

Joint Special Operations Task Force - Philippines (JSOTF-P) Joint MEDCAP Planning

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“The Moro Islamic Liberation Front [MILF is a separatist organization in the Philippines] has described the latest approach to the insurgency problem in Mindanao....which is civil-military operations, as more lethal than brute force.”¹

Executive Editor's Note: HMC Jody Fletcher, SFC John Dominguez, HM1 Travis Walker, and HM1 Patrick Gallaher are all to be congratulated for writing this article. I have never rejected an article written by medics. The number of articles in the JSOM authored by medics is only limited by the number we are sent.

ABSTRACT

Over the last several years civil military operations (CMO) have increasingly become a vital part of a commander's overall mission strategy. Special Operations Forces Medics help support a commander's CMO plan by planning, coordinating, and executing medical civil action programs (MEDCAPs). SOF Medics face unique challenges in planning and successfully executing MEDCAPs at the operational and tactical level of war. However, because of shared experiences in different combatant commands, civil affairs teams (CAT-As), and operational detachments alpha (ODAs) are developing successful tactics, techniques, and procedures (TTPs) for conducting MEDCAPs through a professional peer exchange within the JSOTF-P. The TTPs developed enable the CAT-A or ODA to immediately establish credibility, foster rapport, and improve contacts with local government units, local government organizations, non-government organizations, and host nation counterparts. The professional peer exchange provides the CAT-A or ODA team with the opportunity to learn the planning and logistical requirements of conducting a MEDCAP in the Joint Special Operations Task Force – Philippines AOR.

Marine Special Operations Company A (MSOC-A) was tasked with a new mission in the Republic of the Philippines. After only five weeks in the joint operational area (JOA) the MSOC-A was assigned the mission of conducting two MEDCAPs in two different barangays. (A barangay is the smallest unit of local government in the Philippines. It is a Filipino term for district or village.)

MSOC-A had to move medical supplies and people from more than thirteen different military and civilian organizations among several islands. CAT-As and ODAs have been conducting MEDCAPs in the Philippines for several years and unlike MSOC-A, generally have the advantage of conducting transition operations with outgoing teams to ensure continuity of effort.

The Corpsmen of MSOC-A are primarily Special Amphibious Reconnaissance Corpsmen (SARC), who

begin their training at the Field Medical Service School followed by the Basic Reconnaissance Course, Marine Combatant Diver School, Amphibious Reconnaissance Corpsmen Course, Basic Airborne School, and end with the Special Operations Combat Medic Course. The SARCs' medical training and tactical experience is equivalent to that of their counterparts in Special Forces, Civil Affairs, and Naval Special Warfare (NSW). Until recently, the opportunity did not exist for them to execute MEDCAP missions. Their recent entry into SOCOM and current deployment into the JSOTF-P's JOA illustrated one aspect of Special Operations that neither the MSOC-A, nor their Marine comrades had yet encountered – the non-kinetic fight.

The lack of experience in conducting MEDCAP operations led MSOC-A to quickly realize the need to search for subject matter experts in MEDCAP operations. Imme-

diately, the SARC's began searching for information and anyone who could help them accomplish their missions. The JSOTF-P's civil affairs planners offered assistance and referred them to the 97th Civil Affairs Company – the company then operating in the JSOTF-P JOA. The senior Medic for the CA Company was tasked with providing MSOC-A personnel with information on planning procedures and processes for MEDCAPs in this particular AOR.

In JSOTF-P JOA the mission is to work “by, through, and with” the Armed Forces of the Philippines (AFP), as described in the article, “A New Look on Military, Civil Military Operations”² by LT Johnson in the *Journal of Special Operations Medicine*. The article posits that operational success is measured by the AFP's ability to be self sufficient, with U.S. forces solely acting in advisory roles. MSOC-A was seeking this type of success and thus looked critically at the planning process performed by CAT-As in JSOTF-P's AO. The MSOC-A SARC's and the senior Medic for the JSOTF-P CA company reviewed the planning processes developed by the CAT-As for conducting MEDCAPS in the JOA and developed additional steps to further enhance the planning process. The results of their efforts improved the planning process and yielded a step-by-step planning model, which the JSOTF-P has adopted as the MSOC MEDCAP Model (3M).

What they discovered in their joint effort were minor shortfalls in the JOA's current MEDCAP planning process. Shortfalls identified included: the lack of a defined planning sequence; identifying host nation individuals and resources for the MEDCAP; and synchronizing efforts among all stakeholders. The shortfalls had not been identified earlier because information had not been disseminated throughout the JOA. The advantage of creating a planning model became readily apparent – it would support continuity of effort.

