Defining Health Diplomacy: Changing Demands in the Era of Globalization

R E B E C C A   K A T Z ,   S A R A H   K O R N B L E T ,
G R A C E   A R N O L D ,   E R I C   L I E F ,
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Context: Accelerated globalization has produced obvious changes in diplomatic purposes and practices. Health issues have become increasingly preeminent in the evolving global diplomacy agenda. More leaders in academia and policy are thinking about how to structure and utilize diplomacy in pursuit of global health goals.

Methods: In this article, we describe the context, practice, and components of global health diplomacy, as applied operationally. We examine the foundations of various approaches to global health diplomacy, along with their implications for the policies shaping the international public health and foreign policy environments. Based on these observations, we propose a taxonomy for the subdiscipline.

Findings: Expanding demands on global health diplomacy require a delicate combination of technical expertise, legal knowledge, and diplomatic skills that have not been systematically cultivated among either foreign service or global health professionals. Nonetheless, high expectations that global health initiatives will achieve development and diplomatic goals beyond the immediate technical objectives may be thwarted by this gap.

Conclusions: The deepening links between health and foreign policy require both the diplomatic and global health communities to reexamine the skills, comprehension, and resources necessary to achieve their mutual objectives.

Keywords: Global health, diplomacy, foreign policy.

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T HE ACCELERATED PACE OF GLOBALIZATION IS DISSOLVING THE distinctions between many domestic and foreign issues. One nation's health status and risks can affect not only its own prospects and those of its neighbors but also those of the entire world. The SARS outbreak of 2003, followed by the 2009 H1N1 influenza A pandemic, exemplified how quickly emerging infections can spread, costing lives and curtailing travel and trade among interdependent economies. Practitioners and policymakers alike who might once have advocated international health programs now speak of *global* health. The increased number of commitments to global cooperation in public health surveillance and response have placed new demands on international institutions and legal instruments and required new agreements between and among nations. In the United States and abroad, global health has become part of foreign policy agendas and is included in discussions on national security, trade, and diplomacy.

As nations integrate health into their broader foreign policy strategies, traditional population health concerns join other goals, which in turn create the need for new resources. Stakeholders look to global health diplomacy as a means to accomplish a variety of outcomes, from the aspirational to the purely pragmatic. One result is the larger number of health actors. To counter the effects of disease burdens on economic development, wealthy donors have dramatically increased their willingness to pool and project resources for health. Indeed, the outpouring of new health assistance from governments and philanthropists over the last decade has set the stage for major new public-private partnerships and global health initiatives, a profusion that has elicited calls for more formal global health governance.

The United States remains the world's largest single provider of health assistance, and therefore its policies have a disproportionate influence on global health. U.S. decision makers increasingly understand that the health status of developing nations has implications for national security beyond the threat of emerging infections. Consequently, the United States is spending more money than ever on global health assistance, through traditional development aid agencies as well as agencies whose conventional aims are defense and diplomacy (Kates et al. 2010). In 2009, Assistant Secretary of State Kerri-Ann Jones affirmed that "better global health promotes stability and growth, which can deter the spread of extremism, ease pressure for migration, reduce the need for humanitarian and development assistance and create opportunities for stronger political alliances and economic relations" (Jones 2009).

These priorities have prompted the U.S. government to invest heavily in new mechanisms to implement ambitious global health initiatives while at the same time securing favorable perceptions in a changing diplomatic space. Policymakers often refer to such efforts collectively as *global health diplomacy*, a term also used by academics and practitioners for activities ranging from formal negotiations to a vast array of partnerships and interactions between governmental and nongovernmental actors. This article examines the foundations of the various definitions applied by the international public health and foreign policy communities in order to create a framework for understanding this evolving subdiscipline of global health diplomacy. We review the contexts, practice, and components of global health diplomacy as defined operationally, focusing on U.S. policies and actions. Based on these examples, we then propose a taxonomy that reflects the increasing diversity of global health actors and drivers.

