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14. ABSTRACT

The Department of Defense seeks to form the foundations of a peaceful and prosperous world through security cooperation. EUCOM's Theater Security Cooperation Plan (TSCP) seeks to ensure access, promote stability and security, and strengthen capabilities for self-defense and coalition operations through a number of various programs. The particular program that is the subject of this paper is Humanitarian and Civic Assistance (HCA) and, more specifically, medical or health related HCA activities in Africa. Past and current medical HCA activities have not been focused on long-term public health capacity building despite the strong relationship between population health and security. Building public health capacity of developing African nations will improve their stability, thus improving the security environment. They will be better equipped to handle their own health issues without outside intervention and to assist in humanitarian crises in the region, thus reducing the workload on U.S. resources in the long-term.

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Should Medical Humanitarian and Civic Assistance Activities Focus on Building Public Health Capacity in Africa to Better Influence Theater Security Cooperation Objectives?

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A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

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Abstract

The Department of Defense seeks to form the foundations of a peaceful and prosperous world through security cooperation. EUCOM's Theater Security Cooperation Plan (TSCP) seeks to ensure access, promote stability and security, and strengthen capabilities for self-defense and coalition operations through a number of various programs. The particular program that is the subject of this paper is Humanitarian and Civic Assistance (HCA) and, more specifically, medical or health related HCA activities in Africa. Past and current medical HCA activities do not focus on long-term public health capacity building despite the strong relationship between population health and security. Building public health capacity of developing African nations will improve their stability, thus improving the security environment. They will be better equipped to handle their own health issues without outside intervention and to assist in humanitarian crises in the region, thus reducing the workload on U.S. resources in the long-term.

Introduction

United States European Command (EUCOM) finds itself in an unfamiliar and still evolving environment at this start of the twenty-first century. This undeveloped environment includes emerging threats and challenges, as well as some opportunities for long-term economic prosperity and developing democracy as part of the world's globalization process. EUCOM's mission is to provide a peaceful security climate in the area of responsibility (AOR) to support the Department of Defense goal of forming the foundations of a peaceful and prosperous world through security cooperation.

EUCOM's Theater Security Cooperation Plan (TSCP) seeks to ensure access, promote stability and security, and strengthen capabilities for self-defense and coalition operations through a number of various programs. One such program, the subject of this paper, is Humanitarian and Civic Assistance (HCA), which includes medical or health related HCA activities.

The thesis for this paper is that EUCOM could better influence the successful achievement of TSC objectives in Africa and the overall AOR by utilizing medical Humanitarian and Civic Assistance activities to build long-term public health capacity. The research represented in this paper will seek to answer the following questions: What is the association between public health and security? What is the state of public health in Africa and why is it important to the United States? Have past medical HCA activities improved long-term public health? What should EUCOM do to improve public health capacity in Africa?

As stated above, I will argue that building public health capacity in developing African nations will directly improve their stability as nation-states and, thus improve both the immediate region and worldwide security environment. A nation properly equipped to handle their own

health issues without outside intervention and to assist others in humanitarian crises in the region, will reduce the workload presently placed on U.S. resources.

Security and Public Health

Africa's largest public health threat is infectious disease. HIV/AIDS, tuberculosis, and malaria are just a few of the communicable diseases that are prevalent in Africa. The prevalence of infectious disease clearly undermines the stability and security of African nations and the region. Political scientist Andrew Price-Smith provides empirical evidence in his book, "The Health of Nations," that a significant negative relationship exists between the incidence of infectious disease and a state's economic productivity, governance and security. Protection from infectious disease is a function of public health. Therefore, it is logical and reasonable to posit that a significant negative relationship also exists between the lack of adequate public health and security.

Infectious Disease and Economics

The idea that a nation's prosperity would result in a healthy population is widely held, but Price-Smith's empirical data has shown that the opposite is true. His evidence supports the concept that the contribution of public health to economic productivity of a society is greater than the converse. A society plagued with infectious diseases will suffer economically. A nation with economic woes opens the doors for civil unrest and outside threats. In this cart before the horse scenario, it comes clear that a healthy society is the force that moves the economy in a positive direction rather than the other way around.

