
Can We Build a Better Medical Civic Assistance Program? Making the Most of Medical Humanitarian Civic Assistance Funding

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Medical Civic Assistance Programs (MEDCAPs) or also known as Medical Readiness Training Exercises (MEDRETES) are one way that the military health services contribute to the theater security plan. MEDCAP funding is primarily through the Humanitarian Civic Assistance (HCA) program which is authorized by Title 10 Section 401 of the United States Code. According to the U.S. Code, HCA goals are:

- Promote the security of the host nation and the United States
- Enhance readiness skills of the members of U.S. military medics¹

The most common MEDCAP mission provides short-term medical care to a rural population in a developing country². Under this model, a U.S. military medical unit will deploy to a pre-determined location and set up a clinic in schools, community centers, local health facilities or tents and provide rapid triage, medical and dental care to as many patients as possible. After spending a day or two in one community, the MEDCAP will move on to another pre-determined site and repeat the process. It is important to note that some MEDCAPS are surgical in nature, for example, providing reconstructive or cataract surgery to local populations. This paper does not address these surgical MEDCAPS.

MEDCAPs are a convenient tool for military medical units to practice deployment to a developing country.³ They are also a means for engagement with host nation militaries and underserved civilian populations. In SOUTHCOM alone, there are from 60-70 MEDCAPs annually.⁴ In a typical two week mission, several thousand patients will receive medical care. While a few of these patients may be treated for life-threatening conditions, the vast majority are either healthy or have chronic medical conditions that cannot be addressed by a one-time clinic visit.

Is There Room to Improve Medical Humanitarian Civic Assistance Programs?

One problem with MEDCAPs is a lack of data that objectively demonstrate benefit. Objective outcome data; commonly referred to as Measures of Effectiveness (MOEs), is lacking from both host nation benefit and military training standpoints. After Action Reports (AARs) are the primary information source about MEDCAP outcomes. Unfortunately, AARs focus exclusively on process

1. United States Code: Title 10 Section 401: *Humanitarian and Civic Assistance Provided in Conjunction with Military Operations*. July 12, 2005.

2. Crutcher JM, Beecham HJ, Laxer MA: "Short-Term Medical Field Missions in Developing Countries: A Practical Approach", *Military Medicine*, 1995, pp.160, 339-343.

3. Mario V. Garcia, Jr., "Achieving Security Cooperation Objectives Through the United States European Command Humanitarian and Civic Assistance Program-Security Assistance Community", *DISAM Journal*, Winter 2003, Vol. 25 No.1 and No.2 p, 105-108.

4. Loomis, E., "Humanitarian and Civic Assistance Program", *DISAM Journal*, Winter 2000.

assessments such as numbers of U.S. military deployed and patient visit counts. Outcome assessments that document readiness skills developed and health improvements to local population are invariably absent from AARs.

Several authors and studies have discussed the weaknesses of medical HCA. Drifmeyer and Llewellyn reviewed dozens of MEDCAP AARs from several countries and received feedback from hundreds of U.S. military medic-participants in MEDCAPs.⁵ They noted the lack of MOEs and inadequate pre-deployment training. They and other authors have also noted the lack of long-term benefit to host nation.^{6, 7, 8} A recommendation of many of these authors has been to shift MEDCAP focus from short-term clinics towards public health improvements.

Another recommendation has been to coordinate MEDCAP activities with non-governmental organizations (non-government organizations) to provide long-term care. This is seen as the obvious answer to the conundrum of attempting to do a medical intervention without getting bogged down with long-term care to host nation civilians.⁹

The non-government organization solution ignores several problems.

- One, non-government organizations are inherently politically neutral and may be reluctant to get involved with an operation provided by U.S. military.
- Two, the extreme short-term nature of MEDCAPs makes it difficult for a non-government organization to have a practical reason to cooperate.
- Three, most military medical units have little experience with non-government organizations and have not had the opportunity to develop the relationship of trust that is needed for effective cooperation.

