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HEALTH CARE AS AN INSTRUMENT OF FOREIGN POLICY
(A Proposed Exapnded Role for the Army Medical Department)

BY

COLONEL JOHN F. TAYLOR, MC
LIEUTENANT COLONEL JERRY L. FIELDS, MSC

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Since the end of World War II it has been the consistent policy of the United States to utilize various forms of foreign assistance as one method of furthering U.S. national objectives in foreign nations. This assistance has taken many forms through the years but the most prominent has been economic assistance for the rebuilding or development of friendly foreign nations, and ~~miliary~~ Military assistance in the form of weapons transfer

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and military training to support the legitimate defense needs of these friendly nations. Numerous factors, including U.S. domestic and international economic issues, questions of the appropriate role for the United States relative to foreign developing nations, and domestic political issues have all served to make unclear current United States foreign assistance policy.

It is the thesis of the authors that U.S. foreign assistance programs in support of lesser developed nations of the world remains a powerful U.S. policy tool. One of the priority needs of all developing nations is technical and managerial assistance in the development of an appropriate health care delivery system. Current legislation empowers the Agency for International Development (AID) to undertake long-range development programs, including health care systems, in friendly developing nations. However, the military medical departments of the U. S. armed forces, by virtue of past experience, technical expertise, and organizational strength, could play a much expanded and vital role in such humanitarian assistance efforts. Although organizational and budgetary problems exist which make it difficult to achieve the postulated expanded role for the military medical departments in foreign assistance, these problems do not appear to be insurmountable.

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USAWC MILITARY STUDIES PROGRAM PAPER

HEALTH CARE AS AN INSTRUMENT OF FOREIGN POLICY
(A Proposed Expanded Role For The Army Medical Department)

A GROUP STUDY PROJECT

by

Colonel John F. Taylor, MC
Lieutenant Colonel Jerry L. Fields, MSC

Lieutenant Colonel Alden M. Cunningham, FA
Study Adviser

US Army War College
Carlisle Barracks, Pennsylvania 17013
9 May 1984

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ABSTRACT

AUTHORS: John F. Taylor, COL, MC
Jerry L. Fields, LTC, MSC

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It is the thesis of the authors that US foreign assistance programs in support of lesser developed nations of the world remains a powerful US policy tool. One of the priority needs of all developing nations is technical and managerial assistance in the development of an appropriate health care delivery system. Current legislation empowers the Agency for International Development (AID) to undertake long-range development programs, including health care systems, in friendly developing nations. However, the military medical departments of the US armed forces, by virtue of past experience, technical expertise, and organizational strength, could play a much expanded and vital role in such humanitarian assistance efforts. Although organizational and budgetary problems exist which make it difficult to achieve the postulated expanded role for the military medical departments in foreign assistance, these problems do not appear to be insurmountable.

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CHAPTER I

INTRODUCTION

BACKGROUND

Historically,the United States' uniformed services have been utilized in a non-combatant assistance role to aid in the furtherance of US foreign policy objectives. This has been true since the end of World War II and equally valid for the first half of the twentieth century. For the most part, the US Army has been the primary service involved in these foreign policy support efforts. With a few notable exceptions, the Army Medical Department's role has been limited to disaster relief.

The present international environment might best be characterized as dynamic. Although the alignment of United States interests continues to be generally East-West, new alignments are being developed by political "realities" in the North-South relationships. The global impact of the petroleum producing nations of Southwest Asia and the potential threat of a radicalization within Latin America have made it imperative for US policy makers to re-assess where and how United States influence should be projected and its interests protected. No

doubt the emerging nations of Sub-Saharan Africa and of the ASEAN grouping will also receive more attention in subsequent years.

As a result, it will be in the best interests of the United States to cultivate or to improve relations with nations where we have not perceived a great interest in the past. Of the options available to the US for the peaceful projection of power or influence in these countries, economic and military are the ones most likely to be used. In most instances, the use of military force will be within the framework of security assistance.

Most of these nations where the United States may wish to increase its influence in the near and mid-term are among those countries characterized as lesser developed or developing. Although a generalization, these countries are characterized by subsistence agriculture, one or few commodity export economies, poorly developed infrastructure, and relatively high morbidity and mortality among the population. As these developing countries attempt to achieve a higher standard of living they will require capital, educational development, technology, and organization and management skills. The US Army can provide the latter two with security assistance programs and, within the US Army, the Medical Department (AMEDD) can perform a major function in these efforts.

The possible role for the AMEDD to influence American prestige in developing countries has been recognized for more than thirty years. In the early 1950's the Army Surgeon General, Major General Hayes, postulated such a role for the AMEDD. Less

than a decade later the incumbent Surgeon General, Lieutenant General Leonard Heaton, was sent to Thailand by General Maxwell Taylor, the then Army Chief of Staff, to provide medical care to the Thai Prime Minister and to improve American prestige in that country. In his memoirs, General Heaton postulates that this early military medical presence in Thailand was valuable in gaining air basing rights in Thailand during the Vietnam War. Heaton is quoted as saying that "medicine represents a very important part of diplomacy".[1]

PROBLEM STATEMENT

Although the AMEDD leadership has recognized the potential value of health care initiatives in support of national policy objectives, no formal, continuing role for military medicine has evolved. Army Field Manual (FM) 100-20, Low Intensity Conflict, mentions the medical support for Internal Defense and Development (IDAD) operations in foreign countries where US forces are involved, but the doctrine is general in nature. It addresses in broad terms medical support of committed US forces and medical civic action programs (MEDCAP) among the host nation populace.[2] The FM 8 series, which provides doctrinal precepts for US Army medical operations, is silent on the subject of AMEDD involvement in support of foreign policy.

This is not say that there is a complete lack of medical assistance provided by United States agencies to foreign nations.

Whenever US Army security assistance forces are deployed there is included medical personnel. These are usually Special Forces soldiers whose mission includes, in addition to caring for US personnel, the training of host nation medical personnel in field medical techniques and establishing clinics to provide treatment within the limits of their capability for the local population. Where the sophistication of the medical training or the treatment required exceeds the resources of the Special Forces medics, augmentation is required from other medical sources.

The Agency for International Development, or AID, is responsible for humanitarian programs, to include medical, in support of United States foreign assistance initiatives. AID is organized to survey and document the host nation's total health care requirements with emphasis on preventive medicine programs and dietary requirements. AID can then assist the host nation to develop an appropriate long-range health program, including possible financing plans.[3] When direct grants from the United States government are made available for specific health care programs, AID can contract with non-profit agencies such as church groups or Project Hope, to implement the program. Many such projects have been very successful but it may be questionable if the recipients of such program benefits realize that their benefactor was the United States government!

