
Humanitarian Medical Assistance In U.S. Foreign Policy: Is There A Constructive Role For Military Medical Services?

By

Captain Arthur M. Smith, Medical Corps, USNR

and

Colonel Craig Llewellyn, Medical Corps, USA (Ret.)

During the past 45 years, U.S. armed forces focused their missions almost exclusively upon controlling communism. While American military forces heavily concentrated their efforts upon deterring a Soviet invasion of central Europe, the U.S. also sparred with the Soviet bloc in undeclared wars and insurgencies throughout the underdeveloped world. Although the Cold War kept peace between the superpowers, its demise did not eliminate the continuing threat of international conflicts involving smaller powers. To this day, many local disputes based upon age old tribal, ethnic, national, and religious hatreds, continue to fuel dozens of civil and regional wars.

Although some would argue that the U.S. should stop serving as the “world's 911 emergency number,” the security of the United States in this politically, economically, and militarily interdependent world is still affected by changes everywhere. With imports and exports comprising 20 percent of its economy, U.S. prosperity still depends upon international stability.¹ Because of these far reaching global dependencies, it has frequently been proposed that the U.S. military be assigned broader responsibilities in support of foreign policy objectives.

In this context, increased military involvement in foreign affairs would be accomplished by having it provide logistical, organizational, medical and other nation-building skills to needy Third World countries. These would be especially directed toward those nations whose stability and growth are in harmony with U.S. national interests. Recently highlighted examples of this potential benefit to foreign policy were the programs of military humanitarian assistance implemented with and for Kurdish refugees in northern Iraq during “Operation Provide Comfort,” as well as disaster relief operations following extensive flooding in typhoon ravaged Bangladesh. Quite obviously, the military's inherent strengths of organization, speed, and efficiency allow it to operate under hostile conditions and adverse circumstances where there is a very limited societal infrastructure. Such qualities make it ideal for short term disaster relief operations. In analyzing its capacity for the assumption of long term responsibilities, however, an examination of previous military experiences in the spheres of both humanitarian health support and medical civil action may prove especially useful.

HUMANITARIAN ASSISTANCE VERSUS CIVIC ACTION: A DIFFERENCE

Prior to 1985, U.S. humanitarian assistance activities overseas, in the context of long term commitments to “nation building” civic improvement projects, were the primary responsibility of civilian branches of our government.

¹Richard Nixon, *Seize the Moment* (New York, N.Y.: Simon & Schuster, 1992), 32-33.

Medical assistance to civilian populations by the U.S. military was offered only where the United States had committed ground forces. In that context, the military services utilized their medical assets through short term "civic action" programs to assist or "pacify" the local populace. Limited military medical aid was also proffered in the setting of U.S. support for friendly governments engaged in low intensity conflict. In a civil war setting, for example, where both sides were competing for the allegiances of the non-combatant civilian population, the influence of civic action as an implement in the complex dynamics of insurgency could not be denied. Initiatives such as food programs, relief or refugee efforts, as well as medical treatment activities periodically became tools to win the "hearts and the minds" of the population.²

Congress subsequently authorized the expenditure of military funds for humanitarian activities "incidental to authorized military training maneuvers." As a result of these expanding indications, military medical services achieved limited authority to provide humanitarian aid to the medical infrastructure of developing nations through the medium of Medical Readiness Training Exercises (MEDRETEs). This was generally accomplished where the geographic CINCs desired an enhanced ability to expand their cooperation with friendly governments, whether or not U.S. combat troops were present.³

Early justifications for expanding the role of the U. S. military into the sphere of humanitarian medical assistance included legitimate moral and humanitarian impulses, a recognition of the public relations benefit through the resulting goodwill, and the potential for augmenting counter-insurgency strategy. Furthermore, it reflected increasing impatience with the vacuum left by perceived shortcomings of civilian agencies in carrying out effective humanitarian assistance in regions considered to be strategically important. The appropriateness of the assistance was further justified by the belief that in some cases the military was the only organization with the expertise and capability to provide the aid. In essence, military medical participation in humanitarian assistance "nation building" was now permitted, but still within an international security context.

