Medical Seminars: A New Paradigm for SOF Counterinsurgency Medical Programs

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Abstract

Medical programs are valuable tools when they properly align with operational objectives. In counterinsurgency operations, the medical program should promote the capacity of the host nation government and lead to greater self-sufficiency. The Medical Civic Action Program (MEDCAP) often fails to fully integrate host nation providers and officials which may undermine local medical infrastructure and rarely provides sustainable improvement. The Medical Seminar (MEDSEM) was developed during Operation Enduring Freedom-Philippines to address the shortcomings of the traditional MEDCAP. The MEDSEM greatly enhanced the MEDCAP by adding education to the venue, thereby promoting self reliance and improving the sustainability of medical interventions. Furthermore, the MEDSEM forged relationships and promoted interoperability through collaboration between local medical providers, governmental leaders, host nation forces, and U.S. Special Operations Forces.

Introduction

Medical programs are but another tool available to Special Operation Forces (SOF) commanders to influence an operationally important geographical area or population. The MEDCAP has long been utilized to deliver medical services to areas of interest during peacetime and wartime operations. These programs have been known by a variety of titles throughout the last century, but the primary concept has remained constant: Providing medical services to achieve an operational end-state.

The role of medical staff is to successfully bridge the gap between the commander's intent and end-state with solid medical planning and sound medical practices. Often, the traditional MEDCAP provides little more than short-lived, non-sustained effects. This is key to understanding the fundamental inadequacies of traditional MEDCAPs conducted in long-term support of counterinsurgency (COIN) operations. All operations conducted in support of COIN should be as progressive as possible, promoting the capacity of the host nation (HN) and eventually lead to greater self-sufficiency. A single-day event with insufficient planning and inadequate follow-up produces few positive effects and does not build enduring capacity.

Traditional MEDCAPs can counteract COIN objectives by creating unachievable expectations without attending to basic health needs. Addressing basic needs is the first step toward building medical self-sufficiency. Furthermore, traditional MEDCAPs often fail to fully integrate HN health officials into the event. Treatment is then credited to the visiting force's providers, while local providers are perceived as inferior. This degrades public confidence in its government's ability to provide essential services, ultimately undermining HN medical infrastructure. This article will outline our understanding and observations of traditional MEDCAP operations. Our assessment is the cumulative outcome of SOF experiences in Somalia, Haiti, Iraq, and Southeast Asia. We will then present a comprehensive model that was used to address MEDCAP shortcomings during Operation Enduring Freedom- Philippines (OEF-P).

Ideal Medical Programs

All military medical engagements should align with operational objectives. In practice, the ideal medical program fully integrates HN medical assets, enhances information sharing by promoting interoperability, and addresses the health needs of the targeted population. The first two are the means to the end. Host nation health officials should be at the forefront at all times. This accomplishes two important functions. First, it connects those doctors, nurses, midwives, informally-trained persons, or government officials with their patient population. They are responsible for the health of their citizens and the people should perceive them as such. Second, information sharing and interoperability increase as those providers coordinate with other medical officials, local governments, non-governmental organizations, and security personnel. The first steps to improving public health and starting on the road to self-sufficiency are the identification of needs and collaborative pooling of information and assets.

From a public health perspective, coordinated planning and continued progression are the most important aspects of improvement. This will have a much greater impact on long term public health than any single intervention. Providing direct care results in only temporary relief of the medical situation and contributes little or nothing to long-term improvement in the health system. The emphasis should be on developing capability over providing direct service.[1] However, from the patient's view, the direct delivery of medical care is the tangible validation of impending improvement. This cannot be dismissed. Population confidence in their medical system must be established in order to bolster immediate HN support and facilitate progress.

