, and we will describe such a process. What we can learn from other countries is that an essential element of an explicit process is transparency and public participation.

Policy-makers could respond to this suggestion by claiming that any requirement of open participation would only invite endless, fruitless debates and delays, none of which would improve the quality of the budget finally adopted. We argue that public participation in government decision-making is an important, even essential element of democracy. Public involvement encourages health administrators to think more carefully about the practical impact of their proposals on a range of stakeholders and prepares them to be held accountable for their decisions (Doyal, 1997). If the decision-making process were enacted in public, involving all critical stakeholders, the public might be willing to accept reasonable limitations on access to the most expensive medical treatments and technology in order to ensure equitably accessible basic care for the entire population (Benatar, 2008).

The goal of such a publicly accessible, participatory process would be to provide rational, predictable budgets which each health institution could use to make plans to provide services that would not be interrupted catastrophically by the sudden withdrawal of funding as one or another crisis intervenes. Where budgets must be redirected from one sector to another, this would be done with planning over the long-term in order to ensure some measure of stability and predictability in standards of service delivery, rather than through sudden pronouncements that make unreasonable immediate demands on patients and health workers. This would require the adoption of a transparent, participatory process at all levels of decision-making.

While this approach to engage in transparent, participatory budgeting might seem to be a straightforward prescription to achieve a better allocation of scarce resources, it is not as simple as it may appear to implement this in practice.

### ***The 'Accountability for Reasonableness' process***

Any proposal to engage in rational priority setting faces a threshold problem. Though society accepts that allocation of scarce resources should be 'fair and just' in theory, it cannot easily, if at all, agree on what specific set of priorities would be 'fair and just' in practice (Benatar, 2008). Advocates for every possible patient population and treatment will surface when budget reallocations, cuts or increases are proposed, and each will argue that his or her view is the most 'rational' and ethical. While policy-makers and other participants may agree that resources must be fairly and

efficiently allocated, and that health priorities must be made ‘rationally’ rather than arbitrarily, any chance of achieving consensus evaporates when we seek to apply these agreed-upon principles in a practical situation.

As an alternative to ambitious consensus-seeking on such policies, commentators have proposed that a fair, deliberative political process for the allocation of HIV and other health resources should be developed, through which competing proposals can be openly debated and a definitive distributive policy chosen (Arras & Fenton, 2009; Daniels & Sabin, 1997). Recognising this need in the context of potential inability to set priorities based on any agreed definition of ‘fairness’ or ‘justice’, and the adverse impact this failure has on decision-making in the health sector, Daniels and Sabin (1997) have proposed a process called ‘Accountability for Reasonableness’ (‘A4R’). Initially formulated for use in the private sector in the United States of America, the A4R process has already been used to inform priority setting in the Canadian public health system and in several other countries (Benatar & Martin, 2008). In this context, Daniels and Sabin (1997) argue that although a diverse, pluralistic society cannot always agree on definitions of ‘fairness’ and ‘justice’ to guide substantively just decisions, it is nonetheless possible to agree on a fair process for making such decisions. While this process cannot resolve all the dilemmas that arise when priorities need to be set, four constitutive conditions take us a step towards a more rational approach.

First, policy-makers must provide *relevant reasons* for their resource-allocation decisions, and have these reasons supported by both medical and scientific evidence and ethical principles and values. Relevant reasons include those that stakeholders agree are central to meeting the diverse needs of society under resource constraints, even though some may disagree with how resources are allocated. Second, these decisions and their rationale must be made *publicly accessible*. Third, there should be *opportunities for dispute resolution*, which may involve appeals to revisit and revise decisions in the light of new evidence or arguments, or in response to changing conditions. Finally, those charged with responsibility for making decisions must provide *the leadership to ensure that all of these conditions are met*.

### ***Advantages of using A4R***

The major advantages of A4R are the following: (1) it provides a framework for engagement and accountability across and between those stakeholders most concerned with how limited health resources are distributed, (2) these decisions are based on relevant evidence and ethical considerations and (3) such decisions are both effective and ethically and legally justifiable. When the public knows and understands why a decision was made, and how priorities were set, it will generally be more willing to accept the decision. This is especially true when non-governmental representatives from the general public have been meaningfully involved in the decision-making process.

An additional, and critically important, advantage of the A4R process is that if policy-makers meet its essential conditions, they are more likely to satisfy the requirements of South Africa’s Constitution that the government’s health-resource allocation policies must be ‘reasonable’. For example, South Africa’s Constitutional Court approved a resource-allocation policy adopted by a hospital to limit costly, long-term dialysis to patients who meet medical criteria for a kidney transplant,

and who therefore would have a chance to be cured. The court explained that it would be ‘slow to interfere with *rational decisions taken in good faith* [by hospital administrators]’ (*Soobramoney v. Minister of Health, Kwa-Zulu Natal*, 1998) [emphasis added].

In a subsequent case, the Treatment Action Campaign (TAC), an activist organisation representing people with HIV, sued the government, demanding that it provide nevirapine to pregnant HIV-positive women to reduce the chance of their transmitting the infection to their babies. It provided evidence that many poor, rural women who urgently needed the drug had no access to the limited number of ‘experimental’ centres, the only clinics in the country, where the government was willing to administer the drug (*Minister of Health v. Treatment Action Campaign*, 2002).

The Court rejected the government’s claims that more research was needed to prove the safety and effectiveness of nevirapine and that the state could not afford to provide this drug to all HIV-positive pregnant women. Accepting the evidence submitted by TAC that showed that the drug was safe and effective and that the government had the capacity to expand its programme to reach many more women, the court concluded that the government’s policy was ‘unreasonable’. The court added that for a policy to be reasonable, ‘those whose needs are the most urgent and whose ability to enjoy all rights therefore is [sic] most in peril, must not be ignored by the measures aimed at achieving realisation of the [Constitutional] right [to access treatment]’ ” (ibid.).

The court ordered the government to provide the drug immediately through public health facilities that already had the capacity to do so, and to develop a plan to roll out treatment to all HIV-positive women throughout the country. The court made several pointed comments that could be taken as practical advice for policy-makers. It called for ‘*proper communication, especially by the government*’ and insisted that for a programme to ‘meet the constitutional requirement of reasonableness’, its contents must effectively be made known to ‘*all concerned, down to the district nurse and patients.*’ [Emphasis added.] (ibid.). The A4R process thus echoes the court’s judgement that an allocation policy must be based on ‘relevant, rational reasons’, including evidence that shows that the policy will lead to effective outcomes, taking into account the interests of all stakeholders.

### ***Economic considerations in A4R: the use of cost-effectiveness data***

Resource-allocation decisions for public health programmes are increasingly based on the availability, analysis and application of up-to-date cost-effectiveness information on the expense, outputs, outcomes and impact of alternative intervention types. This methodology, aimed at achieving the socially optimal level of health-resource allocation, can be applied both within and across disease groups to facilitate technical efficiency (the distribution of resources across similar interventions aimed at the same disease or condition) and allocative efficiency (the distribution of resources across different disease groups and interventions). This approach is in keeping with recent calls for the South African government to divide health resources and set priorities on the basis of available epidemiological and cost information (Hofman & Tollman, 2010).



In the case of the HIV epidemic, an increasing body of evidence from economic, social and ethical perspectives points to the promotion of a change in the current balance of expenditure between HIV prevention and treatment strategies from an economically, socially and ethically optimal viewpoint. Such considerations do not appear to have informed the South African government's policy on treatment versus prevention resources, which remain heavily skewed towards treatment expenditure in spite of its lesser cost-effectiveness (Lyman & Wittels, 2010). However, recent analyses do indicate important HIV prevention gains from treatment programmes (Granich et al., 2010). There is also no evidence that the South African government has considered the cost-effectiveness of a more inclusive range of non-HIV health interventions, such as those identified by the Disease Control Priorities Project (Laxminarayan et al., 2006) when allocating an increasing level of resources to the HIV epidemic in the context of static health expenditure elsewhere.

While the application of academic, economic and scientific evidence for HIV resource allocation is attractive, a number of practical limitations to this approach should be recognised. The achievement of the 'social-ethical optimum' at the expense of the individual optimum goes against a number of medical ethical principles, including the 'rule of rescue' (Cookson, McCabe, & Tsuchiya, 2008). In addition, cost-effectiveness evidence is by no means comprehensive, and evidence of the impact of alternative investments such as health-systems strengthening are still unknown (Biesma et al., 2009). Finally, the application of such evidence needs to be tempered by consideration of the political, ethical and social acceptability of economically driven resource-allocation decisions. However, failing a consensus on substantive issues, at the very least, the A4R process would facilitate rational decision-making that would seek to weigh and balance both economic and non-economic considerations (Benatar, 2006).

### ***Policy considerations in A4R: global health diplomacy***

In addition to consideration of economic and ethical criteria, it must be recognised that any national government must make resource-allocation decisions in the context of broader policy decisions and 'realpolitik'. To this end, the emerging field of 'global health diplomacy' is focused on the broader, strategic evaluation of public health interventions in the public and foreign policy context. While the first duty of health-care resource-allocation decisions is, of course, to maximise positive health outcomes in an ethically acceptable manner, consideration must also be given to the collateral 'diplomatic' effects of alternative health interventions (Fidler, 2007; Lyman & Wittels, 2010); resource-allocation decisions must also be politically and socially acceptable, culturally sensitive, and, wherever possible, take into account their interactions with a range of broader policy considerations and goals for optimal overall social, development and economic effects (Labonté & Gagnon, 2010). Undertaking resource-allocation decisions without consideration of these issues creates a 'tense and dangerous duality' and may lead to missed opportunities to achieve multiple health and other social, political or developmental goals simultaneously (Center for Strategic and International Studies, 2010). To this end, policy-makers should, wherever possible, adopt a holistic monitoring and evaluation system (Jan, 1998) that takes into account not merely the more traditional, but notoriously narrow, outcomes of health interventions such as disability-adjusted life years

(‘DALYs’) and quality-adjusted life years (‘QALYs’), but also, in the interest of more transcendent goals, a range of practical considerations such as programme acceptability, geographical coverage, cultural appropriateness, equity, health-systems strengthening, strategic, political, international relations and diplomatic considerations (Conseil et al., 2010; Fidler, 2007). With the inclusion of such foreign and public policy considerations, a more socially acceptable allocation of resources both within HIV and across public health programmes in general may be achieved. As noted in the previous section, all of these factors, to the extent relevant to the allocation policies under consideration, could be considered under the A4R process.

### ***One province adopts A4R to allocate health resources***

Until recently, there have been only isolated examples of explicit, transparent rational resource allocation in South Africa (Benatar, Fleischer, Peter, Pope, & Taylor, 2000). Since 2008, the DOH of the Western Cape has engaged in a project based on the A4R process, adapted to local circumstances that would, through transparency and public participation, create explicit resource-allocation policies. Although the project is in its early stages, it has excited considerable interest and produced some promising results. Most recently, a policy for allocation of limited renal replacement therapy was proposed and adopted (Rayner & Swanepol, 2011). It is expected that other scarce medical resources (e.g., admission to ICUs and access to very expensive treatments) will be subject to a similar process over the coming years.

Unfortunately, there is no evidence that any of the other eight South African provinces, much less the national DOH, have begun to engage in any similar process that would engage with a wide variety of stakeholders such as clinicians, academics and health administrators actually responsible for delivering health care (Benatar, 2008). Without broader use of such a tool, it is not likely that resources will be allocated any differently in the future than in the past, just as it is not likely that the current ad hoc and somewhat arbitrary allocation of resources that has produced unfair, inequitable treatment of patients will change.

Given the arbitrary nature of past policy, and the resulting dysfunctions that threaten to undermine our public health system, we believe it is critical for South Africa’s national health policy-makers to take the lead in developing a transparent rationing process by which they themselves are accountable for their decisions. In our view, the key to accomplishing this in a politically, ethically and legally justifiable way is to adopt a decision-making process that is publicly accessible and accountable, and in which all major stakeholders have the opportunity to participate in a meaningful manner. While adherence to the A4R process will not solve all resource-allocation problems, this process would go a long way towards achieving more politically, ethically and legally justifiable decisions.

### ***Future challenges***

Other possibilities for increasing equitable access to health care, such as widespread adoption of the primary health-care approach or the government’s proposal to develop a form of national health insurance, cannot be addressed here. However, if implemented, both programmes would have potentially important implications for the sustainability of the current HIV treatment funding arrangements. We also

recognise that South Africa's DOH actually has limited control over the allocation of resources to vertical HIV programmes, as opposed to other forms of health expenditure, given the high proportion of HIV-specific donor funding and the associated agendas that are involved. Nonetheless, as donor contributions to HIV continue to decline (Lyman & Wittels, 2010), it becomes even more important that the DOH adopt a process by which its limited funds will be allocated amongst many competing users in a transparent, diplomatic, cost-effective and rational way.

## Conclusion

South Africa, along with many other developing countries, faces seemingly insurmountable difficulties in improving standards of, and access to, health care. Many more health professionals will be needed, as well as considerable infrastructural improvement within public sector health institutions, to meet idealistic demands of equity. How to train and retain more professionals and how to achieve an improved health-care infrastructure are additional major challenges and will take several decades to achieve. These challenges, along with others discussed above, provide some insight into the serious limits of what could be achieved in the quest for an entirely equitable health-care system in our economic context. They also highlight the need for modesty regarding what could be achieved in the short-term in a middle-income country bearing a massive burden of disease with the largest HIV-positive population in the world. While aspiring to achieve equity in health care, it should also be remembered that neglect of the social determinants of disease will seriously impede achievement of equity and improved population health. In such a challenging environment, the only option for governments such as that of South Africa is to work as fairly, and intelligently, as possible with the limited resources available to them.

To deal with this serious challenge to the sustainability of the South African national public health system, we recommend that national and provincial health administrators adopt the A4R process, tailored to suit South Africa's unique circumstances. We believe that through collaborative, participatory endeavours, such as those gradually being undertaken by the Western Cape's Department of Health, policy-makers could achieve greater consensus among all interested parties who participate in priority setting. Finally, budgetary decisions allocating health resources pursuant to a fair, transparent process would be more likely to be accepted as reasonable, non-discriminatory, fair and appropriate under conditions of severe resource constraint.

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## References

- Amico, P., Aran, C., & Avila, C. (2010). HIV spending as a share of total health expenditure: An analysis of regional variation in a multi-country study. *PLoS One*, 5(9), 12997. doi:10.1371/journal.pone.0012997
- Anderson, B. A., & Phillips, H. E. (2006). *Adult mortality (age 15–64) based on death notification data in South Africa: 1997–2004* (Report No. 03-09-05). South Africa: Pretoria.

- Retrieved October 2, 2012, from <http://www.statssa.gov.za/Publications/Report-03-09-05/Report-03-09-052004.pdf>
- Arras, J. D., & Fenton, E. M. (2009). Bioethics & human rights: Access to health-related goods. *Hastings Center Report*, 39(5), 27–38. doi:10.1353/hcr.0.0185
- Baleta, A. (1999). South African budget targets AIDS campaigns. *The Lancet*, 353(9155), 822. doi:10.1016/S0140-6736(05)76496-5
- Baleta, A. (2003). South Africa approves plan for universal access to antiretrovirals. *The Lancet*, 362(9398), 1811. doi:10.1016/S0140-6736(03)14944-6
- Barron, P. (2008). Health care in South Africa. In P. Barron, (Ed.), *South African health review, 2008* [online]. Health Systems Trust: Durban. Retrieved from: <http://www.hst.org.za/publications/841>
- Benatar, S. R. (2004). Health care reform and the crisis of HIV and AIDS in South Africa. *New England Journal of Medicine*, 351(1), 81–92. doi:10.1056/NEJMr033471
- Benatar, S. R. (2006). Facing ethical challenges in rolling-out antiretroviral treatment in resource poor settings: Comment on ‘they call it patient selection in Khayelitsha’. *Cambridge Quarterly of Healthcare Ethics*, 15, 322–330. Retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=434001>
- Benatar, S. R. (2007). An examination of ethical aspects of migration and recruitment of health care professionals from developing countries. *Clinical Ethics*, 2(1), 2–7. Retrieved from <http://ce.rsmjournals.com/content/2/1/2.full.pdf+html>
- Benatar, S. R. (2008, June 25). Meeting infinite demands with finite means. *Cape Times*, p. 9.
- Benatar, S. R., Fleischer, T. E., Peter, J. C., Pope, A., & Taylor, A. (2000). Treatment of head injuries in the public sector in South Africa. *South African Medical Journal*, 90, 790–793. Retrieved from <http://archive.samj.org.za/2000%20VOL%2090%20Jan-Dec/Articles/08%20August/1.12%20BIOETHICS%20DEBATES.TREATMENT%20OF%20HEAD%20INJURIES%20IN%20THE%20PUBLIC%20SECTOR%20IN%20SOUTH%20AFRICA.pdf>
- Benatar, S., & Martin, D. (2008). Resource allocation: International perspectives on resource allocation. In K. Heggenhougen & S. Quah, (Eds.), *International encyclopedia of public health*. Vol. 5 (pp. 538–543). San Diego: Academic Press.
- Benatar, S. R., & Saven, A. (1995). Morbidity trends in the medical wards of Groote Schuur Hospital—1971 and 1982. *South African Medical Journal*, 67, 968–974. Retrieved from <http://archive.samj.org.za/1985%20VOL%20LXXVII%20Jan-Jun/Articles/06%20June/3.7%20MORBIDITY%20TRENDS%20IN%20THE%20MEDICAL%20WARDS%20AT%20GROOTE%20SCHUUR%20HOSPITAL-1971%20AND%201982.%20S.R.%20Benatar%20a.pdf>
- Beresford, B. (2008a, November 21). On the way down. *Mail and Guardian* [online]. Retrieved from: <http://www.mg.co.za/article/2008-11-21-on-the-way-down>
- Beresford, B. (2008b, November 21). A healthier future. *Mail and Guardian* [online]. Retrieved from: <http://www.mg.co.za/printformat/single/2008-11-21-a-healthier-future>
- Biesma, R. G., Brugha, R., Harmer, A., Walsh, A., Spicer, N., & Walt, G. (2009). The effects of global health initiatives on country health systems: A review of the evidence from HIV/AIDS control. *Health Policy and Planning*, 24(4), 239–252. doi:10.1093/heapol/czp025
- Blecher, M. (2002). Downsizing of a provincial department of health—causes and implications for fiscal policy. *South African Medical Journal*, 94, 144–146.
- Blecher, M., & Thomas, S. (2005). Health care financing. In R. Ijumba & A. Padarath, (Eds.), *South African health review 2003/04* (pp. 269–290). Durban: Health Systems Trust. Retrieved from: <http://www.hst.org.za/publications/423>
- Bodibe, K. (2011). HCT campaign: The numbers so far living with AIDS. *South Africa health e-news* [online]. Retrieved from: <http://www.health-e.org.za/news/transcript.php?uid=20033204>
- Bradshaw, D., Groenewald, P., Laubscher, R., Nannan, N., Nojilana, B., Norman, ... Schneider, M. (2003). *Initial estimates from the South African national burden of disease study, 2000*. Medical Research Council Policy Brief. Cape Town: South African Medical Research Council.
- Burch, V. C., & Benatar, S. R. (2006). Rational planning for health care based on observed needs. *South African Medical Journal*, 96, 796–802. Retrieved from <http://www.samj.org.za/index.php/samj/article/view/1251/676>
- Cairncross, L. (2007, May 28). Hospitals forced to save money instead of lives. *Cape Times*, p. 3.

