

U.S. Health Diplomacy in Afghanistan: A Development Tool in Health System Reconstruction of a Fragile and Conflict-Affected State

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Abstract

Residing at the interface of global health and foreign policy, health diplomacy is a new archetype of diplomacy that involves the interaction of state and non-state actors. While there are a multitude of peer-reviewed articles that present health diplomacy as being driven by either global health or foreign policy intentions, there is a paucity of literature that illustrates an alignment of these objectives. Similarly, there is a dearth of articles that have analyzed how health diplomacy can play a part in progressing state-building and legitimacy in areas of conflict and instability. Afghanistan is a fragile and conflict-affected state whose health system was on the verge of collapse by the time U.S. reconstruction efforts commenced in 2002. This work examines how U.S. health diplomacy has not only sought to achieve the global health aim of improving quantity and quality of life in Afghanistan, but also accomplish the foreign policy goals of fortifying Afghan state institutions and processes, and assisting the Afghan government in fulfilling its social compact through the delivery of health.

Keywords: Health diplomacy, fragile and conflict-affected state (FCAS), health system reconstruction, state-building, legitimacy

1. Introduction

Health and foreign policy have been inextricably linked for at least the last half millennium. During the height of the bubonic plague contagion of the late medieval era, the first Italian embassies were actively involved in disseminating information about patterns of communicable disease in proximal city states (Kickbusch & Erk, 2009). More recently, infectious outbreaks caused by Zika virus, Ebola virus and Middle East respiratory syndrome coronavirus (MERS-CoV) are examples of transnational health crises that have been elevated within foreign policy agendas (Francis, 2016; Renwick, 2016; Garrett, 2013). The effects of globalization continue to intensify the link between health, trade and national security. Therefore, health diplomacy has arisen as a modern diplomatic approach to promote and protect population health and national interests. Although there have been numerous definitions of health diplomacy (Katz, et al., 2011; Lee & Smith, 2011; Global Health Diplomacy Network, 2011), the term is generally characterized by the multi-level, multi-stakeholder negotiation processes which shape health policy issues that lie at the interface of foreign policy.

Health diplomacy activities are essential to implementing, financing, and delivering health in regions with pervasive political and economic instability. Defined by a limited ability to govern and secure national borders (Menocal et al., 2008), and constituting 50% of the world's population living in poverty (Jones & Tortolani, 2013), fragile and conflict-affected states (FCAS) fail to institute fundamental economic, political and social functions for a given populace (OECD, 2008). One of the chief social services that FCAS are unable to provide is equitable, affordable, and quality healthcare. In fact, six of the seven states that have not met any of the Millennium Development Goals (MDGs) are FCAS (Solheim et al., 2014).

By providing development assistance for health, donor nations can engage in health diplomacy as a means of promoting global health and forwarding national interests, particularly in FCAS. Bilateral economic and development agencies of donor states can partner with recipient FCAS government institutions and other non-state actors to develop policies for delivering a set of core health services that endeavor to augment performance indicators and establish a foundation for a sustainable health system. At the same time, the coordinated actions of donor and host entities can enhance FCAS capacity to respond to the health needs of its populace, contributing to the state-building process and increasing the legitimacy of the state (Jones et al., 2008).

Possibly the most prominent example of American health diplomacy in an FCAS is exemplified by U.S. involvement in Afghan health system reconstruction. The United States Agency for International Development (USAID) has been a central figure in U.S. health diplomacy activities in Afghanistan through its administration of bilateral civilian foreign aid. Since 2002, USAID has provided almost U.S. \$1 billion in on- and off-budget aid to the Afghan health sector for essential health and hospital services, treatment of communicable diseases, family planning, and private sector engagement (SIGAR, 2015; USAID, 2015). U.S. development assistance for health in Afghanistan has been steered by an array of provisions for financing, delivering and monitoring health services that were negotiated by USAID, the Afghan Ministry of Public Health (MoPH) and various multilateral and non-government organizations (NGOs). Consequently, USAID and the other stakeholders have not only sought to improve population health outcomes, but also strengthen MoPH governance capacity such that it can bolster capability in other Afghan central government institutions.

The intent of this paper is to investigate U.S. health diplomacy as a development tool in the reconstruction of the Afghan health system and its role in achieving the global health aim of improved health performance indicators, as well as the foreign policy goal of advancing state-building and legitimacy. There are a total of seven sections in this work. Following the introduction, the second section includes details of the methods that were used for data collection. The third section presents health diplomacy as a contemporary diplomatic platform that is characterized by a negotiation process which involves both state and non-state actors. The fourth section discusses health diplomacy as a medium in which U.S. development institutions can engage in FCAS health system reconstruction and concomitantly accomplish global health and foreign policy objectives. The fifth section examines U.S. health diplomacy in Afghanistan since 2002, and evaluates the relationship between U.S. health diplomacy and expanded state-building and government legitimacy in Afghanistan. The sixth section provides policy recommendations for U.S. health diplomacy in Afghanistan moving forward. The seventh and final section contains the conclusion.

2. Methodology

The focus of this paper was selected because of the author's experience and prior scholarly work on the role of health diplomacy in the reconstruction of the Afghan health system. Literature reviewed for this project consists of both peer-reviewed documents and policy publications that were published from January 1, 2002 to July 25, 2016. This time period is significant because it corresponds with the ongoing health system reconstruction activities in Afghanistan. World Cat, EBSCO, Scopus, and Google Scholar were used to search for key terms that included: "fragile and conflict-affected states", "development assistance for health", "health diplomacy", "health system strengthening", "health system reconstruction in Afghanistan", and "health diplomacy in state-building and legitimacy". A number of institutional websites such as the World Health Organization (WHO), World Bank, USAID and others were also reviewed for pertinent information. The documents that were investigated consisted of primary and secondary pieces of literature from journal articles, policy reports, books, and periodical publications. Even though some works were available in different languages, only those written in English were evaluated.

Additionally, gray literature represented by manuscripts from conferences, symposia, and governmental and private sector research was reviewed. An analysis of the collected data was then conducted in order to compare common themes across the different sources of literature. The author also conducted interviews with officials from current and former officials from the MoPH, USAID mission in Afghanistan, U.S. diplomatic mission in Afghanistan, Delegation of the European Union (EU) to Afghanistan, World Bank, NGOs, privately-held companies operating in Afghanistan, and other U.S. governmental agencies.

These individuals represented a cross-section of the numerous state and non-state entities involved in the reconstruction of the Afghan health system, and provided various viewpoints on the relationship between U.S. health diplomacy, improved health indicators and advanced state-building and legitimacy in Afghanistan. As a result, the biased collection of data was avoided. Interviewees were recommended by a cadre of Foreign Service, academic, and private sector colleagues, as well as present and past senior government officials from the U.S., United Kingdom and Afghanistan. Interviewees were asked as to whether they would like to be quoted, maintain anonymity, or be listed as an interview participant. In order to have candid conversations, the interviewees agreed to discussions that were on a modified, not-for-attribution basis. Thus, interviewees welcomed the use of the information discussed in sessions and reference of their affiliations, but not their names. Interviews took place between the years 2013 – 2016, and were completed via phone and Skype in the U.S., and in-person at various locations in the U.S., Europe, Asia, and the Middle East. Interview questions were designed to analyze the impact of U.S. health diplomacy on Afghan health system reconstruction efforts, and its role in state-building and government legitimacy. Each interview session typically lasted 60 – 120 minutes and afforded time for follow-up and discussion.