Department of Defense Directive 5132.3 establishes DOD policy for security assistance and states that "security assistance is an integral part of the DOD mission". The

directive directs the emphasis of security assistance to lesser developed countries on the development of host nation capabilities to "organize, employ, and manage national resources allocated to defense".[4] This DOD mission is carried out through military equipment transfer and training of host nation military personnel through Foreign Military Sales (FMS) programs, Military Assistance Programs (MAP), and Internati Military Education and Training (IMET). The Foreign Assistance Act of 1961, as subsequently amended, governs these security assistance initiatives and for the most part mandates that the recipient nation reimburse the US government for all equipment and services received.

Thus, any efforts by the Army Medical Department to assist a foreign nation, either through the transfer of medical equipment and supplies or training of the host nation medical personnel, must, by law, be purchased. This provision does not apply to local assistance efforts undertaken by Army medical personnel who are part of an Army force deployed under exercise or operational conditions. However, the use of OMA funded medical supplies for local assistance efforts does raise questions of legality. Similarly, disaster relief in foreign countries may be either congressionally funded or reimbursed by the recipient nation.

It is almost axiomatic that health care services in developing countries, especially in rural areas, are far from adequate. Communicable diseases, the effects of malnutrition, and chronic parasitism are almost universal in these nations and

extract a terrible toll from the nation's population. Many developing nations where mortality and morbidity declined since WWII are experiencing a resurgence of disease and nutrition related mortality during the past decade. This has been the indirect result of the international economic crisis related to energy prices, decreasing commodity prices, and high interest rates.

Thus the people in some developing nations are vividly experiencing the erosion of a basic human need - a life relatively free from preventable disease. The government of these nations are not heedless of the plight of their people but frequently lack the capital, the health care infrastructure, and the management experience to effectively counter these terrible trends. Frequently these governments face concurrently the overwhelming challenges of external debt servicing, development of a favorable balance of trade, and a myriad of tasks necessary for nation building. Nothing can be more destabilizing to a population than to see an erosion of basic human services, especially when the legitimate government is perceived as impotent. When this situation is capitalized on by externally supported agitators, insurrection can be the outcome.

The Soviet Union and its surrogates, notably Cuba, recognize the destabilizing effect of social crisis and the potent propaganda benefit of humanitarian assistance. It is estimated that nearly one-half of the 7,000 Cuban and East Bloc "advisers" in Nicaragua are nurses, teachers, and sanitarians.

The United States cannot solve the internal problems of another sovereign state, but surely it is in the national interests of the United States to assist the legitimate governments of selected countries to resolve these internal dilemmas. In similar fashion, it is beyond the Department of Defense's capability or the Army Medical Department, to solve the myriad problems facing the developing world. Nevertheless, the United States' military establishment has certain strengths, other than war fighting, which could be utilized to support national policy.

This paper then evaluates the capability of the AMEDD to support US foreign policy in developing nations by the ability to assist in resolving health care delivery problems. If there appears to be areas of congruence between the needs of these developing nations and AMEDD capabilities, then would it not be in the best interests of our nation to utilize these abilities in support of foreign policy objectives? Finally, are there organizational or legal obstacles to implementing such initiatives and if so, is it reasonable to expect these obstacles to be modified?

CHAPTER I

FOOTNOTES

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CHAPTER II

A HISTORICAL PERSPECTIVE OF SECURITY ASSISTANCE AND HEALTH CARE INITIATIVES

It is not surprising that there exists ambiguous areas in our country's foreign assistance programs when the history of these efforts since World War II is considered. Following the cessation of hostilities, the United States found itself as the only economically viable nation among the victorious Allies. The decision by the Truman administration to implement the Marshall Plan for rebuilding Western Europe remains the largest and most successful foreign assistance initiative undertaken. In spite of the plan's early successes, it became quickly obvious that the nations of Western Europe would not regain the vitality required to withstand the Soviet Union's expansionist aspirations.[1] The North Atlantic Treaty committed the United States to assist Europe and the Military Defense Assistance Act of 1949 provided the basis for rearming our allies in NATO. Later, the Mutual Security Act of 1954 transferred the responsibility for managing security assistance programs from several independent agencies to the Departments of State and Defense.

By the late 1950's the international political and economic

environment had altered significantly and the rationale for foreign assistance was questioned. President Eisenhower appointed a commission to study the entire issue of economic and military assistance to foreign nations. The report of this commission, known as the Draper Committee, became the basis for much of the Foreign Assistance Act (FAA) of 1961.

The role of the Secretary of State as the ultimate responsible official for the coordination of all aspects of foreign aid, military and economic, in order to provide clearer foreign policy objectives was a prime recommendation of the Draper Committee report.[2] Section 622 of the Foreign Assistance Act of 1961 clearly delineates the responsibility of the Secretary of State in that he is, under the direction of the President "responsible for the continuous supervision and general direction of (all) the assistance programs authorized by this Act, including.....determining whether there shall be a military assistance program for a country".[3]

Section 623 of the Foreign Assistance Act gives the Secretary of Defense the responsibility for determining the content of foreign military assistance programs and for managing those programs. Notably, the Act directs the President and the Department of Defense to establish budgetary programming procedures whereby military assistance programs must compete against other military programs in the overall defense budget. The intent of this constraint was to force careful consideration of the value of foreign military assistance programs in the

context of overall defense objectives.[4]

In the Senate Foreign Relations Committee report on the 1961 FAA, the purpose of the bill is to "give vigor, purpose, and new direction to the foreign aid program".[5] In the committee comments, foreign aid was described as "both an unavoidable responsibility and a central instrument of our foreign policy. It is dictated by the hard reality of the Cold War and by a moral responsibility resulting from poverty, hunger, disease, ignorance, feudalism, strife, revolution, chronic instability, and life without hope."[6] The Act language makes it clear that the support of long-range economic and social development would receive priority. Furthermore, development loans were to be emphasized rather than outright grants and recipient countries were defined as those responsible to the legitimate aspirations of their people.

The Foreign Assistance Act of 1961, as subsequently amended, provides the legal basis for all assistance efforts undertaken by the United States government in support of foreign nations. Foreign assistance, in this regulatory context, includes all forms of economic assistance in addition to the security assistance programs managed by the services and agencies within the Department of Defense. The Department of State is responsible for overall foreign assistance policy, while within the Department of State the International Development Cooperation Agency (IDCA) is the agency responsible for development and humanitarian assistance.

