

Strategy Research Project

Synchronizing Interagency Health Diplomats in Support of National Security Interests

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Abstract

Global Health Diplomacy is an increasingly recognized soft power element in support of the United States National Security Strategy. Multiple United States agencies employ personnel globally to positively affect host nation population health indicators, combat active or prevent emerging disease threats, build partner capacity and increase interoperability with the international community. Interagency coordination is a key element to synchronize medical efforts in support of global health activities. Several identified governance challenges lead to inefficient and desynchronized efforts. Health diplomats lack standardized training and education despite many of the same requirements. Interagency personnel distribution leaves potential gaps in global surveillance and limits effective support to Ambassadors. If the United States is to synchronize health diplomacy across the interagency, formalizing a governance structure with clearly articulated authorities as well as evaluating the attributes and distribution of health diplomats is strategically vital in improving global health effects in support of national security objectives.

Synchronizing Interagency Health Diplomats in Support of National Security Interests

President Obama identified increasing global health security as a key tenet of the 2015 National Security Strategy (NSS) to highlight the United States' (US) responsibility for underwriting international security because it serves our interests, upholds our commitments to allies and partners and addresses health threats that are truly global.¹

Admiral William J. Fallon stated, "It is now widely accepted that nations with healthy populations are more likely to be productive, prosperous, and peaceful. This matters to the United States because peaceful nations generally make good neighbors.

Conversely, poor health indicators are usually a sign that something is not right in the society."² Executing global health activities during times of peace is an effective use of soft power for the nation. Investing in health diplomacy creates conditions to anticipate global health challenges and negative effects, ensures a proactive approach to resource allocation and ensures the United States maintains a leading role for health stability on a global scale. These efforts not only improve health around the world but also provide for the national defense by reducing the potential spread of global diseases to the United States. However, in a recent review of the U.S. Government (USG) engagements in global health, the Kaiser Family Foundation noted that, "US funding for global health has plateaued in recent years in the wake of the financial crisis and continued fiscal constraint."³

Interagency coordination is a key element to synchronize medical efforts in support of global health activities. The Kaiser review stated interagency coordination "will help achieve desired end states by facilitating cooperation in areas of common interest or avoiding unintended negative consequences when working in the same

space as other stakeholders.”⁴ While there are pockets of success, interagency coordination on health diplomacy remains immature. The RAND National Security Research Division published a 2013 study titled *Lessons Learned from Department of Defense (DoD) Disaster Relief Efforts in the Asia-Pacific Region* and stated, “While the quality of interagency coordination has generally improved, it depends greatly on specific circumstances for each disaster.”⁵ A 2012 Government Accounting Office (GAO) report involving humanitarian and development assistance similarly found “DoD has taken steps to coordinate with the Department of State (DoS) and the United States Agency for International Development (USAID) on projects...but coordination challenges remain.”⁶ When similar inter-service challenges were identified within the DoD, the 1986 Goldwater-Nichols Act mandated a reorganization to improve joint integration and define new leadership responsibilities.⁷ Now is the time to perform a holistic review of the interagency health diplomacy process to determine if adjustments like those of the Goldwater-Nichols Act could produce similar interagency coordination, cost savings and lead to improved health activities targeting national security goals.

Merriam Webster defines a diplomat as “a person who represents his or her country’s government in a foreign country: someone whose work is diplomacy.”⁸ Health diplomats are the key to “build trust and confidence, share information, coordinate activities, maintain influence and achieve interoperability” with partner nation military or civilian authorities.⁹ Several departments across the USG develop and employ health experts around the world to monitor health/disease indicators, partner with host nation civilian and military leaders to improve their capabilities, and manage programs of national or international health importance. This paper reviews the governance structure

managing their efforts and the current development and utilization of health diplomats within the USG. While similar skills, qualifications and distribution of health diplomats among the interagency demonstrates possible opportunities for synergy, an analysis of the entire health diplomacy process highlights a disjointed structure at the national level. This lack of clear authority at the national level to drive global health priorities sets conditions for reduced effectiveness at the local and regional level. In the face of deepening fiscal constraints, US government agencies must coordinate a whole of government approach to global health priorities and review requirements for health diplomats to achieve synchronized and sustainable medical effects around the world in support of US national security interests.

