

Building U.S. Diplomatic Capacity for Global Health

A Report of the CSIS Global Health Policy Center

AUTHOR
Harley Feldbaum

May 2010



Building U.S. Diplomatic Capacity for Global Health

A Report of the CSIS Global Health Policy Center

AUTHOR
Harley Feldbaum

May 2010

About CSIS

In an era of ever-changing global opportunities and challenges, the Center for Strategic and International Studies (CSIS) provides strategic insights and practical policy solutions to decisionmakers. CSIS conducts research and analysis and develops policy initiatives that look into the future and anticipate change.

Founded by David M. Abshire and Admiral Arleigh Burke at the height of the Cold War, CSIS was dedicated to the simple but urgent goal of finding ways for America to survive as a nation and prosper as a people. Since 1962, CSIS has grown to become one of the world's preeminent public policy institutions.

Today, CSIS is a bipartisan, nonprofit organization headquartered in Washington, DC. More than 220 full-time staff and a large network of affiliated scholars focus their expertise on defense and security; on the world's regions and the unique challenges inherent to them; and on the issues that know no boundary in an increasingly connected world.

Former U.S. senator Sam Nunn became chairman of the CSIS Board of Trustees in 1999, and John J. Hamre has led CSIS as its president and chief executive officer since 2000.

CSIS does not take specific policy positions; accordingly, all views expressed herein should be understood to be solely those of the author(s).

© 2010 by the Center for Strategic and International Studies. All rights reserved.

Cover photo: October 6, 2009—Istanbul, Turkey. World Bank/IMF Annual Meetings 2009. Opening plenary session. Creative Commons 2.0.

Center for Strategic and International Studies
1800 K Street, NW, Washington, DC 20006
Tel: (202) 775-3119
Fax: (202) 775-3199
Web: www.csis.org



BUILDING U.S. DIPLOMATIC CAPACITY FOR GLOBAL HEALTH

*Harley Feldbaum*¹

Overview

The partnership between American science and American diplomacy dates to Thomas Jefferson and Benjamin Franklin's tenures as secretary of state and ambassador to France. However as U.S. funding for global health has increased to \$8.38 billion in 2009,² U.S. diplomatic capacity for supporting and leveraging our global health funding remains stagnant and fragmented. This lack of capacity to manage the political aspects of global health is dangerous, because the politics of global health have never been more divisive, and the opportunities for improving health and controlling disease epidemics never more extraordinary.

U.S. diplomatic capacity for global health represents the organization, staffing, and direction necessary to engage, not only on the charitable, technical, and scientific aspects of global health, but on the political and diplomatic aspects as well. The current lack of diplomatic capacity for global health at the Departments of State, Defense (DOD), Health and Human Services (HHS), the U.S. Agency for International Development (USAID), and the National Security Council (NSC) results in continually missed opportunities to support global health efforts and to leverage U.S. global health funding to support foreign policy objectives, and this imperils the success of U.S. global health aid. In a small number of cases, this lack of capacity threatens U.S. national security by undermining negotiations on influenza virus sharing and global health security.

Numerous reports have outlined the goals the Obama administration should pursue in global health.³ This brief does not seek to add to those or to propose detailed policy solutions to the cases

¹ Dr. Harley Feldbaum is director of the Global Health and Foreign Policy Initiative at the Johns Hopkins University School of Advanced International Studies. He thanks those who provided their thoughts confidentially during interviews for this paper.

² Jennifer Kates, "The U.S. Global Health Initiative: Overview & Budget Analysis," Policy Brief, Kaiser Family Foundation, Menlo Park, Calif., December 2009, <http://www.kff.org/globalhealth/upload/8009.pdf>.

³ See, for example, Committee on the U.S. Commitment to Global Health, *The U.S. Commitment to Global Health: Recommendations for the New Administration* (Washington, D.C.: National Academies Press, 2009); Nancy Birdsall, ed., *The White House and the World: A Global Development Agenda for the Next U.S. President* (Washington, D.C.: Center for Global Development, 2008); Laurie Garrett, *The Future of Foreign*

discussed. Instead it seeks to demonstrate that U.S. global health policy has global political ramifications that cannot be ignored and that demand permanent capabilities within the U.S. government. This brief describes the need for improved U.S. diplomatic capacity on global health, outlines the currently fractured architecture of the U.S. government on this issue, and issues recommendations for building diplomatic capacity for global health. It recommends ending the artificial separation between the Global Health Initiative (GHI) and global health security activities and building capacity, particularly at HHS, USAID, the State Department, and the NSC, to better address the political and diplomatic aspects of global health policy.

