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14. ABSTRACT There are numerous elements that contribute to the Theater Security Cooperation Plan (TSCP). Among the tools available to the Combatant Commander are Humanitarian Assistance and Humanitarian Civic Assistance (HCA). Within HCA, medical services have been employed, chiefly as either Medical Civic Assistance Programs or as Medical Readiness Training Exercises. The role of Health Services Support in the TSCP is examined and an assessment of its effectiveness is discussed. It is concluded that while HSS is a valid component of the TSCP, long-term health benefits rarely result for the served population. Long-term health benefits would have a greater potential for being realized if Non-Governmental Organizations and Private Volunteer Organizations were engaged in the process. Health Services Support is often employed as a tool for winning the "hearts and minds" of a population, however, the people of that population would be served better medically if the local health system infrastructure were improved, which would produce greater long-term health effects and would result in maintaining a healthier population.					
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**The Role of Health Services Support in the Theater Security Cooperation Plan:
Do We Have It Right?**

by

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A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

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Abstract

There are numerous elements that contribute to the Theater Security Cooperation Plan (TSCP). Among the tools available to the Combatant Commander are Humanitarian Assistance and Humanitarian Civic Assistance (HCA). Within HCA, medical services have been employed, chiefly as either Medical Civic Assistance Programs or as Medical Readiness Training Exercises. The role of Health Services Support in the TSCP is examined and an assessment of its effectiveness is discussed. It is concluded that while HSS is a valid component of the TSCP, long-term health benefits rarely result for the served population. Long-term health benefits would have a greater potential for being realized if Non-Governmental Organizations and Private Volunteer Organizations were engaged in the process. Health Services Support is often employed as a tool for winning the “hearts and minds” of a population, however, the people of that population would be served better medically if the local health system infrastructure were improved, which would produce greater long-term health effects and would result in maintaining a healthier population.

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The Role of Health Services Support in the Theater Security Cooperation Plan: Do We Have It Right?

Introduction

There are numerous elements that contribute to the Theater Security Cooperation Plan (TSCP). Among the tools available to the Combatant Commander are Humanitarian Assistance (HA) and Humanitarian Civic Assistance (HCA), which will be defined subsequently. Within HCA, medical services have been employed, chiefly as either Medical Civic Assistance Programs (MEDCAP) or as Medical Readiness Training Exercises (MEDRETES).

This paper will explore MEDCAPs in the context of the TSCP of representative Combatant Commands as they shape their respective theaters. The research represented in this paper will seek to answer the following questions: What is the appropriate role of Health Services Support (HSS) in the TSCP? Is the current employment of MEDCAP the most effective HSS means to support the TSCP? Should the effect of HSS in the TSCP be only “window dressing,” or should an effort be made to affect the long-term health of the recipient population? The thesis for this paper is that although Health Services Support is often employed as a tool for winning the “hearts and minds” of a population, the people of that population would be served better medically if the local health system infrastructure were improved, which would produce greater long-term health effects and would result in maintaining a healthier population.

This discussion is relevant because most Combatant Commander’s theaters include developing countries. These countries are often the focus of the respective Theater Security

Cooperation Plans, especially when employing HA or HCA. If a conclusion is reached that the current application of health services support is not achieving the desired outcome, then alternatives for improvement should be made. Perhaps the HSS component of the TSCP can be effectively applied in support of the Combatant Commander's objectives and simultaneously have lasting effects on the population. This all must be explored in the context of the Combatant Commanders' objectives for their respective theaters.

This issue will be examined by starting with the origins of the Theater Security Cooperation Plan and a review of the joint doctrine as it addresses the TSCP and MEDCAPs. This will be followed by a review of representative TSCPs of some of the Geographic Combatant Commands with examples of historical MEDCAPs. The latter will be assessed for their impact with respect to support of the TSCP and their contribution to improving the health of the recipient populations.

