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**May 16 Briefing: The Department of Defense's Role in the U.S.
Global Health Policy and Programs
Kaiser Family Foundation
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JEN KATES: Good morning. Thank you for joining us here today at today's event, which will be a discussion of the role of the Department of Defense in US Global Health Policy. I am Jen Kates of the Kaiser Family Foundation, and you might be wondering what the Kaiser Family Foundation is doing focusing on the DOD and global health, but this work is part of our larger effort to examine and analyze US global health policy and programs and how the US government interacts with a broader constellation of actors and stakeholders around the world aiming to address health problems that primarily and disproportionately affect low and middle income countries.

As part of this work, we became quite interested in the very important but less known role of the Department of Defense in this effort. While DOD's primary mission is to protect US national security and defense interests around the world and it is not a health or development agency, it is increasingly involved in the health of people—in addressing the health of people in other countries through medical research, capacity building, and other activities and its role has been evolving and changing.

This led us to research and prepare a report. You have an executive summary in your packets. It was released in September of last year, which really we think was the first

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very broad, and then also deep, look at what the department is doing overall in the area of global health. This conversation today is a continuation of that effort. We are very pleased that we have speakers and experts here who will help us through that conversation, and so I'm going to just briefly provide an outline of how we'll proceed, and then I'll be able to turn to our first speaker. I'm a little short, so I'll also stand up on my tippy toes.

A brief outline for today's event. We'll first hear opening remarks from Dr. Kathleen Hicks, who I'll introduce in a moment, and then we'll hear an overview of the findings from our report, briefly, just to set some context, and we'll turn then to the panel and we'll have time for Q&A from all of you.

Let me now turn to introduce Dr. Kathleen Hicks. There are full bios in your packets, so I'm just going to touch some of the amazing things that each of our panelists have done, and our speaker.

Dr. Kathleen Hicks, thank you for being here today. She is the Principal Deputy Under Secretary of Defense for Policy, and in that role is responsible for advising the Under Secretary of Defense for Policy and the Secretary of Defense on all matters pertaining and execution of US national defense policy and strategy. She previously served as the Deputy Under Secretary of Defense for Strategy, Plans & Forces where, among

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other duties, she led the development of the 2012 Defense Strategic Guidance and the 2010 Quadrennial Defense Review. She also led DOD's policy efforts to provide strategic guidance and implementation oversight to the department's planning, program, and budgeting processes and assessments of US military force structure and associated defense activities and capabilities and was a senior fellow at CSIS where, among many project, looked at the national security community's role in improving global health.

We're very pleased that she was able to join us. She is going to speak, but then has to leave for another engagement. Dr. Hicks, thank you.

KATHLEEN HICKS: Thank you to Dr. Kates, and I am also a little short, so I'm just going to push this down a little bit and maybe that will help. Thank you again for the very kind introduction, and for inviting me here today. It's an honor to be here to speak to you about what the Department of Defense is doing in global health and our perspective from a policy level on global health.

Before I get too far into the remarks, I really want to take the opportunity to recognize and thank all of you in the audience who day in and day out are tirelessly working to promote health and prevent disease, not only within the United States but around the world.

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I know many of you, I can tell at least by uniform, that many of you in the audience are very familiar with what DOD does in global health, but to the broader US public our military is commonly known really, foremost, for its unequalled ability to bring force to bear any time, any place. Of course, the Department of Defense plays an important role in supporting the US government's global health activities worldwide.

The Department engages in these activities for reasons directly related to our country's fundamental national security interests. We recognize that the world, more crowded and interconnected than ever, is increasingly vulnerable to catastrophic health threats. For example, pandemic conditions may arise at unpredictable intervals and from unexpected sources. Preventing, containing, and eliminating these lethal outbreaks has obvious relevance to DOD's mission of helping to ensure geopolitical stability and security.

DOD performs an important role in supporting the US Interagency response to human-made and natural disasters, including such health threats as infectious disease outbreaks. In such situations, our military draws upon its incredible logistical capabilities, providing air and sea transport for medicines, equipment, and personnel.

Even outside the context of immediate disasters, DOD serves the public health mission by maintaining an extensive

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network of laboratories, technologies, therapies, and medical expertise, all of which can be used in support of public health efforts in the United States and abroad.

While the Pentagon can indeed bring formidable resources to bear, we are mindful that when it comes to public health, ours is a supporting role. This humility, and, yes, the Defense Department is capable of humility, must manifest itself on two levels.

First, we need to recognize the role of our fellow agencies within the US government. We in DOD know that a fully coordinated interagency approach to global health is essential. At times, DOD health projects have focused on short-term efforts in support of purely military objectives without adequately taking into account longer-term health and development objectives, which, by the way, can easily end up having a direct and lasting impact on military and security interests.

The second level at which DOD needs to exercise a certain measure of institutional humility is internationally. We need to recognize the importance of enabling our partner nations to take the lead in protecting the public health of their own people. After all, it is they who must live with the consequences of any public health initiative on their own soil. It is they who are best qualified to know their own national

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circumstances and to continue investing in their own progress and stability. In short, we at DOD need templates to understand how best to engage with our fellow government agencies and our foreign partners in the complex and vital work of protecting public health in actual and potential crisis situations. Many of you in this room played a tangible role in this by helping us develop our first-ever DOD policy guidance on global health engagement.

Four years ago, when I was at the Center for Strategic and International Studies, I and two colleagues published a study that analyzed DOD's global health engagement activities. The study addressed DOD's role in global health, including the effect of its health activities on national and regional security. That paper's recommendations included creating a strategy for global health engagement as well as a health security cooperation plan to guide our efforts to build the public health and medical capacity of partner militaries. Above all, our analysis underscored the importance of ensuring that we do a better job of synchronizing our efforts, not only with fellow government agencies here in the US, but also among our own commands and components worldwide.

Since that study was published, we've seen many improvements in the areas we identified, such as DOD coordination with the state department and USAID, coordination

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across DOD itself, and the incorporation of humanitarian and global health scenarios in our military exercises.

The Department has made significant strides over the last year in establishing measures of effectiveness for its global health-related activities, similar to what was recommended in the September, 2012 Kaiser report titled *The US Department of Defense and Global Health*. This progress is exemplified by the Measures of Effectiveness in Defense Engagement Learning Study, led by Assistant Secretary of Defense Woodson and Deputy Assistant Secretary of Defense Smith and conducted through the Uniformed Services University.

Through this study, we are developing a global health engagement framework that aims to link broad strategic guidance to our on-the-ground tactical activities with a focus on aligning those engagements with the objectives of our combatant commanders around the world. There is a good reason for this approach. The proper place for the Department to integrate and coordinate its global health efforts internally and with other federal agencies is through our geographical combatant commanders. This helps ensure DOD has the appropriate, effective, and legal mechanisms for humanitarian response and public health response.

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Through health-related activities and exchanges, we are able to improve the capacity of our partners and foster closer ties between those militaries and our own.

We also support our partners in developing effective and legitimate health institutions that can provide multilateral responses to health-related threats as a result of natural or man-made causes. Already in 2013, there have been at least two noteworthy examples of how we have used global health engagement to help partner nations address an urgent health need.

The first of these occurred after the nightclub fire in Santa Maria, Brazil in late January, a disaster in which 241 people died. Brazil's ministry of health put out an urgent request to the US government for assistance; specifically, for Cyanokits that could treat victims suffering from cyanide toxicity due to inhaling fumes from burning acoustic foam.

After determining that no other agency in the US government was in a position to respond with the necessary speed, US Southern Command coordinated transport of the medication from St. Louis to Brazil via Miami by working closely with Miami-Dade aviation officials, the Transportation Security Administration, and American Airlines, which volunteered to fly the medicine to Brazil free of charge.

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This was a great example of public and private collaboration; exactly the kind of partnership we are likely to need as we continue to respond to urgent crises of all kinds.

A second health emergency took place just last month following a measles outbreak in the country of Georgia. As a result—I'm sorry, I think I'm hitting this. I'm going to close this. As a result of the request from that nation's health ministry at the US embassy in Tbilisi, the Department of Defense funded 75,000 emergency evacuations. UNICEF handled the procurement and the Georgia National Center for Disease Control took charge of distributing the vaccine.

