THE USE OF MILITARY MEDICAL ASSETS IN HUMANITARIAN ASSISTANCE

This paper offers the technical point of view of the Pan American Health Organization, Regional Office of the World Health Organization, on the use of Military Medical Assets in humanitarian assistance operations based on the attached revised list of questions. The following observations and comments are valid in the context of humanitarian UN operations. Obviously, a distinct position may be required in case of operations undertaken bilaterally with some UN endorsement or approval.

1. Rapid initial assessment

1.1 *Need*

A rapid initial assessment may be the only means to secure information on the health situation (worst case scenario: no national government, little international presence and existence of casualties from conflict) or be merely optional (the Haiti scenario: extensive expertise available locally, strong presence of WHO/PAHO and NGOs, existence of legally recognized health authorities). So the need for a rapid initial assessment may vary considerably according to the political and military situation. In Haiti, in our opinion, there was no need for a distinct field survey.

1.2 *Who should conduct the assessment?*

If national health authorities can be expected to play a leading role impartially and efficiently, they should have the overall responsibility. If not, the *international agency* with a mandate in health (e.g., WHO or PAHO/WHO in the Americas) is the second in line to assume this overall responsibility. Military assets should be used to strengthen the capacity of the first and second line responders, not to substitute it.

Under any political or operational scenario, local or international health experts (WHO, NGOs) should be closely involved in the planning, execution and interpretation of the on-site assessment.

1.3 *Role of military personnel in assessment*

The role of the US Military in the on-site assessment should be, above all, to provide *support* for a joint inter-agency assessment. Support should include logistic, communication and health expertise. Regarding the latter each agency (and the US Military) has some definite "comparative advantage" in the health field. The first that come to mind are medical care of traumas or casualties for the US Military, public health (disease prevention and control including surveillance and epidemiological analysis) for WHO/PAHO, and community level care for NGOs.

In the early stages of past humanitarian operations, failure by the military to recognize the mandate or make good use of the respective strengths of other partners of the international community has contributed to the communication gap between military and humanitarian agencies.

In a nut shell, the military might have control of the transportation/logistic capacity needed, but much of the public health and medical expertise and knowledge of local conditions might be found outside its ranks.

The constitution of on-site assessment teams should reflect the "comparative advantages" of the various partners as well as the mandate *and* capability of the national government and WHO.

2. Determining needs and priorities

This issue cannot be dissociated from the initial rapid assessment. Assessment has one essential purpose: to determine priorities for action of the national authorities and the international community (not to collect data for making a report or a publication). Determination of health priorities must be done collectively and not only by and for the US Military (otherwise the entire exercise and discussion would be futile).

To answer the question of "who is conducting" (i.e., directing or leading) the on-site assessment also answers the question of who should be interpreting the results and setting priorities. In order of priority it should be the national authorities, WHO, and other generally accepted parties including, possibly, the UN peace-keeping forces.

It should be noted that even with one recognized agency (or individual) coordinating the health assessment and setting priorities, every agency will "interpret" these priorities according to their mandate, resources, and, basically, their institutional interests.

2.1 *Standard for assessment*

The standards or yardstick adopted for the assessment must be a reasonable compromise between the high health standards of intervening countries (US Military) and the lower standards of the affected country prevailing before the crisis that justified the humanitarian or military intervention. The standard must be as close as possible to the prevailing standard and practice in existence in the affected country or other neighboring developing countries. The US Military definitely should not use the same health standard or yardstick in Macedonia as in, for example, Somalia.

3. Measure of effectiveness: Monitoring

Measuring the effectiveness of the operations of any agency/partner in humanitarian assistance is difficult at best. There may be no cause and effect relation between one's operations and the improvement (or lack thereof) of the health situation.

The US Military should establish its own criteria for measuring the immediate effectiveness of its own health operations. The international community should, along with the US Military, establish support for and participation in a joint/collective process for the evaluation/monitoring of the health situation. The data collected in the on-site assessment will serve as base line data.

The role of the national authorities (if applicable), WHO, and NGOs should be increasingly dominant in this monitoring process as the presence of the US military is likely to be relatively brief. It is preferable for the US Military to accept early on the seemingly less "efficient" arrangement resulting from national/UN leadership, than to run smooth, short term health operations, which, when terminated, will leave behind a vacuum resulting from weakened national or international agencies, as well as considerable frustration.

4. Involvement of US Military in medical and public health activities

In general, a US Military intervention brings great and apparently unrealistic health expectations from the local population, NGOs and international organizations.

The following may be factors or criteria determining the extent of the US Military involvement:

- *Unmet* health needs: the principle of complementarity is essential. The US (or other)

Military should complement and strengthen existing health operations and capabilities and not substitute them.

