

# NAVAL POSTGRADUATE SCHOOL MONTEREY, CALIFORNIA



## THESIS

**THE USE OF DOD MEDICAL ASSETS  
IN INTERNATIONAL HUMANITARIAN  
AND DISASTER RELIEF OPERATIONS**

by

David E. Gilliland  
December 1996

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Thesis  
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# REPORT DOCUMENTATION PAGE

Form Approved OMB No. 0704-0188

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1. AGENCY USE ONLY <i>(Leave blank)</i>	2. REPORT DATE December 1996.	3. REPORT TYPE AND DATES COVERED Master's Thesis	
4. TITLE AND SUBTITLE THE USE OF DOD MEDICAL ASSETS IN INTERNATIONAL HUMANITARIAN AND DISASTER RELIEF OPERATIONS			5. FUNDING NUMBERS
6. AUTHOR(S) David E. Gilliland			
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Naval Postgraduate School Monterey CA 93943-5000			8. PERFORMING ORGANIZATION REPORT NUMBER
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)			10. SPONSORING/MONITORING AGENCY REPORT NUMBER
11. SUPPLEMENTARY NOTES The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. Government.			
12a. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution is unlimited.			12b. DISTRIBUTION CODE
13. ABSTRACT <i>(maximum 200)</i> The use of U.S. DoD medical assets in International Humanitarian and Disaster Relief Operations (IH/DRO) has been extensive in the past and has grown markedly since the end of the Cold War. It is important that DoD personnel understand the complex interagency coordination and political ramifications of their participation in IH/DRO. This thesis examines the history, current planning, interagency coordination, law, DoD doctrine, and budgeting issues affecting the use of DoD medical assets for IH/DRO. To research the current state of IH/DRO execution by the DoD, Federal laws, DoD doctrine, professional journals, and current periodicals were reviewed. Additionally, interviews were conducted with personnel in OSD, USCENTCOM, and the DoD medical community to obtain insight from recent participants in IH/DRO. Research indicated that three levels of control, coordination, and planning exist within the U.S. government to conduct IH/DRO. The strategic level consists of the U.S. Congress, the NCA, USAID, and the Joint Chiefs of Staff. The operational level consists of the Unified Combatant Commands, who conduct contingency planning for their Areas of Responsibility (AOR). Finally, the tactical level consists of the Joint Task Force (JTF) stood up by the Unified Combatant Command to execute the operation. Doctrine to execute these operations is lacking and acknowledged by DoD Doctrine Commands, who are working to address this shortcoming. The current command and coordinating structure documented in this thesis is in a dynamic state of evolution and development as the DoD strives to meet the demands of IH/DRO in a downsizing military.			
14. SUBJECT TERMS Humanitarian, disaster relief, DoD medical assets			15. NUMBER OF PAGES 102
			16. PRICE CODE
17. SECURITY CLASSIFICATION OF REPORT Unclassified	18. SECURITY CLASSIFICATION OF THIS PAGE Unclassified	19. SECURITY CLASSIFICATION OF ABSTRACT Unclassified	20. LIMITATION OF ABSTRACT UL



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**THE USE OF DOD MEDICAL ASSETS IN INTERNATIONAL  
HUMANITARIAN AND DISASTER RELIEF OPERATIONS**

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Submitted in partial fulfillment  
of the requirements for the degree of

**MASTER OF SCIENCE IN FINANCIAL MANAGEMENT**

from the

**NAVAL POSTGRADUATE SCHOOL  
December 1996**



## ABSTRACT

The use of U.S. DoD medical assets in International Humanitarian and Disaster Relief Operations (IH/DRO) has been extensive in the past and has grown markedly since the end of the Cold War. It is important that DoD personnel understand the complex interagency coordination and political ramifications of their participation in IH/DRO. This thesis examines the history, current planning, interagency coordination, law, DoD doctrine, and budgeting issues affecting the use of DoD medical assets for IH/DRO. To research the current state of IH/DRO execution by the DoD, Federal laws, DoD doctrine, professional journals, and current periodicals were reviewed. Additionally, interviews were conducted with personnel in OSD, USCENTCOM, and the DoD medical community to obtain insight from recent participants in IH/DRO. Research indicated that three levels of control, coordination, and planning exist within the U.S. government to conduct IH/DRO. The strategic level consists of the U.S. Congress, the NCA, USAID, and the Joint Chiefs of Staff. The operational level consists of the Unified Combatant Commands, who conduct contingency planning for their Areas of Responsibility (AOR). Finally, the tactical level consists of the Joint Task Force (JTF) stood up by the Unified Combatant Command to execute the operation. Doctrine to execute these operations is lacking and acknowledged by DoD Doctrine Commands, who are working to address this shortcoming. The current command and coordinating structure documented in this thesis is in a dynamic state of evolution and development as the DoD strives to meet the demands of IH/DRO in a downsizing military.







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## I. INTRODUCTION

### A. OVERVIEW

Assisting populations affected by disasters of natural or human origin is important for the maintenance of peace, security, and stability in today's world. According to national security policy, emergency humanitarian assistance<sup>1</sup> will be an essential capability of U.S. forces in the 21st century. [Ref.1:p.14]

The end of the cold war has triggered a discussion about the opportunity for new roles and missions for the Department of Defense. With the end of the Soviet empire, our geopolitical compass has lost its magnetic north. The inability of developing nations to cope with disasters and the rising tides of ethnic chaos provide a partial substitute. [Ref.2:p.46] U.S. military involvement in International Humanitarian and Disaster Relief Operations (IH/DRO) now known as Operations Other Than War (OOTW) has been extensive in the past and has grown markedly since the end of the Cold War. We have participated bilaterally with the United Nations and unilaterally in many of these operations in the past. The Nicaraguan earthquake in 1972

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<sup>1</sup> Humanitarian Assistance is defined by DODD 5111.10 as any activity, issue, program, situation, or other function with a humanitarian component. Humanitarian assistance includes, but is not limited to: worldwide humanitarian assistance; foreign disaster relief; humanitarian demining; humanitarian intervention; humanitarian and civic assistance; law of war; provision of humanitarian excess property; migration emergencies; refugee assistance; and space available or other transportation of privately donated humanitarian relief.



and Operation Sea Angel in Bangladesh in 1994 are good examples of purely Humanitarian/Disaster Relief Operations that were very successful using DOD medical assets.

