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## “Collateral Duty Diplomacy”: The U.S. Department of Defense and Global Health Diplomacy

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**I**N a world of increasingly diverse and complex actors, political forces, and transnational issues, global health diplomacy is emerging as an important arena of international relations across societal groups, including the education, policy, research, operational, and response communities. In the past, health as a foreign policy matter was largely seen as a charitable humanitarian concern or, in the case of infectious diseases, an issue primarily of quarantine laws and border inspections.

By the turn of the twenty-first century, however, improving health at national and global levels increasingly became a foreign policy goal in its own right, as well as a vehicle for other foreign policy interests. Various trends contributed to this change: the globalization of travel and trade and the correspondingly increased risk of transnational epidemics; the recognition of the importance of health as a driver of economic development; and the belief that health, as an agent of “soft power,” was a means to affect political agendas.

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Health as a soft power tool seemed particularly attractive and relevant in developing world settings where poor health and other fragile elements of human security might abet the growth of violent extremism. Internationally, the significance of health as a foreign policy priority was highlighted by events such as the Oslo Ministerial Declaration on health and foreign policy in 2007, signed by the ministers of foreign affairs of seven developed and developing countries, as well as real-world crises such as the 2005 Boxing Day tsunami, the 2009 H1N1 influenza pandemic, and the thirty-year global struggle against HIV/AIDS.

In recent years the concept of “health security,” whether as an aspect of development, emergency preparedness, or a distinct set of emerging threats and vulnerabilities, has underscored the close linkage between improved health and improved security at local, national, regional, and global levels. In 2014 the Obama administration launched the Global Health Security Agenda, a partnership of more than forty nations committed to accelerating progress in preventing, detecting, and responding to outbreaks of infectious disease of natural, accidental, or deliberate origin.

At the same time, the unprecedented outbreak of Ebola in West Africa demonstrated unambiguously the threat that emerging infectious diseases pose to underdeveloped nations and under-resourced health systems. Among its many firsts, the Ebola outbreak prompted the first-ever UN Mission, under the authority of the secretary-general, deployed to stop an infectious disease, as well as the first U.S. military operation (Operation United Assistance) in modern times in support of an infectious disease emergency.

For more than a century U.S. military departments, including the Department of Defense (DOD), the Department of the Navy, and the Department of War, have engaged in health promotion activities around the globe, with significant collateral roles in global health diplomacy. Acting originally in support of national interests in the Americas and the Far East, and later in support of America’s superpower role and its forward-deployed military forces, the U.S. military continues to have a major impact on global health and health cooperation. By one estimate<sup>1</sup> the DOD spends more than half a billion dollars a year on activities that may be considered to have “global health” relevance. Despite the fact that the U.S. military does not have a mission, as such, in global health, the DOD’s activities have an impact on global health in surprisingly broad and effective ways, measured by both health metrics and political/strategic success.

## **Conceptual Framework of Global Health Diplomacy**

There is no single definition of “health diplomacy.” One commonly cited characterization is political action that simultaneously advances public health as well as relations between states.<sup>2</sup> Katz et al.<sup>3</sup> propose three levels of health diplomacy: “core” (interactions between governments); “multistakeholder” (interactions involving governments and multilateral institutions, in support

generally of transnational and “polylateral” agendas); and “informal” (engagements at the technical or program level among actors in health).

In this model, the DOD has no specific mandate to engage in “core” or “multistakeholder” diplomacy by representing, per se, the U.S. government. However, its extensive activities in “informal” diplomacy have ramifications across all three levels as well as engagements beyond the health arena. This accords well with the DOD’s self-identification as a “supporting, not supported” global health actor: the U.S. military’s global health engagements are not derived from the pursuit of global health as a good endeavor in its own right, but as complementary to the primary purpose of defending U.S. national interests. As such, there is not an overarching “health goal” that governs U.S. military health diplomacy efforts. Instead, each institution, program, or mission is justified with reference to a U.S. military strategy or priority beyond the health domain.

The DOD is making determined efforts to better characterize these broader strategic outputs of health engagement, including developing measures of effectiveness to determine how health engagements affect these “non-health” end points, with the goal of improving decision making and resource allocation. Although no comprehensive analysis yet exists, a brief survey of historical and ongoing initiatives demonstrates that the impact of the U.S. military on the global health agenda is extensive, and its interactions, though “informal,” contribute considerable significance in the foreign relations of the U.S. government.

