

MEDICAL DIPLOMACY IN THE UNITED STATES ARMY:
A CONCEPT WHOSE TIME HAS COME

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

MEDICAL DIPLOMACY IN THE UNITED STATES ARMY: A CONCEPT WHOSE TIME HAS COME, by Lieutenant Colonel Mary V. Krueger, 107 pages.

Prior to the attacks of September 11th the United States Military founded defense plans on a threat-based model, with the nation being prepared to conquer adversaries with the most advanced combat power. The 2001 attacks and subsequent Global War on Terrorism have led to a new geopolitical reality, where military planners must increase US combat effectiveness in a new way by denying refuge to the terrorists who wish to defeat US troops, as well as the Western way of life. Medical diplomacy is a nonlethal tool used in combination with economic and diplomatic efforts to achieve this end.

The Army has engaged in activities labeled as medical humanitarian assistance throughout the 20th century with varying degrees of success. The current, continuous, low-level conflict makes a consistent, effective plan for leveraging medical diplomacy, a directed form of humanitarian assistance, of paramount importance. When utilized effectively, medical diplomacy can alleviate suffering, as well as provide stability, through economic development, and legitimacy to the supported government. These actions collectively deny refuge to terrorists. This thesis will define medical diplomacy, review its history in Army medicine, and determine through qualitative analysis the characteristics of effective medical diplomacy. These characteristics will then be used to create a framework with which to evaluate current Army doctrine and lessons learned observations from OIF/OEF in regards to their adherence to sound principles of medical diplomacy.

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TABLE OF CONTENTS

	Page
MASTER OF MILITARY ART AND SCIENCE THESIS APPROVAL PAGE	iii
ABSTRACT.....	iv
ACKNOWLEDGMENTS	v
TABLE OF CONTENTS.....	vii
ACRONYMS.....	ix
ILLUSTRATION.....	xi
TABLES	xii
CHAPTER 1 INTRODUCTION	1
Primary Research Question	2
Assumptions.....	3
Limitations	4
Delimitations and Scope	4
Significance of Study.....	5
Summary	5
CHAPTER 2 LITERATURE REVIEW AND METHODS	6
Definition	6
Military Literature.....	8
US Government Directives	8
Joint Doctrine.....	10
Army Doctrine	12
White Papers and Handbooks	12
Guidelines for Civil-Military Cooperation in Medical Care to Civilians.....	17
Books	19
Journal Articles	21
Research.....	22
Research Methodology	25
Study Design.....	31
CHAPTER 3 BACKGROUND	36

The History of Medical Diplomacy in the US Army.....	36
Does Military Medical Diplomacy in the Form of Humanitarian Aid Really Make A Difference in Host Nation Support and Sentiment?	45
The Role for Medical Diplomacy in the Current Operational Environment	47
CHAPTER 4 Results and Discussion	52
Introduction.....	52
Core Competencies in Medical Diplomacy	53
Evaluation of Military Doctrine Based on Core Competencies	58
Evaluation of Lessons Learned Observations Based on Core Competencies	63
CHAPTER 5 Conclusions and Recommendations	68
Conclusions.....	68
Coordination	69
HN Development	71
Training.....	71
Assessment.....	72
Recommendations:.....	73
Personnel and Organization	73
Doctrine.....	75
Education and Training.....	77
Assessment.....	78
APPENDIX A LESSONS LEARNED OBSERVATIONS	81
APPENDIX B SAMPLE FRAGO FOR CMO.....	85
APPENDIX C: TACTICAL CONFLICT ASSESSMENT FRAMEWORK	87
Steps for TCAF (Derleth and Martin 2007).....	87
Checklist for Programs Designed Using TCAF	87
WORKS CITED	89
INITIAL DISTRIBUTION LIST	95

ACRONYMS

AAR	after action review
AMEDD	army medical department.
AO	area of operations
CA	civil affairs
CCDR	combatant commander
CDR	commander
CME	continuing medical engagements
CMO	civil military operations
CMOC	civil military operations center
COIN	counterinsurgency
DOD	department of defense
DOS	department of state
EBA	effects based approach
FM	field manual
GWOT	global war on terrorism
HA	humanitarian assistance
HCA	humanitarian civic assistance
HN	host nation
HUMRO	humanitarian relief operations
IO	international organization
JP	joint publication
MCMO	medical civil-military operations
MEDCAP	medical civic action program

MEDRETE	medical readiness training exercise
MOH	ministry of health
MOE	measures of effectiveness
MOOTW	military operations other than war
MD	medical diplomacy
NGHO	non-governmental humanitarian organization
OCHA	office for the coordination of humanitarian affairs
OHDACA	overseas humanitarian, disaster and civic aid program
OEF	operation enduring freedom
OIF	operation Iraqi freedom
PEO	peace enforcement operations
PKO	peace keeping operations
PMESII PT	political, military, economic, social, infrastructure, information, physical environment, and threats
PVO	private volunteer organization
ROMO	range of military operations
SASO	security and stability operations.
S/CRS	department of state's office of the coordinator for reconstruction and stabilization
SSTR	stability, sustainment, transition, and reconstruction
UN	United Nations
USAID	United States agency for international development

ILLUSTRATION

	Page
Figure 1. Steps of Qualitative Analysis.....	32

TABLES

	Page
Table 1. Medical Diplomacy Competencies.....	54
Table 2. Medical Diplomacy Competency Frequency of Appearance	56
Table 3. Evaluation of Army Doctrine for Medical Diplomacy Core Competencies	59
Table 4. Evaluation of Joint Doctrine for Medical Diplomacy Core Competencies	60

CHAPTER 1

INTRODUCTION

Medical diplomacy must be made a significantly larger part of our foreign and defense policy, as we clean up from costly and deadly wars in Afghanistan and Iraq. America has the best chance to win the war on terrorism and defeat the terrorists by enhancing our medical and humanitarian assistance to vulnerable countries. By delivering hope we will deliver freedom.

Tommy G. Thompson, 24 October 2005, The Boston Globe (Thompson 2005)

Prior to the attacks of 11 September 2001 the United States military established defense planning on a threat-based model, with the nation being prepared to conquer adversaries, most often in the form of near-peer competitor states . Since the terrorist attacks on the United States, the focus of its defense planning, as expressed in the 2006 Quadrennial Defense Review Report (Rumsfeld 2006), has shifted to a capability-based model, focusing on what capabilities the enemy possesses to fight and defeat the US. Current enemies are more often failed nation states or ideologues who flourish in unstable societies, where disenfranchised populations see the “freedom” fighters as the only way to escape their destitute living conditions. The tactics necessary to defeat this contemporary enemy require Army planners to consider their critical capabilities and vulnerabilities. Former US Secretary of Defense Donald Rumsfeld believed that direct attacks on the enemy would fail, instead arguing that it is necessary to “drain the swamp they live in” to defeat them (Lennon 2003, 6).

One strategy the US government has used to “drain the swamp” is to use medical diplomacy to degrade the critical enemy advantage of living among the people and recruiting susceptible populations to insurgent causes. This nonlethal weapon builds medical capabilities within the host nation (HN) to improve the health of the population,

thus decreasing its vulnerability to terrorist recruiting. This is done in concert with political, diplomatic, and economic efforts, coordinated closely with interagency organizations, to achieve ends that are beneficial to United States and allied interests.

While the US has been involved in humanitarian assistance (HA) for many years, medical diplomacy takes this one step further, by ensuring that all medical efforts are orchestrated with diplomatic and economic efforts in a manner which builds capacity within the HN. This can lend legitimacy to a fledgling or struggling government, while strengthening the relationship between this government and the US. When exercised as a matter of policy, this form of diplomacy can work towards furthering US interests on the global political stage and may have the secondary effect of increasing national security.

There is some question as to how well the emerging concept of medical diplomacy is understood, how well it is translated into Army doctrine, and how that doctrine is subsequently implemented in the field environment. Towards the ends of finding these answers, this thesis seeks to answer the following questions:

Primary Research Question

Does the United States Army's current doctrine translate into effective conduct of medical diplomacy?

Secondary Research Questions

1. What current Army doctrine speaks to activities that could be identified as medical diplomacy and does this translate into the conduct of effective medical diplomacy in the current operational environment?
2. What is medical diplomacy and what are the characteristics of effective medical diplomacy?

3. What is the history of the Army's involvement in activities that could be identified as medical diplomacy and what can be learned from successes and failures in this involvement to inform future operations?

Assumptions

There are certain assumptions that must be addressed to lay the groundwork for the relevance of this work. The first assumption is that the United States will continue to be engaged in the War on Terrorism for the foreseeable future. Secondly, terrorist networks will continue to flourish in areas where poverty, disease, and failed governments exist. The events of the last six and a half years since the attacks of 11 September 2001 support both of these assumptions.

Assumptions must also be made about the continued need for the Army to work collaboratively with interagency, joint, and private organizations to stabilize failed nation states, and assist in the initial stages of reconstruction. While there is much debate about the military's involvement in stability, security, transition, and reconstruction (SSTR) tasks, the reality of the situation is that the Army and sister services will continue to be best situated, staffed and resourced to accomplish these tasks where combat has recently ended or where the security situation is such that other agencies are denied freedom of movement.

In asking the question, "how can the Army execute the medical diplomacy mission" it is assumed that the Army Medical Department (AMEDD) has the ability to correct deficiencies identified in the answer. One argument is that all the providers, nurses, planners, and technicians are already fully engaged in the fight, and do not have time to do the humanitarian piece. However, the counterargument could be that the

AMEDD cannot afford not to staff medical diplomacy adequately. This argument is analogous to a physician saying he does not have time to treat a contaminated well, because he is deluged in his office treating hundreds of cases of diarrhea daily. Being proactive with diplomatic tools may significantly cripple terrorist recruiting efforts, which could adversely affect the terrorists' ability to maintain force strength, rendering them mission-incapable.

Limitations

The topic of medical diplomacy within the Army is very broad and can not fully be addressed within the limited time and number of pages allotted for this thesis, even by the most experienced researcher. As this project is a learning experience, it may also be limited by the experience of the researcher, particularly in the area of military doctrine. This limitation is addressed by additional readings and by the inclusion of an expert on military doctrine on the thesis committee.

Delimitations and Scope

In order to meet page and time constraints, certain delimitations will be placed upon this research to ensure completion. Joint and interagency doctrine will not be addressed, other than in the literature review to provide background. While the operational environment is acknowledged to involve more joint and interagency missions, the doctrine and field performance of medical diplomacy by these groups is beyond the scope of this thesis. Likewise, there are topics relating to the conduct of medical diplomacy that will not be addressed due to space considerations. These include materiel, leadership, organization, personnel, training, and facilities, each of which could

be thesis topics in themselves. Finally, the ethical question of whether or not medical personnel involved in medical diplomacy should still be protected as noncombatants under the Geneva Convention, when they are using nonlethal weapons to combat terrorism is also a topic beyond the scope of this research.

Significance of Study

This study aims to detect variation among the principles of effective medical diplomacy, Army doctrine on the conduct of medical diplomacy, and the implementation of that doctrine in the current conflict. If gaps are found among these areas, corrections in the form of revised doctrine, training, organization, and personnel could be implemented to overcome barriers to effective medical diplomacy.

Summary

Medical diplomacy is one of the most effective weapons of freedom in the US arsenal against those who would attempt to gain power through creating havoc and then co-opting the political will of those who seek a way out of the chaos. When used effectively, it can build capacity, improve the health of the population, and build positive relationships, while building legitimacy of the host-nation government. When executed poorly, it can decrease HN capacity, increase dependency on foreign agencies, and violate cultural norms, causing more harm than good. The following chapters will explore lessons learned by Army medical personnel over the past century, how these have been applied to current doctrine, organization, and training, and how this mission is being carried out on today's battlefield.

CHAPTER 2

LITERATURE REVIEW AND METHODS

Health is a powerful, underutilized common bond for all people, all nations. Health diplomacy can help to bring peace, safety, and security to an unstable world.

- VADM Richard H. Carmona, MD, MPH, 10 November 2004 (Carmona 2006)

The term medical diplomacy is relatively new, though components of this concept have been practiced for many years. As such, there is not an authoritative text on exactly what the concept fully entails, either in the military or civilian arenas. A first task of the literature review will be to clearly define medical diplomacy, based on the best available expert consensus opinion, to establish a common understanding of the term. Books, journal articles, previous academics works on the subject, and related subjects will then be reviewed to explore common themes in medical diplomacy, both on how it should be conducted and in relation to what difficulties are encountered in its execution. This chapter will then outline the method used to transform this information into a tool to analyze Army doctrine as well as lessons learned from the War on Terrorism in relationship to conduct of effective medical diplomacy. This analysis will aid in answering the questions of what principles medical diplomacy should follow in the United States Army and how current US doctrine reflects these principles.

Definition

A first important distinction to make is between health diplomacy, cited by former Surgeon General of the United States, Vice Admiral Richard Carmona, in the opening quote, and medical diplomacy. Health diplomacy is defined as a political change activity

that meets the dual goals of improving global health while maintaining and improving international relations abroad, particularly in conflict areas and resource poor environments (Corbin 2007). It has been described in simpler terms as public health with the political gloves off (Gurel 2007). Health diplomacy encompasses diplomatic efforts to enact international health measures, and overlaps with, but is not the same as, medical diplomacy.

According to Dr. Ogan Gurel, medical diplomacy is a form of international relations in which medical and healthcare assets and resources are used to encourage positive relations between nations and/or exchange specific benefits between nations (Gurel 2007). Major Jay Baker of the US Army describes it as part of a long term strategy to build capacity in local institutions, rather than replacing HN medical services with direct care by US forces (Baker 2007). Former Secretary of Health and Human Services Tommy Thompson described medical diplomacy as, “the winning of hearts and minds of people ... by exporting medical care, expertise, and personnel to help those who need it most.” (Thompson 2005) In another interview Secretary Thompson defined medical diplomacy as, “the knitting of health policy and foreign policy to improve the lives of vulnerable populations while serving the best interests of the United States.” (Still 2007) While the words may differ slightly, the sentiment is the same in that medical assets are used in a deliberate manner to improve health conditions in a region or country to benefit relations between the aided nation and the US government.