Strengthening Interagency Coordination

Each agency performing health diplomacy activities specifies interagency coordination as a guiding principle to development but concentrates on activities specific to its element of national security on behalf of the USG. The DoD focuses on security cooperation and building partner capacity while also remaining expeditionary global health responders. As part of its guiding principles, DoD must also communicate and coordinate with the other agencies. DoD Joint Publication 3-08 states, “At the President’s direction, military power is integrated with the other instruments of national power to advance and defend US values, interests, and objectives.”¹⁰ DoD Instruction 3000.05, “Stability Operations,” mandates the DoD to “collaborate with other U.S. Government agencies and with foreign governments and security forces, international governmental organizations, nongovernmental organizations, and private sector firms as appropriate to plan, prepare for, and conduct stability operations.”¹¹ Geographic combatant commanders and subordinate component commanders assign medical

personnel to develop military-to-military engagement plans as part of their collective and joint training events in support of the theater campaign plan. A Secretary of Defense memo states global health engagements are “a means to partner with other nations to achieve security cooperation and build partner capacity through health-related activities and exchanges.”¹² The geographic combatant command (CCMD) collects, reviews and prioritizes DoD projects nominated for funding across its region. Representatives from USAID are present but there is no formal mandate to review every project across the interagency at the CCMD or higher governmental level.

The Ambassador/Chief of Mission is the President’s representative within a country and is responsible for mission activities to support US national security interests. All efforts within a country should be coordinated through the Ambassador’s office or staff. In support, the DoS Office of Global Health Diplomacy’s (OGHD) guiding principles include working “with USG agencies representing our interests in multilateral organizations to advance our global health priorities and improve and save more lives.”¹³ DoS primarily coordinates with the Department of Health and Human Services (HHS) to execute initiatives or programs on behalf of the President or US ambassadors. The HHS policy is to “engage and coordinate with international partners, including responding non-governmental organizations (NGO), the World Health Organization (WHO), and other donor countries, in an effort to limit the burden on US domestic resources and support a coordinated global public health response.”¹⁴

DoS and HHS provide “ambassadors and health teams on the ground to strengthen high-level diplomatic engagement needed to enhance partner country capacity, political will and shared responsibility required to build sustainable country-

owned health systems that effectively improve the health status of their populations.”¹⁵ They “mitigate the negative impact of a potential, or actual, medical or public health emergency abroad and support USG foreign policy objectives, international frameworks, agreements and other arrangements, and HHS regional and country-specific goals.”¹⁶

As part of HHS, the Centers for Disease Control (CDC) deploys personnel to “protect and improve health globally through science, policy, partnership and evidence-based public health action” and it operates in over 60 countries.^{17 18} DoD Security Cooperation Officers (SCO) are also on the ambassador’s staff to focus on military-to-military engagements and assess security cooperation. Because SCOs rarely have medical training, they receive support from the CCMD or service component command (SCC) to develop military health effects desired by host nation and US leadership. While approval of all activities in the country lie with the Ambassador, each agency may also “coordinate independently with the WHO, United Nations, NGOs, health institutions, multilaterals, universities and the private sector” as a result of their relationships, the scope of their efforts in a region or their funded mandate.”¹⁹

The USAID policy on cooperation with the DoD states, “Cooperation is an essential condition for the achievement of US development and defense objectives.”²⁰ The USAID’s mandate is to offer support within developing countries only to “ease the transition between conflict and long-term development by investing in agriculture, health systems and democratic institutions” in support of the Ambassador’s strategic plan or as directed by specific project requirements.²¹ The USAID team performs activities in cooperation with the Ambassador’s country team and host nation leadership. With

Ambassador approval, they may also take guidance regarding regional priorities and efforts from USAID or higher leadership.

