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Health for health's sake, winning for God's sake: US Global Health Diplomacy and smart power in Iraq and Afghanistan[1]

COLIN McINNES and SIMON RUSHTON

Abstract. Ideas of smart power and Global Health Diplomacy have developed considerable prominence over the past decade in, respectively, the foreign policy and public health communities. Although in some respects separate, both suggest the potential for using health assistance to generate political as well as health benefits. The conflicts in Iraq and Afghanistan provide an opportunity to examine these assertions at the 'sharp end'. We consider both the health and wider strategic benefits of health assistance in these conflicts, as well as some of the ethical challenges involved. We conclude however that we should adopt the precautionary principle because: there is doubt over the quality of health services provided in such circumstances; concern over the wider effects of politicising health aid; and little proof that the claimed strategic benefits materialise in practice.

Colin McInnes is Director of the Centre for Health and International Relations at Aberystwyth University and UNESCO Professor of HIV/AIDS Education and Health Security in Africa. His most recent books are *Global Health and International Relations* (2012, with Kelley Lee); and *The Transformation of Global Health Governance* (2014, with Kamradt-Scott, Lee, Roemer-Mahler, Rushton, and Williams).

Simon Rushton is Faculty Research Fellow in the Department of Politics at the University of Sheffield, UK. He is editor of the journal *Medicine, Conflict & Survival* and Associate Fellow of the Centre on Global Health Security at the Royal Institute of International Affairs, Chatham House.

The superordinate quality of health has resulted in health assistance attracting attention over the past decade, not least in the US, for its political as well as its health benefits. According to the rhetoric (much of which has emerged from the US Department of Defense (DoD)), targeted interventions in the form of health aid and assistance can not only help recover or improve health systems and health care, but may also create a positive image of the donor, leading to wider political gains. This potential has been explicitly identified in two relatively recently established concepts: Global Health Diplomacy (GHD) and smart power. Although ostensibly separate developments, the former originating in public health[2] and the latter in foreign policy/

[1] With apologies to Eric Stewart and Graham Gouldman for this parody of their lyric 'Art for art's sake/money for God's sake'. 10cc, 'Art for Art's Sake', *How Dare You!* (1976).

[2] See, for example, Nick Drager and David Fidler, 'Foreign policy, trade and health: At the cutting edge of Global Health Diplomacy', *Bulletin of the World Health Organization*, 85:3 (2007), available at: {http://www.who.int/bulletin/volumes/85/3/07-041079/en/index.html} accessed 10 September 2013; Kelley Lee and Eduardo J. Gomez, 'Brazil's ascendance: The soft power role of Global Health Diplomacy', *European Business Review*, 10 January 2011, available at: {http://www.europeanbusinessreview.

International Relations,[3] the two share a common core: that actions undertaken for a benevolent purpose (in this case, developing and providing health services for populations in need) may also be used to leverage political benefits.[4]

Despite this new language of smart power and GHD, the attempt to use health assistance for political benefit is not in itself new, and neither is it limited to the US. Historic attempts to use health in this way include Cuba's training of medical personnel,[5] visits by US Navy hospital ships,[6] 'days of tranquility' in El Salvador,[7] 'health as a bridge for peace' in Bosnia,[8] and the provision of humanitarian assistance after natural disasters.[9] This article however is concerned with health interventions in a particular context, namely those at the 'sharp' end – those undertaken during conflict. The wars in Iraq and Afghanistan in particular saw the US (and its allies) delivering a wide variety of forms of health assistance, ranging from 'tailgate medicine' (*ad hoc* interventions provided by military medics on a local scale, sometimes literally from the back of a truck) to strategic infrastructure programmes such as the building of hospitals and primary care centres. Crucially, these interventions were not simply 'for health's sake', but were explicitly linked into politico-military strategies of stabilisation, reconstruction, and counterinsurgency and – as we discuss below – were often delivered through the DoD rather than traditional humanitarian aid providers.

com/?p=3400} accessed 10 September 2013; Kelley Lee and Richard D. Smith, 'What is "Global Health Diplomacy"? A conceptual review', *Global Health Governance*, 5:1 (Fall 2011), available at: {http://blogs.shu.edu/ghg/files/2011/11/Lee-and-Smith_What-is-Global-Health-Diplomacy_Fall-2011.pdf} accessed 16 October 2013; Ilona Kickbusch, 'Global Health Diplomacy: How foreign policy can influence health', *British Medical Journal*, 342 (2011), available at: {http://www.bmj.com/content/342/bmj.d3154} accessed 16 October 2013.

[3] Smart power is a development from Joseph S. Nye's concept of soft power (see below). Nye claims he introduced the term 'smart power' in 2003, it first appearing in print the following year in Joseph S. Nye, *Soft Power: The Means to Success in World Politics* (New York: Public Affairs, 2004). See also Joseph S. Nye, 'Get smart: Combining hard and soft power', *Foreign Affairs*, 88:4 (2009), pp. 160–3. Suzanne Nossel also uses the term at around the same time. See Suzanne Nossel, 'Smart power', *Foreign Affairs*, 83:2 (2004), pp. 131–42. Both had been members of the Clinton administration. Secretary of State Clinton made the significance of smart power for the Obama administration clear in her nomination hearings. See Hillary Rodham Clinton, 'Nomination hearing to be Secretary of State: Statement before the Senate Foreign Relations Committee' speech, 13 January 2009, available at: {http://www.state.gov/secretary/rm/2009a/01/115196.htm} accessed 10 September 2013.

[4] Not least one of the key proponents of Global Health Diplomacy, Ilona Kickbusch, was also an early proponent of the soft power potential of health interventions. Ilona Kickbusch, 'Influence and opportunity: Reflections on the U.S. role in global public health', *Health Affairs*, 21:6 (2002), pp. 131–41.

[5] See, for example, Julie M. Feinsilver, 'Cuba's medical diplomacy', in Mauricio A. Font (compiled), *A Changing Cuba in a Changing World* (New York: CUNY Bildner Center, 2009), pp. 273–86.

[6] See, for example, Richard R. Hooper, 'United States hospital ships', *Journal of the American Medical Association*, 270:5 (1993), pp. 621–3; Lt Cdr Jim Dolbow, 'Let's have a fleet of 15 hospital ships', *Proceedings of the United States' Naval Institute*, 134:2 (2008), p. 12; Derek Licina, 'Hospital ships adrift? Part 1: A systematic literature review characterizing U.S. Navy hospital ship humanitarian and disaster response from 2004 to 2012', *Prehospital and Disaster Medicine*, 28:3 (2013), pp. 230–8.

[7] Ciro A. de Quatros and Daniel Epstein, 'Health as a bridge for peace: PAHO's experience', *The Lancet*, 360:Supplement 1 (2002), pp. S25–6; Stephen Gloyd, Jose Suarrez Torres, and Mary Anne Mercer, 'Immunization campaigns and political agendas: retrospective from Ecuador and El Salvador', *International Journal of Health Services*, 33:1 (2003), pp. 113–28.

[8] WHO Europe, *WHO/DFID Peace through Health Programme: A Case Study prepared by the WHO field team in Bosnia and Herzegovina* (Copenhagen: WHO Europe, 1998). See also WHO, What is Health for Peace?, available at: {http://www.who.int/hac/techguidance/hbp/about/en/index.html} accessed 25 October 2013.

[9] See, for example, interview with Rear Admiral Thomas R. Cullison, reprinted in Richard Downie (ed.), *Global Health as a Bridge to Security: Interviews with US Leaders* (Washington DC: Center for Strategic and International Studies, 2012), pp. 12–13.

It is clear why the idea of using health interventions to leverage strategic[10] benefits is attractive to policymakers, particularly in complex emergencies where (military) intervention is not solely aimed at affecting political elites (crudely, by bolstering, reforming, or removing them), but is also intended to achieve community-level objectives. These objectives may include efforts to improve relationships between local communities and military forces (particularly important in an age of 'asymmetric warfare'); attempts to increase people's perception of the legitimacy of their government; attempts to create a functioning economy and society; and actions designed to promote peace and reconciliation between antagonistic communities within a state. The US's global military dominance means that the really difficult battles for it are no longer traditional military ones. Far more challenging are the tasks of winning the hearts and minds of a people and creating stable and sustainable states in the aftermath of armed conflict. Yet the closer alignment of health assistance with these political objectives has been extremely divisive, with many in the public health and humanitarian aid communities expressing disquiet about the politicisation of their roles and the potential resultant dangers to both their physical security and their ability to effectively deliver services to those who need them.[11]

In this article we investigate this tension, focusing in particular on the question of whether health assistance in conflict can indeed generate both health and strategic gains or whether in practice one may be prioritised over (or even sacrificed for) the other. We choose conflict situations – namely Iraq and Afghanistan – not only because (as highly controversial US-led interventions, and difficult situations in which to 'win hearts and minds') they provide an extreme test for the concepts of GHD and smart power, but because these are by far the most high-profile recent cases in which health assistance has been claimed to provide a strategic advantage. In examining these cases we draw extensively on both the published literature and on a range of primary sources, including Internet discussion forums from service veterans. Of particular significance are the reports of the Congressionally-appointed Special Investigator General for Afghanistan Reconstruction (SIGAR) and Special Inspector General for Iraq Reconstruction (SIGIR).[12] The Offices of the SIGIR and SIGAR were charged, amongst other things, with providing objective and independent analyses of the reconstruction efforts in the two countries and enjoyed extensive access to individuals and documents both in the US and in theatre (including access to Iraqi and Afghan officials). Their reports[13] – some of which were picked up in the

[10] We use the term 'strategic' in this article to indicate wider political and/or military benefits, rather than solely health benefits.

