

**APPLYING LESSONS LEARNED FROM THE MARSHALL PLAN TO THE  
PUBLIC HEALTH MISSION OF U.S. AFRICA COMMAND:  
A COMPARATIVE ANALYSIS**

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## *Executive Summary*

U.S. Africa Command is the newest American combatant command and was fully activated in October, 2008. It was designed to be a new type of command focusing on war prevention rather than war-fighting by incorporating health as a bridge towards security. To accomplish its mission, Africa Command will work in concert with other U.S. government agencies and international partners. It will conduct sustained security engagement through military-to-military programs to promote a stable and secure African environment. Analysis has shown that root causes of conflict and instability in developing nations include inadequate health care and lack of public health infrastructure.

As Africa Command is formulating its long term mission and goals, it may be able to incorporate lessons learned from other American foreign endeavors. The purpose of this project is to examine the similarities and differences that exist between the post-World War II Marshall Plan and today's humanitarian, stability-building, and non-combat focus of Africa Command. Previous lessons learned from the Marshall Plan that can be applied to Africa Command are then extracted.

Africa Command has the potential to have a significant impact on global public health. Health as a Bridge for Peace, a major mission of Africa Command, has been accepted by the World Health Assembly. It is defined as the integration of peace-building concerns into health relief and health sector development. Collaboration between U.S. Africa Command and local African military forces provides an opportunity both to expand U.S. knowledge of emerging diseases and improve the local African

health systems. Military-to-military and military-to-civilian partnerships support ministers of health in obtaining laboratory, epidemiological, and logistical resources.

A qualitative research approach was employed. An exhaustive literature and factor analysis for both Africa Command and the Marshall Plan was performed utilizing PUBMED, Google Scholar, published academic reviews, textbooks, and U.S. government document databases. Additionally, the Proceedings of the Africa Command Health Symposium were analyzed for current mission objectives within Africa Command to identify projects, strategies, and future plans. These were then compared with the historical approaches used by the Marshall Plan administrators. Similarities and differences were comparatively analyzed and trends sought out and documented.

The analysis revealed many similarities and differences between the missions and challenges of Africa Command and the Marshall Plan. Based on lessons learned from the Marshall Plan, key recommendations for Africa Command included enabling African government partners to be perceived as legitimate and maintaining clear program objectives. The U.S. and AFRICOM should be transparent regarding their motives and work to change the perception of a purely destructive U.S. military. Africa Command should be staffed with effective leaders and subject matter experts. It will also require ongoing Presidential, Congressional, and public support to meet its mission. Africa Command should avoid preferential relationships with specific nations and ensure that African nations retain their identity, independence, and dignity. African nations must plan and take ownership of their development programs to ensure sustainability. Since Africa is much larger and more culturally diverse than Europe, Africa Command should not pursue a single health and security program for the entire continent.

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## ***Introduction/Background***

The Marshall Plan has been hailed as one of the United States' greatest foreign policy achievements (Kunz, 1997). In the year following the end of World War II, calorie consumption and agriculture production in Europe were actually below *prewar* levels (Mills, 2008). The Marshall Plan subsequently increased industrial production by 64%, doubled steel production, increased food production by 24%, and saved many from starvation. Many subsequent programs have been compared to it by politicians and historians. Most recently in 2003, the Bush Administration described the rebuilding effort in Iraq as the greatest financial commitment of its kind since the Marshall Plan. However, the success of the Marshall Plan was due to more than just the money spent. As many current national and international crises demonstrate, throwing money at a problem doesn't always solve it. Was it the Marshall Plan's money that saved Europe? Many scholars don't think so because Marshall aid only averaged about 2.5% of the recipients' total national incomes (Mills, 2008).

The African continent is challenged by poverty, a lack of infrastructure, civil unrest, disease, and poor health care systems. Does Africa need a new Marshall-like plan? It has already been the recipient of several Marshall Plans worth of foreign aid over the past 60 years, but still remains as impoverished today as it was in 1946 (McFate, 2008). However, I propose that the strategies and tactics employed by the Marshall Planners laid the foundation of what would become known as "capacity building," which is essential for new American endeavors such as U.S. Africa Command.