The contrast between these two closely related terms is illustrated by Dr. Ogan Gurel in this example from his article “Medical Diplomacy: A Brief Outline” “The World Health Organization (WHO) is an example of health diplomacy while specific U.S.

support of the WHO may be regarded as an expression of U.S. medical diplomacy.”
(Gurel 2007)

Military Literature

US Government Directives

The use of the military to carry out HA is addressed under section 401 of Title 10 United States Code (Health Armed Services Committee 2004). Deployments of this nature are fundamental to maintaining a US forward presence globally, as well as providing training opportunities to ensure readiness of military personnel to perform their mission-essential tasks in austere environments ((U.S. Department of the Army 2003, 5-5). Under Title 10, the Department of State must approve the use of military forces to perform HA in foreign countries for these purposes. Once a geographic combatant commander decides he desires an HA project in his AO, he must submit a request to an interagency policy coordinating panel. HA incurring minimal expenses and being conducted as an integral part of another mission may be considered “de minimus” expenditures which do not require the level of oversight described above. De minimus expenditures are at the discretion of the combatant commander. (U.S. Department of the Army 2003, 5-5).

Department of Defense Directive 3000.05 states that “Stability operations are a core US military mission” and defines stability operations as “military and civilian activities conducted across the spectrum from peace to conflict to establish or maintain order in states and regions.” (U.S. Department of Defense 2005) In the military context, medical diplomacy may be mentioned in the context of SSTR, but it also goes beyond this activity.

The 2007 Quadrennial Defense Review Medical Transformation Roadmap Initiative #3 directs a systematic analysis of DOD /Military Health System (MHS) Capabilities regarding medical civil-military/stability operations. The five major mission responsibilities which must be addressed within this analysis are medical security cooperation, medical military-military capacity building, medical support to disaster response, support to health sector stabilization, and support to health sector reconstruction (Laraby 2008).

National Security Presidential Directive 44 signed by President George W. Bush December 7th, 2005, addresses the management of interagency effort concerning reconstruction and stabilization (National Security Presidential Directive 44: Management of Interagency Efforts Concerning Reconstruction and Stabilization 2005). The purpose of this directive is to coordinate US efforts to achieve maximum effect during reconstruction and stabilization efforts in foreign countries in transition from conflict, or at risk for civil strife. The plan explicitly addresses the harmonization and coordination of military operations with the plans of other US government agencies to ensure unity of effort. The Secretaries of State and Defense are tasked with integrating stabilization and reconstruction plans between their respective agencies.

Coordination between DOD and nongovernmental humanitarian organizations (NGHO) is necessary to synchronize missions between these often co-existent actors, but their differing mandates can lead to conflict. To address this issue, the DOD has written guidelines in cooperation with the United States Institute of Peace and the American Council for Voluntary International Action to set guidelines for the relations between US Armed Forces and NGHOs (United States Institutes of Peace 2007). These guidelines are

non-binding, and recommend actions to make clear distinctions between military and NGHOs, to avoid any appearance of military allegiances by NGHOs, and to establish liaisons between NGHOs and the military to deconflict operations and improve communications. This distinction between liaison and allegiance is vital to the NGHOs interests, particularly during manmade or natural disasters. As humanitarians, NGHOs follow the principles of neutrality, humanity, and impartiality. They are concerned that perceived or real relationships between their organization and the military would damage their credibility as humanitarians, and could damage their future ability to access the most vulnerable populations with aid. The guideline document outlines these issues and emphasizes the importance of NGHOs independence from any governmental foreign policy.

Joint Doctrine

Both civilian and military publications on medical diplomacy stress the importance of inclusive planning, both within the military services, between coalition partners, as well as among civilian and military organizations. Joint Publication 3-07.6 describes the civil-military operations center (CMOC) as the mechanism to “coordinate and facilitate US and multinational forces’ humanitarian operations with those of international and local relief agencies, HN agencies, and HN authorities. (U.S. Joint Chiefs of Staff 2001, III-2), The various groups involved may changed based on involvement within the theater but may include NGHOs, international organizations (IO), United Nations (UN), HN government, HN military, coalition military, Department of State (DOS), and United States military. The role of the CMOC is to facilitate the integration of military and political actions in humanitarian operations between all participants in theater. Whenever

possible, international organizations and NGOs should be invited to participate in meetings of the CMOC. This will provide ample opportunity for their actions to be integrated with both military and HN plans (U.S. Joint Chiefs of Staff 2001, III-3).

Both the Navy and the Air Force have developed programs dealing with humanitarian relief operations distinctive from those conducted through the Army. The Air Force has an International Health Specialist (IHS) Program, described in Air Forces Instruction 44-162, which aims to develop, a cadre of qualified medical personnel who possess secondary language expertise and regional knowledge. These skills will allow these providers to effectively liaison with international military and nonmilitary medical leadership and advise the regional commanders on medical issues (U.S. Air Force 2002). Beyond the IHS program, the Air Force has developed an Operational Capabilities Package for OCONUS Humanitarian Relief Operations. This package accounts for transitional requirements such as training HN personnel in facility/equipment maintenance and repair, as well as supplies which must be left in place, and subsequent visits in the period immediately following transition (U.S. Air Force 2006).

The Navy has the unique ability to conduct operations at sea with the Mercy and the Comfort. Their missions to Latin America and the Caribbean demonstrate America's commitment to the well being of citizens in the Western hemisphere, providing both direct care, as well as establishing training partnerships with local medical personnel in order to build HN capacity. These ships also serve as a model for interagency medical outreach, with a mission by the US Naval Ship Comfort in 2007 carrying personnel from not only the Navy but also Army, US Public Health Service, US Health and Human Services, as well as the private volunteer organization, Operation Smile (Huges 2007)

Army Doctrine

Army FM 3-07 recognizes the importance of ensuring medical care as a basic human need in the execution of stability operations. This support of the population, when delivered in concert with security measures such as police presence and patrols, can be decisive in achieving victory in an area following natural or manmade disaster. It can also lay the groundwork for successful return of interagency personnel who can then proceed with reconstruction (U.S. Department of the Army 2003, 1-14).

White Papers and Handbooks

A powerful use of medical diplomacy is building capacity in a healthcare system to assist in stability operations. Stability Operations is the term which covers the previously used terms military operations other than war, which is no longer doctrinal, as well as stability and support operations, which never was doctrinal, but was used colloquially. Stability operations are “various military missions, task, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief.” (U.S. Department of the Army 2008, 3-68). This may include actions focused on deterring war, supporting HN government, resolving conflict, or promoting peace in response to domestic crises. These operations are performed as part of full spectrum operations and may occur in concert with offensive or defensive operations.

The purpose of stability operations for the US military is to create conditions, as part of full spectrum operations, where other instruments of national power can subsequently take the lead in reconstruction and ultimately transition back to the HN

government (U.S. Department of the Army 2008, 3-82). It is part of SSTR operations. The military achieves this success in this area through accomplishing the stability tasks which will create conditions favorable for other instruments of national power, such as the Department of State (DOS) and its various agencies, to be able to take over. The stability tasks that relate to medical diplomacy include meeting the critical needs of the populace, gaining support for the HN government, and shaping the environment for interagency and HN success. Medical diplomacy focuses on delivering essential medical services in the context of sustainable improvements explicitly intended to stabilize the target region or nation. Other essential services that must be considered in concert with medical activities are described in the acronym SWET-MS, which stands for sanitation, water, electricity, transportation, medical and schools. Stability operations can help restore faltering HN governments, thus encouraging committed partners in our global society. Examples of these operations include Operations Provide Comfort and Restore Democracy.

In the case of Operation Provide Comfort, the US military and its allies defended Kurds fleeing their homes in northern Iraq due to hostilities and delivered humanitarian aid, providing stability in an otherwise chaotic situation (Global Security 2005). This operation included the building of shelters and distribution of supplies to ensure order and provide security throughout this area. Operation Restore Democracy involved support for the legitimacy of a democratic government in Haiti through the creation of a safe and secure environment to permit the return of exiled President Jean-Bertrand Aristide. Capacity building of HN security forces began immediately to aid stability and set the stage for withdrawal of US troops. Under the direction of former New York City

Police Commissioner Raymond Kelly, international police monitors began training Haitian police only two weeks after US troops had arrived. This contributed to the success of this mission, with US troops drawing down from 21,000 to 6,000 in less than three months (Global Security 1996).

The success of both of these missions show that citizens in a community become more invested in maintaining order within their communities when their basic needs are met, and when they believe that their government can provide for their vital needs. This is similar to the theory of fixing broken windows by some metropolitan police departments: Through the correction of smaller deficiencies, the security force can improve the appearance of a neighborhood and subsequently the people who live there will be more likely to police their own streets, not tolerating forces that may threaten the sense of harmony within the community.

Support operations will not be discussed extensively in relation to medical diplomacy, since the current use of the term “support operations” refers to DOD support to US civil authorities, including designated law enforcement agencies, for domestic emergencies and other activities. As medical diplomacy describes activities designed to enhance relationships the US has with global partners, the concept is not relevant when discussing activities within the US or its territories.

Medical diplomacy is never directly mentioned in the Army field manual on counterinsurgency (COIN), but the concepts used to win this fight are key to understanding and maximizing use of the tools of medical diplomacy. COIN is “military, paramilitary, political, economic, psychological, and civic actions taken by a government to defeat insurgency” (U.S. Department of the Army 2006, 1-2). Many of the enemies the

US military faces today are insurgents, so it must be adept at using the most effective methods to counter them. There are several key factors necessary for success in COIN that FM 3-24 highlights. The first is that people must take charge of their own affairs and willingly consent to rule by a government in order for that government to be considered legitimate. This requires that the government eliminate causes of the insurgency, which may include hunger, insecurity, government corruption, and inadequate infrastructure. To assist a HN government in providing these services, the military force must be skilled in application of national power in the fields of policy, law, education, economics, and medicine (U.S. Department of the Army 2006, 1-4).

Secondly, military forces fighting an insurgency must be part of a learning organization. General Peter J. Schoomaker, Chief of Staff of the Army, said about COIN, “This is a game of wits and will. You’ve got to be learning and adapting constantly to survive.” (U.S. Department of the Army 2006, ix) Conventional forces will often try to use their military superiority to fight insurgencies, especially in the early months of a conflict, and inevitably fail. Those military forces that defeat insurgencies learn how to practice COIN, challenge assumptions, coordinate closely with governmental and nongovernmental partners, learn about the culture in which they are fighting, study their opponent, and adapt to overcome. They know that armed forces alone can not succeed in COIN. These principles also apply to the successful conduct of medical diplomacy.

The AMEDD Civil Military Operations (CMO) workbook describes CMO as “those types of military operations that are done by the military, with or without civilian agencies, that are for the benefit of the civilian population and/or infrastructure, and may or may not also benefit the military.” (U.S. Army Medical Department 2007) The

purposes described for CMO fit well with those described for medical diplomacy and include minimizing civilian interference with military operations, mitigating the effects of military operations, gaining the moral and material support of the HN populace for the HN government and the US military, and returning services to their pre-existing standard. This last purpose is particularly important, as it emphasizes that the US military is not to create a new, higher standard of living, but rather is to ensure that basic needs are met. Providers and planners must have clear rules of engagement and rules of disengagement to prevent mission creep in this area. More harm than good can result if US forces bring a higher standard of care to an area which can not be maintained by local providers. The end result can be a loss of honor, particularly important in Eastern countries, for local providers and a feeling of resentment by local populations who believe that the US had committed to provision of a new, higher standard of care. Both of these potential side effects also show the importance of understanding the local culture and meanings of various actions and agreements among people in that culture.

The CMO workbook also provides guidance for project consideration that could also be applied to medical diplomacy planning (U.S. Army Medical Department 2007). These basic conditions for provision of services are: local civilian resources will not be able to meet the needs in a timely manner, the need is beyond that which can be filled by civilian agencies, engagement in CMO (medical diplomacy) does not jeopardize the military mission, and the US military forces will be able to disengage in a timely manner if they are needed elsewhere to accomplish the commander's mission. These conditions are predicated on the assumption that the CMO is not the primary mission. In the case of stabilizing a region which has not yet experienced armed conflict, a medical diplomacy

mission, in conjunction with engineering, law enforcement, education, and other essential service support, could be the main effort of an operation intended to squelch insurgent activity.

US Joint Forces Command places medical diplomacy under the category of medical stability operations, the health support aspects of stability operations ((U.S. Joint Forces Command 2007, 3). In their white paper, “Emerging Challenges in Medical Stability Operations,” they identify the key tasks for the joint military medical force as health sector assessment, recognizing the health and security relationship and catalyzing culturally appropriate health sector capacity growth, consistent with the commander’s mission objectives. (U.S. Joint Forces Command 2007, 5) They recommend the following steps for effective planning of operations to accomplish these tasks: preserve existing infrastructure whenever possible, restore essential health services as a priority, fulfill ethical, legal and moral responsibilities, and start with the intent to transition all services to HN at the earliest opportunity. This last recommendation is consistent with the often heard military admonition to always plan with the end in mind.

Guidelines for Civil-Military Cooperation in Medical Care to Civilians

Medical diplomacy encompasses disaster relief activities conducted in partner nations, and often in cooperation with other civilian and military agencies. Recognizing the need for procedures to guide the coordination of military and civil defense assets, a group of over 180 delegates from 45 States and 25 organizations met in 1992, in Oslo, Norway to develop guidelines for disaster relief activities. The result was the production of The Guidelines on the Use of Military and Civil Defense Assets in Disaster Relief, also known as the "Oslo Guidelines." (Oslo Guidelines 2007, 1) These guidelines

established a framework to formalize and improve both efficiency and effectiveness in the collaborative use of military and civil defense assets employed in disaster relief operations. These guidelines were revised in 2007, reflecting the lessons learned from the prior fourteen years, as well as the changing geopolitical environment within which disasters occurred.

A key to effective civil-military cooperation lies in understanding the underlying precepts and motivations of each party. International humanitarian law outlines the principles followed by the UN Office of Civil Humanitarian Assistance (OCHA). It states that human suffering must be addressed, wherever it is found, with assistance being given in a neutral manner. It further outlines that relief efforts must be guided solely by needs, with priority being given to the most urgent cases, and that groups must not be favored or disfavored due to political affiliation. (Reiterer, International Civil Military Relations from a humanitarian perspective 2008) However, the very principle of medical diplomacy says that aid will be provided in a manner that benefits the interests of the US. The military does not stand alone in this conundrum, since NGHOs provide services based on their charter and the belief systems of those who provide their funding. Accomplishing the goal of bringing together these disparate organizations for a common goal is no small task, and this problem must be addressed in any Army or joint doctrine.

Another primary concern raised by those representing the UN was the importance of determining when military assistance was needed in humanitarian relief. While some felt it should only be used as a last resort, others questioned what defined a last resort and why conditions would have to deteriorate to a certain level before military assistance could be provided. There was general agreement that the military's logistical and security

capabilities were unmatched in the civilian sector. This last resort pretense runs counter to the idea of using medical diplomacy to stabilize an area in the hopes of preventing armed conflict.