Framework and Definitions for Understanding Global Health Diplomacy

The concept of "medical diplomacy" was introduced as early as 1978 by Peter Bourne, special assistant to the president for health issues during the Carter administration. He argued that "the role of health and medicine as a means for bettering international relations has not been fully explored by the United States. Certain humanitarian issues, especially health, can be the basis for establishing a dialogue and bridging diplomatic barriers because they transcend traditional and more volatile and emotional concerns" (Bourne 1978, 121). This concept developed and matured over recent decades, and policymakers and researchers now are familiar with the term *global health diplomacy*, thanks to the trailblazing work in this field (Adams, Novotny and Leslie 2008; Kickbush et al. 2007; Kickbusch, Silberschmidt, and Buss 2007; Novotny 2006; Novotny et al. 2008). Seventy-six of the 106 articles on the topic published in peer-reviewed scientific journals between 1970 and 2010 appeared just in the last decade (Pubmed 2010). Furthermore, government officials and international organizations are increasingly embracing global health diplomacy as a tool to simultaneously carry out programs and improve health and international relations (Drager and Fidler 2007).

Even though the term *global health diplomacy* has entered the mainstream, it has many, vastly different, meanings. These generally fall

into three different categories of interaction around international public health issues: (1) core diplomacy, formal negotiations between and among nations; (2) multistakeholder diplomacy, negotiations between or among nations and other actors, not necessarily intended to lead to binding agreements; and (3) informal diplomacy, interactions between international public health actors and their counterparts in the field, including host country officials, nongovernmental organizations, private-sector companies, and the public.

Core Global Health Diplomacy

The term *core diplomacy* can have multiple connotations and has been defined as interactions between governments, including policy implementation, policy advocacy, negotiation, intelligence, and issue-based diplomacy (Adams et al. 2008). To avoid controversy, we limit the term here to the classical Westphalian interpretation: negotiations between and among nations to resolve disputes and enact formal agreements.

Bilateral Treaties and Agreements. A *bilateral negotiation* between two nations is the most traditional form of core diplomacy. It involves high-level negotiations between national representatives, who may be health officials or other technical experts, and whose outcome may be a signed agreement resulting in obligations on the parties. According to the U.S. Department of State, the United States alone has in force today thirty-one bilateral agreements categorized as "health." Twenty of these agreements specifically address the prevention and mitigation of particular infectious diseases (U.S. Department of State 2010).

Multilateral Treaties and Agreements. Based on Henry Morgenthau's and Henry Kissinger's historical definitions and concepts, our classification of core diplomacy includes international negotiations that fall under the aegis of multilateral institutions such as the World Health Organization (WHO) and other international organizations that shape agreements and norms (Kissinger 1994; Morgenthau 1946). Kickbusch and colleagues describe these as "multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health" (Kickbusch, Silberschmidt, and Buss 2007, 230). There are approximately fifty core multilateral health agreements in the world today (Kates and Katz 2010). The most conspicuous forum for global health negotiations is the World Health Assembly (WHA), the highest decision-making body of the World Health Organization (WHO),

which is composed of representatives from all 193 member states. The number of formal health agreements enacted through WHA multilateral negotiations is small but significant, including the WHO Framework Convention on Tobacco Control (FCTC) and the revised International Health Regulations, which passed in 2005 (IHR 2005) (Gostin 2008; WHO 2008).

The FCTC, adopted in 2003, represents years of efforts by health experts, international law professionals, and diplomats to evaluate the evidence, negotiate the text, conclude the treaty, and move individual nations through the signature and ratification processes (WHO 2003). The negotiations required a significant degree of technical knowledge to create the first evidence-based treaty under WHA auspices—a milestone for global health—as well as the diplomatic élan to shepherd the treaty process.

In the second example, WHA members agreed in 2005 to a sweeping overhaul of the international legal framework for disease surveillance, reporting, and response. The IHR 2005 obligate all WHO Member States to develop and maintain core capacities to detect, assess, report, and respond to public health events and to promptly notify WHO of any public health emergencies that might affect other nations (WHO 2008).