Origins of TSCP and Medical Civic Assistance Programs

Any number of sources address, either directly or indirectly, theater security strategy and medical civic assistance. It is helpful to understand these in a considered review of the topic. At the very highest levels of guidance, one must draw inferences to these specifics because the higher levels speak only in the broadest of terms. Guidance for the Combatant Commanders originates with the National Security Strategy (NSS) and the National Military Strategy (NMS). The NSS addresses strategies to build the infrastructure of democracy. "The United States Government will pursue these major strategies to achieve this goal: *Provide resources to aid countries that have met the challenge of national reform....While continuing our present programs, including humanitarian assistance based on need alone...*"ⁱ

[Emphasis in the original] It goes on to say “Governments must ... invest in health care and education...”ⁱⁱ

The DOD Humanitarian and Civic Assistance Program is authorized under Title 10, United States Code, Section 401. Under this legislation, HCA is authorized in conjunction with military operations if the Service Secretary determines that the military activities will promote the security interests of both the United States and the host country, and that they enhance operational readiness skills of the military members who participate.ⁱⁱⁱ DOD Directive 2205.2 reinforces this legislation.^{iv} Additional clarification is provided by identifying that the Assistant Secretary of Defense for Health Affairs (ASD[HA]) is the advisor to the Under Secretary of Defense for Policy (USD[P]) for the HCA activities proposed by the Unified Combatant Commands. Specifically, ASD(HA) is responsible for certifying that HCA activities involving medical personnel contribute to the improved operational readiness skills of those participating.^v

The NMS addresses shaping the international environment, which will include peacetime engagement activities. Furthermore, as part of protecting United States national interests, “...armed forces can assist with the pursuit of *humanitarian interest* when conditions exist that compel our nation to act because our values demand US involvement.”^{vi} [Emphasis in the original] The NMS goes on to say, “Engagement serves to demonstrate our commitment; improve interoperability; reassure allies, friends and coalition partners; promote transparency; convey democratic ideals; deter aggression; and help relieve sources of instability before they can become military crises.”^{vii} Steinke and Tarbet observe that, “The engagement component of this policy constitutes the preponderance of the requirement to ‘shape the international environment.’ Thus, engagement has taken on virtually equal

importance to that of warfighting (respond) and the research, development, and acquisition (prepare now) aspects of our National Military Strategy.”^{viii}

With the foregoing in mind, it is worthwhile to briefly discuss the transition from a Theater Engagement Plan (TEP) to the Theater Security Cooperation Plan. U.S. Southern Command (USSOUTHCOM) distills the distinction very succinctly.

“...the Office of the Joint Staff had begun to design a new concept called Theater Security Cooperation (TSC) to replace the previous concept of the peacetime Theater Engagement Plan (TEP). The TSC concept is transformational. It represents a distinct shift from general engagement to shape the security environment in peacetime to reciprocal bilateral and multilateral cooperation that promotes U.S. strategic interests. TSC is a focused program intended to achieve predefined outcomes for a specific group of designated Priority Countries.”^{ix}

This subtle change has implications for medical HCA that will become clearer in the subsequent recommendation made in this paper.

Finally, the following definitions will help with understanding the subsequent analysis. The CJCS Manual 3113.01A provides definitions that are consistently used throughout other publications. Humanitarian and civic assistance (HCA) includes medical, dental, and veterinary care provided in rural areas of a country in conjunction with military operations and exercises. “For TEP purposes: planned activities for which specifically allocated humanitarian assistance funds are requested. These activities are primarily provided in conjunction with military operations and include assistance in the form of transportation of humanitarian relief, and provision of excess nonlethal supplies for humanitarian assistance purposes.”^x Further clarification is added by, “Assistance must fulfill unit training requirements that incidentally create humanitarian benefit to the local populace. (Joint Pub 1-02)”^{xi} Humanitarian assistance (HA) includes the elements of HCA plus a provision

addressing detection and clearance of landmines.^{xii} At first, this distinction may not suggest great relevance. However, it becomes rapidly apparent that the terms HA and HCA are often used interchangeably in some writings. It is worthwhile to make the following distinction: “Humanitarian assistance refers to an immediate, emergency response in support of natural or manmade disaster relief efforts. Humanitarian civic assistance missions are usually planned missions designed to promote U.S. interests and assist a host nation.”^{xiii}