While we need to continue to work with our partners to hone our responses to such crises, we also need to plan for future challenges. An excellent example of how we're doing this is the upcoming event sponsored by the Association of Southeast Asian Nations, ASEAN, with the long and ungainly title of Humanitarian Assistance and Disaster Relief Military Medicine Field Training Exercise. This event will take place next month in Brunei and includes 18 countries from southeast Asia and elsewhere, including the United States.

It is an important opportunity for cooperation among our defense forces and for building a regional capacity that can address non-traditional security challenges throughout the vast Asia-Pacific region. One particularly noteworthy aspect

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of this upcoming exercise is that it will include an exchange of US and Chinese medical officers. Three US officers will spend the exercise aboard a Chinese ship, and three Chinese medical officers will be assigned to a US medical treatment facility. The exercise thus provides a valuable opportunity for the United States and China to work together in a practical way on the provision of medical services to those in need.

The United States will need to team with countries throughout the world to counter disease and other threats to public health, but knows no borders. Consider infectious disease outbreaks. The US and our partners work daily to fight infectious disease epidemics that were not controlled at the outbreak stage, including HIV/AIDS and drug-resistant tuberculosis. We remain vigilant for new outbreaks.

The Defense HIV/AIDS prevention program is an excellent example of a military-to-military health engagement program with a direct effect on security. Within the last four years, this program, in collaboration with the National Medical Center San Diego and partnering universities has trained providers in 50 militaries around the world and helped strengthen HIV prevention programs in the trainee's home countries.

Last summer, the Department's prevention program successfully hosted a major international military HIV/AIDS conference, bringing together military representatives from 75

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countries along with numerous government agencies and international organizations. This focus on infectious diseases has tended to be a hallmark of DOD's international public health efforts over the past decade or so. This is understandable, given the enormous stakes involved. However, such an approach can sometimes make us less attuned to other vitally important health concerns.

We should also consider expanding our efforts in global health to encompass challenges outside the realm of communicable diseases. This includes threats like malnutrition and disrupted access to clean water. The expertise and responsibility for dealing with these conditions obviously falls well outside the Department of Defense. However, we at the Pentagon do have a legitimate interest in the degree to which these conditions impair the security and stability of key countries around the world.

A 2008 National Intelligence Council study found that while noninfectious conditions may not present direct threats to US interests, they can have wide-ranging effects on global health. The study concluded that the US should open the aperture of its global health program to include non-communicable diseases, neglected tropical diseases, maternal and child health and mortality, and malnutrition. Conditions such as these can be devastating to the health, stability, and,

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yes, security of entire nations, particularly in the developing world.

As we have seen, the physical health of these poorer populations can have a profound impact on their social and economic health. Expanding on this concept, actions to improve the health of a fragile state may prevent it from becoming a failed state.

This is a segway to the thought that I'd like to conclude with today. Namely, the observation that there is an increasing willingness to link global health to national security. Shifting DOD's global health engagement activities more in favor of building the public health capacity of partner nation militaries and towards synchronizing our efforts with the State Department and its health diplomacy and USAID's health development efforts would create a synergy beneficial to global health and potentially beneficial to global and national security.

Thank you for your time and attention today. Thank you also for your hard work, again, to promote public health around the world. As you listen to our distinguished and much more expert panel of experts who follow here, each of whom has had years of dedicated experience in the areas of global health engagement, I encourage you to use this time to share your thoughts and recommendations with them and with each other.

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I think I can speak for the Department of Defense in saying that we look forward to reviewing the recommendations that result from today's discussion. Thank you.

JEN KATES: That was great. Thank you, Dr. Hicks and her colleagues who are here. Now I am very pleased to be able to introduce my colleague, Dr. Josh Michaud, who is the Associate Director of Global Health Policy here at the Foundation and, really, my thought partner in all of the work that we do in bringing incredible analytic depth and scholarship to our work and also the lead author of the report that we released.

I also want to call out my colleague Kelly Moss over there who, with Josh, worked on this report and really it was the two of them that did all of the hard research and thinking about how to approach this complex topic. I also want to let you know that prior to coming to the Kaiser Family Foundation, Josh was an infectious disease analyst at DOD's National Center for Medical Intelligence, and he also supported infectious disease research and capacity building at the Naval Medical Research Unit, NAMRU 6, in Lima, Peru. Josh will provide an overview of the report findings briefly, and then he is going to join the panel. At that point, I'll introduce the rest of our panelists. Thank you.

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JOSHUA MICHAUD: Okay, I think we're all good. Thank you very much, Jen, and it's a pleasure to be here to talk about the findings of this report. It was the result of a lot of effort by a number of people. I'd also like to thank Kelly, without whom it wouldn't have been possible to put this report together, and certainly this event as well. I'd also like to thank Derek Lysena [misspelled? 00:17:54] of the US Army, who is also a newly minted Ph.D. from George Washington University and Professor Rebecca Katz, also of George Washington, who helped us with the process of research and writing the report.

I will take just a very short amount of time to touch on the very top line issues that we raised and the results of our analysis that were published in the report in September of 2012. Much more detail on any of the points that I'm going to be making are available in the report itself, which you will be able to find online, and again it's available in your packet, printed—the executive summary of the report.

When we approached this—the writing and research for this report, we took a very broad approach and at the time I was going to say the DOD does not have a definition for global health, but apparently that's changed as of yesterday. At the time, there was no definition so we wanted to take a broad look at any activities that the DOD was engaged in which were related to global health, which had impacts, direct or

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indirect, on the health of populations, particularly in low and middle income countries.

One thing to know, if you didn't already, is that there is a long history of this type of engagement at the Department of Defense. I won't go through any of the details on these slides. There is a larger history in our report, but just to point out, for example, in medical research and development, military services have contributed to a number of key scientific medical and public health milestones from the Army researches who identified the mosquito as a vector for yellow fever to the Navy being the first to identify a human case of the H1N1 emerging influenza pandemic in 2009.

As we heard from Dr. Hicks, there is now an increasing use of language related to global health and other activities that are similar to global health in the policy guidance used by policy makers and folks at the DOD and the national security community as a whole. The overarching mission of the Department of Defense, of course, is to provide the military forces to deter war and protect the security of the United States, but concepts of what constitutes an important national security threat or opportunity shift over time and, as she mentioned, there has been an increasing linking between health-global health and US interests. Some of that language is

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included in some of the documents which we highlight here, and the report contains many more.

Turn now to the findings of our report, and one thing that we wanted to do with this report was to try and demystify a little bit what the Department is doing. We found it helpful to come up with a categorization for the types of activities that the Department is engaged in in this space. The three focus areas, as we call them, are listed here that we came up with in our categorization. They are not meant to be mutually exclusive categories. One activity that is a Force Help Protection activity could certainly contribute to the other categories as well.

The first is Force Help Protection and Readiness, which as you can see here contains medical research and development work, disease surveillance, and Force Help Protection education and training work for US personnel.

A second category is Medical Stability Operations and Partnership Engagement, which is a broad category of activities ranging from work in conflict areas to support counterinsurgency to post-conflict recovery and reconstruction work to just broader health diplomacy work such as the Navy's use of hospital ships, partnership missions, and military-to-military training and other health support for disaster response and things of that nature.

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The third category is Threat Reduction, which corresponds to DOD efforts to prevent and prepare for biological incidents. Those efforts focus on natural, accidental, and intentional causes so, of course, endemic and pandemic diseases that aren't of natural cause are a concern for threat reduction efforts.

The nice thing about these categories as well is they correspond somewhat to the organization of the DOD and we tried to capture in this slide—I realize you won't be able to read any of it, but that's partly the point. With this visual, we wanted to show that there was a broadly-distributed nature to the organizational involvement of the DOD in global health.

Basically, all of the major components from the office of the Secretary of Defense, the Joint Staff, the military departments, the combatant commands, are all involved to a lesser or greater extent in overseeing and carrying out these activities, so it's a very broadly distributed, decentralized system of efforts, and for that reason it's very difficult to get a handle on what the DOD would call a bellybutton. Who do you talk to when you want to talk to them about global health? There's not just one person. There's a lot of different people, a lot of different activities going on.

Another thing that we do in the report is try and identify as best we can the funding vehicles and budget lines

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for global health to support these activities in these focus areas that we've identified.