Negotiations for the FCTC and IHR 2005 focused on not just the "high diplomacy" of state sovereignty—the language of principles, standards, and obligations—but also the epidemiological evidence and data-driven decision making. Both agreements impose on the state parties obligations that are legally binding in the service of population health goals (Gostin 2008).

Negotiations affecting health practices directly or indirectly also take place in other UN organizations, in the context of aid-trade negotiations, and even in forums like the Convention on Biological Diversity. For example, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, adopted by the World Trade Organization (WTO) in 1995, demonstrates that agreements that are not strictly related to health can influence the diplomatic and health policy environment. The TRIPS agreement introduced minimum standards for WTO members to protect and enforce intellectual property rights and extended international standards to patent protection. Leaders from many developing nations and advocacy groups argued, however, that TRIPS could make HIV/AIDS treatments unaffordable in the most heavily affected

nations. Ministerial negotiations culminated in a 2001 declaration confirming that TRIPS allows states to issue compulsory licenses in the face of public health crises. Neither this nor successor agreements erased contentions between the high-income countries where most major pharmaceutical manufacturers are based and the emerging economies that seek flexibility in producing pharmaceuticals locally and exporting them under specific conditions. Instead, the acrimonious debate spilled over into other trade and health discussions (Abbott 2005; Aginam 2010).

In the past two decades, perceptions of public health risks amenable to global governance have broadened from existential threats such as epidemic-prone or emerging infectious diseases to underlying determinants of chronic disease, such as tobacco use. The search for international interventions to reduce the toll of communicable and noncommunicable diseases puts new pressures on multilevel governance and on core diplomacy to achieve health objectives through international legal frameworks. This effort requires access to health knowledge throughout the diplomatic and legal exercise of international negotiations, including areas not strictly focused on global health.

Multistakeholder Global Health Diplomacy

Multistakeholder diplomacy refers to international negotiations and interactions in which various state, nonstate, and multilateral actors work together to address common issues (Hocking 2006).

Partnerships between Government Agencies. A substantial number of agreements between national governments are reached not through traditional diplomatic channels but through agreements between agencies in each country (Abbott 2005). For example, divisions of the U.S. Agency for International Development (USAID) and the U.S. Centers for Disease Control and Prevention (CDC) may enter into separate agreements with a particular country's ministry of health. These agreements can take various forms, such as a memorandum of understanding (MOU) or a cooperative agreement, based on institutional culture and program goals. Although these agreements are technically contracts, generally executed through the U.S. diplomatic mission, the negotiations may take place primarily among technical experts in the respective country agencies. Such agreements outline obligations, but unlike formal treaties, they are not necessarily legally binding in international law or on sovereign states. MOUs and other types of informal

agreements provide certain advantages over formal treaties (e.g., they can be confidential, put into effect more quickly, and easily modified) and are increasingly common health diplomacy instruments.

Global Initiatives and International Organizations. Various terms have been used to describe the need for diplomatic representation for organized nonstate entities (Ross 2010). Multistakeholder diplomacy encompasses the larger sphere of interactions among nonstate actors, as well as state actors that have not traditionally participated in foreign affairs. As global health assistance has increased over the last two decades, the number of long-term partnerships between government and nongovernmental organizations (NGOs) to implement health services delivery, capacity-building projects, and research has risen as well. Public- and private-sector institutions now jointly support dozens of global health partnerships, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; the GAVI Alliance (launched as the Global Alliance for Vaccines and Immunization); Stop TB; Roll Back Malaria; and the Global Polio Eradication Initiative (Nishtar 2004). These public-private partnerships, generally governed by a board of directors rather than through the consensus process more common among traditional multilaterals, bring a new dimension to the field.

The setting of norms and standards that cross human, animal, and environmental health sectors also necessitates multistakeholder diplomacy. Multinational engagement in crafting and promulgating such norms requires health and diplomatic expertise, although negotiations often take place in a less formal, more technical forum. For example, the United Nations Food and Agricultural Organization (FAO) serves as a forum for the international community on food production issues, whereas WHO takes the lead on global public health issues, which include food safety. These two specialized agencies jointly administer the Codex Alimentarius process, which is a nonbinding tool to help align consumer health protections and fair trade practices internationally (WHO and FAO 2006).