While this division of program responsibility seems clear enough, there are overlapping areas of functional responsibility. Section 505 of the FAA specifies that military assistance to any country be furnished only for internal security and for legitimate self-defense. The section further states that military assistance programs should "encourage to the greatest extent possible the participation by military forces of less developed countries in programs designed to foster economic development".[7]

Although the foreign assistance legislation does not address specifically health care delivery programs as tools to further foreign policy objectives, the health needs of recipient nations are acknowledged in the FAA. Title IV includes a special assistance program for the Latin American region and states that preference should be given to projects which "promote health, education, and sanitation ".[8] The 1969 Foreign Assistance Act sets priorities for social progress in the total program of assistance to lesser developed countries: ".....the first object of assistance shall be to support the efforts of less developed countries to meet the fundamental needs of their peoples for sufficient food, good health, decent housing, and the opportunity to gain the basic knowledge and skills required to make their own way to a brighter future".[9]

The US military has been involved in foreign policy health care initiatives in numerous countries around the world since 1945. One of the earliest and most extensive efforts was

undertaken in the Republic of Korea (ROK). In the late 1940's, selected Korean military medical personnel began training with US Army medical units located in South Korea. With the assistance of US military medical personnel, a Korean Army Medical School was opened in 1949. The Korean Army Medical Field Service School was staffed by instructors from the USA Medical Field Service School and was supervised by the Military Advisory Group, Korea (KMAG). In 1950 the Department of the Army allocated a limited number of spaces for ROK personnel to train in United States medical schools.[10] Parenthetically , the Korean medical students trained under this program have been the leaders in ROK military medicine and the deans of the Korean medical schools for the past fifteen years.

This medical foreign assistance initiative in the Republic of Korea is the best example available of the long-term benefits to be realized by emphasizing leadership development. Foreign Assistance programs designed for "grass roots" assistance produce an immediate,transitory benefit but the benefits cannot be sustained without local and national leadership.

During succeeding years the medical departments of the US military services have been involved in medical assistance programs throughout the world. In 1962, for example, military civic action programs, including medical teams, were supported in nine countries. The following year these programs expanded to twenty-four countries. Their activities ranged from assisting in establishing potable water points to building clinics and

dispensaries in rural areas and training military aidmen.[11]

During the early and mid-1960's, the greatest effort was focused on Latin American countries where United States military advisors assisted in fifteen nations with civic action programs. The projects included construction of 3,500 schools, clinics, and hospitals; provision of 3.5 million medical and dental treatments; and work on 500 water projects. Much of this work was done by host nation students, who were provided medical and sanitary training at the Inter-American Air Force Academy located in the Panama Canal Zone.

In Thailand, the US Army's 31st Field Hospital sent medical teams to remote areas to provide health care where no Thai physician had ever practiced. The Walter Reed Army Institute of Research, in cooperation with the Thailand armed forces, supported the Southeast Asia Treaty Organization (SEATO) Research Laboratory in Bangkok where invaluable tropical medicine research was conducted. This effort continues today.

These are but a few historical examples of US military medical involvement in foreign assistance programs. Similar efforts continue today. However, since 1961 the Department of Defense has not been the leader in health assistance to lesser developed nations. A companion piece of legislation to the Foreign Assistance Act of 1961 was the Act for International Development of 1961. Under this Act "responsibility and authority for the formulation and execution of the foreign development aid programs will be assigned to a single

agency.....the Agency for International Development".[12] The development of health care delivery systems in lesser developed nations is included in that charter.

The AID 1982 budget proposal to the US Congress concerning proposed health care programs defines AID's purpose: "A decent level of health for the poor is a fundamental part of AID's basic human needs strategy."[13] Health sector programs contain four major objectives.

- support for developing primary health care provision mechanisms
- improve water supplies and sanitation
- control infectious disease
- assist health care systems development and supporting management structures[14]

The AID budget proposal for 1982 was $4.5 billion. Of this amount, $120,400,000, or about 3% of the total, was proposed for health programs. Eighty-five percent of the total health program was expected to be in the form of direct grants.[15] The detailed regional breakout of the program showed that expenditures proposed for Latin America would be third, following Africa and Asia, in magnitude ($22.1 million).

Post-World War II conditions irrevocably forced the United States away from its traditional isolationist tendencies and placed an international leadership role on the US. The succeeding forty years have witnessed monumental changes in the international environment but the leadership role of the United

States remains. It has been the will of the American people, expressed through twenty Congresses and eight Administrations, that it is both necessary and a responsibility for the United States to assist less fortunate nations through some form of foreign aid with the goal of international peace and stability.

The form or emphasis of our foreign aid program has evolved and been modified over the years. The immediate post-war period was characterized by the massive infusion of capital into Western Europe which allowed those nations, both friend and former foe, to rebuild existing infrastructures. There was no need for development assistance or technology transfer in these highly developed but war ravaged nations.

There followed a period, about 1949 to 1960, when the emphasis of United States foreign assistance was military. This was the time of the Cold War and re-arming of those nations sympathetic to Western democracy and opposed to Communism. In the 1960's, the emphasis of US aid shifted toward a balance between military force and humanitarian assistance. Unfortunately, for our overall foreign aid program, the energies and resources of our nation were focused on a war in Southeast Asia and critical domestic challenges.

During the 1970's the United States turned its attention to the Third World. This orientation was thrust upon us and the rest of the industrialized West by a group of relatively under developed nations who possessed a natural resource essential to economic survival - oil. Although it may be unclear what

direction US foreign aid policy is taking, at the present it seems certain the focus, importance, and priorities will shift increasingly toward the Southern Hemisphere.

In similar fashion, the health care aspects of our foreign assistance has certainly not been consistent either in magnitude or emphasis. The military services involvement was greatest in the fifteen years following World War II and has been less important since the mid-1960's with the ascendancy of AID. Types of medical projects have ranged from developing medical delivery systems, such as that provided the South Korean armed forces, through a whole gamut of research projects and direct involvement with patient treatment in hundreds of medical civic action projects throughout the world. The current involvement of US military in health assistance is well summarized by this statement. "The amount of United States military health assistance is small and tends to concentrate on high-impact, short range projects. There is little evidence of coordination or cooperation of country health activities between Department of Defense and Agency for International Development personnel."[16]

A major problem in developing long-range programs for military involvement in health care assistance projects is the difficulty of evaluating the effectiveness of such programs. As indicated earlier, the Department of Defense must prioritize its foreign military assistance programs against all other Defense programs to compete for resources. It is only reasonable that

defense officials responsible for foreign military assistance support those initiatives with which they have a high degree of confidence. Since the overriding objectives of all foreign assistance is to encourage international stability and gain friends for the United States, assistance programs which directly support these objectives will receive the scarce resources.