A patient will place his/her trust (or allegiance) in the person or group that is capable of delivering direct care, regardless of long term implications. Altruistic U.S. medical providers may overshadow local providers in their eagerness to help by providing care. In Vietnam, some observers held that this practice was counterproductive by diminishing confidence in the government's ability to meet population needs.[2] Caution must be exercised to ensure that the main effort is directed at improving the HN provider's ability to care for his/her countrymen. Operations in support of COIN should regain control of population centers and favorably influence perceptions of HN legitimacy and capabilities.[3]

Medical care delivered at all medical engagements must also be sound. Standards of care do not stop at the borders of undeveloped nations. Treatment should be appropriate to the disease process. Limitations should be placed on interventions based on a provider's level of training, availability of follow-up, and access to medications. Every patient does not require medication and adverse reaction rates are similar throughout the world. However, unlike the rest of the world, an adverse effect from an unneeded treatment could be amplified and exploited by the insurgency.

Traditional Medical Civic Action Programs

Over the past six decades, MEDCAP operations have grown to be the leading medical engagement employed by commanders. The MEDCAP truly earned its name during the Vietnam War even though the concept dates back to our American Civil War with the Freedmen's Act of 1865.[4] The Union Army was tasked to provide medical services, as well as food and clothing, to former slaves and freedmen. The inception of using medical services as a policy tool started after the Spanish American War in Cuba and continued during the Filipino Insurrection.[5] The Pacification Policy was instituted in the Philippines to win over the civilian population, and deprive guerrillas of their support base.[6]

During the Vietnam War, MEDCAPs were used for strategic purposes: to win "the hearts and minds" of the people.[7] The U.S. military invested between $500 million and $750 million in MEDCAPs and treated more than forty million Vietnamese civilians.[8] Since the 1960s numerous MEDCAPs have been conducted throughout the world to include the horn of Africa, Asia, Central and South America, Haiti, and the Middle East.

The traditional MEDCAP is typically a single-day event that provides medical or dental care and can vary in size from a few hundred patients to a few thousand. The operation is divided into three distinct phases: planning, execution, and follow-up. The planning phase identifies the MEDCAP location, integrates medical and security assets, and ends with meeting and coordinating with leaders of the area of interest. The execution phase consists of movement to the location, establishment of security, completion of medical treatment, and movement back to home base. Medical treatment usually begins in the early morning and continues until late afternoon or medical supplies are depleted. The follow-up phase is critical as it reengages that population to ensure achieved gains are maintained and available to build upon during future operations.

MEDCAP Shortcomings

Comprehensive and inclusive planning is critical to area preparation and asset development. Within some operations, MEDCAPs are planned and executed at paces unsuitable to relationship and capacity building. Execution of a MEDCAP is often seen as the main effort as opposed to area preparation and follow-up operations. The patient-provider interaction is just as hurried (average of three to five minutes per patient). Time is limited to quick diagnosis and treatment with no time for patient education.

Host Nation providers are typically an afterthought and MEDCAP teams regularly execute with 70% U.S. and 30% HN personnel. Capacity is not enhanced, HN providers are marginalized, and the medical infrastructure is not reinforced by this type of program. In Iraq for example, JB Baker describes the undermining of local medical services sanctioned by the Iraqi Ministry of Health and provincial medical directors, decreasing support for Iraq's national and provincial governments.[9]

Success is routinely measured by the quantity of patients seen instead of the quality of care.[10] The focus is generally only short term. As word spreads, population demand increases. This short term focus can raise expectations and cause dissatisfaction with local medical resources.[11] Often, contacted populations grow skeptical of both U.S. and HN care as a result. Further dissatisfaction results from inadequate follow-up engagements. Any ground gained is tied to the half-life of the dispensed medications which may lead to the loss of patients, contacts, and population/geographical gains. This is not aligned with SOF's need to establish and maintain rapport with a given population.

The average MEDCAP supply pallet contains antimicrobials, analgesics, topical corticosteroids, and multivitamins, yet the majority of patients present with common complaints requiring little or no medical interventions. Most of those patients are mothers looking for something to put in the "medicine cabinet" for their children, much like mothers in the U.S. A smaller percentage of patients require a slightly higher level of intervention, such as antibiotics or anti-parasitic medication. A small percentage of patients have illnesses that require significant intervention and/or follow-up, such as hypertension, renal disease, or surgical conditions. These patients are beyond the scope of practice for any short-term medical engagement. The key is to avoid creating false hope and/or dispensing unneeded treatment.