Counterbalancing Conflict through Diplomacy. Bourne conceived of health diplomacy as a way to "transcend traditional and more volatile and emotional concerns" (Bourne 1978, 121). Perhaps the most spectacular example of multistakeholder health diplomacy during conflict was the U.S.-Soviet cooperation in eradicating smallpox at the height of the cold war, under the aegis of the WHO (Manela 2010). In this case, the rival powers did not sign formal agreements or treaties but

coordinated their assistance informally around a public health goal of mutual interest.

Multilateral institutions as well as governments often negotiate with governments or political factions on behalf of vulnerable populations during conflicts. Negotiations that achieved cease-fires for public health activities in the midst of civil wars in El Salvador and Lebanon in the 1980s showed the promise of multistakeholder health diplomacy during conflicts (MacQueen et al. 2001). The 1990 World Declaration on the Survival, Protection and Development of Children formalized the concept of cease-fires for vaccination or humanitarian corridors (United Nations 1990). Successes include the four-month "Guinea worm cease-fire" of 1995, when the government of Sudan and opposing forces allowed international and local health workers to deliver essential treatments and vaccines to thousands of villages in the midst of civil war (CDC 1995). WHO Member States formally recognized "Health as a Bridge for Peace" as a strategic element in 1998. WHO used this concept as a framework that gives public- and private-sector health leaders tools to negotiate space for public health interventions during conflict, ultimately supporting political, structural, and social peace building (Rodriguez-Garcia et al. 2001).

Informal Global Health Diplomacy

Informal diplomacy encompasses interactions between public health actors working around the world and their counterparts in the field, including host country officials, representatives of multilateral and nongovernmental organizations, private enterprise, and the public.

Government Employees—"Free Agents" in the Field?   The scope of U.S. government (USG) engagement in health assistance helps illustrate the growing complexity, and increasingly crowded field, of global health activities. The launch of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, the largest single disease-focused initiative in history, instantly demanded new government expertise to support vastly expanded overseas health programs and activities. This placed new demands on "traditional" health actors such as USAID and CDC and required new leadership on health issues from embassy staffs and input from various other agencies.

The exact numbers of U.S. government employees who work abroad to implement health assistance programs is unclear. As shown in

figure 1, however, the number of CDC staff deployed abroad to support such initiatives as its Global AIDS Program, Global Disease Detection and Emergency Response Centers, and pandemic influenza preparedness activities reflects one U.S. agency's trend toward broadened long-term partnerships with host nations. In 2008, the CDC assigned 224 U.S. personnel to fifty-four countries around the world for fixed-term appointments—about twice the 2004 levels—and employed about 1,200 local staff to support global health programs (CDC 2009).

The U.S. military, whose global health missions are often overlooked, operates overseas medical research laboratories in partnership with four host nations and each year conducts disease surveillance projects, capacity-building efforts, outbreak investigations, and training exercises in more than one hundred countries. The number of military humanitarian and civic assistance projects, which can include health capacity building and aid, has grown steadily, from about 155 projects in thirty-five countries in fiscal year (FY)1997 to about 480 projects in forty-six countries in FY2007 (Serafino 2008).

U.S. government personnel who participate in such programs are technical experts, governed by their own programmatic requirements, who routinely interact with local communities, organizations, and government officials as a part of their job duties. Their numbers are augmented by even more numerous private contractors who implement U.S. government–funded programs. These health and research professionals represent the U.S. government, even if they do so without strong regard for (or awareness of) the greater foreign policy environment.

Private Funders and NGOs. Private-sector organizations, from large funders like the Bill and Melinda Gates Foundation to charitable organizations that send a handful of volunteers abroad on "medical missions" each year, disbursed more than $17 billion in medical assistance overseas between 2002 and 2006 (Ravishankar et al. 2009). That figure continues to rise. Between 1994 and 2010, the Gates Foundation funded more than $14 billion in global health programs, including local and international organizations like the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance (Gates Foundation 2010).