- Center for Strategic and International Studies. (2010). *Report of the CSIS commission on smart global health policy* [online]. Washington, DC: Center for Strategic and International Studies. Retrieved from: <http://csis.org/publication/report-csis-commission-smart-global-health-policy>
- Chopra, M., Lawn, J. E., Sanders, D., Barron, P., Karim, S. S. A., Bradshaw, D., . . . Coovadia, H. (2009). Achieving the health millennium development goals for South Africa: Challenges and priorities. *The Lancet*, 374(9694), 1023–1031. doi:10.1016/S0140-6736(09)61122-3
- Conseil, A., Mounier-Jack, S., & Coker, R. (2010). Integration of health systems and priority health interventions: A case study of the integration of HIV and TB control programmes into the general health system in Vietnam. *Health Policy & Planning*, 25(Suppl 1), i32–i36. doi:10.1093/heapol/czq055
- Cookson, R., McCabe, C., & Tsuchiya, A. (2008). Public healthcare resource allocation and the rule of rescue. *Journal of Medical Ethics*, 34(7), 540–544. doi:10.1136/jme.2007.021790
- Coulter, A., & Ham, C., (Eds.) (2000). *The global challenge of health care rationing* (pp. 29–37). Buckingham, UK: Open University Press.
- Cullinan, K. (2011). New AIDS plan aims to go big. *South African health e-news* [online]. Retrieved from: <http://www.health-e.org.za/news/article.php?uid=20033352>
- Daniels, N., & Sabin, J. (1997). Limits to health care: Fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philosophy and Public Affairs*, 26(4), 303–350. doi:10.1111/j.1088-4963.1997.tb00082.x
- Day, C. (2004). Facilities survey 2003—Selected findings from the fourth national survey of primary health care facilities. In R. Ijumba & A. Padarath, (Eds.), *South African health review 2003/04* (pp. 269–290). Durban: Health Systems Trust. Retrieved from: <http://www.hst.org.za/publications/423>
- Dohrn, J., Nzama, B., & Murrman, M. (2009). The impact of HIV scale-up on the role of nurses in South Africa: Time for a new approach. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 52(Suppl 1), S27–S29. doi:10.1097/QAI.0b013e3181bbc9e4
- Donaldson, C. (2008). Moving forward on rationing: An economic view. *British Medical Journal*, 337, a1872. doi:10.1136/bmj.a1872
- Dorrington, R. E., Johnson, L. F., Bradshaw, D., & Daniel, T. (2006). *The demographic impact of HIV on South Africa in 2006* [online]. Retrieved from: <http://www.mrc.ac.za/bod/DemographicImpactHIVIndicators.pdf>
- Doyal, L. (1997). The rationing debate: Rationing within the NHS should be explicit: The case for. *British Medical Journal*, 314, 1114–1118. Retrieved from <http://www.bmj.com/content/314/7087/1114>
- El-Sadr, W. (2009). Health systems exist for real people. *Journal of Acquired Immune Deficiency Syndromes*, 52(Suppl 1), S1–S2. doi:10.1097/QAI.0b013e3181bbc7a
- England, R. (2008). The writing is on the wall for UNAIDS. *British Medical Journal*, 336, 1072. doi:10.1136/bmj.39569.497708.94
- Fidler, D. (2007). Reflections on the revolution in health and foreign policy. *Bulletin of the World Health Organization*, 85(3), 243–244. doi:10.2471/BLT.07.041087
- Fleischer, T., Kevany, S., & Benatar, S. R. (2010). Will escalating spending on HIV treatment displace funding for treatment of other diseases? *South African Medical Journal*, 100(1), 32–34.
- Gordon, J. G. (2008). A critique of the financial requirements to fight HIV/AIDS. *The Lancet*, 372, 333–336. doi:10.1016/S0140-6736(08)61117-4
- Granich, R., Crowley, S., Vitoria, M., Smyth, C., Kahn, J. G., Bennett, R., . . . Williams, B. (2010). Highly active antiretroviral treatment as prevention of HIV transmission: Review of scientific evidence and update. *Current Opinion in HIV and AIDS*, 5, 298–304. doi:10.1097/COH.0b013e32833a6c32
- Grépin, K. (2009). *Too much of a good thing? The effects of HIV/AIDS funding on African health systems* [online]. Conference abstract from International Health Economics Association Beijing Conference 2009. Retrieved from: <http://ihe2009.abstractbook.org/presentation/1292/>
- Guinness, L., Arthur, G., Bhatt, S. M., Achiya, G., Kariuki, S., & Gilks, C. F. (2002). Costs of hospital care for HIV-positive and HIV-negative patients at Kenyatta National Hospital, Nairobi, Kenya. *Journal of AIDS*, 16, 901–908. doi:10.1097/00002030-200204120-00010

- Health Systems Trust. (2010). *Health expenditure as a percentage of GDP* [online]. Retrieved from: <http://indicators.hst.org.za/healthstats/79/data>
- Hofman, K., & Tollman, S. (2010). Setting priorities for health in 21st century South Africa. *South African Medical Journal*, 100(12), 798–800.
- Househam, C. (2010). Africa's burden of disease: The University of Cape Town Sub-Saharan Africa Centre for Chronic Disease. *South African Medical Journal*, 100(2), 94–95.
- Houston, S. (2002). Justice and HIV care in Africa—Antiretrovirals in perspective. *Journal of the International Association of Physicians in AIDS Care*, 1(2), 46–50. doi:10.1177/154510970200100202
- Human Rights Watch. (2011). “Stop making excuses” accountability for maternal health care in South Africa. Retrieved from: <http://www.hrw.org/reports/2011/08/08/stop-making-excuses>
- Ijumba, P., & Padarath, A. (2006). South African health care. In P. Ijumba & A. Padarath, (Eds.), *South African health review 2006* [online]. Available from: [http://www.hst.org.za/publications/item.php?item\\_id=697](http://www.hst.org.za/publications/item.php?item_id=697)
- International Association of Physicians in AIDS Care. (2002). TAC, MSF import generic AIDS drugs into South Africa. *International Association of Physicians in AIDS Care*, 8(3), 73.
- Jan, S. (1998). A holistic approach to the economic evaluation of health programs using institutionalist methodology. *Social Science & Medicine*, 47(10), 1565–1572. doi:10.1016/S0277-9536(98)00228-7
- Karim, S. A. (2009). HIV infection & TB in South Africa: An urgent need to escalate the public health response. *The Lancet*, 374(9693), 921–933. doi:10.1016/S0140-6736(09)60916-8
- Kevany, S., Meintjes, G., Rebe, K., Maartens, G., & Cleary, S. (2009). Clinical and financial burdens of secondary level care in a public sector antiretroviral roll-out setting (G F Jooste Hospital). *South African Medical Journal*, 99(5), 320–325. Retrieved from [http://www.scielo.org.za/scielo.php?pid=S0256-95742009000500018&script=sci\\_arttext](http://www.scielo.org.za/scielo.php?pid=S0256-95742009000500018&script=sci_arttext)
- Labonté, R., & Gagnon, M. (2010). Framing health and foreign policy: Lessons for global health diplomacy. *Globalization and Health*, 6(14). doi:10.1186/1744-8603-6-14
- Laxminarayan, R., Jamison, D. T., Mills, A., Breman, J., Measham, A., Alleyne, G., ... Shahid-Salles, S. (2006). Advancing global health: Key messages from the disease control priorities project. *The Lancet*, 367(9517), 1193–1208. doi:10.1016/S0140-6736(06)68440-7
- Lyman, P., & Wittels, S. (2010). No good deed goes unpunished: The unintended consequences of Washington's HIV/AIDS programs. *Foreign Affairs*, 89(4), 74–84. Retrieved from [http://www.academyofdiplomacy.org/publications/article\\_archive/Lyman\\_HIV-AIDS.pdf](http://www.academyofdiplomacy.org/publications/article_archive/Lyman_HIV-AIDS.pdf)
- Marseille, E., Hofmann, P. B., & Kahn, J. G. (2002). HIV prevention before HAART in Sub-Saharan Africa. *The Lancet*, 359, 1851–1856. doi:10.1016/S0140-6736(02)08705-6
- Mayosi, B. (2009). The burden of non-communicable diseases in South Africa. *The Lancet*, 374(9693), 934–947. doi:10.1016/S0140-6736(09)61087-4
- Minister of Health v. Treatment Action Campaign* No. 2. (2002). Version 5 SA 721 (South African Constitutional Court).
- Mooney, G., & Gilson, L. (2009). The economic situation in South Africa and health inequities. *The Lancet*, 374(9693), 858–859. doi:10.1016/S0140-6736(09)61125-9
- National Department of Health. (2003). *Operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa* [online]. Pretoria: National Department of Health. Retrieved from: <http://www.info.gov.za/otherdocs/2003/aidsoperationalplan.pdf>
- National Department of Health. (2004). *Department of health annual report 2003/04*. Pretoria: South African National Department of Health.
- National Department of Health. (2007). *HIV & AIDS and STI strategic plan for South Africa 2000–2011* [online]. Pretoria: National Department of Health. Retrieved from: <http://www.info.gov.za/otherdocs/2007/aidsplan07.pdf>
- National Department of Health. (2011). *National strategic plan (NSP) for HIV and AIDS, sexually transmitted infections (STIs) and TB 2012–2016* [online]. Pretoria: South African National Department of Health. Retrieved from: [http://www.sanac.org.za/files/uploaded/519\\_NSP%20Draft%20Zero%20110808%20pdf%20%20final.pdf](http://www.sanac.org.za/files/uploaded/519_NSP%20Draft%20Zero%20110808%20pdf%20%20final.pdf)

- Ndlovu, N. (2010). *An exploratory analysis of HIV and AIDS donor funding in South Africa* [online]. South African Regional Policy Network: Budget Brief No. 155. Retrieved from: <http://www.sarpn.org/documents/d0001241/index.php>
- Novotny, T., & Kevany, S. (2013). *The way forward in global health diplomacy: Definitions, research, and training*. In 21st century global health diplomacy. Geneva, Switzerland. Organization for Economic Cooperation and Development. (2011). *South Africa country profile* [online]. Retrieved from: <http://www.oecd.org/dataoecd/14/62/40573742.pdf>
- Rabkin, M. (2009). The impact of HIV scale-up on health systems: A priority research agenda. *Journal of Acquired Immune Deficiency Syndromes*, 52, S3–S5. doi:10.1097/QAI.0b013e3181bbcd69
- Rayner, B., & Swanepol, C. (2011, January 12). Not playing god with kidney patients. *Cape Times*, p. 9.
- Rodriguez, W., & La Salvia, T. (2004). Elements of HIV care in resource-poor settings: Policy challenges. *Harvard Health Policy Review*, 5(2), 6–19.
- Shiffman, J. (2009). Has aid for AIDS raised all health funding boats? *Journal of Acquired Immune Deficiency Syndromes*, 52, S45–S48. doi:10.1097/QAI.0b013e3181bbcb45
- Singh, J. A., Upshur, R., & Padayatchi, N. (2007). XDR-TB in South Africa: No time for denial or complacency. *PLoS Medicine*, 4(1), 50. doi:10.1371/journal.pmed.0040050
- Soobramoney v. Minister of Health, Kwa-Zulu Natal*. (1998). (1) SA 765 (South African Constitutional Court).
- South African National Treasury. (2010). *2010 estimates of national health expenditure* [online]. Retrieved from: <http://www.treasury.gov.za/publications/guidelines/2010%20ENE%20Guidelines%2009%20Nov%202009.pdf>
- UNAIDS. (2010). *AIDS epidemic update* [online]. Retrieved from: <http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2006/Default.asp>
- World Bank Disease Control Priorities Project. (2008). *Investing in health* [online]. Retrieved from: <http://files.dcp2.org/pdf/DCP/DCP.pdf>

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# Health diplomacy and the adaptation of global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept (HPTN 043)

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## Abstract

**Background:** Study-based global health interventions, especially those that are conducted on an international or multi-site basis, frequently require site-specific adaptations in order to (1) respond to socio-cultural differences in risk determinants, (2) to make interventions more relevant to target population needs, and (3) in recognition of 'global health diplomacy' issues. We report on the adaptations development, approval and implementation process from the Project Accept voluntary counseling and testing, community mobilization and post-test support services intervention.

**Methods:** We reviewed all relevant documentation collected during the study intervention period (e.g. monthly progress reports; bi-annual steering committee presentations) and conducted a series of semi-structured interviews with project directors and between 12 and 23 field staff at each study site in South Africa, Zimbabwe, Thailand and Tanzania during 2009. Respondents were asked to describe (1) the adaptations development and approval process and (2) the most successful site-specific adaptations from the perspective of facilitating intervention implementation.

**Results:** Across sites, proposed adaptations were identified by field staff and submitted to project directors for review on a formally planned basis. The cross-site intervention sub-committee then ensured fidelity to the study protocol before approval. Successfully-implemented adaptations included: intervention delivery adaptations (e.g. development of tailored counseling messages for immigrant labour groups in South Africa) political, environmental and infrastructural adaptations (e.g. use of local community centers as VCT venues in Zimbabwe); religious adaptations (e.g. dividing clients by gender in Muslim areas of Tanzania); economic adaptations (e.g. co-provision of income generating skills classes in Zimbabwe); epidemiological adaptations (e.g. provision of 'youth-friendly' services in South Africa, Zimbabwe and Tanzania), and social adaptations (e.g. modification of terminology to local dialects in Thailand; and adjustment of service delivery schedules to suit seasonal and daily work schedules across sites).

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**Conclusions:** Adaptation selection, development and approval during multi-site global health research studies should be a planned process that maintains fidelity to the study protocol. The successful implementation of appropriate site-specific adaptations may have important implications for intervention implementation, from both a service uptake and a global health diplomacy perspective.

**Keywords:** Adaptations, Voluntary counseling and testing, Global health diplomacy, HIV, Sub-Saharan Africa

## Background

### The HIV epidemic

From a public health perspective, there is no more compelling crisis in the world today than the HIV epidemic in sub-Saharan Africa. Since the epidemic began, more than 60 million people have been infected with HIV [1], and in 2009, AIDS killed 1.4 million people in Africa alone. In addition to the death and disease burden, the epidemic has had an enormous impact on economies, life expectancies, and society. Globally, about one-third of those currently living with HIV are aged 15–24, and young adults account for 40% of all new infections [1]. From the perspective of national AIDS control planners and policy-makers in these countries, evidence-based strategies that have maximum epidemic impact on target regions and populations are critically important. For this to occur, both planners and implementers need interventions that are both sustainable, and adaptable, to the local epidemiological, cultural, economic and infrastructural context [2,3]. Randomized controlled trials that test such interventions should be correspondingly flexible and sensitive to local needs throughout their development and implementation.

### Adapting global health interventions

Adaptations to health programs are defined as the degree to which they are changed or modified by a user in the process of their adoption and implementation [4]. HIV-related interventions that have been proven for efficacy frequently need to be adapted to different environments and settings when implemented as public health programs [5,6]. Similarly, HIV-related trials, especially those that are conducted in multiple countries or at multiple sites within a country, frequently require site-specific adaptations to the intervention in order (1) to respond to socio-cultural differences [7] (2), to make interventions more relevant and sensitive to target populations (including different risk determinants and risk behaviors) [2,3,8], (3) to improve intervention utilization and effectiveness [9], and (4) to ensure that interventions meet minimum diplomatic [10] and foreign policy [11] standards. For the latter, an inability to align broader policy goals with global health initiatives, has the potential to create ‘a tense and confusing duality’ [12]. In all cases, adaptation development and

implementation should be a planned process that maintains fidelity to core elements of the study protocol [13].

### Project Accept

The Project Accept intervention has been described elsewhere [9]. Briefly, 34 communities in sub-Saharan Africa (at study sites in Soweto and Vulindlela in South Africa, Kisarawe in Tanzania, and Mutoko in Zimbabwe) and 14 communities in Thailand were randomized to receive either a community-based voluntary counseling and testing (CBVCT) intervention in addition to standard clinic-based VCT (SVCT) services, or SVCT services alone. The CBVCT intervention had three major components designed to change community norms and reduce risk of HIV infection among all community members, irrespective of whether or not they participated directly in the intervention. These were (1) to make counseling and testing more available in community settings through mobile voluntary counseling and testing (MVCT), (2) to engage the community through community mobilization (CM), and (3) to provide post-test support services (PTSS), including psychosocial support groups, coping effectiveness and stigma reduction training. The intervention was of 42 months duration, with start and end-dates varying by site.

Although the intervention in each of the countries and study sites was derived from the same theoretical model [14,15], contained the same core strategies, and conformed to common standard operating procedures, the implementation of intervention components was designed to be responsive and adaptable to each local context. To this end, all stages of intervention implementation were determined through intensive collaboration between host-country investigators and institutions, study communities, field staff, and their international partner institutions (listed at end of paper). In particular, the multisite study steering committee worked with representatives of national AIDS programs in host countries throughout the development of the intervention, on both a deliberative and an *ad-hoc* basis, both (1) to keep national planners informed on project activities and (2) to ensure that project activities were implemented in a manner that would be both appropriate and sustainable in resource-limited settings.

An intervention subcommittee was tasked with overseeing all aspects of the intervention and included members from each of the five project sites. The duties of the subcommittee were (1) to monitor intervention implementation to ensure that all sites worked to common standards, (2) develop and conduct regular quality assurance activities, and (3) propose, discuss and determine acceptability of site-specific adaptations to the study protocol. In addition, the intervention subcommittee established an intervention working group at each site including site principal investigators and project directors. These groups worked via conference calls and site visits throughout the intervention. This participatory process facilitated the resolution of both site-specific and cross-site issues— and helped in developing, determining and applying protocol adaptations.

The CBVCT intervention was remarkably successful in terms of service utilization. After 42 months of the intervention, utilization of the CBVCT model was more than 10 times higher than utilization of SVCT in control communities, across sites [9]. This divergence was primarily attributable to the mobile nature of the intervention, combined with extensive CM efforts to promote utilization in intervention communities. In addition to these explanations, the ongoing adaptability of the CBVCT intervention to local conditions may have helped to generate and maintain these utilization levels.

#### **Adaptations to the Project Accept intervention**

Each intervention component was designed with varying allowances for adaptations to local conditions throughout the intervention. For MVCT, sites were free to determine the most appropriate system of service delivery (e.g. tents, caravans, community buildings, or project vehicles) as well as field hours operating schedules. For CM, study staff were asked: 'Is our innovation sensitive to, and compatible with, the community's existing values and beliefs, local culture, indigenous customs, past experiences, and the needs of potential adopters?' In this way, CM staff were responsible for discovering how the intervention could be made more compatible with communities' existing values through (1) suggesting and developing new systems for working with local social networks and (2) the ongoing refinement of information, education and communication (IEC) messages. For PTSS, coordinators were encouraged to work with community representatives to identify local post-test service needs as well as collaborating with related existing services (if any). For certain components of PTSS which had heretofore only been proved for effectiveness in industrialized countries, staff were encouraged to monitor their acceptability to local populations. In this paper, we report on the adaptations development and approval process at each site and the major adaptations developed and

implemented at each site, presented according to (1) intervention component and (2) broader adaptations themes and types. For all components, while scope for possible adaptations was provided in advance of intervention implementation, the adaptation process itself was more precisely developed and 'fine-tuned', in response to specific (and often unforeseeable) issues, subsequent to intervention implementation.

#### **Ethical review**

The study procedures were approved by the following ethical review committees: The Johns Hopkins University Committee on Human Research (Thailand); Chiang Mai University Research Institute for Health Sciences (Thailand); the Ministry of Public Health (Thailand); The Medical University of South Carolina Institutional Review Board (IRB) for Human Research (Tanzania); Muhimbili University of Health and Allied Sciences IRB (Tanzania); The National Institute of Medical Research IRB (Tanzania); The University of California, San Francisco Committee on Human Research (Zimbabwe); and The Medical Research Council of Zimbabwe (Zimbabwe); and the University of the Witwatersrand Health Sciences Research Ethics Committee (South Africa). Project Accept also had an independent Data Safety and Monitoring Board which biannually reviewed project benchmarks, outcomes, and adverse events. These ethical review committees remained active throughout the intervention, reviewing and advising the study steering committee on specific proposed intervention adaptations as part of the approval process. In turn, the project-specific ethics committee was composed of investigators from each site, and advised on when an adaptation would require a protocol modification to be approved by these review boards.

#### **Methods**

##### **Community consultations and adaptation implementation**

Monitoring community members' attitudes toward study activities and promoting community involvement were key elements of intervention development and helped study staff to troubleshoot implementation problems and implement adaptations with the support of intervention communities. Throughout the duration of the study, structured community involvement helped (1) to ensure ongoing two-way communication between study teams and study communities and (2) to respond to the ethical and practical issues raised by trial participants or their representatives. Communication with relevant district, regional and national leadership, including local government representatives, was also maintained throughout the intervention as required. A number of ways of maintaining community involvement in the adaptations process were developed, as described below.

### **Community working groups**

Community Working Groups (CWGs) represented community members' interests in each intervention community. CWGs consisted of approximately 30 representatives from a cross-section of local ethnic, tribal and community groups who were also leading members of local social networks, including faith-based organizations (FBOs), sporting clubs, community health services, and local government. CWG members were encouraged to keep in close contact with their communities, and frequently met in the absence of the research team to solicit feedback on project activities that the community might be reluctant to articulate in a larger forum. CWGs also helped to develop and tailor information, education and communication (IEC) materials relevant to the various social networks within the community and were supported through continuing training and education throughout the intervention. CWG members were not project staff, but were paid a sitting allowance at some sites for attendance in meetings. Representatives from each CWG also served on a Study Advisory Committee (SAC), designed (1) to allow primary stakeholders to exercise leadership at a higher level of study coordination and (2) to ensure community involvement both within and across communities.

### **Community-based outreach volunteers**

As part of the CM team, community-based outreach volunteers (CBOVs) were responsible for liaising with local organizations such as peer groups, FBOs and social clubs on behalf of Project Accept. CBOVs were community members who became early adopters of VCT or PTSS and, where possible, held strategic positions within local social networks. As community members, CBOVs were uniquely placed to monitor and report on the ongoing acceptability of the intervention to participating communities.