3. A New Model of Diplomacy

Until the end of the Cold War, much of post-World War II diplomacy was bipolar and occurred in the form of contentious negotiations and proxy military mêlées between the U.S., Soviet Union, and their respective allies (Davenport, 2003; Bills, 1986). In recent times, the fundamental reordering of global geopolitical power necessitates a new diplomacy that reflects cooperative, multi-lateral partnerships. Though diplomacy has traditionally been performed by foreign ministers, ambassadors, and other senior foreign policy emissaries who carry out high-level dialogue in formal venues and under strict guidelines for engagement, new diplomacy emphasizes the usefulness of formal and informal interactions between diplomats and non-diplomats, especially when their endeavors include negotiation (Lee, 2009). Likewise, new diplomacy underscores the perspective that the interests of communities within sovereign states are not confined to its delineated borders, as globalization brings about more interactions and interconnectedness that transcend geographic and temporal boundaries (Lee, 2003).

Health diplomacy is one of the new diplomatic paradigms. From the establishment of the U.S. State Department Office of Global Health Diplomacy (OGHD) to the appointment of health attachés within USAID and Departments of Defense (DoD) and Health and Human Services (DHHS), there has been an increased demand for a medium which fuses foreign policy and global health interests (Marten et al., 2014; Brown et al., 2014). Yet, there are numerous interpretations of the definition of health diplomacy, as well as contrasting viewpoints on its application and primary objectives. Accordingly, health diplomacy may be best described as:

The policy-shaping processes in which states, intergovernmental organizations and non-state 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 (Fidler, 2009).

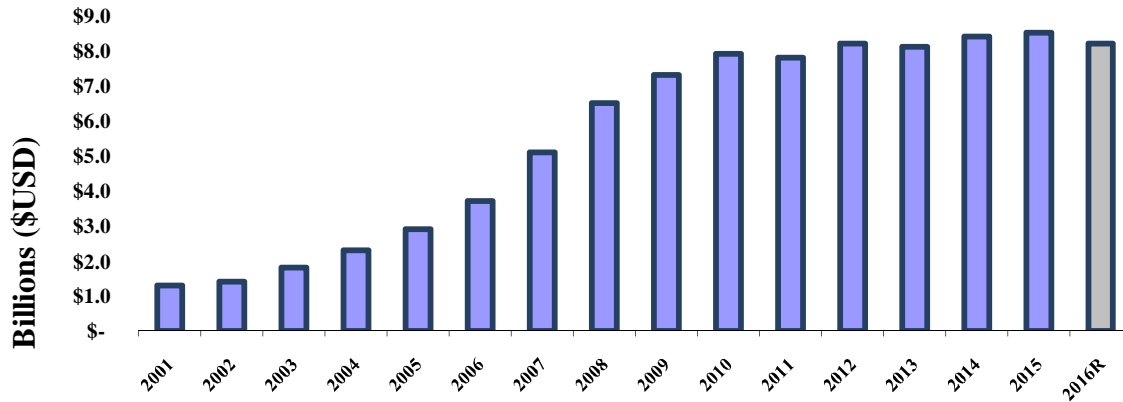
Albeit this definition illustrates that health diplomacy can be used to accomplish health or non-health aims, evidence suggests that it has been most frequently employed to pursue non-health goals related to foreign policy and national security interests (Feldbaum & Michaud, 2010; Michaud & Kates, 2013). Nevertheless, diplomats are proficient in matters of diplomacy and international relations, but they often “lack an understanding of the health dimension” to foreign policy (Lillywhite, 2010). Non-state actors such as non-government organizations (NGOs) and private sector entities can, on the other hand, provide global health expertise while participating alongside diplomats in negotiation processes. Thus, health diplomacy does not support the absence or marginalization of diplomats, nor is it offered as a replacement for traditional diplomacy. Rather, the collaboration of state and non-state partners can be optimized in the formation of a unified diplomatic approach.

4. U.S. Health Diplomacy and FCAS Health System Reconstruction, State-Building and Legitimacy

In addition to safeguarding national security and economic interests, overseas development activities are a key component of the foreign policy framework. Bilateral health aid is perhaps the development activity that has garnered the most political interest in the past decade.

Even though global health issues have traditionally been classified as low priority foreign policy concerns because their perceived value has been limited to humanitarian and altruistic causes (Fidler, 2005), U.S. global health aid to low- and middle-income countries has sextupled from U.S. \$1.3 billion in FY 2001 to U.S. \$8.5 billion in FY 2015 (Wexler & Valentine, 2015).

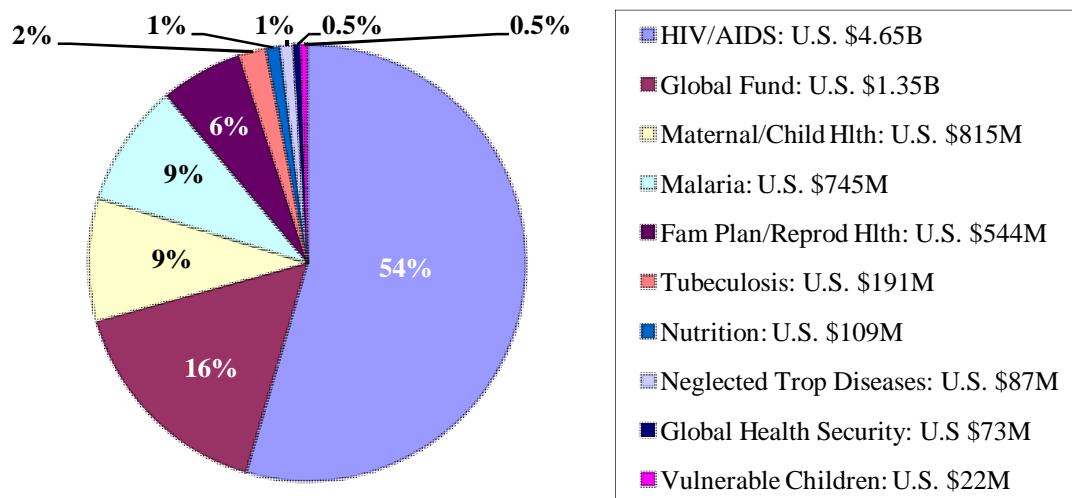
Figure 1: U.S. Global Health Aid to Low- and Middle-Income Countries, FY 2001 – FY 2016 Request



Source: Wexler, Adam, and Allison Valentine. “The U.S. Global Health Budget: Analysis of the Fiscal Year 2016 Budget Request.” Menlo Park: Kaiser Family Foundation, 2015.

In the end, economic and national security threats posed by the proliferation of trans-national diseases have not only driven the exponential rise in U.S. global health aid, but have also directed the bulk of development assistance for health to initiatives that address communicable diseases such as HIV/AIDS, malaria and tuberculosis. Despite the fact that non-communicable disorders (NCDs) like cardiovascular disease, cancer, and chronic respiratory illness cause 80% of morbidity and disability in low- and middle-income nations (CFR, 2014), HIV/AIDS funding accounts for 54% of the entire FY 2017 requested U.S. global health budget (Valentine et al., 2016).