What is evident in this new world order is the massive increase in international emergencies requiring DOD medical assets. Between 1978 and 1985 an average of five emergencies a year occurred. In 1994 alone there were twenty. By 2025 the population in the world's least-developed countries is projected to increase 143 percent from 1990 population figures. These countries will have nearly two times the displaced people that wealthy countries will have. Demographic trends suggest an increase in instability, with the poorest countries finding their scarce resources unable to provide medical care to their population. [Ref.3:p.3] Civilian decision makers repeatedly turn to the U.S. military to create solutions for international crises. Simply put, because no other U.S. agency is comparably equipped, manned, managed, or funded, the U.S. military must be prepared for these missions. The DOD possesses the unique rapid response capability, sea-based forces and logistical requirements to meet challenges of getting medical supplies and personnel to disaster sites faster than any other organization in the world.

The U.S. global security strategy is changing and U.S. strategic interests are being defined more broadly than ever, which includes not only a desire to foster democracy, but to secure peace, human rights, and relief from suffering. This will require an increasing use of U.S. military medical assets in the future to meet our expanding role. Since the Department of Defense will bear the brunt of these efforts, we must review our current planning, coordination of assets, and budgeting efforts in IH/DRO. Can we do it better? And most important, can the job be done more cheaply and with fewer assets in a right sizing U.S. military?

These missions are expensive. Right now DOD is picking up most of the costs. Since FY 1992, the DOD has reported more than \$7 billion in incremental costs for its participation in contingency operations that include IH/DRO. [Ref.4:p.3] There is a \$2.2 billion shortfall in unfunded contingency operations in FY 1996, mostly from Bosnia [Ref.5]. The Administration plans to submit a second reprogramming to cover the shortfall. Planning and budgeting for increasingly costly contingency operations will require better cost accounting procedures. The GAO states that the DOD does a poor job of reporting

incremental costs of these operations because of a material weakness in DOD accounting systems. [Ref.4:p.4] Finally, in regards to funding, the DOD must maximize the use of scarce resources, because the job will not go away even if we are not properly funded for Humanitarian/Disaster Relief contingencies.

This is a topic that warrants further study and could be useful to planners in the U.S. military and other nations interested in utilizing military medical assets in Humanitarian/Disaster Relief Operations abroad.

## **B. SCOPE OF THESIS**

The thesis will begin with a brief summary of our capabilities and the existing political and world climate that allows the use of DOD medical assets for International Humanitarian/Disaster Relief Operations. It is important to note that in peacekeeping operations, such as in Bosnia, U.S. DOD personnel will operate in UN hospitals such as the one in Zagreb, Croatia. Although the hospital has treated a large number of civilians, its primary purpose is to care for UN forces. This could be constituted as humanitarian assistance, depending on the definition. I will review this particular operation in Zagreb which is humanitarian assistance in conjunction with a peacekeeping operation.

However, this thesis will primarily focus on IH/DRO as a unilateral commitment of the U.S. DOD to the host country.

DOD Instructions identify two mandated types of IH/DRO for utilizing medical assets. They are the Overseas Humanitarian, Disaster and Civic Aid (OHDACA) appropriation and the Humanitarian Civic Assistance Program. I will examine the historical role the DOD has played in these two OOTW. The topics will be identified through an extensive literature search of professional journals, military publications and current periodicals. Current planning and executions of these operations will be thoroughly examined at the Unified Command level through interviews with military members on planning staffs and members who have recently participated in humanitarian missions that required DOD medical personnel from U.S. Central Command. I will contact other government organizations to study their interrelationship with the DOD in coordinating the use of medical assets for disaster relief. An example would be the State Department and the U.S. Office of Foreign Disaster Assistance (OFDA) which is part of United States Agency for International Development (USAID). USAID's chairman is the President's coordinator for all U.S. government international disaster relief.

### **C. PRIMARY RESEARCH QUESTION**

The primary research question is this: What is the current structure for planning, coordinating and budgeting for IH/DRO and the use of DOD medical assets in these operations? The current structure for the planning, coordinating and budgeting for these operations is a tangled web of interrelationships between government organizations inside and outside of the DOD. I will document these relationships to identify how we conduct these operations from project identification to completion.

### **D. SUBSIDIARY RESEARCH QUESTIONS**

The following questions are addressed and answered in support of the primary research question. Each question will be answered in one of the five chapters of this thesis.

1. What IH/DRO have we conducted in the past utilizing DOD medical assets and what were the results?
2. What are the current federal laws, military doctrine, and interrelationships between Government agencies that coordinate and execute IH/DRO involving DOD medical assets?
3. How do we plan and execute these contingencies that require medical assets at the Unified Command Level (CENTCOM) and how much does it cost?
4. What trends do we see for the use of military medical assets for IH/DRO?

## **E. CHAPTER CONTENTS**

Chapter II will provide the historical background and political implications of these OOTW operations. I will review the growing role and capabilities for DOD with respect to these operations.

Chapter III reviews the current legal authority for use of DOD medical assets abroad for humanitarian and disaster assistance. It should be noted that medical assets constitute only one segment of the many DOD capabilities employed to conduct International Humanitarian and Disaster Relief Operations. To understand how and when medical assets are utilized it is necessary to understand the legal authority and coordination of IH/DRO as a whole. Current JCS and service doctrine will be examined to indicate how we are expected to carry out these operations. The interrelationships between the DOD commands that carry out these missions, OSD departments and other involved government agencies will be identified and explained, with particular emphasis upon the medical component.

Chapter IV is an analysis of the two distinct types of IH/DRO outlined in JCS Pub 3-07. I have contacted two individuals at U.S. CENTCOM who have been involved in planning, and have actual field experience in the use of



DOD medical assets in International Humanitarian and Disaster Relief Operations. One is operation "SEA SIGNAL" which was a large-scale purely humanitarian operation. These types of operations are funded mainly by the Joint Task Force which in turn utilizes the Overseas Humanitarian, Disaster and Civic Aid (OHDACA) appropriation that allows CINCs to fund major disasters on short notice.