The final issue, and perhaps one of the most heatedly debated, was the importance of having clear separation between civilian and military personnel to safeguard the protection of civilians. There was agreement that this was paramount during combat operations, but less clarity that it was necessary during times of transition, as have been seen recently in Afghanistan and Iraq (Reiterer, Humanitarian Coordination and Mission Integration 2008). The nongovernmental organizations felt this distinction was important in all phases, and were concerned that they were being lumped into the “Westerners” bracket, and subsequently being targeted by militant insurgent groups. There was generalized acceptance that military troops were sometimes needed to set the conditions for reconstruction, but less enthusiasm about the idea of them directly participating in the rebuilding effort, because of the identity confusion issue.

Books

As in the case of military doctrine, there are also no textbooks which have medical diplomacy listed in the title, or even as a key word in the description. There are however several well written books that address the conduct of medical operations in a military context, with one comprehensive text dating back to the Vietnam War. The fact that this concept has been present for that long is notable in that the US Army is still contemplating the best application of this tool. That leads one to believe that there must be significant barriers to the implementation of successful medical diplomacy that must be addressed in any contemporary doctrine and operations.

Robert J. Wilensky in his book, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, discusses medical operations in Vietnam, pointing out the success of those based on long-term, capacity building strategies, and the futility of those based on “tailgate medicine,” handing out medication as quickly as possible with no follow up (Wilensky 2004, 24). He describes operations, such as the advisor program, that were designed on the sound principle of capacity building, only to be abandoned when combat operations became the primary focus, drawing resources and attention away from the original concepts. This history should serve as a warning to military planners today, as awareness of these past shortcomings could be used to help construct future plans to avoid the same fate.

Emphasis has also been placed on the importance of military personnel understanding their roles in peace operations and humanitarian assistance and working successfully with nongovernmental organizations. In his book *US Military/NGHO Relationship in Humanitarian Interventions*, Chris Seiple studied four humanitarian missions conducted between 1991 and 1994 to formulate generalizations about what factors contribute to mission success (Siepel 1996, 3). The most important lesson he learned was the importance of recognizing that all humanitarian operations are political, and that it is the handling of this political dimension at the highest levels that will determine the success or failure of the NGO/military relationship. (Siepel 1996, 167). Other important lessons were the importance of starting relationships early, ideally before a crisis, as well as the importance of including the UN in the process.

Journal Articles

The US Army's current involvement in the War on Terrorism has led to renewed interest in medical diplomacy, both within the AMEDD and in the combat arms branches. Students of COIN doctrine realize that to legitimize the Iraqi government, the US military must help to build capacity in local institutions. The Iraqi Study Group reported that, "building the capacity of the Iraqi government should be at the heart of US reconstruction efforts. Major Jay Baker made a strong case for medical diplomacy based on historical research and his experiences as regimental surgeon with the 3rd Armored Cavalry Regiment in Tal Afar Iraq. Major Baker described the principles of successful civil military operations (CMO) as secure, engage, and build: securing the AO, engaging with local medical leaders, and building medical capacity in the AO (Baker 2007, 72). This approach will support legitimacy of the Iraqi government, eventually leaving them with the tools to continue caring for their own, while achieving America's strategic objectives in the region.

In his article in *Military Medicine* from October of 2006, Rear Admiral William Vanderwagen of the US Public Health Service raises questions about what the requirements are to develop true health diplomacy capabilities (Vanderwagen 2006, s3). He emphasizes the importance of overcoming differences and partnering with NGHOs as a force multiplier. This emphasis on pulling assets together for the good of mission accomplishment as opposed to just pushing assets out to meet the acute need is a key tenet of strong recovery. Training and support are also essential capabilities for mission success in the arena of sustainable improvement through medical diplomacy.

Former Secretary for the Department of Health and Human Services Tommy Thompson pointed to several successful projects completed during his term of office as evidence that medical diplomacy is both effective and efficient (Inglehart 2004). He first recounts the story of an AIDS widower in Africa whom he had the chance to meet. This man's wife had died from AIDS, and he himself was infected with the virus. He and his seven children were living in desperate conditions, with his health deteriorating. He received an antiretroviral drug to treat his HIV infection from an agency supported by US funding. His health had improved enough that he could return to his carpentry job and support his family. He told Secretary Thompson, "Please thank President George Bush and the American people for giving me the opportunity to live" (Inglehart 2004). Mr. Thompson went on to make a case for the cost effectiveness of medical diplomacy, comparing the five million dollars spent refurbishing the Rabia Balkhi hospital in Kabul Afghanistan with the eight billion dollars spent on the Comanche helicopter program, before it was subsequently abandoned. "Women and children are now receiving quality healthcare in a nation that once saw nearly one in five children die at birth", Mr. Thompson pointed out. Those patients being born and treated today in the Rabia Balkhi hospital today may be leading Afghanistan tomorrow, having been positively influenced by United States medical diplomacy.

Research

The topic of military medicine as an instrument of power and foreign policy was reviewed by several authors at the Army War College in the 1980s, again bringing to light that while this idea is not new, the Army has yet to integrate into doctrine. Colonel John F. Taylor, Medical Corps and Lieutenant Colonel Jerry Fields, Medical Service

Corps, theorized in 1984 that US foreign assistance programs were a powerful policy tool, and that medical care was an important part of these programs. They discussed the importance of medical administration; training and infrastructure development for the US Army was to have a lasting, positive impact on developing nations in a manner favorable to US interests (Taylor and Fields 1984, 15). They identified the challenges of measuring efficacy, competition for financial and personnel resources with primary combat missions, and emphasis by field commanders on short range projects (Taylor and Fields 1984, 18).

In 1989 Colonel Robert Claypool addressed the issue of military medicine as an instrument of national power. His premise was that, while military physicians had served admirably in providing humanitarian assistance to foreign governments, there was significant variability in the efficacy of the missions. He emphasized the importance of delivering aid that was needed and requested by the HN rather than wasting time, and possibly creating unintended, negative consequences on “showcase” ventures, undertaken on the whim of US forces in the area. Colonel Claypool discussed negative consequences in the latter case, which may include competing with local providers who may feel slighted by US military presence, lack of sincerity shown by a one-time visit, sense of abandonment and lack of follow-up from a visit performed in isolation, and lack of health improvement from such episodic care (Claypool 1989, 31). Missions he classified as successful were those involving training with HN medical personnel, as they establish professional-professional bonds which enhance goodwill among the involved parties. The HN professionals remain in their countries, ensuring that the expertise gained has lasting benefits for the population of interest and US forces gain experience and training in

working with partner nations. Colonel Claypool's primary recommendation for improving military medical diplomacy included involved training in this area to ensure that professionals are well versed both in the medical duties required and the diplomatic, cultural and statesman roles. He also advocated resourcing and prioritization of these missions. While finances do not seem to be the primary limiting factor in current operations, dedicated forces for these missions is a significant factor, as the US Army's five year involvement in the War on Terrorism, and the resultant deployments have placed a significant strain on available personnel throughout the AMEDD.

In 1991 Lieutenant Colonel Robert J. Poux again asked the question whether military medical should be used as an instrument of military medical power. He concluded with a resounding "yes," citing the positives of being able to train US medical personnel in austere environments, in disease processes that they would be unlikely to see on US soil, but for which they may need to treat US soldiers during deployment; projecting power, presence, and influence throughout the world; and allowing US service members to experience job satisfaction in helping HN civilians (Poux 1991). A recent study of 410 US Military physicians confirms that participation in humanitarian missions is an incentive for both recruitment and retention for many personnel. In this sample 48% of respondents indicated that they considered the opportunity to provide humanitarian service as a factor when deciding to join the military and 62% indicated that the ability to serve on humanitarian missions positively influenced their decision to stay. It is important to note this positive sentiment was not universal, with 25% of respondents citing humanitarian missions as disincentive to remain in uniform (Drifmeyer, Llewellyn and Tarantino 2004).

The question of how the US Army could most effectively provide humanitarian aid in cooperation with NGHOs was addressed by Major Mark Dole in his 2003 thesis, “Military Interaction with Nongovernmental Organizations: A Comparison of Medical Logistics.” He highlighted the CMOC as the center for coordination within a joint task force, and suggested that training and leader development programs should be implemented to maximize effective use of the CMOC at all levels. Additionally, Major Dole’s work found that while NGHOs and the military have differing cultures, they can and should collaborate towards common humanitarian goals (Dole 2003, 54). He also concluded that all planning should be done early and cooperatively, rather than trying to mesh plans that had been developed earlier in isolation. Major Dole’s final conclusion was that the actual medical work should be left to the NGOs, while the military should capitalize on its strengths of transportation, security, and movement control (Dole 2003, 57).

Research Methodology

Medical diplomacy may be employed in a region that is considered to be at risk for instability as a preventive measure. This may be the most effective application of medical diplomacy, providing the aid before widespread instability or public health disaster occurs, thus showing the population that the existing government is able to meet its needs. This may occur initially through coalition efforts, but the goal is to transfer control and maintenance to the host government as soon as possible. This legitimacy denies refuge to terrorists who prey upon a population discontent with living and governance situations.

Having developed a sound understanding of what medical diplomacy is, attention next turns to related terms which have been used over the years to describe similar activities. It is imperative to clearly understand these previously used terms, not only for use in historical literature searches, but also to compare and contrast how they agree with or differ from the new term under consideration. Some of these terms are no longer doctrinal, but will be mentioned for historic reference. Others never were doctrinal, but were used colloquially in the literature, and will be defined for completeness, but also to correct their prior misuse. The reader should understand why certain terms have fallen out of favor so that he can adequately critique and choose future terms which avoid these pitfalls. It is only through this critical analysis that the reader can determine whether a new term adequately describes the desired concept in the field of study. Precision in using these terms is essential to ensure clear communication in planning and coordination.

A discussion of terms historically used to describe activities consistent with medical diplomacy is integral in understanding the context from which the current concept of medical diplomacy arose. The background terms discussed will include HA, stability operations, medical civic action program (MEDCAP), CMO, medical readiness training exercise (MEDRETE), and SSTR. Some of these terms have fallen out of current usage, but are included for historical reference. These terms are by no means exclusive to medical activities, nor do they represent an exhaustive list of possible terms on this topic. They do however provide a sound foundation for the discussing concepts covered in this thesis.

Humanitarian Assistance (HA) programs, whether in the context of military or civilian operations, are intended to relieve or reduce the results of natural or manmade disasters or other endemic conditions. The United States military is well equipped to provide HA because of its ability to respond rapidly to emergencies or disasters and to operate under austere conditions. Examples of HA include provision of food, water, shelter, or emergency medical aid. HA may be part of medical diplomacy, but when provided by US forces, it is generally limited in scope and duration. It differs from medical diplomacy in that its main focus is relief of human suffering. Also in its general form, HA does not imply a diplomatic component. It is similar to medical diplomacy in that it is intended to complement, not replace relief efforts of the HN. This term is still in use, but is an umbrella term, and does not describe the political purpose of medical activities thus employed.

The Medical Civic Action Program (MEDCAP) was created in 1962 during operations preceding the Vietnam War (Neel 1991, 162). Its use in the Vietnam War is detailed below. The intent of the program was to provide outpatient care to medically underserved areas of rural Vietnam through partnering with HN medical officials. With the outbreak of the war, however, many of the gains were lost and the concept of the MEDCAP was abandoned. It was not until the early to mid-1980s that the military and DOD revisited the MEDCAP concept.

MEDCAP funding is through the humanitarian civic assistance program (HCA). This program is authorized by title 10, section 401 of the United States code (Health Armed Services Committee 2004).According to this code, the goals of HCA are to promote the security of both the HN and the United States, while also enhancing the

readiness skills of US Army medics. While the security goal is consistent with the goals of medical diplomacy, the training goal is left over from a time where medics were not frequently deployed to a field environment as part of their routine duties and therefore needed training in delivering medical care in austere environments. As the US Army enters its seventh year of combat in the War on Terror, Army medics are exposed to medical practice in austere environments in their daily experiences, so no longer require as much focus on simulating these situations.

MEDCAPs have frequently been transformed into US-led and US-implemented medical missions to serve the purpose of the unit commander. Many times they represent a rapid response to offensive operations to “make up” for incursions into local communities, or are used as means to win over the local populace in the hopes of gaining information about the enemy. Pressure is placed on medical personnel to see as many patients as possible instead of focusing on the quality of care delivered. Often there is no assessment of the medical need within the target community. This leads to treating “healthy” people, many of whom come to the event out of curiosity or in an attempt to get free medication.

When used in this fashion, MEDCAPs can potentially be more harmful than beneficial. Local nationals typically hold high expectations of American providers. They may expect miracles for incurable diseases, such as blindness, deafness, brain damage, or terminal illness. Anger and dissent may occur when these expectations are not met. Furthermore, rendering care for diseases at a standard that is higher than HN’s capability can undermine the legitimacy of the HN’s health care system. Other issues that have been raised with US-led MEDCAPs include the ethics of medics practicing outside their scope

of practice, not addressing the underlying causes of disease (providing “band-aid medicine”), unfamiliarity with endemic diseases, inadequate continuity of care or follow up, and limited planning and coordination. For these reasons, MEDCAPs may have unintended consequences that are in direct opposition to the desired effects of medical diplomacy.

Medical readiness training exercises (MEDRETES) are exercises conducted by military medical units in a field environment, where personnel conduct medical evaluation, treatment, and health education for persons who are not health care beneficiaries of the US government. The primary mission of these exercises is to train US military personnel how to function in an austere field environment. Because care of the HN population is a byproduct, not the main goal, of these exercises, planning often does not taken into account continuity or follow-up care of the patients encountered. The war on terrorism over the last seven years has provided ample opportunities for Army nurses, physicians, and medics to gain real-world experience practicing medical procedures in the deployed environment, decreasing the need for these types of exercises. The lack of focus on unintended secondary and tertiary unintended consequences makes these exercises an unlikely part of effective medical diplomacy unless they are planned as individual, linked events within the framework of a long-term, integrated operation.

Civil military operations (CMO) encompass five main areas, of which HA is one. Lessons learned from CMO must be considered in any discussion on medical diplomacy, since seamless civil military communications lay the foundation for successful operations. In the setting of CMO, medical HA can aid in minimizing civilian assistance with military operations, as well as reducing the negative impact of military operations by

bringing a positive face to the US presence. This, in turn, may help US troops obtain civilian cooperation and support for both military operations, and the supported government. These are principles that CMO shares with medical diplomacy.