CIVIC ACTION IN LOW INTENSITY CONFLICT: THE MEDICAL ROLE

During counterinsurgency activities, the military assets of indigenous governments are commonly employed in local security assistance, psychological operations, civil affairs activities, and combat operations. The U.S. military's role in support of these indigenous security assistance programs has often been implemented either through advisors providing military training in these traditional counterinsurgency activities, by direct military materiel aid, or less frequently by U.S. troops directly in country.

In the opinion of Major General Edward G. Lansdale, USAF, a pioneer in U.S. military special operations, the populace of the country actually constitutes the true battleground in a revolutionary "people's war!" From his experiences in countering the Hukbalahap guerillas in the Phillipines, Lansdale stressed that the paramount objective in counterinsurgency activities must be to gain the loyalty of people who inhabit the land. Whoever wins them, wins the war!⁴ A similar conclusion was reiterated by Sir Robert Thompson, the British expert on counter-guerilla warfare in Malaya, who noted that "Where a guerilla force enjoys support from the people, whether willing or forced, it can never be defeated by military means, however, much it is harassed and attacked, shelled, mortared, and bombed by superior forces of infantry and artillery, air and sea power."⁵

²Charles Mitchell, *The Medic as an Instrument of National Policy, or What in the World is the Department of Defense Doing in Medical Humanitarian Assistance?* (Carlisle Barracks, Pa.: U.S. Army War College Study Project, 1991), 51.

³*Ibid.*, p. 24.

⁴Cecil Currey, *Edward Lansdale - The Unquiet American* (Boston: Houghton Mifflin, 1988), 279.

⁵Cecil Currey, "Preparing for the Past," *Military Review* 69: (January 1989): 5.

Lansdale emphasized the overriding necessity to improve people's lives by both responsive and responsible indigenous government. His example of a soldier manning a shovel at a rice paddy or dike, or offering a helping hand to villagers of his own country, was depicted as the classic bulwark against insurgency. Lansdale labeled such activities, "civic action."⁶ By so doing, he deemed it possible to isolate the insurgency from their support, while establishing the legitimacy of the government.⁷ *Medical care has often been regarded as an instrument to be employed in such endeavors.*

During insurgencies it has been considered imperative that the military medical capability of the indigenous local government be encouraged to *regularly* reach out into and beyond the conflict zones, and provide regular medical care (including dental and veterinary care) to those civilian populations in remote areas which the Ministry of Health cannot reach for logistical or security reasons. Such medical care, however, must always be integrated with any civilian resources and programs that are already in place at both the local and national government levels. The key to success is *regular* medical care provided *consistently* over time.

In its classic combat service support role, U.S. military medical assets have been given responsibility to serve as advisers to indigenous military commands for both the prevention of disease and injury as well as the treatment of battle casualties. (If U.S. troops are on the ground, this function may also be required directly. If not, it may be needed for assisting local military physicians in this function.) In El Salvador during 1953, for example, an estimated one in three wounded soldiers died because the government did not have air evacuation capability, combat medics, or field clinics. By 1990, the mortality rate dropped to about 10 percent because the United States had trained 1,500 Salvadoran combat medics and helped establish an air evacuation system. As the Salvadorans assumed more training responsibilities as well, the number of U.S. medical trainers decreased from 27 in 1983 to 11 in 1990.⁸ (As areas pass from being contested to being secure under indigenous government protection, the military role in health services must inevitably fade to the background as well, while the indigenous civilian government role moves to the forefront.)

Others have similarly recognized the advantages to be gained by such medical treatment support activities. Focusing upon El Salvador as an example, one observer noted that various organizations sympathetic to the guerrilla cause effectively manifested their support through the medium of health care delivery as well.

Doctors Without Frontiers, the International Red Cross, and [the Catholic] Marynoll [Order] do most of their work in guerrilla-controlled areas, ministering to 'combatientes' and to the 'masas.' Paradoxically, such acts of charity have been tolerated by a government eager to demonstrate its unremitting commitment to human rights: also, the government has been unable to provide minimal medical care, even in uncontested areas.⁹

⁶Cecil Currey, "Edward Lansdale: LIC and the Ugly American," *Military Review* 68: (May 1988): 51.

⁷*Ibid.*, p. 52.