Figure 2: U.S. Global Health Accounts, by sector, for the FY 2017 Requested Budget



Source: Valentine, Allison, Adam Wexler, and Jennifer Yates. “The U.S. Global Health Budget: Analysis of the Fiscal Year 2017 Budget Request.” Menlo Park: Kaiser Family Foundation, March 22, 2016.

Development assistance for health to FCAS remains a daunting but critical activity. There are currently thirty-three countries worldwide that are classified as FCAS, comprising an estimated two billion people (World Bank(a), n.d.). Secondary to civil unrest, weak institutions, limited governance and extensive poverty, FCAS have unresponsive health systems that lack the capacity to deliver basic services to their populations.

As a result, health indicators such as healthy average life expectancy (HALE), infant mortality, and maternal mortality rates are significantly worse than those of non-fragile states (Ranson et al., 2007). Moreover, the relationship between health and state fragility is two-fold such that poor health outcomes may be exacerbated by political and economic instability, as well as indirectly contribute to destabilization. For example, economic decline and decay of state institutions can weaken health system infrastructure and propagate illness and death (McInnes & Lee, 2006). Equally, extensive morbidity and mortality can reduce workforce productivity and exacerbate social inequalities, reducing the population's confidence in state institutions and perpetuate public discord (U.S. National Intelligence Council, 2010).

Whereas global health expenditure has grown exponentially and health system development has been increasingly regarded as a vital component of U.S. global health policy, investment in health system reconstruction has comprised a minimal proportion of development assistance for health to FCAS (Rubenstein, 2009). Notwithstanding U.S. policy on FCAS health system reconstruction is frequently deemed as a component of short-term stabilization and security interventions post-conflict, a more optimal strategy is to view the delivery of healthcare as a core social function that can progress the quality and effectiveness of fragile state governance (Rubenstein, 2011), along with bolstering health indicators. For this reason, health diplomacy has been endorsed as an instrument in which U.S. bilateral aid organizations can partake in FCAS health system reconstruction and attain both health and non-health pursuits. Working with FCAS institutions and other donor organizations, U.S. foreign assistance entities can play an integral part in FCAS health system development and accomplish global health aims by negotiating provisions for funding and delivering crucial services and medicines, workforce expansion, and performance monitoring. Concurrently, U.S. donor agencies can assist in fortifying FCAS governance capacity by enabling a fragile state to fulfill its social contract of providing equitable healthcare, thereby contributing to FCAS state-building and enhanced legitimacy, and advancing U.S. foreign policy objectives.

Although literature demonstrates how health diplomacy has contributed to superior health outcomes in fragile states (Daschle & Frist, 2015; Heijstek, 2015; Gomez, 2014), there is a dearth of studies that have examined the link between health diplomacy and FCAS state-building and legitimacy. However, a number of research papers have investigated the impact of FCAS health system reconstruction on governance capacity and public trust in the state. Indeed, a growing body of evidence suggests that donor participation in FCAS health system strengthening can be a factor in health sector state-building when the fragile state stewards policy, manages financial and human resources, and boosts the quality of health services (Eldon et al., 2008). Even more, studies indicate that donor assistance which buttresses FCAS leadership and accountability in delivering effective and equitable care can reinforce fragile state legitimacy (Kruk, et al., 2010; Haar & Rubenstein, 2012). These findings support the notion that health diplomacy has a role in sectoral state-building, being that the negotiation and policy-shaping processes among state and non-state actors are essential in facilitating donor participation and investment in FCAS health system reconstruction. Still, the degree in which health diplomacy can extend beyond the health sector and take part in wider FCAS state-building and legitimacy is largely anecdotal and requires additional scholarly research.

5. U.S. Health Diplomacy and Reconstruction of the Afghan Health System

5.1 A call for health system reform in Afghanistan

Afghanistan is an FCAS that has been marred by attacks from foreign invaders and civil unrest for the past thirty-five years. By the time the Taliban regime fell in 2001, Afghanistan's health system was nearly collapsed and possessed some of the lowest health indicators of any country in the world. Women and children experienced the most adverse health issues. For instance, the maternal mortality rate (MMR) exceeded 1650 per 100,000 live births in 2002, with over half of all deaths among women aged 15 to 49 years resulting from pregnancy and childbirth (UN Development Program, 2004). On the other hand, infectious diseases and malnutrition brought about high morbidity and mortality rates among children.

In 2002, the infant mortality rate (IMR) was approximately 165 per 1000 live births (Bartlett et al., 2005), with one in four children dying before their fifth birthday (Mathers et al., 2004). One of the major causes of poor health was due to lack of access to care.

In spite of most medical centers being located in urban zones, approximately 75% of Afghan residents have historically lived in rural areas (World Bank Independent Evaluation Group, 2013). Thus, limited access to

healthcare facilities was pervasive, as less than 1 in 10 Afghans lived within a one-hour walk of a hospital in 2002 (International Bank for Reconstruction and Development, 2005). To compound this dilemma, there was a massive shortage of medical personnel. Many health professionals fled Afghanistan during the civil war that persisted during the 1990s, while others were brutalized and executed (Acerra et al., 2009). Moreover, gender segregation policies had prohibited women from receiving education beyond primary school (Faiz, 1997). Consequently, there was a shortage of female physicians and nurses to treat female patients, as 40% of the country's health facilities had no female health professional on site (Afghan Ministry of Health, 2002). Because women were neither able to be treated by men nor in the same medical facilities as their male counterparts, many lacked access to care. Furthermore, a shortage of doctors was propagated by insufficient medical training programs, many of which lacked a standardized curriculum and failed to provide student physicians with adequate treatment protocols or clinical experience (Sharp et al., 2002; Richards, 2003). This shortage of adequately trained healthcare professionals ultimately positioned NGOs as the most important source of primary healthcare, as they delivered approximately 80% of all health services in Afghanistan in 2002 (Sabri et al., 2007; Afghan Ministry of Health(a), 2002).

Financing the Afghan health system also presented a formidable challenge. By the time the temporary government known as the Afghanistan Transitional Administration (ATA) was installed in 2002, almost 90% of the country's total healthcare expenditure (THE) was financed by household outlays, with pharmaceutical drugs and supplies making up the largest component of household expenditure for health (World Bank(b), n.d.). The remaining 10% of THE was funded by non-household sources, primarily contributions from international donors. On the other hand, public health expenditure from the government represented only a small portion of non-household sources for funding healthcare. As a consequence of weak institutions and nearly 40% unemployment (ANDS, 2008), the government had limited capacity to impose, collect, and pool tax revenues that could be used to purchase healthcare. In fact, per capita public health expenditure in 2002 was U.S. \$1, with the country's total health expenditure being U.S. \$16 per capita (World Health Organization (a), n.d.).

5.2 Coordinating, financing and delivering provisions of health through health diplomacy

According to various state and non-state stakeholders, U.S. health diplomacy in Afghanistan is defined by the policy-shaping processes in which the U.S. has engaged other state and non-state actors and negotiated a set of activities to strengthen the Afghan health system and governance capacity (Former Afghan Ministry of Foreign Affairs official, personal communication, June 7, 2013; Lead Public Health Specialist at the World Bank, personal communication, August, 15, 2013; Senior Technical Officer at USAID, personal communication, September 6, 2013). USAID is one of the two principal state participants, receiving its guidance from the U.S. State Department and administering bilateral development assistance for health. The Afghan MoPH is the other principal state institution, and was originally given complete authority to craft domestic health policy by the ATA in 2002 (Sondorp, 2004). The involvement of numerous multilateral donor organizations (e.g. World Bank, European Commission, WHO, etc.) and non-state entities (e.g. domestic and international NGOs) have also been critical in the process of crafting policy, and delivering and financing healthcare since 2002.