Some of these budget lines are shown here, and more are included and discussed in the report, but I'll say that it's difficult to find detailed and comprehensive information about the budget dedicated to these activities. With the information that we had on hand, we estimated a total budget across all these areas in fiscal year 2012 of no less than 560 million dollars, although this can be characterized as only a rough estimate. To put that in perspective, this amount is larger than the Centers for Disease Control and NIH budgets that are directed to global health specifically, but far lower than the global health budgets directed through PEPFAR, for example, and USAID. PEPFAR is about—was 6.6 billion in 2012 and USAID global health programs about 2.6 billion.

I will just close by mentioning a few of the policy issues that we discuss in the report. Improving global health is not a primary mission at the DOD, of course, but the Department has connected engagement in these activities with its core national security objectives, so it raises a number of questions, which I hope we will get to discuss in further detail.

Should the Department place more or less emphasis on these kinds of activities going forward? Does its set of

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approaches effectively work to improve the health of populations in developing countries, and are these efforts sustainable? Policy guidance has emphasized global health-related activities recently, but a corresponding shift in funding to support such activities has not been as apparent. That makes it challenging for the DOD elements that are seeking to adopt these activities into their operations to a greater extent, more challenging and, given budget discussions and sequestration and the current funding environment might be more difficult going forward.

There are perennial problems, of course, of interagency coordination and communication that impact this work, compounded at times by different cultures, vocabularies, deployment, and rotation schedules.

Finally, there is an ongoing challenge of publicizing the efforts of the Department of Defense in this area to key stakeholders such as the public at large, global health colleagues, the US congress, and policy makers in countries where the DOD works who may be unaware of or have misconceptions about the work that the Department does, which is one of the reasons why we wanted to hold this event and write this report, so I am grateful to the panelists for being here, for Dr. Hicks for giving opening remarks, and to all of

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you for joining us today. With that I'll end and we'll move on to the panel. Thank you.

JEN KATES: That seemed to solve it. Okay, now we're on to the fun part. Bear with me while I introduce the panelists here, because I think it's really important to hear a little bit about who is with us. We really tried hard to get a set of experts that we felt could provide a very deep and comprehensive discussion about these issues, and we're very excited that we did get this group. You've already heard about Josh, and please feel free in the Q&A to ask questions about our report and our ongoing work. We're continuing to work in this area. That noise hopefully will stop.

Let me start with introductions. We are very pleased to have with us Dr. David Smith, who is the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness. He directs the department-wide efforts to develop and implement policies and programs related to DOD deployment medicines, force health protection, national disaster support, medical research and development, international health agreements and missions, and medical readiness for over 2 million service members. He is retired from the Navy as a rear admiral last year, and while in the Navy he served in a number of key positions, including the Director of the Medical Resources, Plans, and Policy Division on the Chief of Naval Operations

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staff. As the Medical Advisor in Chief Joint Medical for the International Security Assistance Force in Afghanistan, where he oversaw medical care and health development, and as the Joint Staff Surgeon, the chief medical advisor to the Chairman of the Joint Chiefs of Staff providing counsel to the Chairman of the Joint Chiefs of Staff, and helping coordinate medical and health policies and activities across the military departments and in support of the combatant commands.

We also have Kate Almquist Knopf, who is a visiting policy fellow at the Center for Global Development. She is also an adjunct with the Africa Center for Strategic Studies at the National Defense University, and at CGD works on issues such as the intersection of security and development in the developing world, US foreign assistance reform, and development interventions in fragile and newly-emerging states such as South Sudan. She was at USAID as the Assistant Administrator for Africa, the Sudan mission director, the Deputy Assistant Administrator for Africa, and Special Assistant and Senior Policy Advisor to the USAID Administrator.

We also have Colonel Pete Weina, who serves in the US Army and currently is the Deputy Commander at the Walter Reed Army Institute of Research. He is also an associate professor at the Uniformed Services University of the Health Sciences in the Departments of Medicine and Preventive Medicine. He is a

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recognized expert in infectious disease research and development. He has authored numerous publications and book chapters and, also, you should look at his bio because he has a number of advanced degrees—many. He has led research teams in areas including leishmaniasis, where he is considered an international expert, malaria, and many others. He has served also as the Chief of Pharmacology and Director of Viral Diseases at Rare in the past, among many other positions.

Then, finally, we have Rabih Torbay, who is the Vice President for International Operations at the International Medical Corps. At the International Medical Corps, he oversees global programs in 28 countries on four continents. He supervised the expansion of IMC's humanitarian and development programs into some of the world's toughest working environments, including Sierra Leone, Iraq, Darfur, Liberia, Lebanon, Pakistan, Afghanistan, Haiti, and, most recently, Libya, and I think you just said you were back from Syria just maybe yesterday. He is the organization's senior representative in the nation's capital and serves as IMC's liaison with the US government, including USAID and the Department of State, DOD, and HHS.

As you can see, we think we've got a great panel here. I'm going to start by asking them some general questions, and we will have time to turn to you all.

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I'm going to start with Dr. Smith. Given your current position and where you sit and some of the things we've heard and with all the varied experiences you've had, what are your thoughts about where DOD is and where it's going in this work?

DAVID J. SMITH: Well, thank you for the question. Clearly, I'm somewhat personally biased, but I think the Department recognizes, and I think this audience clearly knows, that global health engagement is a critically important work for the US and for the world.

DOD is a very active participant in that, but I should, as the Secretary noted, caveat that everything that we do is done through the lens and is evaluated relative to how it supports the national security strategy, and so most of our efforts are related to and help support that. Now, that connection is fairly easy to make, I think, because it's well recognized that health and healthy communities aid in stability in a nation and economic development, and clearly we recognize that partnerships around the world are critically important and are a deterrent to conflict, and that's the basis of our involvement.

A lot of the work that we do in the Force Health Protection and Readiness area to protect our force that has to go forward as ready applications, as Josh already mentioned in the global health arena, particularly in the research and

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development area, where we have been some of the pioneers in infectious disease and other areas. I sense that the Department gets it relative to this. We also recognize, however, that we are supporting, as the Secretary also noted, the rest of the USG and the international community, that we are typically not in the lead unless we sort of work that out with our partners, but we bring a lot to the table, so—

JEN KATES: Thank you.

DAVID J. SMITH: I hope that answers.

JEN KATES: Great. Kate, I'd like to turn to you.

Given your experience working at USAID and now being able to sit back a little bit at CGD and think about these issues, what's your perception of—on picking up on some of the issues Josh raised about how the DOD may be viewed—its role in this larger space?

KATE ALMQUIST KNOFF: Right. Thank you. Thank you for the opportunity to be here. I think there are some challenges when we translate the general premise of health as related to national security and to specific actions and clarity of roles and responsibilities. It's important for us to look at the empirical connections, I think, between security and development and look at what's important for fixing or helping to fix fragile states, preventing failed states, what's

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important to empirically—what do we know about violent extremism and efforts to counter that or to counter insurgency.

When we look at all of those things, health is not the first thing that's identified in any of that literature, and in any of the evidence thus far. While, in general, improving health and providing more effective delivery of basic social services is a key ingredient in well-functioning states that are more stable, more productive, can provide for their citizens, we have to be very clear, I think, in terms of what that connection is and then who is best placed within the US government to provide the kind of assistance that would make a difference in the long term to generating more sustainable effective public health delivery systems.

JEN KATES: Thanks, and I hope that's one of the issues we'll get at, is when is it appropriate, or what are the right times and best use of the different parts of the government to approach these challenges?

Colonel Weina, you've had years of experience within the Department and R&D and RARE is such an important part of what the Department brings to this work. Can you talk a little bit about that and give us some background?

PETER J. WEINA: Sure. Thank you for inviting me. On behalf of generations of men and women that have worked in military medical global health, I think we're very proud to be

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part of what I consider an ecosystem. It's kind of hard for any one particular organization to say that they're in the lead because we've got so many different interactions that go on between the different groups, and I think an ecosystem is really the only way to describe that.

An important part of our ecosystem, of course, is our overseas assets, which are remarkable organizations that have had, in some time, in some cases, over 50 years of relationships with our partners all over the world. I think about our laboratory, kind of laboratories, all as gems in the crown, if you will, of—in Thailand and in Kenya and Peru and in Egypt, that have had enduring, trusted partnerships with individuals from all over the world and that is part of that ecosystem that helps contribute to global health.