⁸"El Salvador - Military Assistance Has Helped Counter But Not Overcome the Insurgency," *U.S. General Accounting Office Report GAO/INSIAD 91-166* (April 1991), 22.

⁹Jeffrey Cole, "Assisting El Salvador," *Proceedings of the U.S. Naval Institute* 115: (November 1989): 68.

QUESTIONING THE EFFECTIVENESS OF OUR MEDICAL CIVIC ACTION ACTIVITIES

How effective, however, have organized U.S. activities been in the dimension of medical civic action (especially in the Philippines, Central America, World War II, Korea, Vietnam, and most recently in Honduras and El Salvador)? Unfortunately, we cannot be sure! In fact, there is no clear instance of a successful counter insurgency program where medical support action, whether civilian or military, was reported to have been of significant value. In addition, it has been stated that the traditional Medical Civic Action Programs (MEDCAPs) carried out both officially and unofficially by U.S. military personnel for decades, or more recently by MEDERETEs in Central America, have frequently represented a classic example of impatience and naivete mixed with good will. Emphasis was placed upon production factors during precipitous "Zorro" type visits to isolated areas, where the number of patients seen, numbers of animals vaccinated, number of teeth extracted, etc., were most important, rather than achieving a durable long term improvement in the health of the targeted population.¹⁰ The focus was upon treatment rather than prevention. There were little or no plans for integration with local government activities and personnel, and no long term sustained follow-up of patients. Furthermore, U.S. personnel generally lacked sufficient language skills and cultural training pertinent to the indigenous regions, and were inadequately prepared to diagnose and treat many of those local diseases not generally seen in the U.S.

Following military civic action activities in Vietnam, General Lansdale noted that large U.S. units with their proliferating commands and bureaucracies, commonly "stumbled over themselves," and were rarely effective. "Too often they want to run their own programs at the expense of national ones and to adopt a 'let me do it for you' stance, [which was] damaging to long term growth or improvement in the host country. They regularly stifle local initiative and too often endeavor to convert the programs of foreign nationals into mirror images of themselves."¹¹ Lansdale further stated, "we came in so powerfully as a people, as a nation so organized in management . . . that we overwhelmed the problem. We continued to take the initiative away from the Vietnamese, who would have to solve their own problems, but each time that we did that, we took away from the Vietnamese the right to solve their own affairs."¹²

Some observers have held that traditional MEDCAP/MEDRETE activities may have actually been counter-productive to the overall goal of creating confidence in local governments. They fostered false impressions about local governments' abilities to meet the populations' needs by building expectations which could not be met after U.S. personnel departed. The local governments were viewed as being unable to care for their own, and consequently needed outside help to do so. Cosmetic efforts, amounting to little more than hit-or-miss uncoordinated activity, were actually more harmful in the long run than any good generated. They no doubt provided propaganda ammunition for the insurgents and for the critics of the government as well! The perceived differences between American and Vietnamese hospitals, for example, were so pronounced that in some instances even seriously ill villagers were observed to demand American treatment before consenting to a MEDEVAC to a Vietnamese facility.¹³

¹⁰James Taylor, "Military Medicine's Expanding Role in Low-Intensity Conflict," *Military Review* 65: (April 1985): 33.

¹¹See Cecil Currey, *Edward Lansdale - The Unquiet American*, p. 280.

¹²*Ibid.*, p. 302.

¹³Michael Peterson, *The Combined Action Platoons: The U.S. Marines' Other War in Vietnam* (New York, N.Y.: Praeger, 1989), 116.

The words of a U.S. Peace Corps worker in Central America a decade ago, during a U.S. military medical assistance visit, ring "loud and clear" concerning U.S. shortcomings in this dimension:

There was nearly a feeling of religious devotion and expectation of that miraculous cure sought by those on the verge of despair . . . For the first two hours of the MEDCAP I saw only one person actually examined as doctors listened to complaints and wrote out prescriptions . . . The prescriptions that the doctors wrote were nothing more than scraps of paper with the name of a drug. Patients' names and doses became a rarity as time progressed, as the doctors were unable to keep up with the flow of people. They also showed up with an inadequate supply of antibiotics, and we were forced to give half doses. Every child there was given medications for worms regardless of whether they had or did not have worms. Other medicines had little or no medical effect, such as Visine, vitamins and Tylenol or aspirin. As several of the medical personnel explained: 'Other than P.R. for the Army, we don't do much of anything;' 'We don't hurt anyone and if we get lucky maybe we help someone;' 'We do a little VooDoo and make them think they're going to get well' . . . Dona C., who was given Visine and vitamins for cataracts now realizes what a scam the VooDoo really was. At first elated, she is now bitter and depressed, knowing that she is going blind and that the Gringo Military lied to her . . . I doubt those officers have any idea of the harm they do, how they undermine the credibility of local health professionals, rob people of their incentive to work for change and control of their own lives, and accomplish nothing in the way of true health care . . . They undermine local professionals, contradict health educators, and reinforce age old ideas that people cannot help themselves. . . People had refused to be seen by the local doctor, and yet he is the one who will be there if follow-up care is needed. He is the one with a responsibility and commitment to the people, and can offer them care on a regular basis without the confusion and rush of the mob scene that the MEDCAP had become . . . The dentists too seemed to provide no service that could not have been rendered by our local odontologist. Sure, they pulled a lot of teeth, but that is not a need, for anyone can do that if need be. The true need in dental health is education as to hygiene, and prevention of tooth decay and gum disease . . . The people of the MEDCAP flew off as fast as they came, leaving the people no better off. They raised hopes of miracles, and left people bitter, disillusioned and frustrated . . .¹⁴

U.S. policy execution through Department of State and USAID activities has suffered from similar problems. Program managers, desirous of demonstrating dramatic improvements during their tours in charge of various activities, have sought out high impact, high visibility, short term solutions to problems. This has led to a philosophy of "assault" the problem, and concentrate "forces," and by so doing "conquer" or fix it, so that they can "redeploy." This has led to the "body count" or "tonnage delivered on target" mentality so prevalent in the military during the Vietnam years.

BASICALLY, WHO SHOULD BE IN CHARGE?

In contemporary terms, how can U.S. humanitarian medical assistance policy in Third World regions be best determined, and by whom?

The US response to any foreign concerns affecting our interests is ultimately governed by national policy. The latter is developed by the President in association with the National Security Council, Department of Defense, Department of State, Central Intelligence Agency, and other groups such as the U.S. Agency for International Development (USAID). In addressing the

¹⁴See Charles Mitchell, pp. 52-56.

problems of the Third World, both policy advice and execution are based upon recommendations developed by the local U.S. Ambassador. He is assisted by his Country Team, composed of representatives from USAID, CIA, U.S. Information Service (USIS), and either the U.S. Defense Attache or the Chief of the Military Assistance Mission (MAAG), i.e., the Security Assistance Organization. Those "on scene," through the U.S. Ambassador, advise our national leadership of the critical threats to our interests, and correctly assess their relationships to our overall regional and strategic goals. These individuals are in the best position to ensure that resources are properly applied to achieve the greatest payoff. In light of Third World realities, their recommendations may fall into the spheres of "Nation Building" or Counterinsurgency.

Health assistance activities can be a useful adjunct to overall humanitarian support activities if implemented as part of a "country plan" dedicated to *long term goals*. If the latter is not considered, such ventures can be exceedingly counterproductive. Concomitantly, there must be a general commitment by both U.S. and local government to specific geographical areas. Ultimately, utilizing great flexibility, a "made-to order" force of personnel and equipment should be created.

WHAT ARE THE COMPONENTS OF AN APPROPRIATE MEDICAL PROGRAM?

Of the many facets of humanitarian assistance doctrine, health care assistance could be an important and potentially productive undertaking if thoughtfully and realistically implemented. This does entail, however, a long term commitment to furthering health education, primary level medical care, disease control and prevention, and most importantly sanitation and public health advancement projects.