The other operation, "EAGER TIGER," is typical of a small scale Humanitarian Civic Assistance program operation. The HCA program is funded by O&M funds that are budgeted and maintained by the CINCs. The data collected will answer the question of this chapter.

Chapter V will be divided into sections A, B, and C. Section A *will be an* overview of what was found in the research that answers the primary thesis question. Section B will summarize the subsidiary research questions based on research presented in previous chapters. Recommendations for further research will be presented in section C.



## II. IH/DRO HISTORICAL OVERVIEW

### A. BACKGROUND

The U.S. military has a long tradition of providing emergency humanitarian relief and disaster assistance at home and abroad. U.S. forces provided medical services and supplies to thousands of refugees and displaced persons following earthquakes in Peru(1970) and Nicaragua(1972), flooding in Sudan(1988), volcanic eruption in the Philippines(1990), and tropical cyclones in East Bengal(1970), Sri Lanka(1978), and Bangladesh(1991). [Ref. 6:p.386]

The DoD has been conducting IH/DRO for many years. Since the end of the cold war, the increased number, cost, and complexity of these IH/DRO has stirred debate. During the cold war era IH/DRO were justified in order to help allies or to influence non-aligned countries into the sphere of democracy. As the new world order develops, humanitarian assistance is playing a larger role in American military strategy. In regards to IH/DRO, the current chairman of the Joint Chiefs of Staff, Gen John Shalikashvili stated, "military forces can do a great deal of good because they bring with them an organization and structure that no civilian organization can match"

[Ref.6:p.387]. The U.S. military is the only organization in the world able to carry out independent, large-scale relief operations worldwide.

Why should we become involved in IH/DRO that involve DoD medical personnel? We do incur risk of harm to our people, as in Somalia, and large financial burdens to the U.S. taxpayer. On an emotional level one could say that it is morally "the right thing to do," adhering to Judeo-Christian ethics. President Clinton has stated, "U.S. foreign policy cannot be divorced from the moral principle most Americans share" [Ref.2:p48]. It could be said that dollars spent on IH/DRO are small compared to offsetting future regional conflicts. We can and have used IH/DRO to keep the world's developing nations in the international fold. This is a stated policy of U.S. Agency for International Development (USAID) [Ref.7].

The remainder of this chapter will review the historical aspects of this tradition. I will present a number of examples which show the diversity of types of missions in which medical assets are utilized in IH/DRO. I will then identify and assess our capabilities and limitations associated with IH/DRO. To close chapter II, I will review budgetary trends which tie in closely with the current tempo of IH/DRO.

## B. PAST MISSIONS INVOLVING DOD MEDICAL ASSETS

### 1. 1972 Nicaraguan Earthquake

#### *a. Humanitarian Assistance (HA)*

The 1972 Nicaraguan earthquake is a good example of the type of operation that would now utilize the Overseas Humanitarian Disaster and Civic Aid (OHDACA) appropriation due to its purely humanitarian nature. The OHDACA will be explained further in Part D of this chapter.

#### *b. Synopsis of Mission*

U.S. Southern Command received word at 0400 on 23 December 1972 of the earthquake. Military assistance was requested due to the enormous destruction in the capital city of Managua. The need for medical assistance was especially critical. In addition to the available medical assets within the Canal Zone, two field hospitals were sent from CONUS. They were the Air Force 1st Tactical Hospital from MacDill AFB and the U.S. Army's 21st Evacuation Hospital from Fort Hood, Texas. Within a few hours of this disaster, an impressive amount of medical capability was organized as part of a joint U.S. disaster relief effort.

An assessment of medical needs was performed within 13 hours of the disaster by an Army medical team of

nine physicians, a Medical Service Corps Officer, and eighteen medical corpsman. This team performed the function of the currently utilized Disaster Assistance Response Team (DART). The DART will be reviewed more thoroughly in Chapter III.

Within 72 hours of the earthquake units began arriving. A functioning surgical service was expeditiously established and an infectious disease surveillance system was implemented. In the early days of the disaster this task force assumed the major burden of care for the sick and wounded. Countless thousands were saved by our medical personnel. The Joint Task Force left three functioning hospitals in Nicaragua when they departed. [Ref.8:pp.50-51]

## **2. United Nations Hospital Zagreb, Croatia**

### **a. Humanitarian Assistance with Peacekeeping**

This operation is an example of the utilization of DOD medical assets in conjunction with a peacekeeping operation. The primary use of the hospital was to care for the UN Forces, but due to the substantial number of civilians treated, it warrants review as a humanitarian mission. The costs incurred with any incidental humanitarian assistance provided are paid for out of the contingency fund utilized to pay for the peacekeeping

operation itself. It is therefore almost an impossible task to determine exactly how much the DoD spends on humanitarian relief. This is due to humanitarian relief being provided collaterally in other operations in addition to the Humanitarian Civic Assistance (HCA) program and the Overseas Humanitarian, Disaster and Civic Aid (OHDACA) appropriation.

***b. Synopsis of Mission***

In November 1992 an advance team of medical and support personnel from the 212th Mobile (U.S.) Army Surgical Hospital (MASH) arrived in Zagreb from Germany to care for UN peacekeepers. They were subsequently relieved in succession by the 502nd MASH six months later, U.S. Air Force 48th Medical Group Hospital in Sept 1993, U.S. Navy's Fleet Hospital Six in March 1994, and U.S. Navy Fleet Hospital Five in Sept 1994. This operation is currently manned by an Air Force contingent from Travis AFB.

They have had plenty to do, handling almost 20,000 outpatients and performing over 350 major operations. These statistics are made up of UN Forces and civilians. On a purely humanitarian mission originating from the Zagreb hospital, Fleet Hospital Five received a one-time approval from Washington to go 120 km southwest of Zagreb to care for refugees in the so called Bihac pocket.

The team treated a wide variety of conditions from that of a 58-year-old woman who stepped on a land mine to a large number of pediatric problems, particularly dehydration. The team noted other medical units from Denmark, Jordan, Poland, and Ukraine were there to help refugees. In 12 days the team saw 1500 patients. They noted the importance of having a good interpreter and their own medical equipment.