The newly established United States Africa Command (AFRICOM) intends to incorporate health as a bridge towards security. AFRICOM was declared a fully unified command on October 1, 2008. Africa had previously been divided between three combatant commands, European Command, Pacific Command, and Central Command (Ploch, 2007). It was designed to be a “different kind of command” focusing on war prevention rather than war-fighting (AFRICOM, 2008a; Hanson, 2007). Over half the personnel assigned to AFRICOM are civilians, including representatives from non-military U.S. government agencies. Africa Command’s mission is to work in concert with other U.S. government agencies and international partners. It will conduct sustained security engagement through military-to-military programs to promote a stable and secure African environment in support of U.S. foreign policy (AFRICOM, 2008a).

Unlike other combatant commands, AFRICOM has two Deputy Commanders; one for military operations and one for civil-military activities. The current Deputy to the Commander for Civil-Military Activities is a State Department Ambassador (AFRICOM, 2008b). Having this high ranking civilian with diplomatic credentials within the command should facilitate collaboration with traditional humanitarian/development aid stakeholders, such as non-governmental organizations (NGOs). The intention of this new command is to increase security on the African continent through an integrated and coordinated approach. There is a reflexive relationship between public health, civil security, and economics. Improvements in one of these areas generally help the status of the others.

Deficiencies in transnational governance have created a global public health crisis. The United States has an opportunity to create a new role for itself by

strengthening its soft power position in health. Health is no longer just a humanitarian issue, but rather a major economic and security issue (Kickbusch, 2002). In 2005, a Department of Defense (DoD) directive defined “stability operations” as a “core U.S. military mission” with a “priority comparable to combat operations.” This required the DoD to expand from its traditional war-fighting mission to one that includes preventing or mitigating collapse of failing nations (Carreau, 2007; Reaves, Schor, & Burkle, 2008a; U.S. Department of Defense, 2005).

Analysis has shown that root causes of conflict and instability in developing nations include inadequate health care and lack of public health infrastructure (Bonventre, 2006). As Jeffrey Sachs, director of the Commission on Macroeconomics and Health of the WHO, has said, “U.S. security requires that the world’s impoverished children be fed, educated and given health care (Jeffrey D Sachs, 2001; J. D. Sachs & McArthur, 2005). As a result, the Department of Defense is now responsible for about 22% of total U.S. overseas development assistance expenditures (Center for Strategic & International Studies, 2008; Patrick & Brown, 2007). A RAND analysis concluded that missions with health care components were important for nation-building, but that most academic and policy work had been done on police and military forces, not public health or health care delivery systems (Jones, et al., 2006). There is a need to more critically study how improved security may improve public health indices, and vice-versa (Reaves, Schor, & Burkle, 2008b).

As the new Africa Command engages with other countries’ medical systems, there may be lessons from past U.S stability-building programs elsewhere that could be incorporated into its current mission. U.S. Ambassador Susan McCaw once called the

Marshall Plan the plan that tied together the destinies of Europe and America. She noted that it was an investment in the future security and stability of Europe, the United States, and the world (McCaw, 2007). Greg Behrman wrote, “Its apparent contradictions and the enormity of its scope and ambition notwithstanding – in fact, in large part because of these things – the Marshall Plan would become one of the most successful foreign policy enterprises in the annals of U.S. history.” (Behrman, 2007) In many ways, Africa presents a similar opportunity now.

The approach taken by George Marshall and the State Department he led after World War II may yield productive results today as AFRICOM collaborates with African nations. Marshall said in his Harvard commencement address, “Our policy is directed not against any country or doctrine but against hunger, poverty, desperation and chaos” (Marshall, 1947). Could there be a better description of the challenges facing Africa today?

