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Swords into Stethoscopes: How the U.S. Military Could Conduct Medical Diplomacy

Oliver Kendall

Macalester College, oliver404@gmail.com

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Swords into Stethoscopes:

How the U.S. Military Could Conduct Medical Diplomacy

Oliver Kendall

Project Advisor: Professor David Blaney, Department of Political Science

Submitted April 29, 2015

Since the early 1960's, Cuba and China have won international appreciation by sending doctors abroad to help where they are needed. While there was surprise in some quarters when U.S. military personnel were deployed to combat Ebola in the last months of 2014, the Department of Defense actually has a long history of medical activity. In its current form, DoD medical outreach cannot likely garner soft power in the way that the Chinese and Cuban programs can, but with a few modifications, the U.S. military could be a serious conductor of medical diplomacy that would save countless lives and benefit the image of America abroad.

Executive Summary

Since Harvard's Joseph Nye first introduced the concept, Soft Power has been the definition of a country's ability to influence the action of other countries without the use of military threats or economic inducements. Although the concept of soft power was not formally introduced to the field of international relations until the early 1990's, civilizations from Ancient Rome to Ancient China have for millennia conducted activities geared toward increasing what would be called soft power by modern scholars of International Relations. In recent years, countries have increasingly sought soft power through a variety of methods, the sources of soft power primarily falling into three categories: cultural appreciation, the political values a country demonstrates at home, and the way in which its foreign policy is perceived. China, for example, has built hundreds of "Confucius Institutes" in foreign countries aimed at promoting Chinese language and culture. Japan has gained soft power from the appeal of its cultural exports from anime to Hello Kitty. Many countries have invested significant resources in obtaining soft power through foreign aid.

Despite an uptick in world opinion of the United States after the election of President Obama, the general trend line appears to be down, according to Joseph Nye, the conceptual grandfather of soft power. The United States has historically enjoyed vast soft power resources. Despite revelations about domestic spying and other infringements on personal liberty, the famous quote used by several Presidents describing the America as a "shining city on a hill" remains somewhat true; the United States undoubtedly remains the world's most famous democracy. American television, music and other aspects of popular culture are more prolific now than they

have perhaps ever been. Despite those apparent advantages, however, America's image in the world is less positive than it once was. The proliferation of American cultural products elicits accusations of cultural imperialism, and America's foreign policy (without making a value judgment about its merits), especially under President George W. Bush, has often been received negatively. Although there have been some improvements in this regard under President Obama, who at least pays much more lip-service to the idea of soft power than did his predecessor, the record of his administration has been mixed. Some necessarily combative actions (the drone program, for example) and some foreign policy blunders (ignoring the Green Movement in Iran, abandoning red lines in Syria, and the failure of any high-level members of the Administration to attend the march in Paris following the attack by Islamic extremists on *Charlie Hebdo*, to name a few) have damaged President Obama's image – and, by extension, that of the United States – abroad.

The world is not becoming any less complicated, and it is likely that the United States will continue to be forced to conduct a foreign policy that is at times unpopular. In recognition of this reality, it becomes necessary to explore additional measures to strengthen American soft power. One way in which the United States might do this is to co-opt and adapt a form of outreach commonly referred to as “medical diplomacy,” which is extensively and effectively employed especially by two countries – Cuba and China – with which America has often been at odds. By expanding and further utilizing the medical resources of the Department of Defense, the United States could save countless lives abroad, and win appreciation in the international community.

Medical internationalism has been central to Cuba's foreign policy since the early 1960's. Since the program began, over 100,000 Cuban medical personnel have practiced in over 100 countries. In recent years, Cuban medical teams have provided medical assistance in the wake of most of the world's major disasters, taking a leading role, for example, in combatting Ebola in western Africa. The Cubans have also done pioneering work in medical education, establishing or teaching in numerous foreign medical institutions. Cuba also established the Latin American School of Medicine (ELAM), which has provided free medical education to students from poor communities around the world, including some from the United States.

Cuba's medical diplomacy has been quite effective at improving relations with recipient countries, and has elevated the country on the international stage. Individual countries with negative views toward Cuba have changed their tune after receiving Cuban medical assistance, and Cuba's medical activity has often garnered favor with the United Nations and other international institutions. Cuba's efforts have even resonated in the United States, where high-ranking officials praised Cuban efforts to combat Ebola, and President Obama (for a variety of reasons extending beyond just Cuba's medical activity) has taken steps to restore full diplomatic relations with Cuba. Medical diplomacy has also had commercial benefits for Cuba, which receives compensation from some of the countries it services, as well as the opportunity to export its medical products to health markets Cuban activity helped to improve. Although Cuban health outreach does not operate perfectly – there is, for example, sometimes backlash from local medical practitioners who resent competition – it has

undoubtedly worked in Cuba's favor, and constitutes a resounding foreign policy success for this small communist country.

China began a medical outreach program in the early 1960's around the same time as the Cubans. Vastly larger than Cuba, China deploys doctors to its client countries, primarily in Africa, on a province-by-province basis. Like Cuba, China has established medical training programs abroad. Although China does not operate an international medical school on the scale of Cuba's ELAM, the PRC does host a substantial number of international students, and aims to increase that number as part of an overall strategy to obtain soft power. Medical outreach has also benefited the Chinese pharmaceutical industry, which has worked hard to promote their product in a variety of ways, including sending it abroad with Chinese medical teams.

China's soft power efforts have sometimes been undermined by parallel and complicating economic activity, or by instances in which counterfeit medication believed to be from China has harmed patients (although these drugs were not necessarily furnished by Chinese medical teams). Despite setbacks like this, Chinese medical diplomacy is quite popular with the countries they serve. African leaders promote the medical cooperation as a clear benefit to their countries, and most of those countries either help pay for or cover entirely the full range of expenses for the maintaining Chinese medical support.

Although the Cuban and Chinese programs are by far the most prominent examples of direct medical diplomacy, other countries have engaged in similar activity. Peacekeeping troops of various nationalities have often cared for patients in a way that almost certainly garners soft power. The United States military has

sometimes conducted medical outreach that could potentially result in soft power generation, although these activities are usually conducted under the auspices of stability operations rather than direct medical diplomacy. As Ebola spread unchecked across western Africa in the summer and fall of 2014, for example, the U.S. military (partly at the request of Doctors Without Borders) was a key player in the international effort to stop the virus.

While many were taken aback by what they considered to be the unprecedented involvement of the United States military in a global health campaign, the DoD and its predecessors have, in fact, a long history of medical activity. In addition to domestic medical activity like research and preparation for potential biological threats, the military has often cared for foreign patients in addition to American military casualties. This has often taken the form of disaster relief, or efforts to win over local populations in the context of counterinsurgencies, like in the Philippines, Vietnam and Afghanistan. These operations and other medical outreach conducted by the military usually take the form of stability operations, which are aimed at preventing instability (of the sort that exists in places like Somalia), which, the DoD believes, can produce threats such as terrorism.

Much of the U.S. military's medical outreach does not translate to an effective medical diplomacy program like the ones run by Cuba and China—the current ability of the DoD to gain soft power via medical diplomacy is impeded by variety of factors, some of which are technical problems. Although the military conducts widespread medical activity, some of which is done with and for foreigners, this activity is ad hoc, lacking any deliberate central coordination. This sometimes complicates medical

operations on the ground, hindering the coordination of medical efforts both within different branches of the government and with nongovernmental organizations.

In addition to technical issues that undermine the DoD's ability to conduct medical diplomacy, there are some aspects of U.S. military medical activity that are problems more specifically in a medical diplomacy context. That the military medical corps is so dedicated to preserving resources for potential American casualties – even at times when it is extremely unlikely that there will be any – conveys an image of stinginess and indifference that is not conducive to soft power generation. Military medical operations have also frequently been plagued by missteps grounded in a poor understanding of local culture as it pertains to medical practice. Also, unlike in the case of the Chinese and Cuban medical diplomacy programs, U.S. military medical outreach is frequently very short term, making it difficult to build serious relationships between American doctors and their foreign communities in a way that could bolster America's image abroad.

If its medical activity were modified and expanded, the United States Department of Defense could become an effective conductor of medical diplomacy that could garner significant soft power for the United States. The following recommendations are one way in which some of these issues could potentially be addressed.

- The military should expand medical outreach activities that specifically take the form of medical diplomacy, rather than just stability operations.
- Congress should dedicate clearer funding for operations that would allow greater flexibility.

- To streamline the function of military medical outreach activity, the DoD should appoint a single coordinator to manage foreign medical activity (with sub-positions for various fields as necessary).
- Steps should be taken to improve coordination with outside organizations that play a role in health operations.
- Military medical personnel abroad (through training and doctrinal changes) should be discouraged from treating foreign patients as less important than Americans and from giving the appearance of hoarding medical resources, except in cases where U.S. personnel urgently require those resources. Along similar lines, the complex decision as to whether foreign patients should receive the highest standard of care or merely the local standard must be tailored to the circumstances of operations on a case-by-case basis.
- Increase the length of deployments to allow American doctors to truly connect with foreign populations in a way that could foster understanding and build relationships. One way to facilitate this is by creating bilateral relations with foreign medical institutions, which could include opening the Uniformed Services University of Health Sciences to foreign students even if they did not attend undergraduate school at an American institution.

These recommendations will not create a medical diplomacy program on the scale of the Chinese or Cuban programs – nor should that necessarily be the goal. These changes, though, could allow the United States to gain soft power from the hitherto largely untapped diplomatic resource of the military medical corps.

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Intro: Soft Power

Soft power, says Harvard's Joseph Nye, is the ability of a state to get what it wants from other states without directly employing carrots or sticks. While no terms describing soft power existed before Nye coined the phrase in 1990, political units throughout history have availed themselves of means besides direct inducement or coercion to reach their goals. The economic and military might of the Roman Empire was undeniable, but it also gained influence simply by being admired by outsiders. Chinese Admiral Zheng He's travels during the fifteenth century showcased the power of Chinese civilization, earning it respect from and relations with other nations.¹ While the Marshall Plan was a direct economic investment in the rebuilding of Western Europe in the wake of WWII, it was more than just a payoff in exchange for European loyalty. It bolstered pro-American sentiment and encouraged opposition to the spread of Soviet Communism. Countless other historical examples of soft power prior to its naming abound, and since Nye clarified its existence in 1990, it has become a core concept of international relations.