CHAPTER II

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15. Ibid , p. 4.

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CHAPTER III

LOW INTENSITY CONFLICT AND MEDICAL SUPPORT

Available doctrine concerning the employment of US Army Medical Department units and personnel in support of a foreign nation is almost non-existent. What is available is found in FM 100-20, the Army's doctrine concerning low intensity conflict. This field manual defines low intensity conflict as any level of hostility short of mid intensity conventional war. The manual is specifically concerned with supporting the efforts of foreign governments to either deter or defeat an insurgency.

The introduction to FM 100-20 characterizes developing or lesser developed nations as possessing certain political, social, economic and psychological factors which may contribute to political instability and predispose them to insurgency. Among the social factors which may contribute to domestic discontent the FM notes that "health care available is minimal for a large part of the population".[1] Perhaps a more graphic picture of the health status in many developing nations is offered by Hendley: "In all of the developing nations sickness affects from 50 to 90 percent of the population, threatens life, and reduces the working capacity of adults".[2] Without detailing the

ravages of infectious diseases, poor sanitation, and malnutrition upon the population of many developing nations, these health related problems are a major drain upon the human resources of these countries. Concomitantly these horrible tragedies can be a major source of popular dissatisfaction.

FM 100-20 outlines the components of US foreign assistance as development assistance, humanitarian assistance, and security assistance. The first two are the responsibility of the International Development Cooperation Agency (IDCA) and a component agency, The Agency for International Development (AID). These agencies have responsibility for a wide range of programs designed to support economic and social growth and to alleviate human suffering caused by hunger and natural disaster. The Department of Defense is responsible for the security assistance programs designed to assist foreign nations in developing a defense posture adequate to maintain internal security and resist external aggression.

Foreign military assistance is most effective, at least in theory, when undertaken in a country where there is no active internal or external threat present and adequate centralized governmental control/authority exists. In these circumstances, there are four formal programs available through which military assistance may be provided. The Military Assistance Program (MAP) provides for the transfer of military material and services to a foreign nation or grant aid. US national policy minimizes this type of military assistance and encourages instead the

Foreign Military Sales (FMS) program as the preferred method for transferring such military goods, services and training. Training of foreign military personnel may also be provided through the International Military Education and Training (IMET) program. Training under this program is provided as grant aid and is conducted either in the United States or by using mobile teams (MTT) in the host country. Training provided under IMET assists the host country to better utilize US supplied equipment and to improve its own training capability. Finally, the Economic Support Fund (ESF) may by used, either as grant aid or as a loan, to avert economic crisis during periods when the nation's resources are over extended to support legitimate defense requirements.

Normally, US military personnel, other than Military Assistance Advisory Group (MAAG) members assigned to the US diplomatic mission in a specific country or MTT personnel, will not be deployed to a friendly nation except for joint military exercises. However, if a foreign nation's government requests military assistance from the United States for counter-insurgency operations, and this request is supported by the US ambassador, the National Command Authority may direct the US Army to provide support and to deploy US military personnel.

The Army forces available to support a unified commander in internal defense include theatre-oriented security assistance forces (SAF). These are special operations forces organized under a Special Forces Group and include an organic medical

platoon. The SAF may be augmented by other medical units if the scope of Foreign Internal Development (FID) operations dictate.

FM 100-20 lists three broad missions for assigned and attached medical units.

- "Provide mobile medical advisory teams to advise, train, and assist indigenous military and paramilitary forces and local civilians in medical treatment and preventive medicine procedures

- Establish health service clinics to provide limited medical treatment to indigenous civilians as part of the coordinated Civil Action program and train civilian or paramilitary personnel to maintain and staff clinics.

- Provide unit-level medical support to other deployed elements of the SAF."[3]

Thus, the only Army doctrine available which deals with Army Medical Department support of foreign military assistance is reactive in nature. The doctrine addresses, in a very sketchy manner, basically the support of US forces and host nation forces <u>actively</u> engaged in attempting to suppress an insurgency in progress.

Since the promulgation of FM 100-20 in 1981, the United States Army has not been involved in such a situation. Current US involvement in Central America fits no such military doctrinal framework. The most recent United States experience in low intensity conflict were the initial years of the Vietnam conflict prior to 1965.

Even during the early American involvement in Vietnam, when hostilities might be termed low intensity conflict, Army medical initiatives were ad hoc in nature and mostly medical civic action programs (MEDCAP's). These efforts involved US medical personnel providing immunizations and basic health care to the population in a circumscribed area. Some teaching of local citizens in basic health care measures was done also. These simple efforts were very appreciated by the indigenous population. However, the treated population did not identify these medical efforts with the government of the Republic of Vietnam. Additionally, the MEDCAP's had short-range local impact and were not part of an overall, integrated national plan as was evidenced in the earlier Korean experience.

In Vietnam efforts by US military medical personnel did have a positive, temporary, local impact but did little at all to further specific United States foreign policy objectives.

In those instances where United States ground forces are deployed to assist a nation in combating insurgency a priority of effort must be to restore internal security. Similarly, US military medical priority will be to support the committed US and host nation military forces. As the efforts of US-supported local forces are successful, medical resources are available for civil affairs initiatives ranging from providing direct primary health services to the population of the host nation through a wide spectrum of preventive medicine, sanitation, and training activities.

The medical personnel organic to the previously mentioned US Special Forces units are uniquely qualified to perform this mission. They are regionally oriented with basic language qualifications and knowledge of the countries where they might be deployed. They are trained and equipped to operate in a hostile environment. They are specifically trained in basic sanitation and preventive medicine and the provision of basic primary health care.

Although it is not the intent of this paper to evaluate the effectiveness of low intensity conflict doctrine, two observations are offered. Medical civic action programs undertaken as part of a national civil-military operation program must be coordinated with the AID representative, if present, in the host nation. In this way short-term medical civic action initiatives will be more supportive of long-range health care development plans for the nation. Secondly, in all medical programs benefiting the host nation population every effort should be made to implement the programs through the indigenous military personnel with US assistance and advice as necessary. This will serve to enhance the image of the nation's military and its government, and bolster long-range efforts to stabilize the nation.