A Closer Look at and Analysis of Implementation

With the preceding background, it is time to examine how some of the Combatant Commanders have implemented a TSCP and, more specifically, how health services support has been factored into their theater security plans. The geographic combatant commands will be the focus, with emphasis on USEUCOM, USPACOM, USCENTCOM, and USSOUTHCOM. Some variations will be evident and are useful for conducting an analysis of approaches that may be more effective as compared with those that may be less effective. The discussion will conclude with a look at some potential changes, a review of pros and cons with respect to MEDCAPs in general, potential measures of effectiveness, a brief look at resources, and finally, a view from a representative non-governmental organization (NGO).

The U.S. European Command (USEUCOM) has arguably the most mature MEDCAP program and provides insight into two different approaches. USEUCOM names its humanitarian civic assistance programs MEDCEUR and MEDFLAG for programs performed in Europe and Africa, respectively. Before examining these more closely, one should understand the overall focus of EUCOM’s TSCP.

“The program implementation is strategically focused to meet the five DoD objectives:

- Shape the security environment and foster goodwill furthering U.S. national interests;
- Gain access and influence;
- Bolster the ability of developing countries to prepare and respond to disasters;
- Train U.S. Forces; and
- Demonstrate how a professional military operates with civil military cooperation.”^{xiv}

Although both MEDCEUR and MEDFLAG include education, mass casualty exercises and patient treatment, the emphasis differs for the two programs. Because of the wide disparity between existing health services in Europe and Africa, the latter receives a far greater emphasis on basic health care needs. Both of these programs seem to fulfill the requirement to improve the operational readiness skills of those health care providers who participate. However, one could argue that there is no good evidence that any long-term health benefits are realized by the host population. Indeed, one who has extensively reviewed the experiences in Africa concluded, “As spectacular as they seem, the MEDFLAG exercises have little impact on sustaining the health of the Host Nation, given the infrequency of visits to the respective countries and the individual orientation of the MEDCAP.”^{xv} Furthermore, in the larger picture, another author has suggested that, “In the context of nation building, democratization, economic prosperity, and regional stability, individual MEDCAP teams have minimal impact.”^{xvi} This combination raises a serious question about the worthiness of the programs both in the context of improving the health of a population and in contributing to an improved security climate. Since MEDCAPs are only one piece of the TSCP, the latter question is arguable. However, the lack of evidence demonstrating long-term effects supports the former conclusion.

An interesting contrast can be made when comparing the EUCOM approach to MEDCAP with that of PACOM or SOUTHCOM. PACOM MEDCAPs rarely visit the same country more than once, whereas SOUTHCOM makes repeated MEDCAP visits to countries within its theater. This is an important distinction when assessing the effects of their respective efforts. However, it is beneficial to step back and look at PACOM's overall approach to the TSCP. It is especially helpful to examine their method of assessment. "Similarly, the collective sum of TSC activity assessments is used during USPACOM's annual TSC planning process to answer three fundamental questions: Are we doing the right things? (TSC effectiveness), are we doing things right? (TSC efficiency) and what is the benefit to the U.S.?"^{xvii} [Emphasis in the original] An excellent example of a performance measure is exemplified by the "Mission Performance Plan FY 2005 for the US Mission to India" that establishes targets for each fiscal year.^{xviii} This measure is confined to HIV/AIDS prevention, and although limited, provides insight when considering possible measures of effectiveness.

A look at the SOUTHCOM plan and MEDCAPS is enlightening because it has been reported that nearly fifty percent of the health care in the region is provided through medical HCA.^{xix} Although evidence is believed to exist demonstrating some short-term and long-term benefits, no specific tool for measurement was provided. Indeed, without a policy requiring it, there is no incentive for a host government to use a standard measurement.^{xx} While SOUTHCOM asserts that its programs not only provide training for United States units but also improve quality of life in the recipient communities, there is little evidence to support this claim. On the other hand, "The New Horizons exercise infrastructure efforts center on health and education infrastructure (school and clinic construction) to fulfill a long-

range effort to help hemispheric nations provide a healthy, literate populace with a stable environment.”^{xxi} SOUTHCOM labels its medical programs as Medical Readiness Training Exercises (MEDRETES), but they are similar to efforts conducted in the other geographic commands. They perform 70-80 MEDRETES per year and provide medical treatment to approximately 8,000 civilians in the host nations.^{xxii} The medical activities performed include biomedical maintenance and technical support, disease surveillance, diseases vector control, and basic medical care.^{xxiii} By virtue of the repeated visits made in SOUTHCOM, one could more effectively design criteria for assessing long-term health benefits.