Infectious disease is progressive by nature. First, a few individuals become ill, next their households, their neighbors, the entire neighborhood, adjacent communities, and finally the region. Price-Smith's work illustrates the economic impact on a country as the infectious disease

progresses from individuals to the greater portion of the general population. An individual, specifically head of household, who becomes infected will at best become less productive and miss work. Under the worst circumstances he will die. Either situation will have a negative impact on the economy at large. This translates into reduced family income and a shift in spending toward medical costs and, potentially, costs associated with death. Less money earned and more money spent on medical and funeral bills means households will spend less money on other items such as education, shelter, and clothing. Firms employing infected individuals will experience reduced productivity, high worker turnover, loss of skilled managers, and increased costs in new employee training. Employers may also face further reduced labor productivity because otherwise healthy, productive employees may be required to spend significant time and energy at home caring for infected family members. The negative impact of uncontrolled infectious disease gains size and momentum as it moves through the society. Although labor-intensive sectors like agriculture and mining will most likely feel the largest impact, infectious disease is indiscriminate and no sector of society escapes its reach. The economic well-being of individuals, families, firms, and sectors will drive significant macroeconomic outcomes. Without sufficient public health capacity to prevent or combat infectious disease epidemics, a nation-state will surely experience reductions in gross domestic product, government expenditure per capita, the quantity and quality of labor, and the resulting worker productivity. Consequently, households incur higher costs, per capita income declines, savings diminish, and income disparities widen. A high prevalence of infectious disease in an area generates disincentives for foreign investment, impedes development of natural resources, and results in the embargoing of infected goods. Thus, a state's inability to cope with infectious disease (i.e., insufficient public health) leads to a reduction in its economic capacity and stability.[1]

Infectious Disease and Governance

Disease induced economic instability will undermine otherwise effective governments. As demands by the populace for basic needs rise, the state's ability to provide them lessens. If the state is not able to secure the health of its people, then it soon loses its legitimacy and will ultimately find itself without popular support. As popular support wanes, lower classes may increasingly engage in anti-government activities, middle and upper classes may aspire to seize power, and there may be competition among elites to secure declining or scarce resources. The loss of legitimacy may compromise emerging democracies who, as a result, may return to authoritarian structures. This, in turn, may increase incidence of chronic sub-state violence and state failure. Ruling elites may retaliate with draconian measures in an attempt to stabilize the state. Even the military that the ruling elites may depend upon to restore order will feel the impact of the spread of infectious disease. The pool of recruits or conscripts and force strength will decline, including experienced leaders, compromising military readiness. The affected state's economy is such that it cannot afford to raise a capable military force to protect its territory. Increased sub-state violence, pending state failure and a weakening military may invite neighboring states to seize power, valued territory, or scarce resources resulting in regional instability.[2]

Infectious Disease and Security

The term "security" as it relates to nation states has traditionally conjured up notions of safety from some form of violent attack; the main role of government is to "protect" its citizens. The traditional military definition of "security" however, ignores disease. This seems counter to facts, considering that disease has claimed more lives than war throughout history. The World Bank reported that of the more than 49 million deaths recorded in 1990, infectious disease

claimed over 16 million while war claimed only 322,000.[3] Richard Ullman, a political scientist, suggested that a threat to national security is "an action or sequence of events that (1) threatens drastically and over a relatively brief span of time to degrade the quality of life for the inhabitants of a state, or (2) threatens significantly to narrow the range of policy choices available to the government of a state or to private, non-governmental entities (persons, groups, corporations) within the state."[4]

By this definition, infectious disease, hence insufficient public health, is indeed a threat to national security. The emergence of an infectious disease, allowed to spread unabated throughout a society, certainly leads to degradation in quality of life of the population. Consequently, it increases economic problems, depletes human capital, and reduces state capacity. The long-term effects of which reduce national prosperity, effective governance, and, ultimately, security. One need only look at the U.S. government's reaction to the possibility of "bird flu" to see that America does understand the importance of health to its citizenry.