Conversely, legal issues such as malpractice insurance complicate formal interaction between military medics and non-government organizations. Finally, health care that is provided by non-government organizations without coordination through host nation institutions may actually destabilize security by de-legitimizing the host nation government.¹⁰

Is a Long-Term Health Benefit from Medical Civic Assistance Programs Desirable?

A common interpretation of military doctrine governing medical HCA is that benefit to host nation is incidental to training received by DoD personnel. The interpretation being that benefit to host nation is subordinate to training or even not necessary as long as military training takes place. The origin of this interpretation is unknown; clearly the U.S. Code governing HCA does not state the benefits are incidental to training doctrine. On the contrary, it states the following:

5. Drifmeyer, J. & Llewellyn, C, "Military Training and Humanitarian and Civic Assistance", *Military Medicine*, Vol. 169, January 2004.

6. Kelley JE, *Changes Needed to the Humanitarian and Civic Assistance Program*, United States General Accounting Office Publication, GAO/NSIAD-94-57, December 1993.

7. Luz G.A., De Pauw J.W., Gaydos J.C., Hooper R.R., Legters L.J., "The Role of Military Medicine in Military Civic Action", *Military Medicine*, 1993, pp. 158,362-366.

8. Weisser R.J., Jr., "The Maturing of MEDRETEs", *Military Medicine*, 1993, pp. 158, 573-575.

9. Nickle C.J., *The Role of Health Services Support in the Theater Security Cooperation Plan: Do We Have It Right?*, Published by Naval War College, Newport, Rhode Island, May, 2004.

10. Macrae, J., *Dilemmas of "Post" - Conflict Transition: Lessons for the Health Sector*, Relief and Rehabilitation Network.

“Such activities (HCA missions) shall serve the basic economic and social needs of the people of the country concerned.”¹¹

A short-term clinic of unproven benefit is probably not the best way to meet those needs. Are there other compelling reasons to avoid a long-term health benefit from medical HCA projects? From a planning standpoint, a simple deploy, provide short-term care, and redeploy operation is a convenient way to get a unit into the field. While convenient, this formula ignores the stated goals of the HCA program. When viewed through the prism of training and security enhancement, a long-term health benefit may well be integral, not incidental to meeting the stated goals of the HCA program.

In other words, a long-term health benefit may be the very key to good training and security enhancement. Why would the U.S. Congress authorize funds to train the military to do things that do not provide significant benefit? The basic premise of training is preparing troops to be proficient operationally hopefully all training is aimed at increasing military proficiency in activities that are most beneficial.

Likewise, if a health intervention executed by the U.S. military does not provide lasting benefit; security relationships may be damaged by raising expectations that are not sustained. In a worse case scenario, host nation leaders and locals may view these short-term interventions as nothing more than cynical exercises in public relations.

Proposed Model for Improved Medical Humanitarian Civic Assistance

The following is a list of basic principles of the proposed model:

- On-going projects, not one time events
- Train for Security, Stabilization, Transition, and Reconstruction Operations (SSTRO)
- Coordination with host-nation health officials to provide legitimacy
- Built-in Measures of Effectiveness
- Synergy with other interested parties.

On-Going Projects, Not One Time Events

The key change with this model would be the development of a set of public health projects that specifically address the health priorities of the host nation. Instead of deploying to do a two-week series of short-term clinics, military units would systematically rotate to work on an on-going health project. A reasonable amount of time for project completion would be two to five years. During this time, multiple military medical units would deploy to work on each project. Training would take place simultaneously with project work.

Participating medical units would deploy for two-four weeks, with each deployment building upon the preceding missions to complete the overall project objectives. Prior to deployment, units would receive a set of learning tools that would be task and country specific and also teach general principles of the health-related aspects SSTRO.