I think those of us in the uniform of our country, although we may wear Army or Navy or Air Force or public health service, we kind of think of ourselves as global health officers as well as providing information and help to our soldiers or sailors or airmen or Marines that may be out in harm's way, so hopefully that answers the question.

JEN KATES: I have more questions, so, anyways—Rabih, thank you, for all of you, for being here. As vice president of an NGO with a broad geographic presence and in the work that you do every day, which as we heard is working in some of the

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most difficult parts of the world, how have you interacted with DOD and what do you perceive in terms of their role in your work?

RABIH TORBAY: Great. Well, again thanks for having us here and thanks for inviting me to be on a panel. Many people might be wondering what is an NGO doing here when we're talking about DOD's engagement in global health. I think over the past few years we've realized more and more that we cannot continue working in isolation without actually taking into consideration the work that other partners or that other entities are doing. The DOD is becoming more and more engaged, not just in global health but in humanitarian assistance or disaster relief.

We've seen ourselves working closer together with the DOD than we anticipated. Again, the NGO world is divided. Not many NGOs would want to be seen working with the DOD. That's something that we have to realize, that not all NGOs are the same. In our arena, in our space as well, we've seen the—if we know, if we understand what the DOD is doing and we make them understand where we're coming from, there's a lot of common areas that we could work together on, and we've seen that in many disasters, natural disasters but also when we talk about pandemic preparedness, when you're talking about the threats that we face as a global body, be it the NGOs or the DOD or

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USAID. We have seen that there is more and more room for us to be working together and to collaborate together.

JEN KATES: Okay. Josh, now I get to turn back to you.

JOSHUA MICHAUD: Yes.

JEN KATES: Because I know that as part of the report, and then the work that you've been doing since then, you've talked to many, many people both within the DOD and all parts of the DOD as well as outside, and a lot of that information was culled down as report, but—or there are some things that might not come out in the report if one was reading it or didn't have time to read the 40-something pages and the 60 pages of the technical appendix that you might want to highlight.

JOSHUA MICHAUD: Everyone's required to read it by the time you leave, but—yes, I think in a report of this nature, we wanted to make a snapshot of the organization but it's a dynamic situation, of course.

One thing that became clear after—from the time we started this process to know it's going on two years. One thing which hasn't been captured in the report itself probably but has been clear from conversations we've had not just with Department of Defense personnel, but USG partners as well is the trajectory of relationships. For the most part, from our discussions, that has been towards a positive side, meaning

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more coordination and reaching out, more collaboration in-country. That is a positive sign that would—something I would want to flag.

The other thing is that there has to be recognition of the balance between the day-to-day activities of folks in the DOD who are stationed abroad working on these issues, and the amount of attention that certain areas or activities get, so I think there is probably an under-recognition of the day-to-day work that goes on. I certainly was part of it when I was at the Navy lab in Lima, and so hopefully that balance is properly presented in the report. That's something that I wanted to emphasize as well.

JEN KATES: I actually have a follow-up for you, which is—most of the work we've done at the Foundation besides this is focusing on the broader US global health engagement.

JOSHUA MICHAUD: Right.

JEN KATES: In that work, do you see that there have been clear linkages with what the DOD is doing? That was one of the reasons we wanted to approach it. It wasn't just that DOD might not have been as connected into that work explicitly, but the other way. Could you talk about that cross-fertilization?

JOSHUA MICHAUD: Yes, that's one of the areas where there's been some improvement. I'd say it would be fair to

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characterize a decade ago that there was not a lot of crosstalk going on. There wasn't a lot of work together across between the DOD and the agencies doing global health and development work, but that has improved over time. I'm sure that many people would say that there is still an enormous gulf there that needs to be crossed, and likely in certain situations that's true, but, again, the trajectory is going in the right direction it seems to me, but there are more issues and obstacles to overcome to make this work even better.

JEN KATES: I have a general question. Did you want to jump in? Great.

DAVID J. SMITH: I'll just add that I agree totally that over the last 10 years there has been a lot of more understanding of the importance of the interagency as we get more involved in the global health area, but we have regular—we now have liaisons in many of the organizations and vice versa, which I think is helping that exchange to understand and, as Josh pointed out, the differences in the language and understanding what each group's needs are.

My boss and I meet with State, USAID, and HHS on a regular basis to try to facilitate the exchange at the sort of medical side of the equation, so I do think there are a lot of efforts and we understand the need for that and that it has a

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lot of work required in the future to continue those relationships.

JEN KATES: A general question, picking up on something Dr. Hicks said, which was—she alluded to or mentioned that DOD brings unique assets at times that other agencies or other entities might not have. I just want to—if you could—whoever wants to, touch on what those are, what's different, and when they're best mobilized to be used for global health efforts. Whoever wants to start on that.

DAVID J. SMITH: Well, they're all looking at me, so—

JEN KATES: Yes. Yes.

DAVID J. SMITH: I'll talk again. Well, the first strength is DOD is sort of forward-deployed all over the world continuously, so we're out there and there's a requirement for us to keep our force protected, so we tend to have a global outlook in our research and development and all of our sort of efforts in that regard.

We also have a network and work most of our work through the COCOMS throughout the world, and so those geographic commanders are the ones that sort of set the agenda for that region. They're the ones that know best what fits into the national security strategy, and so most of our work sort of—and relationships with the regional USG actors, NGOs and others, are facilitated through that network that we have

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across the world, and I think serves that purpose very well. We also have already mentioned, but have a pretty strong research and development arm that is oriented towards protection of folks going forward and has lots of cross-correlation then with global health efforts, including a bio-surveillance network, because of those laboratories and all the partnerships that have been developed that really is very important in the global health effort.

RABIH TORBAY: Yes, I would add to this. I think the DOD has got tremendous logistical capabilities that no NGO has, or not even close to it. If we know how to utilize that, it could be an added asset to ourselves.

I'll give you just a couple of examples. After the tsunami—the Indian Ocean tsunami, Banda Aceh, the only way we could get our supplies was actually through the DOD.

Pakistan earthquake. We couldn't get to the mountainous areas without the DOD airlift capacity, but also, most recently, Haiti for example, where we utilized the naval ship to actually refer some of the patients that we couldn't deal with but also at the same time we had doctors there on the ground that were in Port au Prince in 22 hours. We had no food for them. We had no generators. The hospital was destroyed. DOD came and set up perimeter around the hospital. They set up tents. They gave our doctors MREs that we haven't paid for

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yet, and we don't intend to pay—just for the record, not paying for them.

It was just ad-hoc collaboration. It wasn't planned. You can just imagine, if things were planned ahead of time, the impact that we will have rather than having the reaction. The more we get to know each other and work with each other, the better impact we'll have.

KATE ALMQUIST KNOFF: Is this working? Yes?

MALE SPEAKER: Yes.

KATE ALMQUIST KNOFF: Okay. I would just add that certainly in the immediate acute massive humanitarian emergencies that certainly there is no way to beat what DOD can add to the equation in terms of logistics and speed of response. I think the examples Dr. Hicks gave us were exactly right on in terms of that, and then of course the research laboratories and the response to avian influenza. I know when I was a mission director in Sudan and we were concerned about avian influenza outbreak there, it was the research lab in Egypt that provided the testing and the lab work for that, and that was a great example of collaboration.

I think the challenge is when we come to the more sustained on-the-ground local community level development and institution-building longer-term approaches where maybe what DOD is best suited for. It doesn't quite line up there.

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JEN KATES: Could you say a little bit more about that, because we heard that a lot in developing the report. Where's that line, and it's not a hard one, obviously.

KATE ALMQUIST KNOFF: No, it's not always very clear, and I think it's a challenge that even in the development community to try and figure out how to generate and assist countries in building their capacities and having better institutions, both formal institutions and non-formal institutions that can deliver services, that are perceived to be effective and legitimate by citizens is really a challenge. In fact, humility is required on the development side about what we can achieve in those realms as well as on the security side, and I think a greater recognition of just how long-term these endeavors are. It takes generations to change things.