The most recent term encompassing the concepts mentioned above, and addressing the previously mentioned shortcomings in an acceptable manner for joint communications is stability, security, transition, and reconstruction (SSTR). SSTR goes beyond actions of the military, being recognized in the 2006 Quadrennial Defense Review Report (Rumsfeld 2006) as a government-wide mission, encompassing DOD and DOS capabilities. Reflecting a change in defense strategy, the same report identified support to SSTR as a core US military mission for the first time in history. These operations cover a wide range of activities from those required to stabilize a tenuous government or situation, to establishing security in a region where an organized justice system is lacking or inoperable, to the initial stages of rebuilding in the wake of natural or manmade disaster, to transition to the appropriate authorities to sustain the gains that US or coalition forces have made.

Cooperative medical engagement (CME) is the most recent term being used to describe current medical activities with HN populations in Iraq (Pflipsen 2008). CME is the closest in definition to medical diplomacy of any of the terms previously described. This term emphasizes the collaborative and cooperative nature of medical activities, as well as the military “engagement” aspect the CME plays as part of the combatant commander’s tactical and operational plans. In these events, American medics and physicians work side by side with Iraqi doctors, presenting a unified front to the local population (Harrison 2007).

Study Design

This study began with a review of the literature on medical diplomacy to form a common baseline for the reader. Upon discovery that the term medical diplomacy was relatively new, and did not have historical literature to back-up its use, a retrospective review was undertaken, with focused attention upon historical Army engagement in activities consistent with the current concept of medical diplomacy. This historical review encompassed the time period from the civil war, until 10 September 2001. Historical accounts were reviewed for examples of successful as well as failed missions to determine criteria for the conduct of effective medical diplomacy. Data from review of these missions were included in the qualitative analysis described in the next section. A summary of the historical review is covered in the background, chapter three.

The next step was a qualitative analysis of various forms of narrative data, to include journal articles, white papers, theses, web blogs, manuscripts, and point papers on health and medical diplomacy. The steps of qualitative data analysis and interpretation were performed following the technique outlined by Taylor-Powell and Renner (Taylor-Powell and Renner 2003), and are shown in figure 1. This technique is used to bring order and understanding to qualitative data, which can often be more challenging to interpret with the same scientific rigor routinely applied to numerical data.

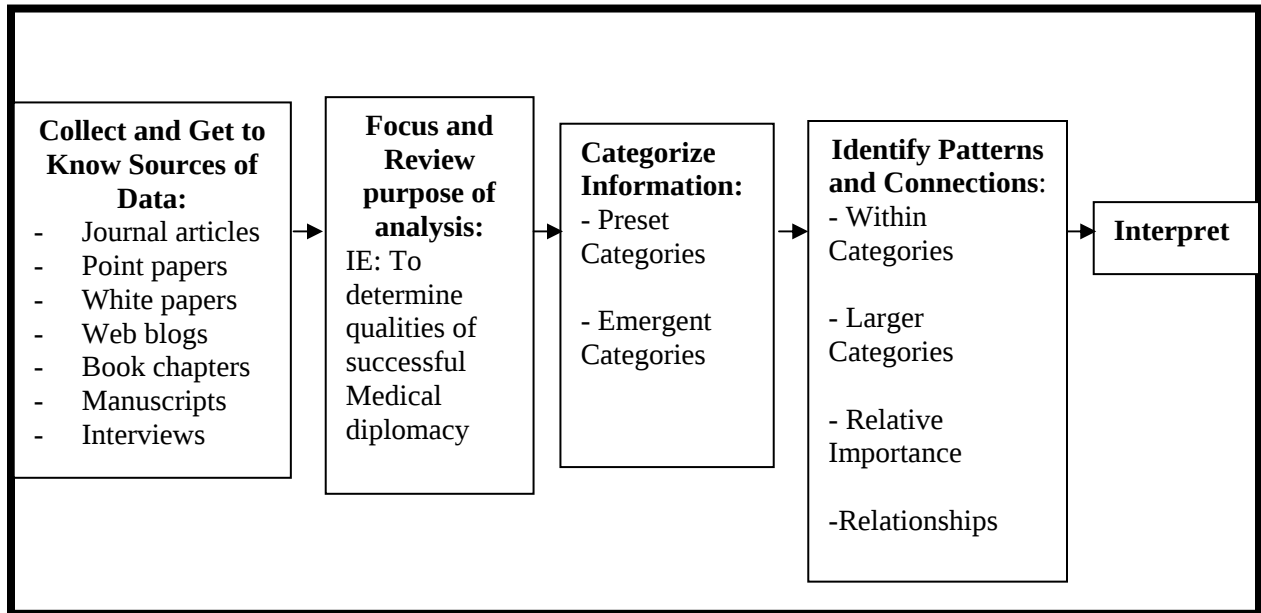


Figure 1. Steps of Qualitative Analysis

Source: Figure created by author. Information compiled from Taylor-Powell, 2003

The process began with collection of qualitative data from the sources listed above. Narrative analysis stresses that the researcher must know the data well, so all sources were then reviewed for content, quality, and to gain an understanding of the topic of medical diplomacy.

Primary and secondary research questions were reviewed and refined based upon an enhanced understanding of the topic following initial source review. The analysis was focused by seeking patterns and themes to answer the research question, “What are the qualities of successful medical diplomacy?” Answers to this question were further categorized by the author of the respective source, i.e. Army, other US military services, interagency, nongovernmental organization, and academic, to determine if there was variation in what qualities were determined to be most important.

The data were then coded to identify themes and organize it into coherent categories. This step involved rereading the texts to code the information and identify the frequency and assigned importance of identified themes. Preset categories of needs assessment, inclusiveness in planning, cultural competency, capacity building, sustainability, and transfer of control were used initially, based on topics that were consistent across the sources during initial literature review. Additional categories that became apparent during subsequent review were need for post-intervention assessment, integrative training, and delivery of services at the appropriate level.

Coded data were reviewed to identify patterns and themes. This review allowed for assessment of the relative importance of various themes, as well as subtle variations among those which had appeared homogenous at first. Data within categories were further subdivided based on the background of the author to determine the impact of personal experience and professional background on the opinions expressed. Relative importance of the principles was determined by the number of sources containing that theme, as well as the number of times the theme appeared within the individual sources.

Key points were interpreted on the basis of how they contributed to answering the initial question, “What are the qualities of successful medical diplomacy?” Those principles which scored a high relevance and answered this question were used to create a tool for scoring current Army doctrine documents on medical diplomacy and related topics, as well as for scoring lessons learned from the War on Terrorism from 12 September 2001 through 31 December 2007.

These scoring tools were applied to each Army doctrine document and War on Terrorism lesson learned to be evaluated. Documents were scored with a plus (+), null

(0), or minus (-) based on whether they supported the key quality, did not mention the key quality, or described actions that were in direct conflict with the key quality.

B. Data gathering tools

Data were gathered on an excel spread sheet, using the core competencies listed on table 1, page 63. Each article was scored, with number of occurrences of a theme being noted, as well as specific references on how the issue was to be addressed in successful execution of medical diplomacy. Emerging themes not covered by preset categories were noted in a separate section for subsequent consideration, and addition to the main category list if this theme was noted in additional sources.

Once the data were interpreted and the key qualities of successful medical diplomacy determined, these qualities were listed vertically on a scoring sheet, with one sheet utilized for review of each doctrinal source or lessons learned source. Horizontal columns, headed with plus (+), null (0), and minus (-), had space to score the documents on these categories and record specific examples to support the scoring.

C. Source Selection

A literature search was performed using the terms humanitarian assistance, medical diplomacy, health diplomacy, military medicine, military humanitarian relief, MEDCAP, CME, MEDRETE, HUMRO, complex humanitarian emergencies, health diplomacy, humanitarian medicine, medical humanitarian relief, military nongovernmental medical, Army medicine, Navy medicine, Air Force medicine, USAID medicine, and irregular warfare medicine. The abstracts of the articles retrieved were

reviewed for applicability to the topic, and articles relevant to the topic were retained for review.

Army doctrine on the topic was searched by search the Combined Arms Research Library (CARL) databases. Doctrine containing sections on SSTR, COIN, stability operations, and civil-military operations were reviewed. In cases where there was more than one publication on these topics, the most relevant was chosen through consultations with subject matter experts in Joint and Multinational Doctrine Division.

Lessons learned from the War on Terrorism were obtained by searching the Center for Army Lessons Learned (CALL), AMEDD lessons learned section. The abstracts of all applicable lessons learned from the War on Terrorism were included in the analysis. It must be acknowledged that this represents all lessons learned submitted to CALL, but that there are surely more missions that had been conducted for which lessons learned were not submitted.

CHAPTER 3

BACKGROUND

Full Spectrum Operations are the continuation of combat operations by other means.

LTG Peter Chiarelli, August 2005 (Chiarelli and Michaelis 2005)

Though the Honorable Tommy Thompson coined the term medical diplomacy while serving as Secretary of Health and Human Services from 2001 - 2005, the concept of utilizing medical resources to exert influence as part of military and diplomatic activities is by no means new (Thompson 2005). This chapter will begin by reviewing terminology the Army has used to describe operations consistent with medical diplomacy, as defined in chapter two. Further discussion on medical diplomacy will cover the history of this activity as the Army has used it from the time of the Civil War through 10 September 2001, highlighting areas of success and failure in these experiences. This review will give the reader background on the breadth and scope of US Army involvement in these activities. Discussion will then focus on the place of medical diplomacy in the current operating environment, making a case for why its use fits so well in the COIN environment.

The History of Medical Diplomacy in the US Army

The Army has been using medicine as a tool for “winning hearts and minds” for as long as it has been fighting wars. As early as the mid 1800s, the US Army established the Freedmen’s Bureau to address the plight of freed slaves during the Civil War. This

organization, established on 3 March 1865, was led by Union General Oliver O. Howard to deliver services for blacks that their masters had previously supplied. It functioned alongside the Army as a health and welfare provider, offering medical aid, food, legal assistance, and labor opportunities. This early bureau exemplified the sound principle of capacity building by focusing on both short- and long-term needs. It provided for the immediate needs of food and shelter, while also addressing education of the freed slaves so that they could join the workforce in a wide range of jobs. Through this bureau the first medical schools for African Americans were established (Span 2002, The Marshall Plan 2003).

Public health measures played a significant role in the pacification campaign in the Philippines Insurrection from 1892–1901. Though much has been written about brutal measures implemented by the US troops in this conflict, the leaders of the Philippine revolution most feared the army's "policy of attraction" (Gates 2002, 4). This term described activities such as the establishment of public health measures, schools, municipal governments, and public works projects that improved quality of life for many Filipinos, thus increasing their acceptance of American presence. Leading scholars believe the US Army's capacity-building programs, not acts of brutality, were the primary element responsible for the success of the pacification campaign (Gates 2002, 5).

Under the Marshal Plan, the United States provided economic, technical, medical and agricultural aid to countries in Europe. Between 1948 and 1951, the United States contributed more than thirteen billion dollars in aid under the Marshall Plan. While the humanitarian outreach in this effort should not be discounted, moving Europeans beyond starvation and disease set the stage for normalization of trade relations between the US

and Europe, thus furthering US interests in the region. The Marshall plan was a crucial step in the formation of the North Atlantic Treaty Organization as well as the European Common Market. Marshall's contribution to world leadership and diplomacy through this plan was recognized when he was awarded the Nobel Peace Prize in 1953 (The Marshall Plan 2003).

In the late 1940s, prior to the start of the Korean War, US Army medical personnel began training with Korean medical personnel, eventually opening a Korean Army Medical School in 1949. This school was modeled after the US Medical Field Service School, and was staffed by instructors from the United States. An exchange program was also established where the Department of Army medical personnel arranged for Korean personnel to be trained in US medical schools. Graduates from this program returned to their home country, becoming leaders in both the civilian and military sides of the Korean medical society (Hendley 1973, 370).

After the Korean War, Congress recognized the need for a standing agency to administer US development efforts overseas, and in September 1961 USAID, the US Agency for International Development, was born. The formation of USAID shifted the responsibility for administering the development of health care delivery systems in lesser developed countries to the State Department, making it appear as if the military would no longer be involved in these activities (Wilensky 2004, 48). Experiences in Vietnam a few years later showed that, while the military did not have to take the lead in medical development, troop presence was necessary for security, mobility, and logistical activities required for successful programs.

Subsequent to the creation of AID, the Foreign Assistance Act was passed on September 4th, 1961 (USAID History 2005). This act called for the Secretary of State to assume responsibility for both economic and military foreign aid. When the Secretary of State determined that military aid was required, he requested this aid from the Secretary of Defense. Any programs funded under this category had to compete with all other programs in the larger defense budget, meaning that the Secretary of Defense had to carefully weigh the potential cost-benefit ratio in the approval process. This process was all being worked through at the outset of the advisor program and subsequent hostilities in Vietnam in the early 1960s.

In the early 1960s incumbent Surgeon General Lieutenant General Leonard Heaton went to Thailand, sent by General Maxwell Taylor, Chief of Staff of the Army, to provide medical care for the Thai prime minister, with the intention of improving the American image in that region. General Heaton later wrote that he believed this visit was partly responsible for the United States gaining air basing rights in Thailand during the Vietnam War. He was quoted as saying that, “Medicine represents a very important part of diplomacy.” (McLean 1979, 26) This example bears witness to the fact that both the Army and the AMEDD leadership recognized the potential value of healthcare initiatives to support national policy objectives, but execution continued to occur sporadically.

The earliest medical efforts in Vietnam began before the outbreak of major hostilities in 1962, while the US troops were still in their advisory role. This program, dubbed MEDCAP I, involved medical training, and education of local providers. The primary goals were to make the Vietnamese capable of maintaining a good level of both preventative and therapeutic medicine, while maintaining a continuing spirit of mutual

respect and cooperation between the Republic of Vietnam armed forces and the civilian population (Wilensky 2004, 53). These programs sought to enhance the overall prestige of the government of Vietnam and win the hearts and minds of the Vietnamese people (Wilensky 2004, 49). A key component of these initial programs was keeping the Vietnamese face in the forefront to make it clear that the Americans were collaborating with the HN physicians, rather than supplanting them. This remains a key tenet of medical diplomacy today, though one that is often overlooked. The US is not there just to look good itself, but also to aid in providing legitimacy to the supported HN government.