Certainly United States military assistance to a foreign nation involved in a low intensity conflict is a form of foreign assistance. Yet, by definition such a situation must represent a failure of US foreign policy if the premise that the ultimate

objective of US foreign assistance is the preservation of world peace and order. The emphasis of all forms of foreign assistance, humanitarian and military, must be the prevention of low intensity conflict, and the development of stable, responsive governments.

Since President Reagan announced his Caribbean Basin Initiatives policy in 1981, Latin America has enjoyed a resurgence of interest among US foreign policy and military planners. The increasing violence of the Cuban supported insurgency in El Salvador since the 1979 coup d'etat has served to heighten that interest, and to a great extent, focus attention on all of Central America. The successful Sandinista revolution in Nicaragua, and the resultant close ties of the ruling junta with Cuba, the Soviet Union and other communist countries, poses a direct threat to US interests in this strategic area. Both Honduras and Costa Rica, which share common borders with Nicaragua, face a real threat of insurgency and invasion from forces within Nicaragua.

The Kissinger Commission in its report on Central America underscores the importance of that region to the United States. The report concludes that ".....Central America is both vital and vulnerable, and that whatever other crisis may arise to claim the nation's attention, the United States cannot afford to turn away from that threatened region. Central America's crisis is our crisis."[4] In addressing the background of the current crisis in the region, the Kissinger report highlighted the role played

by a nation's inability to satisfy the basic nutrition, health, housing, and education needs of its population. The report emphasized the primacy of human development in any comprehensive effort to promote democracy and prosperity in Central America. Noteworthy in the report were seven pages of recommendations for United States efforts to improve the health status of the nations involved.[5]

Unquestionably the United States has legitimate strategic interests in Latin America. These interests range from the direct security of the United States' southern border, the security of sea lines of communication through the Caribbean Sea and South Atlantic, access to vital raw materials and markets, protection of US foreign investments, both public and private, in the region, and defense of the Panama Canal. Additionally, the United States enjoys strong historical and cultural ties with the nations of this region of the world. The United States cannot afford to ignore Latin America. Nowhere in the world is the emerging conflict between the industrial, developed north and the resource-rich, developing south more keenly felt by the US than in Latin America.

CHAPTER III

FOOTNOTES

1. US Department of the Army, Washington D.C., Field Manual 100-20, Low Intensity Conflict , Jan 81, p. 21.

2. Hendley, James Williamson, Health Services As An Instrument of United States Foreign Policy Toward The Lesser Developed Nations , Thesis, Univ. of Iowa, Ann Arbor: University Microfilms, 1971, p. 82.

3. Ibid 1, p. 133.

4. Kissinger Commission, Report Of The National Bipartisan Commission On Central America , Washington, US Government Printing Office, 1984, p. 126.

5. Ibid , pp. 68-83.

CHAPTER IV

THE EXPERIENCE IN US SOUTHERN COMMAND (USSOUTHCOM)

The United States Southern Command, a unified command established by the Joint Chiefs of Staff (JCS), is responsible for US military interests in all of South and Central America except Mexico. The commander-in-chief (CINC), USSOUTHCOM faces many challenges to the security interests of the US in this region of the world.

Latin America is a diverse region geographically and economically but the countries of the region share a common colonial heritage and, with the exception of Brazil, the same language. The nations within the region vary widely in their degree of development and the sophistication of their infrastructures. In general, they are characterized by uncontrolled population growth, extremely burdensome external indebtedness, run-away inflation, and stagnant economies. These economic ills are most pronounced in the Central American isthmus.

Another significant commonality among these Latin American countries is a rather rigid social structure with power sharing held by a landed oligarchy, the church and the military. Almost

without exception the armed forces of Latin America are identified by the population as representing the status quo and are feared and/or respected as a homogeneous, powerful group. One notable exception is Costa Rica where the country's constitution prohibits the formation of a standing military force.

Finally, the most significant commonality between the Latin American countries, particularly Central America, is the threat of substantial domestic unrest and insurgency. In many instances far reaching social and economic change are required. The threat to these nations is the course this change may take. Marxist oriented forces may be able to gain control of and direct these incipient upheavals unless needed social and economic change occurs.

Numerous factors limit the options available to the CINC, USSOUTHCOM in furtherance of US policy objectives in the region. These include the hesitance of the US Congress to support what they perceive as excessive US military involvement in the area, the strong nationalistic feelings of the governments in power in these countries, a lack of attention to the area, and the fiscal restraints imposed by the US domestic and the international economy.

Considering the current political situation in Latin America and the constraints upon CINCSOUTH's freedom of action to influence events in the region, CINCSOUTH "considers humanitarian assistance/civic action by US forces among his <u>primary means</u> to

accomplish US national security objectives in Latin America."[1]

Humanitarian assistance involves primarily efforts by US military medical and engineer units in projects designed to improve the quality of life of the population in a given host country. An opinion of the value of health care humanitarian initiatives specifically was rendered recently by a senior Army officer who stated that "health care is the least expensive, least controversial, and the most cost-effective program with the highest payoff of all the instruments of foreign policy".[2]

The value of US military humanitarian efforts in Latin America to the United States are several. Such efforts:

- compliment the activities of the US country team
- are easier to support by the host nation government than those involving combat forces
- provide superb training in wartime-like missions for involved US combat service/support units

Humanitarian actions undertaken by the US military have strategic or broad policy value in the opinion of USSOUTHCOM. Among other things, these actions provide a US military presence in Central America which is "reassuring to threatened nations and deterring to potential aggressors".[3]

USSOUTHCOM's concept of humanitarian assistance are people-to-people programs which contribute to the improved well-being of the host nation's population without overtaxing the limited resources of the host nation. Any efforts involving US

military personnel must work through the military establishment of that particular country, provide training for that country's military and enhance the public image of the host nation military among their own people. Humanitarian assistance programs undertaken should contribute to long term internal development and be sustainable by the host country. Finally, efforts by the US military compliment humanitarian assistance initiatives of international organizations with common objectives, our allies, and other United States agencies, such as AID, in the host nation.

Within USSOUTHCOM the J-5 is tasked with overall policy development concerning humanitarian assistance, coordination of all staff element humanitarian assistance efforts, and recommending humanitarian assistance projects to the CINC, USSOUTHCOM. USSOUTHCOM Regulation 550-1 outlines procedures and objectives for humanitarian assistance within the command.

