Global Health Engagement

Sharpening a Key Tool for the Department of Defense

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Global Health Engagement

Sharpening a Key Tool for the Department of Defense

J. Christopher Daniel[1]

The president of the United States announced on September 17 that the Department of Defense (DoD) would deploy 3,000 troops to Liberia, to serve as the lead element in a major expansion of the U.S. response to the Ebola crisis in West Africa. Leveraging its command and control, logistics, transportation, and engineering assets as well as its military health personnel, DoD will build 17 field hospitals, each with 100 beds; set up field laboratories and a regional base to expedite the transportation of sorely needed equipment, supplies, and personnel; and provide training for up to 500 health care workers per week. This campaign, to be known as Operation Unified Assistance, will complement and amplify a whole-of-government response that has been building since March—when the first cases were reported—and includes the largest international response by the Centers for Disease Control and Prevention (CDC) in its history, as well as the involvement of specialists from the National Institutes of Health, the Departments of State and Health and Human Services (HHS), and the U.S. Agency for International Development (USAID). A large coalition of international partners are also assisting the affected nations, including the United Nations, the World Health Organization (WHO), the African Union and European Union, the United Kingdom, France, Germany, Norway, and numerous nongovernmental organizations (NGOs).

Although a military-led operation of this scale and complexity in the midst of a major public health emergency is unprecedented, involvement by U.S. military personnel in global health activities is not new, has increased considerably over the past decade, and has often been controversial. Collectively known within the department as global health engagement, the activities can be categorized into three broad areas: U.S. military force health protection and readiness, medical stability operations and partnership engagement, and biological threat reduction.

While acknowledging their value, an earlier CSIS study asserted that these efforts were not well coordinated with global health activities undertaken by U.S. civilian agencies, and sometimes negatively impacted them.[2] More recently, the Kaiser Family Foundation stimulated conversations with the publication (by Michaud et al.) of the first independent effort at an encyclopedic overview of DoD health engagement.[3] That

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[2] E. Bonventre et al., *U.S. National Security and Global Health: An Analysis of Global Health Engagement by the U.S. Department of Defense* (Washington, DC: CSIS, April 2009), http://csis.org/files/publication/090421_Bonventre_USNationalSecurity_Rev.pdf.
[3] J. Michaud et al., *U.S. Global Health Policy: The U.S. Department of Defense and Global Health* (Washington, DC: Kaiser Family Foundation, September 2012). http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8358.pdf.

study revealed multiple programs—derived from other higher-priority activities—scattered across a large, complicated bureaucracy, with fragmented oversight and leadership. With a huge, complicated department in downsizing mode and in the midst of heightened budgetary scrutiny throughout the government, Michaud's study increased awareness of the scope and complexity of these programs and focused debate on the need to demonstrate impact and value.

DoD recently implemented several steps to better organize these activities, make them more complementary with civilian global health efforts, and improve their effectiveness. What drove these developments, and what is their significance for the larger global health community, both for the Ebola response and beyond? What has actually changed, and what will it take to prove the value of these changes into the future? As budgetary uncertainty continues to loom, how can DoD ensure that it captures optimum value from its investment while constructively supporting the broader U.S. global health agenda?

Background

The primary mission of the Military Health System (MHS)[4] is to enhance readiness and protect the health of U.S. Armed Forces, as well as provide health care to retirees and eligible family members. With military medical personnel serving in every theater across the globe, engagement with military and civilian counterparts in other nations is inevitable. A short list of global health engagement activities includes: supporting humanitarian assistance and disaster relief operations as well as military medical exercises to increase interoperability; building clinics and conducting medical, dental, and veterinary civic action programs; participating in subject matter expert exchanges; providing training, education, and assistance in infectious disease prevention and control, surveillance, and response; collaborating in the development of pandemic preparedness and response plans; conducting health-related engineering programs to provide clean water, sewage disposal, and eradication of disease vectors; managing HIV/AIDS prevention programs; assisting governments with containment of biological threats; and conducting medical research with predominantly host-nation staff and government personnel in DoD overseas laboratories.[5]

While DoD's global health investment pales in comparison with global health funding for civilian agencies—expected to exceed $9 billion for a third straight year in 2015[6]—the Ebola effort is expected to cost over a billion dollars, over and above the almost $600 million of DoD's annual budget that Michaud estimated can be traced to global health engagement.[7]

[4] The MHS is DoD's name for its over 130,000 medical personnel along with the military treatment facilities, TRICARE network of civilian health care partners, and other resources it uses to care for its 9.6 million beneficiaries. See www.health.mil.
[5] Secretary of Defense Message (DTG 152052Z May 13), "Policy Guidance for DoD Global Health Engagement," May 15, 2013.
[6] A. Wexler and J. Kates, "The U.S. Global Health Budget: Analysis of the Fiscal Year 2015 Budget Request," Kaiser Family Foundation, April 2014, http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8564-the-u-s-global-health-budget_analysis-of-the-fiscal-year-2015-budget-request1.pdf.
[7] Ibid., 3.

