

US Military Global Health Engagement since 9/11: Seeking Stability through Health

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Following the September 11, 2001 terrorist attacks, the US military expanded its global health engagement as part of broader efforts to stabilize fragile states, formally designating “medical stability operations” as use of Department of Defense (DoD) medical assets to build or sustain indigenous health sector capacity. Medical stability operations have included medical assistance missions launched by US Africa Command and in other regions, deployment of hospital ships to deliver humanitarian assistance and build capacity, and health-related efforts in Afghanistan and Iraq. The public health impact of such initiatives, and their effectiveness in promoting stability is unclear. Moreover, humanitarian actors have expressed concern about military encroachment on the “humanitarian space,” potentially endangering aid workers and populations in need, and violating core principles of humanitarian assistance. The DoD should draw on existing data to determine whether, and under what conditions, health engagement promotes stability overseas and develop a shared understanding with humanitarian actors of core principles to guide its global health engagement.

INTRODUCTION

The US military is not new to the global health scene. For more than a century, to protect its deployed forces, the military has mounted infectious disease research and treatment programs overseas. Seminal contributions include vaccines and drugs for malaria and other tropical infections, many of which are cornerstones of current disease control programs.¹ Since the late 1990s, it built a global infectious disease surveillance and response network from its international research infrastructure, supporting US and global efforts against pandemics.² For the most part, key global health actors have welcomed these contributions to global health.

After the September 11, 2001 terrorist attacks, the US military launched global health activities as part of broader efforts to counter violent extremism and bring stability to conflict-prone areas. Some of these activities resemble humanitarian assistance missions, which provide aid to crisis-affected populations with the primary purposes of saving lives and alleviating suffering; others seek to build health capacities, in both peaceful or conflict-beset areas. Now that the US military has established major initiatives and policies as part of this new global health engagement, it is timely to take stock, and assess the US military’s post-9/11 global health engagement.

FOCUS ON FRAGILE STATES

Following 9/11, the US military projected health assistance abroad with the primary and explicit goal of reducing poverty, poor perceptions of America, and other socio-economic conditions that could facilitate “violent extremism.” These formed part of a broad US Government effort to strengthen failed or failing states, seen increasingly as

potential breeding grounds and safe havens for terrorist movements (apparent in pre-9/11 attacks as well; e.g., the 1998 US embassy bombings in Kenya and Tanzania, linked to Osama bin Laden and associates). President George W. Bush articulated the agenda in a 2005 National Security Presidential Directive:

The United States should work with other countries and organizations to anticipate state failure, avoid it whenever possible, and respond quickly and effectively when necessary and appropriate to promote peace, security, development, democratic practices, market economies, and the rule of law. Such work should aim to enable governments abroad to exercise sovereignty over their own territories and to prevent those territories from being used as a base of operations or safe haven for extremists, terrorists, organized crime groups, or others who pose a threat to US foreign policy, security, or economic interests.³

In support of this policy, the Department of Defense (DoD) identified “stability operations” – “Military and civilian activities conducted across the spectrum from peace to conflict to establish or maintain order in States and regions” – as a core US military mission with priority comparable to combat operations.⁴ Stability operations aim, in the short term, to provide security, essential services, and humanitarian needs; and in the long term, to develop “indigenous capacity for securing essential services, a viable market economy, rule of law, democratic institutions, and a robust civil society.”

The US military has long conducted operations that would meet the definition of “stability operations.” Through programs that came to be called “civil affairs,” it has provided humanitarian assistance, host nation support, post-conflict reconstruction, peace operations, and related missions for more than 200 years.⁵ But until the recent policy, the DoD lacked an enduring, institutional mandate to maintain proficiency in such operations, which were considered less important than combat operations during and immediately following the Cold War.⁶

In 2010, the DoD formally established the category “medical stability operations” for stability operations using DoD medical assets, and directed the military health system “to be prepared to perform any tasks assigned to establish, reconstitute, and maintain health sector capacity and capability for the indigenous population when indigenous, foreign, or US civilian professionals cannot do so.”⁷ By the time DoD established this policy, the US military was already engaged in medical stability operations as part of its campaign against violent extremism in many countries, in both peaceful and conflict settings.