Soft power is interpreted in a variety of ways. It is achieved, according to former Singaporean Senior Minister Lee Kuan Yew, "when other nations admire and want to emulate aspects of that nation's civilization."² Nye believes that there are two other resources in addition to cultural appreciation from which soft power can be acquired: The political values a country demonstrates at home, and the way in which

¹ Bates Gill and Yanzhong Huang, "Sources and Limits of Chinese 'Soft Power,'" *Survival*, Vol. 48 No. 2 (Summer 2006). Pg. 18. Available: <http://www.comw.org/cmp/fulltext/0606gill.pdf>

² Lam Pin Foo, "Only the Tang Dynasty Came Close to Having Influence," *The Straights Times*, October 26, 1996.

its foreign policy is perceived.³ The way in which countries draw on these potential sources of soft power varies, as some countries emphasize different strengths. A country with a widely admired culture but a comparatively weak foreign policy, for example, would draw more of its soft power from its cultural appeal.

Many if not most state actors appear to share Nye's belief that they "have, can and should continue to find ways to effectively develop and use this power resource."⁴ In 2007, China's then-President Hu Jintao identified soft power as a policy priority, and the People's Republic has launched massive efforts at its acquisition since. As other countries like France, Germany and the United Kingdom have also done, China since 2004 has built a network of schools abroad, known as Confucius Institutes. These schools, aimed at promoting appreciation for Chinese language and culture, exist in over a hundred countries; the stated goal is to increase the current number (over 350) to a thousand by 2020.⁵ Other countries also rely heavily on appreciation for their culture to gain soft power—Japanese pop cultural exports like anime and Hello Kitty, for example, have gained a significant following outside Japan.⁶ Some countries have invested significant resources in soft power through foreign aid. The United Arab Emirates in 2013 committed 1.25 percent of its Gross National Income (GNI) to foreign aid, giving the highest percent of any country in the world, followed

³ Joseph Nye, "What China and Russia Don't Get About Soft Power," *Foreign Policy*, April 29, 2013. Available: http://www.foreignpolicy.com/articles/2013/04/29/what_china_and_russia_don_t_get_about_soft_power#trending

⁴ Mattern (2005), 588.

⁵ Dustin Roasa, "China's Soft Power Surge," *Foreign Policy*, November 18, 2012. Available: http://www.foreignpolicy.com/articles/2012/11/18/chinas_soft_power_surge

⁶ "Japan's Soft Power: Squaring the Cool," *The Economist*, June 16, 2014. Available: <http://www.economist.com/blogs/banyan/2014/06/japans-soft-power>

by Norway and Sweden (it should be noted that the United States gave more than any country in the world in terms of actual dollar amount).⁷ China has also launched massive direct aid programs, especially in Africa, ranging from infrastructure construction to medical diplomacy. “While aid from OECD countries stagnates or shrinks under the pressure of budgets and an increasingly skeptical public,” say Claire Provost and Richard Harris, “a host of new emerging donors – including Brazil, Venezuela, and Iran – are expanding their work in other developing countries.”⁸

The United States has traditionally enjoyed vast reserves of soft power. “America’s global domination,” says Matthew Fraser in *Weapons of Mass Distraction*, “has been achieved through largely non-military means.”⁹ The United States is almost certainly the world’s most famous democracy, a fact widely admired in a world where democracy is generally considered a good thing (or at least, as Winston Churchill famously implied, the least bad option). American values and popular culture have also historically been a tremendous soft power resource. During the Second World War, says Fraser, “Mickey Mouse and Donald Duck conducted Disneyland diplomacy to spread American values throughout the world.”¹⁰ The power of American culture has only increased since. American television is “watched daily

⁷ Joshua Keating, “Rich Countries Got More Generous Last Year,” *Slate*, April 9, 2014. Available: http://www.slate.com/blogs/the_world_/2014/04/09/new_oecd_figures_the_surprising_country_that_gives_the_most_foreign_aid.html

⁸ Claire Provost and Rich Harris, “China commits billions in aid to Africa as part of charm offensive,” *The Guardian*, April 29, 2013. Available: <http://www.theguardian.com/global-development/interactive/2013/apr/29/china-commits-billions-aid-africa-interactive>

⁹ Matthew Fraser, *Weapons of Mass Distraction: Soft Power and American Empire* (Toronto: Key Porter Books, 2003). Pg. 10.

¹⁰ Fraser (2003), 9.

in virtually every corner of the earth where TV sets can be found,”¹¹ and American pop-stars have found receptive audiences from Indonesia to Africa. American products from Nike shoes to iPhones are sought after in most of the world. Kentucky Fried Chicken has opened a restaurant in Tiananmen Square, and at Disneyland in Paris, “café intellectuals drink Coca-Cola while railing against American ‘cultural imperialism.’”¹²

During the twenty-first century, however, the United States has seen a decline in its soft power, which Nye attributes in large part (citing polling data) to its foreign policy.¹³ Some dismiss this decline, noting that the United States has recovered in the past from ill will brought on by foreign policy decisions. The recent decline, however, should not be dismissed on the same basis, since, as Nye points out, “that was against the backdrop of the Cold War, in which other countries still feared the Soviet Union as the greater evil.”¹⁴ This decline seems to be especially pronounced among young people. Although young people widely admire American pop culture, Nye says, “the unpopularity of our foreign policy decisions is causing the next generation to question American power.”¹⁵ Problems in one of the three areas of potential soft power generation can undermine the other sources of soft power – the unpopularity of U.S. foreign policy sometimes leads to declining interest in American culture and products as well.¹⁶ Although American popularity abroad improved after the election of

¹¹ Fraser (2003), 10-11.

¹² Fraser (2003), 10.

¹³ Joseph Nye, “Soft Power and American Foreign Policy,” in *Political Science Quarterly*, Vol. 119, No. 2, 2004. Pg. 255.

¹⁴ Nye (2004), 257.

¹⁵ Nye (2004), 256.

¹⁶ Fraser (2004), 12.

President Obama¹⁷ – who certainly pays greater lip service to soft power than did his predecessor – the record of his administration is mixed. Some necessarily combative actions (like the drone program, and various other military actions) combined with some foreign policy blunders (like ignoring the Green Movement in Iran and skipping the march in Paris following the attack by Islamic extremists on *Charlie Hebdo*, to name a few) have damaged President Obama’s standing – and by extension, that of the United States – abroad.

Despite some improvement in America’s image after President Obama’s ascendancy, and the widespread foreign appreciation for American popular culture, it is likely that America will continue to be forced in the future to conduct an aggressive foreign policy that is at times unpopular. The United States, thus, must look for more opportunities to garner soft power. One way in which America could do this is to co-opt and adapt a form of outreach used especially extensively by Cuba and China, two countries with which America admittedly shares very little. By expanding and further utilizing the medical resources of the Department of Defense, the United States could save countless lives abroad, and win appreciation in the international community by conducting what is commonly referred to as “medical diplomacy.”

¹⁷ “Confidence in Obama Lifts U.S. Image Around the World,” *Pew Research Center*, July 23, 2009. Available: <http://www.pewglobal.org/2009/07/23/confidence-in-obama-lifts-us-image-around-the-world/>

Overview of Cuba and China's Medical Diplomacy Programs

Cuba

A specific focus on medicine has been a substantial part of Cuba's post-revolutionary political philosophy. "From the outset of the revolution," says Julie Feinsilver, Fidel Castro "made the health of the individual a metaphor for the health of the body politic." This focus on healthcare by the Cuban government is obvious domestically—between 1970 and 2005, the number of Cuban healthcare workers tripled, the ratio of doctors to population moved from one doctor per 1,393 people to one per 159.¹⁸ As a result, Cuba's domestic healthcare system is far superior to other developing nations, and their healthcare outcomes often rival even some of the world's most advanced countries. Life expectancy in Cuba, for example, is the same as it is in the United States, and infant mortality is actually lower on this small Caribbean island than it is in the world's most powerful country.¹⁹

Cuba's focus on healthcare is also obvious in its medical diplomacy program. Castro's government began what was initially an ad hoc program of medical internationalism soon after their revolution. According to John Kirk, the early stages of the program were a series of responses to emergencies abroad, assistance given without consideration of cost or benefit.²⁰ Cuba dispatched medical resources to Chile in the wake of a major earthquake there in 1960 and sent doctors to Algeria several years later during the mass-exodus of medical professionals there. As the program has

¹⁸ Julie Feinsilver, "Cuban Medical Diplomacy: When The Left Has Got It Right," *Counsel on Hemispheric Affairs*, October 30, 2006. Available: <http://www.coha.org/cuban-medical-diplomacy-when-the-left-has-got-it-right/>

¹⁹ Feinsilver, 2006.

²⁰ John Kirk, "Cuba's Medical Internationalism: Development and Rationale," *Bulletin of Latin American Research*, Vol. 28, No. 4, 2009. Pg. 506.

grown, the amount of medical assistance this small island nation has provided is staggering. Since 1961, more than 130,000 Cuban health workers have practiced in 102 countries. As of 2009, there were nearly 37,000 Cuban medical professionals (not all doctors) working in 73 countries or territories²¹ (by 2014, this number increased to 50,000²²) caring for 70 million patients. This represented more medical personnel than was fielded at the time by the entire G-8 combined (this being prior to Russia's ejection from the group).²³

Over the years, Cuba has been heavily involved in alleviating health crises, offering medical aid to virtually any country where disaster has struck, regardless of the state of political relations between Cuba and the recipient of aid. In 2005, for example, Cuba offered to send 1586 medical personnel and 36 tons of medical supplies to assist New Orleans in the wake of Hurricane Katrina (assistance the Bush Administration turned down).²⁴ Predictably, as of October 23 2014, Cuba had fielded “the largest medical team in west Africa battling Ebola.”²⁵

In addition to sending their own doctors abroad to deal with health crises and help establish better health systems in other countries, Cuba has done pioneering work in medical training. Believing education is essential to having a sustainable impact on the healthcare situation in aid recipient countries, Cuban medical personnel established medical schools or taught in preexisting medical education institutions in a variety of

²¹ Connor Gorry, “Cuban Health Cooperation Turns 45,” *MEDICC Review*, Vol. 10, No. 3, 2008. Pg. 44-47, available: http://medicc.org/mediccreview/articles/mr_22.pdf

²² Connor Gorry, “Cuba calling: what this small island can teach the world about disease control,” *The Guardian*, October 23, 2014. Available: <http://www.theguardian.com/global-development-professionals-network/2014/oct/23/cuba-healthcare-lessons-ebola-sierra-leone-guinea-liberia>

²³ Kirk (2009), Pg. 497.