### ***Public Health Significance***

Africa has many ongoing public health challenges to include basic sanitation, vector borne diseases, HIV/AIDS, and a lack of healthcare infrastructure. It has been described as being at a crossroads where its healthcare workforce is rapidly depleting and its health systems are weak, fragile, and hanging on a precipice (Dare & Buch, 2005). One in six African children die before reaching the age of 5 and a woman dies every 2 minutes from complications of pregnancy and delivery (Unicef, 2005). Africa has had many recent initiatives to improve health indicators such as the U.S. President's

Emergency Plan for AIDS Relief (PEPFAR), the Millennium Development Goals, and investment from private philanthropic entities like the Gates Foundation.

Unfortunately, the African continent continues to face significant health challenges. It has become clear that the Millennium Goals agreed upon by the United Nations in 2000 will not be met within the established timelines (Lee, Walt, & Haines, 2004). Perhaps it is time to take a more organized and broader approach in addressing Africa's health problems.

With globalization, every communicable disease is now potentially only an airplane trip away from any of us. It is imperative that surveillance programs be as robust as possible. Collaboration between U.S. Africa Command and local African military forces provides an opportunity both to expand U.S. knowledge of emerging diseases and improve the local African health systems. Military-to-military and military-to-civilian partnerships support ministers of health in obtaining laboratory, epidemiological, and logistical resources (Chretien, et al., 2007; Pellerin, 2008).

Direct health-related strategic threats to the United States include infectious diseases such as pandemic influenza. However, chronic diseases, maternal and child mortality, sanitation, malnutrition, and access to basic health care also affect U.S. national interests due to their impacts on key countries' economies, governments, and militaries (National Intelligence Council, 2008). Health as a Bridge for Peace, a major mission of Africa Command, was formally accepted by the 51st World Health Assembly in May 1998. It has been defined as the integration of peace-building concerns, concepts, principles, strategies and practices into health relief and health sector development (WHO, 2009).

### *Purpose of Study/Specific Aims*

Africa Command is currently in the process of determining how it can best utilize its resources to support and encourage peace and stability on the African continent. Public health programs and medical professional training initiatives, requiring collaboration between various stakeholders, will be critical for Africa Command's mission to succeed. I intend to examine the similarities and differences that exist between the post-World War II Marshall Plan and today's humanitarian, stability-building, and non-combat focus of Africa Command. Are there previous lessons learned from the Marshall Plan that can be applied to the coordination and execution of humanitarian and public health missions within Africa Command?

### *Methods*

A qualitative research approach was employed. An exhaustive literature analysis that utilized PUBMED, Google Scholar, unclassified U.S. government document databases, and Africa Command's web pages was performed. Current AFRICOM mission objectives and processes were documented and evaluated.

The Africa Command Health Symposium: Health as a Bridge to Peace and Stability was conducted January 8-9, 2009 at the National Academy of Sciences in Washington, DC. The symposium was sponsored by the Office of the Assistant Secretary of Defense for Health Affairs and was convened for the Office of the

Command Surgeon, U.S. Africa Command, which is specifically focused on using health as a bridge to peace and stability.

There was representation present at the Africa Health Symposium from senior international experts, non-governmental agencies, U.S. military, World Bank, the African Union, U.S. State Department, U.S. Agency for International Development (USAID), and the U.S. Health Attaché to the African Union (Martin & Olageshin, 2009). Over 200 people from around the world registered for the conference, and it was well attended. The symposium provided an opportunity for Africa Command stakeholders to network and learn about other participants' perspectives and projects. The Proceedings of this symposium were analyzed to identify current projects, strategies, and future plans within Africa Command and then compared with the approach used by the Marshall Plan administrators.

A literature review of the Marshall Plan was undertaken utilizing historical government documents, published academic reviews, journal articles, and textbooks. A factor analysis of key components, to include approaches, experiences, and policies of the Marshall Plan, were then compared to the current plans of Africa Command. Similarities and differences were comparatively analyzed and key factors were mapped to proposed recommendations for Africa Command.

This research project involved no human subjects, animals, personal information, previously collected privileged data, or radiologic/biologic safety hazards. A Uniformed Services University of the Health Sciences form 3202, student and resident physician research proposal, was submitted and endorsed with final Institutional Review Board approval granted on March 20, 2009.