The distribution of patients seen at MEDCAPs is not that dissimilar to your average U.S. family medicine clinic. A significant proportion of patients do not require medications and a small proportion of them require advanced treatment. Avoiding unneeded medical treatment is a hallmark of good medicine. Another hallmark of good medicine is patient education. When specific interventions are not required, education leads to sustainable improvement in overall health. Good patient education is Western medical standard of care. That same level of care can be practiced in undeveloped nations, allowing the provider to remain true to his/her patients and ensure mission success without exposing SOF to negative information operations (IO) from adverse outcomes.

Medical Seminars

The MEDSEM was created to address the shortcomings of MEDCAPs during counterinsurgency operations on the island of Mindanao in the Southern Philippines. At its core, the MEDSEM is a type of military medical civic action program. However, identifying this unique version as a MEDCAP proved to be confusing and hampered progress during early planning. Therefore, the venue was renamed in order to emphasize the differences between it and traditional MEDCAPs. The MEDSEM was designed to engage an area of interest, deliver sound medical care, foster relationship building, enhance local medical infrastructure, and promote interoperability between HN agencies.

Planning began with detailed analysis of the battle space. The Special Operations Task Force (SOTF) medical staff worked closely with HN military operational planners. Analysis was conducted by a physician, a physician assistant, or a Special Forces Medical Sergeant. Medical staff responsibilities included identifying regional and provincial medical assets, providing assessments of area medical needs, and developing feasibility assessments for various operations. The location of a MEDSEM was either top-down driven from the SOTF or bottom-up driven from the Operational Detachment-Alpha (ODA). In the end, 10 to 15 barangays (villages) of operational importance were identified for a MEDSEM by SOF and HN planners. These barangays typically spanned a 10 to 20 square-mile area.

Medical asset development was required at all levels. The SOTF medical staff forged relationships with regional and municipal health offices, HN medical officers, and area hospitals. The ODA medics did the same with rural health workers, and local HN military, government, and police. These steps were crucial. It involved HN infrastructure from the very beginning and identified public health needs from their perspective. Furthermore, it initiated the vital process of promoting interoperability between the various organizations (medical, governmental, law enforcement, and military). The SOTF and ODAs hosted meetings that facilitated information sharing and event planning. The initial meeting outlined the MEDSEM, proposed a timeline and identified roles. Host nation medical officials remained in the forefront at all times. An average of three planning meetings was required over a two to four week period to solidify relationships and adequately synchronize operations.

Table 1: MEDSEM Outline
PLANNING (Relationship Building/Area Prep)
Identify location of MEDSEM
Identify host nation medical assets
Conduct planning meetings
Send invitations to areas of interest
Meet with area leaders
EXECUTION (Access/Host Nation Promotion)
Opening day ceremonies
Three days of classroom instruction
Graduation, Medical Programs
FOLLOW-UP (Sustainment)
Continue communication with all assets
Follow-up Engagement

Table 1 outlines a MEDSEM. Following the first planning meetings, the HN military would establish initial contact with the barangays and present a formal invitation for three students to attend a MEDSEM. Medical experience was not required. Barangay leaders were given a brief overview of the seminar and subsequent medical programs to be conducted at their barangays. The responses from all MEDSEMs were immensely positive and every invited barangay participated, regardless of the level of insurgent influence.

All entities contributed to the success of a MEDSEM. Municipal health offices identified public health needs, generated lectures, and served as primary instructors and care providers. Local governments typically hosted the three-day seminar at town halls or city centers. At two seminars, the local mayors provided daily lunches and snacks for the students during the seminar. The HN military was responsible for care providers and outer-perimeter security. Host nation police were responsible for crowd control and inner perimeter security. Local public and private healthcare providers often volunteered to deliver care and serve as assistant instructors. Individual barangays were responsible for student transportation. They would typically pool what little money they had ($2.00/student). The amount of cooperation was staggering and directly responsible for mission success.