Fleet Hospital Five, like its predecessors, used telemedicine to good effect. They transmitted x-ray photos or roentgenogram and computed tomography scans to the Naval Medical Center, San Diego, CA. Using telemedicine increases the expertise on site without the need for sophisticated equipment or personnel. The hospital also cooperates with the local Croatian community, and the nearby University of Zagreb Medical School to help indigenous capability. [Ref.9]

### **3. USECOM MEDFLAG OPERATIONS**

#### **a. Humanitarian Civic Assistance Program (HCA)**

Members of DoD medical teams have been working with and training foreign military members in developing medical capability and disaster preparedness. Within Africa



this training is accomplished through USECOM's MEDFLAG Operations<sup>2</sup>.

Operations of the MEDFLAG type have had different program names over the years. In the Vietnam era, programs of this type were called Military Civic Action (MCA), and more recently Humanitarian Civic Assistance (HCA). These different programs refer to the same objectives outlined in JCS Pub 3-07, Military Operations Other Than War. These programs are provided under Title 10 U.S. Code Section 401 and must fulfill unit training requirements that incidentally create humanitarian benefit to the local populace [Ref.11:p.III-10]. They are funded and carried out by the Unified Commands under various operation names.

Humanitarian Civic Assistance and Military Civic Action has its roots in the beginning of the Cold War. We must distinguish HCA as a strategic tool from other forms of IH/DRO. The first formal MCA plan was the Armed Forces Assistance to Korea (AFAK) program. In 1959 Congress funded the Draper Committee to study the usefulness of Military Civic Action. The Committee recommended, "As a matter of policy we encourage the use of the armed forces of underdeveloped countries as a major 'transmission belt' of socioeconomic reform and

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<sup>2</sup> The origin of the name MEDFLAG is believed to represent a showing of the U.S. flag through medical assistance.



development." This early HCA type program was successful in the Philippines and Vietnam. [Ref.12:p.363]

***b. Synopsis of Mission***

MEDFLAG operations are medical HCA operations planned, funded, and carried out by USECOM in various locations in Africa. The major objective of this medical HCA operation and other HCA operations is to conduct combined training with the host nation's military personnel. It should be noted that portions of Africa fall in USECOM's Area Of Responsibility or AOR.

MEDFLAG MOKOLO 88, a joint U.S. Army and Air Force medical exercise, was conducted with a medical battalion of the Republic of Cameroon to simulate a volcanic disaster. In Botswana, in 1988, the scenario was a mine explosion. In 1990, in Mauritania, training centered on an airplane crash. [Ref. 8:p.49]

MEDFLAG 94 was operational 16 to 25 April 1994 in Ghana. Training was held in mass casualty, dental preventive medicine, optometry, disease threats, food and water precautions and the importance of malaria chemoprophylaxis. One of the benefits to our medical personnel during this operation and all other MEDFLAG operations is getting experience in dealing with the problems of deployment in a remote area. The 80 member

U.S. team consisted of three elements of USECOM: 212th MASH, Navy Environmental and Preventive Medicine Unit no. 7 and USAREUR Dental and Optometry Teams. This operation also utilized the services of one Dutch and one German medical officer.

They trained over 100 Ghanaian civilian and military medical personnel which will in turn provide training for their Ghanaian colleagues. Over 4000 patients were seen. This HCA funded operation provided over 3000 children with yellow fever immunization. Approximately 30 tons of medical consumables were donated to the Ghanaian government through USECOM's HCA program. [Ref.10]

Each Unified Command has programs of this nature conducting similar operations but utilizing different operation names.

Col George A. Luz, MSC, USAR and Col John W. Depauw, CA, USAR both of the Office of the Chief, U.S. Army Reserve, Pentagon, have conducted research in the area of IH/DRO. They have brought together people who are critical of and support MCA, including medical MCA. By studying past operations, this group sought to develop a set of guidelines where MCA could be used to defend against current threats, relevant to our defined strategic interest [Ref.12:p.363].

Col Joel C. Gaydos, MC, USA of the Department

of Preventive Medicine and Biometrics, Uniformed Services University of Health Sciences, has conducted extensive research in the area of MCA as well. LTC John T. Little, a military advisor in Laos, established twelve requirements for success in MCA. COL. Gaydos has taken the work of LTC Little and combined it with the work of DePauw and Luz. COL. Gaydos developed a set of criteria that could be used by current HCA project planners on Unified Command Staffs to plan, execute and evaluate the potential success of projects. HCA coordinators at the Unified Commands must submit a list of annual planned projects for DCINC approval before executing. These criteria, developed by COL. Gaydos, are provided in Table 2-1.

### **C. CAPABILITIES AND LIMITATIONS OF DOD MEDICAL ASSETS**

The U.S. DOD is a large, well trained, and highly organized force that is designed for operations that require rapid mobilization and support. This definition sounds like an organization that is ready made to handle IH/DRO. However, the primary mission of the DOD is warfare, not IH/DRO. It would be useful to review the capabilities and limitations of using the DOD medical assets in IH/DRO.

#### **1. Capabilities .**

The ability to impose security is probably the most

## MCA CRITERIA

1	Projects must fulfill perceived needs of the people, and at least be accepted by their government and their military.
2	Projects must have meaningful, feasible, beginning and ending dates, must be completed on time, and must demonstrate that the U.S. Forces involved are competent, capable, and can be trusted.
3	U.S. teams must be staffed with people who have technical and administrative expertise and the interest and desire to successfully complete the project.
4	The indigenous population must be willing to share the workload and make sacrifices for the project.
5	The indigenous people/or their military must be capable of continuing, maintaining, and repeating all projects after departure of U.S. personnel.
6	The primary objectives of the U.S. personnel must be to teach and advise; rough and undesirable management approaches aimed totally at completing a project on time and within budget must be avoided.
7	Interpreters and translators for the U.S. forces must be extremely knowledgeable about the native customs, competent in the language (including the pertinent technical vocabulary), and interested in continually advising and teaching other U.S. team members; U.S. personnel must be knowledgeable about indigenous customs and traditions and must show respect for these at all times.
8	Established lines of communications between U.S. teams, the host government, their military, and the indigenous people must be respected and used.
9	U.S. military people must remain in the background and let praise and publicity fall upon the local people and their civil agencies, military forces, and government.