Despite substantial and consistent strategic guidance mandating interagency cooperation and synchronization of efforts, reports such as those from the RAND Corporation and GAO indicate more effort is required to realize true efficiencies and effects. Each agency primarily focuses on its specific aspect of global health diplomacy and receives funding specific to those areas. At just over \$10 billion, the United States is the largest donor to global health through direct funding of activities and through contracts executed primarily through USAID and the DoS oversight.²² Programs like the President's Emergency Plan for Acquired Immune Deficiency Syndrome (AIDS) Relief (\$5.3B), Maternal and Child Health (\$1.2B), the Global Fund to fight AIDS, tuberculosis and malaria (\$1.1B) and several smaller programs targeting nutrition and vulnerable children around the world are managed by USAID, CDC, Office of Global Affairs (OGA), National Institutes of Health (NIH), and the Food and Drug Administration (FDA).²³ Agencies execute other programs, initiatives and urgent requirements with the residual funds. It remains unclear how these agencies collectively review, analyze and prioritize medical projects to further national security priorities. As health professionals and politicians review emerging threats, do we have the correct focus on true threats to national security as well as improving health indicators around the world and identifying those countries/regions where health engagements now will improve future USG diplomatic efforts? Who is ultimately responsible for health diplomacy activities for the USG? Within a foreign country, the Ambassador has the responsibility but generally does not have a medical advisor on the staff to coordinate the myriad of efforts. At the

national level, it appears no agency or office is holistically reviewing health efforts or effects.

Regionally, combatant commanders and USAID regional directors maintain region-wide visibility of concerns related to their focus areas. However, there is no overarching guidance requiring interagency coordination of all projects in the region potentially leading to duplication of effort or gaps in support to host nation partners. As mentioned, country team and regional leaders often lack strategic guidance related to specific health outcomes to prioritize health diplomacy activities and funding for health effects. Providing strategic guidance specific to regional or national security objectives would drive development of projects and health engagements leading to more effective time management of health diplomats and improving relationships with host nation leaders, who periodically become frustrated when their priorities are not funded by the United States. The following are recommendations to address the challenges and gaps identified during the analysis of interagency coordination.

Recommendations for Strengthening Interagency Coordination:

- Formalize health diplomacy guiding principles or higher United States Code to require interagency synchronization of health-related projects, support the NSS and avoid unintended negative consequences.
- Appoint an office such as the DoS OGHD as the “Health Czar” with the authority to set standards, manage budget and provide priorities across all agencies performing global health activities. While Congress often earmarks money specifically for high priority programs, discretionary funds should be centrally managed to meet NSS objectives and target support to ambassadors and

combatant commanders. Some may view this as leading to a more bureaucratic system counter to the goals of this review. While other agencies certainly engage capably in global diplomacy, the DoS is primarily responsible for setting priorities and executing the national security agenda. With increased authority and moderate augmentation, the DoS OGHD could convene a regular meeting of interagency medical leadership to review the national security objectives, prioritize programs/training opportunities and ensure fiscally responsible distribution of assets. Interagency representation ensures transparency and ultimately leads to improved outcomes in support of US national security.

- Consider formalizing a health-specific interagency coordination cell at the national-level through a memorandum of understanding or presidential directive similar to the “3D” cross-functional governance forum that occurred among DoS, DoD and USAID. Projects or programs nominated by CCMDs, ambassadors or department secretaries receive equal review and prioritization for funding and execution based on NSS priorities. More importantly, country teams receive consistent guidance on national priorities and develop medical efforts within their country to maximize effects-based outcomes.
- Replicate the 3D cell at the CCMD and, to the greatest extent possible, at the country team. A formalized agenda with all the stakeholders present would address the persistent negative findings by auditors from external agencies and enhance interagency visibility and coordination.