When we look at a fragile state, when we look at an area of—is that better? Yes, when we look at a fragile state or an area of perceived vulnerability to extremism, we want a quick fix that addresses the immediate and, unfortunately, our efforts mostly aren't suited to that on the development side, on the aid side, even sometimes on the security side.

These are complicated challenges for us to accept that— that sometimes we just don't have the tools anywhere in the US government for that, but we do have a lot of learning on the development side about what can be done with local communities,

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with state actors, and then, more specifically, on the health side building health systems and bringing those pieces together and finding the right fit of assets and resources and capabilities. It's far more complicated than just transferring knowledge and technical ability, right?

JEN KATES: Yes.

PETER J. WEINA: First of all, I'd like to say we'll take that check now, because of sequester and we're really broke, so—but I'd just like to say that the awesome ability to get on the ground and set things up and be able to respond very quickly, I've been fortunate enough to experience that firsthand in things like going into Iraq and being able to have complete medical facilities set up within hours of literally getting there and being able to help not just our individuals, but also local individuals is an awesome thing. That line is very difficult as to what is the end game.

On the other hand, we also have these long-term trust relationships, or like I was saying with our overseas laboratories, in which we have generations of men and women that have interacted with people in Thailand, people in Cambodia, people in Nepal, people in Kenya and Uganda, Peru, Colombia, that really form a strong backbone for interactions that may in the future become disasters that we can help respond to. Not just that, but also contribute to the global

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health within those areas. I think that is an important aspect of what the DOD brings as well. These things have been going very quietly for fifty-some years in some cases, so it's an important aspect of what the DOD does as well.

DAVID J. SMITH: I would just add on the laboratories, the vast majority of the staff are actually local nationals, so there is a tremendous amount of human capacity-building that goes on because of that enduring relationship we have. I agree, in the short term—that is where we bring the greatest strength, in my opinion, except where we have a need for a long-term lasting relationship.

Frequently, in our partnership building we will partner with either other parts of the USG clearly, but also NGOs and others to try to sustain some of the work that we can help initiate with resources, but make sure then that it is sustainable and someone else can carry that on, so we can supplement work of others but recognize that our mission and our strength is not development, per se.

In post-conflict areas, areas where we're the only ones that really have the resources for security, et cetera, we get involved in that initially but try to hand it on as soon as it's possible and there are actors that can support it.

JEN KATES: Josh?

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JOSHUA MICHAUD: Just to add, if you think about the focus areas that we identified, I think it's fairly clear that there is not a lot of controversy around the medical R&D and the force health protection work such as the laboratories that—in support of global health.

Where there are potential pitfalls, of course, is in the medical stability operations where you start to tie health operations and engagements with particular security outcomes, and that has been the area where I think there has been a lot of learning as well, I was interested to hear Dr. Hicks mention that you could—the DOD engaging in these activities could actually be undermining itself by taking on short-term projects that actually make the situation worse rather than improving the security situation, as they were meant to do. There seems to be recognition of that a little bit more. I'm sure that there could be more, but that's certainly something to be aware of. It seems to have reached high levels.

JEN KATES: I actually have a couple of questions for Colonel Weina and Dr. Smith in particular, but others please chime in. You said the S word, so I'm going to put you on the spot and talk about sequestration. What does that mean from the Department's perspective about this work? Have you seen the impact of that? How are you thinking about it as you move

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forward, or are you just trying not to think about it and keep doing—what is your...?

PETER J. WEINA: Well, first of all, I should have kept my mouth shut about sequester. Principally, I think most of us recognize that we get our direction from above, and we're always going to do what is necessary to carry forward the work that we do.

I think it would be disingenuous to say that it hasn't impacted us. It has impacted us, but it's impacted everybody. It's not just our work. I think that the men and women that work with us, though, are amazingly entrepreneurial and when they have set missions and they have goals that they see need to be done, they find ways of making that work.

As I said, we're part of an ecosystem so just like in a forest you can't pull a vine out and define what that vine does without defining the tree that it's on or the animals that interact with it or the soil that it's in. It's the same thing with us. There is always other individuals there that we can work with, people that we partner with, people that have, during difficult times for us, have stepped forward. Difficult times for them we've stepped forward.

I think that the important work is still going to go forward. It may go forward a little slower or it may take a different form, but I think we're still continuing to stay on

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point and stay focused on what needs to be done. As I said, the amazing ability of our investigators to continue to stay focused on what they're doing—of course, they get distracted once in a while but they quickly get back to where their passions are and that's one of the great things about working and where we are, where I am, is that people are passionate about what they do. They're not going to let that distract them from what they feel is very important work.

JEN KATES: Did you want to—

DAVID J. SMITH: Absolutely.

JEN KATES: You could take a pass if you want.

DAVID J. SMITH: Sequester has clearly been very problematic for us. There are a lot of restrictions in the way that we can actually move money around, et cetera, so we're not being able to sort of manage it to the level that we would like to, but we clearly—I have not seen a specific targeting, if you will, of global health initiatives specifically.

I have had to make very painful cuts across a number of the areas that we have to fiduciary responsibility, we only hope that this is not a sustained way of doing business because we've been able to make it through because we had a number of one-time savings caused by great work previous to knowing, even, sequester was coming that would have saved the budget already, but they're one-time, and so next year, if it repeats

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you've got to sort of go through the whole gut-wrenching process.

Most of the work is actually up to the COCOMs, and the COCOMs have embraced this as a very helpful strategy with their national security strategies and their theater security cooperation plans. Health is an integral component in a substantial proportion of their work, and so the dark clouds of the budget will—and my crystal ball is very cloudy. We'll see where this goes, but I think there's still a lot of enthusiasm and understanding of the value of what we're doing.

JEN KATES: A couple more questions before we turn to audience questions. It was alluded to as well in Dr. Hick's remarks—or, actually, in Josh's, I think, about a new definition yesterday and there has been some reorganization even since our report came out. We had heard about the creation of the Defense Health Agency. Could you shed some light on that? What's happening? What is being stood up, and what will it do?

DAVID J. SMITH: Sure. To be frank, the bottom line is that it doesn't have much effect on this whole area. The Defense Department is working on a new governance system, doing everything it can to promote efficiencies, and so all of our shared services related to health are being examined and an agency is being stood up to do those for each of the services,

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rather than each service doing its own IT and medical, et cetera.

There are 10 different areas that have been targeted to look at, and the decisions are being made of what will be evolving into that, but clearly most of it is being done from an efficiency point of view. I don't think that it has any net effect. Part of the advantage of not having one line in the budget that you can actually attribute to global health is the fact—because we're a very decentralized organization. It's in many of the different budgets, and so I don't see any effect, quite frankly, over the defense health agency having on this other than some of the support and other things required for it may be enhanced because of the—

JEN KATES: Did you want to—

PETER J. WEINA: One of the things about medical R&D and military medicine in general is the fact that we've always done that type of work, that type of interagency work. I think that the Navy and the Air Force and the Army have always worked very closely together. It is tough to be joint on the bottom when you're not joint on the top, and that has created some difficulties in the past.

I think that there's a general feeling of embracing this idea that we're all going to be kind of what has been called for many, many years the purple suiters, where the

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medical people aren't green or blue or white. It's all just one group that's working together. We've functioned that way for-jeez, I mean I've been in for almost 37 years and at least well over half of that it's always been a joint environment. We kind of reach across to our colleagues in different uniforms, and not just within the US but also within our coalition partners as well. It's been very joint at the bottom, and I think we embrace the idea of being joint at the top.

JEN KATES: Okay. Josh, one question for you and then we'll think about your questions. I'll take-we'll take three at a time so people will have a chance. We're working on another report looking specifically at DOD's focus on infectious diseases. Can you talk a little bit about that and maybe give a preview of some of things we're learning?

JOSHUA MICHAUD: I don't want to give away any of the...

JEN KATES: Don't-yes, don't...

JOSHUA MICHAUD: In the course of doing the first report, we actually wanted to include this information in the first report, but that became such a large effort that we thought it would be better to focus on this separately. We've done some follow-up work and we expect in the next month or so, hopefully, to get this out. Clearly, we're focusing on the medical R&D health surveillance, and also the partnership

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engagement aspects of the infectious disease work that the DOD engage in. We talk about all of the different aspects related to the HIV that the Department is working on. Dr. Hicks mentioned DHAP. There's vaccine work. We try and characterize this, the budgets, the support of the organizations that do this work, as best we can so that everyone who is working in this area and is interested in it can get a good sense of what they're doing.