The collaborative engagement of these various stakeholders facilitated the development and implementation of the Basic Package of Health Services (BPHS), a standardized bundle of health interventions to be delivered the populace regardless of one's ability to pay (Afghan Ministry of Health, 2003).

Figure 3: Bundle of Health Interventions Included in the Basic Package of Health Services (BPHS) in 2003

1. Maternal and newborn health
 - Antenatal care
 - Delivery care
 - Postpartum care
 - Family planning
 - Care of newborn
2. Child health and immunization
 - Expanded program on immunization (routine and outreach)
 - Integrated management of childhood illnesses
3. Public nutrition
 - Micronutrient supplementation
 - Treatment of clinical malnutrition
4. Communicable diseases
 - Control of tuberculosis
 - Control of malaria
5. Mental health
 - Community management of mental problems
 - Health facility-based treatment of outpatients and inpatients
6. Disability
 - Physiotherapy integrated into primary health care services
 - Orthopedic services expanded to hospital level
7. Regular supply of essential drugs
 - All essential drugs required for basic services

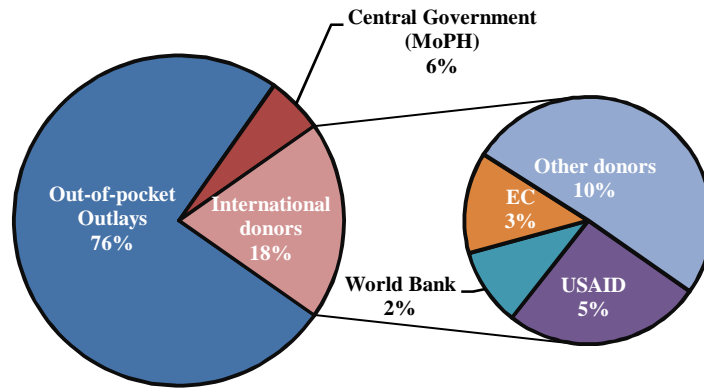
Source: Ministry of Health. “A Basic Package of Health Services, 2003/1382.” Kabul: Transitional Islamic State of Afghanistan, 2003.

Note: Services to be delivered were primarily aimed at improving the health of women and children, with nutrition, communicable diseases, and supply of essential drugs being of utmost priority. Although services related to disability and mental health were included in the original provision, these services did not initially garner high priority.

Instituted in 2003, the BPHS was revised and complemented by the creation of the Essential Package of Hospital Services (EPHS) in 2005, and amended for a second time in 2010. Together, the BPHS and EPHS identified: i) the most urgent population health needs; ii) the services to be delivered in the basic package of care; iii) a nomenclature for multiple health facilities delivering care, as well as defined the staffing, equipment and services offered at each type of facility; and iv) the per capita costs of delivering services that would be funded. Even though the WHO facilitated the initial development of a basic package of health services and many Afghan health officers lacked public health experience in 2002 (Newbrander et al., 2014), the MoPH successfully lobbied for the prime post in governance, oversight, and administration of the BPHS and EPHS (Project Director at Management Sciences for Health, personal communication, April 16, 2015). As such, the MoPH intended to establish itself as a legitimate government agency, obtaining the trust of the Afghan populace by being responsive to their healthcare needs. At the nucleus of the MoPH agenda was a plan to focus on primary care, particularly for women and children (Project Director at Management Sciences for Health, personal communication, April 16, 2015; Ameli & Newbrander, 2008). Following the development of a public health-based decision framework, the MoPH determined that BPHS and EPHS services would be delivered as a cost-effective, integrated package that maximized equity in access to care such that health resources would be redistributed from urban to rural areas (Ameli & Newbrander, 2008).

Whereas the MoPH had negotiated stewardship of health system reconstruction, it had a limited capacity to fund an essential package of services in 2002. As a result, a multitude of international donors collectively constituted 18% of THE, and 75% of non-household healthcare funding sources (Afghan Ministry of Public Health, 2011).

Figure 4: Afghanistan Health System Financing Sources as a Percent of Total Health Expenditure (THE), 2008 – 2009

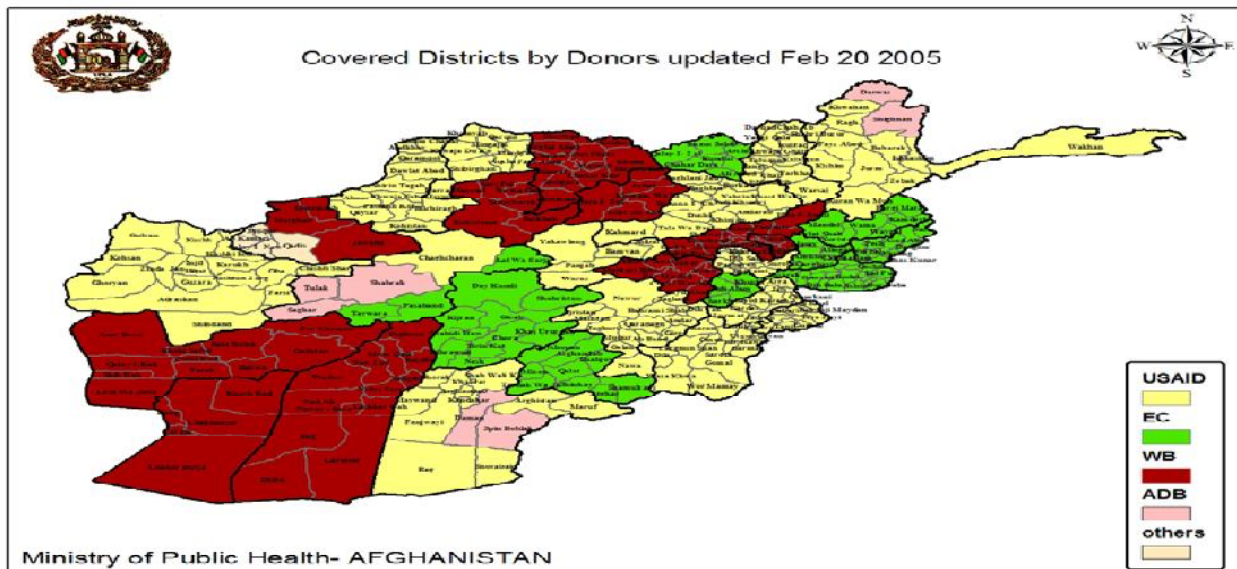


Source: Ministry of Public Health. “Afghanistan National Health Accounts, 2008-2009.” Kabul, Afghanistan: Islamic Republic of Afghanistan, 2011.

Note: Total Health Expenditure (THE) in Afghanistan is approximately U.S. \$1 billion per annum and is financed by three primary sources: i) out-of-pocket outlays from Afghan households (76% of THE); ii) international donors (18% of THE), of which USAID is the largest external donor (5% of THE); and iii) the MoPH (6% of THE).