Three Reasons for Building U.S. Diplomatic Capacity for Global Health

Over the last decade, global health issues have become increasingly intertwined with U.S. economic, foreign policy, and strategic objectives. At the same time, U.S. investments in global health have skyrocketed, with significant investments in HIV/AIDS, malaria, tuberculosis, neglected tropical diseases, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. These investments have not, however, extended to building U.S. diplomatic capacity to support global health investments. Building this capacity is critical to the long-term success of U.S. efforts to improve global health for the following three reasons.

Epidemics Are Political Events

The management of fast-moving transnational disease epidemics will remain a major diplomatic challenge, as diseases new to humanity have been discovered at an increasing rate over the last decades.⁴ A serious emerging pandemic would test U.S. diplomatic capacity in global health well beyond the current influenza A (H1N1) and 2003 SARS outbreaks. If such a pandemic were a novel disease, diplomatic capacity would be required to manage potential border closings between states, impacts on trade, coordination of surveillance and response with the World Health Organization (WHO), and negotiation of intellectual property issues surrounding samples of the disease, vaccines, and treatments. These represent diplomatic actions beyond the significant domestic responsibilities the United States would face in such an outbreak, but they are essential to ensuring the protection of U.S. citizens and efficient global management and potential control of an epidemic.

Even the emergence of a known disease, such as a more severe strain of pandemic influenza, presents significant diplomatic challenges. The ongoing influenza A (H1N1) pandemic, while

Assistance Amid Global Economic and Financial Crisis: Advancing Global Health in the U.S. Development Agenda (New York: Council on Foreign Relations, January 2009).

⁴ K.E. Jones et al., "Global trends in emerging infectious diseases," *Nature* 451, no. 7181 (February 2008): 990–993.

mild, made global inequities in access to vaccines an issue of divisive international politics.⁵ Limited global influenza vaccine manufacturing capacity has created divisions between wealthy countries, many of whom had pre-purchased pandemic vaccine, and poor countries, who were left without access to vaccine or antiviral drugs to protect their populations. Keiji Fukuda, assistant director general of the WHO, argued in September 2009 that “[i]mproving access to vaccine is the central global issue at this time,”⁶ while Tadataka Yamada of the Gates Foundation declared that it “would be inexcusable to force poor countries to wait until the rich have been served under their existing contracts with vaccine manufacturers.”⁷ In response to this political pressure, the United States joined eight other countries in promising to deliver 10 percent of its supply of pandemic influenza A (H1N1) vaccine to the WHO for use in poor countries. The White House touted this donation as recognizing “that the health of the American people is inseparable from the health of people around the world,”⁸ but it was forced to renege on the timely delivery of vaccine due to shortages in vaccine for U.S. citizens. Because the H1N1 strain has been mild to date, the political fallout from this reversal has been minimal. However, inequalities in access to vaccines and pharmaceutical products will remain a structural feature of global health politics. A severe influenza pandemic will exacerbate tensions between rich and poor countries due to vaccine shortages, and it holds the potential to undermine goodwill toward the majority of U.S. global health funding if these diplomatic aspects of global health policy are not acknowledged and managed.

U.S. and Global Health Security Depend on It

The concept of global health security has been a critical justifying rationale for addressing infectious disease epidemics, both globally and within the United States. The WHO defines global health security as “the activities required...to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries.”⁹ This vision of global health security informed the revised

⁵ David P. Fidler, “Negotiating Equitable Access to Influenza Vaccines: Global Health Diplomacy and the Controversies Surrounding Avian Influenza H5n1 and Pandemic Influenza H1n1,” *PLoS Medicine* 7, no. 5 (May 2010), <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000247>.

⁶ David Brown, “U.S. to Donate 10 Percent of Swine Flu Vaccine to WHO,” *Washington Post*, September 18, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/09/17/AR2009091704297.html?hpid=moreheadlines>.

⁷ Tadataka Yamada, “Poverty, Wealth, and Access to Pandemic Influenza Vaccines,” *New England Journal of Medicine* 361, no. 12 (August 2009): 1129–1131.