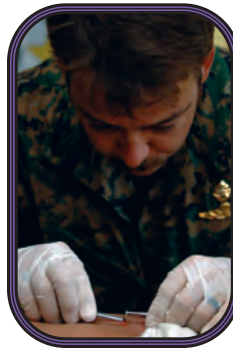


LtCol Bayong (6th Marine Battalion Commander AFP) interacts with children at MEDCAP as Col Alivio and SFC John Dominguez discuss joint training.
Photo by Marine Sgt Robert “Rocky” Smith



Chief Petty Officer Jody Fletcher, MSOC-A SARC's, and CA Medic participate in middle planning conference for MEDCAP with local leaders.

Photo by SFC John Dominguez



Petty Officer 1st Class Patrick Gallaher sutures wound at MEDCAP.

Photo by Petty Officer 1st Class Troy Latham



CSM Terry Peters, MSGT Sidney Voss, and SgtMaj Lustre (AFP) observe as Philippine marines and NGO's treat patients at MEDCAP.

MSOC-A conducted a successful MEDCAP on 7 May 2007 after utilizing the JSOTF-P planning model. Understanding that the patient load is historically twice the amount that was planned for, MSOC-A provided enough medicine for 250 patients. With supplies and additional medicine offered from local groups, and the combined effort of 13 different organizations, 475 patients, out of a population of 2,644, were successfully seen and treated in less than a five-hour period of time. From the initial planning phase to its execution, there was little more than a two-week period in which to facilitate meetings and plan the operation. Though there is no single paradigm that can address all the questions encountered in planning and executing a MEDCAP, the model provided in this article can provide a valuable template for conducting a successful MEDCAP. See figures 1 to 3 and the outline of the MEDCAP model.

REFERENCES

1. <http://www.luwaran.com/modules.php?name=News&file=article&sid=249>.
2. LT Johnson, LT Mickaila, SFC James Shearer, and SFC Woodrow Wilson, “A New Look on Military, Civil Military Operations” – pending publication in the *Joint Special Operations Medical Journal*.

Initial Planning Conference (IPC)

Purpose: To initiate communication between U.S. forces and host nation (HN) (military, local leaders, non-government organizations, etc). This is when timelines and locations will be discussed in “broad stroke” terms.

WHO:

- 1) Unit level medical planner, someone who will see it through the execution phase.
- 2) HN, responsible command (CMO)
- 3) Local civil affairs office / civil military operations officer
 - a) Not required but beneficial

WHAT:

- 1) Tentative Date for: PDSS (if possible) /MEDCAP
- 2) Total number of personnel and transportation considerations
- 3) Request Numbers
 - a) Medical Personnel
 - Physicians
 - Dentists
 - Pediatricians
 - Pharmacists
 - Nurses
 - Midwives
 - Corpsmen/Medics
 - Dental Technicians
 - b) Others (i.e. CMO, Public Affairs)
- 4) Location
 - a) Grid location preferred
 - b) Inquire about previous MEDCAPs in or around proposed site
- 5) Supplies
 - a) Medical supplies that JSOTF will supply (i.e. MEDCAP Palette 250 / 500)
 - b) Any supportive, medical, or other supplies provided by HN assets
- 6) Personnel who will be in attendance for site survey
 - a) Solidify number of PAX
 - b) Obtain points of contact, phone numbers

(NOTE: Time of departure for Site Survey will be given at later date via Phone or email. Time is dependant on number of personnel and mode of transportation.)

- 7) Modes of transportation, from insert to MEDCAP.
 - a) Host nation assets available and lift capacity
 - b) U.S. Forces assets available and lift capacity

(NOTE: Ensure no less than a primary and alternative means of transportation for all personnel involved. Host nation assets can be unreliable)

WHEN: 2 Months - 1 Week from MEDCAP

WHERE: No specific location requirements

Middle Planning Conference (Site Survey)

Purpose: The site survey is when all coordination will cumulate to a final executable plan. All participating agencies will discuss the specifics of the operation and coordinate and finalize responsibilities, timeline, and exact number of participants from each agency.

WHO:

(NOTE: Photograph all key individuals and place into OPORD. DTG correct name.)

- 1) NGOs
- 2) PHO
- 3) HN CMO
- 4) HN CDR
- 5) HN U-7
- 6) Local governmental official (Barangay captain, village leader, mayor, etc)
- 7) Religious leader(s)
- 8) JSOTF
 - a) Military information support team (MIST)
 - b) Unit level planner
 - c) Security representative
 - d) (Optional) J-2, SIGINT, HUMINT
 - e) Civil Affairs

WHAT:

- 1) Local governmental official (Barangay captain, village leader, mayor, etc)
 - a) Estimated population
 - b) Number of households
 - c) Estimated number of registered voters
 - d) Confirmation of MEDCAP date
 - e) Publicize MEDCAP
 - f) Support for site
 - Tables
 - Chairs
 - Shade structures
 - Public address system
 - Water (For volunteers and tooth extraction)
 - Entertainment for waiting patients if possible
 - ice
 - cooler
 - fans
 - g) Religious leaders
- 2) Civil military operations officer (HN)
 - a) Clear and secure site 24 hours prior and maintain presence.
 - b) Confirms lunch for volunteers through local government.
 - c) Develops opening ceremony
- 3) NGOs
 - a) Confirm number of personnel and specific role of volunteers
 - b) Identify what supplies will be provided by each organization
 - c) Verify collection method (numbers for patients) and how / when information can be collected for AAR.
 - d) Facilitate transportation to and from site.