As the war progressed, MEDCAP I gave way to a new program intended to increase the acceptance by the civilian population of a growing number of US military forces. This program, MEDCAP II, aimed to win the confidence and gain the cooperation of the local population in areas where large concentrations of US military forces were stationed (Wilensky 2004, 57). The Military Assistance Command Vietnam, MACV, established three objectives for MEDCAP II: continuity, participation of local national providers, and improvement of the health of the community (Wilensky 2004, 60). This necessitated coordination with and participation by local officials in the conduct of these missions, both elements of sound medical diplomacy. MEDCAP II focused on the care of children, improving the health status in this vulnerable population. US Army providers acted in areas where civilian medical resources did not exist, taking opportunities to train local nationals to provide medical care at the appropriate level.

Despite the sound foundation of MEDCAP II, increasing numbers of American forces, complexity of the mission, increased threat level, and poor coordination caused many of these principles to be abandoned. Commanders often saw the MEDCAP as a

tactical tool to throw out as a reward to villages that cooperated with American troops or to withhold from those who did not. While tactical MEDCAPs were necessary in certain instances, a one-time visit accomplished none of the overarching goals and was viewed as a shotgun approach to care. A good MEDCAP was a recurring activity on a scheduled basis and provided for patient follow-up. As the threat increased, however, medical teams could not announce their presence far in advance, nor could they return to a village on a regular schedule without placing themselves in significant danger (Wilensky 2004, 86).

There were also problems in coordination between the military and Department of State. Duplications in services and programs were worsened by both interservice and interdepartmental rivalries. These inefficiencies resulted in inequity between locations, with some areas having an abundance of services and supplies, while other areas had nothing. Lack of coordination between the military and Vietnamese civilian health care organizations led to misallocation of resources, with several units often arriving in one location, none knowing the other would be there. The Viet Cong were able to use these instances as an example of government incompetence and US favoritism. It is disturbing how many of these situations have been repeated in OEF and OIF, almost fifty years later.

The next medical program was the MILPHAP, Military Provincial Health Assistance Program. In this program, the Army assigned US doctors and nurses to provincial hospitals to train Vietnamese health providers in both preventive medicine and public health practices. This program reverted to the principles of sustainability and training, concepts that had been lost as the MEDCAP evolved. There were other areas where MILPHAP fell short for lack of adequate planning and administration. Program

administrators would act before performing a needs assessment with the Vietnamese health officials in the region, providing care based on what they assumed was needed or what they had available as opposed to what may have been needed. There was also no long-range health plan, so programs were often disjointed, with no clear end in sight. Frequent rotations of personnel, both American and Vietnamese, resulted in lack of institutional memory. Medical supplies went missing from some locations, only to appear on the black market soon thereafter.

MILPHAP also experienced difficulties in how it was received by the Vietnamese people. First of all, the regional hospitals treated all who presented for care, so some of the patients treated were likely Viet Cong. This caused frustration among the US providers when they knew they could be providing aid for the same people who may have ambushed American troops the night before. Also, in this Eastern culture, where honor is everything, some Vietnamese physicians believed that they lost face in their community, with the presence of MILHAP teams implying that the foreign doctors had greater skills (Wilensky 2004, 86). There was also the problem of linkage since some of the citizens did not identify the US Government and the MILHAP as being brought by the Republic of Vietnam government. While the MILHPAP was thought to have contributed to the information operations campaign on the ground, its execution was far from perfect.

Marines on the ground realized that winning the support of the people was just as important, if not more so, than winning the tactical military fight against the Viet Cong. (Wilensky 2004, 62). The Vietnamese people were neither friendly nor unfriendly. They were merely trying to survive, and would lend their support to the group most able to

guarantee that outcome. The Marines utilized a number of modalities for medical assistance, to include teaching at the Hue University Medical School. Not only was this helpful in capacity building, but Marine physicians also learned much from the local physicians about tropical diseases of the region. This knowledge allowed them to be more successful in treating both Vietnamese citizens and US troops deployed in the area (Wilensky 2004, 63).

Both individuals and organizations recognized the powerful impact of the medical operations in the fight against the Viet Cong. Henry Cabot Lodge, the Ambassador to Vietnam, stated that medicine was the prime medium of success in the people-to-people program in 1963. In his 1968 report on the war in Vietnam, General Westmoreland stated, “among the many civic action projects undertaken in Vietnam, perhaps none had a more immediate and dramatic effect than the medical civic action program.” (Wilensky 2004, 11) In 1978, Colonel Bedford H. Berrey wrote that medicine deserved recognition as an active partner of American foreign policy. These statements show that the value of medicine as a tool of democracy was recognized at the time, but a review of later operations show the difficulties that arose in realizing this value. Study of these difficulties show parallels with more recent operations, and provide insight as to how the US can take measures to overcome these obstacles in the future.

In the end, the US Government spent 500–750 million dollars in MEDCAP programs which treated 40 million Vietnamese (Wilensky 2004, 186). The most notable theme in reviewing these programs was that, although planners used sound principles in their design, operational changes, lack of cultural understanding, and communication difficulties among involved agencies resulted in ineffective implementation.

The MEDCAP concept was revived during the mid 1980s as part of the doctrine of low-intensity conflict and COIN operations in Central America. Secretary of Defense at that time Casper Weinberger recognized the potential dual benefits in using MEDCAPs, saying, “Humanitarian assistance and civic action in foreign countries are activities of great importance for the United States..... both from the point of view of our moral principles and to support specific policy objectives.” (Weinberger 1984) The MEDCAP was seen as an avenue to “win the hearts and minds” of the population in areas where the United States government was looking to strengthen ties with its neighbors to the South. The most successful medical exercise during this period was in Honduras, where US forces worked directly with Honduran military and civilian health personnel to bring healthcare to rural communities (JTF-B Public Affairs 2007). Together they deployed to remote areas and provided a variety of medical services, such as immunizations, clinical evaluations, dental extractions, preventive medicine lectures, and disease surveillance. The success of these operations relied on coordination among the multiple levels of the host government, as well as with local communities that benefited from the projects. This coordination helped guarantee that the medical needs of the population were met. Furthermore, the HN used its resources to create local capacity to ensure these programs would continue. Continuity was also ensured by establishing a standing force in the area so that, although the individual providers would rotate into the AO on 45- or 90-day assignments, a command surgeon would be able to provide continuity in communications with the HN. This mission continues today as Joint Task Force Bravo (JTF-B) at Soto Cano Air Base, Honduras. JTF-B’s mission is to provide health service support and mobile surgical teams to U.S. forces deployed in the U.S.

Southern Command area of responsibility, to conduct MEDRETES, and to serve as liaison to Honduran Ministries of Health.

The medical exercises in Honduras illustrate the successful use of a MEDCAP in promoting the legitimacy of the HN medical system and effectively providing assistance to a medically underserved area. Unfortunately, this type of MEDCAP is the exception and not the norm. By clearly identifying characteristics of medical diplomacy, the US Army may be able to retain the positive aspect of MEDCAPs, while correcting their downfalls, and ensuring their integration into the larger plan of the combatant commander.

Does Military Medical Diplomacy in the Form of Humanitarian Aid Really Make A Difference in Host Nation Support and Sentiment?

In the current operational environment military leaders must ask the question, “Does the activity we are engaging in have a role in setting the stage for US success?” The belief that proactive civic assistance initiatives can be used to prevent insurgencies, was held by leaders at Fort Bragg, NC in the late 1960s and is evidenced in the quote, “Military civic actions carried... into countries where dissidence or insurgency is incipient could result in a favorable orientation of the population to the established government and thus prevent insurgency.” (Taylor and Fields 1984, 46)

There is compelling new data to suggest that humanitarian aid is very powerful in increasing public opinion in favor of the United States. A recent poll showed that favorable views of humanitarian aid from the US were the sole issue that united Muslims and Christians in Nigeria (Ballen, Humanitarian Aid: winning the terror war 2006).

Three-quarters of all Nigerians, including nearly 60% of Muslims, felt that American

humanitarian aid to help the victims of HIV/AIDS in Nigeria would favorably influence their opinion towards the US. The organization Terror Free Tomorrow found in their surveys in Indonesia, Pakistan and Bangladesh that American HA served to improve relationships between America and developing nations, for both Muslims and Christians. In three countries, Bangladesh, Pakistan, and Nigeria, where the US had recently provided medical humanitarian aid, there was a substantial favorable change in opinion toward the United States after aid was provided. This approval for the role of American aid was expressed by members of diverse elements of society. In Nigeria regardless of whether respondents were opposed to the U.S. war on terrorism or even favored suicide terrorist attacks, all groups agreed that American assistance led to favorable opinions of the United States. Co-Chair of the 9/11 Commission and the Iraq Study Group Lee Hamilton commented on these survey results:

“Terror Free Tomorrow's new survey of Nigerian opinion reinforces a lesson that America has learned in places as diverse as Pakistan and Indonesia: in the struggle against extremism, the effective and targeted use of U.S. assistance can be as effective - if not more effective - than the deployment of bombs and guns. To win the war of ideas and to combat the swelling turmoil around the world, the United States must use all aspects of American power - including the power of American generosity”. (Dalle 2005)

A subsequent poll addressed the persistence of this feeling of good will as a result of humanitarian assistance. It found that a year after the US provided assistance following the tsunami in Indonesia, the dramatic increase in Indonesian support for the United States and against Bin Laden had continued. This change of opinion was particularly notable since it occurred in Indonesia, the world's largest Muslim country. The follow-up

poll revealed a shift in favorable opinion toward the US and against Bin Laden that was not only sustained, but also strengthened because of American humanitarian relief (Ballen 2006a). Kenneth Ballen, the president of Terror Free Tomorrow, noted that this change in opinion was nothing less than amazing. “This is a stunning turnaround for the United States in the war against terrorism,” he said. “It is the first major shift in Muslim public opinion since Sept. 11.” (Ballen, The myth of Muslim support for terror 2007)

The Role for Medical Diplomacy in the Current Operational Environment

The next question to answer is what role medical diplomacy plays in contemporary operations. The current military operational environment is one marked by persistent, low-level conflict. This often results in manmade disasters, inflicted on vulnerable populations who are already living on the edge of survivability. Disruption in these areas will often leave these populations hungry, without shelter, in an insecure environment, without essential services.

Insurgencies fueled by radical ideologues engage in conflicts with each other or with established nation states (Vanderwagen 2006). This type of enemy can be more difficult to confront, since it is amorphous and not contained within geographic boundaries. This enemy does not seek hegemony of a region, but rather legitimacy for its ideals or religion. This is superimposed in a world where natural disasters also strike the same populations in a disproportionate manner. The resultant situation is a “perfect storm” for terrorist recruiting. This enemy is amorphous and will recruit from pools of disenfranchised populations, using a doctrine based on hatred of the elite for the purpose of winning soldiers over to their way of thinking. Populations that are displaced, hungry, injured or homeless due to either manmade or natural disasters make great targets for

terrorist recruiting efforts (Kaplan 2001, 15). These are the same populations that can experience significant improvements in their quality of life through public health interventions and teaching for a fraction of the cost, both in terms of financial and human capital it would take to defeat them if they were successfully recruited as insurgent fighters.

It is a long accepted moral duty of warriors to help populations struck by disaster, whether natural or manmade. This answer of the call to duty can be used not only for healing bodies and winning the hearts and minds, but also for strengthening diplomatic ties and stabilizing societies in developing or recovering nations. (Vanderwagen, 2006) Effective medical diplomacy may prevent further conflict or deny terrorist recruiting efforts. In these roles medical personnel may save more lives than in execution of their direct healthcare duties.

Programs that have medical diplomacy as their primary goal are planned with key tenets which differ greatly from those used in the past to plan traditional MEDCAPs. These tenets include health sector assessment, cultural sensitivity, preservation, restoration, and enhancement of HN health sector capacity, relationship building with HN officials, post-program assessment, and transition of health sector activities to other parties for long-term implementation (U.S. Joint Forces Command 2007).

Historically, military medical activities with HN civilians were focused as training exercises (see MEDRETE above) a simple way to get troops into the field to provide short-term care, evaluate the skills of the medical teams, and then redeploy back to the home station. Today the geopolitical reality has changed, with most medics getting plenty clinical experience on their combat tours, and medical diplomacy being more

important than ever in providing sustainable medical care and capacity in unstable environments. The good will that was previously a mere byproduct of medical field exercises may be the most effective weapon the US has against the spread of terrorism. For this reason, humanitarian medical activities today should focus on sustainable improvements, both to aid the populations of the HN involved and as well as to provide the medical teams training in the principles of sound, sustainable, medical diplomacy. These teams should learn how to engage HN officials, provide legitimacy to their government, integrate their efforts with other parties in the AO, and build capacity to provide long-term benefit and stability. This latter benefit may do more to enhance the overall security environment than any direct care delivered.

Not only is there agreement that medical diplomacy can help in the War on Terrorism, there is a sense that medical capabilities, considered sustainment functions currently, may take center stage in the future. One need only compare the 2001 and 2006 Quadrennial Defense Review Reports to discover several specific instances which would support a new focus on winning the long war through humanitarian efforts, specifically those implemented by joint and interagency teams. The 2001 report was issued less than twenty days after the attacks of September 11th, 2001, meaning that its contents did not reflect the changes that the nation has subsequently learned it must make to win the war on terrorism. This report did not make a single reference to the words humanitarian and reconstruction in the context of relief and assistance, while the 2006 QDR referenced these terms forty-five times. The 2006 report used the word interagency forty-seven times, compared to only one usage in the 2001 QDR. These priorities are reflected in

budgetary requests, with DOD funding requests for USAID growing 21 percent from the 2007 figure of \$29.9 billion to the 2008 figure of \$36.2 billion (Knopp 2007).

Medical diplomacy can be a very cost effective way to win the war on terrorism. It took five million dollars to refurbish a women's hospital in Kabul which provided delivery services to over 150 mother/baby couplets a day. These women and children were directly affected and would remember that their government, with the assistance of the United States, was able to provide an essential health care service at their time of need. While five million dollars is not a negligible sum, it pales in comparison to expenditures in other areas of the defense budget (Thompson 2005).

This is not to say that medical diplomacy can stand on its own, or that with education and employment development programs it should replace combat operations. On the contrary, hospitals in Afghanistan could not have been rebuilt, and wells could not have been tested and treated if the Taliban had not first been defeated. Full spectrum operations are essential for the United States to achieve success in the War on Terrorism. Reflecting on the experience of the Army's pacification campaign in the Philippines, one recalls that the medical piece was but part of an operation whose goal was to obtain Filipino acceptance of American rule in a way that would gain the cooperation of the Filipino people and prevent the need to hold the Philippines through the continued use of military force. To accomplish that goal the army and the colonial government had to provide acceptable political, economic, and social alternatives to those put forth by the revolutionaries (Gates 2002, 3). Public health strategies consistent with medical diplomacy were an integral part of this plan. Doctrine and implementation of medical

diplomacy must, however, be approached with the same rigor with which traditional combat operations are planned to ensure their most effective use.