### **Community engagement**

Study staff were consistently encouraged to develop new and creative ways to keep participating communities informed about, and engaged in, intervention development, acceptability and adaptation. These included regular, interactive community meetings; the creation and use of informal communication channels (e.g. impromptu group or individual discussions with community members); developing relationships with key informants outside CWG structures (e.g. local business owners); and facilitating linkages between CWGs other community organizations.

### **The adaptations process**

While provision for adaptations was made in the original study protocol, as described above, the adaptations process was primarily developed during the intervention itself, on a

site-by-site, 'learning by doing' basis, as appropriate to the wide range of issues and often unforeseen obstacles that had to be addressed throughout the intervention period. The adaptations process therefore evolved organically, throughout the intervention, on an *expost* rather than on an *ex-ante* basis. In this way, the use of community involvement and feedback mechanisms were essential to the adaptations process across sites. Key features of adaptations development and implementation were consistent across sites, and included (1) identification and discussion of site-specific utilization and uptake issues on bi-weekly conference calls with the intervention sub-committee throughout the intervention period in order to ensure prompt feedback on utilization challenges; (2) submission of a written proposal for adaptation to the intervention sub-committee (3); review of proposals, recommendations, and forwarding to the steering committee for further review; and (4) the steering committee making a final decision on whether to approve or reject the proposed adaptations. As described above, the CBVCT intervention also maintained an ethics sub-committee throughout the intervention period, responsible for the review and approval of any proposed adaptations to service delivery from a human subjects perspective, in order to determine if protocol modifications would need to be approved by the various review boards. Adaptations approved by the ethics and intervention sub-committees, and later by the study steering committee, were then introduced to project staff via periodical cross-site retrainings and intervention sub-committee site visits. Project coordinators were then responsible for pilot-testing the adaptation and, equally importantly monitoring performance of field staff as the adaptation was implemented.

### **Zimbabwe**

In Zimbabwe, adaptations were initially proposed by field staff during weekly debriefings following consultations with and feedback from CWGs, MVCT, CM and PTSS participants, as well as other stakeholders in the study communities, including ward councilors, village heads, local chiefs, and religious and political leaders. Proposed adaptations were then discussed at internal project management meetings with the principal investigator, and approved adaptations were discussed with intervention monitors and the steering committee before implementation. Approved adaptations were then communicated to the local chief community, who then instructed junior chiefs, village heads, and so on down the local hierarchy to assist project staff with their implementation.

### **Thailand**

In Thailand, field staff across components and CWGs were responsible for observing intervention acceptability and performance on a day-to-day basis throughout the intervention. Additional community-level consultations

with teenagers, village health personnel, religious groups, households, and other local volunteer or charity groups were also conducted throughout the intervention. Project staff reported findings and suggestions for adaptations to the project director at weekly project meetings, which were in turn considered at monthly meetings of senior staff, including local principal investigators, the project director, and intervention component coordinators. Implementation of adaptations was rolled-out to the broader community after consultation with CWGs and other local stake holders, including community representatives from government, health care and commerce. CWG meetings were frequently divided into smaller working groups to discuss the implementation of proposed adaptations and, were attended by both senior and field staff.

#### **Tanzania**

In Tanzania adaptation conceptualization and development took place at the field staff and CBOV level. Based on their day-to-day experience of field activities, meetings between field staff and CBOVs were held on a regular basis to exchange ideas on intervention implementation. Proposed adaptations were then referred to component coordinators, the local project director, the SAC, and the local principal investigator. After preliminary approval for adaptations from the study steering committee, further approval was sought from local religious leaders and community groups. Before implementation, all adaptations were publicized and explained in community meetings.

#### **Vulindlela**

Project staff initiated changes to the intervention in Vulindlela. The site used an ongoing data management and fieldwork 'feedback loop' to monitor intervention implementation and adaptations, and weekly review and planning meetings between field staff and senior management were central to ensuring efficiency and effectiveness of adaptation delivery. Using monitoring and evaluation data, including utilization and quality assurance measures to track operational innovation effectiveness was also critical to the adaptations process. CBOVs also played an important role at the Vulindlela site, providing (1) a useful source of ideas for what innovations would or would not work in this cultural context, and (2) ensuring that adaptations obtained the necessary support from traditional, political and community structures.

#### **Soweto**

In Soweto, adaptations to the intervention originated primarily with field staff. Cross-component events planning committees made up of MVCT, CM and PTSS representatives were established in each intervention community to develop adaptations before presentation to the project

director. Adaptations project leaders were then identified by the project director and component coordinators and were responsible for providing organizational leadership in the implementation of adaptations. CBOVs were essential to the implementation of adaptations in Soweto by generating support from the primary stakeholders, including local NGOs, in the community.

## **Results**

### **Cross-component adaptations**

#### ***Intervention delivery adaptations***

Adaptations to the structure and schedules of field teams were required across sites. In Zimbabwe and Vulindlela, the initial division and rotation of field teams across intervention communities by intervention component (MVCT, CM and PTSS) was found to be both inefficient in terms of staff transportation and confusing to participants. In Zimbabwe, separate CM, MVCT and PTSS teams were restructured into two combined teams, each of which included representatives from MVCT, CM and PTSS. Each team was allocated two intervention communities, and operated in each community for a two-week period each month. In Vulindlela, four combined teams were created and assigned to individual communities for the remainder of the intervention. Intervention delivery schedules were also adapted to local conditions. In Zimbabwe, project staff negotiated with mining employers to deliver the intervention at workplaces for clients that would not otherwise have had access to project services during working hours, and, similarly, with farming employers during harvest times. In Thailand, it was observed within the first 6 months of the intervention that utilization by the 18 to 32 year-old target population was higher on evenings and weekends, and intervention delivery was rescheduled for these times. In Vulindlela, a late afternoon and early evening intervention delivery schedule was introduced in response to participant feedback and based on a successful pilot. Weekend service delivery was also piloted, but abandoned after participants reported a preference for attending family activities in Vulindlela and as a result of low demand in Tanzania.

A number of other cross-component adaptations were also introduced throughout the intervention. In Vulindlela, a performance incentive system, including bonuses for staff meeting intervention delivery targets was introduced in response to high levels of staff turnover in the early stages of the intervention. The risk of coercion was mitigated by the exclusion of field supervisors from this incentive scheme. Also in Vulindlela, a reluctance by participants to evaluate project activities using written forms meant that these were replaced by feedback discussions with CBOVs. In Thailand and Zimbabwe, the frequent attendance of intoxicated villagers at intervention activities

meant that the sites had to develop a system to assess eligibility for participation based on the amount of alcohol consumed. In Tanzania, owing to the long distances involved, project equipment was stored in secure village storage areas, including the houses of village leaders.

### **Religious adaptations**

The support of FBOs can be critical to the acceptance of HIV interventions in resource-limited settings [16,17]. Sites were encouraged to respond to objections, suggestions or concerns from FBOs about project activities as they arose, and to adapt the intervention accordingly. Across sites, interaction with FBOs included project staff facilitating HIV/AIDS discussions during religious services, provision of MVCT on religious center grounds, and the establishment of FBO-based support groups. In Zimbabwe, project staff proactively engaged with religious groups with known histories of discouraging members from seeking medical services. In those cases where religious leaders declined all involvement with the intervention, their decision was respected by study staff. In Thailand, support from local monks was essential to community acceptance of the intervention in Buddhist communities, and staff were trained in the correct etiquette and protocol for working with senior religious figures. In addition, monks in intervention communities were invited to participate in training sessions on project goals and the impact of HIV on their communities. As a result of these efforts, Buddhist temples were made available for project activities, and a number of monks worked closely with CBOVs. In Zimbabwe and Thailand, the discussion of religiously-sensitive issues was discouraged during project activities held in, or in close proximity to, Catholic churches (e.g. on church grounds). In Soweto, special sessions for local Christian church leaders (*abafundisi*) were introduced to promote awareness of project activities: as a result, religious leaders both accessed MVCT and disclosed their HIV status during *bafundisi* forums. In Tanzania, intervention activities were divided by gender in Muslim areas, project activities were not provided in mosques, and CM messages were adapted to ensure sensitivity to local Muslim communities, including a suspension of services during Ramadan when requested.

### **Epidemiological adaptations**

Sites were encouraged to adapt intervention delivery to respond to the local HIV epidemic, and in particular to target those high-risk populations with low service utilization. In Zimbabwe, Tanzania and Soweto, high levels of HIV prevalence amongst younger age groups [18] led to the introduction of 'youth-friendly' activities and curricula, including intervention presence at soccer tournaments,

where information sessions were provided before and during matches; presentations on project activities in school guidance and counseling classes; inter-school quiz competitions on HIV and project activities; and the development of support groups for out-of-school youths. In Zimbabwe, the intervention targeted truck drivers and roadside vendors (via intervention delivery at halting sites); military personnel (via information sessions at local barracks); and couples (via promotions encouraging joint MVCT and PTSS attendance). In Thailand, where the HIV epidemic is concentrated in young, high-risk populations [1,19], CBOVs held workshops with teenage groups to assess which aspects of the intervention were most attractive to them. In Soweto, specific population groups were targeted for mobilization, including traditional healers, Zulu males living in hostels, and women's groups.

### **Social, political & cultural adaptations**

Although efforts had been made to include site-specific social and cultural adaptations during protocol development, a range of further and related adaptations were introduced throughout the intervention through the identification of popular local practices by field staff. Across all sites, popular social gathering places (e.g. pubs and community centers) and their times of peak operation were identified over time and included as intervention venues. In Zimbabwe, Tanzania and Soweto, adaptations were made to health and project terminology based on feedback from participants and in keeping with local dialects. In Thailand, these included tribal rituals (e.g. sword dances and costume displays) performed during project events; field staff hired based on their knowledge of local languages and customs; the provision of karaoke facilities to participants during evening sessions; and special liaison staff hired and trained to work with refugee groups residing in intervention communities located on the Thailand-Burma border. In Tanzania, cultural norms meant that women were discouraged from utilizing project services. As a result, targeted campaigns at female gathering places (e.g. water boreholes) to encourage women to access project services were introduced. Also in Tanzania, the intervention was re-named as "Project Afiki" (the local Kiswahili term for "Accept"). In both Thailand and Tanzania, small gifts are frequently exchanged in social settings as a form of etiquette. Although the protocol prohibited the provision of material incentives to attend project activities, it was agreed that the provision of small, valueless presents (e.g. key rings) to participants would be permitted as a cultural concession. In Soweto, field staff observed that many participants were reluctant to access MVCT services alone and preferred to participate in groups. As a result, a 'Bring a Friend' strategy was introduced.

## Mobile voluntary counseling and testing

### *Intervention delivery adaptations*

Ongoing adaptations to MVCT delivery were required across sites, and counseling messages were updated to reflect both new scientific evidence and local needs throughout the intervention. Across sites, (1) culturally-tailored health services messages were introduced into counseling curricula, including information on local availability and referrals (except practices); (2) treatment referral messages were regularly updated to reflect the ongoing expansion of antiretroviral therapy, and (3) special counseling curricula for high-risk population groups were delivered in response to emerging evidence on their role as drivers of the epidemic. In Zimbabwe, clients requested, and received the addition of a bereavement-counseling message to assist in coping with HIV-related deaths.

MVCT adaptations according to ongoing changes in national health policies were also required across sites. In Tanzania, project staff coordinated MVCT delivery with the president's national testing campaign [20], which was rolled out for a three-month period midway through the intervention. In Soweto and Vulindlela, the minimum age of participation in MVCT was lowered from 18 to 16 years old, in keeping with the South African national HIV testing policy [21].

### *Environmental and infrastructural adaptations*

Across sites, MVCT venues and equipment were adapted to local environment and infrastructure. In Zimbabwe, remote villages were frequently inaccessible due to road and weather conditions, and participants reported walking distances of up to 7 kilometers to access designated venues. In response, intervention teams introduced MVCT to a series of remote 'satellite venues' identified in collaboration with CBOs. In Thailand, the communal philosophy of 'house, temple, school' was adopted for MVCT delivery. With the permission of local community leaders, Buddhist temples, Christian churches, other religious centers, private houses, and local health centers were used as MVCT venues, and river-boats and motor-bikes were used to transport MVCT staff to more remote venues. Tables and chairs were provided by the communal temple (*wat*), and community members were active in helping to set up equipment. As a result of this community assistance, the site did not need to invest in caravans or tents throughout the intervention. In Tanzania, roadside service provision was introduced along major transportation routes to increase MVCT utilization. In Vulindlela, Soweto and Zimbabwe, and with the encouragement of teachers, MVCT was provided in local schools. CM staff later reported increased knowledge and awareness of project activities from students' parents. In Vulindlela, the original MVCT caravans were replaced with larger models in order to meet utilization

demands at peak times, while in Zimbabwe and Tanzania, tents were used instead of caravans for less accessible sites.

### Post-test support services

#### *Intervention delivery adaptations*

Community perceptions of PTSS were ambivalent at the introduction of the intervention and PTSS participation was often mistakenly associated with HIV infection by community members. In these cases, community members assumed that only HIV-positive individuals would require PTSS. The resulting initial low uptake of PTSS drove a range of adaptations to eligibility and participation criteria to improve both recruitment and community perceptions of PTSS. Across sites, initial uptake of PTSS services was mainly by people who had not yet been tested for HIV by Project Accept. These individuals were designated as "guests" within the PTSS system and were granted limited access to services. This restriction was abandoned after 'guest' participants requested greater access to PTSS in order to *prepare* for VCT. As a result, the role of PTSS evolved into supporting and advising both VCT participants and those considering VCT. In Zimbabwe, where PTSS groups were initially separated between HIV positive and negative individuals, combined-status groups were introduced, and participants were invited both to contribute to curriculum development and form their own administrative structures.

The structure, content and scheduling of PTSS sessions were also adapted in response to participant demands. Across sites, individual psycho-social counseling sessions were initially only available by advance appointment. As the intervention progressed, and in response to client demand, this service was provided before and after other PTSS activities, on an *ad-hoc* basis. In Thailand, (1) CET sessions were divided by age group to accommodate a wide age range of participants, each of which had different discussion preferences, and (2) support group provision was delivered in collaboration with local government health centers after staff discovered that these centers were delivering an identical service. Also in Thailand, due to the low incidence of HIV in intervention communities, CET sessions were adapted to provide information to HIV-negative persons on coping with the potential risk of HIV and helping others to cope with HIV. In Thailand and Tanzania, the planned 8-hour sessions for coping effectiveness (CET) and stigma reduction activities were found to be too long for participants, and were reduced to three 3 hour sessions over successive days. In Tanzania, more flexible scheduling of PTSS was introduced to respond to community demands.

Various other adaptations were made to PTSS service delivery throughout the course of the intervention. Across sites, PTSS information booths were set up adjacent to MVCT to facilitate recruitment of participants to PTSS.

In Tanzania, sporting activities, card games and board games were introduced into PTSS sessions in order to provide a social forum for HIV discussions. In Zimbabwe, a trainer-of-trainers course was introduced for PTSS participants. In Soweto, PTSS advocates were trained in safe disclosure procedures, and special PTSS sessions designed for the education and training of traditional healers on HIV/AIDS and related issues were introduced. As a result, a number of traditional healers referred their patients to MVCT and PTSS. In Vulindlela, PTSS staff provided telephone reminders of session times to new participants.

#### ***Environmental and infrastructural adaptations***

Across sites, PTSS venues were adapted to the local environment and infrastructure. In Zimbabwe, Vulindlela and Soweto, PTSS was redesigned as a mobile service in order to improve access. Venues included schools, community halls, and local business centers. In Vulindlela, participants indicated a preference for accessing PTSS in communities other than those in which they lived, in order to reduce possible stigma associated with PTSS participation. As a result, Project Accept offices, which were located outside intervention communities, were adopted as PTSS venues. Transport was provided to participants by project staff, and participants subsequently reported a more enabling and open learning environment. In Zimbabwe, participants reported difficulty accessing PTSS referral services due to transport costs. In response, project staff transported service providers, including nutritionists, lawyers, and nurses, to the intervention communities.

#### ***Economic adaptations***

PTSS adaptations also responded to local economic conditions. In Zimbabwe and Tanzania, poverty, hunger and malnutrition were common issues in intervention communities and were frequently cited as reasons for non-attendance of longer sessions. The following adaptations were developed in response: (1) provision of tea, lunch and nutritious drinks (*mahewu*) to participants, (2) income generation and skills development classes provided before and after PTSS activities, (3) development of partnerships with local organizations and government officials to provide farming inputs, food aid, and legal services to participants, (4) support groups were provided with horticultural equipment and training in partnership with local groups, and (5) lay counselors were trained through the Zimbabwe Institute of Systemic Therapy (ZIST-CONNECT). In Thailand and Tanzania, income-generating equipment, including chicken coops and crop seeds, were provided to both unemployed and HIV-positive participants. These adaptations helped both to mitigate the economic effects of HIV-related stigma and to attract HIV-positive persons without other means of income to PTSS.

#### ***Community mobilization***

##### ***Intervention delivery adaptations***

Across all sites, ongoing adaptations to CM messages were required to mitigate both participant fears of blood draws and intervention 'staff stigma', in which project staff were suspected of being infected with HIV. In Vulindlela, the use of pamphlets as an outreach strategy was found to be ineffectual due to poor literacy and was replaced by public mobilization talks held in central and public community areas. In Soweto, CM 'road shows', which involved vehicles and field staff touring through intervention communities, were developed and included a combination of door-to-door activities and participation by prominent local community members; CM 'street dialogues', which involved approaching and engaging community members in conversation about the intervention, combined with the distribution of promotional materials; and skills development workshops, including career counseling, were provided to community members as part of CM activities. In both South African sites, megaphones and loud hailers were used to deliver CM messages and announce MVCT and PTSS venues and activities after staff observed community members using PA systems to announce community events. In addition, youth-specific CM activities were introduced in schools, and project drivers were trained to become part-time CM staff.

##### ***Environmental, political and infrastructural adaptations***

CM activities were continually responsive to the local environment. Across all sites, and in response to community feedback, CM activities were gradually relocated closer to MVCT and PTSS venues, throughout the intervention. In Zimbabwe, (1) CM activities were suspended during election periods to avoid being mistaken for political activism and ensure the safety of staff, participants and project equipment, and (2) CM staff provided transport and nursing staff wherever possible during disease outbreaks (e.g. cholera), which was beyond the initial scope of the protocol. In Soweto, CM campaigns specifically focused their efforts on Zulu hostels, which were initially opposed to male involvement in HIV testing activities, and, in both South African sites, CM staff promoted the intervention as a part of the "life skills" curriculum in local schools. In Tanzania, CM activities in remote communities were concentrated in the dry season, and CM team size was adjusted across communities in inverse proportion to intervention demand.

##### ***Community-based outreach volunteers***

Across sites, the role of community-based outreach volunteers (CBOVs) evolved in response to intervention needs. In Vulindlela, unanticipated demands of CM work on field staff resulted in the increased recruitment and utilization

of CBOVs. CBOVs were given individual and group targets for PTSS and MVCT recruitment, and stipends, transport allowances, and other incentives were provided. As a result, CBOVs were renamed Community-Based Outreach Mobilizers in keeping with their enhanced CM role. Also in Vulindlela, a strong family culture led to the deliberate recruitment of CBOVs from large families, who then encouraged their social networks to attend MVCT and PTSS. In Zimbabwe, initial low levels of involvement by women prompted the training of increased numbers of female CBOVs. In Tanzania, CBOVs helped to advise on the choice of intervention venues, giving them an unanticipated role in the intervention delivery process.

## **Discussion & conclusions**

### **Consistency & flexibility in adaptation development**

Both the adaptations process and implementation of the adaptations themselves were critical to the acceptance, utilization and sustainability of the Project Accept intervention across study sites. The adaptations process, which had to balance sensitivity to the local context in order to improve utilization against consistency in the core elements of intervention delivery in accordance with the multi-site study protocol, also needed to ensure a minimum level of comparability across sites. In this way, site-specific adaptations processes, while procedurally variable, maintained a common set of features. These included (1) involvement of field staff in the generation of adaptations, (2) community acceptance measures, and (3) the role of the study steering committee, ethical review boards, and intervention sub-committees in their approval and implementation.

The adaptations developed across sites, while diverse, also maintained a common set of themes and approaches. In many cases, the same cross-component, or component-specific, adaptations would be developed independently across sites. In other cases, successful adaptations in one site would quickly be adopted by other sites. In these ways, a number of common themes in adaptation types, such as those identified above, were readily identifiable across sites.