A formal opening ceremony initiated all MEDSEMs. These ceremonies were attended by local dignitaries, religious leaders, and HN civilians. The local government and HN military coordinated for press coverage during the ceremony, seminar, and medical programs in order to maximize positive IO effects. Following the opening ceremony, students underwent a short in-processing that consisted of turning in their application with name, barangay, and contact information. All students were issued a textbook that contained all lectures.

Classroom instruction began immediately following inprocessing and continued for three days. Our MEDSEMs focused on basic women's and children's healthcare topics. They were taught by municipal nurses and midwives in the local language (Tagalog).

Table 2: Example MEDSEM Curriculum

MEDSEM Curriculum
Filariasis
Malaria
Dengue Fever
Tuberculosis
Hansen's Disease
Measles
Animal Bites and Rabies
Common Childhood Infections
Childhood Emergencies
Immunizations
Malnutrition and Vitamin Deficiency
Family Planning
Maternal Medical Care
Breastfeeding
Obstetrical Emergencies
Wound Care
Avian Influenza
Cervical and Breast Cancer Awareness
Medical Reporting
Medical Programs

An example curriculum is listed in Table 2. These topics were directed at the layperson. The municipal health workers emphasized public health awareness and developed the students for medical surveillance and reporting.

The last class taught at a seminar was Medical Program Preparation. Students received instruction on preparing and hosting a medical program at their barangays. Essentially, these engagements were short municipal health workers and student-lead MEDCAPs, but this title was avoided to prevent confusion once again. This class prepared students for medical programs following the seminar and developed assets for future engagements. The final class was followed by a formal graduation ceremony where students received a graduation certificates and class photo (see Figure 1). The graduation photo was immensely popular with all students at all MEDSEMs.

Figure 1: *MEDSEM Graduation Photo*

All students were responsible for conducting a medical program at their barangay on one of two days following the classroom instruction. This was their "final exam." Host nation medical care and security teams were used for all programs. Host nation military and ODA members conducted key leader engagements and area assessments. Prior to the medical team's arrival, the students would register patients (typically between 200 to 400 patients) and deliver one of their recently learned preventive medicine lectures. Students then identified up to 50 patients to be seen by HN providers while they, under the supervision of HN nurses and midwives, delivered individual education and dispensed over-the-counter medications (See Figure 2). Follow-up engagements were scheduled and executed for 90 to 180 days following the MEDSEM. These events typically consisted of small medical engagements run by MEDSEM graduates.

MEDSEM Results

A typical MEDSEM trained 40 to 50 students/medical contacts in three days and treated 2500 to 4000 patients in 10 to 15 separate barangays. Relationships were formed between graduates, medical providers, governmental officials, military, and security entities. The cost of a MEDSEM averaged

Figure 2: *MEDSEM graduates provide education and dispense over-the-counter medications under supervision of HN providers.*

$2.50/patient. Compare the above with traditional one day OEF-P MEDCAPs that treat 500 to 1000 patients with an average cost of $5.00/patient. The significant difference in costs reflects the decrease in prescription medications on MEDSEM pallets. Benefit analysis of continued relationships with an area of interest is difficult to quantify, but positive impacts on operational objectives, intelligence, and sphere of influence are obvious. Measures of performance for a MEDSEM are listed in Table 3. There were no adverse outcomes and no effective negative information operations from the insurgency.

Table 3: MEDSEM Measures of Performance

Categories	Measures	
# Barangays Invited	17	
# Barangays Engaged	17 (100%)	
Agencies or Political Groups Involved in Planning	Local Government, Local Health Officials, Local Police, HN Military, NGOs, U.S.	
Agencies or Political Groups Remained Until Completion of Event	Local Government, Local Health Officials, Local Police, HN Military, NGOs, U.S. (100%)	
# Students Trained	51	
# Patients Treated	4,413	
% Patients Treated by U.S. vs Host Nation	US: 20%	
	Host Nation: 80%	
Cost Sharing	Personnel	U.S.: 12; HN Government/Police: 80; HN Military: 45; Participating Locations: 204
	Materials	U.S.: 2 x medication pallets (~$10,000)
		Local Govt: Opening Ceremony, Lecture Hall, Daily lunches for students ($500)
		Participating Locations: Student transportation costs, food for visiting medical teams ($100)