CHAPTER 4

Results and Discussion

Every effort we take to demonstrate the depth of America's compassion and generosity is an important step in the global war on terror.

- Secretary of Defense, Donald Rumsfeld (Lennon 2003)

Emphasizing health issues can offer an innovative approach to the resolution of apparently intractable problems. Identifying the common concerns, of even the most bitter enemies, can provide an initial basis for dialogue and lead to diplomatic initiatives.

- K.M. Cahill (Cahill 1997)

Introduction

In addressing combat operations, FMI 5-0.1 discusses the importance of developing a baseline for assessment, "Commanders and staffs develop a standard or baseline against which they compare measures and trends. Once established, this baseline remains a fixed reference point." (U.S. Department of the Army 2006, 5-33) In this chapter the core competencies of medical diplomacy will be developed by analyzing civilian, governmental, and nondoctrinal military literature on that topic. This analysis will be performed using the qualitative methodology outlined in chapter three, noting trends based on military versus nonmilitary affiliation, and based on seniority of the author. For military authors, officers with the rank of O-5 (lieutenant colonel for the Army) or below were ranked in the junior category, while O-6 (colonel for the Army) and above were ranked in the senior category. For the government and civilian authors, those with an undergraduate degree and no designation as a "senior fellow" or "senior advisor" were ranked junior, while those with a graduate degree and/or "senior" status designation were ranked senior.

This set of core competencies will then be applied to relevant US Army and joint doctrine, as well as lessons learned from the War on Terrorism to determine how closely US Army and joint doctrine reflect the core competencies in medical diplomacy, as well as how well medical diplomacy is being practiced in the field.

Core Competencies in Medical Diplomacy

Descriptions of what qualified as core competencies are listed in table one. These descriptions were based on common themes gleaned from the literature review. A competency was checked as positive for a reviewed article if the author mentioned it as was an important part of effective medical diplomacy. It was also marked positive if the article mentioned absence of this competency as a deficit in performance of the operation being discussed.

Table two lists core competencies in descending order of frequency mentioned in all articles reviewed. The third column lists the percentage of authors in each of the categories military, government, or civilian who mention the competency in their writings. The final column shows the percentage of junior or senior authors mentioning the competency.

Table 1. Medical Diplomacy Competencies

Competency	Description
Needs Assessment	Evaluation of the medical, political, situation performed in advance to inform mission planning
Communications with:	
• Commander/Line Colleagues	Medical personnel ensure clear and consistent communication with their line counterparts to ensure planning for the medical mission is synchronized and supports the COCOMs intent
• Local Officials	HN officials are consulted as to what assistance they require to meet their population's needs
• Interagency	DOD coordinates and liaisons with DOS to ensure synchronized planning and execution
• Joint	DOD services coordinate and liaison to ensure synchronized planning and execution
• NGOs	DOD planners and providers coordinate and liaison with NGO personnel to ensure synchronized planning and execution
• Others	DOD coordinates and liaisons with other groups not previously mentioned to ensure synchronized planning and execution
Cultural Competency	Incorporating elements of language training, cultural views, and customs.
Training forces	Providing specific training on SSTR operations for US military personnel
Sustainable	Projects have a long-term, strategic focus rather than consisting of short-term, disconnected operations

Table 1. Medical Diplomacy Competencies (continued)

Competency	Description
Capacity building	Assistance efforts focus on building capacity of HN to meet the needs of their population
Services at appropriate level	Medical assistance provided is at a level that is consistent with the standard in that region and can be maintained after military forces withdraw
Support legitimacy of HN government	All actions are performed to support the legitimacy of the HN government rather than primarily for popularity of US forces
Post-mission Assessment	Assessment is conducted to detect the effects of medical diplomacy in a region. Both positive and negative consequences are measured against the baseline and pre-determined benchmarks
Transition of Authority	Transition of control of mission to civil authority is integrated into mission planning and execution

Table 2. Medical Diplomacy Competency Frequency of Appearance

Competency	Total	Military	Civilian	Govt.	Junior	Senior
Coordinate with NGOs	17	63% (12/19)	43% (3/ 7)	67% (2/ 3)	53%	47%
SSTR specific training	16	68% (13/19)	29% (2/7)	33% (1/3)	44%	56%
Sustainable intervention	13	47% (9/19)	43% (3/7)	33% (1/3)	50%	50%
Coordinate with Interagency	12	53% (10/19)	14% (1/7)	33% (1/3)	33% (4/12)	66% (8/12)
Capacity building	12	32% (6/19)	71% (5/7)	33% (1/3)	50%	50%
Coordinate Jointly	11	42% (8/19)	14% (1/7)	67% (2/3)	46%	54%
Coordinate with HN officials	10	47% (9/19)	14% (1/7)	0% (0/3)	40%	60%
Cultural Competency	9	37% (7/19)	14% (1/7)	33% (1/3)	56%	44%
Coordinate with Others*	8	26% (5/19)	29% (2/7)	33% (1/3)	0%	100%

Table 2. Medical Diplomacy Frequency of Appearance (continued)

Competency	Total	Military	Civilian	Govt.	Junior	Senior
Train HN personnel	8	37% (7/19)	0% (0/7)	33% (1/3)	25%	75%
Pre-mission needs assessment	7	32% (6/19)	14% (1/7)	33% (1/3)	43%	57%
Services at the appropriate level	7	21% (4/19)	29% (2/7)	33% (1/3)	0%	100%
Post-mission assessment	7	21% (4/19)	29% (2/7)	33% (1/3)	71%	29%
Support of HN legitimacy	6	26% (5/19)	0% (0/7)	33% (1/3)	50%	50%
Coordinate with Commander	3	16% (3/19)	0% (0/7)	0% (0/7)	0%	100%
Transfer of Authority	3	16% (3/19)	0% (0/7)	0% (0/7)	43%	57%

*: Other included private-public partnerships, media, civil affairs, embassy relationships, and direct relationships with HN personnel, not in an official leadership capacity.

The top three competencies -- coordination with NGOs, training forces, and long-term mission -- were rated highly by all three, and equally valued both by senior and junior authors. The lowest two competencies -- coordinate with commander and/or line and transfer of authority -- were mentioned solely by senior authors. The only

competency mentioned significantly more often by junior authors was post-mission assessment.

Several competencies were rated proportionately higher by the military than by either the government or nonmilitary government authors. These competencies were interagency coordination, transition of activity, support legitimacy of HN government, and training of HN medical personnel. The first two of these competencies are specific to the nature of the military mission. The third competency rated highly by the military, support legitimacy of HN government, involves the political ulterior motive that NGOs avoid based on the humanitarian mandate. This is a key factor which separates the medical diplomacy practiced by the military from the humanitarian assistance as defined by the NGO community. The final competency in this grouping, training of HN medical personnel, is a sound public health action that should be generalizable to anyone involved in medical humanitarian assistance, so it is interesting that mention of this competency is more prevalent in the military literature.

Evaluation of Military Doctrine Based on Core Competencies

Joint and Army doctrine were evaluated for the core competencies of medical diplomacy. Results are shown in tables three and four for the Army and joint doctrine review respectively. While the phrase “medical diplomacy” was not mentioned in any of these documents, evaluation was undertaken for concepts that contained the core competencies of medical diplomacy as outlined in table two. References listed in the table for Army doctrine reviewed refers to the paragraph number, while those listed for joint doctrine are page references. For conciseness only one citation was listed for each competency though the document may have contained multiple references to the concept.

Table 3. Evaluation of Army Doctrine for Medical Diplomacy Core Competencies

Competency	FM 3-0 (Feb 2008)	FM 3-07 (Apr 2003)	FM 3-24 (Dec 2006)	FM 4-02 (Feb 2003)	FM 8-42 (1997)
Coordinate with NGOs	Yes; p. 1-52*	Yes; p. A-8*	Yes; p. 2-1*	Yes; p. 3-2	Yes; p. 1-2, p. B-4
SSTR specific training	Yes; p. 1-88*	Yes; p. vi	Yes; p. 6-59*	No	Yes; F-7
Sustainable intervention	Yes; p. 2-14*	Yes; p. C-3*	Yes; p. 6-29*	No	Yes; p. 3-22
Coordinate with Interagency	Yes; p. 1-12*	Yes; p. A-1*	Yes; p. 5-19*	Yes; p. F-1	Yes; p. B-3
Capacity building	Yes; p. 3-81*	Yes; p. C-2*	Yes; p. 5-88*	No	Yes; p. 3-22
Coordinate Jointly	Yes; p. B-4*	Yes; 5-4*	Yes; p. 6-15*	Yes; p. F-1	Yes; p. 4-1
Coordinate with HN officials	Yes; p. 2-19*	Yes; 5-8*	Yes; p. 5-31*	No	No
Cultural Competency	Yes; p. 1-25*	Yes; p. 6-3*	Yes; p. 3-17*	Yes; p. B-7	Yes; p. 3-21
Coordinate with Other Groups	No	Yes; p. A-2*	Yes; p. 2-54*	No	Yes; throughout document
Train HN personnel	Yes; p. 2-19*	Yes; p. 5-8*	Yes; p. 6-66*	No	Yes; F-4, F-15
Pre-mission needs assessment	Yes; p. 3-71*	Yes; p. 2-11*	Yes; p. 8-36*	No	Yes; p. 3-7, 3-8, F-7, E-2
Services at the appropriate level	No	Yes; p. 6-7*	No	No	Yes; p. 3-22

Table 3. Evaluation of Army Doctrine for Medical Diplomacy Core Competencies
(continued)

Competency	FM 3-0 (Feb 2008)	FM 3-07 (Apr 2003)	FM 3-24 (Dec 2006)	FM 4-02 (Feb 2003)	FM 8-42 (1997)
Post-mission assessment	Yes; p. 5-84*	No	Yes; p. 6-37*	No	No
Support of HN legitimacy	Yes; p. A-23*	Yes; p. 6-7*	Yes; p. B-10*	No	Yes; p. 1-3
Coordinate with Commander/Li ne	No; medical not discussed	Yes; p. 2-11*	No; medical not discussed	Yes; p. F-5	Yes; p. 1-7, 1-8
Transfer of Authority	Yes; p. 6-58*	Yes; p. 6-8*	Yes; p. 8-39*	No	No

- Mentioned in FM as SSTR principle but without specific medical reference.

Table 4. Evaluation of Joint Doctrine for Medical Diplomacy Core Competencies

Competency	JP 1 (May 2007)	JP 3 (Feb 2008)	JP 4-02 (Oct 2006)	JP 3-07.6 (Aug 2001)	JP 3-57.1 (Apr 2003)
Coordinate with NGOs	Yes; p. VII-4*	Yes; p. xiii*	Yes; p. 1-9	Yes; p. II-11*	Yes; p. VII-31*
SSTR specific training	No	Yes; p. xxi*	Yes; p. K-33	Yes; p. III-8*	Yes; p. II-3*
Sustainable intervention	No	Yes; p. VII-6*	Yes; p. K-20	Yes; p. IV-12*	Yes; p. IV-10*
Coordinate with Interagency	Yes; p. I-20*	Yes; p. VII-10*	Yes; p. II-13	Yes; p. II-12*	Yes; p. II-12*
Capacity building	Yes; p. VI-1*	Yes; p. V-26*	Yes; p. IV-2	No	No
Coordinate Jointly (by definition)	Yes	Yes	Yes	Yes	Yes

Table 4. Evaluation of Joint Doctrine for Medical Diplomacy Core Competencies
(continued)

Competency	JP 1 (May 2007)	JP 3 (Feb 2008)	JP 4-02 (Oct 2006)	JP 3-07.6 (Aug 2001)	JP 3-57.1 (Apr 2003)
Coordinate with HN officials	Yes; p. xxi*	Yes; p. VII- 10*	Yes; p. III-2	Yes; p. K-5*	Yes; p. I- 11*
Cultural Competency	No	Yes; p. II-7*	Yes; p. K-8	Yes; p. V-5*	Yes; p. II-4*
Coordinate with Other Groups	No	Yes; p. VII- 10*	Yes; p. IV-8	No	Yes; p. II- 16*
Train HN personnel	Yes; p. III- 11*	Yes; p. IV- 13*	Yes; p. K-19	Yes; p. II-6*	Yes; p. II-3*
Pre-mission needs assessment	No	Yes; p. IV- 30*	Yes; p. IV-9	Yes; p. II-8*	Yes; p. II-2*
Services at the appropriate level	No	No	No	Yes; p. IV- 13*	No
Post-mission assessment	No	Yes; p. IV- 33*	No	Yes; p. IV- 11*	Yes; p. II-4*
Support of HN legitimacy	No	Yes; p. v- 27*	Yes; p. IV-8	No	Yes; p. I- 11*
Coordinate with Commander/Line	Yes; p. IV- 15*	Yes; p. III- 5*	Yes; p. II-8	Yes; throughout document	Yes; p. II-1*
Transition of Authority	Yes; p. I-17*	Yes; p. IV- 27*	Yes; p. K-20	Yes; p. I-9*	Yes; p. II- 10*

* Mentioned in JP as SSTR principle but without specific medical reference.

Army doctrine reviewed included FM 3-0, Operations (U.S. Department of the Army 2008, U.S. Department of the Army 2003); FM 3-07, Stability Operations (U.S. Department of the Army 2003); FM 3-24, Counterinsurgency (U.S. Department of the Army 2006); FM 4-02, Force Health Protection in a Global Environment (U.S. Department of the Army 2003); and FM 8-42, Combat Health Support in Stability Operations and Support Operations (U.S. Department of the Army 1997).

Joint doctrine reviewed included JP 1, Doctrine for the Armed Forces of the United States (U.S. Joint Chiefs of Staff 2007); JP 3 Joint Operations (U.S. Joint Chiefs of Staff 2006); JP 4-02, Health Service Support (U.S. Joint Chiefs of Staff 2006); JP 3-07.6, Joint Tactics, Techniques, and Procedures for Foreign Humanitarian Assistance (U.S. Joint Chiefs of Staff 2001); and JP 3-57.1, Joint Doctrine for Civil Military Operations (U.S. Joint Chiefs of Staff 2003).