The View from Outside DoD

During a decade marked by two major wars, the military's global health engagement activities received increasingly close attention and discussion, for at least four reasons.

First, the magnitude, scope, and complexity of these activities dramatically increased. Leveraging its unmatched logistical and transport capabilities and its expeditionary medical personnel, DoD supported a seemingly ever-larger number of humanitarian assistance and disaster relief operations. At the same time, its medical personnel effectively delivered extensive wartime health service support to achieve an unparalleled record of saving the lives of warfighters in Operation Enduring Freedom and Operation Iraqi Freedom. It also fell to MHS personnel to perform many functions for which they were not prepared. In particular, DoD assisted in rebuilding broken military and civilian host-nation health systems during stability operations in Afghanistan and Iraq, and simultaneously filled huge gaps in those systems by providing direct health care to an unprecedented degree. One senior official estimated that caring for Afghani nationals amounted at times to as much as 70–90 percent of the military medical workload.[8]

Second, friction often surfaced as U.S. military health personnel increasingly interacted with others—from U.S. civilian health agencies, other nations (civilian and military), international donors, and NGOs—who were much more familiar with performing these roles, though not necessarily in such dangerous conditions.[9] Early efforts by DoD to support civilian health in both Afghanistan and Iraq frequently had an ad hoc, short-term focus, resulting in numerous unintended consequences. Direct provision of health services—coupled with insufficient understanding of local norms, expectations, and shortfalls—left local civilians with unrealistic expectations that U.S. military would continue to be available for their health care needs. It also left them with diminished confidence in their own health care providers and in their government's ability to provide essential services. Meanwhile, allegations of favoritism sometimes arose from those in neighboring villages that did not receive health services from U.S. military forces. In Afghanistan, MHS personnel trained skilled birth attendants and midwives, but unequal distribution left many areas underserved, so maternal mortality remained extremely high in most rural areas. DoD built a great deal of medical and educational infrastructure without assuring that trained Afghan personnel would be available to operate and sustain the new facilities. Difficulties in communication and coordination between military and civilian agencies were common, often leading to significant tensions among front-line personnel.[10]

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[8] Personal communication with Dr. Warner Anderson, March 10, 2014.
[9] This was similar to the dynamic in other sectors as military personnel worked in nontraditional roles to reestablish essential services to civilian populations in war-torn areas.
[10] D. A. Tarantino and S. Jawad, *Iraq Health Care Reconstruction: An After Action Review* (Washington, DC: CSIS, August 2007), http://csis.org/images/stories/globalhealth/Iraq%20AAR%20final%201%20OCT.pdf; D. Thompson, "The Role of Medical Diplomacy in Stabilizing Afghanistan," *Defense Horizons*, May 2008, http://fas.org/man/eprint/meddip.pdf; E. Bonventre and J. Peake, "Preserving and Improving Civilian Health in Conflict-Affected Nations," in *From Conflict to Pandemics: Three Papers from the CSIS Global Health and Security Working Group*, ed. E. Bonventre and J. Peake (Washington, DC: CSIS, May 2010), http://csis.org/files/publication/100506_Bonventre_FromConflictToPandemics_Web.pdf.

Third, even in nonconflict settings, DoD global health activities (particularly those directed toward civilians) were often not well integrated with civilian agencies or NGOs and demonstrated poor cultural awareness, resulting in wasted opportunities. For example, DoD conducted a medical clinic in a remote village of Djibouti, but only three days' notice to the predominantly nomadic villagers resulted in minimal participation.[11] An earlier CSIS study, by Roughhead et al., noted that humanitarian visits by U.S. Navy hospital ships frequently occurred with little or no connectivity to ongoing health-related activities by U.S. civilian agencies and NGOs in the area.[12]