⁸ White House, “President Announces Plan to Expand Fight Against Global H1N1 Pandemic,” news release, September 17, 2009, http://www.whitehouse.gov/the_press_office/President-Announces-Plan-to-Expand-Fight-Against-Global-H1N1-Pandemic/.

⁹ The World Health Organization (WHO) uses the term “global public health security.” WHO, *The World Health Report 2007: A Safer Future: Global Public Health Security in the 21st Century* (Geneva: WHO, 2007), p. ix.

International Health Regulations (IHRs) in 2005 and offered significant improvements over previous incarnations of the health regulations. The 2005 IHRs expanded the scope of reporting requirements from a small number of specific diseases¹⁰ to all “public health emergencies of international concern,” whether they are naturally occurring or deliberately released. The 2005 IHRs also empower the WHO to utilize electronic surveillance and information from nonstate actors to detect disease outbreaks, accelerating disease detection and largely breaking the power of states to deny the existence of outbreaks within their territory. These global health security advancements were successfully used to manage SARS and the recent influenza A (H1N1) outbreak.¹¹ The United States has strongly supported global health security efforts, predominantly in the context of pursuing biosecurity, listing the promotion of global health security as “Objective One” of its National Strategy for Countering Biological Threats.¹²

These successes however are increasingly under threat, as middle- and low-income countries argue that, as currently practiced, global health security means little for the protection of their populations from either new or existing disease burdens. Aldis reports that “[d]eveloping countries are increasingly suspicious of global health initiatives justified on the grounds of ‘global health security’” and that they are “unlikely to accept a ‘global health security’ justification for international agreements which are not perceived to benefit all countries.”¹³ The view that global health security and “the harvest of outbreak intelligence overseas is essentially geared to benefit wealthy nations” is strongly exemplified by Indonesia’s refusal to share influenza A (H5N1) virus samples with the WHO. Indonesia argues that it sees few benefits from sharing influenza viral samples, as the vaccines made from their samples are likely to be too expensive or pre-purchased by wealthy countries.¹⁴ Indonesia’s position, described as “extremely dangerous” to global health,¹⁵ is supported by Brazil, India, and Thailand. These same countries are fielding savvy

¹⁰ The IHRs from 1969 applied only to cholera, plague, yellow fever, smallpox, relapsing fever, and typhus. Smallpox, relapsing fever and typhus were removed from the regulations by 1981.

¹¹ See David P. Fidler, “From International Sanitary Conventions to Global Health Security: The New International Health Regulations,” *Chinese Journal of International Law* 4, no. 2 (September 2005): 325–392; and Rebecca Katz, “Use of Revised International Health Regulations during Influenza A (H1N1) Epidemic, 2009,” *Emerging Infectious Diseases* 15, no. 8 (October 2009): 1165–1170.

¹² National Security Council, *National Strategy for Countering Biological Threats* (Washington, D.C.: White House, November 2009), http://www.whitehouse.gov/sites/default/files/National_Strategy_for_Countering_BioThreats.pdf.

¹³ William Aldis, “Health security as a public health concept: a critical analysis,” *Health Policy and Planning* 23, no. 6 (August 2008): 369–375.

¹⁴ Endang R. Sedyaningsih et al., “Towards Mutual Trust, Transparency and Equity in Virus Sharing Mechanism: The Avian Influenza Case of Indonesia,” *Annals of the Academy of Medicine Singapore* 37, no. 6 (June 2008): 482–488.

¹⁵ Richard Holbrooke and Laurie Garrett, “Sovereignty that Risks Global Health,” *Washington Post*, August 10, 2008, <http://www.washingtonpost.com/wp-dyn/content/article/2008/08/08/AR2008080802919.html>.

health diplomats to oppose further implementation of the global health security concept, as well as U.S. support for strong intellectual property protections on pharmaceutical products.

To be clear, these states are not opposed to the advances embodied in the 2005 IHRs, which have already proven beneficial to the health of all states. Their objection is to the perceived lack of benefits for poorer states of global infectious disease surveillance, in the form of greater access to vaccines, pharmaceutical products, and capacity building. Strong U.S. diplomatic capacity for global health will be required to negotiate the reinstatement of cooperative global action on disease surveillance and response and to prevent further damaging political schisms within global health.