- Magnitude of the needs as *perceived by the public* in the US and other countries. Perhaps, the mass media coverage is the most critical factor in this regard.

- Balance between military/security and humanitarian concerns and priorities. Looking at both ends of the spectrum, there is, on one end, the purely humanitarian intervention following an earthquake, and on the other end the example of military protection for evacuation of UN peace keeping troops. Involvement of US medical assets in civilian public health activities should be high in the former, nil in the latter. The operations in Somalia, Rwanda and Haiti called for distinct levels of involvement.

- *Sustainability*: Needs can be short-lived (for instance, occurrence of casualties ending with military operations, starvation relieved by the next crop). In this case, sustainability is less of an issue. If health needs and problems addressed result from poverty and underdevelopment, they will outlive the duration of the US military presence. In such cases, sustainability of operations following the withdrawal of the military must be a key criteria: Is the military strengthening or weakening agencies who will carry on after their departure? Will some equipment and supplies be left behind for the government and or NGOs to carry out some of these humanitarian functions? If sustainability is not considered, the result, while it might be excellent in terms of public relations, will be a nightmare for the health authorities and NGOs (US or other) remaining behind.

In general, we would tend to support active operational involvement of the US and other military medical assets provided that they respond to health priorities identified by the international community at large, and WHO in particular, and that this involvement be compatible with the long term needs which will require extended support from WHO and NGOs in the actual delivery of humanitarian health assistance.

Major involvement of the US Military in humanitarian assistance is generally planned with significant lead time. This lead time could be used much more effectively than it has been in the past. The US Military should consider the following short-term measures prior to a mission:

- Clear and unambiguous statement and discussion of what humanitarian assistance the US Military can or cannot be expected to provide under distinct scenarios. That also should include a set of policies/procedures for use by the US Military Medical assets.

- Prior contacts must include and actively involve key operational agencies. Meetings of PVOs and international organization cannot be limited mostly to the UN Secretariat, for example, but should take place with the *policy* and *operational* level of agencies such as WHO, PAHO, UNICEF, WFP. This implies that the US Military develop a good knowledge of "Who's Who" in the international field and assess objectively the *actual* capacity of each agency in the affected country.

- Contacts should not be limited to a few briefing meetings but there must be a constant dialogue and consultation process leading to *joint planning* of the humanitarian component of the US Military operation. Flexibility and willingness to adjust plans should be part of the process.

- In the health sector, special consideration and treatment should be given to WHO (or PAHO/WHO in the Americas). If the operations are under the aegis of the UN, the planning process must reflect this international dimension. The World Health Organization is not just another health PVO!

- Most important, the commanding officers in charge of the humanitarian action must be identified in advance, be introduced to their partners and lead the consultation process. Not knowing our interlocutors in advance was one of the most limiting factors in coordination with the US Military in Haiti.

- The role, structure and chain of command of the Civilian Military Operation Center needs clarification before its establishment. Who has the authority to make what decision needs to be understood by the civilian partners. Perhaps simulation exercises (humanitarian war games!) involving the *actual partners* should be organized in advance of the mission. The objective is for *these persons* to learn to work together.

- Resources and assets (budget, vehicles, personnel) should be assigned in advance by the US Military for logistic support of humanitarian assistance, with the understanding that this assistance is contingent upon the military/security situation.

In addition to the short-term measures to be taken in the planning phase of an actual operation, long-term measures are also needed to bridge the gap between two (or more) cultures= US Military, PVOs and International Organizations.

- Seminars, simulation exercises, training activities should be planned and organized *jointly* at the regional level between US Military and the UN (WHO in the health field). The model that comes to mind is the "Trade winds" field-exercise organized

by the Caribbean Regional Defense System *jointly* with regional organizations such as Caribbean Disaster and Emergency Response Agency (CDERA) and PAHO. The most important aspect is the joint planning of this exercise rather than the participation of "guests" in a military exercise. Similarly, PAHO has participated/contributed to a few seminars organized by and for the Southern Command. To be effective, similar meetings must be more frequent and involve the military units likely to be involved on the humanitarian side. PAHO will be most willing to assist, in its field of competence in such a joint readiness effort.

- Periodic high level meetings between US Military and key partners (global and regional) to discuss pending issues. Meetings should be both intersectoral and sectoral. In the health field, PAHO/WHO, being located in Washington, D.C., is willing to play an active role to promote this dialogue.

- After action meetings: after each major operation, an after action meeting should be held to discuss issues and suggest improvements. As many of the difficulties encountered at field level often result in a misunderstanding of the respective mandates, terms of reference and constraints, this meeting should be frank and in an informal environment encouraging constructive debate on controversial items. There is still time to hold such a meeting to discuss the most recent operations, including Haiti.