We don't see anything else like this out there, and we hope it'll be a good resource, just as the broader report is for those interested in the infectious disease activities in particular. Much of the global health community, I think, will be interested in hearing about this.

JEN KATES: I see Kelly is our point person on that, so if anyone has any thoughts that you want to share with us, please find Kelly and she will be happy to take them.

Okay, we are going to open it up for some questions, and let's take three at a time. Please just stand, get a mic, and identify yourself so we know who's here. Somebody over here. We have a second over there. Do I see—this is like an auction. Right here in the front, and then the gentleman there and then the woman right over there.

MALE SPEAKER: Hi, I'm Dr. Faroukh Risvi [misspelled? 01:01:19]. I have a question that we have heard about

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interagency agreements and cooperations and all that. What's your thought about public/private partnerships, like engaging Gates Foundation and other private agencies with the DOD?

JEN KATES: Okay, and thank you for keeping that short and sweet, so we'll try to follow that.

KEITH MARTIN: Keith Martin, Consortium of Universities for Global Health. I wondered what the—if there is an opportunity to combine efforts with DOD state and USAID to act as facilitators to deal with countries intention to be able to address common issues in health, so building up primary care in Afghanistan/Pak/India, the same in the Sahel, whether there is any effort to have a rapid response mechanism to do that.

Lastly, Dr. Smith, I served 18 years as a member of parliament in Canada for the largest military base in the west, and I wondered if there is any efforts to share best practices in terms of the care of our men and women in uniform to deal with the OSIs and suicide challenge taking place. Thank you.

JEN KATES: Okay. Last round?

JUDY HEICHELHEIM: Hi, I'm Judy Heichelheim from Population Services International. I was listening to Dr. Hicks' remarks about discussion around engaging more in non-communicable diseases, and she specifically mentioned malnutrition and maternal and child health, and I was wondering if any of you can speak a bit more to that specific issue.

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JEN KATES: Okay. Great. I'm going to let whoever wants to start take it. We have a general question about public/private partnerships, one around joint efforts to go in and stand up primary care and other basic needs, and also something around sharing military-to-military knowledge, and then lastly around maternal and child health and non-communicable diseases. I think I got all those. Who would like to start?

KATE ALMQUIST KNOFF: I can.

JEN KATES: Great.

KATE ALMQUIST KNOFF: I can make one or two comments, perhaps. In terms of rapid response in particularly fragile or conflict environments, I don't think it's as much a matter of a rapid response where we can come in and give a state capacity in that sense. While we can go in and set up clinics and deliver some services for some amount of time, eventually that capacity has to leave and something is either left behind or not, and the challenge of reforming institutions, building institutions if they haven't existed in a particular area, tying them back to a central government of some sort, it's quite complex and takes a lot of time and, I think, a high degree of sophistication in terms of the political economy of what's happening in a region. It's not just a matter of they don't know how to do health.

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I would recommend and encourage those who are interested in this, a colleague of mine at the Center for Global Development has been looking at Afghanistan in particular, and to contrasting aid projects that went, what we say on-budget in the development world, where they go through government country-owned systems, which is a desirable practice from a development standpoint in terms of building capacity and strengthening institutions as opposed to more what the PRTs and the quick rapid response set-up has done, where it goes in and we just deliver a project or a service more directly, you know "to local community".

In fact, there have been some really excellent health outcomes through a program with Johns Hopkins University and working with the Ministry of Public Health in Afghanistan in regions of the country that have the highest rates of poverty. Those that don't happen to be the same regions that have the most incidence of violence and attacks, and that's where you see more of our PRT and our US aid going overall and, in fact, we don't have good results and outcomes to show for that assistance.

There are some important questions and I think learning to draw from the research that's coming out of what has been effective in Afghanistan, how we can, in fact, even with a very challenging partner, a very weak partner in terms of a state

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capacity and legitimacy, we can still be more effective working through government systems than doing our aid directly in a tripartite interagency rapid response kind of situation, like a PRT.

I would just offer, secondly, on malnutrition and MCH and all of the other non-communicable disease challenges. By this logic, one could extend to that everything in the development field, every development need, is somehow a national security priority, and therefore DOD should be involved. I would just suggest that in interest it does not equal responsibility or capability or appropriate action for the Defense Department.

These may be important issues, but they're civilian challenges. This is where the line, I think, needs to somehow get drawn. In fact, of course, USAID and other development agencies of the US government do spend an immense amount of time and effort focusing on these challenges, and DOD's support for that and support for resources for that back here as Secretary Gates and so many others have been very prominent in arguing for I think is the appropriate way of engaging that interest in making sure that those needs are being met.

JEN KATES: Yes.

PETER J. WEINA: I can answer at least one of them regarding public/private partnerships. I think across the R&D,

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but I'll speak specifically about the Walter Reed Army Institute of Research. We have—and this is why I talk about an ecosystem. We have agreements that go across US government. Interagency agreements. We also have interactions with drug companies, vaccine companies. We have interactions with universities. We have interactions with, sometimes, with foreign governments as well so there is a tremendous web of interactions.

I actually chair an agreements review committee for the Institute of Research, and we may review anywhere from 10 to 20 different agreements every single week that we enter into relationships with. Some of these may be short-term, one-time type interactions for a project, but some of them may last for 10, 20 years and reach across all different spectrums, including the Gates Foundation, the Medicines for Malaria Venture, a variety of different public and private partnerships.

As far as interactions with our coalition partners on best practices, I know that this goes on all of the time. As a matter of fact, the Canadian Special Forces actually has reserved spot of three people every single—every three months for our tropical medicine course in which we get together with special forces medics that come and actually interact with us, learn about tropical medicine, talk about tropical medicine,

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and exchange ideas back and forth. The Canadians aren't the only ones that do that.

I guess lastly, just on issues other than—and development other than infectious diseases, I think it's fairly well-recognized that most of our tropical diseases, if you will, are linked to issues of poverty. That's really one of the things that we need to address, and that's clearly outside the lane of Department of Defense to address the poverty itself. I think that that's a strong piece of the puzzle, that we have to make sure that we're communicating with our partners all over the world in which we're working on this. The work that we're doing isn't going to be sustainable if there isn't addressing economic issues and things other than just infectious disease health issues as well.

JEN KATES: Yes.

RABIH TORBAY: I just want to address the issue of the partnership. I think a partnership between DOS, DOD, and USAID on the planning side of things is great, and it's needed, but when it comes to implementation we have to be very careful. There are a lot of issues.

It could work in a natural disaster setting or in a sudden onset emergency but we cannot, for example, talk the same way about India that we would talk about the Sahel, where there is an active counterinsurgency program going. NGOs, for

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example, that are the main implementing partners, NGOs and contractors and the main implementing partners for USAID cannot be seen engaged because it has serious security implications, not just in the Sahel.

We really need to realize that it has a global impact on us. If we get engaged in a measure like that in Mali, for example, trust me, when we're working in Libya or Iraq it is not easy for them to find out IMC is working closely with the DOD on an issue that is linked to counterinsurgency, for example, and we'll pay the price globally.

This is why we have to be really careful. Again, I don't want to come across as we would work with the DOD everywhere. We have to be very selective. We've got nothing against the work that DOD is doing, but we have a role to play in the emergency as well as in the development that's community-driven and we'll look at the sustainability. It's not driven by a specific objective.

JEN KATES: I think it speaks, too, to the mission difference that we've alluded to. Does anyone else want to—yes.

KATE ALMQUIST KNOFF: If I can just add on to that comment, because I think it's a really important point in terms of building trust. In fact, NGO partners, other implementing partners, contractors, UN development agencies and officials,

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humanitarian actors work in very ungoverned and poorly governed spaces, very insecure spaces, without having armed security around them because they have the trust of local communities and even, sometimes, of the insurgent actors who are part of the conflict situation. When they come under suspicion for calling in the air strikes in Somalia, for instance, were delivering a vaccine under the guise of collecting intelligence, then we do a huge disservice to the whole humanitarian and development endeavor worldwide.

