An Easier Service

Is the Department of Defense Getting Good Value from Humanitarian Operations?

BY STEPHEN G WALLER

Serving God is doing good to man,
but praying is thought an easier service
and therefore more generally chosen. – Benjamin Franklin[1]

Mr. Franklin's commentary on human nature and our tendency to take the easy route, even if that route does not serve the public interest, is still pertinent today. When one analyzes the Department of Defense's (DoD) humanitarian activities, we see that tendency in evidence. Cold War era inertia, reluctance to expose failures, and a culture of short-assignment-cycle accountability have all contributed to a lack of introspection and evaluation of DoD's humanitarian work. Cost efficiency is calculated using only current costs, even as the deferred future costs of a mismanaged humanitarian action may dwarf those in the current budget cycle. With a lack of evaluation come misguided budget priorities and unproductive – even counterproductive – activity. Yet the tide is turning, and some solutions for better service are within sight.

DoD's humanitarian activities have a longstanding, rich role in the theater commander's portfolio. Ambassadors love them. Photo ops are plentiful, with happy host nation recipients smiling for the camera. Yet, a comprehensive analysis of return on investment has not been carefully done by any organization within DoD, and the link between humanitarian activities, particularly in health, and subsequent security is tenuous at best.

Many thoughtful observers see a limited role for DoD in non-kinetic scenarios. DoD's humanitarian efforts may blur the boundaries between defense, diplomacy, and development ('The 3 D's'). Each 'D' has its own lead federal agency, and all have large, complex mandates. Some would say that there is little need for any of those agencies to stray into another's lane. Others would argue that the term "humanitarian" should not be applied to military forces, even medical, because they do not have "neutrality" in the Red Cross sense (The Congress and Title 10 do not agree.) Yet there are clearly tasks that intrude on more than one lane, such as doing development work in an insecure environment.

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The spillover into diplomacy and accomplishment of diplomatic goals by medical and humanitarian interventions has been called "track two diplomacy," falling outside the customary diplomatic "track one" channels.[2] There is a large body of scholarly work on "track two," and much anecdotal support for its effectiveness. Health activities, while clearly beneficial to individuals or communities, are less clearly linked to the achievement of security goals.

On the other hand, many careful observers believe that such efforts can pay dividends in mutual security. Both DoD and the Department of Health and Human Services have placed "health attaches" at selected embassies worldwide, to facilitate the use of health interventions and cooperation in achieving political and diplomatic goals. These individuals operate in close coordination with the regional Combatant Command, but the outcomes are rarely evaluated in a scientific way.

DoD brings rapid response and world-class logistics capabilities that are essential to an effective response to large, sudden disasters, especially when security is also an issue. The deployment of portable air traffic control to Port-au-Prince airport after the 2011 Haiti earthquake could not have been done so well by any other nation or agency. The Chinook helicopters used in the Pakistan earthquake of 2005 filled a vital humanitarian lift role that no one else could do. Surely, deployed military hospitals or medical teams, even in non-emergency humanitarian situations, must provide a similarly clear benefit?

Gunnery Sgt. Chago Zapata, U.S. Marine Corp

U.S. Navy Chief Jeffrey Cavallo examines a 13-year-old Iraqi child during a Humanitarian Assistance Operation in the village of Ash Shafiyah, Iraq. This HAO provided medical and dental treatment to more than 115 Iraqi citizens.

Historically, most of the non-crisis DoD humanitarian efforts fell under the rubric of training for future military missions. The Defense Security Cooperation Agency funded much of this work and kept a second focus on its own raison d'être: security cooperation with allies. Recent DoD policy elevated "stability operations" to a core military competency, equivalent to combat operations.[3] U.S. military forces are now expected to be ready to perform all tasks necessary to maintain stability and order when civilian agencies cannot. Not surprisingly, medical care and disaster response are key components of both stability operations and security cooperation programs. There are indistinct borders between activities that support DoD's national security mandate and those activities that reduce transnational health threats. DoD carries out these activities without the clarity or the oversight that could be easily provided.