Diplomacy Can Benefit Global Health and U.S. Foreign Policy

U.S. global health programs have clear benefits for U.S. foreign policy and in conveying a positive image of the United States abroad, but they are poorly coordinated with each other and leveraged in relation to other U.S. foreign policy objectives. The President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative, and disaster relief efforts have boosted the image of the United States in strategically important states including Pakistan, Indonesia, and Nigeria. The HHS health attaché program has been successful in contributing health expertise to U.S. embassies abroad, in facilitating normalization of relations with Vietnam, and in rebuilding the Iraqi health system. The Obama administration's Global Health Initiative goes some way toward addressing coordination between U.S. global health initiatives but to date is silent on the role of U.S. leadership and diplomacy in global health.¹⁶

Leaving out the diplomatic components of U.S. global health assistance is a mistake, because U.S. diplomats can be a powerful tool to improve global health by contributing statecraft toward addressing the political dimensions of global health issues. This was demonstrated when Secretary of State Colin Powell's attention to the polio vaccine boycott in Nigeria was instrumental to bringing the State Department's resources to bear on the problem, which caused an outbreak of polio in 20 countries and imperiled U.S.-supported polio eradication efforts.¹⁷ In that case, State Department access to high-ranking officials in Ministries of Foreign Affairs and at the United Nations was critical to enabling diplomacy to resolve the crisis. Such small efforts by diplomats and high administration officials can have a major impact on promoting U.S. global health objectives, if health is made part of their portfolio.

U.S. multilateral engagement in global health is another critical element of global health policy that can benefit both global health and U.S. interests. U.S. leadership was essential to the establishment of the Global Fund to Fight AIDS, TB and Malaria and is needed now to ensure the continued high functioning of the fund as it seeks to support needs of health systems while

¹⁶ U.S. Department of State, "Implementation of the Global Health Initiative: Consultation Document," <http://www.pepfar.gov/documents/organization/136504.pdf>.

¹⁷ Judith R. Kaufmann and Harley Feldbaum, "Diplomacy and the Polio Immunization Boycott in Northern Nigeria," *Health Affairs* 28, no. 4 (July-August 2009): 1091–1101.

maintaining its disease-specific mandate. Even more importantly, the WHO has emerged as a critical player in global health governance, playing an essential role in global disease surveillance and response, mediating issues of global health security, and developing international agreements to support global health, including the 2005 IHRs and the Framework Convention on Tobacco Control. U.S. leadership could strengthen the functioning of this vital institution, particularly through democratizing WHO's secretive elections process and starting efforts to remedy the debilitating imbalance between its regular budget and extra-budgetary contributions, but only if diplomatic capacity to support global health exists within the U.S. government.

As the Obama administration moves forward, addressing major diplomatic challenges in outbreak response, negotiating broad support for global health security, and pursuing global health objectives through bilateral and multilateral channels requires strong U.S. diplomatic capacity for global health.

The Current Situation: Fragmented and Stagnant

Although the need for U.S. diplomatic capacity in global health has grown, the reality of that capacity is fragmentation and stagnation. The State Department is the clearest example of this. Scheduled to receive 61 percent of the GHI FY2010 budget request,¹⁸ the State Department has no mechanism for coordinating action across vertical health initiatives, for achieving synergies that benefit global health or foreign policy, or for contributing statecraft to support U.S. global health policy. The Office of International Health and Biodefense (IHB) has been weak and poorly staffed in recent years and has had most major health issues removed from under its authority. IHB's current position under the Bureau of Oceans and International Environmental and Scientific Affairs (OES) likely ensures that global health concerns will remain a secondary priority after climate change in this bureau. Finally, the dissolution of the State Department's Avian Influenza Action Group *during* the influenza A (H1N1) outbreak underscores the State Department's current inability to contribute diplomacy to U.S. global health efforts.

Building such capacity in the State Department will face the institutional barriers of being the province of the Civil Service in functional bureaus, away from the power centers of the geographic bureaus and Foreign Service. Despite these challenges, the need for a substantive State Department office to support U.S. global health policy through statecraft, coordination, and negotiation remains.

Global health responsibilities currently reside across the NSC senior directors for development and international economics and for multilateral affairs and human rights, with no one senior director responsible for coordinating and implementing U.S. global health policy. This limits the White House's ability to prioritize and set U.S. global health policy and to ensure this policy is implemented across the agencies. Furthermore, a senior NSC official on global health could

¹⁸ Kates, "The U.S. Global Health Initiative: Overview & Budget Analysis."

provide high-level access to foreign governments on global health negotiations and issues critical to U.S. national security. The Clinton administration's successful experience with a senior adviser for international health at the NSC demonstrates the merits of this approach.