Public Health in Africa

Lack of adequate public health to protect a population, and the resulting incidence of infectious disease, has been identified as a considerable vulnerability to a nation's security. This is nowhere more evident than in Africa, where poor public health plays an integral part in the chronic failure of states. Almost every piece of literature regarding global health issues today points to Africa as the bleakest region.

According to the 2003 World Health Report, communicable diseases continued to be the leading causes of death in Africa. The leading diseases include HIV/AIDS, lower respiratory infections, malaria, diarrheal diseases, childhood diseases, measles, and tuberculosis. All of these diseases are preventable and many are treatable. Dramatic improvement is possible with

the implementation of low cost, prevention programs consistent with public health initiatives. According to the World Health Organization, 35 % of Africa's children are at a higher risk of death today than they were 10 years ago. In excess of 500 African mothers lose a child every hour, and more than four million African children died in 2002. Children who make it to adulthood face adult death rates that are higher now than they were 30 years ago. Life expectancy in some African countries has declined by 20 years.[5]

Why is Africa important to the US?

Africa is an important supplier of essential resources to the United States. Several African countries in the EUCOM AOR are direct exporters of oil to the United States. The continent is also rich in raw materials. The continent has the world's highest concentrations of chromium, cobalt, manganese, and platinum, all of which have strategic importance to U.S. industry. Therefore, the United States has a distinct interest in maintaining this source of essential supplies for the American economy. Severe continued disease induced population decline in many African nations could disrupt supply.

Africa also is an important part of the global war on terrorism. In particular, U.S. interests in the development, support, and nurturing of democracy and democratic institutions in Africa is challenging because a number of countries face economic development problems, civil and religious strife, poverty, and health issues. This results in significant geographic areas of instability and poor governance, that provide fertile ground for non-state actors engaged in drug trafficking, extremism training sites and, terrorism planning havens. Successfully influencing Africa's development is critical to Department of Defense's overarching role in shaping the international security environment to promote and protect U.S. interests. Public health is an essential component of sustained development.

EUCOM understands that there is a link between health and security. In fact, it specifically states that their "primary objective should be to continue working many of the security cooperation initiatives in Africa with our partners there to support humanitarian operations, and to increase the local countries' capacities to handle the HIV/AIDS epidemic and other associated health problems."[6]

Medical HCA and Public Health

If building public health capacity so that African countries can handle their own health issues is EUCOM's objective, will the employment of the same old medical HCA programs accomplish it?

DODI 2205.3 instructs Unified Combatant Commanders (UCC) to submit mid- and end-of-year reports to Under Secretary of Defense for Policy (USDP) covering all HCA activities conducted in their respective AORs. The Defense Security Cooperation Agency (DSCA) is DOD's focal point for Security Cooperation. DSCA provides oversight to all HCA activities, and receives and consolidates the reports from the UCCs on behalf of USDP. The instruction also indicates that the UCCs are to submit a third report, along with their end-of-year report, that provides a narrative assessment of the overall effectiveness and long-term impact of HCA activities conducted during the previous two fiscal years. The instruction does not provide any measures of effectiveness on which to base the assessment. EUCOM and DSCA were contacted to get past copies of this long-term impact report, but neither could provide. EUCOM has never prepared such a report and has indicated that it would probably be cost prohibitive to do so, since there was no mechanism designed to capture long-term impact. DSCA indicated that they have never seen such a report, from any UCC.