Several trends appeared through the doctrine review. First, FM 8-42, the medical-specific Army doctrine, contained the most references to the principles of medical diplomacy. Notably, this was the most dated doctrine reviewed, being most recently revised in 1997. It fell short in the areas of HN coordination, failing to cover the importance of coordination with HN officials and transferring authority for activities to their control. The joint medical doctrine, JP 4-02, focused on health service support to US soldiers, but did also make reference to most principles of medical diplomacy, missing only delivery of services at the appropriate level and post-mission assessment. The area of post-mission assessment was the only competency that was not mentioned in any of the medical-specific doctrine.

Doctrine that was not topically focused on military medicine made references to the principles of stability, reconstruction, and transition in the context of nonlethal effects, but did not associate these with medical actions. This is not to imply that a case was made against the use of medicine in this way, but rather that the doctrine did not make specific reference to the use of medical activities in this capacity. FM 3-24 mentioned all of the core competencies of SSTR, many of which are identical to those of medical diplomacy, but did not list any of them in the context of medical care. JP 3-57.1 also covered these concepts in the framework of the civil affairs mission, but failed to give examples or guidelines of how these concepts could be applied in medical missions. FM 3-07, Stability Operations, contained all but one core competencies, the exception being post-mission assessment, but none were mentioned in a medical context. This FM is currently being revised, and would be a natural place for guidance from various Army corps to be collectively addressed.

Evaluation of Lessons Learned Observations Based on Core Competencies

Core competencies were then used to construct a framework with which to analyze lessons learned observations from OIF/OEF. The core competency was met if it was practiced throughout the operation of interest or if it was noted as a lesson learned observation during the operation. The majority of lessons learned observations focused on competencies which developed over the course of a unit's deployment. A total of eighty-eight lessons learned observations were pulled from a literature review and from the Army Medical Department Center and School Lessons Learned Observations website. These observations met the search criteria referenced in the methods section.

Review of these lessons learned observations found thirty that were not applicable, as they dealt with topics unrelated to medical diplomacy, such as aeromedical evacuation or the care of contractors on the battlefield. Of the remaining fifty-eight documents, forty-one were from OIF, five were from OEF, and twelve did not identify the theater from which they were drawn. The results of this review are listed in Appendix A, with the first column listing the number of the lessons learned observation as assigned by the AMEDD lessons learned website. For those lessons learned that were drawn from an outside literature review, observation numbers were assigned by the author and correlate with the reference citation.

All core competencies were listed in the lessons learned observations documents with the exception of “coordinate with joint forces.” This may be due to the fact that both Iraq and Afghanistan are combined, joint theaters, so this coordination may be assumed. The core competency mentioned most frequently was “coordinate with HN leaders.” This was marked as present if the lessons learned document mentioned coordination with either HN governmental or medical leaders.

“Coordination with command” was the second most frequently noted competency. There were several emerging concepts noted in this area. The first was the importance of having medical missions integrated from the earliest stages of planning, and having these missions outlined in policy or annexes to the order providing guidance to subordinate units. Absence of this explicit guidance was noted as a shortfall by several units. One observation cited, “Repeated vigorous attempts to get a clearly stated specific policy from higher HQ were futile.” (AMEDD Center and School Lessons Learned Observations 2008, 1611) Another unit recommended, “MEDCAPS guidance should be

sought initially and incorporated into the medical ROE annex to the OPORD.” (AMEDD Center and School Lessons Learned Observations 2008, 1612) The second emerging concept was that of clear designation of a project officer. Because humanitarian projects often involve soldiers from more than one branch, confusion as to who is in charge was noted as a common problem. One lesson learned was, “Without clear assignment of a project officer.... humanitarian projects will not be funded.” (AMEDD Center and School Lessons Learned Observations 2008, 1470) Another observation stated, “Without the rose clearly pinned on a project manager, there were misunderstandings and three weeks time was lost.” (AMEDD Center and School Lessons Learned Observations 2008, 1468)

Capacity building and needs assessment tied for the third most frequently mentioned competency. Included under the topic of capacity building were both infrastructure development and the training of HN personnel. This training included both direct medical care and executive medical skills such as management and leadership courses. The need for subject matter experts was identified and one unit recommended a solution for ensuring that these personnel were available in the US military personnel inventory when the need arose. “The AMEDD might consider developing a PROFIS-like system to identify TDA assigned subject matter experts (SMEs) for activation and deployment into the civil affairs world as necessary.” (AMEDD Center and School Lessons Learned Observations 2008, 2820) Infrastructure development included both physical buildings and development of systems, such as an emergency response network.

The topic of training soldiers in the skills required to successfully execute medical diplomacy drew particularly strong comments in the observations. Soldiers expressed

frustration with the mission preparation they received, feeling that excessive time was spent on tasks in which they were already proficient, while not enough time was spent preparing them for their stability mission. “Units are conducting non-standard missions. They need to train on what they will do – not what they are capable of doing.” (OIF/OEF Operational Lessons Review Working Copy 2008) “In light of the ongoing requirements in Iraq, a greater orientation in CMO to all officers would be helpful.” (Center for Army Lessons Learned 2004)

Those competencies least frequently mentioned included “transition of authority” and “coordination with interagency.” In this author’s opinion these are also areas that have been two of the most significant problems in OIF, not just for the US Army Medical Department but for coalition forces in general. It could be that these lessons are yet to be learned, so that they are not yet included in the AMEDD observations database.

Several observers noted the danger of traditional MEDCAPs, due not only to their lack of effectiveness medically, but also to possible unintended consequences.

“MEDCAPs in particular are medically ineffective, undermine Iraqis’ support of their government health system, and place troopers at unnecessary risk.” (AMEDD Center and School Lessons Learned Observations 2008, 3572) “A MEDCAP, with a large number of US personnel and Iraqis in a fixed location, can be a very tempting target to the enemy.” (Center for Army Lessons Learned 2006) Medical personnel, however, sometimes felt pressured to perform MEDCAPs by their command, who still viewed these activities as useful in their traditional form. “Medical people should not fight CDRs on MEDCAPs. They will do them anyway. Try to give them guidelines on how to do it.” (AMEDD Center and School Lessons Learned Observations 2008, 3480)

These results show that the concepts of medical diplomacy are very similar to those practiced throughout the military in both counterinsurgency and SSTR operations. While many of these concepts are present in military doctrine, they are infrequently presented in medical-specific doctrine. Review of lessons learned from the field show that these concepts are being practiced in the deployed setting, though many of the lessons are being learned new by each unit, due to a lack of guidance in the execution of these missions. Conclusions drawn from these results and recommendations for future directions will be covered in the final chapter.

CHAPTER 5

Conclusions and Recommendations

Nothing can be more destabilizing to a population than to see an erosion of basic human services, especially when the legitimate government is perceived as impotent. When this situation is capitalized on by externally supported agitators, insurrection can be the outcome.

COL John F. Taylor, (Taylor and Fields 1984)

... a government that cannot secure the health of its people has failed its most fundamental responsibility, lacks legitimacy, and will ultimately find itself without popular support.

Randy Cheek, "Public Health as a Global Security Issue" (Cheek 2004)

Success in the current operational environment requires effective application of all tools at the disposal of the US Army, both lethal and nonlethal. Medical diplomacy is an emerging nonlethal tool, distinct from traditional MEDCAPs, which may help to stabilize areas with fledgling or absent governments, thus denying recruiting grounds to terrorist who would aim to attack US interests. In order to be used most effectively, this tool must be understood by both Army leadership and soldiers, with guidelines for its use being consistent, accessible and understandable. The US Army also must be able to clearly communicate its use of this tool with international, interagency, host nation, and joint partners to synchronize efforts and maximize synergy. This chapter will draw conclusions from the preceding analysis as to how the US Army can best meet these challenges.

Conclusions

Medical diplomacy is a form of international relations in which medical assets and resources are used to encourage positive relations and/or exchange specific benefits

between nations. The US Army has a long history of involvement in operations following these concepts, though success in the diplomatic components of these operations has been varied. Review of successful medical diplomacy in Army operations as well as review of the current literature reveals core competencies of effective medical diplomacy. These competencies are listed in table 1.

The US Army's current doctrine addresses the conduct of SSTR operations but has significant gaps in the area of medical diplomacy, as shown by review of tables 3 and 4. When core competencies of medical diplomacy were present, they were most often discussed in the context of other SSTR missions. The doctrine that is present appears to translate well to the field environment, but soldiers and commanders need further guidance to maximize effectiveness in the area of medical diplomacy. The areas of deficiency found through analysis of Army doctrine, joint doctrine, and field application of the core competencies in medical diplomacy can be summarized in four main areas. These areas are coordination, HN development, training, and assessment. Each one has implications for Army doctrine development, with conclusions in this respect addressed in the following section.

Coordination

Medical diplomacy is almost never conducted in isolation by the US Army, making effective interagency and HN coordination key tenets of successful operations. While most authors, military doctrine writers, and lessons learned observers recognized the importance of coordinating within the command structure, with HN governments and medical professionals, as well as with NGHOs, joint and interagency coordination was largely ignored in the writings reviewed. The joint coordination can not be assumed and

must be codified in Army field manuals and joint publications. Since the Department of State and USAID are the lead in overseas development, this deficiency in coordination must be addressed. It is only through this coordination that the military will undertake synergistic missions with interagency organizations. This synergy may allow for timely and coordinated transfer of authority to these organizations as soon as the security situation allows. Without this coordination, the US Army runs the risk of planning and executing missions that are difficult to transition, resulting in forces being spread too thin across the AO and the globe, negatively affecting readiness to defend against the next threat. US Army doctrine must reflect this coordination as integral, not optional, for mission success.

Coordination with United Nations agencies and NGHOs is recognized as a crucial factor, but is plagued with use of conflicting terms and inconsistent motivations. The US Army must be forthcoming in its motivations for involvement in SSTR activities, such as medical diplomacy. When the Army labels its activities as humanitarian and these activities are clearly not based on the principle of neutrality inherent in this term as used by the UN and NGHOs, the Army loses credibility with the humanitarian community, and coordination likely will not proceed. In order for successful coordination to occur between military and humanitarian forces, each must have a clear understanding of the other's underlying mandate and terminology, agreeing to work together for common goals in spite of these differing motivations. In working collaboratively to stabilize a country or region stricken by natural or manmade disasters, NGHOs, the UN, and the military can all achieve their goals: the NGHOs and UN the goal of humanitarian primacy, and the military the goal of expedient withdrawal from the area. Only by setting

aside their differences can the NGOs, UN, and the military realize their collective and individual goals.

HN Development

Development of HN capacity is recognized as a vital element in effective SSTR operations, of which medical diplomacy is one. Building capacity can involve training personnel, developing systems, or building infrastructure. These capacities must be developed in concert for any to reach their full potential in helping to legitimize the HN government's ability to care for its population. Army planners must ensure that US forces have the skill sets necessary to support development of capabilities in these diverse areas. Training of personnel must include not only direct medical care, but also administrative functions, which are often lacking in post-conflict or developing countries.

Projects undertaken in the name of medical diplomacy must be sustainable and tie in with the long-term developmental goals of the US interagency effort in the HN. They should be developed in conjunction with the HN governmental and medical leadership to ensure that they meet the needs of that area, instead of just highlighting the capabilities available in the US forces assisting with development. They must be approached in such a way as to facilitate long term feasibility and transition from a military lead to civilian control. They also must reflect the local standards of care, utilizing supplies and equipment that can be maintained and repaired with HN capabilities.

Training

The US Army is well trained to win and fight the nation's wars through lethal means. Contemporary training must also focus on skills required to succeed in the current operational environment. These skills include those of cultural competence, foreign

language mastery, and civil-military operations. The principles of medical diplomacy must be taught in a manner that provides an underlying framework, while acknowledging that the very nature of these missions will require flexibility and agility in the application of these principles.

US Army personnel are prepared for their sustainment mission, but most are unfamiliar with the concepts of medical diplomacy. They are often happy to participate in MEDCAPs because it is familiar to them and allows them interact positively with the HN population. Medical personnel must be trained in the SSTR concepts so they can best use their skills in an advisory and developmental role, rather than in direct patient care. Training must acknowledge that medical services should be delivered in a way and at a level that is appropriate for that region and that culture.

Commanders must be educated as to the shortfalls inherent in traditional MEDCAPs and be instructed on alternative uses for their medical assets in SSTR. Since the concepts of medical diplomacy can also apply to engineering diplomacy, police forces training diplomacy, economic diplomacy, and the like, it may be useful to cover these as a group, so that commanders can see them as complementary developmental tools in his nonlethal armamentarium.

Assessment

Assessment of HN needs should be one of the initial actions undertaken by units involved in any type of reconstruction or development mission. Both Army and joint doctrine reflect this concept, and lessons learned observations support its practice in the deployed environment. In order to maximize support and legitimacy of the HN

government, projects must be based on true needs of the communities involved. This involves both site assessments and meetings with local leaders to determine these needs.

A pre-mission needs assessment addresses only the first half of mission planning. A post-mission assessment must be conducted to determine the efficacy of the operation and inform the planning of subsequent missions. While US forces are accustomed to evaluating their unit activities through after action reports, they are less accustomed to measuring their effectiveness in accomplishing the strategic, diplomatic objectives of the higher headquarters. Doctrine should address not only conduct of these assessments but also their incorporation into future plans and policies, so that commanders in the same theater will have this information available upon which to build.

Recommendations:

Recommendations following these conclusions fall into the four main categories of personnel and organization, doctrine, education and training, and assessment. These recommendations address how the conclusions above can be applied to improve the US Army's conduct of medical diplomacy in future operations.

Personnel and Organization

Designate leaders in DOD and DOS to provide strategic guidance in development of health policy. NGHO input must be solicited into the development of such strategic guidance. This will require information being fed up from the ground level to ensure policy is serving the needs of those forward deployed, while also maintaining a clear connection to US military and political interests.

Qualified personnel in the surgeon's office of each regional command should maintain a current assessment of the area, with medical and environmental threats, real

or potential, using this information to advise the combatant commander. This threat data base should be proactively monitored to detect potential problems that could destabilize the HN government or be part of a humanitarian disaster. Qualified personnel should be present in the regional surgeon's office to monitor this list, as well as to provide expert advice to the CCDR in the use of medical diplomacy in the designated region as part of the larger strategic and operational plan.

Elevate the importance of the CMOC in the military culture. It should not just be a liaison center; it must be an operations center. Duty in the CMOC must be noteworthy. Humanitarian work in the medical, engineering, or civil affairs fields is often seen as a dead-end career path for military officers, and thus does not attract personnel for a career-long commitment to master the complexities inherent in this field. If all the doctrine is eloquently written and the organizational structure considers medical diplomacy at each level, but qualified people who are effective communicators and knowledgeable about civil-military affairs are not in the positions because it is a dead-end career track, then all is for naught.