In the absence of State Department and NSC attention to global health during the George W. Bush administration, the HHS Office of Global Health Affairs (OGHA) assumed a primary role in directing and coordinating U.S. global health policy. While controversies about the political uses of OGHA during the Bush administration remain,¹⁹ OGHA provided a necessary bureaucratic focal point for shaping U.S. global health policy and addressing the links between global health and foreign policy. With new leadership, this office is uniquely suited to bring scientific expertise from the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH), into interagency deliberations. In fact, most U.S. government global health expertise resides within HHS, and a primary goal of the OGHA should be to deliver this expertise into global health, foreign policy, and national security deliberations. The CDC in particular has deep technical expertise in global health, and operates the Global Disease Detection (GDD) and Field Epidemiology Training Program, both of which have diplomatic components and would benefit from greater linkages with broader U.S. global health policy through OGHA.

Though Department of Defense (DOD) global health funding is less than 1 percent of U.S. global health funding, several of the department's initiatives are highly publicized and have diplomatic implications. The USNS Comfort and Mercy hospital ships use health interventions to "win hearts and minds," but they would benefit from greater integration with broader public health efforts to increase their public health impact.²⁰ U.S. military forces conduct Medical and Veterinary Civil-Assistance Programs in Iraq and Afghanistan as part of "supporting pacification, gathering local intelligence, or rewarding locals for their cooperation."²¹ These efforts may contribute to the politicization of health assistance and have been criticized as an ineffective tool of counterinsurgency, but they are likely to continue to be used as a tool of the U.S. military.²² The DOD's Global Emerging Infections Surveillance and Response (GEIS) laboratories²³ and HIV/AIDS Prevention Program are significant investments both scientifically and politically and merit coordination with other U.S. global health activities. However, responsibility for each of

¹⁹ Jocelyn Kaiser, "Science Policy: The Man Behind the Memos," *Science* 305, no. 5690 (September 2004): 1552–1553.

²⁰ William Vanderwagen, "Health diplomacy: winning hearts and minds through the use of health interventions," *Military Medicine* 171, no. 10, suppl. 1 (October 2006): 3–4.

²¹ Jay B. Baker, "Medical Diplomacy in Full-Spectrum Operations," *Military Review* 87, no. 5 (September 2007): 67–73.

²² Harley Feldbaum and Joshua Michaud, "Health Diplomacy and the Enduring Relevance of Foreign Policy Interests," *PLoS Medicine* 7, no. 4 (April 2010), <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000226>.

²³ J.J. Sueker et al., "Global Infectious Disease Surveillance at DOD Overseas Laboratories, 1999–2007," *American Journal of Tropical Medicine and Hygiene* 82, no. 1 (January 2010): 23–27.

these initiatives is fragmented across DOD, service branches, and the combatant commands, with no central point of coordination for DOD global health activities, essentially precluding coordination with other U.S. global health or foreign policy efforts.

Finally, the Obama administration has sought to separate its Global Health Initiative (currently led by PEPFAR, USAID, and the CDC) from U.S. activities that support global health security (currently operationalized through the State Department, DOD, and the NSC). For example, the WHO and 2005 IHRs are discussed prominently in the National Strategy for Countering Biological Threats, but the 2005 IHRs are not mentioned in the consultation document on the Implementation of the Global Health Initiative, while the WHO is mentioned only in passing. This artificial division between global health aid and global health security is both bad politics and bad policy. This division reinforces the notion that there are two tiers of diseases: important diseases that impact U.S. interests, and other diseases that affect poor countries. This is precisely the argument Indonesia, Brazil, Thailand, and India make against the concept of global health security. Perhaps more importantly, dividing global health aid from global health security prevents the significant funds dedicated to global disease surveillance and response from being better utilized to address broader burdens of disease in poorer countries. Surveillance, laboratory, and response capacity can be built to address both transnational disease epidemics of national security import and local burdens of disease of great importance to partner countries. The CDC's GDD and DOD's GEIS laboratories already work at this interface to address both local and global health needs, but the artificial division between global health aid and global health security undermines further efforts in this direction.