*Results*

**Table 1: Lessons learned during Marshall Plan that may be applied to Africa Command**

<p>AFRICOM should enable African government partners to be perceived as legitimate, which requires the ability to provide health care to their population</p> <p>Objectives for AFRICOM programs should be clear</p> <p>The U.S. and AFRICOM should be transparent regarding their motives</p> <p>AFRICOM needs to change perception of a “kill people and break things” U.S. military</p> <p>AFRICOM should be staffed with effective leaders and subject matter experts</p> <p>AFRICOM will require ongoing Presidential, Congressional, and public support to meet its mission</p> <p>Building and improving African infrastructure will be essential for the development and delivery of public health care</p> <p>AFRICOM needs to augment the deficiencies of current UN/WHO and NGO development programs without compromising the credibility and mission of these international partners and stakeholders</p> <p>AFRICOM should avoid perceived preferential relationships with only certain African nations</p> <p>Ensure African nations retain their identity, independence, and dignity</p> <p>African nations must plan and take ownership of their development programs to ensure sustainability</p> <p>Africa is much larger and more culturally diverse than Europe. AFRICOM should not pursue a single health and security program for the entire continent</p>
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## *Goals and Objectives*

The Marshall Plan needed to stabilize a volatile geographic region, and Africa Command will need to perform a similar mission in the future. Post World War II Europe was economically vulnerable and government systems needed to re-establish credibility with their populations. Some blamed capitalism for the financial crisis of the Great Depression, which was widely seen as contributing to the tensions that resulted in World War II hostilities. The Communist Party was successfully using this line of logic to influence governments' choice of ideologies by offering the suffering masses equality, food, dignity, and peace (Behrman, 2007). Secretary of State Robert Lansing said, "Empty stomachs mean Bolsheviks." Capitalism needed to regain its legitimacy by improving the economic and social situation of the population.

Today, African governments are in a similar situation. The ability to provide health care and other basic services is viewed as a measure of a government's legitimacy. When there is a health care void, non-state actors such as terrorists have gained influence by providing services that formal governments have failed to deliver (National Intelligence Council, 2008). If Africa Command can provide training and support that enables governments to improve health care systems within Africa, thereby legitimizing the host government, it will help stabilize the region.

It is important to have clear and well defined objectives to succeed in the type of capacity building that may improve public health in Africa (Drifmeyer & Llewellyn, 2004). Marshall stated in his Harvard address that "assistance must not be on a piecemeal basis...Any assistance that this Government may render in the future should

provide a cure rather than a palliative.” (Marshall, 1947) Marshall recognized that the key to European recovery was self-sustainability. Of note, the Marshall Plan did not provide a specific blueprint on how to achieve the ultimate objective, European recovery. It was really more of a suggestion than a plan. Behrman writes, “The speech had painted broad strokes, but nevertheless, it contained an objective (European recovery), a time line (three to four years) for getting there, the means (aid, structural economic reform and European initiative) for achieving it and an expression of resolve and willingness to meet the commitment.” (Behrman, 2007)

Another goal within Africa Command should be to avoid negatively affecting current programs on the continent. The AFRICOM Commander’s Guiding Principles already include: “Do no harm... The command will seek support, but not disrupt or confuse, ongoing U.S. government, international, and nongovernmental efforts in Africa.” (AFRICOM, 2008a)

### *Perceptions of United States’ Motivations*

Both the Marshall Plan and Africa Commands’ motivations and intents have been questioned. Overcoming the perceptions of secondary gain have been challenges to both entities. French Communists warned that the Marshall Plan was a Trojan horse for American imperialism (Behrman, 2007). Marshall countered these types of concerns in a letter to Senator Arthur Vandenberg saying, “We should make it clear that it is not our purpose to impose upon the people of Europe any particular form of political or economic

association. The future organization of Europe must be determined by the peoples of Europe.” (Mills, 2008)

Africa Command has faced much skepticism and criticism as well. Some believe this distrust is justified given the predominately offensive military operations conducted in Algeria and Somalia since September 11<sup>th</sup>. There is fear that America is hiding militarism in the guise of humanitarianism. In order for Africa Command to be successful in its public health endeavors, it must divorce itself from offensive military engagements (Berschinski, 2007). Overall, Africa Command will need to change the perception that all the U.S. military does is “kill people and break things” (Munson, 2008). Africa Command’s activities must also not be viewed as simply competitive “political warfare” with other nations such as China for natural resources and regional influence (Chau, 2007; Walker, 2008).