SEEKING STABILITY THROUGH HEALTH

Africa, home to many fragile states (several of its countries consistently make the top of a global ranking),⁸ porous borders, and terrorist groups linked to Al Qaeda, became a focus of the US military’s stability operations after 9/11. The US military established the Combined Joint Task Force-Horn of Africa (CJTF-HOA) in Djibouti in 2002, which remains its only substantial presence in Africa. CJTF-HOA uses “civil military operations as the cornerstone to countering violent extremism and building partner nation and regional security capacity” in East Africa.⁹ Its health-related activities include building and renovating clinics and hospitals, and providing medical care to local populations in medical civil action programs (MEDCAPs). CJTF-HOA became part of US Africa Command (AFRICOM) after it was established in 2007. AFRICOM also

provides medical care to indigenous populations through its Trans-Sahara Counterterrorism Partnership, in northwestern Africa.¹⁰

Other US military regional commands also conduct stability operations, most prominently in Central and South America (by US Southern Command) and the Asia-Pacific region (by US Pacific Command). The medical stability operations in these regions include MEDCAPs and infrastructure projects, as in Africa, but also regularly scheduled deployments of hospital ships and large-deck amphibious vessels to deliver assistance in multiple countries over several months.

As the hospital ship USNS *Comfort* embarked on a 5-month, 12-country deployment with 500 medical staff, then-Chief of Naval Operations (and current Chairman of the Joint Chiefs of Staff) Admiral Mike Mullen reflected on these ship-based medical stability operations: “It’s a mission that continues to grow and one about which I am very excited. And like Sailors around the world, they’re making such a difference in people’s lives, and I think that’s, in the long run, how we’ll impact the global war on terror[ism].”¹¹ The Navy has also used the *Comfort*, its sister ship, USNS *Mercy*, and other vessels to provide emergency medical assistance following natural disasters. Recent examples are numerous: the South Asian tsunami in 2004; the earthquake in Pakistan in 2005; the cyclone in Bangladesh in 2007; the earthquake in Haiti in 2010; and the flooding in Pakistan in 2010.

The US military also trained its medical professionals for the growing global health mission. Notable examples of training initiatives are shown in Table 1 below.

Table 1: Selected Examples of Global Health Training Initiatives for US Military Medical Professionals

Training initiative	Host	Description
Guide to Nongovernmental Organizations for the Military	International Health Division, Office of the Assistant Secretary of Defense (Health Affairs)	“A primer for the military about private, voluntary, and nongovernmental organizations operating in humanitarian emergencies globally.” ¹²
Medical Stability Operations Course	Defense Medical Readiness Training Institute	“...familiarize DoD healthcare personnel with the complexity of military medical diplomacy within the context of US strategy and international relations.” ¹³
Clerkships and practicums for medical and graduate students	Center for Disaster and Humanitarian Assistance Medicine (Uniformed Services University of the Health Sciences)	“...opportunities for students to gain greater insight into the world of medical humanitarian assistance/disaster relief from the perspectives of US Government, Interagency entities and foreign communities.” ¹⁴
United Nations Civil-Military Coordination Course	Center of Excellence in Disaster Management and Humanitarian Assistance	“...designed to address the need for coordination between international civilian humanitarian actors, especially [United Nations] humanitarian agencies, and international military forces in an

		international humanitarian emergency.” ¹⁵
International Health Specialist Program	US Air Force	“...has members deployed around the world, engaging in building global health partnerships, humanitarian assistance, disaster response, health care infrastructure development during wartime and building partnerships through stability operations in times of peace.” ¹⁶

In the Iraq and Afghanistan wars, stability operations became a key part of US military counter-insurgency strategy. They aimed to correct governance deficiencies that insurgents exploited, and to strengthen local support for national and local governments and international forces. Two programs have been especially important for implementing these initiatives: Provincial Reconstruction Teams (PRTs) and the Commander’s Emergency Response Program (CERP).

PRTs are civil-military units designed to “improve stability in a given area by helping build the host nation's capacity; reinforcing the host nation's legitimacy and effectiveness; and bolstering [the host nation’s capacity to] provide security to its citizens and deliver essential government services.”¹⁷ PRTs began operating in Afghanistan in 2002 and Iraq in 2005; they are led by the United States and other coalition countries. They generally include 50-100 people, most of whom are US or coalition military personnel, with US or coalition government civilians specializing in agriculture, engineering, law, public health, and other priority areas for PRT projects. PRT health-related projects include building clinics, donating technology, and training healthcare workers, addressing both immediate and longer-term health capacity needs (mirroring the range of activities that other, non-military organizations conduct in the same countries; for example, the US Agency for International Development supports delivery of health services as well as healthcare worker and lay training in Afghanistan, among many other health-related programs).¹⁸