(NOTE: Facilitate communication between all NGO's and volunteers)

- 4) Provisional health officer / local health unit official

- a) Use of locals for registration
 - b) Basic medical demographics by:
 - Age
 - Sex
 - Prominent medical conditions
 - c) Confirm number of personnel that can be seen (Supplies being the limiting factor)
 - c) Major concerns
 - Effect on economy?
 - d) Number and type of medical personnel available to volunteer
 - Physicians
 - Dentists
 - Pediatricians
 - Dental Technicians
 - Corpsmen
 - Midwives
 - Nurses
 - Pharmacists
- 5) General concerns to be discussed
- a) Establish timeline of MEDCAP events
 - b) Coordinate and confirm modes of, and timeline for transportation.
(NOTE: Anticipate delays, cancellation, and no-shows)
 - c) Opening ceremony events developed and confirmed
 - d) Walk through patient flow.
 - e) Propose the registration form to be used
- 6) Site selection considerations
- a) Layout facilitates patient flow, mitigate congestion
 - Consider the pharmacy as the last stop before the exit
 - b) Minimum of four rooms / partitions
 - Medical
 - Surgical
 - Dental
 - Pharmacy
 - Registration (Optional)
 - c) Operational concerns (U.S. Forces)
 - Distance / transport time from insert to MEDCAP location
 - Field sketch of building layout
 - Photographs of buildings, avenues of approach, key terrain.
 - Ten digit grid of key locations
 - Hard room / Distinguished Visitor (DV) room
 - Easily defensible
 - Traffic concerns
 - Ingress / Egress routes
 - Management
 - Choke points
 - HLZs
 - CASEVAC
 - Emergency extract
 - Communications position/ equipment required

WHERE: Location should be the actual site of the MEDCAP. If unable to visit the actual site then the nearest military / host nation compound or area coordination center (ACC) should be utilized.

WHEN: 3 – 10 days prior to MEDCAP

Final Planning Conference (FPC)

Purpose: All events, transportation, and personnel will be confirmed and finalized

WHO:

- 1) Unit level medical planner, someone who will see it through the execution phase.
- 2) HN, responsible command (CMO)
- 3) Local civil affairs office / civil military operations officer
 - a) Not required but beneficial

WHAT:

- 1) Finalize and confirm
 - Total number of personnel by nation / service / position
 - Timeline of events
 - Transportation of all parties involved

WHEN: 24-48 hours post site survey.

WHERE: Same as IPC

Confirmation Brief

Purpose: Every U.S. Service member involved needs to attend

WHO: The following is a list of individuals and what they can provide

Public Affairs Office (PAO) – Positive information operations effectively targeting both host nation and U.S. audiences.

Combat Camera – Documentary photography submitted to joint services

Medical Personnel – Facilitate treatment

J-2 – Collections, HUMINT / SIGINT

MIST

Chaplain

Representative from unit providing transportation.

WHEN: 24 – 48 hours prior to execution of MEDCAP

Considerations:

- 1) Notify Special Operations surgical team (SOST) to be on stand-by
- 2) Plan on 2 to 10 DVs during planning
- 3) Prioritize manifest in anticipation of transportation changes.
 - Medical personnel are prioritized as per above.
- 4) Ensure and facilitate communication between ALL parties / personnel involved



HMC Jody Fletcher is currently the senior Corpsman for 1st MSOC-A. He is a Special Operations Independent Duty Corpsman with 16 years experience. His deployments include Iraq, Philippines, and Afghanistan.



SFC John Dominguez is currently serving as the F Co 97th Civil Affairs Battalion (Airborne), company senior Medic assigned to the Joint Special Operations Task Force Philippines (JSOTF-P). His other deployments include Afghanistan '01-'02 (Task Force Dagger), Iraq '03, and Horn of Africa '05-'06. He is a SOCM paramedic with 10 years field medical experience.



HM1 Travis Walker is a Special Operations Independent Duty Corpsman with 14 years experience. His deployments include the Philippines and Afghanistan.



HM1 Patrick Gallaher was formerly an 18D with 19th Special Force Group, a former instructor at JSOMC, and is now on active duty with 1st MSOC-A. His deployments include the Philippines and Afghanistan.