[11] See, for example, Nellie Bristol, 'Military incursions into aid work anger humanitarian groups', *The Lancet*, 376:9508 (2006), pp. 384–6; Abby Stoddard, Adele Harmer, and Victoria DiDomenico, 'Providing aid in insecure environments: 2009 update', *Humanitarian Policy Group Policy Brief*, 34 (April 2009), available at: {http://www.otages-du-monde.com/base/IMG/center_international_security.pdf} accessed 11 October 2013; Jude Howell and Jeremy Lind, 'Changing donor policy and practice in civil society in the post-9/11 aid context', *Third World Quarterly*, 30:7 (2009), pp. 1279–96. For a useful discussion of these issues, see the debate between Nicolas de Torrente and Paul O'Brien: Nicolas de Torrente 'Humanitarian action under attack: Reflections on the Iraq War', *Harvard Human Rights Journal*, 17 (2004), pp. 1–30; and Paul O'Brien, 'Politicized humanitarianism: A response to Nicolas de Torrente', *Harvard Human Rights Journal*, 17 (2004), pp. 31–40.

[12] SIGIR completed its work in 2013 and official information on it as well as its reports are archived at: {cybercemetry.unt.edu}. At the time of writing, SIGAR is still operational and information about it is available on its website: {www.sigar.mil}.

[13] These included quarterly reports, special reports, audits, testimony to Congress, and 'lessons learned' documents.

mainstream media – were often highly critical of the conduct of US operations. For us they represent a particularly interesting source because they were very much Washington policy insiders. Stuart W. Bowen, Jr, SIGIR, was a former Deputy Assistant to President George W. Bush,[14] while the SIGAR post has been held by a number of individuals including Major General Arnold Fields Rtd (2008–11) – formerly the Deputy Commander of US Marine Corps Forces in Europe. Thus while the Special Investigators were independent, they were individuals who could be expected to be broadly aligned with the US government's policy approaches. Their reports showed that this was not always the case. Although such sources have proved invaluable, as we note in the article there are several areas in which there is a lack of available evidence – an issue to which we return in the conclusion.

The US's health interventions in Iraq and Afghanistan raise a number of important issues including whether health initiatives do in fact deliver the strategic benefits that have been ascribed to them; the quality of efforts to evaluate their impact; the suitability of the DoD as a humanitarian aid agency and the challenges of successfully pursuing 'silo-busting' cooperative efforts between government departments; the potentially divided responsibilities of individual military medics and others involved in delivering these health initiatives on the ground; and whether there is evidence to support the concerns of some about the broader politicising impact on health and humanitarian aid. Our key message is that there is a need for extreme caution in future efforts to instrumentalise health assistance, because there is doubt over the quality of health services provided in such circumstances; legitimate concern over the wider effects of politicising health aid; and little proof that the claimed strategic benefits materialise in practice. In public health terms, then, we are advocating the application of the precautionary principle since the positives are unproven and negatives exist.

Smart power and Global Health Diplomacy

One of the themes underpinning this Special Issue is that the study of policy developments in the field of global health can help to illuminate broader changes in international relations.[15] In this case, we suggest that the rise of the concept of GHD (as Frederick M Burkle has noted, 'the [US] military has renamed many ''humanitarian'' projects under the mantle of ''health diplomacy'' ')[16] should be seen in the context of – and contributes to an understanding of – a wider shift in US foreign policy towards a 'smart power' approach. Although as we show below US operations (including the delivery of health assistance) in both Iraq and Afghanistan preceded the official adoption of 'smart power' terminology into US foreign policy discourse,[17] in many ways they offer a classic example of the exercise of smart power: the blending of hard and soft power tools, with health assistance being delivered alongside a military strategy, and in many cases being delivered by the military themselves.

[14] SIGIR, 'Leadership', available at: {http://cybercemetery.unt.edu/archive/sigir/20130930185751/http://www.sigir.mil/about/leadership.html} accessed 3 April 2014.

[15] See, for example, the articles by Davies, Elbe, Howell and Roemer-Mahler in this Special Issue.

[16] Frederick M. Burkle Jr, 'Throwing the baby out with the bathwater: Can the military's role in global health crises be redeemed?', *Prehospital and Disaster Medicine*, 28:3 (2013), p. 197.

[17] The DoD began using the phrase 'smart power' around 2007, and it subsequently became a mainstream part of the Obama administration's foreign policy discourse from 2009. See discussion below.

The conceptual origins of 'smart power' however lie further back, in Joseph S. Nye's work in the 1990s. At the beginning of that decade, and with the Cold War ending, Nye wrote that there had been a shift from traditional measures of power in foreign policy – military strength, population, geography, and resources – and the methods of exploiting these based on payment and coercion (what Nye termed 'hard power'). Instead he argued that 'soft power' was becoming more significant, where the emphasis was on cooption and attraction through culture, values, and institutions.[18] For Nye, however, soft power was not a progressive liberal alternative to hard power, but a different type of power to be used in conjunction with hard power. By the next decade, Nye was even more explicit that soft power alone could not necessarily bring about desired policy outcomes. Similarly, there are limits on what hard power alone can achieve, especially in (more obviously normative) areas such as democracy promotion, human rights, and good governance. Instead both hard and soft power had to be combined in what Nye termed 'smart power'.

> Power is one's ability to affect the behavior of others to get what one wants. There are three basic ways to do this: coercion, payment and attraction. Hard power is the use of coercion and payment. Soft power is the ability to obtain preferred outcomes through attraction. If a state can set the agenda for others or shape their preferences, it can save a lot on carrots and sticks. But rarely can it totally replace either. Thus the need for smart strategies that combine the tools of both hard and soft power.[19]

Underpinning smart power therefore is the argument that there is not a binary choice between hard and soft power; rather there is a spectrum of options combining different elements of hard and soft power to different degrees, with the appropriate balance varying according to context. For our purposes, Iraq and Afghanistan demonstrate the application of smart power in that hard power (military operations) was used alongside soft (here, health interventions) as part of a wider strategy.

The language of smart power entered the US foreign policy discourse in a major way with the advent of the Obama administration. At her Senate confirmation hearings in January 2009, Obama's first Secretary of State, Hillary Rodham Clinton, used the term 'smart power' no less than four times in her prepared statement and 9 times in her testimony:

> We must use what has been called smart power, the full range of tools at our disposal – diplomatic, economic, military, political, legal and cultural – picking the right tool or combination of tools for each situation. With smart power, diplomacy will be the vanguard of our foreign policy.[20]

Similarly, Andrew J. Shapiro, Assistant Secretary of State, Political-Military Affairs noted in September 2009 that:

[18] Joseph S. Nye, 'Soft power', *Foreign Policy*, 80: Twentieth Anniversary (1990), pp. 153–71

[19] Joseph S. Nye, 'Get smart', p. 160. See also Joseph S. Nye, 'The war on soft power', *Foreign Policy* (12 April 2011), available at: {http://www.foreignpolicy.com/articles/2011/04/12/the_war_on_soft_power} accessed 17 October 2013; Richard Armitage and Joseph S. Nye, *CSIS Commission on Smart Power: A Smarter More Secure America* (Washington DC: Center for Strategic and International Studies, 2007); Richard Armitage and Joseph S. Nye, 'Implementing smart power: Setting an agenda for national security reform', Statement before the Senate Foreign Relations Committee (24 April 2008), available at: {http://csis.org/images/stories/smartpower/080424_armitage-nye_sfrc_transcript.pdf} accessed 17 October 2013.

[20] Hilary Rodham Clinton, 'Nomination hearing to be Secretary of State' speech, 13 January 2009, available at: {http://www.state.gov/secretary/rm/2009a/01/115196.htm} accessed 23 October 2013.

> The concept of 'smart power' – the intelligent integration and networking of diplomacy, defense, development, and other tools of so-called 'hard' and 'soft' power – is at the very heart of President Obama and Secretary Clinton's foreign policy vision.[21]

Obama and Clinton's advocacy of 'smart power' was often compared to the Bush administration's perceived (over)concentration on 'hard power' and American unilateralism. In the liberal narrative, the terrorist attacks of 9/11 had led the Bush administration to adopt an aggressive unilateralism based on preponderant military power.[22] According to this critique, the liberal internationalist agenda of promoting human rights and democracy had been coopted by the Bush administration as part of an evangelical militarism promoting American values, with influential Columnist Charles Krauthammer capturing that mood in his 2001 call for a 'new unilateralism'[23] based on the recognition that American power was such that 'it could decide what was right and expect others to follow'.[24] Like all 'new' approaches to foreign policy, then, the official adoption of smart power fused a particular reading of history (not least the perceived failures of previous foreign policy positions) with a series of claims about the benefits to be gained from a change in direction. In particular the proponents of smart power argued that it offered the Obama administration an alternative to his predecessor's approach of aggressive unilateralism and a vision for a more effective future foreign policy stance.

However, the idea that the beginning of the Obama administration marked a watershed moment, when smart power replaced militaristic unilateralism, simplifies the complexity of American foreign and security policy. The sense both of moral purpose and of the value of hard power remained in significant parts of the US policy elite after the end of the Bush administration[25] – as witnessed in the Obama administration's extensive use of drone warfare and targeted assassinations. At the same time, the ideas underpinning smart power long predated the Obama administration. During the Bush administration's second term, Defense Secretary Robert M. Gates[26] in particular had argued that the military could not defend US interests alone, and that more attention and resources should be devoted to other 'soft power' tools to be used in conjunction with hard power.[27] Further, the idea that health assistance could be used in this context had been actively promoted by a number of key Bush

[21] Assistant Secretary of State Andrew J. Shapiro, 'Politico-military affairs: Smart power starts here', Keynote address to ComDef 2009, Washington DC, 9 September 2009, available at: {http://www.state.gov/t/pm/rls/rm/128752.htm} accessed 11 September 2013.

[22] See, for example, Eric Etheridge, 'How "soft power" got "smart"', *New York Times* (14 January 2009), available at: {http://opinionator.blogs.nytimes.com/2009/01/14/how-soft-power-got-smart} accessed 13 March 2013.