### **The U.S. Military Overseas Health Research Programs**

The U.S. Army and U.S. Navy maintain a network of biomedical and public health research facilities around the world, each staffed by a small cadre of U.S. military and civilian personnel with a much larger complement of host-country nationals. Over the years, these laboratories have contributed not only to major advances in science (malaria, HIV, diarrheal disease, pathogen discovery) and public health (influenza surveillance, International Health Regulations capacity building), but also, in the course of these accomplishments, have helped cement ties between the U.S. government and the respective host nation.

For example, Naval Medical Research Unit 3 (NAMRU-3) has maintained a continuous presence in Cairo, Egypt, since 1946. Even when Egypt and the United States broke diplomatic relations after the 1967 Arab-Israeli War, the laboratory maintained operations, with the commanding officer serving as the de facto chargé d’affaires in the absence of formal diplomatic representation. Now recognized as a major public health resource for Egypt, the Eastern Mediterranean Regional office of the World Health Organization (WHO), and a WHO collaborating center for influenza, NAMRU-3 continues to serve its primary mission of public health-oriented biomedical research. The Navy justifies its continued support of NAMRU-3 as an American military asset because of the laboratory’s role in providing high-

quality applied research toward diseases and conditions of operational relevance to American military members (e.g., traveler’s diarrhea). In other words, its strength as a public health resource, training establishment, and scientific capability for the Egyptian people is grounded in its core mission of focusing on operationally relevant disease.

The United States operates five other overseas military research laboratories, each hosted by the national government (either the ministry of health or defense). These laboratories have very individualized histories of collaboration in their respective regions, but each continues to provide active collaboration on diseases of mutual interest to the United States and the host governments. They are mostly located in tropical, developing regions, where most emerging or neglected diseases occur, and they make significant contributions toward disease surveillance, outbreak response, diagnostic development, and treatment evaluation.

At times a laboratory’s location has had to change in accordance with the shifting dynamics of U.S. foreign policy. This was the case with NAMRU-2, which at various times has been located in Taiwan, the Philippines, Indonesia, and currently Singapore. As host countries inevitably continue to develop their own national capacities, these laboratories must also adapt to remain relevant and continue to be meaningful collaborators in the fight against tropical and neglected diseases.

U.S. military personnel at the laboratories are generally subject matter experts in infectious disease, preventive medicine, or laboratory science who rely for sustained operations on local employees, many of whom are distinguished scientists with decades of service. By cultivating close professional relationships with the scientific leadership of the host country and contributing significantly to the host country’s scientific infrastructure and training of junior scientists, the U.S. military laboratories become important avenues of American influence and help build state-to-state relations beyond purely technical cooperation.

Remarkably, these deeper relationships have been created and supported for decades despite the lack of any overarching diplomatic engagement strategy or doctrine supporting the laboratories’ role in this regard, and despite the lack of any formal training in the tradecraft of diplomacy being given to the U.S. personnel stationed there.

## **The DOD HIV-AIDS Prevention Program**

The DOD HIV/AIDS Prevention Program (DHAPP), based in San Diego, California, is the executive agent for the DOD within the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the largest single-disease international public health program in history. DOD efforts in international HIV prevention began in 1999, a year before HIV was designated a national security threat. The Defense Department justified this engagement on the grounds that HIV,

particularly among military forces, could undermine partner military capability. Some estimates forecast that in some African militaries at the height of the HIV/AIDS pandemic, the equivalent of one battalion out of every brigade (as much as 10 to 25 percent of personnel) might either be ill of an HIV-related illness or caring for a family member and unable to carry out duties.

UN Security Council Resolution 1308 in 2000 explicitly cited the risk that UN peacekeeping missions might be jeopardized if nothing were done to mitigate the epidemic—the first time in history the UN Security Council addressed an infectious disease as a security threat.<sup>4</sup>

After the creation of PEPFAR in 2003, DHAPP had the existing relationships with partner militaries as well as in the in-house technical knowledge to rapidly expand its activities beyond prevention to include treatment of HIV. That not only benefited military populations in affected countries but also improved public health and health systems broadly. DHAPP has worked with more than eighty countries in Africa, Europe, and Asia to strengthen HIV prevention and treatment in their military forces.