Discussion

The MEDSEM is one variation that addresses the inadequacies of traditional MEDCAPs. It aims toward improvement and highlights the essential elements of an effective operation that is aligned with COIN objectives. All MEDSEMs conducted in support of OEF-P were very successful. Measures of effectiveness for a single MEDSEM are listed in Table 4.

There will still be times when a traditional MEDCAP might be employed. Time constraints, limited population access, enemy activity, and security may dictate a smaller, single day event. For example, a small, "tailgate" MEDCAP may be utilized to make initial contact with an isolated population center. Additionally, larger MEDCAPs that provide definitive treatment such as surgical procedures or ophthalmic interventions may provide invaluable care to underserved populations. However, these large MEDCAPs require extensive resources and manpower that are supplied predominately by visiting forces. These engagements may better serve humanitarian operations, which is beyond the scope of this article. Regardless of the variant of MEDCAP, the operation will be successful if planners recognize and avoid past pitfalls. Planning considerations should include the advancement of HN medical infrastructure, promotion of interoperability, and genuine improvement of public health. These are exceptionally important to long term efforts.

Host nation medical assets may be insufficient or even non-existent in some undeveloped nations. This does not change the fundamental requirements of good medical operations. It only changes the starting point from which capacity building begins. Special Operations Forces must be masters of force multiplication and training. Developing medical assets is no different. This is a role tailor-made for the Special Forces Medical Sergeant. In these environments medical infrastructure enhancement is a grassroots operation with ODAs developing assets and improving public health (and subsequent security) within their areas of responsibility. Those

Table 4: MEDSEM Measures of Effectiveness	
Categories	**Measures**
Capacity to Govern	
Municipal leadership strengthened by hosting event	• Local government viewed as responsible for hosting event • Local officials view interaction with its constituents as positive
Security	
HN military and police capacity within areas of interest increased	• HN military and police viewed as responsible for executing event • Military and police operations enhanced in areas of interest • Hostilities are decreased or non-existent
Access	
Access obtained into barangays of interest and future access granted by local leadership	• Access obtained into all barangays of interest • Barangay leadership supportive of future engagements • Possible venues identified for future engagements
Interoperability	
Cooperation and info sharing fostered between participating groups	• Local government, HN military and police operations synched • Communication facilitated between leaders and government • All medical personnel share info/ideas
Focused Engagement	
Areas of interest primarily engaged	• Engagement reaches target audience • Main effort delivered in area of interest
Medical	
Meaningful and sustainable improvements in current and future health of barangays	• Graduates share knowledge with their barangays • Graduates coordinate and execute and effective MEDCAP • Graduates continue to be asset for future engagements • Barangays learned how to access care through HN
Information Operations	
MEDSEM portrayed in positive light to broad population	• Positive message delivered to population outside of engaged area • Press attended MEDSEM event • No negative or adverse events

assets can later be connected to others at operational and strategic levels of development. This would establish the rudimentary framework for emerging medical infrastructure.

The MEDSEM was a model used to address our observed inadequacies of the traditional MEDCAP within OEF-P. This specific model may not apply to all situations. However, the presented principles of successful medical operations conducted in support of COIN should always apply. Unlike most conventional forces, SOF success is intricately tied to the population. In many situations, survival depends on this relationship. They are tied to the people and the people are the center of gravity for mission success. Methodic, well planned, progressive operations that build HN capacity are the path to self-sufficiency and ultimate victory over insurgents. Medical operations are no exception. Effective engagements build upon past successes, enhance HN medical infrastructure, increase interoperability between local assets, and instill national confidence within the population. Special Operations Forces medical personnel possess the training and ability to incorporate those principles into medical operations aligned with COIN objectives.

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