Once you violate that trust, you don't get it back. It's this mixing of mandate and roles and responsibilities, because DOD's primary objective is to defend the interest and the security of the United States of America, and because it is the premier war-fighting machine in the world and it has been deployed very significantly in the last decade, it's very hard to take off that hat and to just be seen as we're here to help, when in fact you may not just be there to help. You may be there to gain access, build relationships, and many of DOD's own documents and policy guidance says that our primary purpose is to do that, not to build a health system or to promote economic development or to deliver humanitarian aid.

That's where we come into real problems in terms of, I think, using the best assets and capabilities in the right

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combination to achieve the broader objectives with the US government.

JEN KATES: Josh, just to put you on the spot on this a little bit because you and I have looked at this from the global health diplomacy perspective, and thinking about the new or emphasis by the US government on global health diplomacy and that pitfall as being one that we have flagged. Can you just talk a little bit about that?

JOSHUA MICHAUD: Well, certainly. Yes. When you're talking about linking any national interest, be they defense, national security, foreign policy interests, and the use of health engagement and health operation development work, whatever it might be, again it brings up this problem that we've referenced a number of times of are you actually working against your ultimate goal by doing that? There has to be great care taken in these, and I think there has been some learning from mistakes that have been made, but this is a continuing issue that the national security staff, the DOD, the State Department in general will have to consider. There's the Office of Global Health Diplomacy at State. They—Ambassador Goosby was here and he was talking about how that is something that they are concerned about and that they were going to be addressing going forward. I would assume the same would be true for the DOD.

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JEN KATES: Dr. Smith, did you want to...

DAVID J. SMITH: I totally agree. We know that there has to be careful consideration. There has been a lot of learning that has gone on, and I think that understanding those relationships and who has the strength and what makes the most sense in a particular environment is part of that learning.

JEN KATES: Okay. Let's go to three more questions.

JUDITH COFFMAN: Hi. I'm Judith Coffman [misspelled? 01:14:27] and I think this last discussion has been rich. It leads me to a question, which is whether a more formal, even if behind-the-scenes discussion, such as took place between interaction and DOD to set up some guidelines on how humanitarian organizations work with DOD might be appropriate, whether that is appropriate and useful to help set out some of those roles and responsibilities, discuss the lessons learned, draw the line, and do forward planning instead of having this sniping at each other that can sometimes occur in the moment.

JEN KATES: Thanks.

MAGGIE LINNICK: Thank you. My name is Maggie Linnick [misspelled? 01:15:15]. I work for the Senate Health Education Labor and Pensions Committee, and I have kind of a two-fold question about chronic diseases, one being that chronic diseases are what's keeping Americans out of military and what the addressing on that front is, and then the second is when-in

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PEPFAR briefings, we're starting to hear comments from people receiving services in other countries saying I wish I had HIV and not diabetes, because then I could get help. How do you see the chronic disease being the evolution of the burden of disease in the future?

JEN KATES: Just a few easy questions for the—one more?

ROBERT LOVELACE: My name is Robert Lovelace. I work with the Trade Union Sustained Development Unit, but I also was a consultant to the UNAIDS report on security resolution 1983. I'm wondering if you could comment about the US role in the implementation of 1983. Maybe go back to 1308 if you want to, but particularly with respect to the contribution that the United States makes. Now there's this concern about national security, where the line is, and so on, but the contribution that the US makes in terms of DDR and SSR is tremendously helpful in terms of democratization and the elimination of extremism, and I wonder if you could elaborate a bit on that.

JEN KATES: Okay. Who wants to start?

DAVID J. SMITH: Well, I can start with—I think it's an excellent idea to have those discussions between all the various organizations a priority before something actually occurs, and we've been sponsoring a number of symposiums with NGOs, the whole global development community to try to get more clarity in an area that we're never going to get absolute

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pristine clarity in. I would wholeheartedly endorse any of those discussions.

We're always looking for how we can do our work better, how each—and I think each organization feels the same way. There have been a number of those kinds of meetings, and I think their numbers are increasing. We're starting to put out—just yesterday she referred to a cable that sort of helps across the DOD, lining out what global health engagement means, what are our various approaches, some of the dos and don'ts, and I think there will be more of that as we continue to learn and evolve in that.

Relative to the chronic disease, we clearly understand, as was pointed out, for example, with our recruitment, the effects of chronic disease and are doing a fair amount of research that is relevant to our ability to maintain a force, recruit a force, et cetera, on chronic disease but most of that work, of course, is being done by other government agencies and the private sector. I think some of that work will be applicable to the developing world. As economic development increases, clearly infectious disease and other issues become less of the main cause, as everybody knows in the audience, and so chronic disease is clearly going to be a huge development issue as the world continues to become more prosperous. I

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certainly don't have the solutions, and I hope the world figures out what the solutions are to that.

RABIH TORBAY: On the guidelines, the interaction guidelines—actually, there are already published interaction guidelines that cover—at least that guide the civil military interaction in conflict and post-conflict setting. That was done, if I'm not mistaken, in 2006 or 2007. There is an interaction civ-mil working group that works with the DOD with the policy side of the DOD, as well as the different combat commands to actually advance it.

There has been a lot of improvements made, actually, through that interaction, both on the NGO behind-the-scene talking to the DOD to the different universes to the different combatant commands to try to find a way to understand each other. You'll never get an agreement across the board. From an NGO side of the world, we never agree on anything so there will always be sniping at each other with the DOD and USAID when they don't give us the funding. That's life. Alright, but if you look at where we were in 2003 and where we are now, it's night and day. There's still a lot of work that needs to be done. I'm not denying that, but at least we're having discussion. At least we're sitting down and saying okay, you know what, here's what you've done wrong. Here's how you can do it better, or stay out of our way in this one. We're trying

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to encourage more and more NGOs to actually engage, because there will be absolutely no way forward if we don't start respecting each other's mandates and understanding each other. That's the beginning.

On the chronic disease, you're singing to the choir here. I think chronic disease is a major, major issue as a health organization that we face in every country we work. When you look at the funding that goes for chronic diseases, it is very limited. I think there is more realization now that this is actually a problem of the 21st century and we need to tackle it, but when you look at the budgets that come to support that problem versus what is going to other activities, that is really, really minimal.

We're hoping that not just the US government—we try to focus on the US government quite a bit, but a lot of other donors all over the world. The European union, the FID [misspelled? 01:21:04], the Australians, the Canadians, actually will take the same interest in highlighting the chronic disease issues versus just the communicable diseases.

JEN KATES: Yes.

KATE ALMQUIST KNOFF: Maybe just to talk on a related comment in terms of PEPFAR versus chronic diseases or any other budget priority, just to give some color to this. In Africa, USAID programs are probably between 5, 6 billion dollars a

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year, just USAID. Not the State Department, not other development agencies. 60 to 70-percent of that is in health. USAID is a health agency in sub-Saharan Africa, and the vast majority of that is PEPFAR.

Now, clearly, we have made an extraordinary commitment to combating HIV/AIDS and we have had a profound impact because of that, but if you look at the needs of weak states, fragile states, poverty in Africa, the first thing we wouldn't have identified, again, is HIV/AIDS as the most critical challenge to those broader threats and problems that we see.

We face this even going from health to other non-health priorities as well, but in terms of interagency collaboration, I know there are USAID colleagues here who maybe could speak to current approaches and perspectives on, I think, the improvements since I've left the agency in terms of coordinating planning and strategies and trying to be more thoughtful and productive with each other.

JEN KATES: Okay. I think we have time for one more round, so if there are more questions out there—make them quick so we can...

MEGAN REED: I'm Megan Reed from the Institute of Medicine. I just had a comment—or a question about in the report I noticed you mentioned a recommendation for more evaluation in measuring of effectiveness of some of the efforts

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that DOD takes on and usually after disasters, so I wanted to know if you could talk a little bit more about what spurred that recommendation, where it came from, and then also, moving forward, any thoughts on how to address that need.

JEN KATES: Yes.

MELANA SULLIVAN: Hi. My name is Melana Sullivan [misspelled? 01:23:19] and I am a health consultant. I wanted to hear from you a little bit more on the division of resources for the needs of countries overseas and also our own population here, specifically with respect to pandemic preparedness, medical countermeasures. I know that those tend to be more of the HHS responsibility, BARDA, but how much does the DOD get involved with that, in view, for example, the avian influenza outbreak now that we're facing?