Skills, Training and Education for Health Diplomats

Health diplomats must be experts in the evaluation of healthy behaviors, disease trends and development of projects or initiatives that promote health. They must be savvy in international engagements and communication techniques to support diplomatic efforts. While the overall knowledge, skills and abilities of health diplomats across the agencies are similar, enough variation exists to potentially reduce the effectiveness of interagency communication and lead to inefficient health diplomacy activities.

The HHS uses the name health attaché to describe its diplomats who “collect, analyze, and act on information concerning health in a foreign country or countries and provides critical links between public health and foreign affairs stakeholders.”²⁴ Health attachés are required to “understand health issues while being able to negotiate effectively in the multinational foreign policy space.”²⁵ Core competencies include conducting relevant policy negotiations on behalf of his/her respective government, an in-depth knowledge of public health issues and possession of broad based general knowledge, sound judgment and strong interpersonal skills.²⁶ All officers currently serving as health attachés possess professional expertise in health-related fields but there does not appear to be a published position description with minimal qualifications specific for a health attaché beyond health expertise.

The USAID’s Foreign Service Officers (FSO) “must hold a graduate degree [related to their specific position] or some combination of a bachelor’s degree and relevant work experience.”²⁷ They attend a 5-week orientation program with follow-on language training (as needed), detailed position-specific training and then a series of on-the-job and formal classroom events prior to moving to their overseas assignment.²⁸

The position description for a Population/Health/Nutrition (PHN) below describes skills required of USAID health workers:

USAID Population/Health/Nutrition (PHN) officers are responsible for developing, overseeing, managing (staff, financial and technical resources), and evaluating PHN programs in any or all of the following areas: population/family planning and reproductive health; child survival (including immunizations, acute respiratory infections, diarrheal diseases); maternal health; HIV/AIDS and sexually transmitted infections; infectious diseases such as tuberculosis and malaria; nutrition (including micronutrient supplementation and fortification); social marketing of commodities as well as behavior change endeavors; population, health or nutrition policy reform; operations/programmatic research and biomedical/clinical research; commodity/pharmaceutical logistics and supply chain management; health systems strengthening and health economics.²⁹

In response to the Secretary of Defense's 2013 Global Health Engagement (GHE) memo, the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight and the Joint Staff Surgeon established the Global Health Working Group (GHWG) to "stand up a DoD global health specialist capacity."³⁰ The GHWG established the Capabilities Committee with representatives across all three Services, National Guard (NG), Uniformed Services University of the Health Sciences (USUHS), and the Joint Staff to define requirements and make recommendations on the process for GHEs within the DoD, including personnel requirements to perform duties. The committee recommended the International Health Specialist (IHS) program, originally developed by the Air Force (AF) in 2001. IHS program officers, now referred to as global health specialists, are "fully qualified in their primary role as either AF Medical Service health-care providers or support staff who have (1) additional language and cultural competency, (2) expertise in regional medical threats and infrastructure, (3) knowledge of joint and interagency coordination process, and (4) the ability to build medical "bridges" to support coalition partnerships."³¹ Defined personnel competencies include

“language, regional and cultural; organization, knowledge; civil-military operation; principles of military medical and public health; military operations; legal/ethics; funding; security cooperation; and operational databases.”³²

The GHWG Capabilities Committee Report recommended two tiers of joint global health specialists and specific training requirements to validate competency.³³ Tier two is an entry level position recommended to work at the SCC level while tier one specialists serve at the Joint or CCMD level of military command. Although advanced degree requirements are not specified, personnel working as global health specialists are expected to be drawn from medical personnel with advanced degrees. In addition, region-specific training offered by the combatant commands, the USUHS or USAID sponsor courses such as the GHE/Medical Stability Operations Course or the Joint Humanitarian Operations Course to meet additional training and education requirements.