[23] Charles Krauthammer, 'The "new unilateralism"', *Houston Chronicle* (8 June 2001), available at: {http://www.chron.com/opinion/editorials/article/Krauthammer-The-Bush-doctrine-new-2055304.php} accessed 11 September 2013; Joseph S. Nye, 'The U.S. can reclaim "smart power"', *Los Angeles Times* (21 January 2009), available at: {http://www.hks.harvard.edu/news-events/news/news-archive/us-reclaim-smart-power} accessed 13 March 2013.

[24] Nye, 'The US can reclaim "smart power"'.

[25] Alexandra Homolar-Riechmann, 'The moral purpose of US power: Neoconservatism in the age of Obama', *Contemporary Politics*, 15:2 (2009), pp. 179–96; Nye, 'The war on soft power'.

[26] Gates transitioned from the Bush administration to remain as Obama's first Secretary of Defense.

[27] Secretary of Defense Robert M. Gates, 'Landon lecture', delivered at Kansas State University, 26 November 2007, available at: {www.defense.gov/speeches/speech.aspx?speechid=1199} accessed 15 March 2013. However, Gates's predecessor, Donald Rumsfeld, claimed not to know the meaning of the term 'soft power'. Joseph S. Nye, 'The decline of America's soft power', *Foreign Affairs*, 83:3 (2004), p. 16.

officials, including Tommy G. Thompson, Secretary of Health and Human Services from 2001–5. In a highly publicised *Boston Globe* editorial, Thompson argued that health interventions could be used in the battle for 'winning hearts and minds' and '[d]efeat[ing] the terrorists', and, later in the article, 'win[ning] the war on terror – at a relatively low cost'.[28] Even in 2005, however, Thompson's comments were building upon already well-established US practices in Afghanistan and Iraq, where the US military was using military medics to provide medical services to the host population and had engaged in health sector (re)construction – what came to be known at the end of the decade as 'medical stability operations'.[29] By the time Obama came to power, therefore, such operations were a core part of the US military's mission. Indeed while the Obama administration's smart power rhetoric was still being seen by many in 2009 as 'new', some commentators were already retrospectively examining the DoD's track record of integrating soft and hard power approaches and questioning whether these ideas were actually working in practice.[30]

Although the concept of GHD had a very different genesis from smart power, its origins lying in the discipline of (Global) Public Health, it echoes the idea that the soft power potential of health can be integrated into broader foreign and security strategies. While GHD has rapidly become commonplace in the Global Health literature, its usage is often vague, sometimes contradictory, and generally lacking coherence and clarity.[31] Broadly speaking however, it has been used to describe two distinct things. The first is the use of diplomacy to negotiate health-related international agreements such as the Framework Convention on Tobacco Control,[32] to solve health-related disputes such as the Indonesia virus-sharing crisis,[33] or to promote health more generally as seen in the Oslo Declaration.[34] For all of these, health is the overall goal and diplomacy is being used to pursue that goal. The second use of the GHD terminology – and the one that interests us here – is the flip side of this: that health, and especially health assistance, can be instrumentalised in pursuit of

[28] T. G. Thompson, 'The cure for tyranny', editorial, *The Boston Globe* (24 October 2005).

[29] Instruction 6000.16 (17 May 2010) on 'Military Health Support for Stability Operations' stated that: 'a. MSOs [Medical Stability Operations] are a core U.S. military mission that the DoD Military Health System (MHS) shall be prepared to conduct throughout all phases of conflict and across the range of military operations, including in combat and noncombat environments. MSOs shall be given priority comparable to combat operations and be explicitly addressed and integrated across all MHS activities including doctrine, organization, training, education, exercises, materiel, leadership, personnel, facilities, and planning b. The MHS shall be prepared to perform any tasks assigned to establish, reconstitute, and maintain health sector capacity and capability for the indigenous population when indigenous, foreign, or U.S. civilian professionals cannot do so.' Department of Defense, Instruction 6000.16 (17 May 2010), pp. 1–2, available at: {http://www.dtic.mil/whs/directives/corres/pdf/600016p.pdf} accessed 16 October 2013.

[30] David Axe, 'Implementing "smart power" in Afghanistan poses challenge for the US', *Voice of America* online (2 November 2009), available at: {http://www.voanews.com/content/a-13-2009-09-16-voa33-68665117/408431.html} accessed 16 October 2013.

[31] See, for example, Harley Feldbaum and Josh Michaud, 'Health diplomacy and the enduring relevance of foreign policy interests', *PLoS Medicine*, 7:4 (2010), e1000226; David Fidler, 'Navigating the global health terrain: Mapping Global Health Diplomacy', *Asian Journal of WTO and International Health Law and Policy*, 6:1 (2011).

[32] Kelley Lee, Luis Carlos Chagas, and Thomas E. Novotny, 'Brazil and the framework convention on tobacco control: Global health Diplomacy as soft power', *PLoS Medicine*, 7:4 (2010), e1000232.

[33] Rachel Irwin, 'Indonesia, H5N1 and Global Health Diplomacy', *Global Health Governance*, 3:2 (2010), available at: {http://eprints.lse.ac.uk/28272/1/Irwin_Indonesia_and_Global_Health_Diplomacy.pdf} accessed 18 February 2013.

[34] Oslo Ministerial Declaration, *Global Health: A Pressing Foreign Policy Issue of our Time*, available at: {http://www.regjeringen.no/en/archive/Stoltenbergs-2nd-Government/Ministry-of-Foreign-Affairs/taler-og-artikler/2007/lancet.html?id=466469} last accessed 25 October 2013.

wider foreign policy objectives. Senator William H. Frist, for example, has written about medicine as both a moral imperative and as a 'currency for peace', noting a range of ways in which GHD could deliver foreign and security policy benefits.[35] Somewhat more sceptically, David Fidler argues that

> linking 'health' and 'diplomacy' captures the attempt to use health instrumentally to achieve other foreign policy and diplomatic goals not grounded in health thinking or interests. Far from being transformative, health merely becomes another mechanism for a country individually, or countries collectively, to exercise 'soft power' or 'smart power' to achieve other strategic or tactical interests in global politics.[36]

For our purposes, the significance of both GHD and smart power is that they make essentially the same claims about the potential of health sector initiatives to deliver foreign and security policy benefits, not least through winning hearts and minds in conflict situations. Yet their separate origins in the very different foreign policy and public health communities – each of which has its own agenda, preconceptions, and norms – leads us to ask whether the dual aims of smart power and GHD are commensurable, or whether there are inevitably tensions between the two which become particularly apparent 'at the sharp end', when health assistance is used in a conflict environment. We therefore move on to examine the nature and success of health assistance as part of reconstruction efforts in Iraq and Afghanistan, before considering it as part of a wider strategy for stabilisation and 'winning the war' and some of the ethical challenges posed by this latter approach.

Health for health's sake? Reconstruction efforts in Iraq and Afghanistan

Iraq and Afghanistan were the two largest reconstruction efforts in US history, costing US taxpayers $60 billion and $89 billion by 2013, respectively.[37] For both countries, an important part of the expenditure devoted to reconstruction was to rebuild and improve the local health systems, although separating out precisely what proportion of this overall spend was invested in health is highly complex. With Iraq, for example, the SIGIR's final report stated that between May 2003 and September 2012, the US government expended $934 million specifically on health projects.[38] This figure, however, excludes the very substantial expenditure on areas such as water and sanitation, the public health benefits of which would have been high on decision-makers' minds. Whatever the precise amount of money spent, in both cases the reconstruction of the health sector proved to be far from straightforward. In Iraq, the already fragile post-war health system was targeted by insurgents, while large numbers of Iraqi medical professionals fled the country, often for their lives. Even health-related NGOs were

[35] Senator William H. Frist, 'Medicine as a currency for peace through Global Health Diplomacy', *Yale Law and Policy Review*, 26:1 (2007), pp. 209–29, available at: {http://www.jstor.org/stable/40239691} accessed 17 October 2013.

[36] Fidler, 'Navigating the global health terrain', p. 5.

[37] SIGIR, 'Learning from Iraq: A Final Report from the Special Investigator General for Iraq Reconstruction' (March 2013), pp. vii, 110–13, 193, and ch. 4 generally, available at: {http://www.sigir.mil/learningfromiraq/index.html} accessed 10 September 2013; SIGAR, 'Quarterly Report to the United States Congress' (30 January 2013), p. iv, available at: {http://www.sigar.mil/pdf/quarterlyreports/2013-01-30qr.pdf} accessed 10 September 2013.

[38] SIGIR, 'Learning from Iraq', p. 110.

targeted, most notably the ICRC's headquarters in Baghdad in 2003.[39] The volatile security situation also led NGOs to periodically leave the country, perhaps the most noteworthy being MSF which, despite its reputation for working in insecure and demanding environments, pulled out of Iraq on two occasions.[40] Whereas Iraq's previously largely effective health care system had been badly weakened through 'a combination of wars, sanctions and reckless neglect by Saddam's regime', as well as a consequence of the invasion,[41] that in Afghanistan was already extremely weak and heavily dependent upon donor aid. Further, the reconstruction, or perhaps more accurately the development, of the Afghan health care system was hindered by widespread corruption and, like Iraq, the volatile security situation.