Very little information on the CENTCOM program has been found, but suffice it to say that CENTCOM’s TSCP is described as very similar to those that have already been examined. “The HA program is restricted to developing countries in the AOR...based on need and status of political-military relations with the United States. Projects include Medical Civic Action Projects (MEDCAPs), which consist of medical and dental screening, inoculations, and veterinary care;...”^{xxiv} The CENTCOM program is managed by “...close planning and coordination between USCENTCOM, country teams, host nation governmental agencies, and executing component commanders.”^{xxv} This approach lends support to an argument for interagency cooperation.

With the foregoing brief descriptions of representative COCOM TSCP and MEDCAPs, it is worthwhile to analyze the effects of the various programs. One of the criticisms of the MEDCAP made by re-deploying forces to nations that have previously hosted MEDCAPs is that they find a population that is in even worse circumstances than upon the prior visit. It has been argued that a false hope has been instilled in the population and that a lack of follow-up procedures intensifies this view.^{xxvi} This view was exposed by

Llewellyn when he observed that confidence in local governments may have been eroded because the local governments could not sustain the level of care introduced by United States personnel.^{xxvii} This is one of the hazards of short-term programs that do not improve infrastructure. The Public Health/Preventive Medicine sector has long-recognized that lasting health improvement of a population is dependent upon improving the infrastructure to support improved preventive health practices rather than coming in for a short period of time to administer health services. Llewellyn's assessment of humanitarian medical assistance would agree. "The focus was upon treatment rather than prevention. There were little or no plans for integration with local government activities and personnel, and no long term sustained follow-up of patients."^{xxviii} He concluded that "Health assistance activities can be a useful adjunct to overall humanitarian support activities if implemented as part of a 'country plan' dedicated to *long term goals*."^{xxix} [Emphasis in the original] However, Joint Doctrine can be interpreted as not intending to provide long-term health benefits to the targeted population.^{xxx} Due consideration to this issue is also provided by guidance that advocates "...supporting and supplementing whatever medical infrastructure exists [but] no operation should be considered that would or could have the effect of supplanting the existing medical infrastructure."^{xxxi}

The last statement may offer insight into why measures of effectiveness for HCA and MEDCAPS do not exist. One could clearly argue that if the benefit to the local population is only incidental to unit training requirements that are accomplished during these exercises, then there is no mandate to measure health effects. So long as long-term effects are not the objective, then one could reasonably surmise that assessments will be, at best, subjective. Even in the robust program employed in SOUTHCOM, the only assessments made are

relative to a funding analysis, a force analysis (man-days), a capability development assessment, and lastly in the after-action reports.^{xxxii} The resource issue is not insignificant. While only limited examples of costs entailed for MEDCAP have been found, the impact of resources on the total TSCP program have been alluded to by other authors. Steinke and Tarbet adeptly identify the resource constraints for the Theater Engagement Plan (forerunner of TSCP) and address the Commanders' attempts to adapt to the lack of dedicated funding for engagement. "For example, Pacific Command has established an Engagement Working Group as a forum to resolve funding and policy issues, and other commands, like Southern Command, 'fence' funds to ensure the means are available for engagement activities."^{xxxiii} In the final section, measures of effectiveness will be examined in greater detail.

Although somewhat dated, the following argument supporting MEDCAPs remains relevant. Considering the limited time investment and the relative minimal expense, Nuechterlein contends that humanitarian assistance programs are an excellent means for shaping United States foreign policy and United States national security strategy.^{xxxiv} Although this argument has merit, he later goes to further assert that humanitarian assistance programs can have long-lasting results to a country and enhance stability.^{xxxv} One could argue that while this may be true for the overall humanitarian assistance program, it is not true with respect to health improvement for the reasons stated earlier.