Fourth, the Michaud study, completed in 2012, was the latest of several outside analyses to reveal a picture of far-flung, widely scattered efforts, with little high-level DoD oversight, coordination, or even measurement.[13] A U.S. Institute of Peace study, by Rubenstein, noted in 2010 that military programs were not "evaluated for effectiveness, measured either by improvement in the health of people served or by contributions to security, or evaluated for potential unintended harms such as setting unattainable expectations or placing civilian programs at risk of attack."[14] Meanwhile, opinions have been mixed on the value of DoD's contribution to the larger body of U.S. government global health efforts. The 2009 CSIS report by Bonventre et al. acknowledged DoD's contributions in biodefense, biosurveillance capacity building, diplomacy, and development. The authors commended DoD's sharing of information and expertise with CDC and WHO in disease surveillance and outbreak response, while noting that combining interagency efforts would yield greater synergy. However, they asserted that "the most controversial areas of DoD's involvement in global health [were in] diplomacy and development," noting that while it was well equipped to serve in a supporting role, DoD's projects sometimes duplicated or undermined the efforts of NGOs and civilian government agencies.[15]

DoD Responds

Awareness of these problems—poor oversight, coordination, and measurement, and significant friction in interactions with other global health players—prompted action within the department. DoD has attempted to better organize itself internally, with changes in policy, new offices, and new coordination mechanisms. The department has increased its outreach and use of interagency liaisons, seeking to better collaborate with civilian agencies and partner country militaries. It has begun to tackle the challenging yet critical task of evaluating effectiveness. The following sections describe these developments.

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[11] U.S. Government Accountability Office, "Defense Management: Improved Planning, Training, and Interagency Collaboration Could Strengthen DOD's Efforts in Africa" (GAO 10-794), July 2010.
[12] G. Roughhead et al., *U.S. Navy Humanitarian Assistance in an Era of Austerity* (Washington, DC: CSIS, March 2013), http://csis.org/files/publication/130226_Roughead_NavyHumanitarianAssist_Web.pdf.
[13] Ibid., 3.
[14] L. Rubenstein, "Health Initiatives and Counterinsurgency Strategy in Afghanistan," U.S. Institute of Peace, March 5, 2010, http://www.usip.org/sites/default/files/PB%2012%20Health%20Initiatives%20and%20Counterinsurgency%20Strategy%20in%20Afghanistan.pdf.
[15] Ibid., 2.

Global Health-related Policies

Global health engagement figured prominently in several national security policy documents between 2010 and 2013:

- The 2010 National Security Strategy declared for the first time that the nation has a "moral and strategic interest in promoting global health."

- Underscoring the value of public health-related activities in addressing the root causes of terrorism, the 2010 Quadrennial Defense Review announced an expansion of biological threat reduction activities "to create a global network for surveillance and response."

- DoD had previously recognized the importance of achieving success in stabilizing post-conflict and reconstruction environments, elevating stability operations to a core DoD mission. In 2010, a new instruction similarly mandated that the Military Health System "shall be prepared to conduct [medical stability operations]…across the range of military operations…in combat and non-combat environments," and that medical stability operations shall be "explicitly addressed and integrated across all MHS activities including doctrine, organization, training, education, exercises, materiel, leadership, personnel, facilities, and planning."[16]

- The 2011 National Military Strategy highlighted the importance of theater security cooperation activities conducted within the geographic combatant commands. Those include projects funded by Overseas Humanitarian, Disaster, and Civic Aid (OHDACA) appropriations, over half of which have been health-related in recent years.[17]

- Perhaps most significantly, the secretary of defense issued policy guidance defining the parameters of global health engagement in May 2013. The guidance stressed the importance of focusing these activities on building sustainable partner nation capacity, synchronizing with civilian agencies to complement broader U.S. government health programs, and dedicating sufficient resources for measurement and evaluation. It requires combatant commands to annually submit humanitarian assistance strategies and describe how proposed theater security cooperation projects align with their respective theater campaign plans. This was an endorsement from the top, not only of the value of these activities, but also of the need for strategic alignment and for thoughtful needs-based planning and coordination with partner nations, NGOs, and other U.S. agencies. The guidance makes it clear that these activities are intended to build partner-nation capacity and "improve DoD visibility, access, influence and interoperability" in alignment with theater campaign plans, but that they should also "supplement or complement…but not duplicate or replace" the efforts of agencies responsible for foreign assistance and development. When health services are provided directly to civilian personnel, the policy emphasizes that local standards of care should be carefully considered to avoid well-intended but unsustainable interventions and a