²⁴ Kirk (2009), Pg. 497.

²⁵ Gorry, 2014.

countries, a process that has continued since the 1970's.²⁶ In 1998, the Cuban government established the Latin American School of Medicine (ELAM), which is geared specifically toward training students from poor communities around the world, including even some Americans per an arrangement reached at the turn of the century between Fidel Castro and the Congressional Black Caucus (as of 2012, Cuba no longer planned to accept students from the United States beyond those already enrolled in the school).²⁷ Every year, ELAM accepts 1,600 new students into their six-year program, the largest medical school in the world,²⁸ a majority of whom now are women.²⁹

Performance of ELAM graduates on medical licensing tests in their home countries, among other things, indicates that the school provides a high quality of education.³⁰ Indeed, since ELAM students are expected to work in areas that lack medical supplies and infrastructure, resourcefulness is taught to students at this school perhaps more than at most other medical institutions. According to American ELAM students Razel Remen and Lillian Holloway, Cuban professors at ELAM frequently ask their students questions like “how would you make the diagnosis if you were working in the middle of the Amazon and did not have access to any diagnostic tests?”³¹ Students attend for free in exchange for the promise that they will work in

²⁶ Feinsilver, 2006.

²⁷ Catherine Porter, “Cuba-trained doctors making difference around the world,” *The Toronto Star*, June 2, 2012. Available: http://www.thestar.com/news/world/2012/06/02/cubatrained_doctors_making_difference_around_the_world.html

²⁸ Porter, 2012.

²⁹ Kirk (2009), Pg. 497, 502.

³⁰ Feinsilver, 2006.

³¹ Razel Remen and Lillian Holloway, “A Student Perspective on ELAM and its Educational Program,” *Social Medicine*, Vol. 3 No. 2, 2008 Pg. 160.

underserved communities upon graduation. Although this promise is not formal, about 80 percent follow through³² despite pernicious efforts by at least one U.S. based NGO to lure ELAM graduates into defection. The extent to which ELAM's graduates seem to believe in giving back is exemplified by the hundreds of graduates who returned to help deal with the catastrophic earthquake in Haiti that killed 300,000 in 2010. Eladio Valcarcel Garcia, one of the ELAM's founders, proudly recounts that after so many ELAM alumni from around the world volunteered to assist in Haiti, "we had to stop calling. All of them said yes."³³ After the initial success of ELAM, Cuban medical personnel have led in the creation of a second ELAM, a sister school of sorts, in Venezuela.

Cuba's medical diplomacy program has been quite effective at improving bilateral relations with recipient countries and elevated Cuba's status in the international community. Countries with poor relations with Cuba have often changed their tune to some extent after Cuba willingly provided them with medical aid regardless of diplomatic tensions (as in the case of Guatemala in 1998, when Guatemala reopened a diplomatic relationship with Cuba after the latter sent them hundreds of doctors after a devastating hurricane).³⁴ "While it is unclear if medical internationalism is just a cold analytical move to win 'symbolic capital' and political support for Cuba," says Kirk, "what is indisputable is the success that Cuba has enjoyed in international fora."³⁵ Every year for more than two decades, for example, the U.N. General Assembly votes overwhelmingly against the American embargo of

³² Porter, 2012.

³³ Porter, 2012.

³⁴ Kirk (2009), Pg. 505.

³⁵ Kirk (2009), Pg. 504.

Cuba (the vote in 2014 was 188-2, Israel being the only country to vote with the United States), and this year, Latin American countries defied American objections and invited a Cuban delegation to the Summit of the Americas.³⁶

Cuba's efforts have had an impact even in the United States. Calls domestically to end the embargo have even appeared with increasing frequency, as in the case of this *New York Times* editorial praising Cuba's activity vis-à-vis Ebola: "This should serve as an urgent reminder to the Obama administration that the benefits of moving swiftly to restore diplomatic relations with Cuba far outweigh the drawbacks."³⁷ Even some high-ranking U.S. officials from Secretary of State John Kerry to U.N. Ambassador Samantha Power have spoken more positively of Cuba lately in the context of Cuba's role in fighting Ebola.³⁸ Despite being unable to singlehandedly repeal the embargo (an action that now requires Congressional authorization), President Obama, for a variety of reasons, recently moved to restore full diplomatic relations with Cuba.³⁹

There is evidence also of a commercial benefit to Cuba accruing from their medical diplomacy program. The degree to which recipients of Cuban aid compensate Cuba varies based on the ability of recipients to pay. While the rate at which Cuba is compensated (if paid at all) is well below market value, it is estimated that medical

³⁶ Jon Lee Anderson, "Cuba's Ebola Diplomacy," *The New Yorker*, November 4, 2014. Available: <http://www.newyorker.com/news/daily-comment/cubas-ebola-diplomacy>

³⁷ The Editorial Board, "Cuba's Impressive Role on Ebola," *The New York Times*, October 19, 2014. Available: <http://www.nytimes.com/2014/10/20/opinion/cubas-impressive-role-on-ebola.html?hp&action=click&pgtype=Homepage&module=c-column-top-span-region®ion=c-column-top-span-region&WT.nav=c-column-top-span-region&r=3>

³⁸ Anderson, 2014.

³⁹ Peter Baker, "U.S. To Restore Full Diplomatic Relations With Cuba, Erasing a Last Trace of Cold War Hostility," *The New York Times*, December 17, 2014. Available: <http://www.nytimes.com/2014/12/18/world/americas/us-cuba-relations.html?r=0>

diplomacy brings Cuba more profit than does their tourism industry.⁴⁰ Furthermore, Cuba produces up to about 80 percent of the medicine their doctors use at a fraction of the cost of what is charged by multinational pharmaceutical companies.⁴¹ Although many of the governments that contract Cuban medical services provide the medical equipment, the spread of Cuban doctors to so many countries could increase Cuba's ability to export medical products. Indeed, although exact sales data is difficult to come by, Cuba exported medical biotech products to as many as 40 countries as of 2006,⁴² and has joint ventures with companies in a variety of different countries, especially in Asia. Cuba's extensive medical cooperation with Venezuela in particular has been a boost for Cuba's economy; it is essentially a direct trade for oil, of which the small island country is in desperate need.

Although widely hailed as an extremely successful program, Cuba's medical internationalism does not operate flawlessly. While not particularly successful, efforts have been made by forces in the United States to sabotage the program by targeting Cuban medical personnel directly. The Bush administration took steps to make life difficult for potential ELAM students and graduates (by restricting travel and other such measures), and NGO's like the Miami-based *Solidaridad Sin Fronteras* (Solidarity Without Borders, an unsubtle play on "Doctors Without Borders") encourage Cuban doctors to defect via a special visa program created by the Bush administration in 2006.⁴³ Despite editorials occasionally appearing in the United States positing ill-treatment by Cuba of its medical personnel (one particularly frantic

⁴⁰ Feinsilver, 2006.

⁴¹ Kirk (2009), Pg. 504.

⁴² Feinsilver, 2006.

⁴³ Porter, 2012.

op-ed referred to Cuba's doctors as "slaves in white coats"⁴⁴), as of 2009, only about two percent of Cuban medical personnel abroad had chosen to defect, whereas about nine percent of Canadian medical graduates leave for the United States every year.⁴⁵

Critics also charge that after failing to spread communism via guns and guerillas, Castro has switched to 'doctor diplomacy', sending medical personnel abroad to spread ideology. These claims might have some merit if Cuban medical diplomacy was a recent development, but as the program has existed for half a century, it can hardly be seen as a pivot. Also, writes Feinsilver, Cuban doctors are not a fifth column promoting communism; rather they threaten the status quo by setting a good example of providing medical care in poor areas avoided by local doctors.⁴⁶

In this regard, Cuban doctors have sometimes made enemies of local medical associations and personnel who resent competition from their Cuban counterparts. In some countries, medical associations have gone on strike protesting the influx of Cuban personnel. Almost invariably, though, those country's governments have sided against their own medical personnel and defended the Cubans. Bolivian President Evo Morales, for example, promised that the Cubans would stay so long as he continued to hold office. According to Feinsilver, "the benefits to the host society far outweigh the costs to the local medical professions,"⁴⁷ so the governments (and often the citizens) of host countries accept and appreciate the Cuban medical personnel despite angering local medical associations. Despite these small issues and setbacks, even many of

⁴⁴ Carlos Alberto Montaner, "Slaves in white coats," *The Miami Herald*, September 13, 2005. Available: <http://www.cubanet.org/htdocs/CNews/y05/sep05/13e12.htm>

⁴⁵ Kirk (2009), 509.

⁴⁶ Feinsilver, 2006.

⁴⁷ Feinsilver, 2006.

Cuba's avowed critics recognize that Cuban medical diplomacy is producing positive effects, both for Cuba and for the countries served by their medical personnel.⁴⁸

China

The first Chinese medical teams arrived in Algeria (like those from Cuba) in 1964 soon after the French withdrew from their former colony. Since then, says Drew Thompson in *China Brief*, the People's Republic has "establish[ed] a relationship between Chinese doctors and millions of ordinary Africans, and earn[ed] the gratitude of many African leaders eager to be seen providing public goods to their citizens."⁴⁹ Rather than a more central system for distributing doctors, China allocates its doctors to countries around the world based on which province they are from. According to Li Anshan, a professor of International Studies at Peking University: "In general, [Chinese medical teams] are dispatched on the basis of one province per one or more African country."⁵⁰ This, perhaps, could lead to more personalized relationships than if doctors were sent from all over China; it could also potentially decrease the degree to which medical diplomacy comes across as centrally controlled propaganda.

Between 1964 when the program began and 2005, China sent more than 15,000 doctors to Africa,⁵¹ and the scale of the program has grown since China's substantially increased focus on soft power. "Since the beginning of the 21st century," says Li,

⁴⁸ Feinsilver, 2006.