### *Leadership*

Leadership was critical to the Marshall Plan’s success and Africa Command should place internationally well-known and respected subject matter experts on its staff. Marshall’s personality and abilities are legendary. In 1939 at the recommendation of General Pershing, President Roosevelt passed over 34 other senior Army generals when he chose then Brigadier General Marshall as the Chief of Staff of the U.S. Army. Marshall inherited an Army of less than 200,000 that was ranked nineteenth in the world. He accepted the post on the condition that he would have the right to tell President Roosevelt exactly what he thought at all times (Behrman, 2007).

As Secretary of State, Marshall surrounded himself with exceptionally talented people who were among the best in fields such as economics, diplomacy, logistics, and business. He was apolitical; saying, “I have never voted, my father was a democrat, my mother a republican, and I am an Episcopalian.” (Mills, 2008) Africa Command now has a four-star General leading it with an Ambassador overseeing civil-military activities. Africa Command must recruit our Nation’s top subject matter experts in the fields of development, economics, cultural anthropology, and public health to be successful.

### *Resistance to Increased U.S. International Commitments*

In 1945, there was little support for new foreign burdens or commitments with Assistant Secretary of State Dean Acheson telling an audience: “I can state in three sentences what the ‘popular’ attitude is towards foreign policy today: 1. Bring the boys home; 2. Don’t be a Santa Claus; 3. Don’t be pushed around.”(Behrman, 2007) Africa Command faces similar challenges today with the U.S. military still engaged on 2 active war-fronts and the Nation involved with multiple other national and international crises.

Africa Command will require ongoing support from the U.S. President and Secretary of Defense to remain a credible and empowered organization (Morrison, 2007). It will also require funding from Congress for its various initiatives. This could be a hard sell in these difficult economic times. The Marshall Plan had similar challenges, but found support increased after members of Congress saw Europe first hand. From August to November of 1947, over 200 congressmen, including Richard Nixon and John Kennedy, went to Europe to investigate for themselves the need and viability of

Marshall's proposal (Behrman, 2007). Engaging today's congress members to see the challenges and potential facing Africa may have a similar effect on increasing support for capacity building.

### *Disruptions of Society and Infrastructure*

Lack of infrastructure is a challenge shared by both post-WWII Europe and today's Africa. In 1945, more than 50 percent of the housing in major European cities was destroyed. Additionally, thousands of bridges, tens of thousands of kilometers of railroads, and many merchant ships had been decimated. In short, it was almost impossible to transport goods throughout Europe (Behrman, 2007). Africa suffers from similar infrastructure challenges today in regards to lack of roads, running water, sewage systems, and medical facilities.

Both groups have also suffered enormous loss of life. As of V-E Day, the workforce of Europe had been decreased by 36.5 million people as a result of war-related deaths and there were about 20 million displaced persons. It is estimated that more people faced starvation in the first year following 'victory' than had faced it in all the war years combined (Behrman, 2007). Africa has tragically lost many of its most productive workers as well to HIV/AIDS, malaria, diarrhea diseases, and civil-strife related violence. Public health initiatives to decrease transmission of these infections along with better access to medications for treatment are imperative. Continuing efforts to re-settle internally displaced persons is also important for the mitigation of disease transmission and overall improvement of public health.

## *Modification of International Organizations*

There are parallels between the international bureaucratic organizations of the 1940s and today. The United Nations Relief and Rehabilitation Administration (UNRRA) was established in 1943 to provide humanitarian assistance to those suffering because of the war. UNRRA likely prevented famine during the war, but became dysfunctional by 1946. The United States provided 75% of the funding to UNRRA, but only had 1 out of the 17 votes. As a result, two-thirds of the aid was going to eastern and central Europe and the U.S. had no way to increase aid to western countries. The U.S. had spent \$10 billion on Europe and it wasn't working (Behrman, 2007).