The USSOUTHCOM Surgeon's Office became a full-time staff element only in 1983. The current staff includes six officers, two NCO's and a civilian secretary. In addition to the Surgeon, the officers are a Deputy Surgeon (USAF), Executive/Senior Operations Officer, Plans Officer, Operations Officer, and a Medical Logistics Officer. Only the Surgeon and the Senior Operations Officer are authorized positions.

The potential effectiveness of the USSOUTHCOM Surgeon's office has been limited by the lack of Spanish language fluency among the entire staff except for the Surgeon. Another problem

is a complete lack of prior experience or training in security assistance among the entire staff of this office. Nevertheless, the Surgeon's Office has been very active and amazingly effective during the past year.

USSOUTHCOM has had more recent experience with medical humanitarian assistance efforts in the recent past than has any other joint command. Since 1983 US military medical personnel, both active duty and reserve component forces, have been involved in every country in Central America, except Nicaragua and Belize. A review of these experiences highlight some strengths and some problem areas encountered.

US Army medical personnel have been active in El Salvador almost continuously since early 1983 when the Commander, US MILGRP, El Salvador requested a military medical survey team be dispatched to evaluate the military medical capability of the host nation. A three-man team was sent from USSOUTHCOM in March 1983. Because of the political sensitivity of US support of military operations in El Salvador, the team chief was ordered to Washington to brief ranking representatives of the NCA, OSD, and OJCS. The briefing presented an appalling situation of morbidity and mortality among wounded Salvadoran soldiers due to the absence of a responsive and effective military medical system.

An earlier military medical survey team had been dispatched to El Salvador in August 1980 at the request of the MILGRP commander. The three members of the team conducted an intensive two-week survey of the Salvadoran military medical system and

submitted a final report which included seven pages of recommendations which suggested far-reaching changes in organization, procedures, and support mechanisms. Apparently little was done by either the US government, including the US Army representatives in El Salvador, or by the host nation to implement these recommendations.[4]

Following the March 1983 survey the Assistant Secretary of Defense for Health Affairs (ASD (HA)) and a general officer representative from OTSG conducted a site visit in El Salvador at the request of the US Ambassador to that nation. Their findings were equally grim as those of the survey team. The ASD (HA) proposed, and OSD approved support of the El Salvadoran government with a 26-man medical assistance team. The Congressionally imposed 55 person ceiling for US Army military assistance personnel in El Salvador and funding for this proposed medical effort were obstacles to implementing this program. The personnel ceiling was obviated by structuring the medical group going into El Salvador as a mobile training team (MTT) which would not count against MILGRP assets. Funding was evidently a multi-agency, ad hoc effort.

The Army's Surgeon General was tasked to provide personnel for this team. Based on recommendations of the March 1983 survey and staff appraisals, the Army Medical Department Personnel Support Agency (AMEDDPERSA) screened available AMEDD officers for individuals with the appropriate skills and fluency in Spanish. Tasking was then passed to Health Services Command

to provide the personnel.

The MTT arrived in-country in July 1983 and because of the previous experience of two of it's members was able to set to the task at hand quickly. According to the team chief, guidance concerning the mission was scanty: "find out what's wrong and fix it". There was a continuing perception among the team members that the Army Medical Department staff did not have a clear understanding of the problem in El Salvador or how best to approach the mission. Although the Latin American desk officer, Health Care Operations, within OTSG was both knowledgeable and helpful, the MTT chief had a continuous problem determining who to report to or with whom to discuss personnel, logistics, or funding requirements. There was no single office within the AMEDD with the experience and tasking authority to resolve urgent issues surfaced by the medical MTT in El Salvador.

This perception by the medical MTT is not new. An official evaluation of the Army's security assistance program published in 1977 details the same conclusion. "Security assistance within the AMEDD has no single entity charged with overall policy and coordination."[5] The same study went on to say that AMEDD involvement in Army security assistance programs was so limited that there was no separate AMEDD policy for security assistance action.

There was also a perception among the team that the MILGRP in the host nation did not know quite how to relate to and support the medical MTT. Examples were given of apparent efforts by the

MILGRP to divert funds earmarked for the medical effort to other uses. Evidently, a very low priority was given to the medical MTT, which is perhaps understandable when support of the besieged El Salvadoran Army was a constant requirement.

The MTT identified the absence of an evacuation system and lack of continuity of care as the major factors in the problem of the Salvadoran Army medical system. Important other, but ancillary, problems were lack of organization within the Salvadoran medical system, poor medical supply support, and no biomedical maintenance support. The single military hospital located in San Salvador was reasonably equipped and staffed by well trained and capable physicians.

The MTT's first effort was the training and equipping of frontline medics to provide primary care for immediate casualties. Some improvements were made in the evacuation system but to this date there has been no success in obtaining dedicated helicopters for medical evacuation. Medical Service Corps officers were trained to provide the required organization for the combat medical system. Extensive training was provided to the nurses at the military hospital in surgical and critical care nursing. A medical supply and biomedical maintenance system was developed and Salvadorans trained to operate it.

The chief of the medical team highlighted several problems which included:

- dedicated funding
- no clear medical chain of control/command

- relationship with MILGRP

- selection of the qualified team members

- lack of knowledge of tropical medicine within the US Army

Some suggestions by the MTT chief included:

- be prepared to provide resources, as well as advise, to the host nation

- develop AMEDD personnel with linguistic ability and knowledge of the area where work is to take place

- re-institute some medical training within the School of the Americas in Panama[6]

This first medical MTT departed El Salvador in December 1983 after completing their maximum six month temporary duty (TDY). The recommendations of the first medical team included sending further medical MTT's to El Salvador to complete the effort and a second team was dispatched to that country in late January 1984.

The US medical effort in El Salvador is unique in that an entire army medical system is being developed in a foreign country from combat medical corpsman, through the evacuation system, to the central military hospital. The supporting administrative, medical supply, and biomedical repair systems are being concurrently developed. These efforts are totally supportive of that beleaguered nation's struggle against a savage insurgency and are completely congruent with United States foreign policy objectives in El Salvador.

Another significant medical effort undertaken by US Army personnel has occurred in Honduras beginning in 1983. The program in this country is substantially different from that in El Salvador in that the majority of the initiatives have been in the form of medical civic action programs staffed by personnel of the 41st Combat Support Hospital which deployed to Honduras in support of the combined training exercise Ahuas Tara II. During the 6 month deployment of the 41st CSH, over 40,000 medical and dental patients were treated and almost 13,000 animals received veterinary care.