Finally, an evaluation of HCA and MEDCAP from an NGO perspective is beneficial, especially in view of recommendations that will be made later. Although the following is taken from HCA within NATO, it is relevant because it is a current assessment, as well as being instructive and representative of the NGO perspective. The authors are civilian and their comments need to be understood in the context that they see the military involvement

as being in “their domain.” Some of their comments reflect views expressed previously. “Neglect of these principles (and a short-term approach to disaster relief), often led to the establishment of inappropriate programmes, which neither met the immediate health needs of the population they were intended to assist nor were the benefits sustainable or affordable in the national context.”^{xxxvi} Although these authors were highly critical of the apparent political motivation for the military involvement, like noted above, they expressed additional concern about the short-term missions rather than long-term commitment.^{xxxvii} They go on to allege that the military does not conduct an objective assessment of the needs in the locale where they operate. The authors offer four case studies to highlight their agenda. For purposes of later discussion, the most pertinent were “lack of appreciation of public health problems and priorities,...problems of civil military coordination and cooperation leading to duplication in some sectors/areas and gaps in others,...and poorly targeted aid.”^{xxxviii} Whether or not one subscribes to the objections raised by these authors, the point to be realized is that NGOs can view military medical humanitarian assistance in a very negative light. In view of a recommendation to be made later, this must be kept in mind.

A Final Assessment and Recommendations

A recurring theme throughout the foregoing is the failure to produce a long-term positive health effect with MEDCAP. This is a valid criticism. Llewellyn argued that success requires “...a long term commitment to furthering health education, primary level medical care, disease control and prevention, and most importantly sanitation and public health advancement projects.”^{xxxix} President Bush acknowledges the essential element of prevention programs, but lays the responsibility on the host nation government. “Resources from the developed world are necessary but will be effective only with honest governance,

which supports prevention programs and provides effective local infrastructure.”^{xl} One could argue that the best opportunity for achieving long-term health benefits in the targeted countries will be through a rigorous partnership with NGOs and Private Volunteer Organizations (PVOs). This arrangement would seem to accomplish an appropriate avenue for COCOMs to affect their TSCP with MEDCAP, while promoting a relationship with the interagency that is more suited to implementing the changes required to produce long-term public health and preventive medicine measures. This approach can be argued as even more consistent with the subtle changes between TEP and TSCP described earlier (see p. 4).

Further support for this recommendation is found at various levels of our military structure. The NMS directs that joint forces act in concert “...with other US government agencies, and with Non-governmental Organization (NGOs), International Organizations (IOs), and Private Voluntary Organizations (PVOs) in a variety of settings.”^{xli} This has been further codified and expanded to include regional and international organizations.^{xlii} PACOM recognizes the importance of synchronizing with other U.S. government agencies and allies to reduce duplication and develop unity.^{xliii} Finally, doctrine promotes medical HCA missions as a joint effort with civilian agencies.^{xliv}

Determining appropriate measures of effectiveness is a daunting task. One suggestion has been to develop medical mission-essential task lists (METLs) for assessing long-term medical benefits. METLs currently provide for the assessment of medical readiness training, but not for the health effects produced within the host population. Measures of effectiveness need to be developed, but the military personnel generally will not be in the area of the exercise at a time for evaluating these long-term effects. Here again, a partnership with NGOs, PVOs and IOs could provide a solution. These agencies would be in

a far better position to monitor long-term effects. One author suggested the following parameters to evaluate effectiveness: life expectancy, infant mortality, and percent with access to safe water.^{xlvi} These measures have merit and could be employed, again, through partnership with the various civilian agencies. The JCS has described the characteristics for measures of effectiveness and cites as examples reduced mortality rates, decreased incidence of disease, and increased participation by NGOs.^{xlvi}

An argument has been made by at least two authors for altering the composition or training of health care professionals in an effort to affect long-term health outcomes.^{xlvi xlviii} The argument against these proposals is based upon the fact that the health services expertise for combat troops should remain the focus of the military healthcare system. Arguably a long-term medical expert would be advantageous and it is proposed that this expertise would reside better in the Department of State with its country teams.