The Gates Foundation is exceptional in terms of resources and profile, but it is not the only private-sector organization with a growing health assistance portfolio. Ravishankar and colleagues showed that overseas health expenditures by U.S.-based private-sector organizations have also climbed steadily, with three large organizations (Food for the Poor,
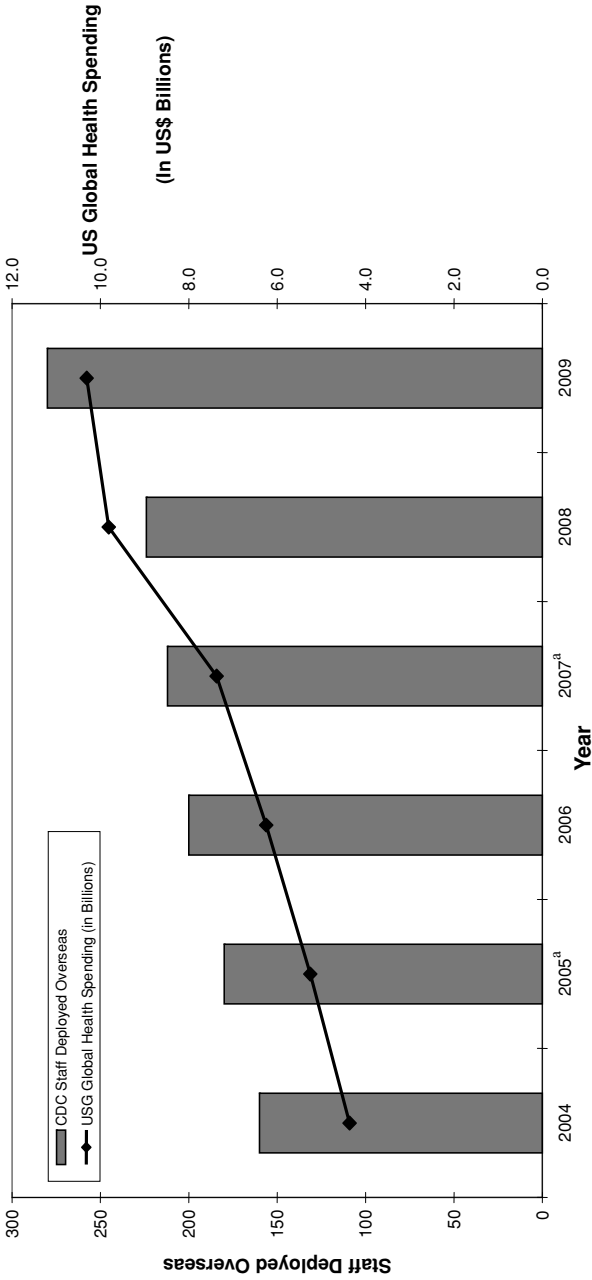
FIGURE 1. Total US Government Global Health Spending and CDC Personnel Deployed Overseas, 2004–2009
Note: [a] Data are not available for staffing levels. Values represent an average of the previous and following year.
Sources: CDC 2004, 2006, 2008; Kates et al. 2010.

PSI, and MAP International) accounting for more than $4 billion from 2002 through 2006 (Ravishankar et al. 2009). These private-sector organizations vary widely in their objectives and sources of support and include corporations, exclusively donor-funded private voluntary organizations and NGOs, and for-profit and nonprofit organizations that rely on a mix of private and public funds. Their work also varies, from the provision of basic services driven primarily by institutional missions (e.g., PSI and Feed the Children) to the implementation of U.S. government health policies and programs (e.g., Management Sciences for Health). Private consulting companies (such as Abt Associates, Chemonics International, Futures Group International, and RTI International) play a significant role in implementing USAID projects in developing countries worldwide, either directly or through awards to local and international subcontractors (USAID 2010).