[16] DOD Instruction 6000.16, "Military Health Support for Stability Operations."
[17] Over a recent five-year period, 52 percent of OHDACA-funded theater security cooperation projects with completed after-action reports were health related. See G. Diehl et al., "Measures of Effectiveness in Defense Engagement and Learning (MODEL): conceptual study design," *Lancet* 381 (June 17, 2013): S39.

consequent decline in "positive perception of the U.S. military or…the [host-nation] government."[18]

Taken together, these documents suggest that global health engagement has become an important tool for DoD. It is too early to tell whether the policies will have a long-term impact on DoD's activities. However, the department has created new offices and coordination mechanisms in seeking to ensure that this tool will be used effectively.

New Offices

In 2007, soon after taking office as assistant secretary of defense for health affairs, Dr. Ward "Trip" Casscells took an important first step in focusing DoD's attention on global health, establishing an International Health Division within the MHS. Dr. Casscells had personally experienced global health engagement's value, as well as its challenges, during a 2005 deployment to Iraq.[19] While his ultimate objective was to "bring evidence into the picture in order to optimize the role that health could play in enhancing stability while improving people's lives," this action also immediately gave DoD a designated interlocutor for interagency discussions on global health, and enabled it to begin the process of identifying and translating into policy the many lessons observed from its capacity building efforts in Afghanistan, Iraq, and elsewhere.[20]

In 2011, a military position was established for a "DoD global health engagement coordinator" within the newly renamed Office of Humanitarian Assistance, Disaster Relief and Global Health, under the undersecretary of defense for policy. This action closed a critical gap by creating a focal point for the services, the geographic combatant commanders, and the numerous agencies (Armed Forces Health Surveillance Center, Defense Threat Reduction Agency, National Center for Medical Intelligence, and many others) that conduct these activities. The formation of this office, along with the International Health Division, laid the groundwork for DoD to synthesize its policies and to coordinate those policies and programs with other U.S. government agencies involved in global health.

New Coordination Mechanisms

Two entities now exist within DoD to coordinate global health policies and operations: a Global Health Engagement Cell and a Global Health Working Group.

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[18] Ibid., 5.

[19] A distinguished civilian cardiologist, Dr. Casscells joined the Army Reserve in 2005 and survived a shelling and an insurgent ambush while serving as medical liaison to Gen. George W. Casey Jr., the U.S. military commander, and Zalmay Khalilzad, the U.S. ambassador. He worked extensively with Iraqi medical personnel and, as Khalilzad noted, "helped [the United States] a lot to focus on increasing the capacity of the Iraqis to take care of themselves." See E. Langer, "S. Ward Casscells III dies at 60," *Washington Post*, October 16, 2012, http://www.washingtonpost.com/local/obituaries/s-ward-casscells-iii-dies-at-60-cardiologist-and-army-reservist-served-in-iraq-pentagon/2012/10/16/0ce3ec2c-170b-11e2-8792-cf5305eddf60_story.html.

[20] Personal communication with Dr. Warner Anderson, March 10, 2014.

- The DoD global health engagement coordinator chairs the first of these. In addition to the International Health Division, joint staff surgeon, and the services,[21] the cell includes representatives from other key stakeholders including the Combating Weapons of Mass Destruction and Homeland Defense offices within DoD Policy, Joint Staff Strategic Plans and Policy, and the Readiness Division of the new Defense Health Agency.[22] Meeting at least monthly, the cell provides strategic guidance to combatant commands, and is drafting an instruction to govern global health engagement activities.

- The Global Health Working Group, cochaired by the joint staff surgeon and the deputy assistant secretary of defense for force health protection and readiness, includes the director of humanitarian assistance, disaster relief and global health along with service representatives. This working group has three active committees:

    - A "Provision of Care Guidelines Committee," which has been tasked to incorporate standards of care, medical ethics, and credentialing/licensing issues into a DoD instruction by March 1, 2015;

    - A "Measure of Effectiveness Process and Learning Tool Committee," which has two deliverables due by December 15, 2014: to develop a process to ensure global health engagement activities are meeting U.S. national security goals, and to establish a learning tool that assesses efficiency and effectiveness of health engagements; [23] and

    - A "Global Health Capability Committee," which is responsible for drafting a strategic plan, or concept of operations, for a DoD global health capability by December 15, 2014.