⁴⁹ Drew Thompson, "China's Soft Power in Africa: From the 'Beijing Consensus' to Health Diplomacy," in *China Brief*, Vol. 5 Issue 21, October 13, 2005. Available: http://csis.org/files/media/isis/pubs/051013_china_soft_pwr.pdf

⁵⁰ Li Anshan, *Discussion Paper 52: Chinese Medical Cooperation in Africa* (Uppsala: The Nordic Africa Institute, 2011). Pg. 12. Available: <http://nai.diva-portal.org/smash/get/diva2:399727/FULLTEXT02>

⁵¹ Thompson, 2005.

“China has strengthened its international medical cooperation.”⁵² Reports in China differ as to the exact number of countries in which Chinese medical teams are currently active, but one source put the estimate as high as 65, including some countries outside of Africa (the lowest estimate was in the mid 40’s).⁵³

Regardless of the specific number of countries to which China sends doctors, the program is very well received, and is promoted “by both Chinese and African leaders as a tangible public good.”⁵⁴ “This long term medical cooperation,” says Thompson, “builds person-to-person relations between Africans and Chinese, and brings benefits to both sides.”⁵⁵ The teams are so popular that most African countries receiving Chinese doctors pay the expenses of medical teams themselves, including airfares, the stipends of doctors and support staff (Chinese cooks included), and some of the medical supplies and equipment brought with the team. In the case of the poorest countries, China covers most of the costs itself.⁵⁶ “While many countries offset the costs of paying the expenses and salaries of the medical teams with grants and loans from China or other donor nations,” Thompson continues, “host nations repeatedly demonstrate their appreciation by continuing the program and covering the expenses of the team out of national budgets.” Chinese medical teams frequently receive national awards in both Africa and China for their contribution.⁵⁷ In addition to their work directly with African civilians, Chinese military doctors have deployed with U.N. peacekeeping operations. Many U.N. soldiers in Africa hail from the

⁵² Li (2011) Pg. 9.

⁵³ Li (2011) Pg. 12.

⁵⁴ Thompson, 2005.

⁵⁵ Thompson, 2005.

⁵⁶ Thompson, 2005.

⁵⁷ Thompson, 2005.

continent, which allows China also to build good will among Africa's military class in the same way that by conducting training operations and deployments with foreign militaries, the American military builds relationships with the soldiers of other countries.

Chinese medical aid to Africa goes beyond just the many medical teams operating on the continent. Recognizing that malaria is the number one killer of African children under the age of five (causing the death of about a million children there annually), the Chinese government, says Li, has taken several steps simultaneously to combat malaria, including medical teams, training programs, free drugs and facilities and several other projects.⁵⁸ "In 2002, the Chinese Ministry of Health conducted a two-part international training course in techniques for the prevention and treatment of malaria and tropical diseases, in which 30 students from 17 African countries participated."⁵⁹ After a summit in 2006, China set up a number of anti-malaria centers in various African countries where Chinese and African malaria specialists can exchange ideas and train more medical personnel.⁶⁰

China does not have an operation like Cuba's ELAM dedicated to training foreigners in medicine. China does, though, welcome a fair number of foreign students into its universities (many of whom will almost certainly go into medicine) in addition to training medical personnel on the ground in Africa. It is evident by the launch of their 'bring-in strategy' (*qing jilai zhanlue*) that the People's Republic wishes to expand its soft power by encouraging students to attend universities in China. After these efforts, the number of foreign students in China (while still

⁵⁸ Li (2011), Pg. 13.

⁵⁹ Thompson, 2005.

⁶⁰ Li (2011), Pg. 17.

significantly lower than in the United States) has dramatically increased—In 2000, China hosted 52,150 foreign students,⁶¹ and by 2011, according to the Institute of International Education’s Project Atlas, that number reached 292,611.⁶² While it is difficult to say exactly what percentage of foreign students in China are studying medicine, it is fair to assume that a significant number of them are.

The Chinese pharmaceutical industry, which has coordinated with some African leaders, has also benefited from China’s medical diplomacy program, specifically the focus on malaria. Claire Provost and Rich Harris claim in *The Guardian* that the objectives of Chinese medical teams in Africa have “expanded to include promotion of China’s pharmaceuticals such as antimalarials.”⁶³ According to Li, “Cotecxin, the most effective anti-malarial drug produced in China, has earned a great reputation in Africa.”⁶⁴ This drug has, since 1996, been carried by all of China’s medical teams, and is often donated by Chinese leaders when they visit the continent,⁶⁵ both moves that can be assumed to benefit the industry.

While the Chinese program of medical diplomacy has won the People’s Republic significant respect among those it has served, it faces some serious issues. The increase in the number of medical personnel deployed in recent years projects an image of strength, but despite this recent push, the long-term viability of the program in its current form, despite its having existed for half a century, is increasingly

⁶¹ Xiaohe Cheng, “Education: The Intellectual Base of China’s Soft Power,” in Minjiang Li (ed), *Soft Power: China’s Emerging Strategy in International Politics* (Landham: Lexington Books, 2009). Pg. 112-113.

⁶² Project Atlas, *Institute of International Education*. Available: <http://www.iie.org/Services/Project-Atlas/China>

⁶³ Provost and Harris, 2013.

⁶⁴ Li (2011), Pg. 13.

⁶⁵ Li (2011), Pg. 16.

uncertain. The provincial structure of the program is becoming a hindrance as rural tax reforms have led to shrinking provincial budgets.⁶⁶ Government doctors in China are increasingly called upon to address hitherto neglected public health issues in their own country. Also, as the Chinese healthcare system has become increasingly privatized, doctors (who supplement their meager government stipend with patient fees and medicine sales) find less incentive to accept two-year postings abroad where these private opportunities do not exist. Indeed, in order to meet their obligations to the countries to which they are linked under the medical diplomacy system, wealthier provinces where more private opportunities exist “have reportedly been forced to recruit doctors from inland provinces” to send in place of their own.⁶⁷ Unless something changes relatively soon domestically (e.g. the Chinese healthcare system becomes less privatized, or the provincial structure of the program is altered), this system of direct health diplomacy could be at serious risk on the home front.

Furthermore, some problems have arisen on the other end of the program, in the places receiving Chinese medical aid. Rumors have begun to spread in many of the areas most impacted by malaria of fake drugs being introduced. In Uganda, says Kathleen McLaughlin through the *Pulitzer Center on Crisis Reporting*, estimates exist that as much as thirty percent of malaria cures are “either fake, substandard or counterfeit.”⁶⁸ News like this undermines China’s attempt to garner soft power with the citizens of the various African countries in which they provide aid. In spite of

⁶⁶ Thompson, 2005.

⁶⁷ Thompson, 2005.

⁶⁸ Kathleen McLaughlin, “Kathleen McLaughlin Reports on China’s Problem with Fake Drugs in Africa,” *Pulitzer Center on Crisis Reporting*, August 13, 2013. Available: <http://pulitzercenter.org/education/meet-journalist-kathleen-mclaughlin-china-in-africa-uganda-tanzania-bad-drugs-fake-medicine-healthcare-aid>

these recent problems, though, the Chinese program has managed to foster good relations with a significant number of recipient countries' governments (even if some of their citizens are wary of Chinese activity), and treat nearly 200 million patients, which is no mean feat.⁶⁹

US DoD Global Health Activity

Operation United Assistance, the American plan to send 3,000 troops to West Africa to help stem the tide of Ebola in the fall of 2014, was the largest humanitarian deployment of U.S. forces since the 2004 tsunami that wreaked havoc (killing nearly 300,000 people⁷⁰) in Southeast Asia,⁷¹ and played a significant role in halting the spread of the virus. In fact, the involvement of the Department of Defense in the fight against Ebola was inspired partly by a request for aid from Doctors Without Borders. According to Laurie Garrett in *Foreign Policy*, “never before had the typically

⁶⁹ Thompson, 2005.

⁷⁰ “Indonesia quake toll jumps again,” *BBC News*, January 25, 2005. Available: <http://news.bbc.co.uk/2/hi/asia-pacific/4204385.stm>

⁷¹ Laurie Garrett, “Can The U.S. Army Degrade and Ebola?” *Foreign Policy*, September 16, 2014. Available: http://www.foreignpolicy.com/articles/2014/09/16/can_the_us_army_degrade_and_de_stroy_ebola

pacifist, neutral humanitarian organization asked for military assistance, but the Ebola epidemic has exhausted MSF's capacities, and compelled radical policies.”⁷²

This high-profile deployment to solely and specifically fight the spread of a disease caused a significant stir; it was considered a novel and unprecedented idea to use the military to fight a disease. Some reacted positively, believing this showed the United States was serious about combatting the disease (the *Washington Post* said the deployment “reflects the growing concern of U.S. officials” about the spread of Ebola⁷³). Others reacted negatively, decrying America’s deployment of soldiers as the Cubans deployed doctors. A characteristically anti-Western op-ed in *Russia Today*, which has come to replace *Pravda* as the Kremlin’s preferred organ of propaganda, best sums up the negative attitudes toward the commitment of U.S. troops in its conclusion that “the difference between a nation whose first response to a natural or humanitarian disaster is to send doctors and nurses, and a nation whose first response is to send troops is the difference between civilization and barbarism.”⁷⁴

While this medical deployment of military units received widespread attention, it was not the first time the defense department has been used in a healthcare capacity—in fact, the U.S. military has been directly involved in significant medical activity for at least a century. Military medical activity historically has fallen (and continues to fall) into three categories, although the results of work in one area can

⁷² Garrett, 2014.

⁷³ Lena Sun and Juliet Eilperin, “U.S. military will lead \$750 million fight against Ebola in West Africa,” *Washington Post*, September 16, 2014. Available: http://www.washingtonpost.com/national/health-science/us-military-to-lead-ebola-fight/2014/09/15/69db3da0-3d32-11e4-b0ea-8141703bbf6f_story.html

⁷⁴ John Wight, “Ebola crisis response: Cuba sends doctors, US deploys troops,” *Russia Today*, October 1, 2014. Available: <http://rt.com/op-edge/192176-cuba-doctors-ebola-aid-mission/>

obviously impact the other areas. The first of these categories is force protection, which involves seeing to the healthcare needs of American military personnel. The second is threat reduction, or identifying and confronting potential biological threats to the United States as a whole. The final category is stability operations and partner engagement, which is the Department of Defense (DoD) healthcare activity most likely to be a source of soft power along the lines of the Chinese and Cuban programs.