Many United Nations / World Health Organization programs have been met with similar frustrations. Many of the donor funded health programs in Africa today are inefficient, unproductive, and corrupt. Even with the correction of these flaws, the World Health Organization believes that Africa will require the rest of this century to wean off donor funding (Kirigia & Diarra-Nama, 2008). The Marshall Plan responded to UNRRA's limitations in Europe in a way that some would now like to see Africa Command respond to the shortcomings of past UN/WHO programs in Africa. The Marshall Plan, with its political influence, money, and few involved nations, was able to compel Europeans to cooperate and compromise on a consolidated rebuilding plan. Given the complexity, diversity, and history of the African continent, I don't think it will be possible for Africa Command to influence other nations and international organizations to the same extent. It is not realistic, nor appropriate, for it to supplant the UN/WHO, NGOs, or other international aid/development programs.

### *Politics of Dealing with Recipient Nations*

It is essential that Africa Command treat African nations equally and resist the temptation to establish preferential relationships with specific nations. William Clayton, the U.S. Undersecretary of State for Economic Affairs was approached by Ernest Bevin, Marshall's British counterpart, who sought a "special" privileged partnership with the United States. Clayton resisted and explained that Europe's problems would be dealt with in a holistic manner without preferential partnerships (Behrman, 2007). He knew that the perception of England getting special treatment would undermine America's credibility with the other European nations. Africa Command must also now be sensitive to any perceptions of playing favorites among African nations.

Africa Command should strive to maintain a small footprint. The Marshall Planners were sometimes seen as 'Americanizing' Europe, and while Europeans needed the aid, they were also sometimes humiliated by it (Behrman, 2007). Africa Command must be sensitive to the need for African nations to preserve their own dignity and independence. Many African nations have publicly said they do not want to host the new command and the U.S. has made no official requests (Delevingne, 2008). Having the Headquarters remain in Germany is a good idea and also prevents the perception among other African nations of there being a "favored" nation.

## *Need for Autonomy*

Autonomy is one of the greatest requirements for success. As Behrman wrote, “If integration was to work, and if recovery was to be sustainable, Europeans needed to assume responsibility for their own affairs, and they needed, a controlling voice in the determination of their future.” (Behrman, 2007) Marshall in his Harvard address said, “It would be neither fitting nor efficacious to draw up unilaterally a program designed to place Europe on its feet economically. This is the business of Europeans.” (Marshall, 1947)

Africa Command must recognize its limits in helping all nations. As George Kennan, the head of the State Department’s Policy Planning Staff, said, “With the best of will, the American people cannot really help those who are not willing to help themselves... What America should do instead of taking charge is provide ‘friendly aid’.” (Mills, 2008) The problem with many previous aid programs to Africa is their lack of sustainability. In other words, people have been given fish instead of being taught to fish for themselves. A central principle within the proposed AFRICOM military-to-military programs is the concept of training the trainer. In addition to Americans merely using our own labs to diagnose malaria, we need to train African personnel on how to prepare and read their own blood smears. Perhaps even more important than the technical aspects of public health provision, we need to help African nations establish functional health care systems which the local government can take credit for. This goes back to legitimizing the government.

## *Challenges of Regional Logistics*

The U.S. approach to rebuilding Europe centered on a consolidated plan that required the various individual nations to work together in concert. The Marshall Plan recognized that for individual countries to succeed, Europe as a whole had to cooperate as a functional unit (Johnson, 2002). Since economies, infectious diseases, transportation, and political stability do not respect national boundaries, one must apply regional solutions to problems. In his Harvard address, Marshall said, “The program should be a joint one, agreed to by a number, if not all European nations...The initiative, I think, must come from Europe” (Marshall, 1947) Much as the Committee of European Economic Cooperation (CEEC) was established to get all the post-WWII nation stakeholders on the same page regarding recovery priorities, Africa Command needs to assure consensus within an organization such as the African Union. African nations must collectively and proactively determine which priorities they want to address on their continent and then bring these to Africa Command for consideration.