The US reconstruction effort for Iraq, however, got off to a bad start. Initial planning in late Summer-Fall 2002 envisaged USAID, the expert development agency of the government and part of the State Department, taking the lead in an inter-agency effort. Throughout late 2002 however, interagency cooperation and planning was fragmented rather than coordinated. This appeared to have been resolved when, on 20 January 2003, President Bush signed National Security Presidential Directive 24, which gave the DoD lead responsibility for the reconstruction of Iraq. This decision, however, created a number of new problems because, while NGOs and UN agencies were willing to work with USAID, they were much less so with the DoD, fearing that their independence and impartiality might be compromised (or at least be seen to be so). This reflected widespread tensions around the issue of humanitarian organisations working alongside the military, which some felt endangered the neutrality of the 'humanitarian space' within which such organisations operate.[42] Anticipating the decision to place reconstruction in its hands, the DoD had already begun earlier that year to establish an organisation in the Pentagon for this – the Office of Reconstruction and Humanitarian Assistance (ORHA), under retired Lt General Jay Garner (previously commander of US forces in the 1991 Operation Provide Comfort in Northern Iraq). A few weeks before the invasion, Garner began his work for the reconstruction of Iraq with almost no staff or plans, crossed lines of authority between the Pentagon and CENTCOM, and an uncertain relationship with other US agencies. Moreover many of the external contractors, on whom the reconstruction effort would be heavily dependent, had yet to receive contracts, often because of the complex bureaucracy surrounding their award. The chaotic planning was perhaps best exemplified by Defense Secretary Rumsfeld who, just two days

[39] ICRC, 'Iraq: Two ICRC employees killed in Baghdad bomb attack', *New Release 03/71* (27 October 2003), available at: {http://www.icrc.org/eng/resources/documents/news-realease/2009-and-earlier/5sqexb.htm} accessed 9 April 2014.

[40] Bruno Himmler, 'Health care diplomacy: The Iraq experience and how it can shape the future', *Military Medicine*, 174:12 (2009), pp. xviii–xx; I. T. Katz and A. A. Wright, 'Collateral damage – médecins sans frontières leaves Afghanistan and Iraq', *New England Journal of Medicine*, 351:25 (2004), pp. 2571–3; Paul C. Webster, 'Iraq's health system yet to heal from ravages of war', *The Lancet*, 378:9794 (2004), pp. 863–6, doi: 10.1016/S0140-6736(11)61399-8, accessed 12 Jan 2013. On timings and reasons for MSF's withdrawal, see MSF's 'Timeline' available at: {http://www.doctors-withoutborders.org/aboutus/timeline.cfm} accessed 11 September 2013.

[41] SIGIR, 'Learning from Iraq', p. 110.

[42] Róisín Shannon, 'Playing with principles in an era of securitized aid: Negotiating humanitarian space in post-9/11 Afghanistan', *Progress in Development Studies*, 9:1 (2009), pp. 15–36; Marion Birch, 'Delivering health care in insecure environments: UK foreign policy, military actors and the erosion of humanitarian space', *Medicine, Conflict & Survival*, 26:1 (2010), pp. 80–5.

before the invasion, attempted to replace OHRA's nominees for lead US personnel to work in Iraqi Ministries with his own – often highly experienced and well regarded individuals, but with little or no experience of development and/or the Arab world.[43]

Although the DoD was formally in the lead of reconstruction efforts in Iraq – and had a significant presence in the field as well as the ability to operate in increasingly dangerous situations – it was nevertheless poorly prepared and initially lacked the necessary additional funding to do this. In June 2003 however, Ambassador Bremer gave the US military access to reconstruction funds under the 'Commander's Emergency Response Program' (CERP). This was used mostly for small-scale projects, often poorly integrated into a wider plan, and which were delivered by the military in the context of its counterinsurgency project.[44] Nor did the military at that time possess the doctrinal guidance to undertake health system reconstruction or even to assess local health needs. Typical of the problems faced was, when 28th Combat Support Hospital took over an Iraqi hospital in Baghdad's Green Zone to treat US military, it was inundated with local people seeking treatment, but had no policy on whether or how to deal with them.[45] In the absence of adequate policy guidance from Washington, the military fell back on the 'MEDCAP' (Military Civil Action Program) model of *ad hoc* local projects and treating immediate health needs – a model that had been used in previous conflicts including Vietnam.[46] Although this had some successes, it failed to address sustainability both of the heath care system and of patient care.[47] Nor did it encourage cooperation with local partners and NGOs. By the end of the decade, these problems with military led programmes had contributed to CERP's replacement with a new programme of Cooperative Medical Engagements and an approach which included a much greater emphasis on relations with NGOs and local partners.[48]

Overall, the DoD's reconstruction effort in Iraq, exemplified by its plan 'A Vision to Empower Iraqis',[49] appears to have been fundamentally flawed. Notably, it failed to consult with Iraqi officials, presenting them with plans that they were 'just going to have to eat'.[50] Although this was perhaps understandable in the health sector where the Ministry of Health was 'under the thumb' of Shia militia leader Muqtada

[43] SIGIR, 'Hard lessons: The Iraq reconstruction experience' (January 2009), pp. 18–45, available at: {http://www.sigir.mil/publications/hardLessons.html} accessed 13 March 2013; Michael J. Tarpey, 'The role of the US in health system reconstruction and development during counterinsurgency' (unpublished Masters thesis, Fort Leavenworth KS: Army Command and General Staff College, 2012), pp. 43–4, available at: {http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA562985} accessed 19 Jan 2013.

[44] SIGIR, 'Hard Lessons', pp. 81–2, 97–8.

[45] Atul Gawande, 'Casualties of war – military care for the wounded from Iraq and Afghanistan', *New England Journal of Medicine*, 351:24 (2009), pp. 24–72.

[46] See, for example, Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War* (Lubbock TX: Texas University Press, 2004).

[47] Christopher Bulstrode, 'Medcaps – do they work?', *Journal of the Royal Army Medical Corps*, 155:3 (2010), pp. 182–4. See also Colin McInnes and Simon Rushton, 'Smart power? Health interventions for strategic effect in Iraq and Afghanistan', *International Political Sociology*, 6:3 (2012), pp. 328–31.

[48] Tarpey, 'The role of the US Army', pp. 17, 56–7; E. C. Michaud and G. L. Maxwell, 'Medical capacity building efforts in Northern Iraq 2009–2010', *Military Medicine*, 177:6, (2012), pp. 676–80.

[49] Coalition Provisional Authority (CPA), *A Vision to Empower Iraqis*, 4 July 2003 version, available at: {http://www.dod.mil/pubs/foi/operation_and_plans/PersianGulfWar/A_Vision_to_Empower_Iraqis.pdf} accessed 12 September 2013. The 'Vision' appears to have been drafted by the head of the CPA, Paul Bremer.

[50] Quoted in SIGIR, 'Hard Lessons', p. 98.

al-Sadr, who was both using the Ministry as his personal 'piggy bank' and discriminating along sectarian lines,[51] too often it led to plans which failed to appreciate local circumstances or which lacked stakeholder engagement. Moreover, projects, including those with external contractors, were set overly ambitious goals with unrealistic completion dates and poor oversight. The 2004, $243 million project to equip 142 primary health care centres by December 2005 for example was found in 2006 to have only six centres ready for use despite $186 million being spent, while the $50 million Basrah children's hospital was completed behind schedule and with cost overruns of $115 million.[52] Infrastructure projects also proved to be targets for insurgents, especially in 2004–5, affecting their delivery; but the emphasis on building tangible assets, which did not always address health priorities but which could be identified as achievements, rather than the less tangible investments in people and institutions, also appeared misguided.[53]

In contrast, US involvement in the reconstruction of Afghanistan was led by USAID. From the start it was apparent that the health system in Afghanistan was extremely weak and would continue to be dependent on donor assistance for some time.[54] The result was the involvement of a multitude of agencies from the US government, the International Security Assistance Force (ISAF) and NGOs, a major effort, which, as in Iraq, for some time lacked effective coordination.[55] This lack of coordination extended to the US military, one USAID official commenting 'there are so many different military entities in Afghanistan (just with U.S. government components alone, not counting [ISAF], which add layers of complexity) that it is often difficult to reach the appropriate people at the appropriate levels'.[56] USAID attempted to work with the Afghan Ministry of Public Health (MOPH) to develop national ownership and community engagement in projects such as increasing access to primary health care. At the same time, it demonstrated an engagement with NGOs through contracting work to them. Projects were not just 'bricks and mortar' infrastructure, but included training and development, while USAID's experience in development projects led to its tighter oversight, using a variety of techniques from household surveys to data quality assessments.[57] NGOs were critical, however, of how the political pressure to demonstrate results led to a 'quick fix' approach, an approach which also appeared to be geared more to the military's hearts and minds strategy than the

[51] Interview with S. Ward Casscells, Assistant Secretary of Defense, Health Affairs 2007–9, published in Downie (ed.), *Global Health as a Bridge to Security*, 47.

[52] SIGIR, 'Construction of Primary Healthcare Centers Reported Essentially Complete, But Operational Issues Remain, Audit Report 09-15' (29 April 2009), available at: {http://www.sigir.mil/files/audits/09-015.pdf#view=fit} accessed 12 September 2013; SIGIR, 'Report of the US Agency for International Development's Management of the Basrah Children's Hospital Project, Audit Report 06-26' (28 July 2006), available at: {http://www.sigir.mil/files/audits/06-026.pdf#view=fit} accessed 12 September 2013. See also SIGIR, 'Learning from Iraq', pp. 110, 112.

[53] For a detailed assessment of the reconstruction effort and its flaws, see SIGIR, 'Hard Lessons'.

[54] See SIGAR, 'Quarterly Report' (January 2013).

[55] See, for example, Donald F. Thompson, *The Role of Medical Diplomacy in Stabilizing Afghanistan* (Washington DC: Center for Technology and National Security Policy, National Defense University, 2008), available at: {http://www.ndu.edu/CTNSP/docUploaded/DH63.pdf} accessed 11 February 2013.

[56] Quoted in Matt Pueschal, 'DoD making strides in preparing for Afghanistan health missions', *International Health* (undated), available at: {http://intlhealth.dhhq.health.mil/newsID142.mil.aspx} accessed 18 June 2013. This is an official US website maintained by Force Health Protection and Readiness Command.