To ensure interoperability and active management of those with special training in global health, the GHWG recommended the propagation of “Special Experience Identifiers (SEI) or Additional Skill Identifiers” across the services.³⁴ The AF has active SEIs for the IHS program while the Navy is in the midst of developing a similar “Additional Qualification Designator” without the language component requirement. The Army is still reviewing options.

Each agency’s health diplomat must possess several key skills to achieve optimal effects. Foremost, they must be trained healthcare professionals that understand the nuances of human interaction with their environment and the impacts of sanitation, poverty, disease and wellness activities on overall health. They must also be

skilled diplomats with excellent interpersonal skills, a depth of knowledge on international relations, and the ability to anticipate the long-term consequences of actions or failure to intervene. The skill to then articulate these details to a wide variety of audiences and gain consensus displays the real talent and effectiveness of a health diplomat. For this reason, proficiency in local or regional language is critical. Health nuances often do not translate effectively through an interpreter. Two healthcare professionals must be able to communicate directly with each other in a common language for true understanding to lead effective programs and partnership. Too often, subtle misunderstandings lead to unmet expectations and potentially international discord.

Health diplomats must also possess the training and foresight to develop long term, sustainable projects that may take a generation or more to realize significant health impacts. As William Adamson points out, “measuring prevention is difficult, if not impossible. Measures of effectiveness for shaping and engagement activities are unclear and determined by individual geographic commands.”³⁵ In his remarks on global health as a bridge to security, Admiral Fallon notes, “If the USG is going to continue to devote substantial resources to global health, the US Congress will demand results. But measuring health improvement is difficult, particularly over the short term...”³⁶ The 2013 National Defense Authorization Act (NDAA), Section 714, directs “the Secretary of Defense to develop a process to ensure that health engagements conducted by the DoD are effective and efficient in meeting the national security goals of the US.”³⁷ While this requirement is an important step forward to mandate an effects-based system of project generation, indicators of positive health outcomes are generally not evident

within a budget cycle. Too often, health diplomats cannot adequately generate or articulate true measures of effectiveness in a way that prompts senior leaders to effectively allocate precious resources over the long term and grow critical partnerships leading to sustained health effects.

Health diplomats working with host nation partners often lack formalized training, expertise and guidance to develop long-term country-specific or regional projects. While more extensive projects like the President's Emergency Plan for AIDS Relief, Global Pandemics Policy and childhood immunizations are notable examples of global programs targeting international diseases over an extended time, these programs are developed and managed within the US by a small cadre of health experts with extensive training in public health. Standardizing the skills and attributes of all health diplomats across the interagency can lead to a higher quantity of health experts capable of developing and sustaining health efforts leading to enhanced national security objectives while also benefiting military leaders, ambassadors and congressional requirements. The following are recommendations to increase the quality and quantity of personnel performing duties as health diplomats on behalf of the USG.

Recommendations for Skills, Training and Education of Health Diplomats:

- To meet the requirements of the FY13 NDAA, the DoD GHWG's Measures of Effectiveness Committee recommends using the Measures of Effectiveness in Defense Engagement and Learning study process, supporting the US Pacific Command's DOTMLPF assessment process and improving database portals to enhance data entry and quality.³⁸ While DoD specific, these recommendations have merit for the interagency in order to bring the art of statistical measures into the science of health effects. Through common understanding and meaningful

measures defined over a specified period to observe the desired outcomes, projects can be developed by health diplomats that truly impact host nation health, partner capacity and support US national security objectives.