**Table 2-1** [Ref.12:pp.363-366]

obvious capability. Effective relief was not tenable in northern Iraq or Somalia until our armed forces restored order.

A well developed transportation and logistics capability enables the ability to transport and distribute large volumes of emergency supplies to remote areas. Once within the disaster area, the military can develop a transportation and delivery system. In Kurdistan, Bangladesh, and Somalia, the military used its trucks, helicopters, airplanes, and ships to transport thousands of tons of food, medicine and relief workers. A large military field warehouse was established in northern Iraq. Military logistics teams worked with NGOs<sup>3</sup> and local medical personnel to catalog, store, prioritize, and distribute materials. This is an example of the U.S. military acting as the coordinator between a number of players in conducting an efficient relief effort.

[Ref.6:p.387]

The "three Cs": command, control, and communication were used in northern Iraq or Kurdistan. Our organizational structure, superior communication infrastructure, and international stature put the U.S. DOD

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<sup>3</sup> NGO: Non Governmental Organization. This term is used to refer to private organizations such as CARE, Doctors Without Borders and Save The Children that provide a number of services associated with humanitarian assistance or disaster relief efforts.



in the position as the de facto coordinator of this large scale IH/DRO. In Kurdistan we coordinated the efforts of 15 other coalition forces, 20 NGOs, and local Kurdish groups.[Ref.6:p.387]

The military brings a self sufficiency to the field no other organization can provide. The military deploys with its own food, water, electricity, and shelter needed to sustain operations. The military can rebuild infrastructure and hospitals that will benefit the population after they leave.

Acute medical care can be provided via our deployable clinics, field hospitals, hospital ships, and medical evacuation systems. These units can establish medical services quickly in austere and remote environments. Preventive medicine teams contribute to the efforts of relief workers. They can conduct surveys that determine the state of health of a given population, prevalent diseases, vaccinations, and sanitary needs. These teams bring with them public health labs that are often the only ones in the area.

## **2. Limitations**

### **a. Training and Supplies Inadequate For IH/DRO**

The primary limitation associated with the use of U.S. military medical assets for IH/DRO is that the

primary focus is to support combat operations, not IH/DRO. This is why military medical care is designed primarily to provide acute care to a population of predominantly young, male, medically screened adults. This training may help for trauma cases created by sudden disasters such as earthquakes.

However, the highest priorities in humanitarian relief are to provide potable water, sanitation, good nutrition, immunizations, health surveillance, education systems, and primary care to a full spectrum of age groups [Ref.6].

Our deployable medical units have minimal quantities of medications recommended by the World Health Organization (WHO) for IH/DRO. This WHO medication list consists of large quantities of rehydration salts, pediatric supplies, and antibiotics.

Few DOD medical personnel receive adequate training to treat problems common in women and children, and few physicians receive training in humanitarian assistance.

**b. Inadequate Doctrine and Interservice Coordination**

There is minimal guidance in standing orders, contingency plans, basic instructions, or field manuals that address procedures for emergency relief. Medical



relief missions are typically planned quickly and on an ad hoc basis. These missions normally utilize a Joint Task Force for command and control. They involve units from all branches that are unfamiliar with each other with few personnel experienced in IH/DRO.

Based on conversations with medical personnel who have participated in IH/DROs, we do very well due to the superior personnel in our medical units. They simply make it happen.

During my thesis travel to the 6th Medical Group Hospital at MacDill AFB, I had the opportunity to talk to Air Force Maj. Joann E. Lankford, the Nurse Exec., Medical Services Flight, about training. It was her opinion that if these missions are to continue, we need to change our training of medical personnel from solely combat related to medical training that encompasses the needs of IH/DRO. Most military medical personnel I spoke with agreed with this opinion.

### **c. Supply Problems**

In Kurdistan during operation Provide Comfort, 90 percent of the deaths of children under 5 were diarrheal disease, dehydration, and malnutrition. Supplies of medications to help these conditions were initially inadequate. Common military supplies may not be suitable

for the local population.

An example is the "Meals Ready to Eat" (MREs). MRE's have 6000 calories per meal and a high concentration of salt. This is an inappropriate meal for dehydrated children. Another potential problem is illustrated by providing MREs with pork products to a Muslim population.

The DoD has addressed this problem with the development of an MRE designed for humanitarian relief. This "civilian MRE" is called the Humanitarian Daily Ration (HDR). It was developed utilizing Foreign Disaster Relief Program funds which is one of the three components of the Overseas Humanitarian, Disaster and Civic Aid Appropriation(OHDACA). OHDACA is utilized for purely humanitarian assistance type operations, referred to by the CENTCOM HAST as HA Other.

The U.S. Naval Medical Logistics Command has developed a humanitarian support block of medical supplies for humanitarian assistance. This "code 05" block contains medical supplies and can be used to overcome past initial supply problems when supplies were intended for a young male population instead of the full spectrum. The DoD is making progress on the supply and logistics side of conducting IH/DRO.

**3. Center of Excellence in Disaster Management and Humanitarian Assistance, Tripler Army Medical Center**

The Center of Excellence in Disaster Management and Humanitarian Assistance was developed as a result of the lessons learned from recent IH/DROs in the Middle East, Sub-Saharan Africa, and the Balkans. This congressionally supported center opened in October of 1994. The mission is very simple: to create a Center Of Excellence (COE) to address the provision and facilitation of education, training, and research in civil-military operations, particularly those involving international disaster management and humanitarian assistance. [Ref.13] This COE has the potential to significantly enhance the capability of the DoD in conducting IH/DRO.

Retired General Colin Powell envisioned a command that would bring together a critical mass of experts in disaster relief and conduct joint training in IH/DROs [Ref.8:p.55]. The COE at Tripler Army Medical Center is not as ambitious as Gen Powell's proposed command, but it is a step in that direction. The expertise and services they provide to the U.S. DoD and allies are identified in Table 2-2.