[57] SIGAR, 'Quarterly Report' (January 2013), pp. 26, 149–50; Tarpey, 'The role of the US Army', p. 85.

underlying causes of poverty and ill-health. In particular an Oxfam-led report, reflecting the views of several major NGOs with experience of working in Afghanistan and intentionally published just prior to the major January 2010 International Conference on Afghanistan held in London, criticised the 'harmful effects of this increasingly militarized aid strategy'.[58]

Despite USAID's lead, the US military played a large part in delivering and developing health care in Afghanistan – not least because, as in Iraq, they were able to operate in volatile regions and had a sizeable presence on the ground (including significant military medical assets). Special forces in particular received favourable coverage in providing medical assistance, largely because of their training, which emphasised rapid assimilation into communities and the development of a local awareness. Nevertheless, as in Iraq, because of a lack of guidance over their role in health provision, the US military quickly defaulted to MEDCAPS, with little attention to sustainability, coherence, or developing a good working relationship with the MOPH. Moreover, MEDCAPS continued to be seen in terms of their effectiveness for counterinsurgency rather than solely for health benefits.[59] The provision of health assistance, both military and civilian, was also limited by what the SIGAR referred to as the 'pervasive corruption' in Afghanistan and the 'reluctance' of the Afghan authorities to take serious action to tackle it.[60] Perhaps the most notorious example of this was at the Dawood (Daoud Khan) National Military Hospital, the main hospital for treating Afghan wounded military, run by Afghan staff but with US funding and mentoring. In September 2011, Maria Abi-Habib, writing in the *Wall Street Journal*, exposed widespread corruption and neglect of patients by Afghan staff in this blue riband project. This had been reported by US staff to the Afghan Ministry of Defence in as far back as 2006, but no action had been taken either by the Afghan or US authorities (the latter, it was later claimed, due to political sensitivities with the Afghan authorities). Corruption included demanding bribes for food and basic care, allowing infections to go untreated through neglect (including maggots feeding off open wounds), and the use of counterfeit drugs (the original US supplies presumably having been diverted to the black market). Abi-Habib wrote of how after the surge in US forces in 2010, 'several patients died of simple infections because their bandages would go unchanged for weeks, while at least four died from malnourishment'.[61] In July 2012, Congress identified both 'Auschwitz-like' condi-

[58] A. Jackson, 'Quick impact, quick collapse: The dangers of militarized aid in Afghanistan' (2010), available at: {http://www.scribd.com/doc/25889897/Oxfam-QuickImpact-Quick-Collapse} accessed 27 January 2013.

[59] D. S. Kauvar and T. A. Drury, 'Military medical assets as counterinsurgency force multipliers: A call to action', *Small Wars Journal*, 28:4 (2012), available at: {http://smallwarsjournal.com/jrnl/art/military-medical-assets-as-counterinsurgency-force-multipliers-a-call-to-action} accessed 11 February 2013; Tarpey, 'The role of the US Army'; Matt Pueschel, 'US special forces medics in Afghanistan look to partner with NGOs on rural health', *International Health* (undated), available at: {http://intlhealth.fhpr.osd.mil/newsID133.mil.aspx} accessed 18 June 2013.

[60] SIGAR, John F. Sopko, 'Testimony Before the Subcommittee on National Security, Homeland Defense, and Foreign Operations', Committee on Oversight and Government Reform, US House of Representatives, 13 February 2013, available at: {http://www.sigar.mil/pdf/testimony/2013-feb-12-ig-testify.pdf} accessed 13 March 2013.

[61] Maria Abi-Habib, 'At Afghan military hospital, graft and deadly neglect', *Wall Street Journal* (3 September 2011), available at: {http://online.wsj.com/news/articles/SB10001424053111904480904576496703389391710} accessed 17 October 2013.

tions at Dawood and a DoD cover-up.[62] In his opening statement to Congress on Dawood, Schuyler K. Geller, Command Surgeon for the NATO Training Mission, commented on persisting levels of corruption:

> Today, not just in 2010 or 2011, individuals wearing ANA [Afghan National Army] uniforms, being paid salaries that US taxpayers support and who perpetrated or allowed to be perpetrated unspeakable abuses upon Afghan soldiers, civilians and family members, walked [*sic*] the hall of the Daoud Khan Hospital unrepentant, unscathed, enriched and still unprosecuted. I am informed that they are running very active private fee-for-service practices with our equipment, fuel, supplies and drugs in the National Military Hospital.[63]

Health interventions: An uncertain success story

Scandals such as Dawood aside, it is difficult to judge the overall success of reconstruction operations in Iraq and Afghanistan *in health terms*, both because of the lack of the sort of independent quantitative data normally used to assess health interventions, and because of the extremely challenging security situation in both countries, which makes comparisons with aid projects elsewhere problematic. It is perhaps even more difficult to assess the impact of the widely used MEDCAPS because of the lack of independent evidence and the short-term nature of the interventions.[64] Nevertheless, two distinct narratives on Iraq and Afghanistan can be identified. In Iraq, although reconstruction efforts clearly benefitted the weakened health system, the emerging narrative seems to be that these were suboptimal. Prime Minister Nuri al-Maliki, when interviewed by the US Special Investigator General for Iraq (SIGIR) on the overall reconstruction programme, stated that the investment could have brought much greater improvement but did not, partly because of 'poor American knowledge about what Iraq needed' and an overreliance on ill-informed or dishonest subcontractors.[65] Similarly, US Ambassador James Jeffrey concluded 'the U.S. reconstruction money used to build up Iraq was not effective', though he identified the competing goals of development and counterinsurgency as a key reason.[66] Although US commander in Iraq, General Petraeus, was somewhat more positive, he too implied the overall programme was suboptimal and identified the lack of effective

[62] House Committee on Oversight and Government Reform, 'Dawood national military hospital Afghanistan: What happened and what went wrong?', Serial no. 112–164 (24 July 2012), available at: {http://oversight.house.gov/wp-content/uploads/2013/02/2012-07-24-Ser.-No.-112-164-SC-Natl-Sec.-Dawood.pdf} accessed 14 October 2013.

[63] Opening Statement of Schuyler K. Geller, 'Hearing to examine the facts and circumstances surrounding alleged corruption and mismanagement at the US taxpayer-funded Dawood National Military Hospital located in Afghanistan', US House of Representatives Committee on Oversight and Government Reform, 24 July 2012, p. 5, available at: {http://oversight.house.gov/wp-content/uploads/2012/07/Geller-Statement.pdf} accessed 13 October 2013. See also Gerry J. Gilmore, 'Caldwell supports review of troubled Afghan hospital', *American Forces Press Service* (13 September 2012), available at: {http://www.defense.gov/News/NewsArticle.aspx?ID=117851} accessed 17 October 2013; and Rebecca Elliott and Michael Hastings, 'Horror hospital', available at: {http://www.buzzfeed.com/rebeccaelliott/horror-hospital-the-most-shocking-photos-and-test} accessed 13 March 2013.

[64] Tarpey, 'The role of the US Army', p. 7; S. Gordon, 'Health, stabilization and securitization: Towards understanding the drivers of the military role in health interventions', *Medicine, Conflict and Survival*, 27:1 (2011), pp. 54, 60; J. P. Chrétien, 'US Military global health engagement since 9/11: Seeking stability through health', *Global Health Governance*, 4:2 (2011), available at: {http://www.ghgj.org/JeanPaulChretien.pdf} accessed 12 February 2013.

[65] Interview with Prime Minister Nuri al-Maliki, in SIGIR, 'Learning from Iraq', p. 11.

[66] Interview with Ambassador James Jeffrey, in SIGIR, 'Learning from Iraq', p. 29.

oversight as a key reason for this.[67] This general narrative of under-performance is reflected in the health sector where, despite some significant successes (including vaccination programmes and capacity building), the overall impression is of outcomes being compromised due to programmes being poorly designed, lacking local input and ownership, not always fit for purpose and poorly executed with weak oversight.[68] Typical of these shortcomings was a SIGIR inspection of the HaiMusalla Primary Health Care Centre, which revealed that the US-funded equipment was not being used because of a failure to train the Iraqi staff.[69] Indeed by 2006, when the initial $18.4 billion allocated for rebuilding Iraq's public infrastructure was coming to an end, there was an 86 per cent shortfall in completions for the major health reconstruction project of 142 primary care centres. Although most areas of Iraqi reconstruction were behind schedule at that time (only 300 of 425 electricity projects and 49 of 136 water sanitation projects had been completed for example), health reconstruction appeared especially poor.[70] This pattern continued after 2006, such that the SIGIR, Stuart Bowen, concluded in 2013 that of all the reconstruction efforts in Iraq, those in the health sector fell the furthest short of expectations in terms of results, and performed the worst in term of cost overruns, delays, and poor planning.[71] Similar sentiments were reflected in the public health community. Paul Webster writing in *The Lancet* in 2009 stated that the country was still 'struggling to cope with the needs of the population',[72] while a 2013 review of health services in Iraq concluded that 'Iraq's health services are struggling to regain lost momentum'.[73]

The dominant narrative for Afghanistan however focuses on significant improvements to an extremely weak system. A number of key health indicators – including child mortality, adult life expectancy, and maternal health – have all shown improvements, while health campaigns such as polio vaccination and deworming have been hailed as major successes. By 2010, the USAID-funded Afghanistan Mortality Survey was able to show marked improvements in key health indicators, including a 15–20 year increase in life expectancy, which appeared to be the result of reconstruction efforts.[74] Ellen Embrey, Assistant Secretary of Defense for Health Affairs commented on how vaccination programmes and prenatal care had reduced the 'incredibly high' mortality rate for pregnant women and babies, but also admitted that 'I wouldn't say our effort was a total success because there were cultural issues we didn't think enough about.'[75] The SIGAR also reported how, through US assistance, '60% of

[67] Interview with General Petraeus, in SIGIR, 'Learning from Iraq', p. 24.

[68] The most detailed and generally best informed sources on the reconstruction programme in Iraq are the series of SIGIR audit reports, initially available online at: {http://www.sigir.mil/directorates/audits/auditReports.html} accessed 17 October 2013, but now archived at {cybercemetry.unt.edu} from which these conclusions are drawn.