DSCA was able to provide some data for EUCOM covering fiscal years 2000 through 2004. These reports specified that EUCOM conducted 28 HCA activities in 15 different countries over the five fiscal year period. The location, cost, and type of HCA activity is the only information consistently provided in the reports. Occasionally, a report will list the actual accomplishment, such as number of patients seen, but that was not the norm. Twenty-three of those activities included some health related project. The reports indicated some of the medical HCA activities provided construction or renovation of medical facilities. Donation of excess medical equipment and supplies could be construed as providing long-term capability, but the majority of effort by the U.S. military was toward providing direct patient care. The focus on direct patient care, while providing long-term benefits for a few treated individuals, does not leave the positive impact on public health that is necessary to bring security and stability. Without long-term impact reports, it is questionable whether those treated individuals benefited from the care. Over a five-year period, only five of the fifteen countries received more than one visit. This suggests a lack of follow up to medical care provided on previous projects. It also indicates that there was no plan to link successive projects to improving long-term public health. Unfortunately, the paucity of information contained in the report makes further EUCOM specific analysis impossible. For that reason, a literature review of research applying to all medical HCA activities follows.

One researcher concluded that, "As spectacular as they seem, the MEDFLAG (medical HCA activities in Africa) exercises have little impact on sustaining the health of the Host Nation, given the infrequency of visits to the respective countries and the individual orientation of the MEDCAP (acronym for medical civic action program, synonymous with medical HCA)."[7] Yet another who examined the issue of the long-term impact of medical HCA activities found that,

"One of the criticisms of the MEDCAP made by re-deploying forces to nations that have previously hosted MEDCAPs is that they find a population that is in even worse circumstances than upon the prior visit."[8] Still another observed that confidence in local governments might have been eroded because the local government could not sustain the level of care introduced by U.S. personnel.[9] One researcher argued that medical HCA programs focused on direct patient care with no follow up mechanism instills false hope in the population.[10] These researchers corroborate that the current focus is entirely on direct patient care, there has been no attempt to link successive HCA activities, and there is no follow-up to assess long-term impact. For these reasons, one researcher suggested that, "In the context of nation building, democratization, economic prosperity, and regional stability, individual MEDCAP teams have minimal impact."[11]

Jeff Drifmeyer and Craig Llewellyn conducted the most extensive research on medical HCA projects. Although his work did not focus specifically on EUCOM, his research covered such a large number of projects that it is logical to conclude that they are highly applicable to EUCOM's HCA activities as well.

Drifmeyer surveyed 215 military members from all services who had led or participated in health related HCA projects and reviewed over 100 after action reports. Most of those surveyed had participated in, on average, four HCA projects accounting for an aggregate of almost 1,000 HCA projects in more than 100 countries. He also surveyed 38 foreign nationals – host nation officials, health care providers, and patients – who had recently received medical HCA. At the time of publication, his work was the largest compilation of individual and collective experiences. He found that medical HCA was just one of many duties held by the personnel selected to lead or participate in these activities. The study revealed that the majority of HCA projects were short-term, one-time interventions that provided care to hundreds or

thousands of individuals, but unfortunately not very many in the context of the hundreds of millions in need. However, there was no follow-up with patients to assess their long-term health status. Drifmeyer further found that the projects were almost never linked to previous projects in the same country. He also discovered that military and civilian humanitarian providers rarely shared information: working in close proximity, but instead were largely independent of each other. Regarding the perspective of those who received assistance, respondents told Drifmeyer that there was inadequate U.S. – host nation coordination, host nation representatives were passive not active participants, that there was a great need to evolve to more effective projects, and that current projects had inadequate pre- and post-project assessments.[12,13,14]

Recommendations

Public health does indeed influence both national and regional security, including all aspects of economic, diplomatic, and military stability. Africa is riddled with poor public health, and EUCOM's current health related HCA programs fall short of providing any long-term health benefit to engaged countries. Part of EUCOM's tasking should be to improve Africa's capacity to deal with its own health problems.