Former Secretary of Defense Robert Gates often talked about "the other elements of national power." He spoke of "Building Partners" (BP) and "Building Partner Capacity" (BPC) to illustrate the complexity of modern defense-development-diplomatic missions.[4] BP is the entry contact with another nation, when diplomacy is strained or non-existent. DoD humanitarian activities, especially non-threatening medical interventions and disaster response, can open the door to create non-zero-sum benefits for both the recipient and donor nations. Humanitarian deployments like the Medical Civic Action Projects (MEDCAP) and the medical efforts of Provincial Reconstruction Teams (PRT) often fall into this category. My own experiences in a 30-year Air Force medical career were largely of this type. BPC activities require a more mature, collegial partnership, often resembling development more than diplomacy. DoD can provide education and training, exercises, and equipment that create resilience in an allied nation, and produce mutual security. Both BP and BPC missions can relieve our government of future military or humanitarian disaster response costs and responsibilities, but when do health interventions lead to better security?

The Hypothetical Relationship Between Health and Security

Do humanitarian efforts to improve the health of an allied nation lead to improvements in its stability and security? On its surface, this seems like a simple question with an obvious answer. In reality, the causal link from health and other humanitarian intervention to security progress is tenuous at best. It may be that security improves due to economic progress, and health indices rise from those same economic changes – not directly from better security. Human and national security may directly improve health indices, but health improvements may not directly contribute to better security. This distinction is important because other organizations, such as the U.S. Agency for International Development and the World Bank, are charged with leading economic progress. Yet the DoD invests substantial resources in humanitarian health programs, with the goal of enhancing mutual security.

In fact, DoD invests enormous resources in humanitarian "global health" (GH) work. In September 2012, the Kaiser Family Foundation published an informative and comprehensive review of GH activities in DoD, and estimated that DoD spent $600 million on such work in the prior fiscal year.[5] This review defined GH activities and policies as "those with actual or potential impacts on the health of populations in low- and

middle-income countries." This definition contrasts markedly with other recent thoughtful attempts to define GH in the academic and medical literature. The author believes that a more rigorous definition of DoD's role in GH may inform and enhance this discussion.

To improve clarity, DoD should define GH from its own perspective. There are a number of academic definitions in the medical literature, but none fit DoD's unique role and interests in humanitarian work. An Institute of Medicine's report in 2009 states that GH is: "health problems, issues, and concerns that transcend national boundaries, and may best be addressed by cooperative actions with the goal of improving health for all people by reducing avoidable disease, disabilities, and deaths."[5] Some members of the leadership of the Consortium of Universities for Global Health, a rapidly-growing North American academic community, proposed a comprehensive definition of GH: "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care."[7]

Several of the principles of the U.S. Government's Global Health Initiative (GHI) provide additional insight into global health: encourage country ownership and invest in country-led plans; build sustainability through health system strengthening; strengthen and leverage key multilateral organizations, GH partnerships, and private sector engagement; increase impact through strategic coordination and integration; improve metrics, monitoring, and evaluation.[8] To the extent that DoD GH engagement activities are aligned with the objectives of the GHI, an operational definition of GH for DoD could utilize some of these principles. Given the primacy of DoD's security mission, its role in GH is focused on mitigating transnational threats and limited by design to those situations where mutual security can be nurtured or where its world-class logistics expertise is essential to the meet humanitarian challenges. There are indistinct borders between activities that support DoD's national security mandate and those activities that reduce transnational health threats.

How do these attempts at defining GH influence the DoD? Not at all, if we use current doctrine to judge. There is no definition of GH (or international health) in the definitive Joint Publication 1-02, DoD Dictionary of Military and Associated Terms. A search of other relevant Joint Publications finds the term GH rarely used, and when it does appear, it comes from quotes lifted from the literature of international or non-governmental organizations. The services' doctrine is equally quiet. The glossary of the Air Force Instruction 44-162 (International Health Specialist Program) defines Global Health Engagement, but not GH itself. Likewise, a cable sent last summer from the Assistant Secretary for Special Operations and Low Intensity Conflict exhaustively defined GH in eighteen mind-numbing lines of text. The cable definition includes transnational threats, focus on the underserved, a multidisciplinary effort, both prevention and clinical care, building host nation capacity, and stabilizing host nation governments. It was not wvery different from the scholarly journal articles cited above, and too long for a memorable sound bite.