[69] SIGIR, 'Learning from Iraq', p. 43.

[70] Ellen Knickmeyer, 'U.S. plan to build Iraqi clinics falters', *Washington Post* (3 April 2006).

[71] See Robert Siegel's interview with Stuart Bowen for National Public Radio, available at: {http://www.npr.org/templates/story/story.php?storyId=129535004} accessed 13 October 2013.

[72] Paul Webster, 'Reconstruction efforts in Iraq failing health care', *The Lancet*, 373:9664 (2009), pp. 617–20.

[73] Thamer Kadum Al Hifi, Riyadh Lafta, and Gilbert Burnham, 'Review: Health services in Iraq', *The Lancet*, 381:9870 (2013), pp. 939–48. See also David A Tarantino, Melinda J. Morgan, Akhila Kosaraju, Shakir Jawad, and S. Ward Casscells, 'Health system reconstruction in Iraq – the way ahead', *World Medical and Health Policy*, 1:1 (2009), pp. 125–42.

[74] {http://www.measuredhs.com/pubs/pdf/FR248/FR248.pdf} accessed 17 October 2013. See also fn. 55 above.

[75] Interview with Ellen Embrey, Assistant Secretary of Defense for Health Affairs 2009–10, in Downie (ed.), *Global Health*, p. 26.

the population can now reach a healthcare facility within one hour by foot compared to 9% in 2002. Healthcare in urban areas is accessible to 97% of the populace, but that number drops to 63% in rural areas and 46% among nomads.'[76] Although critical health weaknesses remain (for example in child malnutrition) and the country's health system is still some way from self-sufficiency, the narrative has focused on successes in a somewhat different manner from Iraq.[77]

It is of course necessary to handle such narratives with care. While noting overall improvements in Afghanistan's health system, Michael et al., for example, have argued that the very high official figures for health service coverage tend to mask the actual situation on the ground where those services are often either nonexistent in reality, of poor quality, or under-utilised due to a lack of confidence in them amongst the local population. Importantly, they also suggest a political motive for talking-up the success of health sector reconstruction efforts, arguing that 'The BPHS [Basic Package of Health Services] has become a visible symbol of the state moving towards regeneration, with an inflated ''optimal presentation'' necessary in preserving support in the donor community, as much as meeting domestic expectations.'[78] Whatever the real level of health benefit to the recipient population, however, both Iraq and Afghanistan demonstrate a growing sense that health, and health workers, are no longer perceived as neutral or superordinate, but as part of the struggle. In both countries, health workers and aid agencies providing heath assistance were attacked by insurgents, for whom they presented 'soft targets'. Distrust may also have been engendered amongst the wider (noninsurgent) community, undercutting the aim of the intervening forces to win hearts and minds. As an Oxfam report noted, '[r]esearch in Afghanistan, Pakistan and ''extremism-prone'' regions of Kenya indicates that perceptions of Western aid donors in areas of strategic aid remain overwhelmingly negative, not least because beneficiaries recognize the strategic motivations of highly visible, unsustainable aid projects.'[79]

Health interventions for strategic effect

In both Iraq and Afghanistan, health interventions were seen not simply in terms of improving public health, but also as delivering strategic benefits. This was especially so in the foreign and security policy communities, and not least in the context of counterinsurgency (COIN). Health was, in other words, an integral part of a wider strategy based on ideas of smart power. Indeed the degree of incorporation of what would traditionally be seen as humanitarian projects into what many would consider

[76] SIGAR, 'Quarterly Report' (January 2013), pp. 148–9.

[77] See, for example, SIGAR, 'Quarterly Report' (January 2013); J. P. Chrétien, S. L. Yingst, and D. Thompson, 'Building public health capacity in Afghanistan to implement the International Health Regulations: A role for security forces', *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science*, 8:3 (2010), pp. 277–85, available at: {http://online.liebertpub.com/doi/abs/10.1089/bsp.2009.0058} accessed 17 October 2013; B. Loevinsohn and G. D. Sayed, 'Lessons from the health sector in Afghanistan: How progress can be made in challenging circumstances', *Journal of the American Medical Association*, 300:6 (2008), pp. 724–6.

[78] Markus Michael, Enrico Pavignani, and Peter S. Hill, 'Too good to be true? An assessment of health system progress in Afghanistan, 2002–2012', *Medicine, Conflict & Survival*, 29:4 (2013), pp. 322–45.

[79] Oxfam, 'Whose aid is it anyway? Politicizing aid in conflicts and crises, *145 Oxfam Briefing Paper*, p. 23, available at: {http://www.oxfam.org/sites/www.oxfam.org/files/bp145-whose-aid-anyway-100211-en_0.pdf} accessed 4 October 2013.

a military campaign is one of the noteworthy aspects of operations in Iraq and Afghanistan. This more expansive view of military strategy – that it involves more than the preparation and execution of combat operations – is reflected in the work of the highly influential David Kilcullen, an Australian infantryman seconded to the US State Department as Chief Strategist for counterterrorism. As Kilcullen argues, '[c]ounterinsurgency is armed social work; an attempt to redress basic social and political problems while being shot at …'.[80] Here we examine three specific claims made by US officials concerning the strategic benefits of health interventions in both Iraq and Afghanistan: that they could promote stability and combat extremism; that they could improve relations at both local and national levels with the US and allied forces; and that they could build the legitimacy of the host government.

The first of these claims centres around the idea that by improving health, political stability can be improved and the likelihood of conflict reduced.[81] Ellen Embrey, for example, commented that '[u]ndoubtedly, health leads to stability, and stability leads to security. It's a very clear, repeated, proven path.'[82] From the Department of State, Kerri-Ann Jones argued '[b]etter global health promotes stability and growth, which can deter the spread of extremism.'[83] Rear Admiral Thomas R. Cullison suggested that health assistance 'will deny a base to those who would like to see countries stay unstable',[84] while Admiral William J. Fallon argued 'nations with healthy populations are more likely to be productive, prosperous, and peaceful … Nations with high numbers of unhealthy citizens are more likely to be poor, badly governed, weak and prone to instability or even conflict.'[85] The idea that health interventions could promote stability was not new to Iraq and Afghanistan – MEDCAPS had traditionally been used as short term measures to stabilise situations, not least after natural disasters[86] – but Iraq and Afghanistan saw this idea widened into a broader political strategy and eventually incorporated into doctrine as a core mission for the US military. Specifically, the failure of post-conflict planning in Iraq and the stalling of reconstruction efforts in Afghanistan led in 2004–5 to a new narrative of 'stabilisation'.[87] From 2005, a succession of DoD instructions and manuals saw stabilisation emerge as a key mission for the US military.[88] As Michaud and Maxwell comment, it was 'hard to imagine stability operations not including a public health

[80] David Kilcullen, 'Twenty-eight articles: Fundamentals of company-level counterinsurgency', p. 8, available at: {http://smallwarsjournal.com/documents/28articles.pdf} accessed 17 October 2013. This is the original edition circulated as an unpublished paper dated 29 March 2006. The paper was subsequently published in the May 2006 edition of *Military Review* ('Twenty-eight articles: Fundamentals of company-level counterinsurgency', *Military Review*, 83:3 (2006), pp. 103–8), and is now part of formal US doctrine, being published as Annex A to FM 3-24, the US Army's counterinsurgency doctrine. It is also used for training purposes by a number of other armies, including a number of those deployed in Afghanistan and Iraq.

[81] See, for example, Tarpey, 'The role of the US Army', pp. 21–2; Gordon, 'Health, stabilization and securitization'.

[82] Ellen Embrey interview in Downie (ed.), *Global Health*, p. 25.

[83] Kerri-Ann Jones, 'New complexities and approaches to Global Health Diplomacy: View from the U.S. Department of State', *PLoS Med*, 7:5 (2010), e1000276.

[84] Downie (ed.), *Global Health*, p. 11.

[85] Admiral William J. Fallon, 'Introduction', in Downie (ed.), *Global Health*, p. v.

[86] B. T. Ackermann, 'Assisting host nations in developing health systems' (unpublished Masters thesis, Army War College Carlisle Barracks, PA, 2010), available at: {http://www.dtic.mil/dtic/tr/fulltext/u2/a522017.pdf} accessed 8 Jan 2013.

[87] Gordon, 'Health, stabilization and securitization', p. 53.

[88] DOD Instruction 3000.05, 'Stability Operations' (16 September 2009), available at: {http://www.dtic.mil/whs/directives/corres/pdf/300005p.pdf} accessed 25 October 2013.

element',[89] and in 2010, 'medical stability operations' were formally identified by the DoD, whereby military assets would be used to maintain health system capacity as part of stabilisation operations.[90] At the same time, ideas on how to use health to promote stability began to be developed.[91] But the success of this is less clear. A major Wilton Park conference concluded that the evidence of health interventions leading to increased stability and security was weak, while Gordon suggests the evidence is 'slim'.[92] In contrast however, S. Ward Casscells, Assistant Secretary of Defense for Health Affairs from 2007–9, argues that '[w]e can't prove that health has been an effective bridge for peace, and there are critics who say that in Iraq today, the Iranians have more influence than the United States. But those of us involved in health care feel it has a positive impact.'[93]

The second claim is that the provision of services directly to the population can play a role in improving relations with US and allied forces at the local and national level – what historically has been termed 'winning hearts and minds'. As Ackerman comments: 'When looking to win the ''hearts and minds'' of the locals, as during the conduct of counterinsurgency operations, the provision of medical services is intended to influence the population to look favourably on US and host nation operations.'[94] The superordinate quality of health means that this is, *prima facie*, an especially effective service to provide in this context. General Peter Pace, Chairman of the US Joint Chiefs of Staff, commented:

> It was in Somalia … that the possibility of strategic medical impact first crystallized in my mind …When you drive through [Mogadishu] and you see kids picking through a trash dump, looking for food, you know you're in a situation where the health needs of the population are enormous. It was during this second tour [of Somalia] that I began to think more about what we might use, other than force, to gain the influence we wanted to have … [T]o the extent that you do medical activities for a population, you increase the probability of making friends, and you decrease the probability of having to get into a gunfight with them … Health issues are a means of building up credits in the soft power account.[95]

In Iraq and Afghanistan, attempts to use health interventions to cultivate trust included not only strategic programmes such as CERP, but more frequently local initiatives including MEDCAPS and tailgate medicine. The latter appears to have been common amongst special forces in Afghanistan, where it was used to engage the population at grassroots level in highly volatile areas, while in Iraq the military

[89] E. C. Michaud and G. L. Maxwell, 'Medical capacity building efforts in northern Iraq', *Military Medicine*, 177:6 (June 2012), pp. 676–80.