- Standardize the health diplomat position description across the interagency to include requirements resident in the DoS' FSO skills requirements. While special skills may be required to fulfill specific duties in some programs, a common set of minimum standards increases effective communication and provides confidence across the interagency in the professional qualifications of partners from other agencies.
- Mandate an interagency database and project nomination process. Agencies could expand the Overseas Humanitarian Assistance Shared Information System program beyond DoD humanitarian activities or replace it with another interagency program to generate true whole of government visibility, tracking and centralized approval of project nominations.
- Define specific interagency training and demonstrated proficiency requirements similar to what the DoD is proposing for their health diplomats. DoD requires completion of specific training classes with demonstrated competence in the use of database systems prior to deployment outside the US. When combined with the recommendation to standardize interagency databases and project nomination requests, this skill will lead to improved data quality and effective nominations for consideration.
- Mandate minimum language proficiency for the country or ensure availability of health-trained bilingual interpreters for high-level coordination meetings. Across

the interagency, this could be a highly contentious issue. However, language proficiency is key when communicating with host nation medical experts on the subtle nuances of global health.

- Within the DoD, codify specialty skill identifiers in order to manage and retain this vital expertise for foreign service. The skills and attributes required of a health diplomat require years to develop. Traditional non-commissioned officer and officer selection and promotion systems lack the specificity to effectively manage this professional niche community. While the AF has a SEI, the other Services should adopt similar standards to improve tracking, utilization and increase career satisfaction. The other agencies should also review this closely to assess if their systems allow for opportunities to advancement if the employee advances their skills.
- Across the interagency, publish meaningful measures of effectiveness metrics that articulate both short term and long term sustainable effects supporting national security objectives. These must cover both the art and science of health development and be understandable by military and civilian leaders across the interagency.

Interagency Distribution of Health Diplomats

Each agency assigns their health diplomats to their posts based on program requirements or mission goals. Priorities for US global health programs “are based on a number of factors, with burden of disease faced by countries as an important factor...”³⁹ Other factors include “the presence of willing and able recipient partner governments, a history of positive relations and goodwill between the countries, strategic and national

security priorities, funding and personnel availability.”⁴⁰ With these as priorities, it is clear some nations receive substantial personnel resources while others receive little or none. Leaders must focus on the health diplomacy goals of improving global health and increasing host-nation capacity and intergovernmental interoperability when determining interagency distribution of personnel. This ensures the United States maximizes effective utilization of health diplomats and furthers national security interests.

As evidence of increasing interagency cooperation, personnel from DoD work within HHS’s attaché program, USAID leaders are embedded into the CCMDs, and there are countries around the world where health experts from multiple agencies work to improve the diverse aspects of that nation’s health. While these are pockets of interagency coordination, personnel assignments are subject to adjustment without coordination with other stakeholders. Informal agreements and unilateral policy papers currently articulate these assignments but they are not formal arrangements. This leads to potential inefficiency and loss of capability if higher priority efforts require recall of those serving as liaisons.

Agencies fund the vast majority of health diplomats to manage a specific program, provide intergovernmental assistance/build partnerships, or engage with specific government officials to enhance host nation capability. As a result, full visibility of efforts and agency interoperability has not been a point of emphasis. However, a coordinated assignments or enhanced interagency visibility process could lead to more effective health diplomacy and reduced overall costs to the US. With enhanced coordination and understanding, international agencies could be coopted to partner more effectively and improve host nation capabilities.

In the HHS, medical personnel specifically assigned to perform duties as health diplomats are posted to only a few Ambassadors' country teams. As of September 2014, the HHS identified 12 international positions for health attachés around the world, including five full-time positions managed by the OGA in China, Brazil, Switzerland, South Africa and India, four dual-hatted (CDC and HHS) positions in Thailand, Vietnam, Guatemala, and Kenya, two Navy Officers in Vietnam and Papua New Guinea, and one USAID officer in Indonesia.⁴¹ One additional officer was subsequently assigned in Mexico City under the OGA for a total of six officers. These do not represent countries with small embassies with potentially the greatest need, highlighting a significant gap in coverage of health expertise.