Research. International research collaborations among laboratories, NGOs, academic institutions, government agencies, and private companies have become more and more common, although not always without controversy. Activities range from peer-to-peer scientific partnerships to large-scale clinical trials with thousands of participants. For example, a U.S.-based academic researcher supported by public funding may collaborate directly or through an institutional "twinning" agreement with a counterpart based in a low- or middle-income country where specific diseases of interest remain prevalent. Such collaboration provides mutual benefits for professional development: one side obtains access to desired specimens or data, and the other is given opportunities for international recognition and the transfer of skills and technologies. Health professionals from the public and voluntary sectors often forge agreements with host nation officials to study health behaviors, risks, and interventions of public health significance in local populations. But these relationships become problematic when either side perceives unfair treatment over issues such as authorships or access to data. Tensions can rise even higher when the stakes include human subjects protection in research, intellectual property rights, and profits. With globalization, the number of clinical trials outsourced from U.S.-based pharmaceutical companies to overseas sites has climbed steadily (Glickman et al. 2009). The impact of such trials on local public perceptions can be substantial, particularly if regulators hold researchers to a different standard at home and abroad (Lurie and Greco 2005) or if researchers communicate risks poorly to their local interlocutors.

Humanitarian Assistance and Disaster Response. Individual and institutional interactions among the public, private, and voluntary sectors become even more complicated during high-pressure responses to natural disasters and complex humanitarian emergencies. In 2005, the UN system and major relief organizations endorsed reforms to improve the effectiveness of humanitarian responses, by promoting more effective partnerships among international, national, and local actors in the field. This framework demands health diplomacy at two levels. First, multistakeholder negotiations take place at the operational level through the UN "cluster" system, in which the lead agencies (WHO in the case of the health cluster) coordinate task division and information sharing among the actors providing related services.

Decision making under this system may create frictions in the informal interactions among stakeholders. As widely noted, there often are unresolved tensions between civil and military actors over adherence to the humanitarian principles of neutrality, impartiality, and independence (Morton and Burnham 2010). Nor do civil society and humanitarian relief organizations speak with a single voice. Local NGO leaders may be inadvertently excluded from multistakeholder and informal negotiations conducted in English and organized through nontransparent international processes. The success of "disaster diplomacy" varies widely at national and subnational levels, with local perceptions influenced by the adequacy and coordination of the response as well as the perceived cultural sensitivities and motives of the humanitarian actors (Wilder 2008).

Diplomacy in a Changing Health Landscape

Two recent incidents illustrate vividly how the outcomes of core diplomacy, multistakeholder diplomacy, and informal diplomacy can converge to precipitate—and potentially resolve—health crises with international implications.

In 2003, the people of Kano State in northern Nigeria began refusing WHO-supported polio vaccination based on rumors, echoed by political and religious leaders, that the campaign represented a Western conspiracy to sterilize Muslims. These rumors gained momentum among communities sensitized by the "war on terror" as well as by a private-sector clinical trial alleged to have caused serious harm in

local children (Frishman 2009). Over the next year, officials from the WHO, other UN agencies, the Organization of the Islamic Conference, and the U.S. government engaged in unusually intense diplomatic efforts with Nigerian authorities to resolve the impasse (Kauffmann and Feldbaum 2009).

Ultimately, these negotiations plus switching production of the vaccine from the United States to Indonesia helped lead to the resumption of vaccinations (although not before outbreaks spread to previously polio-free countries in sub-Saharan Africa, Southeast Asia, and the Middle East). As Kauffman and Feldbaum pointed out, however, there was no blueprint to solve the vaccine boycott; it was a health problem exacerbated by local and international political trends. Informal diplomacy had eroded public trust, and multistakeholder diplomacy proved demanding and time-consuming. State Department appeals for suggestions from U.S. agencies with health expertise, such as USAID and CDC, entered new territory. The technical experts who understood epidemiology had little idea of the tools that the U.S. mission could employ (i.e. demarches, communiqués, and/or direct contact between the ambassador and host government officials) or how to put them into action (Kauffmann and Feldbaum 2009).