[90] Chrétien, 'US military global health engagement since 9/11', p. 2; D0D, Instruction 6000.16.

[91] See, for example, G. H. Avery, and B. J. Boetig, 'Medical and public health civic action programs: Using health engagement as a tool of foreign policy', *World Medical & Health Policy*, 2:1 (2010), pp. 54–76; J. B. Baker, 'The doctrinal basis for medical stability operations', *Military Medicine*, 175:1 (2010), pp. 14–20, available at: {http://www.dtic.mil/dtic/tr/fulltext/u2/a522474.pdf} accessed 5 February 2013.

[92] Report on Wilton Park Conference WP1022, 'Winning hearts and minds in Afghanistan: Assessing the effectiveness of development and operations', Wilton Park Conference, 11–14 March 2010, available at: {http://www.eisf.eu/resources/library/1004WPCReport.pdf} accessed 13 October 2013; Gordon, 'Health, stabilization and securitization', p. 601.

[93] Cascells in Downie (ed.), *Global Health*, p. 49.

[94] Ackerman, 'Assisting Host Nations', p. 18.

[95] Interview with General Peter Pace, Chairman of US Joint Chiefs of Staff 2005–7, in Downie (ed.), *Global Health*, pp. 30-1. See also K. Bond, 'Commentary: health security or health diplomacy? Moving beyond semantic analysis to strengthen health systems and global cooperation', *Health Policy and Planning*, 23:6 (2008), p. 377; Gawande, 'Casualties of war', p. 29.

were given 'walking around money' to gain public support and improve local perception of US forces, the use of which included the building of health clinics.[96] Both local initiatives and strategic programmes proved controversial however, on grounds of principle and effectiveness. The principled objection concerned not only whether health assistance should be based on need rather than political opportunism, but the consequent loss of humanitarian space when this occurred. The counter, from the likes of David Kilcullen, is that 'there is no such thing as impartial humanitarian assistance or civil affairs in counterinsurgency. Every time you help someone, you hurt someone else – not least, the insurgents.'[97] Controversies over effectiveness ranged from criticisms of the manner in which health interventions were used – including both strategic investments and local *ad hoc* initiatives – to more basic questions of whether the dual purpose of such interventions inevitably compromised their effectiveness.[98] In particular, local initiatives have been the focus of a lively debate amongst military medics in Iraq and Afghanistan. The special forces internet forum *soc.net* for example ran a thread on MEDCAPS,[99] with contributions from corpsmen with service experience in both of these conflicts as well as conflicts elsewhere. Views – often expressed in somewhat uncompromising language – ranged from '[MEDCAPS] are a waste of resources for everyone except the public relations team' to '[MEDCAPS] was the only available medical treatment … it made us some points and actually helped save a few lives'. What is however clear is that the assertion made by Pace and others that health interventions can be used to build trust remains at best unproven and clearly raises concerns over its impact on how humanitarian operations may be perceived.

The third claim is that health interventions can build confidence in and bolster the popular legitimacy of the national and local government. For example, JP [Joint Publication] 4-02 on 'Health Service Support', which provides US 'doctrine for the planning, preparation, and execution of health service support across the range of military operations'[100] explicitly notes that

> The focus of HSS [Health Service Support]initiatives during medical civil-military operations is to improve HN [Host Nation] capacity to provide public health and medical services to its population, *thereby enhancing legitimacy of the HN*, enhancing force protection, and accomplishing the JFC's [Joint Force Commander's] political-military objectives. HSS initiatives during medical civil-military operations should emphasize long-term developmental programs that are sustainable by the HN.[101]

[96] SIGIR, 'Hard Lessons', pp. 238–9; Tarpey, 'The role of the US Army', p. 95.
[97] David Kilcullen, 'Twenty-eight articles', p. 8.
[98] See, for example, E. L. Bryan Jr, 'Medical engagement: Beyond the MEDCAP' (unpublished Masters thesis, Army Command and General Staff College, Fort Leavenworth, KS School of Advances Military Studies, 2008), available at: {http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA485508} accessed 19 January 2013; M. A. Sokolowski, 'Employing US navy hospital ships in support of soft power projection' (unpublished Masters thesis, Army War College Carlisle Barracks, PA, 2011), available at: {http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA560217}; Kauvar and Drury, 'Military medical assets'; Tarpey, 'The role of the US Army', p. 36.
[99] {http://www.socnet.com/showthread.php?t=103364} accessed 13 October 2013.
[100] Joint Chiefs of Staff, JP 4-02, 'Health Service Support' (26 July 2012), available at: {http://www.dtic.mil/doctrine/new_pubs/jp4_02.pdf} accessed 23 October 2013.
[101] Joint Chiefs of Staff, JP 4-02, pp. v–4, emphasis added. See also Tarpey, 'The role of the US Army', p. 19; Gordon, 'Health, stabilization and securitization', p. 51; Michaud and Maxwell, 'Medical capacity building efforts'.

Whether or not planned projects will 'enhance the legitimacy of the HN' is also one of the key planning considerations set out for force commanders.[102] The assumption behind this is that providing health services will bolster the social contract, while the loss of health professionals and services in Iraq under Saddam and in the aftermath of the invasion was evidence of a dysfunctional state.[103] However, the operationalisation of this proved less effective, particularly in the early years. Poor planning, a lack of local involvement in decision-making and delivery, widespread corruption (especially in Afghanistan), and the (ab)use of the health system along sectarian lines in Iraq, all undermined the potential for health investments to bolster confidence and legitimacy in the national government.[104] What was also clear was a tension between whether credit should be assigned to local and national authorities to build legitimacy and confidence in them, or to intervening forces to build local support for their operations as part of a hearts and minds strategy. Although it might be possible to combine the two, this did not appear to be the case in either Afghanistan or Iraq – especially at the local level where MEDCAPS and tailgate medicine were extensively deployed on an *ad hoc* basis, sometimes demonstrating the continued inadequacies of local and national government.

The ethical challenges of health interventions for strategic effect

The attempt to leverage health assistance for strategic ends also creates tensions with traditional humanitarian principles and ideas, which have historically been seen as fundamental to the operation of humanitarian and health agencies working in conflict situations. The International Committee of the Red Cross (ICRC), for example, sees its status as an 'impartial, neutral and independent organization' with an 'exclusively humanitarian mission' as being not only an ethical imperative but also fundamental to its ability to deliver humanitarian assistance.[105] The Sphere Humanitarian Charter also lays out principles of humanitarian action which stress the right to receive humanitarian assistance

> according to the principle of impartiality, which requires that it be provided solely on the basis of need and in proportion to need. This reflects the wider principle of non-discrimination: that no one should be discriminated against on any grounds of status, including age, gender, race, colour, ethnicity, sexual orientation, language, religion, disability, health status, political or other opinion, national or social origin.[106]

These echo some fundamental principles of medical ethics – not least of nondiscriminatory service provision and prioritising the needs of the individual patient – which can place the military medics responsible for delivering assistance in situations like

[102] Joint Chiefs of Staff, JP 4-02, pp. L–18.
[103] See, for example, Avery and Boetig, 'Medical and public health civic action programs'; Himmler, 'Health care diplomacy'.
[104] See, for example, SIGIR, 'Hard Lessons', pp. 97–101, 190–1; SIGAR, 'Testimony'; Jackson, 'Quick impact, quick collapse', available at: {http://www.oxfam.org/sites/www.oxfam.org/files/quick-impact-quick-collapse-jan-2010.pdf} accessed 13 October 2013.
[105] Nicholas De Torrente, 'Humanitarian action under attack: Reflections on the Iraq War', *Harvard Human Rights Journal*, 17 (2004), pp. 1–29.
[106] Sphere Project, 'Humanitarian Charter and Minimum Standards in Humanitarian Response' (2011), p. 22, available at: {http://www.ifrc.org/PageFiles/95530/The-Sphere-Project-Handbook-20111.pdf} accesssed 4 April 2014.

Iraq and Afghanistan in a particularly difficult position. As well as the expectation that physicians will provide emergency medical treatment to those in need, there is a more general, ethical expectation (reflected in humanitarian principles outlined above) that they will not discriminate amongst potential patients. The American Medical Association's ethical guidelines, for example, state that

> physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination.[107]

The logic of utilising healthcare provision for strategic effect, however, would suggest that in some cases, it may in fact be desirable to treat only certain parts of a population, or at least to prioritise the treatment of some over others for reasons other than medical urgency (triage). An extreme example of this occurred when Muqtada al-Sadr's Mehdi Army, ostensibly providing protection to hospitals, harassed and attacked Sunnis and non-Sadrist Shiites seeking hospital care.[108] But more generally in counterinsurgency efforts, it may be deemed a better use of resources to focus provision on those elements of the population whose 'hearts and minds' are 'winnable' or where aid may be traded for support. Oxfam drew attention to examples of this occurring in Afghanistan, where '[l]eaflets distributed by US-led forces in southern Afghanistan in 2004, for example, told communities that ''[i]n order to continue the humanitarian aid, pass on any information related to the Taliban, Al Qaeda and Gulbaddin''.[109] While NATO forces repudiated such trading of assistance for information after 2004, the fact that it happened does demonstrate the potential tensions between prioritising the needs of the patient/recipient of humanitarian aid in a non-discriminatory way and broader strategic objectives. It is important nevertheless to be clear here that we are not accusing US military medics of having systematically operated in a discriminatory fashion in either conflict. Neither does military doctrine support such discrimination, and even if it did it would not be surprising to find individual military medics ignoring doctrine and behaving in a nondiscriminatory fashion in practice. Yet, the priorities of strategy and health at the very least have the potential to come into conflict in deciding who receives treatment and when.[110]

An analogous problem can be seen in decisions over where health facilities are (re)constructed, including which communities they serve. Again it is possible that it might be seen as strategically advantageous to focus efforts on some communities rather than others, challenging notions of health equity and 'health for all'.[111] Again, Oxfam pointed to evidence that this has indeed occurred:

[107] American Medical Association 2012, Opinion 9.12, 'Patient-physician relationship: Respect for law and human rights', available at: {http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion912.page} accessed 23 October 2013.