One very significant difference between the Marshall nations and the African nations is their numbers. There were only 16 countries involved in the Marshall Plan as compared to 52 African nations within Africa Command’s area of responsibility (AOR). This AOR contains almost 3,000 culturally distinct groups, over 2,000 different languages, and various religious and animist traditions (Mbiti, 1989). It will not be possible to pursue a one size fits all plan for the health and security needs of the entire African continent. Programs should be targeted initially towards specific nations or local regions with similar cultures when possible.

Africa Command should also consider working with non-traditional partners and stakeholders that may bring additional insight into local operations. The inclusion of Islamic NGOs as partners has been suggested to defuse potential insurgent exploitation and provide cultural insight when dealing with Muslim nations, which comprise one-third of the total African nations (Berschinski, 2007).

### *Discussion*

By the end of 1946, the U.S. had already spent at least \$10 billion aiding Europe and it wasn't working. The United Nations Relief and Rehabilitation Administration was widely seen as ineffective (Behrman, 2007). There is similar frustration with the progress of current African humanitarian programs. Is there a better way to manage humanitarian assistance programs? The Marshall Plan required Europeans to take the initiative and assume responsibility for drafting the economic recovery program. It was founded on the principle of self-help and provided "friendly aid" (Hogan, 1997).

Africa Command will focus on "training the trainer" and collaborating with nations, as opposed to dictating policy. Self-sustainability is the goal of AFRICOM's public health programs and it may learn much from the past experience of the Marshall Plan. Some believe that the Marshall Plan's greatest tool was not its money, but its ability to alter the environment in which economic policy was made (De Long & Eichengreen, 1991). Africa Command must take this same sort of broad approach.

Africa Command represents a new type of combatant command in which civilian inter-agencies work side by side. Not everyone thinks this is a good idea. There has

been concern among members of the State Department that inter-agency integration within combatant commands will not provide their civilians the “required leadership, authorities, funding or coordination needed to develop a robust operational and regional capacity and capability.” (Monroe, 2008) The realization of successful and productive Africa Command will require a lot of patience on the part of all stakeholders.

Can countries be grouped regionally? The Marshall Plan countries were not ideologically or economically identical. In fact several had just finished fighting a war against one another. Is it possible to bring together previously (or currently) warring nations through health initiatives? I believe so. If individual nations are brought together as stakeholders in a regional problem, such as malaria, diarrhea, or HIV/AIDS, it can provide regional stability which leads to peace for those individual nations.

Paul Hoffman, the head of the Economic Cooperation Administration that oversaw the implementation of the Marshall Plan, coined the term “the multiplier effect.” He described how one could buy several hundred dollars worth of metal, and through manufacturing, turn it into a \$2000 car. However, one had to have the metal first (Behrman, 2007). Africa is in a situation where it has the metal (natural resources and people), but doesn’t have the trained skills to harness the full potential of its environment. If Africa Command can provide military-to-military training in the basics of security, public health practices, and promote capacity building, their investment will likely be multiplied several-fold.

In respect to current challenges facing the United States, Nicolaus Mills writes, “We face, as the Marshall Planners did not in their dealings with Western Europe, the challenge of intervening in countries in which ethnic strife is high, democratic traditions

are few, and America's presence is a source of suspicion (Mills, 2008). It is important to remember that Africa is not post-WWII Europe. We can not just superimpose the Marshall template onto the African continent. However, I do believe that there are specific lessons from the Marshall Plan that can be extrapolated to our approach to African health initiatives and stability operations.

Should the U.S. military be engaged in promoting peace and humanitarianism in the first place? This paradox was noted by Marshall himself as he was receiving the Nobel Peace Prize in 1953. He said, "I am afraid this does not seem as remarkable to me as it quite evidently appears to others. I know a great deal of the horrors and tragedies of war." (Marshall, 1953). Given its recent combat experiences, the U.S. military may possess more empathy towards victims of conflict than is readily apparent. The U.S. military also brings a logistical capability that is unmatched by any civilian organization.