Working to Become More Complementary of Civilian Global Health Efforts

The current assistant secretary of defense for health affairs, Dr. Jonathan Woodson, has spearheaded extensive DoD outreach to civilian agencies and national and international NGOs, resulting in increased mutual understanding of global health roles and activities, particularly among those at the front line, and improved channels of communications among these organizations.[24]

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[21] With a robust International Health Specialist program dating back to 2001, the Air Force was the first service to establish a formal global health engagement office within its medical department. In 2012, the Navy Bureau of Medicine and Surgery created an Office of Navy Global Health Engagement; the Army followed suit in 2013.

[22] Established in 2013 when the Tricare Management Agency disbanded, the Defense Health Agency's mandate as a combat support agency is to ensure the MHS can meet the needs of combatant commands—in this case for global health engagement.

[23] These deliverables were mandated in Section 715 of the Fiscal Year 2013 National Defense Authorization Act.

[24] In addition to this outreach, organizations like the U.S. Institute of Peace, CSIS, and the UN Office for the Coordination of Humanitarian Affairs have convened meetings between military health personnel and counterparts from civilian agencies and NGOs, often specifically focused on improving interactions in the field. A collaboration between Harvard Medical School and NATO is an example of an international effort

One of Dr. Woodson's first interagency meetings after taking office in December 2010 was with Dr. Kerri-Anne Jones, assistant secretary of state for oceans and international environmental and scientific affairs. This initial meeting led to a working relationship that has evolved into an ongoing forum for U.S. agencies involved in global health. Now quadpartite, with the addition of the HHS assistant secretary for global affairs and USAID assistant administrator for health, the meetings are convened quarterly to discuss issues of mutual interest.[25] They have become known as "3D Meetings," reflecting the principals' joint commitment to supporting overarching U.S. foreign policy goals (through the "3Ds" of defense, diplomacy, and development) while conducting their respective global health efforts. Other relevant stakeholders attend on an ad hoc basis, including the HHS assistant secretary for preparedness and response and the assistant secretary of state for global health diplomacy.

Despite initial skepticism, this forum is seen as valuable at the working level, with increased engagement by the principals on challenging issues translating into more effective deliberations and facilitating progress by their staffs. Meeting agendas have reflected key administration priorities and common strategic issues. Topics have included the Global Health Security Agenda (see next section), health engagement in Southeast Asia in the context of the Asia-Pacific rebalance, and noncommunicable diseases. Discussions have also focused on seeking suitable opportunities for collaboration, and on resolving operational issues related to the responsibilities of personnel assigned as health attaches.

Another important mechanism for enhancing DoD's relationship with other U.S. agencies and international organizations involves the assignment of selected military health personnel as interagency liaisons. These officers are detailed to civilian agencies, where they help coordinate issues involving common interests and equities. Since January 2014, such postings must be approved by the deputy assistant secretary of defense for force health protection and readiness, another indication of DoD's commitment to improving coordination with its civilian counterparts.

DoD has also seen an increase in liaison officers received from civilian agencies. USAID representatives work within each geographic combatant command, facilitating early interagency collaboration and coordination for international health engagement activities. DoD now requires projects that support military-to-civilian engagement to receive USAID concurrence before being submitted to chiefs of mission for approval. Although the quality of constructive feedback on engagement projects in early stages of consideration has been variable, there is optimism that this early dialogue will mature, resulting in projects that better align with each mission's other global health activities.[26]

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to seek cohesion between military and civilian organizations involved in trying to strengthen health systems in crisis situations.

[25] The initial meeting between Drs. Woodson and Jones was an outgrowth of a relationship formed between the International Health Division and the State Department's Office of International Health and Biodefense.

[26] While seeking to better complement and support civilian agencies working in the health sector, particularly in preparing for and responding to disasters and in biosurveillance, senior DoD health officials repeatedly emphasize that partnerships with foreign military medical counterparts—a niche that civilian agencies cannot fill—should be the primary focus for global health engagement. Over 25 specific

Global Health Security

"Prevent, Detect and Respond" have long been watchwords for DoD's programs in bioterrorism response and public health preparedness. Recognizing the need to synchronize these previously stove-piped programs to optimize global health situational awareness, the assistant secretary of defense for nuclear, chemical and biological defense programs and the assistant secretary of defense for health affairs signed a memorandum of understanding in 2012, making the Armed Forces Health Surveillance Center (AFHSC) the "home" for all the department's biosurveillance activities.[27] DoD has been able to leverage its combined capabilities in this area to lend support to public health capacity-building efforts led by U.S. civilian agencies and the international global health community.