Concluding Remarks

One political issue will determine the extent and nature of cooperation between humanitarian agencies or international organizations and the US Military, that is, the perceived possibility of "conflict" between the humanitarian rôle of the agencies and the political objectives assigned to the military mission.

How "distinct", independent or even compatible are those two objectives (humanitarian and military) in a complex disaster? Not very! Experience has shown that the humanitarian considerations (e.g., getting assistance to the victims) is almost always totally subordinated to military objectives, even though these objectives are supposed to be, or to include, the protection of the humanitarian effort.

An operational issue is the need to provide/recognize some "authority" (rank) to legal level representatives of UN agencies. In Yugoslavia, humanitarian supplies or personnel have the lowest priority for space on military flights. Any military private outranks the Director of UN agency relief operations. No major improvement in coordination will result if the humanitarian role is not "somewhat" insulated from political objectives and given some operational priority over other operations to the degree security allows.

OPERATIONAL AND TACTICAL GROUPS

Emerald Express '95 - Phase II
11-14 April

Issue: Health Interventions

Moderator: Claude de Ville de Goyet, M.D.
Chief, Emergency Preparedness and Disaster Relief Coordination Program
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Discussion: A key to successful humanitarian operations is the mitigation of suffering and the saving of lives. Rapid accomplishment of this goal requires early health assessments and the initiation of a program to improve health conditions. This working group will address the assessment process and discuss objective measures of effectiveness which are critical in guiding the overall effort Military medical assets can support medical and health efforts, but their capabilities and limitations must be understood by mission planners. Standardized protocols and joint training are also essential to a unified medical effort

Related Questions:

1 Who is responsible and who is conducting the rapid on-site assessment of health conditions? What criteria/standard/yardstick should be used?

- How can military personnel assist in the assessment process?

2 Who determines the medical and public health needs and sets priorities for international humanitarian health assistance?

- How are the data of the assessment and proposed priorities communicated to the US military operational planners and other operational partners?

3 Who is responsible for establishing health-related measures of effectiveness and how are these communicated to the planners and operations staff?

4 Should US military personnel be involved in delivering direct patient care or carry on public health activities?

5 What can be done prior to operations to coordinate the efforts of medical relief organizations and the military?

6 What are the criteria for:

a) requesting assistance from the US medical structure

b) the US medical structure responding or taking the initiative

Related Topics:

1. Role and mandate of international organizations
2 Standard protocols
3. Disease prevention
4. Force medical care
5 Increase or change in US medical structure to accommodate humanitarian assistance
6 Title X US Code funding
7 Relief workers working in US medical facilities
8 US medical personnel working in civilian or NGO facilities
9 Cultural concerns

Products:

1. Define policy and outline doctrine for the military medical mission in humanitarian operations.

a guidelines for levels of medical care to civilians by US forces and the authorization needed for each.

b. Outline procedures for faster movement of US military support in emergencies

2. Develop standard protocols for interaction of US military medical assets and civilian relief agencies

Summation of Health Issues Group Discussion
12-13 April

Question: Who is responsible for and who is conducting the rapid on-site assessment of health conditions? What criteria/standard/yardstick should be used?

Discussion: A rapid on-site assessment is absolutely critical to effective task force planning. Different entities may be responsible for this assessment in different situations. A CINC-directed assessment team may make a preliminary site visit prior to force deployment, or the Disaster Assessment Response Team (DART) from the Office of Foreign Disaster Assistance (OFDA) may make the assessment. Regardless of the entity performing the assessment, the main purpose is to define potential mission objectives of a task force. Recommendations for specific health service support objectives for the local population should be defined at the outset of the mission. The general nature of the rapid assessment should be as follows:

1. The assessment team should include a preventive medicine professional, preferably with training and experience in international relief.

2. A list of potential task force mission goals should be developed in concert with officials from the UN, embassy, local government, NGO's, and bilateral relief organizations. This general list should be reviewed prior to the team's departure. This list should be the basis of the team's recommendation to the CINC. It should include proposed health-related measures of effectiveness whenever possible.

3 The team should gather as much advance information as possible prior to the site visit

a. information sources might include UN, State department, OFDA, WHO, others

b if a CINC team is employed, it should ideally have a standing relationship with major players in their area of responsibility

c. information of particular interest includes:

-baseline health data is highly desirable

-information on NGO's, bilateral relief organizations and others operating in the country is also critical

-an assessment of the local health infrastructure and capabilities

-an assessment of public health programs, water and sanitation

4 The first contact in country should be with US Embassy, which initially requested the team

a. If a CINC team performs the assessment, coordination with the DART team is preferable

b Information derived by the DART team should be sought

c. Contact with the local government should be arranged through the embassy

d. All available health indicators should be assessed

5. Consultation should begin with the UN coordinator (generally the UN Development Program Resident Representative) in country and the Minister of Health (if applicable). Following initial.