The primary health care provider has been properly identified as the critical element in the Third World setting. Community based projects, emphasizing the training and support of village health care workers, are key objectives. Our aim should be the establishment of a network of local health promoters within the targeted regions of the country. It was with good reason that Cuban foreign policy, for years, consistently addressed this issue. Cuba undertook long term commitments to grass roots health improvement projects in rural sections of the Third World, at the village level and below. This involved, as a cornerstone, grass roots sanitation promotion, health education, and austere low level medical care. Language capable Cuban personnel, trained in the diagnosis and treatment of local (endemic) diseases, were posted to such positions for long term commitments, functioning in low profile, low visibility positions, with paradoxically high sustained impact. (Even in Grenada, most rural health posts were staffed by Cubans, who were living with the people.) In addition, local citizens were transported to Cuba to train as rural health care providers (as physicians, nurses, and technicians). The overall emphasis of the Cuban program was upon preventive medicine and health improvement.

If U.S. military medical resources are to be utilized in humanitarian support activities, the traditional principles and philosophies of military medical support must be expanded and extensively modified to support Third World medical operations. *Cadres of U.S. medical specialists with appropriate language fluency, educated in the cultural nuances of the regions supported, must be developed to support these health care projects.* This requires people well trained in the diagnosis, treatment, and prevention of diseases unique to the region, operating under clear and well defined policy and operational guidelines, rather than untrained personnel lacking the ability to speak the local language, merely sent out to remote areas to "show the flag" and dispense untold quantities of pharmaceuticals. These cadres may well include a spectrum of health care providers—individuals with not only military medical skills, but also those trained in practical facets of the general medical disciplines, including Preventive Medicine and Public Health, as well as in the primary care skills inherent to the areas of Pediatrics, Obstetrics and Gynecology, and Psychiatry.

TRAINING MILITARY MEDICAL PERSONNEL FOR HUMANITARIAN SUPPORT MISSIONS

In preparing U.S. military health care personnel for humanitarian operations, the training goals should be pragmatic, and adapted to the cultural and economic realities of the region and not focused upon a wholesale adoption of U.S. medical standards. The performance expectations of such personnel should not exceed their training, and their job skills should match the desired requirements. The medical and social status of our representatives should match those of their local counterparts, and their standard of living should be similarly austere and commensurate with local standards and customs. Humility and understanding are keystones of any relationships.¹⁵

The conduct of health care operations requires an in-depth knowledge of the local socioeconomic structure of the various nations involved. U.S. military medical representatives in foreign countries should also be obligated to spend significant time in gaining an understanding of the people, their customs, mores and traditions. They must also become status conscious within the context of local customs, downplaying the appearance of competition with the established system while attempting to understand and appreciate the politics of public health in the local region as well. (It was no doubt for that reason, when discussing Vietnam, that General Lansdale believed it to be essential for Vietnamese leaders to claim credit for any successes, changes, and reforms resulting from humanitarian activities.)¹⁶

Where armed conflict exists, it is also incumbent upon both the staff and training personnel of military advisory groups to understand low intensity conflict materiel requirements in the context of the specific and often unique deficiencies of the host nation. For example, medical assistance units in many countries require high mobility to achieve their goals. This generally entails sufficient four wheel drive vehicles, riverboats, and helicopters, but may also require the imaginative use of traditional modes of transportation, such as the horse and mule.¹⁷ Other required capabilities include facilities, communications, and medical intelligence data such as disease prevalence rates in specific regions. All of these are items with which the U.S. military has extensive experience.

A cadre of military health service foreign area specialists must consequently be developed, and a career pattern designed which provides multiple opportunities to work in designated areas of the world for both long term health care promotion and security assistance purposes. Each service must develop a cadre of regional experts for service in those parts of the globe where it is the sole military representative of our national interests. This requires the assumption of long term placement commitments in order to earn the friendship and respect of the local populace; not the traditional one to six month temporary duty assignments heretofore characteristic of such positions.

At the administrative level, such regional medical experts are needed to further assist in the development of policy, concept, doctrine, organization, plans, and requirements for health services as well as public health support in these various settings. In addition, a cadre of medical information and intelligence collectors, trained with technical knowledge regarding medical matters and the biological sciences, should be positioned worldwide to increase the flow of raw scientific and technical medical intelligence information.

In a broader context, trained health service foreign area specialists must also be assigned to the military advisory groups and local AID advisory groups, providing input to the country teams.

¹⁵See Charles Mitchell, pp. 40-41.

¹⁶See Cecil Currey, *Edward Lansdale - The Unquiet American*, p. 302.