### **Measuring adaptation impact & estimating effects on uptake**

While our experiences, and associated anecdotal evidence, provide compelling support for the hypothesis that these adaptations influenced the impact of the CBVCT intervention through increased MVCT and PTSS utilization, it is, of course, not possible to establish a purely causal link between adaptation implementation and such outcomes. A range of potential confounding factors exist, including, but by no means limited to, the stage of intervention implementation, increased community acceptance over time, and broader environmental changes in knowledge of, and

attitudes towards, testing for HIV in intervention communities. Nonetheless, it is notable that intervention uptake in intervention communities was over 10 times higher than in control communities, in which no adaptations were permitted, by the end of the intervention [9]. In addition, service utilization monitoring and evaluation data, when reviewed on a site-by-site basis, may be chronologically associated with the implementation of significant adaptations, when allowing for appropriate time lags. For example, at the Vulindlela site, service uptake for MVCT rose by over 100 per cent (mean uptake for the first two quarters of 2007 was 142 participants, as compared to 289 participants in the second two quarters, and increasing further to 369 participants in the first two quarters of 2008), directly after the service provision plan was adapted from rotating specialized MVCT, PTSS and CM teams to community-based, integrated, and multi-skilled teams. Given the temporal proximity of such improvements in utilization with adaptation implementation, it may be postulated that such adaptations may have had, across sites, a significant impact on service utilization.

### **Determining when to challenge societal norms**

One of the most challenging aspects of the CBVCT intervention was determining when to challenge societal norms in intervention delivery and adaptation. For example, as described above, gender issues were circumvented through the adapted delivery of female-specific interventions. On the other hand, religious issues were, in general, accommodated, rather than challenged, by adapting the intervention. Decisions around when societal norms should be challenged, through intervention adaptations are inherently subjective and environment-specific [15]. However, as a general principle, adapting to, rather than challenging, societal norms was found to be most appropriate in the CBVCT context.

### **Diplomacy, global health, and foreign policy**

The capacity to adapt global health interventions to local conditions also has considerable significance from the foreign policy perspective, in the context of the discipline now known and recognized as global health diplomacy [10]. Under this aegis, the inclusion of scope for adaptability in intervention design and delivery has the potential to make significant differences to local perceptions of international development activities, including the approval and acceptance of programs and interventions by recipient countries, communities, and individuals, and, by extension, the profile and prestige of donor organizations and countries [22,23]. Over time, such interventions may need to become more sensitized to these broader roles and responsibilities, as currently reflected at the policy level by increased integration between departments of foreign policy and foreign assistance in donor countries - helping to



maintain, or even increase, levels of development funding on a 'smart power' basis. Systems of more formally considering the value and worth of global health interventions from a 'foreign policy' perspective may be developed, including such considerations as community acceptance and involvement, so that such they can be monitored and evaluated on this basis [24]. The associated capacity of interventions to adapt to local economic, cultural, religious, and other environmental conditions in recipient countries may have the potential to make a substantial difference to these broader 'collateral' diplomatic, and foreign policy outcomes of foreign assistance programs [25].

### Recommendations

A number of adaptation-related recommendations for related future interventions may be gleaned from the Project Accept experience. Collaboration with local actors, not just in service delivery, but at the highest levels of intervention design and planning, is, of course, a *sine qua non* of any enlightened intervention in the 21<sup>st</sup> century. Perhaps most importantly, however, the necessity of building in provisions and scope for adaptations to the study in advance of intervention implementation, on an *ex ante* basis, should be borne in mind both by planners and scientists. This may be achieved, most directly, through the use of appropriate terminology in both the study protocol and standard operating procedures documents: in avoiding the use of excessively dogmatic or didactic language, interventions may be implicitly permitted appropriate levels of flexibility in intervention delivery, whilst maintaining fidelity to the original study protocol. Similarly, related and future studies should, wherever possible, make allowance for the monitoring and evaluation of changes in service utilization consequent to adaptation implementation—though, as described above, this may be difficult to achieve in the presence of multiple competing factors effecting service uptake. Nonetheless, wherever possible, the effect of adaptation implementation on key study outcomes should be carefully reviewed, on a site-by-site basis, and with reference to appropriate lead times, in order to determine their effectiveness. Finally, as described above, the broader 'collateral' gains of such adaptations, such as improvements in international relations and community acceptance, should be carefully considered, wherever possible, through the development and application of appropriate metrics.

### Conclusions

Adaptations are particularly important in the design of HIV-related interventions. Given the oft-contentious nature of such interventions from a social, cultural and religious perspective [26], it is essential to ensure that, wherever possible, and from both the service delivery and the global health diplomacy perspectives, these interventions are designed with the expectations and needs of

recipient communities in mind. In the more specific case of VCT, for which utilization by most-at-risk populations is frequently a key issue [27], adaptability to local conditions may help to break down a both behavioral and environmental barriers to the testing process.

Ultimately, the need for intervention adaptation is based on challenges that could not have been foreseen during the design and launch of the intervention. Preparations will never be perfect, so time, money, capacity and flexibility to produce interventions has to be 'built-in' to the design of both trials, and interventions themselves, at all stages of the planning process. Without this inherent adaptability, program designers and implementers risk achieving sub-optimal utilization levels. As long as integrity to the key elements of the intervention protocol can be maintained, such adaptations can only enhance the value of the intervention in the eyes of policymakers, communities and individuals - in both donor and recipient countries.

### Competing interests

The authors declare that they have no competing interests.

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### References

1. UNAIDS: *Global Facts and Figures 2009*; Accessed on December 1 2009 through [http://data.unaids.org/pub/FactSheet/2009/20091124\\_FS\\_global\\_en.pdf](http://data.unaids.org/pub/FactSheet/2009/20091124_FS_global_en.pdf).
2. Veniegas RC, Kao UH, Rosales R: **Adapting HIV prevention evidence-based interventions in practice settings: an interview study.** *Implement Sci* 2009, **4**:76.
3. Veniegas RC, Kao UH, Rosales R, Arellanes M: **HIV prevention technology transfer: challenges and strategies in the real world.** *Am J Public Health* 2009, **99**(Suppl 1):S124–S130.
4. Rogers EM: *Diffusion of Innovations*. 4th edition. New York: The Free Press; 1995.
5. Castro FG, Barrera M, Martinez CR: **The cultural adaptation of prevention interventions.** *Prev Sci* 2004, **5**(1):41–45.

6. Wegbreit J, Bertozzi S, DeMaria L, Padian N: **Effectiveness of HIV prevention strategies in resource-poor countries: tailoring the intervention to the context.** *AIDS* 2006, **20**:1217–1235.
7. Wingood GM, DiClemente RJ: **Enhancing adoption of evidence-based HIV interventions: promotion of a suite of HIV prevention interventions for African American women.** *AIDS Educ Prev* 2006, **18**(4 Suppl A):161–170.
8. King W, Nu'Man J, Fuller TR, Brown M, Smith S, Howell AV, et al: **The diffusion of a community-level HIV intervention for women: lessons learned and best practices.** *J Womens Health (Larchmt)* 2008, **17**(7):1055–1066.
9. Khumalo-Sakutukwa G: **Project Accept (HPTN 043): a community-based intervention to reduce HIV incidence in populations at risk for HIV in Sub-Saharan Africa and Thailand.** *J Acquir Immune Defic Syndr* 2008, **49**(4):422–431.
10. Kickbusch I: *Public Health Diplomacy: Training Across Disciplines.* *Bull World Health Organ* vol.85 no.12. Geneva; 2007.
11. McInnes C, Lee K: **Health, security and foreign policy.** *Rev Int Stud* 2006, **32**:5–23.
12. Center for Strategic and International Studies: *Final Report of the CSIS Commission on Smart Global Health Policy*, 2010. Accessed through: <http://csis.org/event/rollout-final-report-csis-commission-smart-global-health-policy>.
13. McKleroy V: **Adapting evidence-based behavioral interventions for new settings and target populations.** *AIDS Educ Prev* 2006, **18** (Supplement A):59–73.
14. Valente TW: **Social network thresholds in the diffusion of innovations.** *Soc Network* 1996, **18**(1):69–89.
15. Gladwell M: *The Tipping Point: How Little Things Can Make a Big Difference.* 1st edition. Boston: Little Brown; 2000.
16. Liebowitz J: *The impact of faith-based organizations on HIV / AIDS prevention and mitigation in Africa*, Health Economics and HIV/AIDS Research Division. Durban: University of KwaZulu-Natal; 2002.
17. Woldehanna S, Ringheim K, Murphy C, et al: *The role of faith-based organizations (FBOs) in HIV/AIDS prevention, care and treatment efforts: A key informant survey.* *International Conference on AIDS (15th: 2004: Bangkok, Thailand)*; 2004.
18. Buvé A, Bishikwabo-Nsarhaza K, Mutangadura G: **The spread and effect of HIV-1 infection in sub-Saharan Africa.** *Lancet* 2002, **359**(9322):2011–2017.
19. Surasiengsunk S, Kiranandana S, Wongboonsin K, et al: **Demographic impact of the HIV epidemic in Thailand.** *AIDS* 1998, **12**(7):775–784.
20. Tanzanian Prime Minister's Office: *National HIV/AIDS Testing Campaign* 2007. Accessed through <http://www.tacaids.go.tz/home/13-example-category/13-national-hivaids-testing-campaign.html> on October 28, 2009.
21. National Department of Health: *HIV & AIDS and STI Strategic Plan for South Africa 2007–2011.* *National Department of health document* 2007. Accessed through: <http://www.info.gov.za/otherdocs/2007/aidsplan07.pdf> on October 28, 2009.
22. Fidler D: **Reflections on the revolution in health and foreign policy.** *Bulletin World Health Organization* 2007, **85**(3):243–244.
23. Feldbaum H: **Health diplomacy and the enduring relevance of foreign policy interests.** *Plos Medicine* 2010b, **7**(4):e1000226.
24. Bonventre E: **Monitoring and evaluation of department of defense humanitarian assistance programs.** *Military Review* 2008, :66–72.
25. Lyman NP, Wittels SB: *No Good Deed Goes Unpunished: The Unintended Consequences of Washington's HIV/AIDS Programs.* Foreign Affairs; July-August 2010.
26. Bayer M: **AIDS prevention and cultural sensitivity: are they compatible?** *Am J Public Health* 1994, **8**(6):895–898.
27. Hutchinson PL, Mahlalela X: **Utilization of voluntary counseling and testing services in the Eastern Cape, South Africa.** *AIDS Care* 2006, **18**(5):446–455.

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## COMMENT ON

**THE GEOPOLITICS OF EBOLA AND GLOBAL HEALTH SECURITY: WHY ANTHROPOLOGY MATTERS**

BY FIONA LARKAN\*, CAROLINE RYAN, SEBASTIAN KEVANY

**Introduction**

The combination of an exceptionalised disease, fragile health systems and a failure of global health leadership and governance constituted a perfect storm for the spread of Ebola in West Africa. In this heightened sense of emergency, a shift in global health securitization<sup>i</sup> has occurred, which should not go unnoticed or unchallenged. Globally mediated epidemics are highly political and anthropologists are uniquely placed to interrogate the geopolitics of Ebola and global health security.

The outbreak of Ebola in three West African countries has raised the worldwide profile of this zoonotic infectious disease to an unparalleled level. No previous Ebola outbreak spread so widely; the previous 24 epidemics remained within national borders and were never reported to have killed more than 300 people (Lancet Ebola Resource Centre, 2014). International responses to the West African Ebola outbreak have elicited a wide range of responses – not all positive, some openly critical – and much hyperbole.

Only 3% of World Health Organisation (WHO) non-support staff have the non-medical skills (e.g. law, diplomacy, trade, economics and anthropology) required for epidemic preparedness (Gostin & Friedman, 2015). Clearly anthropology can

contribute to understanding outbreaks in terms of customs and practices and local responses to disease (Hewlett & Amola, 2003; Hewlett & Hewlett, 2007). Following a One-Health approach, anthropologists have also explored the extent to which human-animal-environment interactions (Brown & Kelly 2015) and hunting practices (Wolfe *et al*, 2000; Saez *et al*, 2014) are central to the emergence of zoonotic diseases. Indeed because of this, anthropology also has a significant role to play in reviewing and critiquing the repercussions of Ebola on international politics and international relations.

**The Perfect Storm***Exceptionalisation of Ebola*

The framing of a disease as exceptional or unique from other diseases (and therefore warranting exceptional response) has vast, often problematic, consequences. As evidenced by AIDS exceptionalism, 30 years of targeted interventions has been criticised for shifting resources disproportionately away from endemic diseases and health system strengthening (Smith & Whiteside, 2010), and for contributing to the problem of stigma and self-stigma (Cameron 2006, Kelly 2006) in low income contexts. Infectious diseases (widely referred to as ‘emerging infectious diseases’), and include the inappropriately named haemorrhagic viruses, such as Ebola. The haemorrhagic term stems from a westernized, media-hyped image surrounding the gastro-intestinal haemorrhagic

clinical symptoms, sometimes seen towards the late stages of the disease. However the more apt and recently applied title, Ebola Virus Disease (EVD) has not normalized the exceptional image of Ebola. Portrayed as an uncontrollable threat, particularly to the westernized nations, EVD is viewed as one of the greatest threats to global security warranting co-ordinated global action (Kalra *et al*, 2014). In 2015 that global action took the form of military deployment by donor countries in West Africa.

Bass (1998), Bennett & Edelman (1985) Sontag (1989) and Wald (2008) have all documented the consequences of consistent and stereotypically negative narratives of a disease. By fashioning an account around a priori assumptions,

*'history seems clear and undeniable because the analytical perspective has made it so [...] leaving the psychological impression that one is experiencing reality-driven objectivity' (Bennett & Edelman, 1985:162).*

Sontag (1989:141) observed that 'from class fiction to the latest journalism, the standard plague story is of inexorability, inescapability'. Bass (1998:446) argues that this 'hegemonic residue of imperial 'contamination' remains embedded in our culture'.

Thus, along with a 'disease-knows-no-borders' rhetoric, this move toward securitised response strategies has emerged from a concept of 'universal consensus'. Granted, the concept of universality in terms of collaboration and sharing resources to resolve major global challenges is hard to challenge. However targeting responses to Ebola from the perspective of containment in terms of securitization, and placing such response strategies at the top of the global health agenda, may support a 'universal consensus' that in Connell's (2007) words represents 'the views of

the most privileged 600 million assuming the same views are experienced by the whole 6000 million who are actually in the world'.

#### *Fragile Health Systems:*

The high mortality from Ebola in this instance is in part due to inadequate health systems and lack of resources (Boozary, Farmer & Jha, 2014)- problems that will continue to challenge these three West African governments when the outbreak is contained. Edelstein, Anglides & Heymann, (2015) detail some of the challenges that are already being observed - decreased vaccination coverage for infectious diseases (including measles); a disruption to HIV, TB and Malaria programmes, and the loss of more than 800 health workers from an already depleted health workforce. The focus on Ebola at the expense of other health programmes has resulted in an increase in the rates of other treatable diseases including respiratory viruses, diarrhoea, Lassa fever, malaria (Lancet Ebola Resource Centre, 2014). And this does not begin to explore the economic, social, and psychological impact of the outbreak which will also have repercussions for many years to come.

#### *Failure of Global Health Leadership and Governance*

It is clear that global health leadership failed West Africa in this instance (Farrar & Piot 2014, Gostin & Friedman 2014, 2015, Horton, 2015, Rosling 2015, Boozary *et al* 2014). The early response was left to national governments of the three most affected countries – Sierra Leone, Guinea and Liberia – which are amongst the world's lowest ranking countries in terms of the Human Development Index<sup>ii</sup>; none had the capacity or infrastructure to respond to the worsening crisis.

The WHO over the past decade has reduced its core budget, and the bulk of its remaining budget is project/programme driven, with relatively little core budget to respond quickly to situations such as Ebola (Rosling 2015). Despite the establishment by the WHO in 2005, of a legally binding governing legal framework – the International Health Regulations – there is no coordinated, funded commitment to countries with reduced capacity to comply with the regulations (Wilson, Brownstein & Fidler, 2010). Global health governance is shown to be an ‘ad hoc series of institutions, laws and strategies that do not function as a coherent whole’ (Gostin & Friedman 2015:1903). In the vacuum created by the lack of clear leadership we saw a shift in power from the WHO to the UN in the form of a UN Mission (UN Mission for Ebola Emergency Response – UNMEER) which, as Boozary *et al* (2014) point out, gained more support than any resolution since the founding of the United Nations in 1946.

### **Global Health Security**

The West African Ebola outbreak, constituted a serious crisis for the people of West Africa, not for the world. It was without doubt a humanitarian emergency that merited international support and assistance. However the securitization and militarization that followed should not go unnoticed or unchallenged.

While the idea of Global Health ‘security’ has been in existence for some time, in recent years this has increasingly been shaped by the war on terror (Collier *et al*, 2004). Ingram (2005) explores the origin of the structure and dynamics of the security discourse, and its shift from the paradigmatic case of war. Extending the security discourse to other realms he argues, ‘risks mis-stating the nature of the problem, rendering ‘security’ analytically fuzzy, or calling forth

inappropriate state involvement’ (2005: 524). Global health security thus becomes extraordinary, or outside the frame of ‘normal politics’. The decision to introduce forces (in a civil defence capacity) might seem attractive, even understandable, advantages include the productive and humanitarian employment of personnel and equipment otherwise designed for destructive purposes and the increased integration between international development and broader international affairs and relations under the ‘smart global health’ (CSIS, n.d.) paradigm. However, the ‘norm of preparedness’ (Lakoff, 2008) which shapes, and structures, the Emergency Response discourse and strategies has ongoing consequences for global health and involves ‘the migration of techniques initially developed in the military and civil defense to other areas of governmental intervention’ (2008:422). The concern here is while the key to preparedness would undoubtedly be a robust health system in each country, that goal is being usurped by preparedness for an ‘emergency response’. The best possible form of preparedness would be a combination of long-term, well resourced health systems in-country and strong global health governance structure.<sup>iii</sup>

Of particular concern is the manner in which donor countries, such as the United States and European Union member states (including the Republic of Ireland), dispatched military forces on the basis of an ‘emergency response’ – on the basis that armed forces are considered to have the most well-developed capacity to respond to epidemic outbreaks that threaten health security in a way that the more lumbering, bureaucratic structures of the United Nations and other supranational and multilateral organizations could never hope to do.

This interface between societal, political and medical forces is where anthropology should situate itself. How have recipient and other severely-affected societies been affected by the international response? To what extent have issues of national sovereignty and independence been jeopardized by the occupation of international armed forces in West Africa? How are legislative, diplomatic and organizational structures developed and maintained – often at very short notice – to govern such measures? How are local communities affected? And, perhaps most importantly, what precedent does this set on an international level? Could the incumbent Russian government, for example, employ similar measures – on the basis of national security – in response to perceived or actual disease outbreaks in the Ukraine?

In the 21<sup>st</sup> Century, security concerns – including specific elements such as global health security – tend to trump all other considerations, including the diplomatic, the societal, the medical, the political and (given the costs of securitization) the economic. Similarly, at the individual, community and national population levels, these concerns may have eroded other priorities. The gains are manifold; including diversification of military roles, greater resource allocation to global health, and tangible increases in human security. But what are the costs, most particularly at the societal and cultural levels? The imposition of global health security measures, including surveillance, the employment of health service provision from outside the national health system without an official mandate, and the associated disempowerment of the individual in related policy decisions all stand to erode social and political empowerment in developing countries. In order for future interventions comparable to the Ebola response to be successful, the employment of anthropological perspectives and preparations are therefore essential.

### Conclusion

The combination of disease exceptionalism, fragile health systems and a failure of global health governance has contributed to a shift in power in global health emergency responses, and the setting of unfortunate precedents. The overlap between military forces and global health initiatives is not limited, as one might imagine, to global ‘superpowers’. In conjunction with the global response, the Irish Department of Defence deployed 4 personnel to the United Kingdom’s Ebola treatment centre in Sierra Leone in 2015. Although the recent involvement of the Irish Navy in the European migrant crisis does not transgress international sovereign borders, these efforts provide a further compelling example of the armed forces’ enhanced role in health and humanitarian endeavors – with a specific focus on emergency responses – in the 21<sup>st</sup> Century.