The three foremost external donors include USAID, the European Commission (EC) and World Bank. Ultimately, these three donors utilized their position to sway provisions for funding the BPHS. The MoPH conceded a reference cost of U.S. \$4.55 per capita per year that would be used by donors to negotiate reimbursement to NGOs delivering the prescribed package of services, with the BPHS initially set to cover 80% of the population throughout the 34 provinces in Afghanistan (Newbrander et al., 2003). From the onset of the BPHS, USAID funded 13 of Afghanistan’s 34 provinces (14 of 34 provinces from 2002 – 2005), with the World Bank and EC covering 11 and 10 provinces, respectively (Afghan Ministry of Public Health, 2005).

Figure 5: Primary Basic Package of Health Services (BPHS) Donors



Source: Ministry of Public Health. “A Basic Package of Health Services for Afghanistan, 2005/1384.” Kabul: Islamic Republic of Afghanistan, 2005.

Note: The three major BPHS donors include USAID, the World Bank (WB) and European Commission (EC). USAID covers thirteen provinces, of which seven are also covered by the WB. The WB covers a total of eleven provinces— eight provinces and six clusters (i.e. a specified area within a province) are covered through direct contracting with NGOs, plus three provinces and one cluster through the MoPH Strengthening Mechanism (MoPH-SM). The EU covers ten provinces.

USAID, via health diplomacy, has remained the lead external donor and funds the most provinces in the delivery of the BPHS and EPHS, accounting for 40% Afghanistan’s territory and 50% of the country’s total population (USAID(a), n.d.). Through its Rural Expansion of Afghanistan’s Community-based Healthcare (REACH) and Partnership Contracts for Health (PCH) projects, USAID committed nearly U.S. \$400 million to BPHS and EPHS funding between the years 2003 and 2015 (USAID(b), n.d.; USAID(c), n.d.). Even so, the majority of U.S. foreign assistance pledged to Afghanistan has been for security, economic, and governance-related initiatives (Former Director of International Affairs at the U.S. Department of Defense, personal communication, March 22, 2013; USAID(d), n.d.). Similarly, economic development has been central to USAID platforms in Afghanistan since the Cold War era, specifically in regards to its funding the Kandahar International Airport construction and establishing the Helmand and Arghanab Valley Authority (HAVA), the largest development program in Afghanistan’s history (Whitlock, 2014; Cody, 2012; Cullather, 2002).

The MoPH was also confronted with the daunting task of delivering a collection of health services to the Afghan populace. The capacity for NGOs and private organizations to render a basic package of services existed because many of these groups were experts in delivering care to fragile states, being either local Afghan organizations or foreign entities with an extensive history of working in the country. Realizing that a decentralized model of healthcare delivery was compulsory, both the MoPH and donor agencies agreed that NGOs would participate in a competitive bidding process and contract with the MoPH to deliver the BPHS in a defined province or district (World Health Organization(b), n.d.). Moreover, the MoPH concurred with the recommendation of the external donors that NGOs would be remunerated by donors on a capitated basis (Former Program Manager within the EU Delegation to Afghanistan, personal communication, October 17, 2014). The World Bank, EC and USAID originally instituted a management, monitoring, evaluation and remuneration processes that differed from one another in several aspects (Waldman et al., 2006).

Table 1: MoPH Contracting Schemes with USAID, World Bank, and European Commission

Donor	Number of provinces covered	Flow of funds	Contract management	Performance-based elements	Monitoring and evaluation
US Agency for International Development (USAID)	14 (2002-2005)	USAID→ 3rd party→ NGOs (2002-2005)	3rd party (2002-2005)	No bonus; NGO contract extension is contingent upon good performance	Household surveys conducted by the MoPH (2006 onward)
	13 (2006 onward)	USAID→ MoPH→ NGOs (2008 onward)	MoPH (2006 onward)		
World Bank (WB)	11 (8 contracted directly with NGOs; 3 contracted with MoPH through the MoPH-SM)	WB→ Ministry of Finance (MoF)→ MoPH→ NGOs	MoPH	Monetary bonus	Yearly facility and household surveys conducted by a third party; country-wide in scope; quarterly reports
European Commission (EC)	10	EU→ NGOs	EU	None	3 rd party evaluation; annual report to the EU, quarterly report to MoPH

Source: Waldman, Ronald, Lesley Strong, and Abdul Wali. “Afghanistan’s Health System Since 2001: Condition improved, prognosis cautiously optimistic.” Kabul: Afghanistan Research and Evaluation Unit, 2006.

Unlike the other donors, USAID reimbursed NGOs according to costs against budget line items and outsourced procurement and evaluation of NGO contracts to an international NGO in the first funding round which extended from 2003 to 2005 (Sondorp et al., 2009). However, from the year 2006 forward, USAID has modified its original NGO reimbursement mechanism to make it more congruent with a performance-based scheme, as well as grant contract management, monitoring and evaluation responsibilities to the Grants and Contract Management Unit (GCMU) of the MoPH (Sondorp et al., 2009).

5.3 Assessing U.S. health diplomacy efforts to augment Afghan health indicators

U.S. health diplomacy in Afghanistan has accomplished a myriad of health goals. By partnering with the MoPH, NGOs and other international donors, USAID has contributed to the enhancement of numerous health system performance indicators through its use of health diplomacy from 2003 until present. Significant gains have been made in relation to access and utilization of health services for those in rural regions with scarce numbers of doctors and medical facilities. A former WHO Medical Officer described U.S. health diplomacy as a “tremendous benefit” in expanding access and utilization of care for the predominantly rural Afghan population, particularly when considering USAID’s focus on results, as opposed to processes, with contracted NGOs (Former medical officer within the WHO Regional Office for the Eastern Mediterranean, personal communication, April 8, 2015). As a result, NGOs in USAID-funded provinces were allowed to exercise “innovation in practice” in the application of novel health delivery platforms for underserved communities in the more remote areas of Afghanistan (Former medical officer within the WHO Regional Office for the Eastern Mediterranean, personal communication, April 8, 2015). Health sub-centers (HSCs) and mobile health teams (MHTs) are examples of health facilities that were not part of the initial BPHS framework, but were pioneered by NGOs in the mid-2000s because swaths of Afghans in far rural populations remained outside the catchment areas of BPHS health clinics (Former medical officer within the WHO Regional Office for the Eastern Mediterranean, personal communication, April 8, 2015). Per a medical officer with the International Medical Corps, both HSCs and MHTs were subsequently added to the BPHS as two new categories of health clinics in 2008, with health diplomacy serving as USAID’s conduit for coalescing the support of the MoPH, World Bank, EC, Global Alliance for Vaccines and Immunizations (GAVI), NGOs, and other external donors for the integration of HSCs and MHTs into BPHS policy (Senior health officer with the International Medical Corps, personal communication, June 3, 2013). Even more, the expansion of HSCs and MHTs secondary to U.S. health diplomacy has contributed to a sizeable increase in access to health services (Senior health officer with the International Medical Corps, personal communication, June 3, 2013), which has swelled from 9% of the Afghan population in 2002 to an estimated 67% in 2015 (USAID(e), n.d.).