The author recommends that DoD consider a definition of GH that emphasizes the importance of health to national and international security and a definition of Global Health Engagement that is jointly applicable and leaner than the USAF version. DoD should continue in its important role, particularly in those situations where there is a lack of security or where world-class logistics are immediately needed. DoD's role is also based on the importance of success in GH to national security. Health issues that transcend national boundaries can upset regional stability and require DoD intervention to repair. Proactive attention to these issues and threats can position DoD to respond more effectively. DoD has tools to address GH extend far beyond its Military Health System and medical research laboratory assets. Consistent with the established emphasis on multidisciplinary perspectives and collaborative efforts in GH, DoD can call on logistics, engineers, transportation, interagency, and non-governmental organization partners to accomplish its GH goals. To honor all these complex missions and components, I propose the following definition for DoD: "Global Health is the protection against transnational health threats by cooperative, sustainable efforts for improvements in health."

Limiting GH engagement by DoD to activities that are "sustainable" is a new, higher standard than we have seen in the past. It is a broadly accepted standard, in GHI and most of the humanitarian community, and it should be the standard in DoD as well. Keeping a focus on sustainability assures continuous engagement with other stakeholders in the interagency, host nation, and non-governmental organizations. (The National Guard's "State

Expert Infantry

Military relief efforts included addressing health concerns following the earthquake in Haiti as part of Operation Unified Response, 2010.

Partnership Program" is a fine example of this.[9]) Programs that teach preparedness or disaster mitigation lessons, for example, create resilience in partner nations and regions, and reduce dependence on DoD for response to contingencies that are best handled locally. In an era of downsized budgets and increasing opportunities, partner nation resilience and sustainability in GH engagement are essential.

Better clarity of purpose brings an ethical perspective that is presently missing in DoD humanitarian operations. The great ethical principles of respect, beneficence, and justice are analogous to three key pillars – ownership, sustainability, and equity – of a successful humanitarian health intervention. When the humanitarian agenda is driven by the donor, without host nation consultation, we often find a lack of ownership, a "unilateral cooperation" that fails to sustain the improvement. When the host nation stakeholders are not given equal empowerment to plan and execute the humanitarian mission, the lack of equity often leads to wasted resources and a monument to foolishness, such as a new school building now being used as a stable. Insisting on accountability and transparency by the host nation authorities is also integral to ethical humanitarian operations. Doing all this effectively requires nuanced cultural understanding and thoughtful engagement. The right balance of ownership and "donorship" can lead to better mutual security and appropriate development.

DoD's role in Global Health can be called Global Health Engagement (GHE). I propose GHE be defined as; "the utilization of appropriate military assets to promote GH." Regardless of the definition chosen by DoD, having clarity on these concepts could lead to better doctrine, better planning, and smarter oversight of related activities in DoD.

Attribution, Not Association

Finding scientific support for a determinant relationship, what scientists call "attribution," is difficult. Events can occur simultaneously ("association") without a cause-and-effect relationship. The current hierarchy of scientific evidence today puts greatest credence in answers derived from a systematic review, which is a thorough study of all the appropriate literature and combination of the best work to reach a convincing outcome. Efforts to do this to confirm the health to security connection have been frustrating. Searches of the world-class Cochrane Systematic Review database and the vast resources of the Web of Science search engine produce no scientific literary works to support a direct causal linkage. Other objective, reliable sources of information on this topic, like UK's Chatham House, Harvard's Global Health Institute, and the World Health Organization, confirm that there is no direct relationship. However, its pervasive use to justify military humanitarian medical work gives the health-security link an exalted status, like that of Plato's "noble lie."

Circumstances can bear heavily on the appearance of a direct causal linkage. In a complex humanitarian crisis (both humanitarian and kinetic), especially when the decline in health has been acute, the linkage between population health and security seems direct. Rapid declines in population health destabilize society and governments, and therefore create insecurity. But does improving health then reverse the security crisis? A humanitarian health program may be hypothetically related to security if it can help a less-stable government fulfill its obligations to the population.

In DoD stability operations doctrine, health services (especially public health services) are recognized as an "essential service" that populations expect their government to facilitate, if not provide directly.[10] Programs that successfully help the host nation meet this obligation could, at least in theory, directly enhance security. In this case, though, the health-security link may be indirect, or second order. The health-security relationship may be indirect, through other determinants such as governance, socio-economic status, education, or transportation/access to healthcare, or it may flow from security to health, but not from health to security. So should the intervention by DoD be in the directly linked sector, or through second order effects through improving health?