Each specific project would have a lead agent that would be responsible for project development and management. Lead agents could be drawn from several sources; for example, academic military medical departments, the U.S. Army Center for Health Promotion and Preventive Medicine, the Uniformed Services University, and military overseas medical research units could develop project proposals and compete for HCA funding.

11. *United States Southern Command Doctrine 40-46*, March 1, 1995, p. 4.

The Geographic Combatant Command Surgeon office would be responsible for developing selection criteria and assessment of whether a specific project should be continued. The Air Force's International Health Specialist program is another option for assisting with development and oversight. Ideally, all three services would develop a cadre of regional health experts with linguistic and cultural skills to function as medical civil affairs officers

Medical planners would provide administrative support, but defer to the medical experts and command surgeons to develop and execute the projects. Examples of possible projects would include HIV prevention, health education, hospital equipment repair, and disease surveillance programs. Short-term clinical activities may also take place during the deployment, but would not be the primary focus. Training local health workers would be an integral part of each project.

Training for Security, Stabilization, Transition, and Reconstruction Operations

Department of Defense Directive 3000.05, November 2005, directed the DoD to make SSTRO equivalent to combat operations in priority.¹² It further directs DoD to integrate SSTRO across the full spectrum of DoD activities, including training and exercises. The goal of SSTRO includes:

- Meeting humanitarian needs
- Help develop indigenous capacity for securing essential services

Clearly, HCA is found in the full spectrum of DoD activities and training for SSTRO is the logical goal of HCA.

SSTRO will likely take place in post-war, post-disaster, and complex emergency scenarios. Training objectives for medical HCA deployments would therefore, be aimed at teaching U.S. military medics skills that will be critical for these situations. Additionally, pre-planned medical SSTRO may take place in potential at-risk nations, with the goal of shoring up a failing state prior to total collapse. In these cases, medical HCA missions may function as both a training AND operational deployment.

DoD 3000.05 further notes need for U.S. military to build "indigenous capacity" to provide essential services and of the importance of learning to work in civil-military teams. Pre-deployment MEDCAP training cycles would include general SSTRO principles plus preparation for the specific project that the unit would be tasked to work on. Learning to work within a developing nation health system will teach medics how to build the legitimacy of host nation institutions-a key SSTRO goal.

Coordination with Host Nation Public Health Departments

The specific projects would be developed in collaboration with the host nation Ministry of Health (MoH). To best meet HCA program security goals, the host nation must view a project as existing primarily to meet host nation needs. Paradoxically, by making host nation benefit the top priority, U.S. military training will also be improved by teaching medics skills that support public health departments in the developing world. To build legitimacy, the MoH must have final veto power over key project processes and components.

Cooperation will hopefully flow downward from the central MoH level to local community leaders. Of course, local cooperation is never guaranteed, and HCA project managers and participants must be prepared to win the support of local health workers and leaders which will provide further invaluable training opportunities. Follow-on evaluation of program success and failure would be

12. Department of Defense: *DoD Directive 3000.05*, "Military Support for Stability, Security, Transition, and Reconstruction", November 28, 2005.

built-in with specific delineation of responsibilities between U.S. military, host nation military, MoH and local government.

Measures of Effectiveness

Measures of effectiveness (MOEs) would be developed as part of initial project and thoroughly integrated into every aspect of program. MOEs would focus on three areas:

- Health improvement
- Military training
- Security

Funding for these assessments would be integrated into the overall program package. Using standard public health planning models, each project would have specific metrics assessed prior to start and throughout the project life-cycle. Public health outcomes measures such as death and disease rates would be the gold standard for program health effectiveness. MOEs for military training would include pre and post deployment testing of learning objectives and documentation of skills practiced. Use of periodic anonymous questionnaires and focus groups for host nation leaders and local participants are another way to assess program effectiveness. Requiring appropriate MOEs would represent a major step towards professionalizing the medical HCA program.