The Defense Threat Reduction Agency and CDC recently collaborated to help Uganda and Vietnam develop capabilities necessary to meet the requirements of the 2005 International Health Regulations (IHRs). Despite challenges related to interagency money transfers, the partnership has helped lay the foundation for the Global Health Security Agenda, launched in February 2014. The agenda represents a commitment by WHO, the United States, and dozens of other countries, including China and India, to ensure that all nations, individually and collectively, can effectively identify and deal with major health threats.[28]

Meanwhile, AFHSC is partnering with HHS to develop the "Global Health Map," a web-accessible IHR capability mapping tool. AFHSC also works with DoD's geographic combatant commands and through venues like WHO and the International Committee of Military Medicine to identify appropriate opportunities for the global military health community to contribute to the Global Health Security Agenda—and improve public health more broadly—in their own nations and the world.[29]

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programs can be utilized for this purpose, though since many of these programs are governed by narrow funding authorities, military-to-military medical engagements are often funded from operations and maintenance appropriations in support of U.S. military force health protection objectives. From the perspective of combatant commanders focused on achieving desired end states of theater campaign plans, successful military health engagement activities can reap numerous benefits: better military medical interoperability; enhanced productivity among military personnel of partner nations; an indirect impact on the health of the civilian populace (particularly in nations where the military provide health care to civilians); and improved "force health protection" for U.S. military personnel participating in exercises or deployments.

[27] Memorandum of Understanding between the Office of the Assistant Secretary of Defense for Nuclear, Chemical and Biological Defense Programs and the Office of the Assistant Secretary of Defense for Health Affairs, July 12, 2012.

[28] B. Cohen, "DoD, HHS sign agreement on mitigating biothreats," BioPrepWatch, February 26, 2014, http://bioprepwatch.com/biological-threats/dod-hhs-sign-agreement-on-mitigating-biothreats/336177/; CDC, "U.S. Commitment to the Global Health Security Agenda," http://www.cdc.gov/globalhealth/security/pdf/ghs_us_commitment.pdf; CDC, "Global Health Security—Vision and Overarching Target," http://www.cdc.gov/globalhealth/security/pdf/ghs_overarching_target.pdf.

[29] AFHSC information paper (2014), "Global Health Map Overview: A U.S. Government Collaboration Tool to Support Coordination of Capacity Building for Global Health and International Health Regulations"; D. Blazes and K. Russell, "Joining Forces," *Nature* 477 (2011): 395–96; D. Fidler, "Military Forces, Global Health, and the International Health Regulations (2005)," *Journal of Healthcare, Science and the Humanities* 1 (2011): 117–30; K. Russell et al., "Global Militaries Unite: Discussion of Responsibilities under the International Health Regulations (2005): Saint Petersburg (2010)," *Journal of Healthcare, Science and the Humanities* 1 (2011): 131–40.

One area in which military medical personnel have exceptional capacities and expertise to contribute to health security is malaria, long a focus of DoD overseas research laboratories, particularly in Southeast Asia. Numerous civilian partners—including the Global Fund to Fight AIDS, Tuberculosis and Malaria; the President's Malaria Initiative; and the Bill & Melinda Gates Foundation—are now working with Greater Mekong Subregion nations to combat artemisinin-resistant malaria, a significant health threat that imperils the world's impressive recent gains against the disease. Military troops within the subregion, who frequently deploy to high-risk areas, are considered both a vulnerable population and a key to malaria elimination efforts, as they often go undiagnosed and untreated and then contribute to further spread.[30] DoD has begun to partner with the Mekong's militaries to improve their ability to screen, diagnose, and treat their infected personnel, in coordination with the broader civilian-led initiatives.

Assessment and Evaluation

Assessing and evaluating effectiveness of global health activities has historically been challenging for all agencies, military and civilian. For DoD, additional incentive arrived when the Fiscal Year 2013 National Defense Authorization Act required development of "a process to ensure that health engagements…are effective and efficient in meeting…national security goals."[31]

To meet Congress's mandate, DoD first needed to determine the magnitude of global health engagement. Unfortunately authoritative data was not plentiful. As cited earlier, a recent review noted that half of the theater security cooperation projects DoD executed over a five-year period were health related. However, a 2012 GAO report reflected absent or insufficient project evaluations for most projects executed between 2005 and 2009.[32]

Our research suggests that this problem extends to after-action reports in other information management systems, and is accompanied by wide variability in the quantity and quality of information even when reports are submitted. Among personnel participating in these activities, expectations are low that feedback will have any meaningful impact, resulting in numerous submissions containing a bare minimum of information. Evidence that after-action reports are being carefully reviewed, and can lead to improvements or impact future funding, would be an impetus to take them more seriously, leading to improvements in data quality.