Since military forces provide substantial medical services to local civilian communities in many countries, DHAPP-supported programs probably underestimate their overall contribution to achieving national HIV goals. Although DHAPP’s effects are measured (as with all PEPFAR programs) in terms of their public health effects, the benefits for DOD-specific goals of building partner capability are considerable. And at the personal level, the effects are difficult to measure but nevertheless concrete; one of the authors (Lim) recalls vividly a young African military officer telling him, “I don’t like much of what your country does, but I know no other country in the world who helps us with our greatest national crisis the way you do.”

DHAPP has also worked strategically with countries such as Kenya, Nigeria, and Uganda where the HIV prevalence posed a direct threat to regional military readiness. It is noteworthy that the tenuous stability in Somalia and other troubled regions in Africa is due in large part to battlefield successes won by soldiers from these militaries, among others.

## Hospital Ship Missions

Historically, the U.S. Navy’s hospital ships (United States Naval Ship [USNS] *Comfort* and USNS *Mercy*) have been perceived by line commanders as strategic assets for potential use in a major theater conflict. The 2005 Boxing Day tsunami in Indonesia marked a turning point in their history, as the *Mercy* for the first time was deployed for a civil disaster-relief mission. Since then, the Navy has conducted yearly Atlantic and Pacific humanitarian deployments, using either the hospital ships or smaller vessels adapted for this purpose. Since 2005, the

embarked personnel have cared for thousands of foreign nationals either aboard ship or during visits ashore.

These missions are justified by their training value for the U.S. military crews, but line commanders recognize the obvious public diplomacy value as well as the improved access to political and military leadership in numerous countries. Although other nations’ fleets include hospital ships, they are rarely deployed for humanitarian assistance or engagement.

A recent exception to this is the Chinese People’s Liberation Army Navy’s hospital ship, the *Peace Ark*, which is similar in form and function to the *Mercy* and *Comfort*. Launched in 2007, the *Peace Ark* has deployed several times to Africa and around Asia, most recently in support of flood relief in the Philippines.

In 2014, the USNS *Mercy* and the *Peace Ark* co-deployed in the Rim of the Pacific Exercise. Though the United States sponsors the world’s largest international maritime warfare exercise, this was the first time these hospital ships participated, which serves as an example of how health diplomacy can build bridges between countries. As U.S. Navy Surgeon General Matthew Nathan said, “I am encouraged by the beginnings of actually doing things together. ... The significance of this exercise is that in the past we have flown to each other’s countries and talked about doing things together, but here we are actually doing things here together, and that can be the start of a more robust relationship and an understanding of each other’s desires and capabilities.”<sup>5</sup>

U.S. personnel on these missions are typically drawn directly from military treatment facilities in the United States, and in recent years they have been complemented by volunteers from nongovernmental organizations. Such personnel rarely if ever have formal training in diplomatic skills (as understood by the Department of State or other practitioners of “core diplomacy”). Yet they are often in situations where their informal interactions, as for example in the case of the joint exercises with the *Peace Ark*, have notable “core” implications. Recognizing this, the DOD has also been making greater efforts in recent years to ensure that interagency counterparts and stakeholders, such as U.S. embassy country teams in the respective host nations and United States Agency for International Development technical subject matter experts, are consulted and involved in planning.

## Challenges

Although the value of international cooperation in health is self-evident within the health community, it is not without controversy when health goals are perceived to be at risk of being subordinated to political or diplomatic agendas. The concept of “health diplomacy” can be interpreted in different ways: does it mean “diplomacy in the service of health” or “health in the service of diplomacy”? These controversies may intensify when military assets are the chosen instruments of health diplomacy. Since military forces, by definition, exist to help maintain or

achieve a political end state, there is always the chance that health and political goals may not be aligned.

One common concern is that health or health outcomes will be “securitized,” in other words, that the health agenda, traditionally seen as closely linked to the humanitarian sector and existing in what is commonly called “humanitarian space,” will be made subservient to military or political goals. These concerns have been accentuated by the increased prominence of non-state actors, “hybrid warfare,” and counterinsurgency tactics in the wars of the twenty-first century.

Conversely, it can be argued that there is no conflict at all between “health goals” and “political/diplomatic goals,” if it is understood (as per numerous official U.S. statements) that a major foreign policy strategic goal of the United States is heightened international cooperation in the service of reducing health threats menacing the global community.