As mentioned, the USG distributed over \$7.5B in 2015 to the HHS, CDC, OGA, NIH, and FDA to execute global health diplomacy.⁴² Crisis response personnel are also available as required for deployment in the event of natural disaster or emerging global threat like Ebola or Zika Virus. Working with global health experts, intergovernmental organizations, NGOs and international health organizations, HHS personnel manage programs and ensure compliance with requirements. In addition, these efforts are coordinated with country team representatives and in many cases, regional governments. Given the complexity and decentralized nature of medical development efforts within many struggling countries or regions, an Ambassador and his country team can easily be overwhelmed if they do not have a trained health diplomat on staff.

The USAID mission is to “partner to end extreme poverty and promote resilient, democratic societies while advancing our security and prosperity.”⁴³ Deployed in over 100 countries across five continents, many FSOs are health-specific officers.⁴⁴ With

\$2.8 billion dollars earmarked for 2015 global health programs, USAID supports three strategic goals: ending preventable child and maternal deaths, creating an AIDS-free generation, and protecting communities from infectious diseases.⁴⁵ As a result, USAID focuses its efforts in developing countries as part of the Ambassador's mission strategic plan. However, it also maintains regional centers to monitor wider developmental concerns and synchronize efforts across USAID country-specific team efforts. The USAID does not generally operate in developed countries or countries closed to US presence but does collaborate or contract with NGOs or private agencies to further US interests where US personnel are not present. Such overall efforts assist countries that are unable or have inadequate infrastructure to sustain on-ground personnel.

The DoD's primary focus in international engagements is security cooperation and building partner capacity. As stated in the 2015 ANNEX A to Regional Health Command-Pacific Campaign Support Plan, "Health engagements will develop host and partner nation capabilities, capacity and interoperability as well as enhance US DoD personnel training and expertise in global health engagement."⁴⁶ Among the US government agencies, the DoD has the largest available pool of medical personnel and routinely engages global health diplomacy through bilateral or multilateral exercises and training opportunities. These events include small unit training to enhance combat lifesaver capabilities for host nation Soldiers and medical personnel as well as exercises like Cobra Gold where over 30 countries now train together or observe multilateral military operations to enhance interoperability.⁴⁷

Along with active duty DoD medical partnership efforts, the NG builds relationships with over 76 nations around the globe, enhancing interoperability,

relationships and training opportunities.⁴⁸ They conduct military-to-military engagements guided by State Department foreign policy goals, executed by the state adjutants general in support of combatant commander and U.S. Chief of Mission security cooperation objectives and DoD policy goals.⁴⁹ While this program builds relationships and interoperability between the state and host nation, short duration exercises and limited goals make sustainable impacts difficult to accomplish and measure.

As mentioned previously, SCOs from the Ambassador's staff provide key linkages into the country team agendas, evaluations of health challenges and risk analysis for individual countries. Military medical units often execute programs chosen for funding by the CCMD or as requested by USAID or DoS representatives. However, these units generally do not have trained health diplomats as part of their staff. Like the State Partnership Program, these efforts are limited in scope and are the result of a smaller pool of health diplomats generating the projects for execution.

The cadre of true global health specialist positions are presently on the joint manning document (JMD) of three CCMDs (Africa Command, Central Command and European Command). The Pacific Command has one on loan and Southern Command does not have a position.⁵⁰ AF IHS personnel currently fill all positions and risk being recalled to other duties due to personnel constraints. Following consultation with the CCMD surgeons, the GHWG recommended each CCMD receive three JMD positions and each SCC and the Theater Special Operations Command receive one as well for a total of seven across each CCMD.⁵¹ The quantity of truly trained and educated health diplomats in the DoD is very limited given the scope of activities and overall mission of the DoD for global health.

The distribution of health diplomats around the world appears to be governed by agency priorities and desired effects. Interoperability should be improving due to increased communication and resource sharing. However, an overall global strategy for health effects combined with targeted exercises or programs that increase global interoperability remains elusive. In addition, Ambassadors lack an organic health expert on their staff to guide and coordinate health effects. Military leaders require health engagement even in countries with US-level healthcare capabilities to improve interoperability in coalition operations. At present, the distribution of health diplomats to accomplish even some of these goals is inadequate. Agencies must perform a holistic review of the desired health diplomacy outcomes to maximize distribution of these limited resources working on behalf of US national security interests. The following are recommendations to address gaps in interagency distribution of health diplomats.