¹⁷John Fishel and Edmund Cowan, "Civil-Military Operations and the War for Moral Legitimacy in Latin America," *Military Review* 68: (January 1988): 43.

They must be matched by counterparts in the Washington directorates of the State Department, CIA, and USAID.

Collaboration of agencies is also required. For example, medical nationbuilding efforts require the integration of planning and program execution between the Office of the Secretary of Defense (OSD), the Unified Commanders (CINCS), USAID, and the Department of State, in accordance with our national policy.

Medical participation in the security assistance process, also stemming from recommendations made at the country team level, requires additional adequate liason at the OSD level between the Offices of the Assistant Secretaries of Defense (OASDs) for Health Affairs, International Security Affairs, International Security Policy, and Special Operations/Low Intensity Conflict, as well as other appropriate Federal intelligence agencies including the Armed Forces Medical Intelligence Center and the various military Surgeons General.

Is this concept incongruous with U.S. military traditions? Although perhaps a radical departure from the last 45 years, the U.S. military—and the Army in particular—has a long history as the nation's "versatile, obedient military servant." The armed forces, in fact, have been used to quell Indian uprisings in the American West, suppress rebellions in the Phillipines, and even more unglamorous tasks such as delivering the mail, running the Civilian Conservation Corps and building roads. Indeed, the U.S. Military Academy was founded, in part, to provide the nation with a cadre of engineers to help settle the frontier.

FINALLY, HOW POLITICALLY EFFECTIVE IS HUMANITARIAN HEALTH ASSISTANCE ?

In reality, we still do not know! Nevertheless, to attack the ongoing deprivations from disease in the developing world, with the added hope of furthering our own foreign policy needs, long term U.S. commitments in support of public health and medical services activities of indigenous governments would certainly *appear* reasonable! The most logical approach would entail the development of recommendations at the local level by trained experts attached to country team staffs, and then translating them into national policy.

Our military services contain a highly trained, dedicated, and disciplined work force; hundreds of military installations across the U.S. and around the world; state-of-the-art medical and intelligence collection systems; and a highly sophisticated system of transport and supply. Furthermore, the U.S. military medical services constitute one of our most important national resources in the fields of tropical public health and tropical medicine. In addition, the U.S. military is putatively the largest educational organization in the world, with significant experience in designing educational programs to match the needs of students with great variations in capabilities and backgrounds. Combined with its engineering and public health capabilities, could not educational programs be created which would focus upon sanitation and potable water source development in the developing world as well? Similarly, could not its broad capability in large scale immunization delivery be combined with its educational and disease prevention capabilities to also make a meaningful difference in health promotion within underserved regions of the world?

It must be recognized, however, that most of these nations possess stagnant economies tied to meager agricultural dependencies. They also suffer from a lack of social redress due to deficiencies in their indigenous judicial and law enforcement systems. Ingrained opposing cultural proclivities, political corruption, indigenous financial inadequacies, and continuing political instability may thus preclude any meaningful long term benefits. Consequently, a broad spectrum of social, military and economic assistance may be required, of which health improvement is only one part.

Will the aforementioned concepts then provide a template for the development of further responsibilities for our military medical services in the foreign policy arena? Ultimately, the appropriate emphasis of U.S. humanitarian activities must be determined by those on scene. Translating them into additional duties for military medicine will ultimately depend upon the budgetary and policy limitations imposed by our national priorities.

ABOUT THE AUTHORS

Captain Arthur M. Smith, Medical Corps, U.S. Navy Reserve, is Clinical Professor in both the Departments of Surgery and Military Medicine at the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Maryland. He is also Professor of Surgery (Urology) at the Medical College of Georgia in Augusta, Georgia.

Colonel Craig H. Llewellyn, U.S. Army (Retired) was Group Surgeon, 5th Special Forces Group (Abn) in Vietnam 1965-1967; Director, Medical Instruction, JFK Center for Special Warfare; Consultant to the Surgeon General, U.S. Army, for Medical Support of Special Operations; Commander, U.S. Army Medical Research Unit, Brazil (Transamazon); and a Graduate of the Armed Forces Staff College and Industrial College of the Armed Forces. He has been Professor and Chairman, Department of Military and Emergency Medicine, Uniformed Services University of the Health Sciences (USUHS) since 1982.