For better or for worse, the precedent has been set for the militarization of such interventions. The question that both the global health and anthropological communities will face is whether to embrace or steadfastly oppose these changing remits and purviews. If the former, the articulation of a set of standards or guidelines, jointly developed by civil society, the military, and the global health community, governing the boundaries of military involvement in global health efforts according to ‘diplomatic’ standards, should be articulated. It is not enough for Western powers to mobilize responses to resource poor settings and withdraw once the crisis is overcome. Failure to build up strong health systems will inevitably lead to additional crises in the future, and require further rapid (and costly) intervention

## References

- Bass, J. (2009) Hearts of darkness and hot zones: The ideologeme of imperial contagion in recent accounts of viral outbreaks. *Quarterly Journal of Speech* 84(4) 430-447.
- Bennett, L. and Edelman, M. (1985) Toward a New Political Narrative. *Journal of Communication*. pp. 156-171.
- Boozary, A., Farmer, P. and Jha, A. (2014) The Ebola Outbreak, Fragile Health Systems, and Quality as a Cure. *JAMA* 312(18) 1859-1860
- Brown, H. and Kelly, A. (2015) Material Proximities and Hotspots: Toward an Anthropology of Viral Hemorrhagic Fevers. *Medical Anthropology Quarterly*. 28(2) 280-302.
- Cameron E. (2006) Forum Lecture: 'Normalising Testing – Normalising AIDS'. Ronald Louw Memorial Campaign: 'Get Tested, Get Treated. University of KwaZulu, Durban.  
<http://rds.refer.sn/IMG/pdf/CAMERONLouwENG.pdf> [accessed 17.8.2015]
- Collier, S., A. Lakoff, and P. Rabinow (2004) Biosecurity: Towards an Anthropology of the Contemporary. *Anthropology To-day* 20:3–7.
- Connell R. (2007) Social science on a world scale: studying the social in a world arena. In *Southern Theory*, Connell R. (ed.), Cambridge. Polity Press, pp.212-232
- CSIS (n.d.) <http://csis.org/program/commission-smart-global-health-policy> [accessed 17.8.2015]
- Edelstein, M., Angelides, P. and Heymann, D. (2015) Ebola: the challenging road to recovery. *The Lancet* 385(9984) 2234-2235
- Farrar JJ, Piot P. (2014) The Ebola Emergency — Immediate Action, Ongoing Strategy. *New England Journal of Medicine*. 371:1545
- Gostin, L. and Friedman, E. (2014) Ebola: a crisis in global health leadership. *The Lancet* 384(9951) 1323-1325
- Gostin, L. and Friedman, E. (2015) A retrospective and prospective analysis of the west African Ebola virus disease epidemic: robust national health systems at the foundation and an empowered WHO at the apex.
- Hewlett, B. and Amola, R. (2003) Cultural Contexts of Ebola in Northern Uganda. *Emerging Infectious Diseases* 9(10) 1242-1248.
- Hewlett, B. and Hewlett, B. (2007) *Culture and Politics: The Anthropology of an Emerging Disease (Case Studies on Contemporary Social Issues)*. Cengage Learning: Boston.
- Horton, R. (2015) Offline: An irreversible change in global health governance. *The Lancet*. 385 p2136.
- Ingram, A. (2005) The New Geopolitics of Disease: Between Global Health and Global Security. *Geopolitics* 10:522-545
- Kalra S., Kelkar D., Galwankar S.C, Papadimos T.J, Stawicki S.P., Arquilla B., Hoey B., Sharpe R., Sabol D. and Jahre J. (2014) The Emergence of Ebola as a Global Health Security Threat: From 'Lessons Learned' to Coordinated Multilateral Containment Efforts. *Journal of Global Infectious Disease* 2014 Oct-Dec; 6(4): 164–177.
- Kelly M. (2006) Father Michael's 2006 Address: Stigma and Discrimination. World AIDS Day 2006. Dublin, Ireland.
- Lakoff, A. (2008) The Generic Biothreat, or, How We Became Unprepared. *Cultural Anthropology* 23(3) 399-428.
- Lancet Ebola Resource Centre. <http://ebola.thelancet.com/>
- Rosling, H. (2015) Interview. 25.02.2015 on *This Week in Global Health* (TWIGH) <http://www.twigh.org/video>
- Saez, A., Weiss, S., Nowak, K., Lapeyre, V., Zimmermann, F. et al (2014) Investigating the zoonotic origin of the West African Ebola Epidemic. *EMBO Molecular Medicine* 7(1) 17-23.
- Smith J.H and Whiteside A. (2010) The history of AIDs exceptionalism. *Journal of the International AIDS Society* 13:47, 1-8.
- Sontag, S. (1989) *AIDS and its metaphors*. Farrar, Straus and Giroux: New York.
- Wald, P. 2008 *Contagious: Cultures, Carriers, and the Outbreak Narrative*. Durham: Duke University Press.
- Wolfe, N., Eitel, M., Gockowski, J., Muchaal, P., Nolte, C. et al (2000) Deforestation, hunting and the ecology of microbial emergence. *Global Change and Human Health* 1(1) 10-25.
- World Health Organisation (2015). Ebola Situation Report – 12<sup>th</sup> August 2015. WHO, Geneva

**Notes**

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<sup>i</sup> The process of (in this case) supranational and international actors transforming subjects into matters of 'security', thus enabling extraordinary means to be used in the name of security.

<sup>ii</sup> United Nations Human Development Index ranks Sierra Leone, Guinea, and Liberia at 183<sup>rd</sup>, 179<sup>th</sup> and 175<sup>th</sup> respectively on a scale of 187 (UNDP, 2013)

<sup>iii</sup> One of the few good reviews the US military received in this regard was the construction of long-term health clinics – however these are often un-used because of parameters on treatment.

**The West African Ebola Viral Disease (EVD) situation:**

As of 12<sup>th</sup> August 2015 WHO reports 27,929 total cases (Suspected, Probable, and Confirmed) of this strain of Ebola subtype ZEBV (CDC 2014, Baize et al 2014, Kalra et al 2014), with total deaths recorded as 11,283. Guinea and Sierra Leone continue to have new cases though the trend is downward. Liberia, has been declared Ebola-free. The WHO situation report of 10<sup>th</sup> June 2015 states 'case incidence has been below 10 confirmed cases per week for three consecutive weeks, but there remains a significant risk of further transmission and an increase in case incidence in the near and medium term'.

World health Organisation (2015). Ebola Situation Report – 12<sup>th</sup> August 2015. WHO, Geneva



# 12

## The Way Forward in Global Health Diplomacy: Definitions, Research, and Training

*Thomas E. Novotny, MD, MPH\**  
*and Sebastian Kevany, MA, MPH†*

### Introduction

This volume has covered a wealth of historical, political, diplomatic, and technical information in an attempt to describe the deepening links between health and foreign policy and the architecture that characterizes 21st century health diplomacy. Since we began our work, considerable progress has been made in further defining, applying, and expanding our understanding of the growing field of “global health diplomacy” (GHD). An overriding question that arises from our attempts to define this field is: How does foreign policy serve health or how does health serve foreign policy?

Kickbusch and others have asserted that diplomats are no longer concerned only with matters of national power, security, and trade; they also need to deal with global challenges such as development, health, environment, water, and

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food security.<sup>1</sup> Likewise, global health practitioners must look to international agreements, negotiations, and collaborations in order to assure the health of their domestic populations. The skills necessary for success in such activities are not taught in health sciences programs, nor are the in-depth technical health issues normally covered in foreign service training institutes. Nevertheless, such collaborative global engagement by foreign policy professionals, health professionals, and nongovernmental actors is essential not only in sustaining the health of national populations but also in assuring the effectiveness of the substantial investments in global health that have been made in the last two decades.

Increasingly, evidence-based outcomes of investments are demanded by donors and international health financing organizations, and these outcomes rightly depend on the success of the collaborations necessary for fully implementing these interventions. Yet the array of actors participating in global health negotiations, philanthropies, and health diplomacy has also grown enormously over the last two decades.<sup>2</sup> This final chapter will summarize the efforts to define GHD, present research questions that have been formulated by various scholars related to GHD, and briefly describe training scenarios and curricular content for GHD.

## **Defining Global Health Diplomacy**

Feldbaum and Michaud<sup>3</sup> assembled helpful definitions for foreign policy, diplomacy, and global health as a baseline for developing a definition of GHD (Box 1).

In particular, diplomacy is a set of methods used by national governments to “implement their [own] foreign policy.” Today, this diplomacy encompasses “hard power” (military and economic sanctions), “soft power” (co-option and cooperation), and “smart power” (which utilizes all modalities to achieve foreign policy objectives). These concepts help to set the stage for refining our notion of GHD not only as soft power but also as a part of smart power for governments; such an approach includes nongovernmental organizations, multilateral organizations, and a wide variety of donors and private sector actors. Recently, several authors have

### Box 1. Definitions: Foreign Policy, Diplomacy, Global Health\*

- Foreign policy is the “substance, aims and attitudes of a state’s relations with others,” and may be defined as the “activity whereby state actors act, react and interact” between the “internal or domestic environment and an external or global environment.”<sup>4</sup>
- Diplomacy is the art and practice of conducting international relations, and “provides one instrument that international actors use to implement their foreign policy.”<sup>5</sup>
- Global health “places a priority on improving health and achieving equity in health for all people worldwide... emphasizes transnational health issues, determinants, and solutions [and] involves many disciplines within and beyond the health sciences.”<sup>6</sup>

\*Adapted from Ref. 3.

provided definitions of GHD (Box 2). These definitions in fact all relate to the question of whether health drives foreign policy or vice versa. Perhaps, in the end, it does not matter which is the driving force, but certainly this question lends itself to research on several levels. It also lends itself to expanded training needs for health professionals, diplomats, and their non-state partners.

### Health as a Driver of Foreign Policy

Although global health advocates view improving global health as a critical objective of foreign policy in and of itself, and that health diplomacy can “shape and manage the global policy environment for health,”<sup>8</sup> government action on health is motivated by foreign policy interests as well as by health or humanitarian goals. However, Feldbaum and Michaud argue that GHD must be linked to core economic, foreign policy, or security interests if health is to be prioritized in foreign policy. They emphasize that “foreign policy interests are of *primary* [italics added] and enduring

### **Box 2. Definitions of Global Health Diplomacy\***

- *A political change activity that meets the dual goals of improving global health while maintaining and strengthening international relations abroad, particularly in conflict areas and resource-poor environments.*
- *Multi-level, multi-factor negotiation processes that shape and manage the global policy environment for health.*
- *Winning hearts and minds of people in poor countries by exporting medical care, expertise, and personnel to help those who need it most.*
- **Health diplomacy is the chosen method of interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems, and securing the right to health for vulnerable populations.**
- *Health diplomacy is a means of self-preservation in an increasingly interconnected global community... health diplomacy also offers a much-needed opportunity for building bridges between the governments of the world and the private sector, synergizing efforts of nongovernmental organizations (NGOs) and allowing them to work together to improve public health.*

\*Adapted from Ref. 7.

importance to understanding the potential and limits of health diplomacy.” GHD is important in 21st century international relations (and hence smart power) because of the transcendent relevance of health to the following foreign policy priorities: (1) *security*, owing to the fear of global pandemics; bioterrorism; and the health consequences of humanitarian conflicts, natural disasters, and emergencies; (2) *economy*, owing to the economic effects of poor health on global development, of pandemic outbreaks on global trade, and of the growing global market in health goods (especially pharmaceuticals) and services; and (3) *social justice*, which reinforces health as a social value and as a human right, and calls for high-income countries to invest in a broad range of initiatives that benefit the poor.<sup>1</sup>

Katz *et al.*<sup>2</sup> reviewed the contexts, practice, and components of GHD in an operational context and proposed taxonomy to reflect the diversity of the field of GHD. They separated health diplomacy into three categories of interaction around global public health issues: (1) core diplomacy, including formal negotiations among nations; (2) multi-stakeholder diplomacy, involving negotiations among nations and non-state actors; and (3) informal diplomacy (or “freelance” diplomacy), which might include governments, nongovernmental organizations, private sector groups, international actors, and the public.

Lee and Smith<sup>7</sup> distinguished the “new diplomacy,” dealing with health and globalization as a public health enterprise, from “traditional diplomacy,” as practiced strictly in foreign policy circles. They *further* defined GHD, in concert with Kickbusch *et al.*,<sup>4</sup> as “negotiations on population health issues that require global collective action” to effectively address these problems.

GHD is now characterized by diverse actors, and different processes of interaction among these actors. These elements were included in a more concise definition of GHD for use in an international discourse funded by the Rockefeller Foundation at its Bellagio Conference Center in 2009–11. GHD, according to Smith and Fidler<sup>9</sup> in this forum, is “...policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives.”

In all these descriptions and definitions, health diplomacy is consistently and strongly recognized as a key foreign policy practice at multiple levels and in multiple fora that requires collective negotiations. This is especially necessary in an increasingly globalized world with growing economic disparities and with reduced capacity for official development assistance (ODA) among traditional donor nations. What is becoming clear, however, is that evidence is needed that GHD can demonstrate efficacy and effectiveness as a 21st century political investment for donors, multinational organizations, and governments. Such “investments” may include personnel, training, and the extra time commitments required for negotiations, collaborations, and convening activities. Instruments and procedures are available for traditional negotiations, as described by

Bertorelli *et al.* in this volume (Chapter 4), and governance structures and their limitations have been discussed in detail by Hein (Chapter 3). However, research is now needed as to how GHD works, what it can accomplish, and how it can be evaluated. Based on this research agenda and the reviews we have presented in this volume, we can think more about the design of GHD training programs, support networks and learning communities, and then continue to look critically at the outcomes of GHD practices going forward as a research agenda.

## **A Research Agenda in Global Health**

First, let us consider the current state of research activities in GHD. Most scholars involved in such research are part of the Global Health Diplomacy Network (GHD-NET), which had its first formal meeting in June 2011 at Chatham House in London.<sup>10</sup> GHD-NET is an international organization of members that engage in research, training, and the practice of GHD (<http://www.ghd-net.org>). Founded in 2009 through the Rockefeller Bellagio Dialogue mentioned above, it is currently hosted at the Centre for Trade Policy and Law in Ottawa, Canada. GHD-NET's overall objective is "to build capacity for stakeholders to participate in, inform, and influence diplomatic negotiations in ways that reflect public health principles and evidence and improve collective action on global health."

At this writing, the future of the Network is somewhat tenuous; nevertheless, the individuals and institutions involved remain active in both GHD training and research activities. For example, GHD-Net commissioned researchers at the London School of Hygiene and Tropical Medicine to help define the research agenda in GHD. As a result of this commission, Smith, Fidler, and Lee<sup>9</sup> suggested that GHD research should:

- Focus on the processes (rather than the content) through which diplomatic activities address health problems or utilize health concepts or mechanisms to achieve other political, economic, or social objectives.
- Pay particular attention to challenges faced by low- and middle-income countries.

- Inform efforts that GHD-Net stakeholders make to provide policy-relevant input to foreign policy, diplomatic, and advocacy activities on global health issues.

Lee and Smith<sup>8</sup> further proposed a set of more specific research questions in order to move the health diplomacy discourse away from only normative advocacy toward an evidence-based agenda. These issues were discussed as part of the Chatham House meeting cited above (Boxes 3–5). These questions point out the importance of *evaluation* of GHD as a critical part of the research agenda and include the following approaches:<sup>10</sup>

- To measure the impact (both positive and negative) of GHD, on health and on other sectors.
- To establish and track qualitative and quantitative outcome measures.
- To increase understanding of the stages of getting to an outcome, and then how (and whether) the outcomes of diplomacy get implemented on the national level.
- To inform the global health and foreign policy sectors of each other's perspectives, in order to bridge the gap between two

### **Box 3. Global Health Diplomacy and Globalization**

- What role does GHD play in addressing the particular challenges that globalization poses for global health and the broader global community as a whole?
- How does the shifting balance of power in world politics affect GHD?
- How can GHD play a role in maintaining global health as a high policy priority among world leaders in the coming decades?
- What can GHD teach us about the challenges of strengthening collective action in an increasingly global world?

#### Box 4. The Role of Diverse Actors in Global Health Diplomacy

- Who is responsible for undertaking or engaging in GHD?
- How do specific actors (and types of actors) participate in GHD? How do they influence GHD individually and collectively?
- What are the relative roles of state and non-state actors in GHD?
- What are the relative roles of health and non-health actors in GHD?
- Why do certain actors participate in GHD? What are their interests and what goals/interests do they seek to pursue?
- What determines the power and influence of specific actors in GHD?
- Who holds authority in GHD and from where does this authority derive? How does this change by issue area and over time?
- Does authority/legitimacy in GHD coincide with responsibility?
- Which actors are underrepresented in GHD and why? What can be done to improve the representativeness, of GHD?
- How can we assess the quality of GHD in terms of accountability, transparency, representativeness, and effectiveness?

communities that come together in times of crisis but with different contexts — for one group, health is the issue, while for the other, health is just one of many issues that need to be pursued, and not always the central one.

- To better equip those engaged in GHD, in coherence with the Network's training objectives; research processes that include the participation of GHD actors might yield more relevant information, forming a closer loop between research findings and practice.
- To learn lessons from diplomacy not related to health.
- To gain a better understanding of the role of the WHO in GHD, relative to other processes, both bilateral and multilateral.

#### Box 5. Venues and Forms

- How can we assess the quality of GHD in terms of transparency, representativeness, and effectiveness?
- How much GHD takes place in formal venues?
- How does GHD actually function? How is it assessed?
- Which institutions formalize GHD? How do they function?
- Are certain venues more effective than others?
- At what different institutional levels do they function together?
- Can we distinguish between different types of GHD?
- What are the principles of GHD?
- What channels and processes are used for GHD?
- To what extent is GHD formalized? How might this be changing?
- What institutional mechanisms are used for GHD?
- Is there such a thing as a "best practice" for GHD?
- What is the relationship between GHD and global health?

#### Evaluating Global Health Diplomacy: A Research and Foreign Policy Perspective

In the increasingly constrained environment of global health financing and the growing emphasis on measurement of implicit and explicit costs, the principles of performance-based financing (PBF) as the World Bank, the President's Emergency Plan for AIDS Relief (PEPFAR), the US Millennium Challenge Corporation (MCC), and the US Agency for International Development (USAID) to Fight AIDS, Tuberculosis and Malaria (USAID-FATM) have emerged as a key approach to evaluating and improving global health outcomes.



## Global Health Diplomacy

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## Box 5. Venues and Forms of Global Health Diplomacy

- How can we assess the quality of GHD in terms of accountability, transparency, representativeness, and effectiveness?
- How much GHD takes place? How would it be measured?
- How does GHD actually work or not work? How would this be assessed?
- Which institutions formally conduct GHD and how effectively do they function?
- Are certain venues more effective at conducting GHD than others?
- At what different institutional levels does GHD take place? How do they function together?
- Can we distinguish between formal and informal GHD?
- What are the principles of decision making in GHD?
- What channels and processes of “new diplomacy” could be used for GHD?
- To what extent is GHD facilitated or hindered by netpolitik? How might this be changing the nature of GHD?
- What institutional mechanisms are needed to support GHD?
- Is there such a thing as new public diplomacy in global health?
- What is the relationship between new public diplomacy and global health?

## Evaluating Global Health Programs from the Diplomatic and Foreign Policy Perspectives

In the increasingly constrained global health funding environment, the measurement of implicit and explicit outputs, outcomes, and impacts of global health financing has assumed great importance. In keeping with the principles of performance-based funding demanded by organizations such as the World Bank, the President’s Emergency Plan for AIDS Relief (PEPFAR), the US Millennium Challenge Corporation, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the Bill and

Melinda Gates Foundation, development programs are now expected to provide tangible and transparent data on outcomes of donor investments. Traditionally, evaluation measures have been confined to a relatively narrow range of programmatic results, focusing on health outputs and financial disbursements (e.g., cost-effectiveness analysis), and not necessarily on the more implicit, long-term, indirect, or collateral outputs, outcomes, and impacts of program activities. These measures may no longer be sufficient to reflect the actual gains made that are relevant to recipients, donors, or governments — of which the last are increasingly expected to assume responsibility for internationally funded interventions.

Traditional foreign policy interventions include those characterized by hard power (military force), economic sanctions or incentives, and these may be questioned or analyzed as to their efficacy and effectiveness. The old as well as new economic powers are now seeking alternative — and more inclusive — forms of international engagement both to sustain national interests and to assure global security in the world.<sup>11,12</sup> Thus, these GHD practices will need to be evaluated according to their “peace and stability” dividends, as well as for their economic, political, and of course global health dividends.

How can global health programs contribute to “political economy”? While global health programs provide recipient countries with significant international assistance, they also have the potential to support the “enlightened self-interest” of donors. On the economic level, both donor and recipient states — and, indeed, large corporations that may have more significant international investments than many donor nations — are increasingly interested in the role of GHD in supporting their international development objectives and economic interests.<sup>3</sup> The role of health and development programs in ensuring the well-being of the international labor force, in generating international business opportunities, in assuring free trade, and in facilitating access to commodity resources from LMICs complements altruism with hard-nosed economic reasons for development assistance. In a sense, these 21st century GHD efforts hark back to elements of colonial history as articulated by Adams in this volume (Chapter 2).

Today, however, the competition between national economic priorities and foreign aid commitments raises important ethical questions for

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High-Income Countries (HICs).<sup>13</sup> Global health resources more than quadrupled from US\$5.6 billion in 1990 to US\$25 billion in 2011, and the rate of growth accelerated sharply after 2002, when the Millennium Development Goals were launched by UN Member States. However, the alleviation of suffering abroad is seen by many as discretionary in times of fiscal crisis, and therefore such assistance may be subordinated to other domestic economic priorities. The research question then involves showing the current and potential, both implicit and explicit, and national and global benefits of international assistance and how this assistance may more meaningfully serve critical foreign policy objectives when “diplomatically sensitized.” These objectives include the high ideals of world peace, prosperity, and security — goals that may transcend the inherent idealism of global health programs.