There are potential vulnerabilities to the humanitarian programs and funding within Africa Command that could be similar to the Marshall Plan. The Marshall Plan effectively ended when the Korean War started. Three days after Chinese troops entered the fighting in Korea, Congress slashed \$208 million from the Marshall Plan's budget and increased military spending in Europe by \$4 billion. U.S. interest in full European economic recovery was now replaced by the desire to rearm it against a potential Communist invasion (Mills, 2008). The Marshall Plan originally had the benefit of standing up during a time of relative peace, during which the United States did not have any other international military or economic liabilities. The post-war U.S. domestic economy was also booming. This is not the case for Africa Command. The current global economy is in at least a recession and the U.S. is engaged in two separate and

costly wars. To say that Africa Command will be competing for already scarce military personnel, State Department personnel, Congressional funding, and public attention is an understatement.

### *Conclusions*

Africa Command's greatest potential for improving the health status on the African continent is rooted not in band-aids or numbers of vaccinations, but rather in improving health systems through military-to-military interactions. It must strive to develop relationships and programs that are sustainable without indefinite U.S. support and financing. The key to establishing sustainable programs is through capacity building. Capacity needs to be established concurrently in multiple key areas to include physical security, sanitation, food security, and health services.

The factor analysis and recommendation mapping techniques used in this study have several strengths and weaknesses. These qualitative methods enabled a comparative analysis between two historically different organizations that would not have been possible using quantitative techniques. Africa Command is a new organization without significant data available regarding their ongoing initiatives. A limitation of this study is that I had to analyze Africa Command's intended future plans as opposed to what they have already done. The strength of this study is that it allows current members of Africa Command to identify previous lessons learned during the Marshall Plan that are applicable today. Additionally, the majority of recommendations will not cost any money to enact. A future application of this project would be to investigate how many of

the current and future planned Africa Command programs are congruent with the results and recommendations of this study.

While testifying before the House Foreign Affairs Committee in support of his plan, George Marshall argued that if the program was not fully funded, he predicted “economic distress so intense, social discontent so violent, political confusion so widespread, and hope of the future so shattered,” that “the vacuum which war created in Western Europe will be filled by forces of which wars are made.” (Behrman, 2007). Marshall latter put it this way, “Democratic principles do not flourish on empty stomachs.” (Mills, 2008) Africa is full of potential today, both good and bad. Is it going to be a triumph of inter-agency cooperation that raises the social and health standards of the African people, or is it going to deteriorate into worsening despair where extremist groups find their next recruits? The choice is ours.

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*Appendix A – IRB Notice of Project Approval*

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**Notice of Project Approval**  
**Change Number: One (1)**

**Project Number:** T087X8-01-01  
**Principal Investigator:** Martin J. Joseph  
**Department:** PMB-Preventive Medicine and Biometrics  
**Project Type:** USUHS – IRB Tracking  
**Project Title:** “Applying Lessons Learned from the Marshall Plan to the Public Health Mission of Africa Command: A Comparative Analysis”

**Project Period:** 3/01/2009- 06/30/2009

**Assurance and Progress Report Information:**

<u>Name</u>	<u>Sup</u>	<u>Approval Type</u>	<u>Status</u>	<u>Approved On</u>	<u>Forms Rcvd</u>
Progress Rpt	0	Final	Completion of the study		N/A

**Remarks:**

This Notice of Project Approval represents an administrative change from 03/01/2008 to 03/01/2009. The final report should be submitted to the Office of Research upon completion of this project.

Questions regarding this approval should be directed to Sharon McIver at (301) 295-9814 in the Office of Research.

  
for Steven G. Kaminsky 3/20/09  
Vice President for Research  
Uniformed Services University of the Health Sciences

cc: Dr. Tomoko I. Hooper  
COL. Michael J. Ainscough  
Gibbons Mary Kay