Recommendations

U.S. leadership and contributions to global health, particularly the creation of the Global Fund to Fight AIDS, TB and Malaria and PEPFAR, have been extraordinary. However the absence of attention to the political and diplomatic aspects of global health in the recent GHI consultation document, and a lack of diplomatic capacity for global health across the U.S. government, may imperil U.S. leadership in this arena. The increasingly divisive nature of global health politics, divergent state interests on epidemic response and global health security, and opportunities to support both global health and U.S. interests through diplomacy, demand the creation of such capacity.

A number of options exist to build diplomatic capacity on global health. Implementing any of the structural bureaucratic changes listed below will help institutionalize engagement on the diplomatic aspects of global health policy. This will improve the U.S. government's ability to respond to infectious disease outbreaks, support the WHO and Global Fund, and help address divisions concerning global health security. However, personal leadership at HHS, USAID, State Department, and NSC on global health issues is likely to be more important than any single structural change in the U.S. government. Leadership and attention to disease surveillance and response, issues of global health security, and support for the WHO are critical priorities across these offices.

Options to build diplomatic capacity on global health:

- The Obama administration should undo the artificial separation between the GHI and global health security initiatives and coherently engage on the full range of global health issues. This division undermines legitimate diplomatic attempts to reconcile global health security with the health needs of poor countries and inhibits funding for global disease surveillance and response from being better targeted to meet existing burdens of disease. Issues of global health security are politically potent, but they are better managed within the context of broader U.S. leadership on global health.
- The new leadership of the GHI, which includes the administrator of USAID, CDC director, and the global AIDS coordinator, should work to link the development of the GHI with broader U.S. global health efforts on disease surveillance, capacity building, multilateral engagement, and biosecurity. This will entail close coordination with OGHA, the NSC, State Department, and DOD as the GHI is developed and launched. These linkages will ensure that the diplomatic, multilateral, and political aspects of U.S. global health policy are addressed in concert with the GHI, creating a coordinated and coherent U.S. government approach to global health challenges.
- The new director of the HHS OGHA should actively seek to bring HHS agency scientific expertise into foreign policy, development, and national security deliberations. OGHA priorities for HHS agencies should include advocating for improved incorporation of CDC global health activities into U.S. global health policy, assisting the FDA with its increasingly global mission,²⁴ and supporting NIH pursuit of operational research that contributes to the practice and evaluation of global health programs. OGHA should also maintain a leadership role in U.S. representation at the WHO and Global Fund and on negotiations concerning global health security, seeking to ensure that both U.S. global health and foreign policy objectives are addressed in negotiations and multilateral fora.
- The State Department should move global health issues out of OES into its own Office of the Global Health Coordinator, located under the undersecretary for democracy and global affairs, to be directed at the assistant secretary or ambassador level. With support from the secretary of state for the department's engagement in global health, this option would ensure a functioning focal point for diplomacy on global health, ability to work with regional bureaus, and coordination across vertical global health initiatives and the interagency.
- A senior director for global health should be named at the NSC to facilitate White House leadership; provide a forum for high-level coordination of global health agencies, initiatives, and epidemic response; and ensure implementation of global health policy across agencies. A

²⁴ Thomas J. Bollyky, *Global Health Interventions for U.S. Food and Drug Safety* (Washington, D.C.: CSIS, November 2009), http://csis.org/files/publication/091112_Bollyky_GlobalHealthInterventions_Web.pdf.

role for the NSC on global health has been called for before²⁵ and was used successfully during the Clinton administration. It remains an effective option for managing U.S. global health policy and increasing diplomatic capacity to engage on global health issues.

- The Department of Defense should create a focal point for its global health activities, which would serve as a linkage point for the undersecretary of defense for policy, the assistant secretary of defense for health affairs, geographic combatant commands, GEIS laboratories, and the National Center for Medical Intelligence, to other agencies, and to support coordination across DOD global health activities. This focal point will not solve the problem of the dispersed nature of DOD global health activities, but it will provide better coordination with interagency deliberations on global health policy.

²⁵ See, for example, Committee on the U.S. Commitment to Global Health, *The U.S. Commitment to Global Health*; and William J. Fallon and Helene D. Gayle, *Report of the CSIS Commission on Smart Global Health Policy: A Healthier, Safer, and More Prosperous World* (Washington, D.C.: CSIS, March 2010), http://csis.org/files/publication/100318_Fallon_SmartGlobalHealth.pdf.



1800 K Street, NW | Washington, DC 20006
Tel: (202) 887-0200 | Fax: (202) 775-3199
E-mail: books@csis.org | Web: www.csis.org