In 2013, DoD launched a $2 million multiyear effort to determine the effectiveness of global health engagement. The Measures of Effectiveness in DoD Engagement and

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[30] J. S. Morrison et al., *A Greater Mekong Health Security Partnership* (Washington, DC: CSIS, July 2013), http://csis.org/files/publication/130719_Morrison_GreaterMekongHealth_WEB.pdf; J. C. Daniel, *Drug-Resistant Malaria: A Generation of Progress in Jeopardy* (Washington, DC: CSIS, November 2013), http://csis.org/files/publication/131107_Daniel_DrugResistantMalaria_Web.pdf.
[31] Fiscal Year 2013 National Defense Authorization Act, Section 715.
[32] Of projects funded by Overseas Humanitarian, Disaster, and Civic Aid appropriations (which support military-to-civilian engagement) during fiscal years 2005–2009, only half of required 30-day, post-project evaluations, and 10 percent of those required at one year, had been completed. See U.S. Government Accountability Office, "Humanitarian and Development Assistance: Project Evaluations and Better Information Sharing Needed to Manage the Military's Efforts" (GAO 12-359), February 2012, http://www.gao.gov/assets/590/588334.pdf.

Learning (MODEL) study, led by the Center for Disaster and Humanitarian Assistance Medicine at the Uniformed Services University of the Health Sciences, aims to evaluate the impact of health engagement activities on achieving desired strategic and operational end-states. The study leverages current measures of performance from multiple information management systems, including level of effort (funding and personnel) data and contents of after-action reports and evaluations, in order to validate measures of effectiveness within three categories: strategic, health, and readiness.

MODEL's initial results are promising, in spite of variability in data content and quality. One early study demonstrated strong correlation between military-to-military engagement in HIV/AIDS prevention and positive population health outcomes. If successful, MODEL's outputs will enable combatant commanders and other senior leaders to better align future military global health engagement events with host-nation health requirements and U.S. national interests.

A second objective is to standardize data-collection processes and content in order to encourage more complete and meaningful project evaluations. This should create a mindset change among those entering information, improve knowledge integration, and enable better-informed analyses and decisions going forward.

Looking ahead from the whole-of-government perspective, if DoD's collaborative efforts with HHS on the Global Health Map and its MODEL study continue to be successful, both stand as potential tools in evaluating the effectiveness of efforts to build IHR capacity, the keystone of the Global Health Security Agenda.

Recommendations

With thoughtful policies, new internal coordination mechanisms and offices, and serious attempts to determine the capabilities it truly needs and to evaluate effectiveness, DoD has in recent years demonstrated a desire to become more focused and to be a more supportive interagency partner in the global health space. Although it has been a major contributor to the nascent Global Health Security Agenda, it is otherwise too early to determine how much concrete value will be captured by these promising developments. In order to sustain the momentum, we offer these recommendations:

- *Raise the profile of 3D meetings.* The past year has seen a plethora of emerging security crises—from tensions and conflicts in Eastern Europe and the Middle East to the Ebola catastrophe in West Africa—each demanding coordinated action to address major health and humanitarian consequences. What role can and should DoD play in response to each of these crises? In which situations should that role continue as response turns to reconstruction? Periodically bringing assistant secretaries together for 3D meetings has helped build important relationships. If the group would agree to tackle serious, shared policy challenges and set deadlines to resolve them, this forum could serve a meaningful and enduring purpose. One particularly relevant subject would be to decide on clear decision criteria to determine when DoD should transition its involvement to civilian partners in the aftermath of a crisis, as well as a smooth mechanism to implement such

"handoffs." Transition planning needs to be an essential component of Operation Unified Assistance, so this issue carries heightened urgency.

- *Continue to prioritize interagency experience in developing the Military Health System's future leaders.* DoD has recruited very dynamic mid-career officers who have represented it well as interagency liaisons, increasing understanding of and building trust within civilian agencies. This must continue, and be reciprocated, to increase the quality of these interactions.