There are certainly anecdotes that support a causal relationship between health interventions and peace. The Pan-American Health Organization's "days of tranquility" vaccination campaign in El Salvador in the 1980's created cease-fires and an eventual opportunity for diplomacy to end the longstanding civil war.[11] The modern-day International Health Regulations promulgate methods of surveillance and control of a potential pandemic that creates stability and security for all nations.[12] On the contrary side, the health of armies has always been a direct factor in security. The world was safer and more secure after diseases and non-battle injuries – an absence of health – decimated Napoleon's Army during the Russian campaign of 1812. (Nearly 90 percent of his 400,000 casualties were from disease

Vasily Vereshchagin

Following Napoleon's retreat from Russia there was a saying, alluding to the Russian winter and the costs of disease and the elements to Napoleon's forces, that Generals Janvier and Fevrier (January and February) had defeated Napoleon.

and hypothermia.)[13] The ability or inability to maintain the health of fighting forces has affected the outcome of nearly every conflict in history.

The assumption that better peace and security are the outcomes of civilian humanitarian health programs is based on circumstantial evidence, argues Alex Vass and others. They believe that the factors of proximity, an accurate definition of peace, and other confounding variables more precisely describe the linkage. To establish an irrefutable scientific correlation, one must be able to account for the specific contribution of a humanitarian health program to a security outcome. It is more convincing when that specific contribution is withdrawn, then re-introduced, and the security outcome relationship continually shows the expected effects. For complex humanitarian situations, or even in deliberate planning scenarios, this is very difficult to accomplish. However, that does not excuse DoD for failing to evaluate the actual long-term impact and return on investment of its humanitarian programs. At the end of the day, in spite of wishful thinking, health may be a second or third order determinant of peace and security, and DoD's investments in humanitarian health programs should recognize this.

The Essential Ingredients

I believe there are potential solutions for the challenges of validating DoD's engagement in humanitarian work for security objectives. There are two essential ingredients: DoD must

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Somalian children wait for food to be provided during Operation Provide Relief, 1992. A congressional fact-finding delegation toured several humanitarian relief sites to assess the impact of U.S. aid in the country.

first define exactly what it hopes to accomplish. Second, DoD should monitor and evaluate its efforts with greater rigor. Measures to accurately do this can be implemented in this fiscal year, without additional resources or appropriations, and without new Congressional authorization.

To date, the efforts to monitor and evaluate military humanitarian operations are in their infancy, piecemeal and ineffective. DoD Instruction 3000.05 *Stability Operations* directs the robust monitoring and evaluation of stability activities, including humanitarian assistance and medical care, under the direction of the Combatant Commanders. These line officers trust their medical officers to do "the right thing" in humanitarian operations, unaware that there is little scientific evidence of exactly what that might be. In my experience, there has been a disappointing lack of dialogue on this topic between the line leadership and the medical officers, and unwarranted confidence continues. One solution is to begin to do honest monitoring and evaluation of humanitarian outcomes, and to use the lessons learned to change policy and behavior.

I have proposed the implementation of a system of outcome assessments of humanitarian missions, using a simplified "scorecard." The scorecard questions focus on proper planning, coordination, empowerment of host nation stakeholders, execution of the mission, and on measuring outcomes that are sustainable by the host nation. The scorecard questions are written in a yes-no format, to force the responder to provide an opinion on success or failure of that aspect of the mission. All stakeholders from the host nation party, the U.S. embassy, the Combatant Command, and not just the deploying team, should reply, and equal weight is given to their responses. Each scorecard is tallied and the mission is given a score. Using this value as a method of judging relative value of the mission, Combatant Command headquarters can rank all the missions supported during a fiscal year, and use this ranking as part of the decision process in preparing subsequent budgets and priority lists for humanitarian efforts. The scorecard can also be a tool for long-term impact evaluation, a neglected aspect of DoD's evaluation efforts. Currently, there is no similar method of analyzing humanitarian missions for relative value, and only anecdotal efforts to translate lessons learned into more efficient use of resources in subsequent fiscal years.