The need for evaluation studies on the outcomes of GHD and related assistance programs from the economic, political, international relations, diplomatic, and human rights standpoints is evident in the 21st century, smart power era. The following discussion attempts to frame the evaluation of GHD.

### ***Foreign assistance reform: Demands for advanced evaluation techniques***

The need for the evaluation of GHD is reflected in the growing integration between departments of development assistance and ministries of foreign affairs across donor countries (HICs). Fidler<sup>14</sup> described this progression as the “high politics” of global health insofar as HICs may leverage development programs to support their foreign policy goals. This “progressive” approach was noted in a report by the US Global Leadership Coalition,<sup>a</sup> such that “...over the past decade, the importance of using all our foreign policy tools to shore up our national security — development and

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<sup>a</sup>The US Global Leadership Coalition (USGLC) is a network of 400 businesses and NGOs; national security and foreign policy experts; and business, faith-based, academic, and community leaders who support a smart power approach that can elevate diplomacy and development alongside defense to assure global security. See <http://www.usglc.org/about/our-mission/>

diplomacy, alongside defense — has had strong bipartisan support” in the US Congress.<sup>15</sup>

In the United States, closer alignment between the activities of the United States Agency for International Development (USAID) and the Department of State (DOS) has become a central feature of foreign assistance reform under both the current (Obama) and the prior (Bush II) administration; this was further articulated by President Obama in 2009 as the US Global Health Initiative (GHI). The joint DOS and USAID Quadrennial Diplomacy and Development Review (QDDR) set institutional priorities and provided strategic guidance as a framework for efficient allocation of foreign assistance resources under the GHI, and this realignment was intended to be a post-partisan political effort. However, recent political obstructionism has precluded full funding of the GHI, and the initiative has now been moved to a new Office for Health Diplomacy embedded within the DOS.<sup>16</sup> At this writing, the outcome of the GHI’s restructuring is not yet clear, though the broader trend of interdepartmental integration remains evident in the initiative. As a part of the DOS, it can be expected that health will be serving as an important component of US foreign policy and smart power in the “whole of government” approach going forward.

In the United Kingdom, the Department for International Development (DFID) has been recognized as a key element of modern British foreign policy.<sup>17</sup> In fact, it is a cabinet-level entity rather than a department within a ministry; while, in the European Union, the Common Foreign and Security Policy makes explicit reference to the role of development programs such as global health under a smart power framework.<sup>18</sup> These structures represent a determined effort to link global health programming and foreign policy priorities, helping to provide meaningful and effective alternatives to hard power interventions, and have been described earlier in this volume by Silberschmidt and Zeltner (Chapter 11) with a focus on Switzerland.

Fidler notes that “the implications of successful global health programs without foreign policy considerations are just as dangerous to human dignity as the reverse.”<sup>14</sup> In all countries, the demands for key personnel with appropriate qualifications and experience in both the global health and foreign policy spheres are evident. Special, transdisciplinary skills are necessary in order align the mutual objectives of the foreign policy and

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### *Diplomatic evaluation o*

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successful global health programs just as dangerous to human dig- demands for key personnel with e in both the global health and ial, transdisciplinary skills are ctives of the foreign policy and

foreign assistance communities in GHD.<sup>2</sup> In addition, new infrastructures in which to practice these skills may be necessary. For example, “political analysis liaison units” within multilateral health-related donor organizations such as the GFATM would complement the development of health expertise among foreign policy professionals. Equally important, systems of evaluation that “speak a language that people with power really understand,”<sup>19</sup> as well as systems of evaluating the success of such integration efforts within donor governments, will be necessary for cohesive foreign policy and global health assistance programs.

### *Diplomatic evaluation concepts*

How then can the benefits of GHD be more explicitly measured in the foreign policy enterprise?<sup>12</sup> A good starting point may be to examine the distinction between “diplomatically sensitized” global health programmatic outcomes and “global-health-sensitized” foreign policy outcomes. On one hand, diplomatically sensitized global health programs may incorporate foreign policy considerations such as partnership development, recipient perceptions and priorities, strategic geographic issues, social justice and equity, and, of course, effectiveness and efficacy. On the other hand, global-health-sensitized foreign policy may influence the *realpolitik* of global affairs, including traditional foreign policy issues such as balance of power, peacekeeping, geostability, international prestige, economic stability, and other strategic objectives (Ref. 20 and Chapter 8 of this volume). Diplomacy is a tool of foreign policy, and GHD is a specialized version of diplomacy now recognized by many established as well as emerging economies as critically important to their national priorities.

In the more nuanced realm of humanitarian assistance in conflict and post-conflict settings (see Chapter 9), GHD considerations may be even more important (if not mission-critical), even if no formal method of quantifying their effectiveness is currently available. Internationally supported humanitarian or military interventions in settings such as South Sudan, Iraq, and Afghanistan may, intentionally or unintentionally, support (or undermine) peacekeeping, geopolitical, and “nation-building” goals<sup>21,22</sup> to an extent far beyond their stated purview. Perhaps most important in the evaluation of GHD in such settings is the contextual understanding and

responsiveness that is necessary for successful program implementation. This means that while core elements of the intervention protocol are adhered to, these programs are also sensitized to the fundamental needs of recipient communities and the geopolitics of the region.<sup>23</sup>

There remains a need for criteria and associated tools by which global health programs can be monitored and evaluated from a foreign policy perspective. These tools would not aim to evaluate the interventions in terms of their primary health program goals, as numerous metrics already exist to do this, but rather to evaluate their value from a foreign policy perspective. Since "...the top priorities of foreign policy are national security and economic growth...",<sup>10</sup> the health sector must consider how health policy can also have a negative impact on foreign policy goals, just as how foreign policy can have a negative impact on health. This has been described in policy discussions regarding the economic ramifications of different interventions — from the perspective of both the donor and recipient countries, at the national, community, and individual levels.<sup>24</sup> Quantification of such outcomes using standard statistical or epidemiological approaches, however, seems unlikely. Nonetheless, existing rapid assessment tools, such as the on-site data verification (OSDV) and routine service quality assessment (RSQA) tools employed by the GFATM,<sup>25</sup> may suggest opportunities for evaluation of program outcomes from a broader foreign policy perspective. Through the identification of the threats and benefits to foreign policy or diplomatic objectives using an amended rapid assessment tool (SYSRA<sup>26</sup>), policy-makers may be provided with tangible evidence of the relative diplomatic utility of GHD activities in different settings. Such data can help inform strategic decision-making and resource allocation around foreign assistance; in this sense, GHD may in fact fuel foreign policy development or modification.

Criteria to evaluate the utility of GHD must be responsive to the ever-changing global political environment and thus may be objectionable to those who believe that GHD should focus exclusively on global health objectives. These criteria may be developed using *political philosophy* perspectives on GHD as articulated by Fidler.<sup>14</sup> These perspectives include:

- Utilitarian or "neo-utilitarian" considerations: "Does the program possess a culture of measurement and accountability? Is it being utilized, as well as being cost-effective?"

- Rawlsian considerations: “Is there a concern for social justice in the health program? Is the program sustainable, and does it contribute to broader development goals?”
- Kantian considerations: “Has this program contributed to regional stability, nation-building, international relations, helping us move towards world peace?” And even
- Machiavellian considerations: “Does the program assist access to strategic resources or markets? Is the donor’s regional or international influence and prestige enhanced?”

### *Implications for resource allocation*

The rise of evidence-based decision-making in global health programs has, among its other effects, promulgated a dramatically enhanced role for cost-effectiveness analysis. However, this is not just an analysis of technical efficiency (how to best implement an agreed strategy), but also, perhaps more contentiously, includes assessments of allocative efficiency, i.e., informing decisions about how to divide funding among projects which target different populations, geographical areas, and program goals.<sup>27</sup> While such an approach can help to optimize program outcomes in constrained resource environments, it also has the potential to erode general health budgeting — and therefore overall health gains — through a narrow focus on specific program outcomes to the exclusion of broader political and diplomatic considerations. Is it possible, then, that through the channeling of donor funding to interventions, the value of which is judged solely on medical effectiveness, the broader diplomatic and foreign policy dividends of global health programs may be lost? Valentino<sup>28</sup> notes that “in all cases, these are political choices, and they are likely to be made badly if governed chiefly by philanthropic considerations. Instead, it is necessary to think about the two-in-one character of humanitarian aid.”

If Valentino is correct, the implications for resource allocation decisions based on political realities are significant. Decisions about which interventions to support — and in which regions and target populations these interventions are applied — would need to take into account several often-competing criteria: foreign policy objectives, diplomatic considerations, *and* health needs. A recent example is the growing movement

toward treatment of HIV-positive individuals with antiretroviral drugs. Cost-effectiveness analysts had claimed that many more lives might be saved if these funds were reprogrammed toward HIV prevention,<sup>27</sup> but this conclusion does not consider the humanitarian, international relations, and foreign policy dividends that result from the provision of life-saving treatment to those most in need. While such analyses did find that the emotional force of a focus on treatment could leverage overall funding for HIV/AIDS, the analysis concluded that even a 10-fold growth in funding would not justify a strong treatment approach if *the sole evaluation criterion is aggregate health status*. The analysis did not, however, examine other non-health outcomes, such as winning “hearts and minds.” Perhaps more importantly, the risks associated with the suspension of treatment programs on economic or cost-effectiveness grounds have already been flagged as a possible threat both to national political stability and to relations between donor and recipient countries.<sup>29</sup>

With the development of more appropriate GHD evaluation criteria, resource allocation decisions across global health programs may, in the future, be made with favorable diplomatic outcomes included as part of expected program results. Resource allocation decisions will, in turn, need to be made on a more collaborative basis, combining inputs from scientists, economists, and the more “real world” considerations of foreign policy experts and recipient nations.

### ***GHD research agenda conclusions***

Policy-makers are increasingly aware of the special value of global health in the international relations sphere.<sup>30</sup> While agricultural and educational programs may provide compelling gains in measurable outcomes to donors and recipients alike, the specific additional value of GHD components of these programs, including their capacity to win hearts and minds, is perhaps even more important in today’s globalized world. This is a world where pandemics may threaten economic stability and where disease challenges do not recognize national borders. Hence, the challenging task of evaluating global health programs from the diplomatic, international relations, and foreign policy standpoints may provide significant dividends — not only to foreign policy professionals but also to global



health advocates. In the future, when policymakers ask “What is the return on our investment?” in GHD, they will be better informed about and therefore better understand the range of benefits — from national security to domestic economic gains to international prestige — that result from the blending of health and foreign policy objectives. Further, the need for international economic homeostasis achieved through the new global “balance of power” and multinationalism are essential elements of GHD that both transcend and support national foreign policy priorities. The emerging powers (Brazil, China, India, Russia,<sup>b</sup> and South Africa) in fact call for further research to evaluate how notions of “south-to-south” cooperation affect global stability and international economic development.

It is not just policymakers in the traditional donor governments that need to be provided with evidence for the efficacy of GHD. Foreign assistance may be considered by the public as an unnecessary holdover from the 20th century. However, the evidence is accumulating to show that such assistance is not simply a justifiable expenditure of tax dollars but also a critical foreign policy and security concern in the globalized economy.<sup>30</sup> If the public can be provided with compelling evidence that *they themselves* benefit from such investments through domestic economic, security, humanitarian, and national prestige dividends, there will be public support for global health investments and GHD. Thus, the disseminating results of GHD research will play a critical role in informing public opinion as well as national decision-making.

## **Training in Global Health Diplomacy**

The response to global health challenges is heavily dependent on diplomats and health professionals understanding not only the health burden of these challenges but also the interwoven nature of foreign policy and health. Thus, training in GHD requires grounding in global health science as well as in foreign policy practices. It further requires integration at different levels of practice: among governments and non-state implementers

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<sup>b</sup>Russia in fact has explicitly stated that its international development programs are to be designed and used with foreign policy as a primary consideration — see <http://www.guardian.co.uk/global-development/2011/may/25/russia-foreign-aid-report-influence-image>

in the field; among national governments and their various implementing agencies; and among multinational organizations, NGOs, and non-state actors in the global arena. Case-based learning has been increasingly used for understanding GHD. Cases studies are now appearing in published format,<sup>31</sup> but training programs using these cases will benefit from involvement of experienced professionals with expertise in both health and negotiations.

Global health educational programs have proliferated across both north and south, with curriculum content spanning research skills, cultural studies, social sciences, and basic sciences.<sup>32</sup> Skill building in GHD further requires more nuanced understanding of negotiation processes, economic and trade policy, global governance, cultural complexities, and political science. Scientists do not generally possess these skills, and diplomats may need broader understanding of public health principles and the integration of these with human rights regimes. Thus, cross-disciplinary training is critical to the field of GHD.<sup>33</sup> Case studies can illustrate the complexity of negotiations, which involve multi-level, multi-factor and multi-actor repercussions for science, health, trade, security, and ethics that make for complicated negotiations.<sup>34</sup>

### **Approaches to GHD Training**

Different formats of GHD training may be needed to serve different audiences. The original training model of the Global Health Program of the Graduate Institute of International and Development Studies (Geneva) is a week-long summer course ([http://graduateinstitute.ch/corporate/executive/training-workshops/global-health-diplomacy\\_fr.html](http://graduateinstitute.ch/corporate/executive/training-workshops/global-health-diplomacy_fr.html)). This flagship course now uses standardized training materials for capacity building in GHD based on accumulated experiences in Geneva and worldwide. The target audience for this executive training activity includes decision-makers and representatives from governments, international organizations, global health initiatives, and other stakeholders in global governance for health, such as civil society, foundations, the private sector, platforms, and alliances. Additional similar courses have been conducted in partnership with the Graduate Institute in Washington, Ottawa, Nairobi, Beijing, and Jakarta. Partners have included the US Centers for Disease Control and

Prevention (CDC), San Diego State University, Peking University, Mahidol University in Bangkok, the University of Nairobi and Government of Kenya, the Swiss Federal Office of Public Health, the Oswaldo Cruz Foundation of Brazil, the World Health Organization, and other international institutions.

Tailored, one-to-three-day training sessions may also be appropriate for upper- and mid-level participants who cannot take the time to travel to such executive courses. Modules on GHD may now be included in academic global health training programs and evaluated as to specific learning objectives. In addition, foreign service training programs may make use of case studies such as those found in other titles in this book series.<sup>31</sup> Based on lessons learned from such activities, all training models could be followed by refreshers or long-term leadership development programs that keep the learning community in touch and allow continued learning from the experiences of training program alumni.

## **Curricular Content**

Although curricular content will vary according to the participating audience, venue, and training objectives, the Graduate Institute has developed and refined curricular content along with GHD. NET partners in Thailand, China, Kenya, and the United States.<sup>35</sup> Based on lessons learned during various training programs, the following curricular items have been included in GHD training programs:

- (1) *Introduction to Health Diplomacy*. This covers the definition of health diplomacy, the multilayered processes involved in GHD, and the various actors involved in GHD today.
- (2) *Historical Perspectives on Health Diplomacy*. This covers the historical and cultural underpinnings of GHD, including colonialism, trade policy, power asymmetries and recent power shifts, and the development of multinational health and development organizations.
- (3) *Global Health Governance*. This covers the complexities of the various global health organizations, including recent changes in funding sources, philanthropies, development organization priorities, private-public

partnerships, south-to-south collaboration, and the various government global health initiatives.

- (4) *International Health Law*. This module extends the previous discussion to cover theoretical and practical applications of international health law. It sets the stage for the *Instruments* discussion to follow.
- (5) *Global Health Diplomacy Instruments*. This covers “hard law,” “soft law,” consensus agreements, bilateral agreements, country groupings, and new economic arrangements such as the Global Fund for AIDS, TB, and Malaria. Cases studies involve the International Health Regulations, the Framework Convention on Tobacco Control, and other instruments.
- (6) *The Art and Practice of Negotiations*. After basic information on negotiation practices, a series of hands-on negotiation exercises is performed. If possible, these exercises take place in the actual physical settings used for real-life negotiating bodies.
- (7) *Cultural, Ethical, and Legal Challenges in Global Health Diplomacy*. Using case studies, ethical issues are explored, including power asymmetries, global public goods, health and trade, intellectual property rights, and corruption.
- (8) *Evaluating Global Health Diplomacy*. Using case studies, participants are asked to analyze the success, challenges, and lessons learned that can improve the practice of GHD.
- (9) *Specific Global Health Diplomacy Issues*. Depending on the audience’s needs, the following specific issues are addressed through additional lectures and case studies:
  - (a) *Military Health Diplomacy*. This covers recent patterns, development objectives, pratfalls, and case studies of how militaries have engaged in health programs.
  - (b) *Humanitarian Diplomacy*. This module presents a review of how humanitarian groups function in health development and how post-conflict and post-disaster relief activities interface with political, economic, and security issues.
  - (c) *The role of Private Sector Actors in Global Health*. Participants will gain understanding of business practices, marketing issues, and the potential for public-private partnerships in global health.

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This module extends the previous discussion and practical applications of international law for the *Instruments* discussion to follow.

*Instruments.* This covers “hard law,” “soft law,” bilateral agreements, country groupings, and instruments such as the Global Fund for AIDS, and studies involve the International Health Work Convention on Tobacco Control, and

*Negotiations.* After basic information on a series of hands-on negotiation exercises is provided, these exercises take place in the actual physical life negotiating bodies.

*Global Challenges in Global Health Diplomacy.* Key issues are explored, including power asymmetries, health and trade, intellectual property

*Diplomacy.* Using case studies, participants discuss success, challenges, and lessons learned that inform GHD.

*Diplomacy Issues.* Depending on the audience, specific issues are addressed through additional studies:

*Security.* This covers recent patterns, developments, and case studies of how militaries have engaged in programs.

*Humanitarian.* This module presents a review of how health function in health development and how health-disaster relief activities interface with global security issues.

*Key Actors in Global Health.* Participants explore a range of business practices, marketing issues, and public-private partnerships in global health.

- (d) *Rise of the BRICS in Health Diplomacy.* Participants will understand the power shifts that have led to the increased diplomatic strength of emerging economies such as Brazil, China, and South Africa. South-to-south health diplomacy (including Cuba) and extractive diplomacy (China) are cases to consider.
- (e) *Policy Consistency in Global Health.* Participants will evaluate the impact of the Oslo Declaration, the Paris Declaration on Development Assistance, World Bank policies, and other government policies that attempt to place health in the forefront of foreign policy.
- (f) *Participant-Provided Health Diplomacy Cases.* Participants will prepare a case study based on their home agency programs and agendas. These are then discussed by small learning groups in order to establish a pattern of collaboration and group learning.

## Conclusion

We have provided an overview of the efforts to define the field and taxonomy of GHD, a review of some of the key research challenges in this growing field, and suggestions as to how training in GHD might be approached. Certainly, the evaluation of GHD outcomes is the most critical need on the research agenda; it is important for leaders in both foreign policy and health disciplines, as well as in the agencies responsible for these sectors, to have a sense of what works in GHD, who should conduct the GHD, and what skills are needed to prepare for GHD practice. Global health programs are now part of many, many schools of public health, medicine, and political science. However, the integration of training in foreign affairs and public health and the coverage of the transdisciplinary skills necessary for negotiating within the dynamic arena of GHD have not yet been included in most curricula of these programs. We have proposed some training scenarios geared more toward executive, professional, or on-the-job training programs, but the content of these programs may well be translated to the formal academic environment or to the preparatory training of diplomats as well as global health providers. What is clear is that GHD has grown from a notion to a critical need in research and training. The success and sustainability of the complex, heavily funded, and extremely important global health assistance programs that



11. Center for Strategic and International Studies. (2007) CSIS Commission on Smart Power. Accessed through [http://csis.org/files/media/csis/pubs/071106\\_csissmartpowerreport.pdf](http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf)
12. Center for Strategic and International Studies. (2007) Report of the CSIS Commission on Smart Global Health: A safer, healthier and more prosperous world. Accessed through [http://csis.org/files/publication/100318\\_Fallon\\_SmartGlobalHealth.pdf](http://csis.org/files/publication/100318_Fallon_SmartGlobalHealth.pdf)
13. Johri M, Chung R, Dawson A, Schrecker T. (2012) Global health and national borders: The ethics of foreign aid in a time of financial crisis. *Globalization and Health* 8: 19. doi:10.1186/1744-8603-8-19.
14. Fidler D. (2007) Architecture amidst anarchy: Global health's quest for governance. *Global Health Govern* I(1): 1–17. Available from [http://diplomacy.shu.edu/academics/global\\_health](http://diplomacy.shu.edu/academics/global_health)
15. US Global Leadership Coalition. (2012) Smart Power 2.0: America's global strategy. Accessed through <http://www.usglc.org/2012/05/23/what-is-smart-power-2-0>
16. Mungcal I. (2012) Clinton tightens grip on Global Health Initiative. Accessed through [http://www.devex.com/en/news/blogs/new-office-takes-ghi-s-place-at-state-department?blog\\_id=development-assistance-under-obama](http://www.devex.com/en/news/blogs/new-office-takes-ghi-s-place-at-state-department?blog_id=development-assistance-under-obama)
17. Lords Select Committee. (2011) Does UK aid make the right difference? Accessed through [http://www.parliament.uk/business/committees/committees-a-z/lords-select/economic-affairs-committee/news/aid-inquiry — evidence-session-5-july/](http://www.parliament.uk/business/committees/committees-a-z/lords-select/economic-affairs-committee/news/aid-inquiry—evidence-session-5-july/)
18. European Commission. (2010) The EU role in global health. Brussels, March 2010, COM (2010)128 final.
19. Nye J. (2004). The decline of America's soft power. *Foreign Aff*, June 2004.
20. Bonventre E. (2008) Monitoring and evaluation of Department of Defense humanitarian assistance programs. *Mil Rev*, January, pp. 66–72.
21. Kevany S. (2012a) Diplomatic and operational adaptations to global health programmes in post-conflict settings: Contributions of monitoring and evaluation systems to health sector development and “nation-building” in South Sudan. *Med Conflict Surviv* (in press).
22. Eldon J, Waddington C, Hadi Y (2008). *Health System Reconstruction: Can It Contribute to State-Building?* Health & Fragile States Network. HLSP Institute, London. Available from [http://www.healthandfragilestates.org/index2.php?option=com\\_docman&task=doc\\_view&gid=32&Itemid=38](http://www.healthandfragilestates.org/index2.php?option=com_docman&task=doc_view&gid=32&Itemid=38).