One of the ways in which the military has been most involved in healthcare is in the form of research, which can fall into all three categories. Several of the most significant medical breakthroughs of the first half of the twentieth century were achieved with research conducted by the military. It was the military, say Josh Michaud, Kellie Moss and Jen Kates in a report for the Kaiser Family Foundation, that identified mosquitos as the vector by which yellow fever is spread, and the military that first demonstrated “the potential health benefits of large-scale malaria and yellow fever prevention campaigns.” DoD-backed research led to the first vaccines for influenza and Hepatitis A.⁷⁵ The military continues to be heavily involved in medical research today, in areas ranging from basic force readiness (done by entities like the Army’s Military Operational Medicine Research Program⁷⁶ and the Naval Health Research Center⁷⁷) to breast cancer study at Walter Reed.⁷⁸

⁷⁵ Josh Michaud, Kellie Moss and Jen Kates, “U.S. Global Health Policy The U.S. Department of Defense and Global Health,” *The Henry J. Kaiser Family Foundation*, September, 2012. Pg. 6. Available:

<https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8358.pdf>

⁷⁶ “Military Operational Medicine Research Program,” Accessed February 9, 2015, <https://momrp.amedd.army.mil>.

⁷⁷ “Naval Health Research Center,” Accessed February 9, 2015, <http://www.med.navy.mil/sites/nhrc/Pages/default.aspx>.

In addition to force protection and broader medical research, the military has been significantly involved in medical activities in the context of preparing for biological threats. According to the Kaiser report, “DoD seeks to prevent and prepare for biological incidents, such as international and domestic infectious disease outbreaks and epidemics, whether they be due to natural, accidental, or intentional causes.”⁷⁹ The significance of the latter two causes has intensified of late in the context of biologists’ increasing ability to manipulate genetic material in microbes, which, as I stated in an article for *Science Progress*, can “be used to create particularly dangerous pathogens” that could potentially escape a laboratory or be developed for use in terrorist attacks.⁸⁰

Historical Overview of Military Medical Outreach

The area of military medical activity that shares the most with the Cuban and Chinese programs (and the area with the greatest potential to be converted for use in a soft power capacity) is termed “stability operations and partner engagement” by the Kaiser report. Although this sort of activity has never been a high institutional priority, the U.S. military has a long history of healthcare activity that directly affects foreign populations. During America’s military campaign in the Philippines in the late

⁷⁸ “Breast Care and Research Center,” Accessed February 9, 2015, <http://www.wrnmcc.capmed.mil/Health%20Services/Surgery/Surgery/General%20Surgery/BreastCareAndResearchCenter/SitePages/Home.aspx>.

⁷⁹ Michaud, Moss and Kates (2012), Pg. 26.

⁸⁰ Oliver Kendall, “Keeping Good Research from Going Bad,” *Science Progress*, February 22, 2013. Available: <http://scienceprogress.org/2013/02/keeping-good-research-from-going-bad/>

1800's, for example, "commanders saw strategic value in implementing health services in local communities in order to foster support for U.S. forces."⁸¹

It is difficult to find evidence during the Second World War of an explicit objective to win over populations via medical activity. After the surrender of the Axis, however, American military personnel took the lead in rebuilding the devastated healthcare systems of both Japan and Germany. "The U.S. effort to rebuild Japan's public health and health care delivery was quite successful," says a report by the RAND Corporation. While the United States did good work in Germany, its healthcare activities in Japan can be seen as more impressive, since the German healthcare system prior to the war was one of the most advanced in the world. Japan had some developed healthcare infrastructure prior to the war including a centrally run Ministry of Health and Social Welfare. This Ministry, however, did not exercise much local control, which was relegated to prefectural governments, and often conflicted with the Ministry of Home Affairs, which also had oversight of medical personnel.⁸² Due to this and other issues (like inadequate training), the Japanese healthcare system, even before its infrastructure was largely destroyed in the war, was "rigidly stratified"; most average Japanese did not see their healthcare improve even as the number of doctors was increasing.⁸³ Even this progress was stopped in its tracks by the war, in which one in every four of Japan's hospitals was destroyed.⁸⁴

⁸¹ Michaud, Moss and Kates (2012), Pg. 6.

⁸² Seth Jones, Lee Hilborne, C. Ross Anthony, Lois Davis, Federico Gerosi, Cheryl Benard, Rachel Swanger, Anita Datar Garten and Anga Timilsina, "Securing Health: Lessons from Nation-Building Missions," *RAND Center for Domestic and International Health Security*, 2006. Pg. 40-41. Available: http://www.rand.org/content/dam/rand/pubs/monographs/2006/RAND_MG321.pdf

⁸³ Jones et. al. (2006), Pg. 42.

⁸⁴ Crawford F. Sams, *Medic: The Mission of an American Military Doctor in Occupied*

Following the war, Colonel Crawford Sams, an Army doctor with public health experience, was most directly responsible for rebuilding Japan's health system. Working under the Supreme Commander of Allied Powers, Douglas MacArthur, Colonel Sams focused first on sanitation, nutrition and some immunization with the goal of preventing the spread of communicable diseases (typhoid and tuberculosis being the most problematic).⁸⁵ Although Sams sometimes had to fight Washington for resources, several of these initial programs were very successful. Children included in a school lunch program, for example, were an inch taller on average than their peers, and the program, which was wildly popular among the Japanese citizenry, was eventually expanded to eight million Japanese children.⁸⁶

Efforts to contain what were known as “wildfire diseases” – those that could spread rapidly to epidemic levels – were also largely successful, through vaccination and sanitation efforts, and vector destruction (e.g. DDT campaigns to kill mosquitos). Prevalence of diseases like diphtheria, tuberculosis, typhus and others decreased in the years of American occupation following the war.⁸⁷ It could be argued that the success of American military efforts at rebuilding both the Japanese and German healthcare systems were helped by the existence of health systems prior to the war. What is undeniable is that despite a preexisting healthcare infrastructure, Japan's overall health improved significantly during the period in which the U.S. Military was actively involved: “The trends in major indicators show,” says the RAND report, “that

Japan and Wartorn Korea, Zabelle Zakarian (ed.) (New York: M.E. Sharpe, 1998). Pg. 28-29.

⁸⁵ Jones et. al. (2006), Pg. 54-56.

⁸⁶ Sams (1998), Pg. 56, 63.

⁸⁷ Jones et. al. (2006), 61-63.

compared with the pre-war levels, the overall Japanese health status improved significantly during the intervention period.”

Although American military medical personnel almost certainly provided direct care to civilians at times during the Second World War, the American focus after the conflict was more on rebuilding the healthcare systems of the defeated Axis countries on a structural level than it was on individual caregiving of the sort that could foster a connection between American doctors and foreign patients (though some American actions like the school lunch program were extremely popular with Japanese citizens in a way that almost certainly increased American soft power).⁸⁸ This direct contact was more deliberately institutionalized during the Vietnam War. “In the late 1960s and early 1970s the military campaign in Vietnam featured a prominent role for health engagement,” says the Kaiser Family Foundation report.⁸⁹ One of the primary ways in which this health engagement with the Vietnamese civilian population was carried out was through medical civic action programs (MEDCAPs), which are generally short-term assignments (sometimes for training purposes) undertaken by military medical personnel.

Outside major conflicts, the military has at times deployed medical personnel as part of other more recovery-based operations. Military units have frequently been involved in humanitarian aid provision following natural disasters, like an earthquake in Guatemala in the 1970’s, the 2004 tsunami in Southeast Asia, and a devastating earthquake in Pakistan in 2005. This has also included some deployments besides significant natural disasters in the context of post-conflict recovery. During the

⁸⁸ Jones et. al. (2006), Pg. 58.

⁸⁹ Michaud, Moss and Kates (2012), Pg. 6.

1990's, for instance, American military medical units were deployed to the Balkans along with other military personnel. In the 1990's and early 2000's, the military worked in support of USAID efforts at reconstructing Haiti's healthcare system. "The U.S. military helped rebuild hospital and clinic facilities, assisted with rabies control and prevention efforts, aided with vaccination programs, and helped provide equipment to health care facilities."⁹⁰

The recent American military engagement in Iraq and Afghanistan add additional examples of the role played by military medical activity in the context of counterinsurgency, in some ways similar the aforementioned activity in Vietnam and the Philippines. According to the RAND report, "counterinsurgency experts have long argued that winning hearts and minds is a key—if not the key—component in establishing peace."⁹¹ That such hearts and minds activity is called for in today's wars presents somewhat of a problem for the military, says Lawrence Yates in a paper written for the Army. This is because the military has focused most of its attention on fighting or preparing for conventional wars, despite the fact that the vast majority of wars in which the United States have been involved have been smaller unconventional conflicts (America has fought just eleven "conventional" wars, of which only four have been total wars, and all of which had some unconventional aspects).⁹² "One trade off for this preoccupation with conventional warfare," Yates continues, "has been the military's general disinclination to study and prepare for what, in current

⁹⁰ Jones et. al. (2006), Pg. 128.

⁹¹ Jones et. al. (2006), Pg. xxi.

⁹² Lawrence Yates, "The Military's Experience in Stability Operations, 1789-2005," *Global War On Terrorism Occasional Paper 15*. (Fort Leavenworth, Kansas: Combat Studies Institute Press, 2006). Pg. 1. Available: <http://usacac.army.mil/cac2/cgsc/carl/download/csipubs/yates.pdf>

jargon, is referred to as *stability operations*.”⁹³

Stability operations, says Yates citing a draft of a military field manual, are conducted with the goal of establishing and promoting security and control over areas, and entail using military resources to “establish, safeguard or restore basic civil services.”⁹⁴ Although Yates says the military has conducted what would now be called stability operations for centuries, DoD interest has increased significantly in the wake of the 9/11 attacks out of the belief that they are important in the context of preventing terrorism. According to the 2002 *National Security Strategy* cited by the Kaiser Family Foundation report, “The events of September 11, 2001, taught us that weak states, like Afghanistan, can pose as great a danger to our national interests as strong states. Poverty does not make poor people into terrorists and murderers. Yet poverty, weak institutions, and corruption can make weak states vulnerable to terrorist networks.”⁹⁵

The RAND Corporation report argues for the importance of healthcare system promotion in contexts like Iraq and Afghanistan, declaring: “nation-building efforts cannot be successful unless adequate attention is paid to health.”⁹⁶ The report’s authors posit a direct link between health and security in a hearts and minds context:

Health can have an important effect—positive or negative—on security. In Japan [in the aftermath of the Second World War], the introduction of powdered milk into schools created a reservoir of good will that contributed to a benign security environment. In Iraq, however, there is evidence that poor health conditions—especially poor sanitation conditions—contributed to anti-Americanism and support for

⁹³ Yates (2006), Pg. 1, 46.