Question: Who determines the medical and public health needs and sets priorities for international humanitarian assistance? How are the assessment and proposed priorities communicated to the US military operational planners and operations staff?

Discussion:

1. The UN health coordinator should serve as the "honest broker" for NGO's, bilateral relief agencies, and others with competing priorities for medical or support assets He/She chairs a standing health committee or working group of agencies active in the health sector. This committee will:

a. set overall policy in the health field

b formulate a proposed set of priorities for allocation of task force resources, on an ongoing basis

2. The Civil Military Operations Center (CMOC) should have a preventive medicine physician serving as the principal health advisor to the CMOC Commander.

3. The CMOC PM physician should attend the UN health coordinator meetings with NGO's, bilateral relief agencies and others. The role should be as follows:

a. provide basic information to the group about task force mission as outlined by the CINC

b provide basic information on medical, public health and other capabilities of the task force

c. act as an advisor to the UN health coordinator, helping to focus the deliberations of the health committee on specific prioritized support requests and encouraging objective measures of the health situation whenever possible

3 A formal communication of health-related support requests is developed by the UN health coordinator, and presented formally to the CMOC commander in concert with the CMOC PM physician

4 Support requests are continually updated as required based on continuing input from members of the health committee.

Question: Should US military personnel be involved in delivering direct patient care and/or public health assistance to the local population?

Discussion: Attempts to provide direct medical care using US military assets is fraught with significant difficulties. It is important to note that focused provision of sustainable public health programs in concert with local agencies or NGO's can significantly benefit both the military mission and the local population. Line leadership must have the clearest possible understanding of the serious negative consequences of a well-intentioned but misguided application of medical care resources

A. *DIRECT MEDICAL CARE*

1. Care of US forces is the undisputed priority for US medical assets

2. Care of US citizens in country is also a mandate
(NGO's, press, embassy, etc)

3. A policy must be in place regarding the provision of immediate trauma care of locals unintentionally injured by US forces. Local standards of care must be considered if such care is provided.

4. A policy must be in place regarding provision of care to injured civilians encountered by US forces (even if not injured by US forces)
a. transfer to local facilities after stabilization is a priority
b. air evacuation assets will not be used unless specifically authorized
c. legal guidance on standards of care should be explicit
-US vs local level of care
-should be based on a clear understanding of what is sustainable locally

5 Routine primary care of pre-existing conditions in the local population should NOT be undertaken. Reasons for this policy include:
a. level of care is not sustainable
b care may undermine local organizations or practitioners
c US medical resources are not well-suited for local problems
-no oral rehydration salts, no pediatric medications, etc
d opens the door to "mission creep"
e specific example: treating active tuberculosis cases for a limited time may lead to drug resistant strains, creating a worsened medical situation locally

6 Serious epidemic illness or other medical emergencies of limited duration may benefit from direct military medical involvement Examples would include patient treatment during a cholera epidemic

Question: What can be done prior to operations to coordinate the efforts of medical relief organizations and the military?

Discussion: This is a new area for military planning, with the potential for significant improvement and development.

1. Current initiatives include:

a. Emerald Express exercises co-sponsored by I MEF and the State Department

b. An international relief and disaster response seminar for military and civilian personnel organized by CAPT Burkle at the University of Hawaii

2 Potential initiatives to consider in the future might include:

a. Uniformed Services University of the Health Sciences (USUHS) courses for medical department officers, integrating the UN, WHO and NGO communities.

b. Providing civilian university fellowships or advanced study in international relief for military medical department officers

c. Assignment of military officers to key agencies such as UN, OFDA, WHO or other organizations

d. development of a cadre of disaster / humanitarian relief expertise within the Navy PM community

(Navy Environmental Health Center or Navy Environmental and Preventive Medicine Units)

e. establish an interservice workshop on military public health intervention to be jointly sponsored by Pan American Health Organization/WHO and USUHS. Participation of medical professionals from allied armed forces should be encouraged.

f. develop a specific humanitarian assistance operation curiculum for command and staff colleges

3 Other potential approaches include:

a. Disaster response cells at Unified Commands should be modeled after the CINCPAC structure (DJIFAC)

b Characteristics of the CINCPAC cell include

-this cell is in a position to maintain liaison with NGO and UN contacts within the Pacific area of responsibility (AOR)

-a PM physician with specific training should be added to the cell

-this cell should join the JTF staff for actual operations in the AOR

-augment the CMOC?

-this cell should make advance liaison with appropriate NGO or UN personnel at the CINC level prior to an actual operation