The Tripler COE is a partnership of resources of United States Pacific Command (USPACOM), The Pacific Health Services Support Area (HSSA) of Tripler Army Medical Center, and the University of Hawaii. It provides academic

and operational expertise with an international faculty

COE EXPERTISE
Complex Emergencies
Regional and International Disaster Management
Civil - Military Training
Disaster Medicine
Disaster Assessment
International Humanitarian Law
Livestock Emergencies
Curriculum Development
Electronic Information Systems
Electronic Information Access and Retrieval
Internet Connectivity/Applications
Research
Conferencing

**Table 2-2 [Ref.13]**

that has experience in IH/DROs. The COE currently conducts military training with the U.S. DOD, Japan Special Defense Forces, and Singapore Armed Forces. Civil-Military training has been conducted with Indonesia, Mongolia, Thailand, and the former Yugoslavia. The COE has four permanent staff members in office, thirty-one faculty worldwide on stipend to assist in training, and one COE representative at Tripler Hospital and PACOM. The COE is anticipating the number of personnel will grow this year

[Ref.14].

A major component of the COE is the Pacific Disaster Management Information Network (PDMIN). The PDMIN is an Internet link to other disaster-related Internet sites, disaster news, historical data, electronic journals, discussion groups, e-mail, and full text publications which include country specific disaster management plans and handbooks. The current URL is <http://204.208.4.136>.

#### **D. HISTORICAL AND CURRENT BUDGETARY TRENDS**

Budgeting for the costs of IH/DRO has been extremely difficult in the past and will continue to be difficult in the future. One can appreciate the difficult task of budgeting for operations that result from worldwide problems that develop after budget decisions are made. Compounding this problem are material weaknesses in DOD accounting systems that attempt to report incremental costs associated with contingency operations, whether they are peacekeeping or humanitarian in nature [Ref.15:p.1].

It is also difficult to determine an exact amount of the DoD's total expenditure on IH/DRO. As stated earlier, contingency operations defined as peacekeeping can include significant expenditures that could be defined as purely humanitarian in nature. An example would be the \$784

million spent by the DoD from fiscal year 1992 through 1995 for humanitarian airdrops over Bosnia, operation of the Zagreb Croatia hospital, and airlift of food, clothing, and medical supplies to Sarajevo [Ref.16:p. 25].

DoD's characterization of individual operations as combat, peace, or humanitarian is in a state of flux. For example, the Secretary's 1994 report characterized the DoD's operation in Northern Iraq as U.S. forces acting in support of U.N. peace operations, while the Secretaries' 1995 report characterizes this operation as humanitarian and refugee assistance [Ref.17:p.35]. Through fiscal year 1996, DoD has not budgeted for the cost of contingencies. When tasked to perform contingency operations, the DoD shifts funds within existing appropriations. Subsequently, the DoD seeks supplemental funding or reprogramming of appropriated funds to cover its costs. For FY 96, the administration requested \$620 million in supplemental funding and reprogramming of \$991 million [Ref.15:p.9].

This method of dealing with costs of contingencies which include IH/DRO can create budget problems that cut resources to other areas in the DoD. For example, in fiscal year 1993 the DoD sought and received a supplemental appropriation for operations in Somalia. However, \$750 million was rescinded from other areas in the DoD budget,



which means Congress provided no new funds.

A July 1995 Joint Uniform Lessons Learned System (JULLS) document, entitled "Funding of Humanitarian/Peacemaking/Peacekeeping Operations," noted several problems in funding IH/DRO. It stated there are a couple of sources of funding for Humanitarian Operations. However, there is no clear definition of Humanitarian Operations to determine when and where these funds apply.

The JULLS Report recommended that the Secretary of Defense, in conjunction with the Joint Staff, take action to establish a readily available source of funding for IH/DRO. In response to this JULLS, OSD (SOLIC) agreed that new funding mechanisms need to be established for resourcing operations such as Operation Restore Hope. The OSD (Comptroller) stated that Congress has expressed a reluctance in the past to approve funding in advance of specific identified operations. Code J-8 of the Joint Staff has developed a Handbook that describes various sources and authorities for funding military OOTW, such as humanitarian assistance, refugee relocation, and disaster relief. This handbook has been distributed to OSD and the CINC comptrollers. On 8 Feb 1995, the OSD comptroller published changes to DoD 7000.14-R, Financial Management Regulation, Volume 12, Chapter 23. It includes

guidance for determining costs of contingencies and procedures for obtaining reimbursements form other agencies. [Ref.18]

**1. Overseas Humanitarian, Disaster and Civic Aid Appropriation (OHDACA)**

As mentioned earlier there are specific funds that can be utilized for IH/DRO. The one used first and foremost is OHDACA. This appropriations consolidates funding for three existing programs. These programs are the Humanitarian Assistance Program (HAP), which includes transportation, the Humanitarian Demining Program, and the Foreign Disaster Relief Program.

These programs support the regional Unified-Commander-in Chief's (CINC's) peacetime engagement mission. OHDACA activities are prioritized in conjunction with the Dept. of State, and approved by the Secretary of Defense. This is done to insure unity of effort in compliance with foreign policy objectives.

The HAP was established in 1986 and is designed to avert humanitarian crises, promote democratic development, and enable countries to recover from conflict. Objectives are accomplished by transportation of non-lethal DOD property and donated materials from private agencies and NGOs.



The Humanitarian Demining Program assists countries in clearing land mines that are the residue of civil wars. The Department of State estimates that over 100 million mines are scattered across the globe and that 1200 people per month are killed or maimed by mines [Ref. 19].

The Foreign Disaster Relief Program supports DOD response to natural and man-made foreign disaster. This program allows the CINCs to respond to disasters within their Area Of Responsibility (AOR) without dipping into their own O&M accounts. These funds have helped CINCs defray costs in natural disasters in Kobe, Japan, Columbia, and India. OHDACA paid for transportation in manmade disasters as well as in Rwanda and Bosnia.

The FY 1997 President's Budget request totals \$80.5 million for OHDACA programs. A total of \$30 million is earmarked for HAP, \$25 million for the Humanitarian Demining Program, and \$25.5 million for the Foreign Disaster Relief Program. Of note, \$19 million of the \$25.5 million is earmarked to purchase the new Humanitarian Daily Ration (HDR), a humanitarian MRE [Ref.19]. Funds are available for obligation for two years, to preclude end-year interruptions in ongoing programs, such as demining and disaster contingency responses.