Section 401 of Title 10 U.S.C., DOD Directive 2205.2 and DOD Instruction 2205.3 authorize U.S. military forces to conduct such Humanitarian and Civic Assistance (HCA) activities in conjunction with approved military operations. That is to say that HCA programs may not be performed solely or primarily for humanitarian purposes. DODD 2205.2 states that HCA activities must promote the security interests of the United States and the host nation, the specific operational readiness skills of U.S. service members, and the foreign policy interests of the United States.[15] Nowhere does it state that these activities are focused to provide any long-term health benefit to the host nation. Joint Publication 3-07, "Joint Doctrine for Military

Operations Other Than War," states, "This assistance (HCA) is provided in conjunction with military operations and exercises, and must fulfill unit training requirements that incidentally create humanitarian benefits to the local populace."[16] Medical HCA missions are currently designed, planned, and executed according to this guidance. Since the health impact on the host nation has only been incidental to operational training objectives, the intention of the HCA program has never been to build public health capacity in order to create long-term health benefits. Some would stop at this point and conclude that military medicine has no mission to build public health.

DODD 3000.05, "Military Support for Stability, Security, Transition, and Reconstruction (SSTR) Operations", released in November 2005, essentially adds building public health capacity to the list of missions to be accomplished by military medicine. DODD 3000.05 defines stability operations as activities conducted across the spectrum from peace to conflict to establish or maintain order in states and regions and gives them priority comparable to combat operations. It was shown earlier how fundamental health is to achieving security and stability. "The immediate goal (of stability operations) is to provide the local populace with security, restore essential services, and meet humanitarian needs. The long-term goal is to help develop indigenous capacity for security, essential services, a viable market economy, rule of law, democratic institutions, and a robust civil society."[17] Any review of Andrew Price-Smith's empirical research would clearly show that public health must be a primary means by which to achieve the goals of stability operations. Earlier medical HCA activities may have been limited in scope and impact by the statutory requirement to train to U.S. service members' operational or combat readiness, but that is no longer the case with the introduction of DODD 3000.05. If military medicine is to play a role, which it most definitely should, in SSTR operations, then they

must train accordingly. For building public health capacity, no better training ground exists than Africa. Because this DODI is brand new, recommend EUCOM encourage the development of joint doctrine to guide future design, planning, and execution of HCA activities aimed at improving public health.

How to achieve these goals is a more difficult question. The focus must change from short-term, direct patient care to improving public health capacity in Africa through a long-term, focused commitment of resources. The kind of commitment required merits exploring the creation of a Joint Task Force headquarters. Granted, it is a radical departure from the norm, but many have suggested over the years that Africa merits its own geographic combatant command. Short of that, a JTF-Africa might be the lens through which efforts to improve stability and security in Africa are best focused. The JTF's focus would not be split between Europe and Africa, as is necessarily the case in EUCOM. It could develop regional expertise in ways that affect the U.S. security interests in Africa, including health. Whether a JTF is created or not, the following recommendations stand.

The first step is for EUCOM to prioritize its medical HCA efforts. Collaboration with USAID and country teams should identify those African nations in greatest need and with the most substantial existing public health capacity. Focusing first on countries with existing public health capacity will develop regional partners capable of helping developing neighboring countries. Once EUCOM prioritizes selected countries, a strategic plan should be developed for each.

While prioritization includes only U.S. government agencies, plan development should include many more organizations. There are already a number of groups working in Africa on various health related issues. At the present time, no one organization, agency, or authority has

the expertise and resources to make the necessary improvements. Specifically, EUCOM should partner with U.S. government agencies, international organizations, non-governmental organizations, private volunteer organizations, and, most importantly, the host nation. This unprecedented level of coordination and cooperation would reduce duplicative efforts and provide the best results for the host nation in the least amount of time. Host nation officials and providers must be intimately involved to ensure the projects truly meet their needs and are sustainable by their infrastructure.