⁹⁴ Yates (2006), Pg. 2.

⁹⁵ *National Security Strategy*, September 17, 2002. Available: <http://georgewbush-whitehouse.archives.gov/nsc/nss/2002/nssintro.html>

⁹⁶ Jones et. al. (2006), Pg. xvi.

the insurgency.⁹⁷

The Taliban also appears to have grasped the value of healthcare provision as a means of securing local support. According to an article in *Defense Horizons* by Colonel Donald Thompson, an Air Force flight surgeon: “Insurgents have provided medical services to win over the rural population; Taliban-owned hospitals operate in Pakistan along the Afghanistan-Pakistan border and provide medical services to Afghans in the region.”⁹⁸

Problems with the Military’s Recent Healthcare Outreach Activities

The DoD’s increased attention to stability operations is a good thing, but many of the flaws that have traditionally plagued its healthcare outreach activity (like low prioritization and lack of coordination) continue to persist, and will need to be rectified if the military is to become a serious engine of medical diplomacy. Although some minimal steps have been taken to unify the bureaucracy that underpins U.S. military medical activity, this activity remains disorganized, lacking a clear source of central authority; there does not appear to be an explicit medical outreach program as such. This often undermines the effectiveness on the ground of military medical outreach, blunting its potential diplomatic impact. This disorganization includes difficulty coordinating between different parts of the government and with NGO’s that often take the lead in global health activity.

⁹⁷ Jones et. al. (2006), Pg. xvii.

⁹⁸ Donald Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan,” *Defense Horizons* No. 63, May 2008. Pg. 3. Available: <http://fas.org/man/eprint/meddip.pdf>

In addition to technical issues that undermine the DoD's ability to conduct medical diplomacy, some deliberate policy decisions about DoD medical activity create public relations problems that blunt the diplomatic impact of medical outreach. Although the Military Health System has extensive resources at its disposal to care for American military personnel abroad, it is often hesitant to extend the same care to patients outside the U.S. military. This, and the frequently-employed rule that the medical corps provide locals medical attention only up to the local standard of care (although the reasons for this are many, complicated, and sometimes well-justified in certain contexts), does not project the image of benevolent American generosity that would improve American soft power. Medical outreach has also sometimes been undermined by a failure to understand local culture, which can degrade both the ability to practice medicine effectively and to garner soft power. Even if most of these issues were addressed, the short periods during which military medical teams are usually deployed does not often afford enough time for those teams to make a serious diplomatic impact.

The first of several flaws with America's medical stability operations is significant disorganization in the bureaucracy behind them. While the DoD is engaged in significant medical activity, these efforts have not been undertaken intentionally with any particular goal in mind—there is no actual program. “Myriad DoD programs have an impact on global health, but each has different and sometimes conflicting objectives,” say Eugene V. Bonventre, Kathleen H. Hicks, and Stacy M. Okutani in a report for the Center for Strategic and International Studies.⁹⁹ According

⁹⁹ Eugene V. Bonventre, Kathleen H. Hicks, and Stacy M. Okutani, “U.S. National Security and Global Health: An Analysis of Global Health Engagement by the U.S.

to the Kaiser Foundation study, some steps have been taken to organize DoD medical outreach bureaucracy, but as of 2012, “there is no overarching policy or strategic document that guides the Department [of Defense]’s global health related efforts.”¹⁰⁰ In 2011, says Daniel, the DoD created the position of “DoD global health engagement coordinator,” a military position in an office “under the undersecretary of defense for policy” (for the sake of comparison, Cuba’s program is run by a Deputy Minister of Foreign Relations).¹⁰¹ While this laid the groundwork for increased coordination within the military vis-à-vis health efforts, this alone will not turn existing military medical activity into a serious conductor of health diplomacy. Both the Chinese and Cuban programs are organized around ideas of improving global health and gaining soft power, but America’s programs look more like ad hoc, whack-a-mole efforts at maintaining a standard of healthcare in areas effectively controlled by the U.S. military in the wake of an armed intervention.

This internal disorganization has undermined efforts at post-conflict stabilization even in countries where the military is heavily focused, says Colonel Thompson. “Interagency coordination defects... have plagued the United States in its broader approach to post-conflict stabilization efforts.”¹⁰² In the context of a war, one department of the American government is expected to take primary responsibility while the others work in a support capacity (during the fighting the Defense Department takes the lead, during the post-conflict negotiations the State Department

Department of Defense,” *Center for Strategic and International Studies*, April, 2009. Pg. 2. Available:

http://csis.org/files/publication/090421_Bonventre_USNationalSecurity_Rev.pdf

¹⁰⁰ Michaud, Moss and Kates (2012), Pg. 2.

¹⁰¹ Kirk (2009), Pg. 506.

¹⁰² Thompson (2008), Pg. 3.

takes on the primary role). This makes sense in a conventional war, but in an insurgency situation (of the sort where stability operations would be the most effective), this method of coordination falls apart in the face of security persistent threats and hearts and minds issues.¹⁰³

The flaws inherent in this strategy have been particularly clear in Operation Enduring Freedom. “Nowhere is this disorganization more apparent, nor have more opportunities been lost, than in the areas of health and medical care in Afghanistan”, where “poor resource support and central coordination for local efforts are hampering the local and regional counterinsurgency impact of” NATO Provincial Reconstruction Teams (PRTs).¹⁰⁴ One of the highest-ranking American military medical personnel in Afghanistan during 2006 and 2007, Thompson goes on to describe one instance where it took months of negotiation to assign two technical experts from the U.S. Public Health Service Commissioned Corps (under the Department of Health and Human Services) to the Combined Security Transition Command—Afghanistan (under the Department of Defense). These technical experts had extensive experience in communicable disease control, food and drug safety, and “development of basic health services across cultural barriers” – all skills that would have been highly valuable to the health mission in Afghanistan. Despite the fact that these DHHS employees had worked across a variety of federal departments domestically, it took a full 18 months before their expertise could be brought to bear by the DoD due to a bureaucratic technicality about working abroad.¹⁰⁵

In addition to interagency coordination issues, efforts are sometimes hampered

¹⁰³ Thompson (2008), Pg. 3.

¹⁰⁴ Thompson (2008), Pg. 3.

¹⁰⁵ Thompson (2008), Pg. 2.

by the complexity and difficulty of receiving funding for development-related missions; it is often difficult for projects to obtain financial support when Congress has not specifically allocated money. “The complexity of the Federal Acquisitions Regulations (FAR) often results in missed opportunities to act quickly in restoring essential services,” say Merriam Mashatt, Major General Daniel Long and James Crum in a report for the U.S. Institute of Peace.¹⁰⁶ In his article, Colonel Thompson describes one such missed opportunity. In the Kunar province, Taliban militants maimed locals who assisted the NATO PRT’s in an effort to undermine counterinsurgency development efforts. When the PRT commander sought funding to provide the victims with reconstructive surgery in a hospital in Kabul operated by CARE international (a healthcare NGO), that funding was denied by the U.S. Central Command Humanitarian Assistance coordinator. The mere \$430,000 required would have paid to train two Afghan plastic surgeons per year and provide reconstructive surgery to 30 patients in the same period of time. “Funding this initiative,” says Thompson, “would have been a relatively inexpensive way to show U.S. support for local populations, would have helped boost local morale, and would have built needed, sustainable capacity in the Afghan health sector.” Even when funding does come through, red tape surrounding its allocation could potentially dull the impact of projects by delaying the arrival of financial support. The Defense Threat Reduction Agency and the CDC, for example, worked together to assist Uganda and Vietnam in developing health capabilities necessary to meet the requirements of the 2005

¹⁰⁶ Merriam Mashatt, Major General Daniel Long and James Crum, “Conflict-Sensitive Approach to Infrastructure Development,” *United States Institute of Peace Special Report 197*, January, 2008. Available: <http://www.usip.org/sites/default/files/sr197.pdf>

International Health Regulations. According to J. Christopher Daniel in a Center for Strategic and International Studies report, “the partnership has helped lay the foundation for the Global Health Security Agenda, launched in February 2014.” This success occurred, though, “despite challenges related to interagency money transfers.”¹⁰⁷ The same report calls on Congress to facilitate easier and more flexible mechanisms for this sort of operation.¹⁰⁸

In addition to problems coordinating coexisting U.S. government efforts at health outreach, the DoD has suffered problems operating alongside various outside organizations providing healthcare. In situations where multiple organizations are trying to provide services to the same population, it is often helpful when one particular group is declared the “lead actor,” and, according to the RAND Corporation report, “It can be difficult to agree on a lead actor, since donor states, international institutions, and NGOs generally have different priorities, interests, and strategies.”¹⁰⁹ While American military medical forces cooperated well with NGO’s in their efforts at rebuilding the healthcare systems in Japan and Germany, the international system of healthcare NGO’s was far less developed; there were fewer metaphorical strings to be tangled than there are today. When the military deployed doctors to Haiti alongside aid workers from the United States Agency for International Development (USAID), “one of the challenges the international relief community faced was how to integrate the efforts of U.S. military medical units into the larger humanitarian relief and

¹⁰⁷ J. Christopher Daniel, “Global Health Engagement: Sharpening a Key Tool for the Department of Defense,” *Center for Strategic and International Studies*, October, 2014. Pg. 9. Available:

http://csis.org/files/publication/140930_Daniel_DODGlobalHealth_Web.pdf

¹⁰⁸ Daniel (2014), Pg. 12.

¹⁰⁹ Jones et. al. (2006), Pg. xxiv.

rebuilding efforts,” according to the RAND Corporation report. The language of that statement implies that, unlike the successful postwar reconstructions led by the armed forces in the 1940’s, the military may be less effective in a relief effort where it is not the lead actor.