The overall trend for the OHDACA from 1995 to 1997 is

decreasing in amount. The actual FY 95 amount was \$83.4 million, FY 96 \$49 million and \$54.5 million was authorized for FY 97 [Ref.20]. For FY 97, \$20 million is earmarked for demining and the remainder will be used for HAP and Disaster Relief. Unless there is a significant decrease in mission obligations, this declining trend in OHDACA money will place the burden for paying for these operations on the Unified Command comptrollers.

## **2. CINC Initiative Fund**

The CINC Initiative Fund is placed under the control of the Chairman, JCS, for use by the CINCs. For FY 95, \$25 million was appropriated. This fund is to be utilized for unforeseen contingency requirements for which normal service funding is not readily available. Humanitarian and Civic Assistance is one of the authorized activities for this fund. Annual Humanitarian Civic Assistance missions (HCA) cannot utilize this fund because it is already budgeted for in the CINCs' annual O&M budget.

These two funds are two potential sources for funding IH/DRO. More specific guidelines need to be promulgated to first define exactly what constitutes a humanitarian mission, and second, exactly what funding mechanism should be used.

### **III. IH/DRO LAWS, DOCTRINE, INSTRUCTIONS, AND INTERAGENCY COORDINATION**

This chapter reviews the current legal authority, doctrine, DoD instructions, and how U.S. government agencies coordinate to provide medical assets abroad for IH/DRO. Numerous sections of Title 10 USC that pertain to IH/DRO will be reviewed to gain an understanding of the legal ramifications and limits on the DoD to conduct IH/DRO. The limited amount of doctrine developed thus far on how to conduct IH/DRO will be reviewed. Pertinent DoD instructions will be reviewed to give an understanding of the delegation of responsibility within the DoD for conducting IH/DRO. The last section will present a summation of the tangled web of interagency relationships and coordination utilized to conduct IH/DRO.

#### **A. LAWS WHICH AUTHORIZE IH/DRO**

##### **1. Title 10 USC Sec. 401: Humanitarian and Civic Assistance Provided in Conjunction With Military Operations**

Section 401 of Title 10, U.S. Code, in effect, authorizes the Humanitarian Civic Assistance program to be administered by the Unified Commands of USCENTCOM, USECOM, USPACOM, and USSOUTHCOM. This program allows the Secretary of Defense to carry out humanitarian and civic assistance activities in conjunction with an authorized military

operation with the armed forces of an authorized country. The criteria that must be met to conduct an HCA operation are set forth in Table 3-1.

1	The operation will promote the security interest of the U.S. and the authorized country.
2	The operation should enhance the operational readiness skills of members of the armed forces who participate in the activities.
3	HCA activities carried out under section 401 shall complement, and may not duplicate, any other form of assistance provided to the country concerned by any agency or department of the United States.
4	HCA may not be provided under section 401 to any individual or group engaged in military or paramilitary activity.
5	HCA may not be provided under section 401 to any foreign country unless the Secretary of State approves of such assistance.
6	Expenses incurred during HCA activities shall be paid for out of funds specifically appropriated for such purpose.
7	The DoD may use its own O&M funds for minimal expenditures to cover incidental costs of carrying out such assistance.

**Table 3-1** [Ref. 21]

Section 401 requires the Secretary of Defense to submit to the Committees on Armed Services and Foreign Relations of the Senate and the Committees on Armed Services and Foreign Affairs of the House of Representatives a report, not later than March 1 of each year, on activities carried out during the preceding fiscal year. Section 401 defines "humanitarian and civic assistance" to include medical, dental, and

veterinary care provided in rural areas of a country. It also includes construction of rudimentary roads, wells, sanitation facilities, and construction of public facilities. [Ref. 21]

**2. Title 10 USC Sec. 402: Transportation of Humanitarian Relief Supplies to Foreign Countries**

Section 402 of Title 10 authorizes the Secretary of Defense to transport, without charge, supplies which have been furnished by an NGO that is intended for humanitarian assistance. These supplies may be transported only on a space available basis. The restrictions for transport are provided in Table 3-2.

1	Transportation of such supplies is consistent with the foreign policy of the United States.
2	The supplies to be transported are suitable for humanitarian purposes and are in usable condition.
3	There is a legitimate humanitarian need for such supplies by the people for whom they are intended.
4	The supplies will in fact be used for humanitarian purposes.
5	Adequate arrangements have been made for the distribution of such supplies in the destination country.

**Table 3-2** [Ref. 21]

It is the responsibility of the donor to ensure that the supplies to be transported are suitable for transport. The supplies transported may be distributed by the U.S. Government, a foreign government, an international

organization, or a private nonprofit relief organization. Supplies under section 402 may not be transported to a military or paramilitary organization.

The Secretary of State shall submit a report, not later than July 31 each year, to the Senate Armed Services and Foreign Relations Committees and the House of Representatives Committees on Armed Services and Foreign Affairs. This report identifies the origin, contents, destination, and disposition of all supplies transported under Title 10 Section 402 during the 12-month period ending on the preceding June 30. [Ref. 21]

### **3. Title 10 USC Sec. 404: Foreign Disaster Assistance**

Section 404 of Title 10 provides authorization for the DoD to conduct Humanitarian Assistance in disasters abroad, natural or manmade, to prevent the loss of lives. The President must submit a report to Congress no later than 48 hours after commencing the operation. At a minimum, this report must contain the items in Table 3-3 to justify and explain the action.

Executive Order 12966-Foreign Disaster Assistance, was signed into law by President Bill Clinton on July 14, 1995. This order governs the implementation of section 404 of title 10, USC. It directs the Secretary of Defense to provide assistance for natural or manmade disasters when



the Secretary of Defense determines that such assistance is necessary to prevent loss of lives. The Secretary of Defense is permitted to provide disaster assistance only at the direction of the President or with concurrence from the Secretary of State. In an emergency situation to save human lives, the Secretary of Defense can execute disaster relief and notify the Secretary of State as soon as practicable thereafter. This order speeds up the medical response to disasters and therefore saves lives in the critical early hours of a disaster.