Possibly the most noteworthy performance indicator improvements have been in regards to equity in access to care. A former senior official at the U.S. Embassy in Kabul noted that U.S. health diplomacy has played a pivotal part in progressing health equity by redistributing resources to women and children (Former Economic Affairs Officer within the U.S. Embassy in Kabul, personal communication, September 23, 2015). Since the rollout of the BPHS in 2003, USAID has trained nearly half of Afghanistan’s 20,000 community health workers (CHWs), the health workforce that delivers primary care in rural areas (Former Economic Affairs Officer within the U.S. Embassy in Kabul, personal communication, September 23, 2015). In response to Afghanistan’s historical deficit of female health workers, and with the consent of the MoPH, a former international health consultant noted that USAID was a galvanizing force in uniting the respective initiatives of other external donors wherein NGOs recruit midwives and other female allied health professionals from neighboring territories such as Tajikistan (International public health consultant and former independent consultant to USAID, personal communication, October 15, 2014). The proliferation of community health workers and rural health facilities has led to a larger percentage of women delivering at health clinics, greater access to ante- and postnatal care, further utilization of nutrition programs, and expanded immunization coverage and communicable disease surveillance for children (Rasooly et al., 2014; Mayhew et al., 2014; Ikram et al., 2014). Therefore, U.S. health diplomacy has had a considerable impact on improving health outcomes for women and children (Former Senior Afghanistan and Pakistan Health Officer of USAID, personal communication, September 23, 2014), as the MMR has been reduced five-fold (Afghan Public Health Institute, 2011), the respective IMR and under-five mortality (U5MR) rates being decreased by 60% (Afghan Public Health Institute, 2011), and life expectancy at birth has risen from 42 years to 62 years since 2002 (Murphy, 2013).

Table 2: Afghanistan Key Health Indicators, 2003 – 2010

Indicator	2003 (UNICEF)	2006 (AHS)	2008 (NRVA)	2010 (AMS)
Infant mortality rate	165 per 1000 live births	129 per 1000 live births	111 per 1000 live births	77 per 1000 live births
Under 5 mortality rate	257 per 1000 live births	194 per 1000 live births	161 per 1000 live births	97 per 1000 live births
Maternal mortality ratio (MMR)	1600 per 100,000 live births	Not available	Not Available	327 per 100,000 live births
Antenatal care coverage	16%	32%	36%	68%
Deliveries by skilled birth attendants	15%	19%	24%	34%
Full immunization coverage	15%	27%	37%	Not available
Access to primary health services (within 1 hr or 2 hrs by normal mode of transport)	9% (distance in hrs not specified)	66% (within 2 hrs)	85% (within 1 hr)	90% (goal)

Sources: Afghan Public Health Institute. “Afghan Mortality Survey 2010.” Kabul: Ministry of Public Health, November 2011.

Despite the laudable improvements in health indicators, there has been debate about the robustness of reported gains in health service coverage and utilization (Markus et al., 2013), as well as MMR, IMR and U5MR (Akseer et al., 2016; Carvalho et al., 2015). The U.S. Special Inspector General for Afghanistan (SIGAR) opined that outlays on Afghanistan reconstruction in the last fifteen years has eclipsed that of the Marshall Plan to rebuild Western Europe after World War II, but wasteful spending and resource allocation has often led to sub-optimization of intended outcomes (Sopko, 2015). As a result, international donors increasingly seek a value for money (VfM) agenda to improve the impact and efficiency of health investments (Glassman et al., 2013). While the focus of Afghan health system reconstruction since 2002 has been primarily focused on developing infrastructure and capacity, and U.S. health diplomacy has been a critical agent in facilitating improved Afghan health indicators during the same time, a substantial portion of U.S. health aid has not been distributed in a cost-effective manner (Faculty member in the Indian Institute of Health Management Research, personal communication, September 15, 2016). As Afghanistan now moves to build on previous health gains and create a sustainable health system, a former adviser to the GMCU asserts that U.S. health diplomacy can be utilized as an agent to achieve VfM such that health investments are contributed in an economical, efficient, effective, and equitable manner to achieve the most optimal outcomes (Faculty member in the Indian Institute of Health Management Research, personal communication, September 15, 2016). Through continued U.S. health diplomacy, coordinated activities among the cadre of stakeholders involved in Afghan health system reconstruction can be refined to support the efficient allocation of donor resources, potentially translating into even heftier gains with health indicators (Faculty member in the Indian Institute of Health Management Research, personal communication, September 15, 2016).

5.4 Analyzing the impact of U.S. health diplomacy on sectoral state-building, wider state-building and legitimacy in Afghanistan

In addition to impacting health indicators, U.S. health diplomacy has contributed to sectoral state-building. A former senior MoPH official, who defined Afghan health sector state-building as the collaborative activities between the MoPH and international donors which strengthen the Afghan health system and bolster the role of the MoPH in the country’s health sector, contends that U.S. health diplomacy has been a driving force in sectoral that state-building process due to the fact that USAID has remained the second largest source of financing THE behind OOP expenditures from Afghan households (Former senior official within the Afghan Ministry of Public Health, personal communication, September 19, 2016). Through health diplomacy, USAID has unified donors around a common goal of enhanced MoPH institutional capacity and leadership (Former senior official within the Afghan Ministry of Public Health, personal communication, September 19, 2016).

As a result, USAID and other stakeholders have provided the MoPH with the necessary resources to galvanize community involvement in determining health service priorities, train community health professionals, address

health inequities by reallocating health services to vulnerable groups such as women and children, and develop the technical competence to efficiently manage donor funds and monitor NGOs contracts (Dalil et al., 2014).

The effect of U.S. health diplomacy may also extend beyond health system strengthening and contribute to wider state-building and government legitimacy. A former senior State Department official maintains that health sector state-building facilitated by U.S. health diplomacy has enhanced capacity in other Afghan institutions, as well as augmented the legitimacy of the Afghan government (Former senior official in the U.S. diplomatic mission in Afghanistan, personal communication, October 8, 2016). Employing health diplomacy, USAID commenced channeling funds directly through the Afghan Ministry of Finance (MoF) and MoPH in 2008, expanding the governance capacity and legitimacy of both Afghan institutions (former senior official in the U.S. diplomatic mission in Afghanistan, personal communication, October 8, 2016; USAID(f), n.d.). Nevertheless, empirical data is limited and suggests that the strength of the association between health diplomacy, wider state-building and increased government legitimacy is encouraging but not conclusive. For example, a national opinion poll illustrated that state-building was regarded as the leading reason for moving the country in the right direction in 2014 and 2015 (Sadat et al., 2015). Although provisions for social services are fundamental to building a resilient state, and the average rate of satisfaction with the quality of health clinics was among the top three social services that were evaluated (Sadat et al., 2015), the national poll did not specifically measure the impact of health services on populace sentiments toward state-building. Likewise, a nationwide survey conducted in 2012 showed that the majority of respondents rated the central government as legitimate (Sabarre et al., 2013), but did not directly assess the contribution of the MoPH to legitimacy. In the end, further research is warranted to strengthen the evidence-base regarding the role of U.S. health diplomacy in buttressing Afghan state-building and government legitimacy. The existing knowledge base can be expanded by pinpointing health sector achievements that can serve as a model for augmenting governance capacity in other sectors, and identifying the key quality of health service variables that reinforce public confidence and trust.