The main funding mechanism for US-led PRTs is CERP, first implemented in Iraq to enable US military commanders to respond to urgent humanitarian relief and reconstruction needs. PRTs, as well as US military unit commanders in Iraq and Afghanistan, may draw on CERP funds to implement critical small-scale humanitarian relief and reconstruction projects that can be executed quickly, employ people from the local population, benefit the local population, and are “highly visible.”¹⁹ Allowable health-related projects include repairing or reconstructing hospitals or clinics, and providing urgent healthcare services, immunizations, medicine, medical supplies, or equipment. The DoD obligated \$1.4 billion to CERP in Afghanistan during fiscal year 2005 through the 3rd quarter of fiscal year 2009, including \$51.4 million for 969 health-related projects.²⁰

To help US military commanders select and monitor projects funded by CERP or other sources, the US Agency for International Development (USAID) created a tool to identify the underlying causes of instability or conflict in 2006.²¹ US and international forces throughout Afghanistan have used this survey instrument, the Tactical Conflict Assessment Planning Framework (TCAPF), to interview local Afghans and determine

whether lack of security, education, healthcare, or roads, or other factors are significant causes of local instability; and to assess whether stability improves after projects are implemented. The approach became a core part of a broader framework for improving stability in local areas.²² A key principle underlining the TCAPF and the broader framework is that projects should address causes of instability, not simply the needs or desires of the local population.

UNCERTAIN PUBLIC HEALTH IMPACT

Considering the US military's appreciable post-9/11 efforts to promote medical stability operations, the lack of evidence supporting their effectiveness in achieving public health improvements is surprising. In many cases, it is not that medical stability operations clearly failed to bring about improvements in health outcomes – few would argue that US military assistance following large-scale natural disasters has not benefitted the recipients. Rather, it is that the US military has not systematically collected data on their public health results.

Investigators at the Uniformed Services University reviewed 1,000 DoD reports of humanitarian assistance operations recorded between 1996 and 2007, and compared the after-event assessments against aid community standards for assessing the impact of humanitarian assistance missions, such as identifying measures of success and measuring changes in health outcomes before and after interventions.²³ Reports included measures of process, capturing activities and outputs, such as how many patients were treated. Yet, only seven reports mentioned impacts on public health.

Some interpret the failure to monitor health outcomes as evidence that the US military is not serious about improving health through medical stability operations, but rather is focused predominately on projecting an image of US benevolence to counter negative perceptions abroad. In explaining the use of hospital ships and US Navy large-deck vessels to deliver medical assistance – missions the Navy currently conducts about twice per year, not including disaster responses – US Government officials frequently point to public opinion polls in Indonesia after the US military provided post-tsunami assistance in 2005, which showed improved public perceptions of the United States.

In a “medical diplomacy” venture, the USNS *Comfort* deployed to Latin America for over 4 months in 2007. According to President Bush adviser Karen Hughes, the mission was not just to provide medical care, but “to do so in a very visible way.”²⁴

Hughes initiated the *Comfort*'s medical diplomacy mission after a trip to Latin America in 2006, and says publicity was a central goal from the beginning. Although the President considers Latin America a focus of his administration and has overseen a near-doubling of annual assistance to the region to \$1.47 billion, she said the commitment seemed lost on people who live there.²³

Health professionals serving on the ship complained that port calls seemed designed mainly for publicity, and that they failed to effectively use the ship's considerable technological and human resources. One Navy surgeon on board noted, “There's a lot of medical need down here – simple stuff, really – that we can't take care of because we're not here long enough to get into it.”²⁴ Another physician on the mission wondered, “It's one thing to sweep through here and say, ‘Let's do surgery, let's fill cavities,’ but are we really making a difference?”²⁵

In Iraq and Afghanistan, military-led assistance programs also have been criticized for not measuring or achieving appropriate outcomes. A 2008 House Armed Services Committee assessment noted that neither DoD nor the Department of State had “adopted a performance monitoring system to provide an assessment tool that can measure the PRTs’ effectiveness and performance . . . There are no standard metrics by which PRTs are judged.”²⁶ The Special Inspector General for Afghanistan Reconstruction similarly reported that CERP managers focused more on obligating funds than on monitoring how projects were implemented.²⁷

Humanitarian assistance organizations active in Afghanistan went a step further, beyond a critique of how PRTs monitor their programs to a blunt assessment of their effectiveness. A joint statement from seven non-governmental organizations asserted that “development projects implemented with military money or through military-dominated structures aim to achieve fast results but are often poorly executed, inappropriate and do not have sufficient community involvement to make them sustainable.”²⁸

The US military has been responsive to criticism that its medical stability operations do not track or achieve the right public health outcomes. The Navy is developing guidelines for conducting and monitoring medical stability operations, emphasizing long-term, internationally-agreed public health goals and standards. Furthermore, since the initial USNS *Comfort* mission of 2007, medical stability operations launched from large-deck ships have focused more on building host-country capacity than on showcasing medical care of host country populations by US military personnel. Recent US military guidance for PRTs also notes the importance of assessing results, not just outputs like the number of clinics constructed.²⁹

HUMANITARIAN RIFT

Humanitarian organizations, however, not only have criticized the technical competence of military forces in delivering assistance – they also have questioned the ethics of this engagement. The rift has, in many cases, precluded collaboration that the US military has sought, especially in conflict areas. Some humanitarian organizations see medical stability operations as part of a broader and troubling encroachment of military forces on the “humanitarian space,” violating core principles of humanitarian assistance.