The negotiations surrounding the sharing of influenza viruses and access to vaccines have placed similar demands on technical and foreign policy skills. Traditionally, national public health authorities have shared influenza virus samples from locally diagnosed human cases with one of the half dozen WHO collaborating centers for influenza. These centers confirm diagnostic testing, conduct strain analysis, and serve as repositories of virus strains for the international scientific community, including vaccine manufacturers. This process is a vital part of global influenza surveillance and response efforts for several reasons, such as the study of pathogen strains to look for changes in the virus or possible drug resistance, and for developing countermeasures such as vaccines (Makino 2011). In 2006, Indonesia ceased sharing virus samples from human H5N1 avian influenza cases, despite its membership in WHO's coordinated influenza surveillance network. The country cited as the basis of its refusal the unfair distribution of any benefits (i.e., vaccines produced by private pharmaceutical companies) that might result from sample sharing, launching a contentious dialogue on "viral sovereignty" across political and technical organizations (Fidler 2010). The ongoing WHO process launched to address these

issues required negotiators who understood vaccine production, epidemiology, intellectual property rights, and the balance of power among emerging economies.

Unfortunately, the agencies involved do not always possess the skills needed to bridge health and diplomacy disciplines operationally. Mechanisms for systematically integrating science, technology, and health knowledge into the foreign policy community have changed over time, and enthusiasm for cultivating such expertise depends on the political and funding climates. For the United States, this can result in a disconnect between its interests in global health as an aspect of foreign policy and its ability to evaluate and respond to unfolding events. This situation is then exacerbated by the growing number of stakeholders from other areas of government or organizations engaged in discussions that in the past may have been strictly matters of state or simply did not exist.

Expanding global health initiatives require new human resources. Global health stakeholders tend to be sensitive to the potential for "brain drain" among the skilled health workforce within resource-constrained settings. For example, externally funded health assistance programs offering higher salaries may lure scarce skilled health workers away from general practice, thereby diverting resources from essential health services benefiting the whole community into programs that may benefit only a fraction of the population (Kirigia et al. 2006; Pang, Lansang, and Haines 2002). Less often noticed is the parallel demand on a global health workforce not yet formally professionalized even among developed nations. To implement new global health initiatives, governments and international institutions have expanded their overseas health workforces. Private-sector health actors now constitute an overseas presence without precedent, a workforce uncoupled from the overarching priorities of government or multilateral agencies. There simply are not enough old hands with field experience to meet programmatic demands, and few programs offer a continuum of technical, cross-cultural, and negotiations training for health professionals.

Despite this, decision makers clearly hold high expectations for the outcomes of global health diplomacy at every level. For example, the Oslo Ministerial Declaration of 2007 (adopted by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand) expressly articulated an agenda for raising the priority of global health issues in foreign policy (Amorim et al. 2007). The United States

explicitly supports global health initiatives as a projection of "smart power," which depends on public health professionals and researchers to achieve their technical objectives as an element of the country's broader foreign policy strategies. To date, U.S. agencies have not systematically given those professionals a framework for understanding the political milieu in which they act.

Individual experts and programs may not have an enormous influence on local or regional perceptions of U.S. motives and foreign policy. Nevertheless, through local actions (and interactions), global health initiatives create an impression at the community level that may erase or enhance negative stereotypes. The sheer proliferation of current programming by public and private-sector actors and the lack of global mechanisms to track the impact on local leaders and communities can lead to complications, ranging from overwhelming national officials with haphazardly organized or redundant programs to sending profoundly mixed messages about the donor nations' values. Collectively, public and private health actors create an environment that builds or undermines goodwill toward the United States, other nations, and the multilateral organizations they support—and do so with little to no awareness of their own legacies.