23. Kevany S. (2012b) Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: Findings from Project Accept (HPTN 043). *BMC Public Health* (in press).
24. Committee on Foreign Affairs. (2011) Assessing US foreign policy priorities and needs amidst economic challenges. Accessed through <http://www.gpo.gov/fdsys/pkg/CHRG-112hhr64869/pdf/CHRG-112hhr64869.pdf>
25. The Global Fund. (2012) M&E tools and documents. Accessed through <http://www.theglobalfund.org/en/me/documents/>
26. Atun R. (2010) Interactions between critical health system functions and HIV/AIDS, tuberculosis and malaria programmes. *Health Policy Plann* **25**: i1–i3.
27. Marseille E. (2002) HIV prevention before HAART in sub-Saharan Africa. *Lancet* **359**: 1851–1856.
28. Valentino B. (2011) The true costs of humanitarian intervention: The hard truth about a noble notion. *Foreign Aff*, December 2011.
29. Lyman NP, Wittels SB. (2010) No good deed goes unpunished: The unintended consequences of Washington's HIV/AIDS programs. *Foreign Aff*, July–August. Accessed through <http://www.foreignaffairs.com/articles/66464/princeton-n-lyman-and-stephenb-wittels/no-good-deed-goes-unpunished>
30. Knight R. (2012) The Chatham House–YouGov Survey 2012: Hard choices ahead. Accessed through <http://www.chathamhouse.org/publications/papers/view/184631>
31. Roskam E, Kickbusch I (eds.). (2011) *Negotiating and Navigating Global Health: Case Studies in Global Health Diplomacy*. World Scientific, Singapore.
32. Novotny TE. (2007) Global health education and careers. In: Markle W, Fisher M, Smego R (eds.). *Understanding Global Health*. McGraw-Hill, New York.
33. Kickbusch I, Novotny TE, Drager N, et al. (2007) Global health diplomacy: Training across disciplines. *Bull World Health Organ* **85**(12): 971–973.
34. Low-Ber D. (2011) *Innovative Health Partnerships: The Diplomacy of Diversity*. World Scientific, Singapore.
35. Kickbusch I, Drager N, Told M. (2012) *Textbook on Global Health Diplomacy*. Springer, New York (in press).



## REVIEW

# Global Health Diplomacy, “San Francisco Values,” and HIV/AIDS: From the Local to the Global



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### Abstract

**BACKGROUND** San Francisco has a distinguished history as a cosmopolitan, progressive, and international city, including extensive associations with global health. These circumstances have contributed to new, interdisciplinary scholarship in the field of global health diplomacy (GHD). In the present review, we describe the evolution and history of GHD at the practical and theoretical levels within the San Francisco medical community, trace related associations between the local and the global, and propose a range of potential opportunities for further development of this dynamic field.

**METHODS** We provide a historical overview of the development of the “San Francisco Model” of collaborative, community-owned HIV/AIDS treatment and care programs as pioneered under the “Ward 86” paradigm of the 1980s. We traced the expansion and evolution of this model to the national level under the Ryan White Care Act, and internationally via the President’s Emergency Plan for AIDS Relief. In parallel, we describe the evolution of global health diplomacy practices, from the local to the global, including the integration of GHD principles into intervention design to ensure social, political, and cultural acceptability and sensitivity.

**RESULTS** Global health programs, as informed by lessons learned from the San Francisco Model, are increasingly aligned with diplomatic principles and practices. This awareness has aided implementation, allowed policymakers to pursue related and progressive social and humanitarian issues in conjunction with medical responses, and elevated global health to the realm of “high politics.”

**CONCLUSIONS** In the 21st century, the integration between diplomatic, medical, and global health practices will continue under “smart global health” and GHD paradigms. These approaches will enhance intervention cost-effectiveness by addressing and optimizing, in tandem with each other, a wide range of (health and non-health) foreign policy, diplomatic, security, and economic priorities in a synergistic manner—without sacrificing health outcomes.

**KEY WORDS** diplomacy, global health, HIV/AIDS, international relations, San Francisco

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## SAN FRANCISCO AND GLOBAL HEALTH DIPLOMACY, REVISITED

San Francisco has a distinguished history as a cosmopolitan, progressive, and international city,

including associations with the founding of the United Nations after World War II, the emergence of several academic and nongovernmental health and development organizations, and the growth of international philanthropies based in Silicon

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Valley.<sup>1</sup> Over time, this reputation was enhanced by the peace movement of the 1960s, the technological innovation of the 1990s, and by the city's ongoing social and cultural willingness to challenge the status quo to advance humanitarian causes, including human dignity and sexual, social and racial equality.<sup>2</sup> These circumstances have contributed to a new, interdisciplinary scholarship in the field of global health diplomacy. This nascent discipline is based on the combination of previously distinct skills in both global health development and foreign policy, and was originally described in *San Francisco Medicine* by University of California, San Francisco (UCSF), Professors Thomas Novotny and Vincanne Adams.<sup>3</sup> This review provides an update on that commentary, describes subsequent achievements in global health diplomacy (GHD) at both the practical and theoretical levels within San Francisco and other medical communities, traces related associations between the local and the global, and proposes a range of potential opportunities for further development of this dynamic field.

**San Francisco's Global Health Environment.** San Francisco's distinction in both local and global health research and practice has gained international recognition.<sup>4</sup> In a city characterized by diversity, tolerance, and medical excellence, health researchers and practitioners continuously respond to a broad range of social, cultural, and political challenges, at both the individual patient and broader community levels.<sup>5–8</sup> Local public health programs by necessity target the needs of very diverse populations; for example, the tailoring of HIV/AIDS interventions is needed to address a wide variety of highly vulnerable communities.<sup>9</sup> More broadly, this environment has engendered a palpable and thoughtful approach to international health program development that is based on humanist rather than utilitarian considerations<sup>10</sup>; San Francisco's unique milieu requires innovative and interdisciplinary approaches to both health care disparities and epidemic diseases such as HIV/AIDS from all elements of the academic, policy, and medical spectrum. The Bay Area is consequently often considered “ground zero” for what is working—and what is not—in developing solutions for the world's emerging and ongoing complex health and social problems.<sup>11</sup> With international initiatives now placing increasingly high value on the integration of locally inspired “success stories” at all stages of service delivery,

health professionals have been able to develop culturally, diplomatically, and politically informed public health programs that have the capacity to function at both the local and global levels.

## HISTORICAL FOUNDATIONS OF TOLERANCE, HUMANITY, AND DIPLOMACY

The historical foundations of San Francisco's associations with both diplomacy and progressive health and social practices can be dated to the 1849 gold rush when an influx of multiple ethnicities and cultures, each with their own health challenges, converged on the city.<sup>12</sup> Such an infusion of humanity, by necessity, bred a culture of tolerance and diversity that was further enhanced in the aftermath of World War II. San Francisco, as 1 of only 3 national demobilization centers, was again faced with an infusion of immigrants—this time in the context of the emerging civil rights movement and a newly desegregated military.<sup>13</sup> During the 1960s, these events demanded the further development of a culture of social progress and tolerance that not only brought about the rise of the “Beat Generation,” but also, less sensationally, the pursuit of equity in and access to health care through the “Free Clinic” movement.<sup>14</sup> More recent health and social advances have focused on epidemic illnesses and conditions that effect not just mainstream but also marginalized populations. Ground-breaking legislation such as the Ryan White Care Act (RWCA),<sup>15,16</sup> pioneered via bipartisan leadership from Senators Ted Kennedy (D-Mass) and Orrin Hatch (R-Utah), and driven by a succession of San Francisco mayors including Dianne Feinstein, Art Agnos, and George Moscone, established political support for HIV/AIDS prevention and care associated with broader international relations practices.<sup>17</sup> Among other effects, this meant that no damaging (and politically polarizing) debates about the social issues involved in HIV/AIDS treatment and prevention were necessary.

## THE “SAN FRANCISCO MODEL”

As a result of such enlightened “post-partisanship,” as early as 1982, the US Congress allocated \$5 million to the Centers for Disease Control and Prevention for HIV/AIDS surveillance and \$10 million to the National Institutes of Health for associated

research.<sup>18</sup> In parallel, the County Board of Supervisors established the “San Francisco Model” of community-based planning and involvement, which addressed both the health needs of disadvantaged or disenfranchised populations as well as their associated social, cultural, political, and economic challenges.<sup>19</sup> Through development of the city’s “Centers of Excellence” in HIV/AIDS, San Francisco’s medical community was among the first to address many highly controversial issues related to the HIV/AIDS epidemic, including needle exchange programs, methadone clinics, social equality for sexual minorities, and sexually transmitted infection control.<sup>20</sup> These practices thereby informed broader national policies such as the Americans with Disabilities Act<sup>21</sup>; broader structural, social, behavioral, economic, and clinical issues required the inclusion of and sensitivity toward specific marginalized populations residing in Bay Area counties.<sup>11</sup> Through innovative systems of accountability and planning processes, an “unruly melange”<sup>22</sup> of politicians, medical professionals, racial and sexual minorities, substance users, migrants, homeless persons, and the incarcerated joined forces to take “ownership” of the HIV/AIDS response. Through the power of negotiation and diplomacy at the local level, these efforts advanced not just public health, but also social justice.

## TRANSLATING THE LOCAL TO THE GLOBAL

Success in GHD, including the enhancement of recipient country and community leadership, similarly depends on attentiveness to political exigencies and cultural contexts in which global health programs operate. For example, in settings such as Iraq, Afghanistan, and South Sudan,<sup>23–25</sup> appropriately designed and delivered health and development assistance advance not only health outcomes, but also ulterior (and often unanticipated) considerations such as peace-keeping, nation-building, international relations, and diplomacy in mutually supportive manner. In this context, institutions such as UCSF have made unique contributions to the design and delivery of global health programs in resource-constrained, conflict, and postconflict settings through their associations with groups such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the President’s Emergency Plan for AIDS Relief (PEPFAR), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization

(WHO), and other United Nations (UN) agencies.<sup>26,27</sup> Such initiatives are built upon San Francisco’s unique cultural, social, and human rights environment, as well as the city’s pluralist health politics. This work has, in turn, suggested the need for training of health professionals in the integration of diplomatic skills as part of the global health enterprise.<sup>28</sup>

## DEVELOPING GLOBAL HEALTH DIPLOMACY PRACTICES

Global health has not had a perfect record of success in accomplishing diplomatic goals—and sometimes even threatens them.<sup>29,30</sup> Additionally, there is an ongoing unmet need for further intellectual discourse, research, and evaluation science for health diplomacy practice.<sup>31</sup> Currently, ad hoc GHD that seeks to leverage foreign policy goals that may be at odds with the perceived or actual altruistic idealism associated with public health<sup>32</sup> is a “risky partnership.”<sup>33</sup> For example, recent violence against polio eradication workers in Pakistan was likely a result of the purported association of an immunization campaign with security activities against militant political and religious radicals.<sup>34</sup> Such perceived subterfuge within health programs complicates the relationship between global health and foreign policy.<sup>35</sup> However, if ethically conducted, negotiations involving global health and foreign policy goals may, in fact, mitigate political and military conflict, support the pursuit of transcendent ideals such as “world peace,” and simultaneously achieve critical international health objectives.<sup>36</sup> Research at UCSF and elsewhere seeks to evaluate the diplomatic and foreign policy threats, advantages, and broader effects of global health interventions to ensure accountability, local involvement, cultural and political sensitivity, and cost-effectiveness through strategic global health program design and delivery.<sup>37,38</sup>

## PRINCIPLES INTO PRACTICE: PEPFAR, OGAC, AND THE OGH

The integration of public health principles into *realpolitik* practice is demonstrated by the recent establishment of the Office of Global Health Diplomacy (OGHD) within the US Department of State in conjunction with the Office of the Global AIDS Coordinator (OGAC) and PEPFAR.<sup>39</sup> Led by health professionals and diplomats with the rank

of ambassador, this office seeks to establish global health partnerships built on principles of collaboration, sustainability, recipient engagement, and “country ownership,”<sup>40</sup> via both an enhanced political awareness of global health resources and their associated diplomatic implications. For example, the OGH trains US international political ambassadors, diplomats, and envoys to recognize the extent and potential influence of global health resources provided to partner countries, as well as how such contributions might be leveraged to support foreign policy goals.<sup>41</sup> It is increasingly clear that these explicit links between global health, political stability, and international security are implicitly intended to help with conflict resolution, trade disputes, and economic development efforts.<sup>42</sup> GHD may support the idea of “smart global health” initiatives that involve diverse sectors and political perspectives.<sup>43</sup> Just as the San Francisco medical community once used health issues to advance social and political causes, so too the United States and other nations may, using appropriate systems of program design, delivery, and evaluation, leverage global health programs to pursue myriad ulterior strategic foreign policy goals.<sup>44</sup> Similarly, in much the same way as San Francisco embraced all elements of the political spectrum in the battle against HIV/AIDS, so too was PEPFAR constructed as a bipartisan initiative under an expanded US global health agenda.<sup>45,46</sup> Both the San Francisco Model and the OGH are, therefore, compelling examples of enlightened self-interest in foreign policy development and practice, involving both the “winning of hearts and minds” and pragmatic policy applications flavored by altruism.<sup>47</sup>

### THE “COUNTRY OWNERSHIP” PARADIGM

As PEPFAR’s initial “emergency response” model became unsustainable in the wake of the global financial crisis,<sup>48</sup> combined with concerns that the vertical structure of the plan threatened to undermine and “crowd out” local public health system functioning,<sup>49</sup> innovative strategies to ensure the continuation of this largest-ever public health program were required to transition service delivery responsibility to the country level. This transition included a more accountable investment strategy; the development of health systems and personnel to ensure recipient absorptive capacity of resources; and a shift away from vertical interventionism toward integrated, sustainable, and community-led

responses and strategies. This process required significant integration of diplomatic and global health approaches and paradigms. As was the case in San Francisco and other severely affected cities after the initial HIV/AIDS response, PEPFAR continues to respond to an urgent “unmet need” to bring all global health stakeholders into the “ownership” process for intervention design and delivery. In much the same way as individuals and communities were empowered and encouraged to advance their health interests during the 1980s, the post-2009 PEPFAR period must simultaneously reduce dependence on external implementing partners and deliver HIV/AIDS treatment and care systems that can achieve a greater range, scope, and scale of health outcomes with fewer resources.<sup>49</sup> In both cases, the empowerment of local actors to make prioritization, funding, and resource allocation decisions through diplomatic discourse<sup>50</sup> is designed to create a system of local responsiveness and responsibility that advances both recipient country health systems and related international engagements.

### BEYOND HIV/AIDS: OTHER CONTEMPORARY CONSIDERATIONS FOR DIPLOMACY IN GLOBAL HEALTH

Medical, economic, and political concerns are inextricably linked in global health programs.<sup>51</sup> An unprecedented range of actors are currently involved in attempts to contain and roll back other public health crises such as the Ebola epidemic and multidrug-resistant tuberculosis (MDR-TB). These groups include military personnel from the United States and Europe, the health and development agencies of both donors and recipient countries, multinational development banks (eg, the World Bank and the African Development Bank), and intergovernmental health organizations (eg, the WHO and the UN Development Program). Such complexity of effort presents significant challenges—not only for health interventions and related logistical activities, but also for the diplomatic environment in which they operate.<sup>52,53</sup> Unfortunately, multilevel global health diplomacy has not, to date, been given sufficient consideration or attention before or during national and international responses, making coordination of global and local efforts extraordinarily difficult. Issues of sovereignty, health systems capacity, health manpower shortages, logistics, and security all require not only an understanding of the global health architecture, but also

of the negotiations and governance processes involved in order for such responses to succeed. In these situations, diplomats require a thorough understanding of related health issues, whereas, conversely, health professionals need a detailed appreciation of the complex diplomatic considerations involving both donor and recipient countries. A post hoc analysis of how diplomacy was (or was not) employed in the global HIV/AIDS, Ebola, and MDR-TB crises may help to ensure that, in future scenarios, the global community will be prepared to enhance its capacity in this regard.<sup>54</sup>

### A DOUBLE-EDGED SWORD

The complex intertwining of global health with foreign policy—including in the defense, international security, “hard power,” and broader military policy contexts—does, however, also require careful consideration of the moral quandary that such entanglements can lead to. Although such considerations extend far beyond the scope of the San Francisco Model, country ownership approaches, and the evolution of PEPFAR, connections with these paradigms remain relevant. For example, the aforementioned opposition to military–industrial efforts that “San Francisco Values” tend to be associated with may conceivably have helped to influence innovative approaches to foreign policy whereby health and development programs are framed as feasible (and, more importantly, proven effective) alternatives to the use of military force.<sup>24</sup> Nonetheless, examples such as the principled opposition of medical practitioners such as Howard Levy to “hearts and minds” strategies during the Vietnam era illustrate the discomfort with which many still view these nascent strategic and altruistic collaborations.<sup>55</sup>

Despite these reservations, the ascendancy of “smart power” (and even smart global health) approaches suggests that this collision of universes is not only inevitable, but already well advanced.<sup>43</sup> If GHD results in enhanced military contributions toward public health programs, it becomes morally more defensible. Yet, conversely, when global health programs support the military agenda in a developing country, this rationale may become less defensible. The advantages of GHD arguments in creating a rationale for transfer of funds from military–industrial to development initiatives therefore have to be tempered and reviewed in the context of supporting those military agendas that may not necessarily advance the global good. The

recent debate over the use of international armed forces in response to the West Africa Ebola epidemic<sup>56</sup> adds yet another layer of complexity of these issues. Should such efforts be welcomed as providing a new, humanitarian, and nondestructive role for the military? Or should reservations around the possibilities that this strategy opens up for other international actors to deploy international armed forces on ostensible health grounds (eg, Russian military presence in the Ukraine and Syria) be considered more carefully? The advantages and disadvantages of GHD efforts in supporting non-health agendas in recipient countries can only be controlled and optimized for the good of the global community by the careful application of existing “diplomatic” and “foreign policy” criteria by groups such as the OGHG working in collaboration with the State Department.<sup>57</sup> The evolution of GHD practice are not limited to the United States, with corresponding efforts taking place in countries such as Ireland,<sup>58</sup> the United Kingdom,<sup>59</sup> and Australia,<sup>60</sup> although to date, such efforts remain both nascent—and, occasionally, controversial.

### THE FUTURE OF GLOBAL HEALTH DIPLOMACY: SAN FRANCISCO AND BEYOND

Public health, diplomatic, and political professionals in San Francisco have significantly contributed to international health and development programs that extend far beyond their local purview. In so doing, they have come to better understand the forces impacting the goals and objectives of global health programs supported by PEPFAR, the Global Health Initiative (GHI), OGAC, and the GFATM, as well as their programs’ associated collateral, indirect, or “non-health” political and diplomatic outcomes. HIV/AIDS research in the San Francisco Bay Area has, thereby, contributed significantly to public health practice globally.<sup>61</sup> These efforts in turn informed US international efforts on HIV/AIDS prevention and care in southeast Asia, China, and eastern Europe.<sup>62</sup>

The generation of related systems of local accountability, planning processes, and opportunities to empower local actors to proactively address mortality and morbidity resonates of the early experiences and principles of the San Francisco Model. The innovative scholarship and pedagogy necessary for the development of such skills is reflected in the recent formation of the UCSF Institute for Global Health Delivery and Diplomacy under Ambassador

Eric Goosby, a former head of the OGH. UCSF plans to contribute to this nascent field through research, political consultation, and educational activities designed to better prepare health and diplomatic professionals to advance the overall global health mission, foster sustainability through a shared global responsibility, enhance and streamline international discourse and negotiation procedures, and pursue essential global diplomatic goals.