Even in recent situations where the military is clearly in charge, though, the difficult task of coordinating with the larger numbers of actors that are now relevant has complicated the development efforts of the DoD. During the rebuilding of Iraq’s healthcare system, say doctors David Tarantino and Shakir Jawad, there was “a critical need for improved coordination across the DoD, USG, host nation, coalition, IO, and NGO leadership.”¹¹⁰ Due to the similar lack of cooperation in Afghanistan, Dr. Thompson called for the establishment of a health sector reconstruction office that would “integrate and unify nationwide planning and implementation with the government of Afghanistan, representatives of other nations, and international organizations and NGOs.”¹¹¹

Poor communication between NGO’s and the military has sometimes resulted in the alienation of healthcare NGO’s working in conflict zones. According to the Kaiser Foundation report, “In certain circumstances, such as Afghanistan and Iraq, NGOs have at times expressed reluctance or refused to work with DoD, because they believe doing so negatively impacts their ability to carry out their work and increases

¹¹⁰ David Tarantino and Shakir Jawad, *Iraq Health Sector Reconstruction: An After-Action Review* (Unpublished report of the Iraq Health Sector Reconstruction After-Action Conference at the Uniformed Services University, January, 2007), Pg. 8, available:

<http://csis.org/images/stories/globalhealth/Iraq%20AAR%20final%201%20OCT.pdf>

¹¹¹ Thompson (2008), Pg. 6.

risks to their staff and programs in the field.”¹¹² Better communication, the report continues, could clarify “expectations, roles and other issues.” Another impediment to coordination between the military and healthcare NGO’s has been reluctance on the part of the military to share information. “The U.S. Military at times “over-classified” information contained in health assessments such as the locations of hospitals and clinics, and other health sector information, making it impossible to share this information with NGO’s,” say Tarantino and Jawad.¹¹³

Presenting a less directly administrative issue, providing care to anyone other than Americans is often a low priority for U.S. Military medical units stationed abroad. According to the RAND report, this was on full display during the U.S. Military’s medical mission to Kosovo during the 1990’s, and thrown into particularly sharp relief when compared to America’s more medically generous allies in the effort:

Countries with a long history of peacekeeping and humanitarian relief missions, such as Norway and Canada, tended to define their medical mission more broadly. In particular, this included involvement with the host country and the local community in providing direct medical care, as well as undertaking public health activities and helping rebuild the health sector infrastructure. U.S. policy tended to favor a narrower definition of the medical mission, one that focused on providing medical support to the force and provided care to civilians only in emergencies. According to U.S. policy, military medical units were not to get involved in refugee care or in rebuilding the health care infrastructure.¹¹⁴

This policy of strongly prioritizing the health of American soldiers (even when they are not particularly at risk) was also in place when the military medical corps assisted USAID with their efforts in Haiti. “The U.S. military’s policy

¹¹² Michaud, Moss and Kates (2012), Pg. 34.

¹¹³ Tarantino and Jawad (2007), Pg. 44.

¹¹⁴ Jones et. al. (2006), Pg. 179.

was to transfer civilian patients to local hospitals as soon as possible.”¹¹⁵ Even in Operation United Assistance, the DoD’s mission to combat Ebola, U.S. military personnel “rarely left their bases.”¹¹⁶ “The army’s battle against Ebola,” says VICE news, did not look like a war. Helicopters flew no dead bodies or Ebola patients, or even blood samples. Combat medics treated no sick people. Soldiers didn’t rescue victims from streets, or enforce quarantines, or provide armed security against mobs crazed by fear and illness.”¹¹⁷ That American troops worked in relative isolation building facilities that would be used in the future to treat Ebola patients certainly kept U.S. forces safer (while still helping to an extent to combat the disease) but prevented the sort of human contact that would likely have done more to garner soft power.

The fact that the primary mission of the Military Health System is usually considered to be force protection (caring for American troops) creates a rationale for saving military medical resources for use on Americans in the unlikely event that those medical resources would be tapped out. A different report also published by RAND even decried a tendency of military doctors to be too generous with foreigners if explicit rules for medical resource allocation were not set prior to the mission. “Without clear guidelines for giving or withholding care,” said this earlier report, “medical providers will tend to react to the immediate need, regardless of the long-term consequences for

¹¹⁵ Jones et. al. (2006), Pg. 139.

¹¹⁶ Brian Castner, “Hearts, Minds and Ebola: The US Army Drops In On Liberia,” *VICE News*, February 13, 2015. Available: <https://news.vice.com/article/hearts-minds-and-ebola-the-us-army-drops-in-on-liberia>

¹¹⁷ Castner, 2015.

readiness.”¹¹⁸ While this attitude makes sense in the context of the military preparedness issues, it is detrimental to the military’s ability to garner soft power through medical outreach.

Another military policy that impedes potential DoD medical diplomatic activity requires that a resident of an area where the military is deployed should receive medical attention only up to the local standard of care. There are legitimate rationales for this policy in several military contexts. In a situation where the military has other non-diplomatic objectives, efforts to achieve these objectives could be significantly impeded by local populations seeking medical services from military personnel whose focus is on a different goal. Thus, maintaining a policy of providing only the local standard of care prevents a potentially significant distraction from affecting the ability of U.S. military personnel to carry out the mission at hand.

Refusing to systematically provide medical attention above the local standard of care also makes strategic sense in the context of a stability operation where the objective is to increase the credibility of local institutions. The goal of stability operations is indeed frequently to increase the legitimacy of the local government; providing care that goes beyond what the local government can achieve could serve to undermine that government. According to Bonventre, Hicks, and Okutani, for example, in 2004 after the Banda Aceh tsunami, the Indonesian government complained that healthcare delivered by the U.S. Navy hospital ship *Mercy* had “undermined its legitimacy and authority” since “the standard of care delivered far

¹¹⁸ Lois Davis, Susan Hosek, Michael Tate, Mark Perry, Gerard Hepler and Paul Steinberg, “Army Medical Support for Peace Operations and Humanitarian Assistance,” *RAND*, 1996. Pg. 86. Available: http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR773.pdf

exceeded what the Indonesian government was able to provide after the ship departed.”¹¹⁹ This highlights the need for coordination with the local government in the context of a medical diplomacy situation, unless good relations with the local government are not considered a priority. The Indonesia scenario also indicates the benefit of American medical personnel potentially remaining in an area for longer than just the time it takes to clean up after a natural disaster.

The high premium placed on military readiness (to which the second RAND report alludes) is another oft-cited reason for rationing military medical resources. In some situations, though, this rationale rings hollow, and it certainly is not helpful diplomatically. In Haiti, for example, the motivation behind the policy of transferring Haitian patients as quickly as possible to local hospitals was “to free up inpatient capacity in the event of a surge in demand—especially U.S. military casualties.”¹²⁰ While it makes sense to preserve military readiness and force protection is and should obviously remain a key priority of the Military Health System, it was deeply improbable that a military medical unit would be called upon to care for large numbers of American soldiers in the context of a development operation in Haiti coordinated primarily by USAID. That being the case, those looking in from the outside could view the stockpiling of medical resources that are then not used to help people in immediate need negatively, undermining potential diplomatic benefit of the mission. This was indeed the case in Kosovo, where the actions of America’s more medically generous allies cast a poor light on the U.S. military’s unwillingness to use their medical resources more extensively.

¹¹⁹ Bonventre, Hicks, and Okutani (2009), Pg 18.

¹²⁰ Jones et. al. (2006), Pg. 139.

Differences in coalition partners' medical policies created unrealistic expectations of the U.S. medical units and complicated interactions with government officials, the health NGO's, and civilian healthcare providers and civilians. Local officials, health NGO's and some coalition partners criticized the United States for not allowing U.S. medical units to get more involved in healthcare delivery and in healthcare reconstruction efforts.¹²¹

The impression that the Military Health System is a fancy car that the U.S. is unwilling to let out of the proverbial garage will surely not contribute to soft power via medical diplomacy—if the military is to conduct more effective health outreach, policies restricting the extent to which military doctors are allowed to help the local populace should be loosened.

Another key to conducting good medical diplomacy operations is the ability to conform to or at least be aware of local culture as it pertains to health issues. There are, of course, times when a medical mission must ignore or even combat local customs that effect medical practice. Female genital mutilation – widespread in parts of Africa and much of the Muslim world – comes to mind. Whether or not certain local traditions deserve respect, awareness of them is essential to both the acquisition of soft power and to good medical practice. A key part of the mission to combat Ebola in West Africa was convincing locals to abandon traditional burial rites that involved, says *Science* magazine, “washing, touching and kissing the body” (which, in the case of Ebola, remains highly infectious after death).¹²² According to VICE

¹²¹ Jones et. al. (2006), Pg. 179-180.

¹²² Abhishek Pandey, Katherine Atkins, Jan Medlock, Natasha Wenzel, Jeffrey Townsend, James Childs, Tolbert Nyenswah, Martial Ndeffo-Mbah, Allison Galvani, “Strategies for containing Ebola in West Africa,” *Science*, October 30, 2014.

News, “it took months to convince the majority of families to cease handling dead bodies.”¹²³ Awareness of this local practice, though, allowed it to be identified early on by epidemiologists as a significant driver of transmission, which in turn allowed medical professionals to push safer burial practices that decreased transmission of the virus.

While sound knowledge of local traditions has helped halt the spread of Ebola in West Africa, military medical outreach efforts have sometimes been plagued by clumsy mistakes driven by a lack of attention to local culture. In one case Daniels describes in his report for the Center for Strategic and International Studies, “DoD conducted a medical clinic in a remote village of Djibouti, but only three days’ notice to the predominantly nomadic villagers resulted in minimal participation.”¹²⁴ Military medical operations have frequently suffered from a poor cultural understanding of the people the operation exists to serve. “Efforts to provide humanitarian medical assistance after a major 1976 earthquake in Guatemala were hindered by the inability of U.S. military personnel to adapt to local customs,” say doctors Bradley Boetig and George Avery in *World Medical & Health Policy*.¹²⁵ According to Tarantino and Jawad, Military medical operations in Iraq also suffered from a

Available:

<http://www.sciencemag.org/content/early/2014/10/29/science.1260612.full?explicitversion=true>

¹²³ Castner, 2015.

¹²⁴ Daniel (2014), Pg. 4.

¹²⁵ Bradley Boetig and George Avery, “Medical and Public Health Civic Action Programs: Using Health Engagement as a Tool of Foreign Policy,” *World Medical & Health Policy*: Vol. 2, Iss. 1, 2010. Pg. 73-74.