6. Policy Recommendations for U.S. Health Diplomacy to Align Foreign Policy and Global Health Aims in Afghanistan

The Afghan health system has accomplished some noteworthy gains, but various challenges persist. Violence and insecurity continue to impede access and utilization of care (Médecins Sans Frontière, 2014). In fact, the provinces of Kandahar, Paktika, Paktia, Ghazni, and Khost not only lie at the center of the ongoing insurgency, but also represent regions that USAID funds in the BPHS platform. This has not only led to maternal and infant mortality rates remaining considerably worse than other countries in the region and at the lower end of international rankings (Singh et al., 2013), but has also precipitated an enduring mental illness epidemic (Rasmussen; Ventevogel et al., 2012). Still, barriers to care are not necessarily confined to areas of conflict. When compared to urban centers, rural regions have greater disparities in staffing and supplies at medical facilities, access to care, and utilization of care (Norland, 2014; Singh et al., 2012). To compound matters, the MoPH has been queried following a 2013 report from the SIGAR which claimed that funds provided to the MoPH for the PCH program were at risk of mismanagement (SIGAR, 2013).

Notwithstanding the aforementioned obstacles, the remarkable progress that has been made in the Afghan health system cannot be understated. Since 2002, health system gains have been considered the crowning achievement of development activities in Afghanistan (Dany et al., 2014). The collaborative efforts of USAID, the MoPH, World Bank, EC and others have been more akin to health system construction than reconstruction, transforming Afghanistan's almost nonexistent means of health service delivery into one that addresses the country's most dire health needs. Even more, these stakeholders have impacted health sector state-building by asserting the MoPH's position as the custodian of the health system and implementation of the BPHS. As Afghanistan embarks on its "transformation decade", a period of transition that spans from 2015 – 2024, the government ultimately seeks to reduce the country's dependence on international aid (Hamdullah, 2016). The Afghanistan National Development Strategy (ANDS), an Afghan-created roadmap for poverty reduction and private sector-led economic expansion (Hamdullah, 2016), embodies the government's long-term plan for legitimacy and state-building.

While provisions for improved security and governance represent two of the three pillars for growth in the ANDS (Hamdullah, 2016), economic and social development is the third and most vital pillar for future prosperity (Lynch, 2016; Viehe & Gunasekaran, 2015). Along with agriculture, mining and education, investment in health

is one of the economic and social development platforms that will serve as a catalyst for economic growth (International Monetary Fund, 2006). Albeit further research is necessary to illustrate the full extent of its correlation with Afghan state-building and government legitimacy, U.S. health diplomacy nonetheless represents a VfM medium that can be employed to achieve greater return and efficient use of development dollars to support the ANDS, taking into account that investment in health averaged only 2.5% of the overall U.S. development budget for Afghanistan between 2012 – 2015 (U.S. Foreign Assistance, n.d.).

The role of U.S. health diplomacy in advancing the goals of the ANDS has profound policy implications. Inevitably, a host of factors suggest that U.S. health diplomacy is a vehicle that can be utilized to achieve global health and foreign policy objectives through investments in health system reconstruction. First, the public health sector achieved a higher percentage of targeted outcomes (88%) than any other sector during the ANDS implementation period of 2008 – 2013 (Afghan Ministry of Economy, 2014). Next, empirical evidence shows that improved health contributed to nearly 25% of full income growth in low- and middle-income countries between 2000 – 2011 (Jameson et al., 2013). Furthermore, health system reconstruction is intimately related to education and economic development, being that the training of health professionals requires an educational platform and the labor of those in the health industry produces an economic output (Royal Institute of International Affairs, 2009). Consequently, health diplomacy can promote intergovernmental interactions at different levels of state and greater governance capacity for other Afghan government institutions and sectors.

6.1 Using Health Diplomacy to Reinforce Multilateralism

Even though the ANDS provides a long-term framework for a market-based economy driven by investment and regional trade, the current Afghan administration has called for reassurances of financial assistance from the U.S. and other international donors during the transformation decade (Islamic Republic of Afghanistan, 2014). The aligned support of numerous countries is necessary to build on health and governance gains and move toward a sustainable health system. In recent years, the U.S. has increasingly engaged in a multilateral foreign policy approach (Drum, 2016; Landler, 2011), advocating American leadership as an instrument to attract other nation partners and their resources (Office of U.S. President, 2015). As the lead-nation donor in Afghan health system reconstruction activities, U.S. health diplomacy can be utilized to prompt additional health investments from other stakeholders that share a common interest in Afghanistan's economic, political and national security. Due to its geographical position as a land bridge between Central and South Asia, Afghanistan is a strategic trade and investment partner for countries such as Iran, Pakistan, China and Russia that seek regional stability and hegemony. Although these countries have strained diplomatic relations with the U.S. and have typically invested in non-health sectors within Afghanistan, there is a precedent for Iran, Russia, Pakistan, and China to engage in health diplomacy in resource-constrained regions, and with countries such as the U.S. that they currently or historically have had hostility (Miller et al., 2014; Public-Private Task , 2013; Mancuso et al., 2008; Long, 2011). Hence, U.S. health diplomacy in Afghanistan presents a unique opportunity for American leadership to co-opt further investments in health from antipathetic regional powers.

India is perhaps the country that affords the U.S. the greatest opportunity for expanded partnership. In addition to sharing longstanding cultural and historical ties with Afghanistan, India was rated as the most favored foreign country among 71% of Afghans in a national opinion poll (NDA India, 2010). India has also pledged U.S. \$2 billion to Afghanistan since 2002, making it the fifth largest bilateral aid donor to the reconstruction campaign (Price, 2013). Like other regional powers, investments in health have not constituted a substantial portion of Indian development aid. However, India acknowledges that economic and social development is crucial to Afghanistan's future viability and plans to increase financial outlays to the Afghan health sector (Price, 2013). Japan is also one of the most critical U.S. development partners in Afghanistan. Besides hosting international conferences on the reconstruction of Afghanistan in 2003, 2006, and 2012, Japan is the second largest aid donor to Afghanistan (Tuke, 2013). Despite the fact that appropriations for health have customarily been around 2% of Japanese official development assistance (Bliss et al., 2013), the country launched its Strategy on Global Health Diplomacy in 2013 as a foreign policy priority to broaden universal health coverage (Abe, 2013).

Thus, U.S. health diplomacy in Afghanistan has the potential to promote greater allocation of health resources from India and Japan through investment, knowledge transfer, and science and technology innovation.

6.2 Innovation in the Financing and Delivery of Health in Afghanistan

Developing a long-term strategy for financing the Afghan health system continues to warrant considerable attention. The principle challenge is that the system has been incessantly underfunded. Out-of-pocket (OOP) expenditure from individual households is the chief source of health financing in Afghanistan, comprising approximately 75% of THE (Afghan Ministry of Public Health, 2013). Moreover, limited government revenue has facilitated a profound reliance on donor aid, in which some contend has been insufficient since the establishment of the BPHS. In spite of WHO estimates that the cost to deliver a collection of primary care services was U.S. \$34 per capita (Commission on Macroeconomics and Health, 2001), the three major donors of the BPHS have funded contracted services at U.S. \$4.30 – U.S. \$5.12 per capita (Newbrander et al., 2007). Not to mention, per capita health expenditure in Afghanistan is significantly below other low-income FCAS with comparable gross domestic product (GDP) such as the Ivory Coast, Sierra Leone and Yemen (World Bank(c), n.d.). Working across multiple levels of the state to increase the scope of state-building, U.S. health diplomacy has the potential to extend the Afghan government's capacity to assume a greater role in financing care.