EUCOM's strategic plan for each country should include the identification of country specific objectives pertaining to health. Consistent with the emerging concept of effects based operations, the objectives must be translated into measurable indicators of effectiveness for both the short- and long-term. Short-term measures might include percentage of the population immunized while long-term measures could include infant mortality and life expectancy. The interagency coordination mentioned previously could play a large part in providing assessment. USAID, country teams, NGOs and PVOs often maintain physical ties to the host nation and, in that regard, would be in a much better position than the military to assess long-term impact. The eventual goal, of course, is for the host nation to conduct its own assessment. Feedback of this type is critical to ensuring objectives are being met. This could alleviate the lack documentation and follow-up associated with current medical HCA activities. Another approach might be to establish habitual relationships between U.S. military medical units and African communities in order to provide desired continuity. Even if the community could not be visited by the unit each year, the unit could maintain contact with community officials in order to foster continued, productive relationships. This would create in those units a base of HCA experience, an understanding of community specific health problems, priorities, and cultural nuances, and

would likely result in significant buy-in to the prospect of improving "their" community's public health.

The strategic plan should emphasize community-based capacity where the majority of the population lives. Specifically, the training and support of village health care workers. Training must be appropriate in the context of their culture, health needs, medical capabilities, and infrastructure. Not doing so might create a standard of medical care that is not sustainable by the host nation. Again, improved coordination and cooperation with NGOs, PVOs, or habitual unit relationships could facilitate this. A few individuals in the community with training equivalent to an Army Medic or Navy Hospital Corpsman, with an appropriate supporting network, could provide sustained positive impact. EUCOM should investigate exporting such a training package to select communities.

In addition to training host nation personnel, U.S. military medical personnel must also receive training. One author argued that the focus of health services expertise should remain on providing combat health care.[18] However, DODD 3000.05 clearly placed SSTR operations on a level comparable to combat operations. Therefore, military medicine must be expected to do their part in stabilizing countries and regions of importance to U.S. national interests. Thus, providers, administrators, and technicians must all be trained and educated on how to build public health capacity as it relates to HCA activities and SSTR operations. One way to train and prepare military medicine professionals for the task might be to develop an internship or fellowship program with USAID or an NGO or PVO. Not only could this serve the need to train military personnel, but it might also alleviate some of the tension that exists between the armed forces and Department of State, NGOs, and PVOs.

Conclusion

Some may argue that some other entity besides the military might be better suited to lead the efforts. However, the U.S. armed forces are particularly well suited because they are highly trained, dedicated, and disciplined. Additionally, military medical units maintain state-of-the-art medical and intelligence collection systems, operate a highly sophisticated system of transport and supply, and are fully equipped to do on-site medical education and training. Of particular importance is the military's ability to plan. No other organization concerned with public health in Africa has such an extensive planning background or mechanism. The introduction of DODD 3000.05 gives EUCOM the authority to conduct activities beyond combat operations that help to establish and maintain security and stability. Thus, training military medical resources for SSTR operations may be as mission related as combat operations. Military medicine's contribution to SSTR operations will undoubtedly revolve around public health.

This paper has presented the findings of empirical research that concludes that inadequate public health capacity to mitigate the destructive nature of infectious disease represents a serious threat to a nation's security. If unchecked, infectious disease can lead to a state's decreased economic capacity, loss of effective governance, and failure. The overwhelming pervasiveness of infectious disease and the dire public health situation in Africa is unquestionable. Disease induced state weakness or failure in Africa creates conditions favorable to those who wish to harm the United States. The resulting security environment is contrary to the one EUCOM is trying to achieve. One author states, "public health is the basic tenet upon which all other forms of security rest."[19] If this is true, and evidence provided in this paper suggests that it is, then it is necessary to address the public health issues in Africa in order to achieve TSC objectives.

Past medical HCA activities did very little to improve public health, primarily because their focus had to be on U.S. military operational readiness training instead of long-term health benefits for the host nation. Continuing in that direction will not achieve TSC objectives. Therefore, change is in order and the recommendations presented in this paper are one viable approach to that end.

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