The preceding are re-enforced in joint doctrine that summarizes many aspects of the foregoing.

“The use of HSS resources has historically proven to be a valuable low-risk asset in support of CMO. **HSS is generally a noncontroversial and cost-effective means of using the military element to support US national interests in another country.** The focus of HSS initiatives, although possibly targeted toward the health problems in the operational area, is not normally curative, but primarily long-term preventive and developmental programs that are sustainable by the HN. HSS operations conducted to enhance the stability of a HN must be well coordinated with all concerned agencies and integrated into the respective US Embassy plans. Independent, unplanned health service civic action programs should not be undertaken.”^{xlvi} [Emphasis in the original]

Conclusion

This work set out to examine the Theater Security Cooperation Program and what role Health Services Support could or should play in support of that program. The guiding documents were reviewed and were followed with an examination of how various Geographic Combatant Commanders implemented TSCP, especially MEDCAP.

The thesis of this paper was that the recipient populations would be served better by programs that supported public health and preventive medicine measures that would result in long-term improvement in the health status of the respective country's population. Nothing in the reviewed materials appears to refute that. On the other hand, MEDCAP is only a part of the TSCP. In the context of the Combatant Commander's overall theater strategy, MEDCAP in its current form is a successful, relevant piece. The long-term health objectives are not supported well by the military component of the TSCP, but that is not the objective of the TSCP. The long-term health objectives have a better chance of being attained if those who plan MEDCAP receive the concurrence of their respective commanders to engage with NGOs and PVOs for the sustainment of the efforts initiated by the military units.

Therefore, the evidence appears to support an argument that MEDCAPs and MEDRETEs provide a portion of essential health care benefits in a recipient country and are a credible component of the humanitarian civic assistance element supporting the overall TSCP. Evidence does not exist that long-term health benefits are realized. This outcome has a better chance of being observed if NGOs and PVOs are engaged leading to a better opportunity for improving infrastructure that would support long-term public health and preventive medicine outcomes. These outcomes are measurable over time.

Finally, the role of military health care providers cannot be to establish the requisite infrastructure to promote long-term health benefits. Their role needs to remain focused on

providing care to combatant forces. A partnership with NGOs, PVOs, and IOs is a plausible solution for effecting long-term health benefits and should be pursued.

In conclusion, have the original questions been answered? Health Services Support has a role in the TSCP. MEDCAPs and MEDRETEs are an effective means even with their limited potential for producing long-term health benefits. In this light, they are most effective as training exercises for the health care providers within DOD. Thus, HSS in the TSCP is more than “window dressing.” However, the next step is to increase interagency cooperation and establish means that can ultimately lead to long-term health benefits.

NOTES

ⁱ George Bush, The National Security Strategy of the United States of America (Washington, DC, The White House 2002), 21-22.

ⁱⁱ Bush, 22.

ⁱⁱⁱ General Military Law, U.S. Code, Title 10, Chapter 20, Section 401.

^{iv} Department of Defense, Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations, DODD 2205.2 (Washington, DC: 1994), 2.

^v Department of Defense, Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations, 5.

^{vi} John M. Shalikashvili, National Military Strategy of the United States of America (Washington, DC: The Pentagon, Office of the Chairman Joint Chiefs of Staff, 1997), 6.

^{vii} Shalikashvili, 7.

^{viii} Ralph R. Steinke and Brian L. Tarbet, "Theater Engagement Plans: A Strategic Tool or a Waste of Time?", Parameters, (Spring 2000): 71.

^{ix} United States Southern Command, United States Southern Command FY 03-05 Theater Security Cooperation Strategic Guidance (Miami, FL: 2002), iii.

^x Chairman, Joint Chiefs of Staff, Theater Engagement Planning, CJCSM 3113.01A (Washington, DC: 2000), GL-4.

^{xi} Joint Chiefs of Staff, Interagency Coordination During Joint Operations, Joint Pub 3-08 (Washington, DC: 1996), GL-7.