“lack of understanding of the cultural context.”¹²⁶ In their report, Tarantino and Jawad call on the U.S. Government to “expand and improve education, training and career development opportunities in the areas of civil-military medicine, medical stability operations, and public health and health care delivery in international and conflict settings.”¹²⁷ Given the military’s history of missteps vis-à-vis local culture, the DoD should provide “opportunities to increase cultural awareness and intelligence.”¹²⁸

The diplomatic impact of military medical outreach has sometimes been dampened when poorly conceived and coordinated health operations have had a negative impact on local civilian populations. Many countries, whether intentionally or not, create a multitiered healthcare system in which the superior military health system is accessible to the dependents of military personnel and political dignitaries. This, understandably, leads to resentment amongst those relegated to the often underfunded and under equipped civilian healthcare system. “The United States,” Thompson argues, “is developing such a disparate system in Afghanistan by putting almost all of its health sector reconstruction resources into the security sector while ignoring the civilian sector.”¹²⁹ While maintaining good relations with foreign militaries has historically been a high priority of the DoD, it pays to avoid doing so at the cost of alienating foreign civilians.

In addition to potentially disenfranchising certain populations if they are excluded from receiving care, medical diplomacy runs the risk of triggering a backlash

¹²⁶ Tarantino and Jawad (2007), Pg. 32.

¹²⁷ Tarantino and Jawad (2007), Pg. 47.

¹²⁸ Tarantino and Jawad (2007), Pg. 47.

¹²⁹ Thompson (2008), Pg. 4.

from local medical professionals. These personnel could feel undercut by an influx of foreign doctors who sometimes provide better care more cheaply than the local doctors, damaging the reputation and bottom line of those local medical practitioners. Cuban medical personnel on mission have often been met with hostility from local medical associations, says Julie Feinsilver. Doctors in some countries serviced by the Cubans have gone on strike in protest, others have attempted legal action or taken their complaints to the press.¹³⁰ After initially being essential to recovery after a devastating earthquake in Pakistan in 2005, American medical personnel became an object of resentment for Pakistani doctors who, say Boetig and Avery, “could not compete with U.S. units providing a higher standard of care for no cost.”¹³¹ Boetig and Avery argue that the damage done to the local healthcare system in this particular case hurt America’s image with some Pakistanis. While it is possible that the locals in this situation were especially quick to vilify Americans due to other political realities, this instance, similar issues in Indonesia following the 2004 tsunami,¹³² and the backlash sometimes faced by Cuban doctors, highlights the importance of understanding the local medical situation. Medical diplomacy or stability operations cannot be conducted with the assumption that one-size-fits-all; they must be calibrated to the unique realities and needs of the area being served.

Operations must also identify at whom the “diplomacy” part of medical diplomacy is targeted. Cuban medical outreach is obviously not conducted with the aim of winning favor amongst the medical personnel of the countries they serve, it is conducted to win over the governments and populations of those countries. Cuba has

¹³⁰ Feinsilver, 2006.

¹³¹ Boetig and Avery (2010), Pg. 74.

¹³² Boetig and Avery (2010), Pg. 74-75.

calculated that the diplomatic benefit of their medical operations is worth the cost of alienating some local medical practitioners, a calculation that appears to be correct: “despite protests (and strikes),” says Feinsilver, “numerous press and other reports from different countries extol the benefits to the patients,” whose governments often take notice. The administrations in most countries served by Cuban doctors have repeatedly ignored the protests of local medical personnel, since the overall benefit to society significantly outstrips the cost to local medical practitioners.¹³³ That Cuban medical diplomacy is generally well received by the populations and governments in most of the countries they serve – even at the expense of angering local doctors – is indication that American doctors abroad could have the same effect despite the problems with the medical operation in Pakistan in 2005.

One of the issues that undermined the medical mission in Pakistan has negatively impacted other American medical outreach: medical personnel were deployed long enough to displace (and thus draw the ire of) local medical personnel, but not long enough to effectively replace them. The very temporary nature that characterizes U.S. military medical outreach sometimes undermines its potential to garner soft power via medical diplomacy. One way of conducting medical diplomacy in a more lasting way, suggests Major Bradley Boetig in *Military Medicine*, is through institutional relationships rather than just ad hoc assignments. Boetig calls for the establishment “of enduring, bilateral relationships between U.S. and host-national medical institutions,”¹³⁴ of the sort that are conspicuously more present in the Chinese

¹³³ Feinsilver, 2006.

¹³⁴ Bradley Boetig, “Bilateral Institutional Relationships: A New Mission for U.S. DoD Medical Capabilities in Support of Health Diplomacy,” *Military Medicine*, Vol. 177, July, 2012. Pg. 763.

and Cuban programs, which contain much more extensive cooperation with and training of foreign medical personnel. Institutional (rather than purely individual) partnerships, Boetig believes, “would cultivate relationships that endure beyond the length of the individual assignment cycle.”¹³⁵

Much as the U.S. military’s patient-centered health outreach is basically limited to brief, ad hoc missions, often in response to some crisis, the rare occasions where military medical personnel work with non-American medical personnel are frequently limited to just a few weeks. While military Medical Readiness Training Exercises (MEDRETE’s) that involve foreign personnel are often considered successful based on the number of “relationships established,” this model does not result in a very permanent connection, since “those relationships are almost always fleeting... as individuals move in and out of units quite frequently; and rarely do units—let alone individuals return repeatedly to the same location.”¹³⁶ Compare this to the Chinese system, where doctors usually deploy for two years at a time, and specific Chinese provinces are paired with individual foreign countries, ensuring a more consistent long-term relationship,¹³⁷ or the Cuban system, where doctors also deploy for long periods and significant numbers of medical students are exchanged for the entire duration of their medical training.

The obstacles preventing the military from conducting effective health outreach are not insurmountable, but they are many, they are varied, and they require attention if the DoD is to become an entity that can successfully conduct medical diplomacy in a way that will garner soft power for the United States. The following

¹³⁵ Boetig (2012), Pg. 763.

¹³⁶ Boetig (2012), Pg. 764.

¹³⁷ Thompson, 2005.

recommendations are one way in which some of these issues could potentially be addressed.

Recommendations

- The Department of Defense should expand medical outreach, and conduct some of these medical outreach activities specifically under the guise of military medical diplomacy, rather than just stability operations. Changing the name of something can change its fundamental meaning; military medical personnel carrying out missions in this context would likely be more mindful of diplomatic objectives if diplomacy were the stated goal.
- Appoint a single coordinator of all DoD medical operations, with sub-positions as necessary. Personnel beneath these positions should be easily transferable (including cutting through red tape in dealing with other executive departments) in order to avoid the sorts of coordination issues that have sometimes plagued military medical operations (like the eighteen months required to transfer the three technical experts to Afghanistan during Operation Enduring Freedom).¹³⁸
- Improve coordination with bodies outside the DoD so that U.S. military medical personnel can better play a role in health operations that are not under the complete (or any) control of the U.S. military. In the context of USAID operations where U.S. military personnel are involved, for example, military personnel could be allowed greater flexibility in their orders in a way that would allow them to get more directly involved with the aid mission rather than just waiting for potential American casualties.

¹³⁸ Thompson (2008), Pg. 2.

- Congress should expand and help streamline funding for health outreach operations, allowing greater flexibility and authority for military medical personnel on the ground.
- Push back against the idea that foreign patients are less important, at least in the context of a medical diplomacy operation (this could be done through changes in training or doctrine). The appearance that American forces disregard foreign patients undermines American soft power, especially in situations where U.S. forces are deployed alongside personnel from other countries who may appear more generous. Except in situations where there could plausibly be an influx of American personnel needing care, U.S. military resources should not be hoarded in service to force readiness. Doing so is unnecessary (we are not going to run out of Band-Aid's anytime soon, and if we do, we can easily afford more unless the military budget is significantly cut), and projects a negative image of the U.S. military and America as a whole.
- Carefully address the question of local standard of care. In situations where soft power can be gained without undermining local institutions (or in situations where preserving local institutions is not a high priority), U.S. military medical should provide the best care they can; taking better care of someone than local resources allow projects a good image of the United States. In situations where going above the local standard of care would undermine local institutions in a way that could seriously harm either America's soft power or the people American personnel are deployed to serve, medical personnel should do their best to adhere to the local standard of care, with the hope that the presence of American military medical resources could help increase the standard of care over time.
- U.S. military medical personnel should receive more training on the cultures and traditions of the places to which they deploy. Failure to understand local

culture as it pertains to medicine has undermined U.S. military medical outreach in more than one instance, whereas a proper understanding of local culture was essential to the fight against Ebola in the summer and fall of 2014.

- Deployment of U.S. military medical personnel should be long enough to ensure that they actually have a diplomatic and medical impact—brief deployments are better than none, longer deployments are better than brief ones.
- Longer deployments could sometimes take the form of bilateral exchanges between existing medical institutions (like military hospitals or the Uniform Service University). Boetig proposes a longer-term bilateral exchange of medical personnel in order to “truly acquire the much-hyped ‘cultural competency’ skills that have to be earned by actually cultivating a partnership that endures beyond a 2-week MEDRETE.”¹³⁹ A partnership such as this would be beneficial for the host institution, whose credibility would likely increase with the implicit vote of confidence from the U.S. as indicated by the presence of American military medical personnel. Additionally, established institutional partnerships would improve the readiness of medical subspecialists, since “there is no better way to maintain their skills than to provide our specialists with the opportunity to consult routinely on the more challenging cases that arise at partner military hospitals overseas.”¹⁴⁰
- The Uniform Services University of Health Sciences should expand opportunities for foreign students to take courses there even if they did not graduate from an undergraduate institution in the United States (international students are currently admitted only if they went to college in America).¹⁴¹

¹³⁹ Boetig (2012), Pg. 764.

¹⁴⁰ Boetig (2012), Pg. 764.

¹⁴¹ “Uniformed Services University of the Health Sciences Graduate Programs in Biomedical Sciences and Public Health,” Accessed April 1, 2015, <http://www.usuhs.edu/graded/prospectivestudents.html>.

These recommendations alone will not turn the U.S. military medical corps into a health diplomacy program on the order of the Cuban or Chinese models—nor should that necessarily be a goal. The U.S. Military Health System, though, is a significant untapped soft power resource that, with some changes, could save lives and bolster America’s image abroad.