Additionally, US medical personnel from the 41st Combat Support Hospital (CSH) assisted Honduran military medical personnel in a comprehensive immunization program in the most isolated areas of the host nation. This effort received praise both from US military personnel and from high officials of the government of Honduras.

Although improving the condition, at least temporarily, of some citizens of Honduras who benefited from these medical efforts and enhancing the US image among this population segment, the efforts thus far in Honduras do not seem to be particularly supportive of a long-range internal development plan. It is also questionable whether the people of Honduras who have benefited by these efforts see them in any way as an attempt by their own government to improve their lives.

In July 1983, CINC, USSOUTHCOM requested a medical survey team to travel to Honduras to evaluate the Honduran military

medical system. The team completed the survey and reported very serious shortcomings in both organization and resources for the Honduran military medical system.

This US medical survey team recommended that a MTT, similar to that in El Salvador, be deployed to Honduras to establish a training curriculum for medical corpsmen and to assist the Honduran military medical authorities in developing a workable military medical system based on the US model. To this date an MTT has not been deployed to Honduras, primarily due to US congressional reluctance to commit more assets to Latin America and to funding limitations. However, staff members of the 47th Field Hospital, which replaced the 41st CSH, have made important contributions to these goals.

More recently, in January 1984, representatives from the USSOUTHCOM Surgeon's Office visited Ecuador to establish better liaison with the officials of the military medical system in that country and to evaluate the capabilities of the Ecuadoran medical system. In Ecuador the US team found a good basic medical infrastructure within the military. In fact, these US officers discovered that the Ecuadoran military has an overall health care delivery system that surpasses, in most instances, its civilian counterpart. It was further determined that the most pressing health problems in this country are in the areas of preventive medicine and environmental sanitation.

Ecuador faces a high risk of a developing insurgency in at least two of its most isolated provinces. In these provinces

basic health services, rudimentary sanitation, and potable water are notably lacking. The Ecuadoran military leadership desired a pro-active, well structured, planned civic action program, rather than sporadic, opportunistic appearances in an effort to meet the needs of the population in these areas where insurgency could become a threat. USSOUTHCOM is now exploring numerous options, including medical, to support the government of Ecuador.

USSOUTHCOM is certainly not the only US unified command with the opportunity to exploit humanitarian assistance to further foreign assistance objectives. However, USSOUTHCOM is more actively involved in this type of assistance effort currently than the other commands.

It would appear that European Command (EUCOM) has equally good opportunities to exploit this foreign policy tool in Sub-Saharan Africa. This same observation could apply in the Central Command (CENTCOM) area of responsibility, South West Africa and the Horn of Africa. Though probably not an urgent US foreign policy priority at this time, considering the growing economic significance of the region to the US, the developing nations of Southeast Asia may present similar opportunities in the Pacific Command (PACOM) in the future.

CHAPTER IV

FOOTNOTES

1. Message, 212105Z84, Subject: DOD Task Force On Humanitarian Issues , USCINCSO to SECDEF.

2. MG William P. Winkler, MC, USA, unpublished remarks, September 1983.

3. Op cit, USCINCSO Message.

4. Morales, Hernan, COL, MC, USA, Report of the Medical Survey MTT, El Salvador , September 1980.

5. Department of the Army, The Army Security Assistance Program Study Report (TASAPS 77) , Washington, October 1977, p. 9-1.

6. Morales, Hernan, COL, MC, USA, personal communication with author, April 1984.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The forty year tradition of foreign assistance, both developmental and military, is a major component of United States foreign policy and will continue to be so for the foreseeable future. Foreign assistance policy from its inception has weathered the criticism of influential segments of American society from both within and outside the government and has been a cornerstone of US foreign policy through eight succeeding administrations since World War II.

United States foreign assistance policy has been evolutionary throughout its history. This will likely continue to be true. Economic pressures, a more slowly growing economy, and the extent of United States foreign interests dictate that a greater proportion of our foreign assistance be loans rather than outright grants. Another evolutionary trend is a decreasing emphasis on purely military aid in favor of developmental aid and humanitarian assistance. There also has been a definite change in the recipient focus of US foreign aid since World War II, that is from the rebuilding of industrialized countries ravaged by

that war to assisting developing nations become more industrialized. Now the emphasis of US assistance is on the poorly or lesser developed nations.

These lesser developed nations of the Third World are chacterized by widespread domestic unrest, insurgencies, and frequent overthrow of existing governments, often with the active assistance of Marxist-inspired forces. Often the governments of these lesser developed nations are repressive and self-serving. Almost universally the majority of the population of these lesser developed nations lack even the basic social needs such as adequate food and housing, employment, education, and health and sanitary services. Even in those nations where the existing government recognizes the need for improvement of the basic conditions of life, too often there are insufficient resources and knowledge to initiate and sustain the much-needed changes in these conditions.

The current direction of US foreign aid toward these lesser developed nations is likely to continue for the next ten to twenty years. To do otherwise would ignore the reality of raw material sources and potential markets in these nations. Equally important, these Third World nations are faced with potential or on-going insurgencies and violent revolutions which could destabilize the global balance of power and directly threaten the security of the United States. Also, these is the moral imperative to assist the millions of people who exist now with only the barest of economic and social support.

There is a great potential for US foreign assistance within the realm of humanitarian and basic developmental assistance. This potential for humanitarian assistance initiatives as a component of overall military assistance strategy appears to be receiving interest among defense policy makers. Secretary of Defense Casper Weinberger underscored this interest recently: "Humanitarian assistance and civic action in foreign countries are activities of great importance for the United States.....both from the point of view of our moral principles and to support specific policy objectives."[1] There is a legitimate need for the Defense Department to encourage stability of political institutions and support long-term US strategic interests in the Third World nations.[2]

The military forces of the United States possess a wealth of organizational experience and technical knowledge which could be a great asset to US foreign policy humanitarian assistance initiatives. Military personnel and equipment can be rapidly projected anywhere in the world. Military health personnel have experience in a centrally managed health care delivery system, are accustomed to training and working with lesser skilled paramedical personnel, and have experience in managing complex health care delivery systems.[3] Furthermore, the military medical services, especially those of the US Army, have a tradition of research and treatment involving many of the diseases which decimate these lesser developed nations. The capability for applied medical research is maintained by all

three US military medical services.

US military assistance efforts in Central America underscore a recurrent theme in the history of United States security assistance. That is the tendency to mobilize military resources for humanitarian or civic actions projects after the threat of insurgency has become real. Certainly US experience a decade and a half ago, and today in El Salvador, supports this conclusion. The pacification of villages or regions in order to deny local assistance to the insurgents becomes the stimulus for all civic action programs.