Synergy

Projects that demonstrate synergy with other relevant resources would be preferred and more likely to be selected for HCA funding. HCA moneys would be viewed as seed money to grow a multi-faceted, synergistic program. For example, projects that combine HCA funding with resources from research grants, civilian philanthropic funding, or other U.S. government development programs would be considered more competitive. Because these projects would be on-going, enlisting the cooperation of non-government organizations would be far easier than for short-term clinics. Working with other groups would both serve to do more with less DoD resources as well as fulfilling important training objectives such as learning to coordinate and cooperate with non-military organizations.

Current Working Model of These Principles

The San Antonio Military Pediatric Center (SAMPC), a joint Army-Air Force pediatric residency program has established a working HCA program that models these principles. Since 2001, it has fielded teams of military medics to Honduras three times per year to work on an on-going nutritional screening project. The program coordinates all activities with the host nation MoH and program managers meet periodically with host nation representatives to share results and collaborate on new goals.

During deployments, U.S. medics work side-by-side with local health workers to assess the nutritional status of isolated rural communities. Nutritional screening is a key component of post-war/post-disaster needs assessments and thus is an excellent vehicle for military training as well as a means to provide the host nation with important public health data.

Prior to deployment, the teams have a twelve week training cycle that teaches them both how to do this specific operation as well as general military and medical skills that are commonly needed in post-war/post-disaster scenarios. Team members plan the operation from start to finish, learning about deployment, force protection plans and how to coordinate with host nation workers.

The program has lacked the funding to complete some of the relevant MOEs, but has documented base-line public health rates such as malnutrition. It also has assisted the host nation in evaluation of effectiveness of programs such as immunizations and micro nutrient supplementation. Pre and post-deployment tests have documented that participants gained significantly more knowledge through

actual deployment as opposed to a purely didactic learning program.¹³ It also demonstrated significant positive change in attitudes such as participants' confidence in ability to deploy for a humanitarian operation and an increased respect for health workers in developing nations.

Actual HCA expenditures are far lower per participant than a typical traditional short-term clinic MEDCAP. Costs are kept low by having team stay in austere lodging such as local health centers and by using fewer medications. The program also utilizes medical research grants to fund many of the activities and has entered into an agreement with a local non-government organizations to assist teams.

Conclusion

Military Medics have been talking about improving the HCA program for years. With current emphasis on SSTRO as outlined by DoD Directive 3000.05, it is time to re-structure this program to meet today's security and training needs. The simple deploy-do short-term care-redeploy model may not provide U.S. military medics with all of the skills they need to have a meaningful impact in SSTRO. Incremental tinkering with current medical HCA program is unlikely to achieve the required transformation.

The biggest obstacle to improving the HCA program is institutional inertia, not funding. The funds already exist, they just need to be used in a more flexible and sophisticated manner. Project tracking, planning, and MOE institution will require funding, but these costs can be offset by decreased funding for medications and increased synergy with other funding sources.

To institute these changes, project managers and Geographic Command Surgeons will need greater control over medical HCA funds including the ability to apply funding in a flexible fashion-paying for people, equipment and medical supplies from a single source. The current practice of strict stove-piping HCA funds through the individual service components of a geographic command does not allow for inter-service cooperation and is counterproductive. A single pot of money under the control of the command surgeon who in turns provides it to the lead agent for project execution would be ideal.

The link between host nation health benefit, U.S. training and host nation security needs further exploration. Training U.S. medics to support indigenous health infrastructure should be recognized as a primary training objective. Projects that support the host nation will teach medics key principles of SSTRO and are more likely to provide a lasting health benefit. Providing a lasting health benefit will enhance host nation security. Systematic development of MOEs will professionalize the HCA program and ensure that scarce training funds are used appropriately. Instituting this model will improve health, build legitimacy of host nation institutions, and improve military training-all of which will improve security for U.S. and allies.

About the Author

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13. Lemmon, K., Lynch, J., Hartstein, B., Lougee, D., Unpublished data.