Among humanitarian actors, there is broad agreement that humanitarian assistance must be provided according to the core principles of:

- **Humanity:** Human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women, and the elderly. The dignity and rights of all victims must be respected and protected.
- **Neutrality:** Humanitarian assistance must be provided without engaging in hostilities or taking sides in controversies of a political, religious, or ideological nature.
- **Impartiality:** Humanitarian assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race, or religion. Relief of the suffering must be guided solely by needs and priority must be given to the most urgent cases of distress.

These criteria are based on a United Nations (UN) General Assembly Resolution codified in the 1992 multilateral “Oslo Guidelines” for military engagement in disaster relief,³⁰ and later extended to military support for UN humanitarian relief in conflict settings, or “complex emergencies.”³¹ Both sets of guidelines, for peaceful and conflict scenarios, generally encourage use of civilian assets for relief, and allow for military participation in relief only as a last resort.

It is important to distinguish between peaceful and conflict settings in assessing medical stability operations against these principles. Humanitarian assistance providers generally have praised the US military’s response to natural disasters in areas not beset by conflict, noting that no other organization can deliver large-scale logistical capabilities and relief assets so rapidly. In these settings, most humanitarian actors usually would see the “last resort” standard for military engagement met, along with the core principles of humanity, neutrality, and impartiality. Humanitarian organizations have commented less (at least publicly) on medical stability operations in peaceful areas not experiencing an emergency. They have vigorously addressed military-led assistance in conflict settings.

In those situations, the primary charge against the US military’s use of medical stability operations, and of military-led assistance more broadly, is that foreign military forces are neither neutral nor impartial in delivering assistance – and this can have violent consequences (some also argue that even UN efforts may fail the neutrality principle, if it recognizes one side but not the other as the legitimate government in an internal conflict).

A World Health Organization-led coalition of more than 30 humanitarian health organizations, known as the Global Health Cluster, recently released a draft position paper on civil-military coordination during humanitarian health action. In conflict settings, the Global Health Cluster notes, military forces providing assistance “are deployed with a specific security and political agenda,”³² in contrast to humanitarian actors, which (by definition) provide assistance according to the principles of humanity, neutrality, and impartiality.

Any confusion between the different mandates carries the risk that humanitarian aid agencies may be drawn, or perceived to be drawn, into conflict dynamics. Humanitarian agencies that are perceived as acting according to agendas other than their humanitarian mandate may lose their credibility in the eyes of other local actors as well as the trust of the population they are there to serve. This can severely affect their ability to operate and, ultimately, create security risks for their staff and for the aforementioned populations.³³

The key message about the use of medical stability operations in conflict settings could not be clearer: “Humanitarian actions should not be used to advance security and/or political agendas.”³⁴

Some humanitarian organizations point to events in the Afghanistan and Iraq wars in which military involvement has had a negative impact. *Medecins sans Frontieres* (MSF, or Doctors without Borders) left Afghanistan, where it had been active for 24 years, in July 2004 after the murder of 5 of its workers. Three months later, the organization announced it was ending operations in Iraq due to increasing violence against aid workers. The decisions to withdraw from Afghanistan and Iraq because of security concerns were remarkable for the Nobel Prize-winning organization, which had

previously operated in many conflict areas. MSF pointed to military encroachment on the “humanitarian space” as a key culprit in violence against its workers:

Throughout the reconstruction period in Afghanistan, MSF objected to the blurring of boundaries between the military and humanitarian-aid communities, criticizing the coalition government's strategy of deploying provincial reconstruction teams that placed soldiers and civilians side by side when delivering food, medical care, and economic assistance to the Afghans. They argued that nationals were unable to distinguish between MSF clinics and clinics built by the military.³⁵

The coalition of non-governmental organizations that criticized military-dominated development activities on competence grounds also pointed to the “perverse incentives” that military-led assistance brings in Afghanistan, forcing Afghans “to make an impossible choice between aid and security,” by “offering food and other aid in exchange for information in a country where a third of the population is at risk of hunger is not only unethical, it puts Afghans in potential danger of being targeted by anti-government groups.”³⁶

THE HEALTH-STABILITY LINK

If the US military embraces a new approach to medical stability operations that targets and tracks sustainable public health improvements, it is likely that, in many cases, the military could bring about the desired improvements. Efforts in infectious disease research and surveillance show that the US military can make lasting contributions to public health abroad. Yet, the US military does not conduct medical stability operations to improve global health – the goal is stability. From this perspective, the effectiveness of medical stability operations is far from certain: little or no data is available on the stability effects of medical stability operations, and assessments of stability operations in general are less than encouraging.