- *Work with Congress to develop more flexible mechanisms to transfer money during high-priority interagency collaborations.* The Defense Threat Reduction Agency and CDC were able to work together to help Uganda and Vietnam develop important health capabilities. However, significant personal initiative was first required to overcome fiscal restrictions and enable DoD money to be used by a non-DoD agency to implement major portions of this work. Resolving this issue is essential to ensure the success of a key component of the Global Health Security Agenda. On the positive side, the Defense HIV/AIDS Prevention Program has successfully navigated similar challenges to work for many years alongside the President's Emergency Plan for AIDS Relief program, reaching military populations to the benefit of both global health and security.

- *Actively seek additional opportunities to add significant value to civilian-led global health efforts while pursuing DoD's own health and security objectives*:

    - Work with embassies whenever possible to utilize global health engagement activities as opportunities to raise awareness of and enhance ongoing civilian health and development activities.

    - Initiate planning earlier, ideally up to two years for major projects, to facilitate the ability of U.S. country teams, host-country ministries, and local communities to shape upcoming events and to assist in raising public awareness of them. This will allow more time to identify potential synergies or conflicts with ongoing or planned civilian initiatives. It should also enhance participation and improve effectiveness of engagement activities by making it more likely that they will incorporate local norms and customs and be tailored to match community needs.

    - Continue, and expand if appropriate, engaging with the Mekong's militaries to fight malaria, while ensuring complementarity with civilian-led efforts. This offers opportunities to engage meaningfully with China, a strategic priority for the U.S. Pacific Command, and potentially Myanmar, which accounts for three-quarters of Southeast Asia's malaria deaths.

- *Accelerate measurement and evaluation efforts.* Global health engagement is one of many engagement tools available to combatant commanders to increase interoperability and build capacity and stability in partner nations. With resources constrained by sequestration and other downward pressures on the federal budget, the ability to measure the effectiveness of this tool in achieving strategic objectives, validate which activities are helpful and which are not, and compare health engagement to alternative soft power capabilities, is critical. This means standardized data measurement and aggregation practices, rather than multiple

information systems, each of which requests different information in different formats. It also requires a mindset transformation, a sense that after-action reports will actually lead to "lessons learned" rather than merely individual "lessons observed." The secretary of defense guidance suggests dedicating up to 5–10 percent of the cost of global health engagement projects for monitoring and evaluation. We concur and further recommend that such funding be front loaded, particularly for large projects. While incorporating input from health engagement participants, the evaluations should be conducted by qualified independent entities. These steps will greatly increase the likelihood that 30-day and 1-year evaluations will be competently completed, and when aggregated, enable more robust analysis and better decisionmaking.

Conclusion

Responding to pressures from within the department to demonstrate value, and from the broader global health community to improve execution and better harmonize with the endeavors of civilian agencies, nongovernmental organizations, and foreign governments, the Department of Defense has taken steps in recent years to sharpen the focus of its myriad global health engagement programs.

The secretary of defense's policy guidance now emphasizes that while these programs support U.S. force health protection and biological threat reduction, they serve first and foremost as "a means to partner with other nations to achieve security cooperation and build partner capacity."[33] DoD policy now also states that these activities must reflect local customs and standards, focus on sustainability, and be closely coordinated with host nations and with civilian organizations.

The department has created new offices and mechanisms to oversee its programs and to seek improved coordination with civilian agencies.

DoD has also exerted considerable attention and resources to addressing what remains its most pressing challenge: measuring and assessing the impact of global health engagement activities on strategic health and security objectives. This will be essential in the face of continued budgetary pressures. While much work remains, including an attitudinal transformation on the importance of quality data to support these assessments, a bright spot is that its body of work in this area holds the promise of being incorporated into a broader effort to evaluate the effect of the entirety of U.S. global health activities on its national security, diplomatic, and development objectives.

While some may not have noticed, DoD has taken some important steps in defining and communicating—to its own people and to the interagency—its goals for global health engagement, even as its senior leaders seek to discern the resources and competencies it needs to achieve them. Yet whether in emergent humanitarian crises, such as the Southeast Asian tsunami response or the current Ebola catastrophe, or in proactive but no less important efforts, such as building global IHR capacities or

[33] Ibid., 5.

fighting malaria, it is also clear that there will be opportunities for DoD to contribute to broader U.S. government global health initiatives.

The global health community will look to see if DoD leadership sustains its commitment to “smart global health engagement.” If so, the Military Health System has the potential to play a role in advancing the nation’s health, diplomacy, and development goals, as well as its security objectives.

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