

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

The author has no conflicts of interest to declare.

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Valley.¹ 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.² 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.³ 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.⁴ 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.^{5–8} 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.⁹ More broadly, this environment has engendered a palpable and thoughtful approach to international health program development that is based on humanist rather than utilitarian considerations¹⁰; 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.¹¹ 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.¹² 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.¹³ 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.¹⁴ 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),^{15,16} 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.¹⁷ 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.¹⁸ 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.¹⁹ 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.²⁰ These practices thereby informed broader national policies such as the Americans with Disabilities Act²¹; broader structural, social, behavioral, economic, and clinical issues required the inclusion of and sensitivity toward specific marginalized populations residing in Bay Area counties.¹¹ Through innovative systems of accountability and planning processes, an “unruly melange”²² 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,^{23–25} 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.^{26,27} 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.²⁸

DEVELOPING GLOBAL HEALTH DIPLOMACY PRACTICES

Global health has not had a perfect record of success in accomplishing diplomatic goals—and sometimes even threatens them.^{29,30} Additionally, there is an ongoing unmet need for further intellectual discourse, research, and evaluation science for health diplomacy practice.³¹ 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 health³² is a “risky partnership.”³³ 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.³⁴ Such perceived subterfuge within health programs complicates the relationship between global health and foreign policy.³⁵ 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.³⁶ 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.^{37,38}

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.³⁹ 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,”⁴⁰ 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.⁴¹ 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.⁴² GHD may support the idea of “smart global health” initiatives that involve diverse sectors and political perspectives.⁴³ 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.⁴⁴ 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.^{45,46} 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.⁴⁷

THE “COUNTRY OWNERSHIP” PARADIGM

As PEPFAR’s initial “emergency response” model became unsustainable in the wake of the global financial crisis,⁴⁸ combined with concerns that the vertical structure of the plan threatened to undermine and “crowd out” local public health system functioning,⁴⁹ 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.⁴⁹ In both cases, the empowerment of local actors to make prioritization, funding, and resource allocation decisions through diplomatic discourse⁵⁰ 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.⁵¹ 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.^{52,53} 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.⁵⁴

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.²⁴ 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.⁵⁵

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.⁴³ 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 epidemic⁵⁶ 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.⁵⁷ The evolution of GHD practice are not limited to the United States, with corresponding efforts taking place in countries such as Ireland,⁵⁸ the United Kingdom,⁵⁹ and Australia,⁶⁰ 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.⁶¹ These efforts in turn informed US international efforts on HIV/AIDS prevention and care in southeast Asia, China, and eastern Europe.⁶²

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 OGHD. 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.⁶³

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.

ACKNOWLEDGMENTS

The author acknowledges Eric Goosby, William McFarland, George Rutherford, and Stephen F. Morin from the University of California, San Francisco, and Thomas Novotny from San Diego State University.

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