A study from the Feinstein International Center of Tufts University assessed CJTF-HOA's 151 aid projects during 2003-2008 in northeastern and coastal Kenya, projects that were established in Muslim-majority areas considered vulnerable to radicalization and development of terrorist safe havens (28 percent of the projects were health-related).³⁷ It found no evidence that they promoted stability, noting that a multitude of factors beyond the scope of aid projects shape local perceptions (e.g., the relationship between local populations and the Kenyan government, and perceptions of US foreign policy towards other parts of the Muslim world). Some community members viewed the aid as part of broader US efforts to change Muslim communities' faith and beliefs. A local religious leader asked the researchers: “Do they think we are stupid?”

An assessment reached similar conclusions of stability operations in Afghanistan, including PRT activities and CERP-funded projects.³⁹ The 2010 roundtable, “Winning ‘Hearts and Minds’ in Afghanistan: Assessing the Effectiveness of Development Aid in COIN Operations,” was organized by the Feinstein International Center and included academics, military and civilian aid practitioners, and policy-makers. The conference report concluded that aid projects sometimes have short-term tactical benefits, such as establishing access to local populations and gathering intelligence, but that the relationships established are transactional. Little evidence

suggests that local populations can be “won over” to side with the government, away from the insurgency, with aid projects.

Moreover, in Afghanistan, the government itself appears a key driver of instability. Many Afghans perceive their government as corrupt and unjust, so a “COIN strategy premised on using aid to win the population over to such a negatively perceived government faces an uphill struggle,” especially where many view the Taliban as able to provide security and justice more effectively.³⁸

HOW IMPORTANT IS STABILITY TO US NATIONAL SECURITY?

Beyond the issue of the US military’s effectiveness in promoting stability through health and other assistance programs, there is a more fundamental question: How much of a threat do fragile states pose to core US security interests? Recently, criticism has emerged of the central, strategic premise underlying the US military’s stability operations. Stewart Patrick, with the Council on Foreign Relations, wrote in 2011:

In truth, while failed states may be worthy of America’s attention on humanitarian and development grounds, most of them are irrelevant to US national security. The risks they pose are mainly to their own inhabitants. Sweeping claims to the contrary are not only inaccurate but distracting and unhelpful, providing little guidance to policymakers seeking to prioritize scarce attention and resources.³⁹

Studying all 141 developing countries on 20 indicators of state strength, he concluded that, “only a handful of the world’s failed states pose security concerns to the United States.”⁴⁰ Considering the investments the US Government and DoD in particular have made in strengthening fragile states – for example, providing resources, deploying personnel, developing policy and professional skills – it is long past time for a critical appraisal of exactly where fragility is relevant to US national security.

As for the US military’s global health engagement to promote stability, the experience to date suggests two immediate priorities for the way ahead. First, there likely is sufficient data for empirical analysis of whether the military’s health-related programs do promote stability, at the very least, in a local context. While the findings will be context-dependent and cannot be expected to hold universally, they should prove useful in providing evidence for, or against, the current ‘stability-through-health’ heuristic.

Second, the US military should engage humanitarian actors and others with deep understanding of the central, moral tenets of humanitarian assistance in a sustained conversation about difficult, but critical questions. These might include: What is the importance of trade-offs between short-term and longer-term human protection objectives; for example, if military-led health assistance might lead to a safer environment in the longer-term, but only after shorter-term instability? What is the impact of strict adherence to the principles of impartiality and neutrality on the health and safety of innocent civilians, in conflict settings where opposing sides vie for their support? In general, what is the relevance of health outcomes to ethical considerations in determining where, in relation to the humanitarian space, military health engagement appropriately begins and ends?

The US military has brought significant resources (financial, material, and human) to its global health engagement since 9/11. It has learned from criticism on

effectiveness grounds, though careful analysis of effectiveness should remain a priority. However, if it is to have a chance of working in broad, sustained partnership with humanitarian actors, the military must advance toward a shared understanding with those potential partners of the core principles that will guide its global health engagement.

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