Recommendations for Interagency Distribution of Health Diplomats

- Establish a “lead” health diplomat within a country to coordinate efforts on behalf of the Ambassador, HHS and GCC. For example, a USAID health diplomat could be lead agent inside all developing countries where they have a presence while DoD could be lead agent in all countries where defense partnerships are the emphasis. HHS has primacy where CDC or OGA efforts are most significant. This arrangement ensures all health-related efforts are routed through a single health advisor and ensures the Ambassador has an expert providing advice and expertise to the country team. Another potential benefit is to reduce staffing requirements across the whole of government without reducing the intended effects.

- Consolidate a roster across all agencies of personnel working specifically towards global health diplomacy. Identifying where personnel are deployed and defining their scope of actions would allow strategic leaders to ensure national security priorities are maximized and to perform a gap analysis. This level of understanding could then drive the interagency recommendation on the number of health diplomats required to perform duties and in which agency they should reside.
- Reevaluate the GHWG’s recommendation for seven personnel in each geographic command region. This appears too concentrated to provide the breadth of coverage necessary for understanding culture, language and country-specific issues. These personnel would likely be more effective if disbursed onto larger country embassy teams or USAID regional missions to allow focused coverage of countries and foster the lower-level communication that improves quality development efforts with SCOs or USAID FSOs.
- Reevaluate the HHS’s “health attaché” distribution plan to consider increasing the quantity of permanent worldwide HHS attaché positions or USAID FSOs on country teams to allow for greater coverage of health diplomacy in smaller countries with the greatest health development requirements.

Conclusion

The USG increasingly employs global health activities as an effective tool to combat disease, deliver increased capability and capacity in partner nations and improve military partner capacity through security cooperation exercises in support of US national security objectives. Multiple agencies across the USG monitor health

effects, execute programs or develop training priorities, engage international partners and foster interoperability. However, these agencies are not synchronized nor are their medical efforts prioritized by an overall central authority monitoring global health effects for the President. This lack of central authority provides space for potential friction at every echelon of government from national leadership to Ambassadors working in the field. A thoughtful review of national policy related to health diplomacy activities could lead to improved centralization of health effects with improved global outcomes and synergy of effort.

Critical to global health efforts is a trained cadre of healthcare experts from across all agencies of the US government. Health diplomats must be culturally perceptive and understand the interagency environment while maintaining the required medical expertise required to identify vulnerabilities, monitor effects and communicate effectively to host nation as well as US leadership. Personnel across the USG perform these duties for their respective agencies but an interagency solution is required to synchronize and coordinate these efforts in order to produce the greatest impact despite resource shortfalls. Establishing minimum qualifications to perform the duties of a health diplomat is an important first step to ensure effective communication across the interagency and increase interoperability.

Personnel distribution plans across the interagency are required as part of a holistic analysis. Ambassadors require dedicated health experts to manage and coordinate health-related programs and activities in the country. Distribution adjustments and targeting regional experts for areas of limited activity would provide the Ambassador with an expert to engage with host nation health experts and the

international community while potentially monitoring for unanticipated challenges. The interagency approach to health diplomacy increases visibility and coordination while still allowing individual agencies to focus on their specific element of national security.

Interagency personnel working globally on behalf of the USG are saving lives and improving health quality. Similar to the impact the Goldwater-Nichols Act had on the DoD in 1986, fiscal realities, desynchronized leadership and inadequate numbers of trained health diplomats highlight the requirement to review the health diplomacy process across the interagency. If we are to have one voice and synchronize a unified effort across the USG, formalizing policy guidance and authorities of health diplomacy as well as evaluating the attributes and distribution of health diplomats is strategically vital in improving global health and national security objectives.

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