Design an organizational structure that assigns qualified personnel with both adequate medical and diplomatic backgrounds to direct the implementation of medical diplomacy. As long as humanitarian assistance missions are planned ad hoc, with medical personnel being taken away from their primary assignments to participate in them, the effort will never reach its full potential. DOD directive 3000.05 states that these missions should have equal or greater importance than the combat mission in certain situations. The organizational structure must reflect this emphasis by assigning medical planners on the staff to these missions, who have the background to ensure the planning of these

missions receive the same scrutiny and expertise as comparable traditional combat missions. Additionally, participation in these roles must be career enhancing to attract the best and the brightest to these positions.

Doctrine

Avoid use of the term “humanitarian” for actions conducted by military personnel in their line of duty as soldiers. The term humanitarian, as used by the UN and NGHOs, holds implicit the concepts of neutrality, impartiality, and humanity. Since the military works closely with these parties in the SSTR environment, it would be well served to use humanitarian terminology in a manner consistent with its use by these actors. The military is not neutral in its conduct of SSTR missions, so these missions should not be referred to as humanitarian. This is not a value judgment and does not mean that affected populations do not benefit just as much from military aid. It does acknowledge the reality that military forces are employed to protect their respective countries’ interests, and that medical, engineering, or material aid are all means by which they may accomplish this mission. By using the term humanitarian in this consistent manner, the Army may remove a barrier in communicating with the United Nations and NGHO communities, thus improving communication with these groups. Examples of terminology that could be used to refer to military medical aid activities are medical material aid, medical personnel aid, and medical infrastructure aid, to accurately reflect the profession, nature, and assistance inherent in these activities.

Acknowledge that medical diplomacy is a political process. The political process and implications of medical diplomacy must be addressed at the strategic level, with

input from all organizations involved. Personnel involved in relief efforts must be aware of the political impact of their actions in order to exercise individual initiative in a manner consistent with their commander's intent.

Incorporate principles of effective medical diplomacy, currently found solely in specialized military literature, into mainstream military doctrine. While it is important to have a central cadre of trained professionals to guide medical diplomacy policy, its implementation will occur on the ground. If references to medical diplomacy are not made in the primary doctrine, these missions may be undertaken in a haphazard manner, with these inconsistencies having possible long-term negative effects. One recommended venue for codifying this guidance would be in the next versions of stability operations doctrine, for both Army and joint publications.

Ensure that all aspects of AMEDD capabilities are incorporated into the medical diplomacy doctrine. Medical diplomacy encompasses the use of veterinary services, medical education, optometry, nursing care, medical planning, and dentistry. Since professionals from these varied fields may have specialized skill sets that can aid in capacity building, doctrine must address how these skill sets can be employed in a complimentary manner.

Standardize terminology across the services and interagency organizations. Make every effort to ensure terminology is standardized with the DOS, interagency, United Nations, and NGHIO terminology to simplify and synchronize communications. In areas where terminology can not be standardized, acknowledge the differences in meaning to facilitate clear communication among all parties.

Include medical diplomacy and related SSTR operations in orders to provide clear guidance for their conduct. A recurrent deficiency noted in review of lessons learned observations was the lack of clear guidance for medical diplomacy operations. Lack of clear guidance can lead to conflicting operations, decreasing legitimacy of the US military and causing frustration within the individual units. A sample FRAGO used by one unit in Iraq for this type of mission is in Appendix B (AMEDD Center and School Lessons Learned Observations 2008, Observation 4094). While this example will not apply for all operations, it includes a variety of the factors which should be addressed to communicate command intent to subordinate units.

Education and Training

Develop training for both medical personnel and line officers on the role of medical diplomacy in combat and peacetime operations. Until the concept of medical diplomacy is well understood by leaders, military planners, and soldiers on the ground, humanitarian aid will be seen as an ad hoc, “nice to have.” Education for line commanders should instruct them on the uses of medical diplomacy in their AO, while that for medical personnel should include that piece, as well as some practical guidance as to how medical diplomacy can be implemented.

Establish a joint Global Health Educational Program to ensure interservice coordination among joint and interagency players. Speaking the same language is half the battle. This program could be modeled on the Air Force’s International Health Specialist program, described in the literature review. There has been discussion on this topic within the Civil Military Working Group, a group of military officers currently meeting to synchronize joint resources to answer the charge given in DOD 3000.5 that

stability operations be given priority comparable to combat operations and that they be explicitly addressed and integrated across all DOD activities. Implementation of such a program would be a positive first step in ensuring interagency coordination, understanding, collaboration and most effective use of collective military elements of medical diplomacy. This program should include cultural training, language skills, and courses addressing tropical diseases and environmental health, as well as aspects of public health. Consideration should be given as to whether existing civilian programs could meet these academic needs, while also giving military personnel the opportunity to interact with civilians training on the same topics.

Incorporate human capital capacity building at every step. Consider utilization of adult education specialists to ensure that the US Army is implementing curricula in the most effective ways. It is much more efficient and effective to train HN providers than to use US Army providers in their place, damaging the legitimacy of the HN system, as well as creating dependency. As the proverb states, “Give a man a fish; you have fed him for today. Teach a man to fish; and you have fed him for a lifetime.”

Assessment

Perform pre-mission needs assessment, as well as evaluation of outcomes of medical diplomacy to shape future plans and to detect unintended consequences of these missions. One of the acknowledged difficulties in HA is assessment, since it may be weeks, months, or even years before the full effect of a mission is appreciated. USAID has developed an instrument that may provide a framework for both pre-mission analysis and post-mission assessment for humanitarian interventions. This framework is the tactical conflict assessment framework (TCAF) and is included in Appendix C. (Derleth

and Martin 2007) This tool is based on a set of four questions that can be used to establish a baseline in communities where a humanitarian mission is proposed. The four basic questions included in the TCAF are: Have there been changes in the village population in the last year? What are the most important problems facing the village? Whom do you believe can solve your problems? What should be done first to help the village?” Answers to these questions form the baseline, described in FMI 5-0.1, from which planners can determine progress of outcome measures. The TCAF stresses the need for continuous assessment leading up to the transfer of authority and redeployment. This assessment not only tracks mission progress, but also detects unintended, negative effects that occur secondary to humanitarian interventions.

While not universal, the questions that form the foundation of the TCAF apply to most situations and can help to open lines of communication while establishing a baseline against which to measure further progress. Answers to these questions communicate priorities of the civilian population, which may differ from those of the HN government and the military. It is important in gathering answers to these questions that military personnel do not make promises. Any actions must be coordinated through the HN and be synchronized with all parties operating in the area to avoid duplication of effort and/or conflict. From the information gathered in the TCAF and analysis of trend directions, staffs can identify trouble spots and plan operations to reverse negative trends. They can also capitalize on positive trends by determining the etiology of the positive increase and apply the responsible tactics, techniques, and procedures more broadly, thus working to perpetuate favorable conditions.

The United States will continue to face terrorist threats to its national security into the foreseeable future. Medical diplomacy is one nonlethal capability that the US Army can utilize to address this threat, helping to stabilize vulnerable areas around the world, while advancing the United States interests. Its use as a preventative measure may act to diffuse situations created by either manmade or natural disasters, thus saving both economic and human capital. By developing a strong understanding of this concept, codifying sound doctrine, and collaborating with host nation, interagency, joint, international, and nongovernmental humanitarian partners, the US military can maximize its use of this tool while contributing to global security on the world stage.

APPENDIX A

LESSONS LEARNED OBSERVATIONS

References analyzed for Lessons Learned Appendix A:

- (AMEDD Center and School Lessons Learned Observations 2008, Observations 1408 - 17001)
- (Center for Army Lessons Learned 2006)
- (Center for Army Lessons Learned 2004)
- (OIF/OEF Operational Lessons Review Working Copy 2008)
- (Center for Army Lessons Learned 2004)

Appendix A: Lessons Learned Observations Evaluation of Core Competencies in Medical
Diplomacy

	Assess Needs	Coord. with Command	Coord. with HN Leaders	Coord. with Interagency	Coord. with Joint Forces	Coord. with NGHOs	Coord. with Others	Consider Culture	CMO Specific Training	Sustainable	Capacity Building	Appropriate Level Services	Support HN Legitimacy	Post Mission Assessment	Transition of Authority
1															
2	X		X					X	X						
3			X								X	X	X		
4								X							
5	X	X	X	X					X		X			X	
1408									x						X
1446		X													
1468		X													
1469	X							X							
1470		X													
1471	X	X													
1548			X			X									X
1562	X					X									
1563	X	X	X										X		
1564			X					X							
1588	X		X								X	X			
1589		X				X									
1611		X													
1612		X													
1686		X							X						
2104		X	X										X		
2105	X		X			X			X		X				X
2654											X				

Appendix A: Lessons Learned Observations Evaluation of Core Competencies in Medical
Diplomacy (continued)

	Assess Needs	Coord. With Command	Coord. with HN Leaders	Coord. with Interagency	Coord. with Joint Forces	Coord. with NGOs	Coord. with Others	Consider Culture	CMO Specific Training	Sustainable	Capacity Building	Appropriate Level Services	Support HN Legitimacy	Post Mission Assessment	Transition of Authority
2781	X		X			X					X			X	
2818	X										X			X	
2819		X	X							X	X	X			
2820			X								X				
3005									X						
3150			X								X				
3155												X			
3156												X			
3167									X						
3462			X			X				X					
3480		X	X												
3481			X								X	X	X		
3527			X										X		
3572			X	x		X							X		
3591			X					X							
3623	X		X												
3884			X					X	X	X	X				
3885								X	X						
3887	X		X								X				
3889			X								X				
4015	X	X	X							X					
4091	X						X			X				X	
4092			X				X		X						
4093		X	X							X	X		X	X	

Appendix A: Lessons Learned Observations Evaluation of Core Competencies in Medical
Diplomacy (continued)

	Assess Needs	Coord. with Command	Coord. with HN Leaders	Coord. with Interagency	Coord. with Joint Forces	Coord. with NGHOs	Coord. with Others	Consider Culture	CMO Specific Training	Sustainable	Capacity Building	Appropriate Level Services	Support HN Legitimacy	Post Mission Assessment	Transition of Authority
4094		X	X				X							X	
4095			X			X	X						X		
4099	X					X							X		
4103		X												X	
4139									X						
4420	X						X				X				
4517			X								X				
17001	X	X													
Totals	17	18	29	2	0	9	5	7	11	6	17	6	9	7	3

APPENDIX B
SAMPLE FRAGO FOR CMO

COOPERATIVE MEDICAL ENGAGEMENTS (AMEDD Center and School Lessons
Learned Observations 2008, 4094)

FRAGO

T1: COORDINATE WITH MNC-I SURGEON AND MNC-I C9 IN AREA OF DESIRED OPERATIONS TO DETERMINE POTENTIAL CME PROJECTS.

P1: IOT ASSURE ACCESS, ELIMINATE CHANCE OF REDUNDANT PROJECTS, AND ENSURE COORDINATION WITH MINISTRY OF HEALTH DIRECTORATE GENERAL.

T2: SUBMIT WRITTEN (E-MAIL) REQUEST TO MNC-I SURGEON FOR APPROVAL VIA MSC SURGEON WITH BRIEF DESCRIPTIONS OF FOLLOWING: BACKGROUND, BATTLESPACE OWNER, PROBLEM DEFINITION, PROJECT DESCRIPTION, IRAQI INVOLVEMENT, PROJECTED TIMELINE, DESIRED OUTCOME, DESCRIPTION OF PLAN TO INCLUDE WHERE PATIENTS WILL BE REFERRED FOR TREATMENT IF ACTION INCLUDES DISEASE/CONDITION SCREENING, PROJECT LEAD/POC.

P2: IOT ASSURE PROJECT MEETS MNC-I STRATEGIC AND OPERATIONAL GOALS AND OBJECTIVES. PROJECTS MUST BE VETTED THROUGH MNC-I EFFECTS BOARD.

T3: COORDINATE UNIT CME PROJECTS WITH BATTLESPACE OWNER.

P3: IOT MAXIMIZE SECURITY, AWARENESS, AND ASSISTANCE.

T4: SUBMIT AFTER ACTION REPORT TO MNC0I SURGEON OFFICE WITHIN 5 DAYS OF COMPLETING PROJECT.

P4: IOT TRACK RESULTS AND LESSONS LEARNED AND TO ALLOW
MNC-I TO SUBMIT REQUIRED REPORTS TO MNF-I.

T5: COORDINATE CME ACTIVITIES WITH PAO AND IO

P5: IOT MAXIMIZE PUBLIC AWARENESS OF CME.

T6: COORDINATE CME ACTIVITIES WITH SISTER ELEMENTS, G9, 354
CA BDE, 30TH MED BDE.

P6: IOT MAXIMIZE USE OF RESOURCES, REDUCE REDUNDANCY,
SYNCHRONIZE EFFORTS.

APPENDIX C:
TACTICAL CONFLICT ASSESSMENT FRAMEWORK

Steps for TCAF (Derleth and Martin 2007)

1. Assess the situation in the area of concern.
 2. Identify causes of instability/conflict (IN/CON)
 3. Identify and prioritize objectives* (Effects)
 - a. Determine impact indicators (MOE)
 4. . Impact indicators:
 - a. Measure the effectiveness of the planned activity against a predetermined objective.
 - b. Crucial to determining the success or failure of IN/CON programs.
 5. Choose monitoring methods
 6. Identify Activities (Task)
 7. Determine output indicators (MOP): These indicators measure the results of individual civil-military activities against the overarching objective.
 8. Choose monitoring methods. These may be public surveys, decreases in illegal activities, increased information from the HN population about insurgent activities, increased police presence.
 9. Implement activity
 10. Measure impact
- Design programming which will meet the following objectives:
 - o Increases support for the HN government
 - o Decreases support for the insurgents
 - o Increases governmental capability and capacity

Checklist for Programs Designed Using TCAF

The program designer should answer these questions about the program(s) in question.

Does the program:

1. Fit into the local political and cultural context?
2. Include the HN and local population throughout all stages of planning?
3. Allow for implementation by the HN government?
4. Have the unintended consequence of eroding HN civilian or governmental capacity?
5. Focus on programs that provide flexibility, allowing for modification based on on-going assessments?
6. Support other governmental organization (OGAs) and NGHO programming present in the area?
7. Strengthen the accountability and transparency of the HN government?
8. Bring the mission closer to achieving the long-term objectives?

9. Allow for a quick response to unforeseen crises such as violence, natural disasters, etc)?

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