Such efforts can be successful. However, it is obvious that pro-active assistance initiatives which enhance the ability of the governments of lesser developed nations to provide the basic needs of their people better serve US national interests in these countries. "Military civic actions carried.....into countries where dissidence or insurgency is incipient could result in a favorable orientation of the population to the established government and thus prevent insurgency."[4]

The most effective role for military medical services in civic action initiatives which support US foreign policy objectives is working with the leadership of the host nation military in developing the organization for a health care delivery system. The experience of the US Army Medical Department in the Republic of Korea just prior to and during the Korean War is a good example of such an effort. The result of that program is a well organized military medical system in the

ROK and a well trained and influential cadre of medical leaders. The current US medical MTT effort in El Salvador is a timely example of top-down development assistance.

After almost forty years of experience there is still less than optimum coordination of military assistance with overall foreign assistance policy. If you accept Clausewitz's oft quoted dictum concerning war as a continuation of diplomacy by violent means, then it should follow that military (defense) policy in time of peace should also be an extension of foreign (diplomatic) policy. The Draper Commission report of 1959 and the resultant Foreign Assistance Act of 1961 did a great deal to fix responsibility for different aspects - economic, social, military - of foreign assistance but has not resulted in a totally rational, unified approach to the multitude of foreign assistance efforts undertaken by the United States.

RECOMMENDATIONS

The Army Medical Department, along with the medical departments of the other services, should be given the mission to be involved actively in foreign civic action programs as part of a coherent total foreign assistance program. Involvement by US military medical personnel with foreign civic action programs should be as an integral part of an integrated, long-range internal development program which is completely coordinated between the agencies involved. US military involvement must be

between the agencies involved. US military involvement must be with the host nation military establishment and be limited to assisting the host nation military assist their own people. US medical personnel must at all times retain the role of teacher and advisor, not doer.

The range of possible programs where Army medical personnel could contribute is wide - from the development of a total military system to assisting in establishing training programs for paramedical "barefoot doctors" who could provide primary health care to the rural population. The scope of US Army medial assistance would of necessity vary from country to country depending on the resources of the host nation, the ability of the host nation's military to sustain programs, and the requirement to support any long-range development initiatives of AID. The emphasis of military medical assistance in every instance must be "top-down" development. Without the organization and trained leadership, health care programs cannot be sustained.

Any assistance mission assigned to Army medical personnel or units should be short-range, probably six months to two years. AID is tasked for long-range humanitarian development programs: population control, eradication of vector-borne diseases, sanitary system development, etc. Longer deployments of US military units would create problems in maintaining existing world-wide commitments.

As has already been noted, the Army Medical Department is limited by resource availability, particularly personnel, in it's

ability to assume new missions. This situation will not improve in the mid-term. Any expanded foreign assistance role for the Army Medical Department would require a careful prioritization of current missions. It would be possible to develop within reserve component medical units the ability to undertake any of these proposed missions.

The experience in Central America has plainly shown that Army personnel involved in foreign medical assistance must be proficient in the language of the host nation,[5] have a good knowledge of environmental medicine and tropical medicine, and thoroughly understand the mechanism of security assistance. This latter requirement is adequately met by the Defense Institute of Security Assistance Management located at Wright-Patterson Air Force Base.[6] The Defense Language Institute capably handles foreign language training for United States armed forces personnel. The Uniformed Services University of Health Sciences (USUHS) should develop a training program for selected individuals in the requisite environmental and tropical medicine skills

The Army Medical Department should develop a cadre of officers who are qualified as medical foreign area specialists if the AMEDD is to become actively involved in foreign assistance programs. These officers could be regionally oriented rather than toward a specific country. From this cadre would come the staffs of the various unified command surgeon offices, the chiefs of medical MTT's, and other key positions involved in medical

foreign assistance programs.

Each unified command surgeons's office must be staffed with sufficient, qualified personnel. The surgeon's office should develop and maintain a comprehensive evaluation of each nation within the region with emphasis on the major health problems of the nation, incidence of prevalent diseases, and the degree of sophistication of the existing health system and the status of the military health system in each country. This information would be used to develop a prioritized command plan for exploiting medical humanitarian assistance projects within the region.

In those nations where Army medical assistance projects are programmed, an Army Medical Department officer with the required foreign assistance training should be assigned to the MAAG/MILGRP. This officer would provide expert advice to the Country Chief and MILGRP Commander, establish liaison with AID if appropriate, and be the point of contact for all matters involving the deployed medical advisory team.

If non-traditional roles for military assistance such as that for medical programs are worthwhile in supporting US foreign objectives, then legislation is required to amend Title 10, US Code so that humanitarian assistance is included in the missions of the unified commanders.[7] A mechanism for programming such efforts in the Army budget is required. Finally, a careful evaluation is required to determine at what level military health care foreign assistance policy should be formulated. It is the

authors' opinion that this would best be accomplished within the Defense Department.

The most sensitive issue to be faced is a cooperative effort by Congress and the Administration of the United States to re-evaluate and re-define the proper role of US foreign aid as a supporting mechanism for United States assistance policy. The world is a much different place than when the Draper Commission report was issued a quarter of a century ago.

This paper has addressed only a very small segment of United States foreign assistance policy - health care systems development in lesser developed nations. Even within this limited field, the paper has ignored the significant contributions provided by the United States over the years through multilateral organizations such as the United Nations. Nevertheless, it is our conclusion that the US military medical departments, specifically the US Army Medical Department, could contribute significantly to nation building in lesser developed nations in support of US foreign policy. Such a conclusion is based upon the inherent organizational skills, the technology, the deployability, and the experience with environmental medicine techniques characteristic of the AMEDD.

Involvement by Army Medical Department personnel and units in foreign military assistance programs would provide outstanding training for the US forces. The opportunity to work with potential allies, utilizing organic equipment, and living in the climatic extremes common in so many lesser developed nations

would be of great value in achieving readiness proficiency by the involved medical units. It is quite possible that the greatest benefit to the Army and to the United States of medical foreign assistance programs could be the realistic training gained through deployment.

CHAPTER V

FOOTNOTES

1. Weinberger, Casper, Memorandum, DOD Task Force on Humanitarian Issues , Jan 84.

2. Weinstein, John M., "The Effect of Third World Poverty on US Security", Parameters , Vol. XIII, Number 4, Dec 83, p. 54.

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