[108] Maria Lewytzkyj, 'Rebuilding Iraq – confronting access to quality healthcare, providers and medicine' (24 July 2009), available at: {http://www.examiner.com/article/rebuilding-iraq-confronting-access-to-quality-healthcare-providers-and-medicine} accessed 11 October 2013.

[109] Oxfam, 'Whose aid is it anyway?', p. 19.

[110] Christian Enemark, 'Treatment, triage and torture: Ethical challenges for US military medicine in Iraq', *Journal of Military Ethics*, 7:3, pp. 186–201. The detrimental effects that a perception of non-neutrality can have on health programmes have recently been seen in the controversy over the CIA's use of a fake vaccination campaign to locate Osama bin Laden, and the subsequent undermining of polio eradication efforts in the country. See Les F. Roberts and Michael J. VanRooyen, 'Ensuring public health neutrality', *New England Journal of Medicine*, 368:12 (2013), pp. 1073–5, a clear case in which actions seen as strategically beneficial from a security point of view have undermined health (and also, arguably, have undermined longer-term security).

[111] 'Health for all' was enshrined in the 1978 Alma Ata Declaration. See WHO Director General Margaret Chan, 'Return to Alma-ata' available at: {http://www.who.int/dg/20080915/en/} accessed 29 April 2014.

> In Afghanistan, although data is very incomplete, since 2004 over 70 per cent of OECD–DAC aid identifiable by location has been spent either in the capital, Kabul, or in three (of 34) provinces central to major NATO and Afghan troops' counter-insurgency operations: Kandahar, Herat and Helmand. Central and northern Afghanistan, poor but more peaceful, appear to have been neglected in comparison: a difference reflected in aid data and Afghan perceptions alike.[112]

Such examples show the extreme cases of strategic priorities impacting upon the non-discriminatory delivery of health and humanitarian assistance, but there can also be more subtle results of military-led healthcare provision which also challenge the principle that the needs of the patient come first. It has commonly been the case in short-term interventions that services are provided to local civilians on the basis of utilising spare military medical capacity, and that those services may subsequently be withdrawn if the demands of the 'primary' mission (treating injured troops) increase. In such situations we effectively see a 'supply-side' treatment model, which begins not from an assessment of the needs of the individual patient, but rather from the perspective of what services can be delivered (usually, in the case of 'tailgate medicine', relatively minor procedures). While this does not necessarily lead to the inappropriate treatment of patients, it may at the very least lead to a highly selective range of available treatments.

This issue is writ large in health sector reconstruction programmes where a tendency to focus on large-scale (and prestigious) infrastructure projects such as the building of hospitals may be (and in practice often are) prioritised at the expense of less visible projects.[113] The visibility of service provision is, of course, a key issue in winning hearts and minds, whether the intended effect is to improve perceptions of the intervening forces themselves or of the host nation government they are supporting. But such highly visible initiatives may not accurately reflect health needs, and in practice (as noted above) there has frequently been little coordination between US-led reconstruction efforts and the host nation MoH. Improving less high profile 'health system building blocks'[114] such as health information systems or governance arrangements may ultimately offer greater health benefits (and contribute more to long-term and sustainable health system development), but may not fit with the shorter-term strategic concerns of intervening forces.

Both short-term *ad hoc* medical interventions such as MEDCAPS *and* longer-term strategic health sector reconstruction efforts, therefore, highlight potential tensions between the demands of 'health for health's sake' and the broader politico-military concerns of winning the conflict. While we would not go so far as to claim that political-military aims and medical/humanitarian ethics priorities inevitably collide in practice – indeed there are examples from Iraq, Afghanistan and elsewhere of excellent services being provided to populations that would not otherwise have had access to them – there is at the very least reason for concern and some evidence to suggest that this has indeed on occasion occurred over the past decade.

[112] Oxfam, 'Whose aid is it anyway?', pp. 10–11.

[113] See, for example, the succession of reports to Congress from SIGIR and SIGAR on the reconstruction effort. Available at: {cybercemetry.unt.edu} and {http://www.sigar.mil/}.

[114] See, for example, World Health Organization, 'The WHO health systems framework', available at: {http://www.wpro.who.int/health_services/health_systems_framework/en/index.html} accessed 4 October 2013.

Conclusion

In both Iraq and Afghanistan, the US military (sometimes in conjunction with civilian agencies) was involved in the delivery of health services via a wide range of activities, both short-term and longer-term. It did so not only to improve health but as part of a wider strategy aimed at promoting stability, winning hearts and minds and increasing the legitimacy of the host nation governments. In so doing it provides an example of the application of smart power and GHD at the sharp end. We argue, however, that these attempts at the very least revealed tensions between the demands of 'health for health's sake' and broader strategic concerns. In some cases trade-offs were made between the two, including in the most egregious cases the threat of withdrawing aid unless intelligence information was provided.

Military medics – those really operating at 'the sharp end' – are clearly aware of the trade-offs between strategy and humanitarianism, and in many cases are forced to make personal decisions between their duty to the mission and medical ethics. Anecdotal evidence (including from internet discussion forums of service veterans) suggests that in practice many individual military medics have prioritised the demands of the Hippocratic oath, providing treatment to those in need regardless of the overall strategic or military context, sometimes in contravention of their orders, and often at considerable personal risk.

These individual decisions aside, it is clearly necessary to ask whether the demands of health and strategy can be reconciled, as the proponents of health as a smart power tool, and some of the proponents of the idea of GHD, suggest. The record of US military-backed medical interventions in both Iraq and Afghanistan ought to provide a basis on which to reach a judgement on this issue. Moreover, although focusing on conflicts provides us with cases at the extreme end of what soft power/GHD might be used for, equally given the nature of modern conflicts, these are precisely the asymmetric advantages commanders and decision-makers may look for to create popular support. But unfortunately they do not offer a sound basis for doing so for two primary reasons. The first is that there were significant problems of implementation in both cases, with a lack of efficiency, a lack of planning and an overall lack of coordination. Many military medical interventions were undertaken, but in a far from optimal way. Institutional differences at the national level were also in evidence – not least between DoD and USAID – which highlights some of the difficulties of 'silo-busting' inter-departmental collaborations in situations where different agencies have different priorities, working methods, and approaches. To dismiss health as an instrument of smart power in conflict situations on the basis of Iraq and Afghanistan alone, therefore, would leave us open to the charge that these are just failed cases, and that *done well*, health can indeed be successfully instrumentalised in the support of political-military objectives. The second problem is the fact that few of the activities that were undertaken have been properly evaluated, resulting in a lack of evidence. This has been a recurrent problem with military-provided medical services. Very little hard evidence has been collected to monitor and analyse the effectiveness of these operations in health terms,[115] a point that has also been regularly made by, amongst

[115] Jean-Paul Chrétien, 'US military global health engagement since 9/11: Seeking stability through health', *Global Health Governance*, 4:2 (Spring 2011), p. 5, available at: {http://www.ghgj.org/JeanPaulChretien.pdf}, accessed 16 October 2013.

others, the Special Inspector General for Iraq Reconstruction, the Special Inspector General for Afghanistan Reconstruction, and the House Armed Services Committee's Subcommittee on Oversight and Investigation. Even less data has been collected on the effects of health service provision on the attitudes of the recipient population towards US forces and/or their national governments. This leaves us with a debate in search of evidence.

As a result, while it may be too early to reach a definitive judgement, we would argue for caution in attempts to utilise health assistance for strategic ends. We base this argument upon three central concerns. The first is that there is concern over the effect of strategic considerations on the quality and coverage of the health services being delivered. As we noted above, the problem is not only that individual instances of provision produce suboptimal health outcomes (as with the frequently unsustainable treatments that characterise some MEDCAP-type initiatives) but also that service delivery may be instrumentally targeted in ways which constitute a breach of some of the fundamental ethical principles of medicine and public health. The second is a broader danger of politicising the health sector and reducing the 'humanitarian space' within which other providers operate. In Iraq and Afghanistan, the degree to which the US military coordinated with other providers (including other international agencies, NGOs, and the national ministries) varied widely. All of those other stakeholders, however, were potentially affected by perceptions that health assistance was being provided for political purposes. In some cases this may have undermined trust, in the most severe cases it led to violent attacks on health service providers. Third, and finally, there is little hard evidence to support the claimed strategic benefits of instrumentalising health aid. Indeed, we are surprised that, for an approach which is presented as being 'at the very heart' of contemporary US foreign and security policy, little assessment and analysis has been undertaken of smart power. Specifically, for our purposes, health interventions have been widely assumed to deliver foreign and security policy benefits, but there is little evidence beyond the anecdotal to suggest that this is the case. This is an area that has been subject to much rhetoric but little serious analysis. When combined with the interests that some of the actors involved may have in 'talking up' the contribution health can make (and here we point to those from both the security and health communities), the best we can say is that the jury is out.

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