JEN KATES: Is there one other, or—okay.

JOSHUA MICHAUD: Can I...

JEN KATES: Yes.

JOSHUA MICHAUD: ...address the—the report, just to be clear, at the Kaiser Family Foundation we don't make recommendations, so there were no recommendations made for the DOD, but I see you pointing out that we address the fact that measures of effectiveness for health engagements in general and, in some case, in particular for the disaster response work on the actual impact of these and their link to DOD's own

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strategic objectives is an area that came up again and again. The GAO and others have released reports on this. That is an ongoing struggle I understand, and perhaps Dr. Smith can address this in more detail, but in the cable that was just published this is something that was addressed to some extent.

This is—the problem of measuring effectiveness is not isolated to just the DOD's work, of course. All of the efforts, particularly in a disaster situation, and we were just at the IOM and heard the discussion of this. It's challenging for any number of reasons for every organization that gets involved in these situations, and perhaps Bobby can talk about that as well, but just the situation itself doesn't lend itself to careful collection of information and analysis of that, but it is something that—at least there seems to be at least a guidance on this right now for people to follow going forward, which seems to be a good step in the right direction.

JEN KATES: Yes. Maybe on the pandemic preparedness piece?

PETER J. WEINA: I'd just like to address that briefly. When we talk about being prepared for pandemics or what may be, I think, considered emerging diseases, the problem is that, at least in my mind, that there's a thought process that, oh this is coming up and within a year we can produce a vaccine or within a year we can produce a medicine. The real problem, of

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course, is that the lag time from identifying that there's a problem to actually having something that's been thoroughly tested and approved can be as long as 10, 15, 20 years.

While we do know, for example, that we can very quickly turn around some of the—some vaccines because we've got some scaffold to hang them off of, the vast majority of responses to potential disasters is something that we have to have a very long view on and really look at way down the road. There's possibility of, example, malaria ending up here in the United States. We've got the mosquitoes, we've got a very susceptible population. All we need to do is have something happen. If we aren't working on something for these types of potential problems for 10, 15, 20 years, we're never going to be able to have real true preparedness.

I think that this is kind of the role of DOD. We work on diseases that the drug companies aren't going to make a profit off of, so very often they aren't working on them unless there's going to be the imminent potential for making money. Not that they're out to make money, it's just that they aren't going to be in business if they don't make money and they aren't going to work on it.

We work on the diseases that individuals are not necessarily going to be potentially working on because it's got such a long horizon out there, so that's, at least in my mind,

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one of the major contributions that DOD brings in emergency preparedness is working on these emerging diseases, recognizing these emerging diseases, having the surveillance out there and recognizing that the issues are a potential problem before they become disasters.

DAVID J. SMITH: I'll just add that, in addition, within the US government there is a very robust group that deals with biosecurity issues. We've been having meetings every week relative to what's emerging and preparedness for it. The DOD has its preparedness strategy, as does the rest of the federal government, vis a vis the whole nation, then that priority is primarily with HHS and BARDA, but there are an enormous number of groups that are continually meeting on this and trying to stay ahead of it. Then, it's the research, hopefully, that will keep us ahead of it.

To move back to the measures of effectiveness, the secretary had mentioned that we have a project going on now at our Uniformed Services University looking at if we can more analytically measure the effectiveness of interactions, and there is a retrospective piece of it to take our experience to date and what we can actually capture, and then it will be a prospective piece to this model development which, assuming success, I think will be—take us down the road to being able to more analytically look at the effect and hopefully better

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target resources that will be applicable to the entire development community, but we'll see. It's one of the holy grails, I think, of the development community so hopefully this will add to that knowledge base.

JEN KATES: Did you want to add...

JOSHUA MICHAUD: Just quickly on the pandemic preparedness. On area that we haven't focused heavily on, we mentioned in the report and discussed it, is threat reduction. This is mainly work through the Defense Threat Reduction Agency, for example, which supports, as we say, the prevention and preparedness for infectious disease events, whatever source they may come from.

In fact, the budget for the cooperative biological engagement program is run through DTRA was the single largest budget line that we identify in the report, and that goes to support laboratory strengthening, how to handle pathogens in other countries and has increasingly, I think, moved towards public health pandemic preparedness in addition to the biosecurity sort of origins of that effort. There are other efforts going on. There is the global emerging infectious disease system supported by the DOD, the Army, and the Navy as well, and—but they are working together, sometimes at odds, mainly together to try and support this type of work overseas.

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JEN KATES: Okay, so we are just about out of time, but I want to give everyone here an opportunity to very quickly, if you could think about the people—references, the last decade has really been a change in the dialogue and view about the role of the Department in global health and how it intersects with the rest of the USG effort at the NGO sector, et cetera, so in the next five years or so what are your words of wisdom or thoughts about where you could see things progressing?

My selfish interest in this is we're also looking at Kaiser to figure out where we can add some analytic value going forward and try to keep this discussion going, so I'm going to be listening to what people say and you may see it in a report coming out. Please, if anyone wants to offer—whether from your perspective or from the NGO perspective, or as you're developing new products and trying to tackle some of these challenges. Yes.

KATE ALMQUIST KNOFF: Okay, well I'll offer. I think the point that Dr. Hicks ended on in terms of the role of improving health and preventing or mitigating against fragility—state fragility, and, in fact, preventing failed states from happening. We really need to examine this much more seriously in terms of what is the empirical base for making that connection and what then can we draw in terms of programmatic and policy responses for that?

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JEN KATES: Thanks.

DAVID J. SMITH: I remain very optimistic that we will continue development of our relationships within government. We have clearly had issues with interagency coordination in the past. We've learned a lot of lessons, and I'm very excited about all of the developments that have occurred over the last few years and I see that developing. Also, all of the academic and other rigor that is being put into the ability to be able to measure the effect of what we're doing and where to target limited resources, I think, is a huge area of need for the community at large.

PETER J. WEINA: I guess all I would say is that we should keep doing what we're doing. I think that we've too quietly done things in the background for decades and have made significant contributions that I think the public in general thinks of those of us in uniform as carrying a weapon and having our helmets on and firing at people rather than the type of work that I think a significant portion of the DOD does, so I welcome things like this report that help bring out into the light the type of things that we're doing, although—certainly communication and talking to each other and visibility on what we're doing is great. I think that at least from our perspective—from my perspective of military medical, especially R&D and the types of outreach that we have with our partners

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around the world is just to keep doing what we're doing and to continue doing that work.

RABIH TORBAY: I think we're facing new challenges and threats every day these days that we haven't even started to talk about. We discussed some of them here. Some of them we definitely did not discuss at all. I think if we focus on discussing those challenges and joint preparedness and planning together, whether we end up working together or not, it doesn't matter. I think if we focus on that and we acknowledge that we are actually in the 21st century and we cannot continue doing business the same way we've done business in 19th and 20th century, completely separate, I think there's a lot of ground that we could cover together and we can tackle some of those challenges.

JEN KATES: Josh, you get the last word.

JOSHUA MICHAUD: Oh, thank you. I'll also be quick. I'd say there's probably a set of things that internally DOD hopefully will continue to work on. We've mentioned some of those things. I won't reiterate them and they've already been mentioned here in these last comments, but one thing is that we heard that there was a need to support sort of a career path for people within the department and the different services who might be interested in working this area.

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If there is an increased emphasis on this work going forward, as there seems to be, that would seem to be something that would be of importance to support people who are interested in working this from the Department itself, making sure that they get the training and sort of the opportunities to work both interagency and with other organizations, non-government organizations as well, and then outside the DOD, also this interagency work as well in general and making sure that there is cognizance of where that line that we talked about should be.

It's situation-dependent and definitely a lot of factors working into it, but be cognizant of where the health engagement is helpful and where the DOD should be on first or second or in the background on these types of things.

JEN KATES: Thanks, and thanks to all of you. I'm sure you'll agree that this was a very rich discussion. Thank you for giving your time and your thoughts. Please join me in thanking all of our panelists.

Let's see—turn this...

MALE SPEAKER: We just commissioned a work group to actually try to tackle...

[END RECORDING]

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