^{xii} Chairman, Joint Chiefs of Staff, Theater Engagement Planning, GL-5

^{xiii} Department of the Air Force, Military Operations Other Than War, Air Force Doctrine Document (AFDD) 2-3 (Washington, DC: 5 October 1996), 13.

^{xiv} Mario V. Garcia, Jr., "Achieving Security Cooperation Objectives Through the United States European Command Humanitarian and Civic Assistance Program," DIASM Journal of International Security Assistance Management, 25 no. 1/2 (Fall 2002/Winter 2003), 105.

^{xv} Terry Carroll, "Engagement or Marriage: The Case for an Expanded Military Medical Role in America," (Unpublished Strategy Research Project, Army War College, Carlisle Barracks, PA, 2001), 38.

^{xvi} Jeffrey L. Bryant, "Assessing the Long-Term Health Benefits of Medical Humanitarian Civic Assistance Missions," (Unpublished Research Paper, Air Command and Staff College, Maxwell AFB, AL, 1997), 11.

^{xvii} United States Pacific Command, U.S. PACOM FY-04 Theater Security Cooperation Strategic Concept (Camp H.M. Smith, HI: n.d.), 16.

^{xviii} United States Pacific Command, 15-16.

^{xix} William Ward et al, "A Critical Part of Nation Assistance," Military Review, (March 1993), 39.

^{xx} William Ward, 37-39.

^{xxi} United States Southern Command, G-6.

^{xxii} United States Southern Command, G-7.

^{xxiii} United States Southern Command, G-14.

^{xxiv} United States Central Command, United States Central Command Theater Engagement Plan Strategic Concept (FY 02-04), (MacDill AFB, FL: 2001), 27.

^{xxv} United States Central Command, 27.

^{xxvi} James M. Crutcher and H. James Beecham III, "Short-Term Medical Field Missions in Developing Countries: A Practical Approach," Military Medicine, 160 no. 7 (July 1995), 339-343.

^{xxvii} Craig Llewellyn, "Humanitarian medical assistance in U.S. Foreign Policy: Is There a Constructive Role for Military Medical Services?", DIASM Journal of International Security Assistance Management, 14 no. 4 (Summer 1992), 73.

^{xxviii} Llewellyn, 73.

^{xxix} Llewellyn, 75.

^{xxx} Joint Chief of Staff, Joint Doctrine for Military Operations Other Than War, Joint Pub 3-07 (Washington, DC: 1995), III-10.

^{xxxi} Joint Chiefs of Staff, Joint Tactics, Techniques, and Procedures for Foreign Humanitarian Assistance, Joint Publication 3-07.6 (Washington, DC: 2001), G-1.

^{xxxii} United States Southern Command, I-15.

^{xxxiii} Steinke and Tarbet, 79.

^{xxxiv} Donald E. Nuechterlein, America Overcommitted: United States National Interests in the 1980s, (The University Press of Kentucky, 1985), 32.

^{xxxv} Nuechterlein, 34.

xxxvi Patricia M. Diskett and Tim Randall, "Humanitarian Assistance: A Role for the Military?", NATO's Nations & Partners for Peace, no. 3 (2001), 172.

xxxvii Diskett and Randall, 173 and 176.

xxxviii Diskett and Randall, 176.

xxxix Llewellyn, 75.

xl Bush, 23.

xli Shalikashvili, 22.

xlii Joint Chiefs of Staff, Interagency Coordination During Joint Operations, III-1.

xliii United States Pacific Command, 14.

xliv Joint Chiefs of Staff, Doctrine for Health Services Support in Joint Operations, Joint Publication 4-02 (Washington, DC: 2001), II-5.

xlv Bryant, 17.

xlvi Joint Chiefs of Staff, Joint Doctrine for Civil-Military Operations, Joint Publication 3-57 (Washington, DC: 2001), III-10-11.

xlvii Llewellyn, 76.

xlviii Carroll, 12.

xlix Joint Chiefs of Staff, Joint Doctrine for Civil-Military Operations, II-12.

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