Promulgation of the “country ownership” paradigm may also gain added impetus through alignment with broader universal health coverage goals.<sup>63</sup>

Through such initiatives, and in concert with the work of local policymakers, health care

providers, and advocates in recipient countries, the Bay Area’s global health community will contribute not only their formidable health and medical resources to the “global public good,” but also their values of tolerance, political commitment, and cultural sensitivity to the practice of global health diplomacy.

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## REFERENCES

- Segall J. A first step for peaceful cosmopolitan democracy. *Peace Rev* 1997;9:337–44.
- Buhle P. The cultures of socialism in the United States. *Monthly Rev* 2002;54. Available at: <http://monthlyreview.org/2002/07/01/the-cultures-of-socialism-in-the-united-states/>.
- Novotny T, Adams V. Global health diplomacy—a call for a new field of teaching and research. *San Franc Med* 2007;80:22–3.
- Macfarlane SB, Agabian N, Novotny TE, Rutherford GW, Stewart CC, Debas HT. Think globally, act locally, and collaborate internationally: global health sciences at the University of California, San Francisco. *Acad Med* 2008;83:173–9.
- Chen Y, McFarland W, Raymond H. Risk behaviors for HIV in sexual partnerships of San Francisco injection drug users. *AIDS Care* 2014;26:554–8.
- Kellogg T, Hecht J, Bernstein K, et al. Comparison of HIV behavioral indicators among men who have sex with men across two survey methodologies, San Francisco, 2004 and 2008. *Sex Transm Dis* 2013;40:689–94.
- Raymond HF, Chen YH, Syme SL, Catalano R, Hutson MA, McFarland W. The role of individual and neighborhood factors: HIV acquisition risk among high-risk populations in San Francisco. *AIDS Behav* 2014;18:346–56.
- McNeil DC. San Francisco is changing face of AIDS treatment. *New York Times, Health*. October 5, 2015.
- Nemoto T, Operario D, Keatley J, Nguyen H, Sugano E. Promoting health for transgender women: Transgender Resources and Neighborhood Space (TRANS) program in San Francisco. *Am J Public Health* 2005;95:382–4.
- Ubel P, Loewenstein G, Scanlon D, Kamllet M. Individual utilities are inconsistent with rationing choices: a partial explanation of why Oregon’s cost-effectiveness list failed. *Med Decis Making* 1996;16:108–16.
- UCSF Center for AIDS Research. 2nd conference on Overcoming Health Disparities in the Bay Area: Focus on HIV and HCV. Available at: <http://www.hivforum.org/projects/cross-cutting-topics/us-epidemic/840-health-disparities-2>. Accessed January 2, 2016.
- Fetherling D. *The gold crusades: a social history of gold rushes, 1849–1929*. Revised edition. Toronto: University of Toronto Press, Scholarly Publishing Division; 2015.
- Pollard R. *Economic security and the origins of the Cold War, 1945–1950*. New York: Columbia University Press; 1985:20–3.
- Smith D. The 1960s, drugs and the free clinic movement. Available at: <https://www.bakersfieldcollege.edu/sites/bakersfieldcollege.edu/files/FreeClinicMovement.pdf>. Accessed January 2, 2016.
- Buchanan R. Ryan White CARE Act and eligible metropolitan areas. *Health Care Finan Rev* 2002;23:149–57.
- Health Resources and Services Association (2014). *The Ryan White HIV/AIDS program—a living history*. Available at: [www.hab.hrsa.gov/livinghistory/programs/Part-A-pg2.htm](http://www.hab.hrsa.gov/livinghistory/programs/Part-A-pg2.htm). Accessed January 2, 2016.
- Siplon P. *AIDS and the policy struggle in the United States*. Washington, DC: Georgetown University Press; 2002.
- Valdiserri R. Thirty years of AIDS in America: a story of infinite hope. *AIDS Educ Prev* 2011;23:479–84.
- University of California, San Francisco. HIV care: The San Francisco Model. Available at: <http://aids2012.ucsf.edu/2012/07/20/hiv-care-the-san-francisco-model/>. Accessed January 2, 2016.
- United States Department of Health and Human Services. HHS Award \$85 million to Eliminate Health Disparities. Available at: [https://aidsinfo.nih.gov/news/634/hhs-awards-\\$85-million-to-eliminate-health-disparities-medical-research-community-programs-are-high-priorities](https://aidsinfo.nih.gov/news/634/hhs-awards-$85-million-to-eliminate-health-disparities-medical-research-community-programs-are-high-priorities).
- Barusch A. *Foundations of Social Policy: Social Justice in Human Perspective*. London: Cengage Learning; 2008.
- Buse K, Walt G. An unruly mélange? Coordinating external resources to the health sector: a review. *Soc Sci Med* 1997;45:449–63.
- Kevany S, Hatfield A, Workneh N, et al. Diplomatic and operational adaptations to global health programs in post-conflict settings: contributions of monitoring and evaluation systems to ‘nation-building’ in South Sudan. *Med Confl Surviv* 2012;28:247–62.
- Kevany S, Jaf P, Workneh N, et al. Global health diplomacy in Iraq: international relations outcomes of multilateral tuberculosis programmes. *Med Confl Surviv* 2014;30:91–109.
- Kevany S, Sahak O, Workneh N, Saeedzai A. Global health diplomacy investments in Afghanistan: adaptations and outcomes of Global Fund malaria programs. *Med Confl Surviv* 2014;30:37–55.
- Kurtzman L. A decade in, UCSF emerges as a global health powerhouse. Available at: <http://www.ucsf.edu/news/2014/10/118671/decade-ucsf>.

- emerges-global-health-powerhouse. Accessed January 2, 2016.
27. United States Department of State. *Improving Lives: Military Humanitarian and Assistance Programs*. Washington, DC: Diane Publishing; 2004.
  28. Katz R, Kornblat S, Arnold G, Lief E, Fischer J. Defining health diplomacy: Changing demands in the era of globalization. *Milbank Q* 2011;89:503–23.
  29. Boelart M, Van Damme W, Meessen B, Van der Stuyft P. The AIDS crisis, cost-effectiveness and academic activism. *Trop Med Int Health* 2002;7:1001–2.
  30. Piot P, Zewdie P, Turden T. HIV/AIDS prevention and treatment. *Lancet* 2002;360:86.
  31. Lee K, Smith R. What is “global health diplomacy”? A conceptual review. *Glob Health Gov* 2011;4. Available at: <http://www.ghd-net.org/global-health-diplomacy/what-%E2%80%99global-health-diplomacy%E2%80%99-conceptual-review-0>.
  32. Fidler D. The rise and fall of global health as a foreign policy issue. *Glob Health Gov* 2011;4:10–8.
  33. Hala K. Global health diplomacy: the inextricable links between health and foreign policy. Available at: <http://juxtamagazine.org/2014/05/21/global-health-diplomacy/>. Accessed January 2, 2016.
  34. Tiefengraber D. Non-state actors & global health: eradicating polio in Pakistan. Barcelona Institute for Global Health. Available at: <http://www.isglobal.org/documents/10179/25254/15.Eradicating+Polio+in+Pakistan.pdf/639c1179-2694-4e39-82ab-f978631141ea>. Accessed January 2, 2016.
  35. Walsh D. Polio crisis deepens in Pakistan, with new cases and killings. *New York Times*. Available at: [http://www.nytimes.com/2014/11/27/world/asia/gunmen-in-pakistan-kill-4-members-of-anti-polio-campaign.html?\\_r=0](http://www.nytimes.com/2014/11/27/world/asia/gunmen-in-pakistan-kill-4-members-of-anti-polio-campaign.html?_r=0). Accessed January 2, 2016.
  36. Burkle F. Throwing the baby out with the bathwater. *Prehosp Disaster Med* 2013;28:1–3.
  37. Kevany S, Khumalo-Sakutukwa G, Murima O, et al. Health diplomacy and adapting global health interventions to local needs in sub-Saharan Africa and Thailand: evaluating findings from Project Accept. *BMC Public Health* 2012;12:1–11.
  38. Edwards N, Barker P. The importance of context in immunisation research. *J Acquir Immune Defic Syndr* 2014;67:S157–62.
  39. Morrison S. The new state department office of global health diplomacy: a second chance to get things right. Center for Strategic and International Studies. Available at: <http://csis.org/publication/new-state-department-office-global-health-diplomacy-second-chance-get-things-right>. Accessed January 2, 2016.
  40. Kerry J. Remarks at a global health event with partner countries. Available at: <http://www.state.gov/secretary/remarks/2013/09/214733.htm>. Accessed January 2, 2016.
  41. United States Department of state. The Office of Global Health Diplomacy. Available at: <http://www.state.gov/s/ghd/>. Accessed January 2, 2016.
  42. World Health Organization. Health as a bridge for peace—developing concepts and strategies. Available at: <http://www.who.int/hac/techguidance/hbp/strategies/en/>. Accessed January 2, 2016.
  43. Center for Strategic and International Studies. Report of the CSIS Commission on Smart Global Health Policy. Available at: [http://csis.org/files/publication/100318\\_Fallon\\_SmartGlobalHealth.pdf](http://csis.org/files/publication/100318_Fallon_SmartGlobalHealth.pdf). Accessed January 2, 2016.
  44. Feldbaum H. Global health and foreign policy. *Epidemiol Rev* 2010;32:82–92.
  45. Rice C. Remarks by Secretary Rice on fifth annual PEPFAR report: report highlights achievements of worldwide effort to combat HIV/AIDS. Office of the Spokesman. Available at: <http://iipdigital.usembassy.gov/st/english/texttrans/2009/01/20090112141723xjsnommis2.280825e-02.html#axzz3QquPedWA>. Accessed January 2, 2016.
  46. Fauci A. The expanding global health agenda: a welcome development. *Nat Med* 2007;13:1169–71.
  47. Walensky RP, Kuritzkes DR. The impact of the President’s Emergency Plan for AIDS Relief (PEPFAR) beyond HIV and why it remains essential. *Clin Infect Dis* 2010;50:272–5.
  48. Lyman N, Wittels B. No good deed goes unpunished: the unintended consequences of Washington’s HIV/AIDS programs. *Foreign Affairs*. July–August 2010.
  49. Williamson A. Sustainable HIV/AIDS program financing in PEPFAR countries. The results for development initiative. Available at: <http://r4d.org/focus-areas/sustainable-hiv-aids-program-financing-pepfar-countries>. Accessed January 2, 2016.
  50. Jaffe S. The USA and global health diplomacy: goals and challenges. *Lancet* 2013;381:1087.
  51. Kleinman A. The art of medicine: four social theories for global health. Available at: <http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673610606460.pdf>. Accessed January 2, 2016.
  52. Chattu V. The politics of ebola & the importance of global health diplomacy for the CARICOM states. Available at: [http://www.academia.edu/9308776/The\\_Politics\\_of\\_Ebola\\_and\\_the\\_importance\\_of\\_Global\\_Health\\_Diplomacy\\_for\\_the\\_CARICOM\\_states](http://www.academia.edu/9308776/The_Politics_of_Ebola_and_the_importance_of_Global_Health_Diplomacy_for_the_CARICOM_states). Accessed January 2, 2016.
  53. Sonenshine T. Ebola: an opportunity for public diplomacy. *The Globalist* 2014. Available at: <http://www.theglobalist.com/ebola-an-opportunity-for-public-diplomacy/>.
  54. Heymann D. The queen highlights a critical truth about health in West Africa. Chatham House commentary. Available at: <http://www.chathamhouse.org/expert/comment/16301#sthash.xkYHmpCV.dpuf>. Accessed January 2, 2016.
  55. Fried JP. Following up: a 60’s lightning rod, now on history TV. *New York Times* 2002. Available at: <http://www.nytimes.com/2002/07/21/nyregion/following-up.html>.
  56. The Lancet Editorial. National armies for global health? *Lancet* 2015;384:1477.
  57. Kevany S. Diplomatic advantages & threats in global health program selection, design, delivery and implementation: the development and application of the Kevany Riposte. *Global Health* 2015;11:22.
  58. Kevany S, Brugh R. Irish aid and diplomacy in the twenty-first century: optimising enlightened self-interest, supranational priorities and foreign policy impact. *Irish Stud Int Aff* 2015;26:1–19.
  59. Royal Institute for International Affairs. Global health diplomacy: a way forward in international affairs. Chatham House: meeting summary document. Available at: <http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/280611summary.pdf>. Accessed January 2, 2016.
  60. Kevany S, Gildea A, Garac C, Moa S, Lautusi A. Global health diplomacy, national integration, and regional development through the monitoring and evaluation of HIV/AIDS programs in Papua New Guinea, Vanuatu, and Samoa. *Int J Health Policy Manag* 2015;4:337–41.
  61. Pipkin S. Using surveillance data to monitor and evaluate the spectrum of engagement in HIV care. Presentation at the Applied Research, Community Health, Epidemiology and Surveillance Branch, Population Health Division, San Francisco Department of Public Health. San Francisco, California. July, 8, 2012.
  62. Mesquita G, Jacka D, Ricard D, et al. Accelerating harm reduction interventions to confront the HIV epidemic in the Western Pacific and Asia. *Harm Reduc J* 2008;5:26.
  63. World Health Organization. Increasing country capacities for universal health coverage (UHC). Available at: [http://www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/). Accessed January 2, 2016.

# Act Locally

How low profile surf travel can translate to global health and diplomacy

BY SEBASTIAN KEVANY

For me the drive from Cape Town to Elands Bay was a passage from one world to another. As with any crossing, actual or ephemeral, I found that changes in the environment required adaptability. It took time for me, an Irish surfer and global health student at the University of Cape Town—in many ways a fish out of water—to process what I was experiencing.

My friends and I made pre-dawn departures under the shadow of Table Mountain. By the time we reached Yzerfontein, the sun had come up, and the whine of the Peugeot 504's ancient engine would no longer register. Subtle indicators of what kind of day it would be revealed themselves. The real point of no return into what felt like *terra incognita* came with the turn onto the unpaved, heat-shimmering, railway roads, populated only with Armageddon machines straight out of a post-apocalyptic landscape. *Geen Ingang*—"No Entry" in Afrikaans—read the oft-disregarded sign as we peeled into the desert.

Escapades from my professional life in global health and diplomacy, combined with a natural concern for my own skin, caused new ideas to generate first gradually, but then with increasing momentum, in this environment. Most of my thoughts turned toward development—of breaking even with the immense good fortune and stoke of the classic *Elandsbaai* surf mission. But such considerations sit uneasily, or at odds with, the culture of surfing.

Many surfers—myself included—get into the water to escape from the perils and challenges of the world's inequalities, poverty, conflict, and ill-health, rather than to be reminded of them. For me, Elands also represented a chance to escape from the hectic, urban flux of Africa and engage with a kind of reductionist desert stability. A deepening exposure to, and awareness of, the health conditions of its local population—in the vulnerable, vacuous, dry moments between long and shiny point waves—was an uneasy side effect of this escapism.

Driving down those unmarked roads, surfing desert waves, week after week, brought with it unavoidable exposure to the way most people in the world live: long distances walked on foot, penetrating stares, rough shacks, intense heat and dust, subsistence economics. In dispassionate World Bank jargon, it was a "resource-poor" environment. By radical contrast, I was also faced with the

modern range and variety of surf travel—ever more opulent and expensive options for luxury surf destinations, available to the lucky few. But even in the roughest accommodations of Elands, it required Herculean efforts for me to block out the "Affluenza" of privilege in the water compared with the minimalist, survivalism on the land.

The local surfers I knocked around with, and who attempted to address this, included Cape Town stylists Matthew Beatty and James Lennard, architect and industrial designer respectively. Their reductionist aesthetic sought to eradicate the bling, ostentation, and showmanship that is so much the marque of the *nouveaux riches*, and a red flag of discontent and animosity. Related lifestyle approaches by characters such as Pierre de Villiers and wooden surfboard maker Patrick Burnett also deeply impressed me.

Still, it took some time for me to realize quite how much I didn't know. There was no "Eureka Moment," but I eventually reckoned that international surfing, diplomacy, and global health initiatives, seemingly separate universes, had a surprisingly broad range of commonalities. All are pursuits often focused on the poorest countries in the world, in which natural resources are abundant, but ill-health, conflict, and inequity also pervasive. Surfing takes its acolytes to remote parts of the globe. In the same way, global health and diplomatic efforts often take place in obscure latitudes of the world's trickiest regions. Might there be some way to rationalize these pursuits, I wondered? To leverage our good fortune—however feral its style—in service of local populations and barefoot diplomacy?

It is impetuous, naïve, and even dangerous to address the complexities of health or diplomacy in a knee-jerk fashion. Surfing itself can also be a rickety platform for change—no one wants to sit in a hard-earned lineup, waiting for a moment that may have been years in the making, only to be assailed by such considerations. And even then, it is not enough to simply go along for the ride. In much the same way one approaches a set wave at Elands—an experience that requires acute attention to align with the moods and vagaries of the point—awareness and balance are demanded to keep pursuits such as diplomacy, surf travel, and development in trim.

I have spent much of the past decade in some tricky places—from Iraq to Sudan, from South Sudan to Afghanistan, from Zimbabwe to Egypt—trying to make sure global health efforts are not counterbalanced by unforeseen consequences. Any endeavor that does not consider its collateral or domino effects can quite easily do more harm than good. "Global health diplomacy" joins medical altruism with broader concerns of the global community such as health, peace keeping, nation building, and conflict resolution. This "dual role," if pursued according to the right principles, produces much more than better health outcomes.

In many ways, the same perspectives can be applied to global surfing. What has been described as "surf



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diplomacy" takes a successful and well-developed paradigm—wave riding—and attempts to optimize its effects. Is there any reason why all surfers should not also play a constructive part on the world stage in this regard—a polarization, and indeed reversal, of the "Charlie don't surf" cliché?

At the individual level, such efforts manifest themselves by surfers acting as informal conduits of progressive values. Efforts by SurfAid for malaria treatment activities in Indonesia, and surfers such as Easkey Britton working for human rights in the Middle East, provide tangible examples. They also beg the question of how surf, international relations, and development can be innovatively combined, in much the same way that international soccer, for example, may support similar agendas.

Back in Elands, the only conflicts were of the social, cultural, and economic kinds, and the residents had already tapped into appropriate responses. I cannot say that I ever made the slightest difference to this situation. Yet Elands inspired these ideas, and is an appropriate setting for future efforts. A local schoolteacher, Mr. Loyiso Mashawa, painted a picture for me over a *Windhoek* one evening in the bar of the Hotel Eland: of drug use, HIV/AIDS, and neglect in the local township, juxtaposed with the (occasionally extreme) wealth of visiting surfers.

The same evening, the local *Draaihoek* proprietress described surfing efforts for vulnerable children at the point, while the nearby Vensterklip Hotel hosted a youth dance troupe as we swam and ate in the hotel's otherwise private compound. The traveling surfer, myself included, has a lot to learn from such engagement. Both surfing and surfers then become part of the positive milieu of their destinations, rather than a curiosity or tolerated alien presence.

In the 21st century, a combination of surf and global health diplomacy can aspire to address broader issues, such as human rights and conflict resolution. And while identifying with such ideals is often far from easy for

someone who is often functioning, *Second Thoughts* style, in parallel with the locals themselves, what may remain relevant is our reconsideration of the "slash and burn" consumerism of high-end yacht charters; of private beaches, islands, reefs, and waves designed exclusively for the pleasure of affluent patrons.

No longer, then, need surfing be considered a selfish, occasionally guilt-ridden, and often exploitative pursuit. Similarly, no longer are surfers stripped of responsibilities for their human, ethical, and physical environments. No longer is surf etiquette confined to a somewhat absurd bubble in which rules of engagement, recognition, and karma apply only to "equals" floating in the lineup.

I, for one, could have used such guidance, style, and principles long ago. The pragmatic surfing *boets* from Cape Town ironically knew the game far better than the idealistic outsider, intuitively understanding what was appropriate and what kind of "good will gestures" would be misinterpreted as conspicuous largesse or mocked as high idealism. In such circumstances, a set of principles—a guide, or "soft law"—adapted from global health diplomacy principles might help.

If nothing else, at the most basic level, it is a case of bearing in mind one more standard of behavior—of respect, and of style—as one travels, explores, and surfs. A conscientiousness of the tricky consequences of our extreme good fortune. In turn, such recognition stands to build support for both global health and surf diplomacy, making them an important part of the modern and enlightened surfer's quiver. ■

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