To quote President Barack Obama at the UN General Assembly in 2011: “To stop disease that spreads across borders, we must strengthen our system of public health. We will continue the fight against HIV/AIDS, tuberculosis and malaria. We will focus on the health of mothers and of children. And we must come together to prevent, and detect, and fight every kind of biological danger—whether it’s a pandemic like H1N1, or a terrorist threat, or a treatable disease.”<sup>6</sup> In other words, no contradiction need exist between health and diplomacy when the desired objective of both is a safer and more stable world. As long as military health resources, properly coordinated with other sectors and under ultimate civilian authority, can contribute to this goal, the thinking goes, they have a legitimate role.

A more practical objection is whether the role of the military as “health diplomats,” laudable as it may be in the abstract, is sustainable in a time of shrinking military budgets and necessary refocusing on core missions. Even if it can be argued that the military has a role in health diplomacy, does it have the necessary skill set to act effectively to both achieve desired political end states and improve health outcomes? For example, the periodic deployment of the hospital ships is sometimes questioned because missions are not necessarily integrated into longer-term civil society development agendas, which may jeopardize the sustainability of any long-term benefit.

Such concerns reflect the difficulty in calibrating health missions in the context of a larger political strategy and the challenge of integrating missions that focus largely on healthcare delivery with long-term country capacity-building efforts. Recognizing this, the U.S. military has recently been making determined efforts to move away from short-term, quick-impact healthcare delivery missions and toward a more balanced approach that focuses on building long-term capacity in cooperation with partner nations, in the hopes that both diplomatic and health gains will be more durable in the long run.

As part of that effort, the DOD recently proposed a working definition for what it is now calling “Global Health Engagement,” stating that it “comprises health

and medical related actions and programs undertaken by the DOD to improve foreign armed forces’ or foreign civilian authorities’ health systems capacity; and to promote and strengthen their human and/or animal health systems in support of national security objectives.”<sup>7</sup> At the same time, the uniformed services and the geographic combatant commands have been making greater efforts to ensure that health engagement is integrated into security cooperation strategies, both to ensure harmony of efforts in security cooperation and to better demonstrate health engagement’s enduring value in a military context.

As more countries become involved in health diplomacy, with the resultant stakes increasing, there is a definite need for strengthening health diplomacy training for military medical personnel who may be utilized in this role. To this end, several U.S. military physicians have attended the health diplomacy course at the U.S. Department of State’s Foreign Service Institute over the past several years. The DOD has also developed an academic course in conjunction with faculty at George Washington University that targets military medical personnel being assigned at the overseas labs. Other training opportunities exist within the Air Force’s International Health Specialist Program.

These opportunities aim not so much to create formal diplomats of military personnel, but to prepare medical personnel for overseas service so that in their health specialist roles they may also maximize their diplomatic effectiveness. In recent years, Navy officers have even begun serving in diplomatic postings overseas, in Vietnam and Papua New Guinea, in support of a whole-of-government approach under chief of mission leadership. Deploying these health affairs attachés ensures that health engagement across “core,” “multistakeholder,” and “informal” dimensions of health diplomacy are consistent with overall U.S. policy and health and humanitarian values.<sup>8</sup>

## **Conclusion**

While not explicitly intending to do so, the U.S. military has built, from the ground up, a *de facto* capability in global health diplomacy out of innumerable local, regional, and global programs and efforts. These have been remarkably successful for decades and continue to be effective tools for diplomacy. This was displayed to great effect in the latter months of 2014, when Operation United Assistance, under the U.S. Africa Command’s overall leadership, deployed to West Africa in support of President Obama’s orders to respond to the Ebola crisis. The Ebola epidemic demonstrated how the U.S. military’s technical skills and capabilities (logistics, laboratories, command, and control) could support a major health diplomatic initiative of the U.S. government.

The Ebola crisis should stimulate a fresh look at whether the U.S. military has all the tools and capacities it may need to be optimally effective in the twenty-first century health diplomacy environment. A continuing concern, in the austere

funding environment of 2015 and beyond, will be whether in non-crisis situations the U.S. military will be able to demonstrate to senior policy makers the practical medical and diplomatic benefits from its on-the-ground efforts. While diplomacy may be merely a “collateral duty,” the members of the military health department will have an increasing responsibility to think beyond just the short-term, isolated, and tactical medical benefits of a particular mission and more toward the long-term, holistic, and ultimately strategic goals of global health engagement. **SD**

#### Endnotes

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