Afghan policy makers have remained acutely focused on reducing the amount of foreign assistance and the exorbitant OOP expenditure on health. The MoPH has developed a revenue generation strategy to reduce the external aid from 75% of total public expenditure on health to 50%, increase government contribution from 4.2% to 10% of total budget, and decrease OOP outlays from 74% to 50% of THE by 2020 (Afghan Ministry of Public Health, 2014). This proposal includes levying excise taxes on tobacco, vehicles, and fuel, as well as the development of a social health insurance scheme and the introduction of user fees at secondary and tertiary facilities (Afghan Ministry of Public Health, 2014). In total, the revenue generation plan has the potential to yield U.S. \$196 million per year for health (Afghan Ministry of Public Health, 2014). What's more, Afghanistan's estimated U.S. \$1 trillion of mineral reserves presents a unique opportunity in which the government could generate as much as U.S. \$2 billion in annual income from taxes and royalties paid by entities that are granted mining rights (Editorial Board, 2015). If 8% of tax and royalty revenue from mineral taxes were allocated to health, a proportion equal to THE as a percent of GDP, the government would be afforded an additional U.S. \$160 million per year to finance care. Because its budget execution rate is among the highest of the Afghan government agencies (Afghan Ministry of Public Health, 2012), the MoPH can support enhanced MoF governance capacity. As a result of these proposed public financing strategies, U.S. health diplomacy can reinforce health sector strengthening, and potentially create wider state-building through the bolstered interaction between the MoF and MoPH from tax collection to deployment of funds for health programs.

6.3 Public-Private Partnerships and the Rising Importance of Non-state Actors

Private sector confidence in Afghanistan has been impeded by active combat, political and economic fragmentation, undeveloped legal and regulatory frameworks, and corruption. In response to these challenges, and with the support of the international community, the Afghan government has been working assiduously to heighten security, minimize legal and regulatory hurdles, and improve transparency in an effort to incentivize trade and investment (Otto, 2015). As a matter of fact, Afghanistan is one of the most open countries to trade and investment in Central and South Asia, possessing the lowest tariff rates in the region (Afghan Investment Support Agency, 2012). Public-private partnerships (PPPs) are being touted as an essential means for promoting private sector investment in health. Non-state actors, chiefly those in the private sector, have a prominent role in PPPs, and their increased involvement in development activities is compulsory for Afghanistan to transition from an aid-to investment-driven economy. Whilst the construction industry has attracted the greatest amount of private capital (Afghan Investment Support Agency, 2012), the health sector is particularly ripe for investment from the private sector. The demand for medical products and services significantly exceeds supply, especially when considering that Afghans are spending more than U.S. \$300 million for health services in neighboring countries (Afghan Chamber of Commerce, 2016). Therefore, U.S. health diplomacy can serve as the PPP conduit for engaging non-state private sector entities and advancing the ANDS through investments in health. Hospitals have been one of the prime targets for PPPs in health. Through health diplomacy, USAID has assisted in the creation of the Public Private Partnership Unit (PPPU) within the MoPH.

Responsible for the promotion and management of PPPs in the hospital sector, the PPPU seeks private investment partners for three medical centers in Kabul (Afghan Ministry of Public Health, n.d.). Nevertheless, there are a host of opportunities for U.S. health diplomacy to stimulate private sector engagement beyond the hospital segment.

The pharmaceutical manufacturing industry, for instance, has immense potential for growth. It is estimated that more than U.S. \$400 million of pharmaceutical products are consumed in Afghanistan annually, with only 2% of these medicines being produced by twelve private enterprises domestically (Ameer, 2016; Health Economics and Finance Directorate, 2014). Private investment in the Afghan pharmaceutical industry will not only curtail the illicit smuggling of medicines, counterfeit products, and reliance on importation from neighboring countries, but also provide greater capacity to develop an export market for the growing demand in the Commonwealth of Independent States (CIS) region. Similarly, U.S. health diplomacy has the potential to attract private sector investment in Afghanistan's emerging health technology sector. More specifically, the mobile health (mHealth) and telehealth technology platforms have been lauded by the global health community for their cost-effectiveness in resource-constrained areas such as FCAS, where there are innumerable challenges in the delivery of health. Given that the mobile penetration rate in Afghanistan is 80% (Budde Comm, n.d.), private sector entities can capitalize on widespread mobile phone usage via mHealth and telehealth platforms which have been successfully adopted in other FCAS, including mobile-based micro health insurance, electronic health records, data gathering and health system analytics, medical call centers, and SMS texting to name a few (Sandhu, 2011).

Needless to say, galvanizing and incentivizing private capital is imperative if U.S. health diplomacy is to be the binding force which unites state and non-state actors in PPPs. This can be accomplished, in part, by further collaboration between USAID and the Overseas Private Investment Corporation (OPIC), the U.S. governmental finance institution that assists U.S. private sector businesses acquire a presence in developing markets. In addition to offering financial products such as debt financing and political risk insurance, OPIC invests in privately-owned and managed American investment funds, which use these pooled funds to invest in privately-owned businesses in emerging markets. Of the fourteen active OPIC projects in Afghanistan, the two with a healthcare focus total 2% of OPIC funding in the country, and represent debt financing vehicles that do not include appropriations to private investment funds (Overseas Private Investment Corporation, n.d.). The African Technical Assistance Initiative (EDN/ATA), a USAID-OPIC joint venture that provides capital to entrepreneurs and small- and medium-sized enterprises (SMEs) in sub-Saharan Africa (USAID(g), n.d.), is a blueprint for the employing U.S. health diplomacy to encourage private sector investment in the health through PPPs.

7. Conclusion

Despite the fact that the preponderance of literature presents health diplomacy as being driven by divergent global health or foreign policy goals, the case of Afghanistan demonstrates that U.S. health diplomacy can contribute to improvements in health indicators and progress sectoral state-building. Not to mention, several findings suggest that U.S. health diplomacy can also contribute to wider state-building and legitimacy, although further research is needed to build upon the current evidence. Notwithstanding, the collaborative activities of USAID, the MoPH, NGOs and others have led to the health sector being recognized as one of the most successful development platforms in Afghanistan.

During the height of the medieval era, Afghanistan was regarded as a region of tremendous wealth at the heart of world trade (Omrani, 2010). Lying at the center of the Silk Road, the ancient trade routes that connected Europe and East Asia, it was major outpost for the exchange of goods, services and intellectual capital. Even today, a politically and economically stable Afghanistan is vital to future prosperity of Central and South Asia. The New Silk Road Initiative, a U.S.-led regional economic development strategy which aims to strengthen Afghanistan and its neighbors as a hub for trade, transport and commerce (McBride, 2015), underscores Afghanistan's continued importance to U.S. national interests in the region. As the Afghan government moves ahead on its plan to stabilize the country's security, political and fiscal infrastructure, health has been recognized as a key economic and social development platform. U.S. health diplomacy has not only had a significant impact on Afghan health system reconstruction to date, but also has the potential to advance health as a factor in the country's long-term economic growth strategy.

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