Humanitarian missions come in many flavors and sizes – crisis and deliberate action, teaching only, hands-on health care only, infrastructure development, sector-specific or broadly-based – but all share a common core of procedures and metrics that can be objectively compared. The resultant analysis of these common factors will be a limited view of the mission, and often the commander or ambassador will have priorities that dominate the analysis. We argue, however, that without a common core analysis that can "rack and stack" the group of missions supported by higher headquarters, some opportunities to do better next year are lost.

There is much low-hanging fruit to evaluate. For example, there may be substantial value in agile portability in crisis responses. Equipment and personnel packages that can respond within the "golden hour" can provide a robust return on investment in both kinetic and humanitarian crises. There should, however, be investigations of which packages work best in which situations. We should know the definition of a "golden hour" of response (a concept from emergency medicine treatment

of acute injury) for disasters, and how that might vary for responses to different scenarios, like earthquake, flood, explosion, or other potential disasters. We should know the strengths and weaknesses of the "cluster system" disasters response used by the UN to organize crisis action into sectors.[15] (Some would call them "siloes of excellence.") We should know which types of missions create resilience and which create dependency on continued donated services. We may find that health interventions only lead indirectly to mutual security, through programs that provide economic development or better education. These answers come from careful evaluation of outcomes, and varying the initial conditions in sophisticated ways. Host nation stakeholder inputs provide unique insights into these issues, as well as the unintended consequences of an intervention. Many unanswered questions remain, and the evidence for setting reliable standards is very thin.

There are a number of civilian humanitarian organizations engaged in systematic reviews of disaster response scientific articles and reports, and such expertise could guide some of DoD's efforts. The Pan-American Health Organization, headquartered in Washington, DC, has a long record of advocacy for disaster mitigation and preparedness, expertise that could be shared with DoD's humanitarian mission leaders.[16] Interaction, a consortium of nearly 200 non-governmental humanitarian organizations, has an active Evaluation and Program Effectiveness Working Group, and much familiarity with working with military groups.[17] Evidence Aid, a disaster response systematic review group, could assist DoD for mutual benefit.[18] Their reviews show that few civilian humanitarian organizations are doing effective priority setting, and DoD does well at this. Coordination of efforts and avoidance of redundancy is a second area that DoD does well and the civilian humanitarian community does not. The "quality" movement, so prominent in military medicine today, has yet to have a substantial impact on humanitarian work, and DoD can bring much experience to the table in this area.

There is a lot to learn about the science of devising an effective exit strategy, particularly in areas where the pre-disaster situation was pitiful. The most effective exit strategies are created with the mission plan, so key factors are monitored from day one. An efficient method for analyzing an exit strategy is with a spreadsheet listing the many contributing factors, giving each a stoplight color daily, and using the consolidated picture to guide exit decisions. The spreadsheet is a helpful tool in clarifying progress or failures, and in engaging ambassadors, political leaders, and the Combatant Command on redeployment timing. I have seen this technique work well in the redeployment of a helicopter squadron from flood relief in Africa and in the use of a portable Air Force hospital in Houston after flooding of their major hospitals during Tropical Storm Allison in 2001. Knowing when and how to implement exit strategy analysis, and the best tool for the commander to use, can pay enormous political and fiscal dividends for DoD.

An Easier Service or the Best Return on Investment?

Defining DoD's role in using humanitarian health programs for security goals can and should be done. I propose such a definition, but only to begin discussion. Equally important is the implementation of scientific evaluation of humanitarian missions. This can be

done quickly, without new authorization or appropriation legislation. Then DoD can get on with the business of national security, using the humanitarian response tool in the most effective ways. Having good intentions is not enough.

Benjamin Franklin recognized the hypocrisy of substituting good intentions for good works. For DoD to avoid this "easier service" trap in its humanitarian efforts, we must be clear in our intentions, sustainable in our actions, and compulsively thorough in our evaluations. Together, even in the face of a tenuous link between health interventions and peace outcomes, DoD can deliver on its peace and security mandate to the taxpayers and the Congress. PRISM

Notes

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Photos

Page 127 photo by Expert Infantry. 2010. *Military relief efforts in Haiti after devastating earthquake.* From https://www.flickr.com/photos/expertinfantry/5461053831/ licensed under the Creative Commons **Attribution 2.0 Generic** license. https://creativecommons.org/licenses/by/2.0/deed.en. Photo reproduced unaltered.