Opportunities in Health and Diplomacy

Diplomacy is changing. Countries and their representatives do not interact solely through traditional diplomatic channels, and the influence of independent actors on foreign policy is substantial. Despite widespread calls for more effective country-level coordination by health actors, formal mechanisms of communication are often fragmented by disease, sector, or bureaucratic silos. Public health experts may act without awareness of larger diplomatic strategies or tensions that may be at play. Although they clearly owe their first loyalties to humanitarian imperatives, particularly during a crisis, multiyear health initiatives depend on goodwill and trust built with sensitivity to local sociopolitical and cultural contexts. At the same time, the diplomatic community has only just begun to appreciate the complexity of the global health landscape, including the shadow of informal diplomacy for health. As individuals and international networks transcend traditional foreign policy channels, new tools will be needed for the increasingly inclusive sphere of global health diplomacy actors.

The current training of career foreign service and health professionals in the field does not emphasize professionalization of "health diplomats." The new demands on global health diplomacy expertise mean that governments and multilateral organizations cannot wait for their knowledge capacities to grow over decades, or even years. Rather, a better continuum of professional development is needed, from cross-training in core concepts across agencies and institutions to more specialized, operation-specific training opportunities. A 2008 report on U.S. foreign assistance staffing recommended significant investment in increased technical expertise, including health disciplines (Adams et al. 2008). This finding was subsequently confirmed by a sweeping review of U.S. diplomacy and development capabilities calling for more systematic methods of introducing and sustaining such expertise within civilian agency cultures (QDDR 2010). Stakeholders have begun to develop resources to help demystify each community's priorities, principles, and practices, and the support for such endeavors is increasing. For example, only a few years after its own launch, the Global Health Program of the Graduate Institute–Geneva executive course in global health diplomacy has already become a template for the development of country-level courses on health negotiations. The U.S. National Foreign Affairs Training Center/Foreign Service Institute has demonstrated an interest in integrating global health issues into its training curriculum. Other academic and governmental programs are expanding opportunities and identifying best practices for training diplomats in more complex health issues. A much more concerted effort will be required, however, to provide public health professionals and diplomats with the practical tools they need to recognize and manage their roles in core, multistakeholder, and informal health diplomacy.

Recognizing the types of global health diplomacy helps create a framework for understanding the skills and aptitudes that are needed, and should be rewarded, within this subdiscipline. Institutionalizing the training to convey such skills and aptitudes requires acceptance not just by the diplomatic corps but also by the increasingly professionalized global health community. This can succeed only if the continuum of professional development explicitly values training beyond that needed for technical competence in public health, medicine, or the life sciences. This might be an orientation in the types of cross-cultural competence, management, and basic negotiation skills routinely offered to new foreign service professionals. This training has benefits far beyond creating a knowledge reservoir to be tapped for core and multistakeholder

diplomacy. Such capacities can help improve the effectiveness of health programming in the field and encourage the development of transnational communities of practice, with benefits for both the private and the public sector. A relatively new aspect of globalization is the growing number of college graduates boasting overseas experience on their résumés. Offering an orientation in "practical diplomacy" to students on a global health career track would help them understand where their efforts fit in the context of local, regional, national, and global issues and also help them understand the tools and services available to them in the field. The burgeoning interest in global health as an academic field of study (Merson and Page 2009) offers an opportunity to introduce the concepts that are at the intersection of health, diplomacy, and policy to a new generation through formal instruction and field experiences.

Conclusion

Core and multistakeholder diplomacy in global health—an increasingly prominent element of the U.S. foreign policy toolkit—requires a delicate combination of technical expertise, legal knowledge, and diplomatic skills to be used effectively. In reality, the health expertise of the diplomatic corps is uneven at best. International negotiating experience is often just as scarce among U.S. public- and private-sector health professionals, who may struggle to develop and maintain effective partnerships with their counterparts for want of appropriate knowledge of the sociocultural and political contexts in which they work. The deepening links between health and foreign policy require both communities to reexamine the skills, comprehension, and resources necessary to achieve their mutual objectives. No longer is it practical for global health diplomacy to remain an esoteric pursuit for a few specialists. Both groups' skills and strengths will be necessary to realize the promises of health diplomacy, from maintaining the momentum for cross-border cooperation on public health surveillance and response to achieving the vision of using global health to improve international relations—and vice versa.

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