In providing assistance covered by this executive order, the Secretary of Defense is required to consult with the Administrator of the Agency for International Development, in the Administrator's capacity as the Presidents's Special Coordinator for International Disaster Assistance. [Ref. 21]

1	The manmade or natural disaster for which disaster assistance is necessary.
2	The threat to human lives presented by the disaster.
3	The U.S. military personnel and material resources that are involved or expected to be involved.
4	The disaster assistance that is being provided or is expected to be provided by other nations, public and private relief organizations.
5	The anticipated duration of the disaster assistance activities.

**Table 3-3** [Ref. 21]



#### **4. Title 10 USC Sec. 2547: Excess Nonlethal Supplies: Humanitarian Relief**

Section 2547 authorizes the Secretary of Defense to make available for humanitarian relief nonlethal excess supplies. These excess supplies made available for humanitarian relief shall be transferred to the Secretary of State for distribution. The Secretary of State must submit an annual report on the disposition of all excess supplies transferred by the Secretary of Defense to the Secretary of State during the preceding year. This report is submitted to the Committees on Armed Services and Foreign Relations of the Senate and the Committees on Armed Services and Foreign Affairs of the House of Representatives. [Ref. 21]

#### **5. Title 10 USC Sec. 2551: Humanitarian Assistance**

Section 2551 defines authorized assistance. It states that to the extent provided in defense Authorization Acts, funds to be appropriated to the DoD for a fiscal year for humanitarian assistance will be used for the purpose of providing transportation of humanitarian relief and for other humanitarian purposes worldwide. This section allows the Secretary of Defense to transfer appropriated funds to the Secretary of State for the payment of costs incurred. These costs include administrative costs incurred providing transportation, purchase of transportation assets for the distribution of humanitarian supplies in the relief area,

and transportation costs.

Funds appropriated for humanitarian assistance for the purposes of Section 2551 remain available until expended.

[Ref. 21]

## **B. DOD DOCTRINE FOR IH/DRO**

Doctrine governing IH/DRO missions is sorely lacking. This deficiency is widely acknowledged and organizations within the DoD are currently working on developing doctrine for IH/DRO to remedy this deficiency.

An example of one such organization working on mission specific IH/DRO doctrine is the Health Services Support Division of the Naval Doctrine Command. The Naval Doctrine Command is located in Norfolk, VA and the HSS Division is located in Quantico, VA [Ref. 25]. The director of the Center of Excellence in Disaster Management and Humanitarian Assistance, Dr. Skip Burkle, has acknowledged a need for detailed doctrine and this is an area his organization is exploring as well.

The doctrine that is available is very general in nature. Two JCS Pubs pertaining to IH/DRO are JCS Pub 3-07, Joint Doctrine for MOOTW, and JCS Pub 4-02, Doctrine for Health Services Support.

### **1. JCS Pub 3-07: Military Operations Other Than War**

This pub makes a very sharp distinction between

Humanitarian Assistance and the Humanitarian and Civic Assistance (HCA) program [Ref. 11].

**a. Humanitarian Assistance**

The purpose and types of HA operations as specified in JCS Pub 3-07 are illustrated in Table 3-4.

<b>PURPOSE OF HUMANITARIAN ASSISTANCE OPERATIONS</b>	
▶	To relieve or reduce the results of natural or manmade disasters or other endemic conditions.
▶	Limited in scope and duration.
▶	Supplements or complements efforts of host nation.
▶	May cover a broad range of missions.
<b>TYPES OF HUMANITARIAN ASSISTANCE OPERATIONS</b>	
▶	Coordinated by the United Nations.
▶	U.S. acts in concert with other multilateral forces.
▶	U.S. responds unilaterally.

**Table 3-4 [Ref. 11]**

According to JCS Pub 3-07, HA operations may be directed by the NCA when a situation threatens the political or military stability of a region considered of interest to the United States, or when the NCA deems the humanitarian situation itself sufficient to warrant action. The Department of State or the U.S. Ambassador in country is responsible for declaring a foreign disaster that requires HA.

Within the DoD, the Under Secretary of Defense for

Policy has the overall responsibility for developing military policy for IH/DRO. [Ref. 11]

**b. Humanitarian and Civic Assistance**

In JCS Pub 3-07, HCA falls under what is called Nation Assistance Programs. These programs are defined as civil or military assistance rendered to a nation by U.S. forces within that nation's territory during peacetime, crisis, or war, based on agreements between the U.S. and the host country. The goal is to promote long term regional stability. Supporting this goal, HCA operations are integrated through the U.S. Ambassador's Country Plan. Examples of HCA activities include medical, dental, and veterinary care in rural areas. It also may involve construction of surface roads, well drilling, and repair of public facilities. [Ref. 11]

**2. JCS Pub 4-02: Doctrine for Health Services Support in Joint Operations**

JCS Pub 4-02 reiterates JCS Pub 3-07 guidelines for HCA and Humanitarian Assistance in Pub 4-02 chapter IV. In addition to these basic guidelines from Pub 4-02, Pub 3-07 reviews the special requirements and considerations for Health Service Support(HSS) in conducting OOTW in a joint environment.

**a. HSS in Humanitarian and Civic Assistance (HCA)**

These medical civic actions usually occur as a

component of a larger operation. The Unified Command must coordinate with all concerned agencies and ensure integration into the respective U.S. Embassy plan. These concerned agencies are ASD (SOLIC), the host nation government and health service officials, the U.S. Ambassador and Country Team, USAID, and the on-scene commander.

In regard to HCA operations, JCS Pub 4-02 states that the geographic combatant commander should ensure that the mission statement of the HSS organization clearly supports the HCA operation prior to commencing that operation [Ref. 26]. Coordination with the Joint Force Surgeon is essential to ensure that the HSS organization is capable of and legally allowed to fulfill the requirements of the mission statement. These requirements are to ensure that valuable time and resources are not wasted. Assessment factors in planning for medical HCA operations are listed in Table 3-5.

#### **b. HSS in Humanitarian Assistance**

JCS Pub 4-02 refers to purely humanitarian assistance as Other HA to distinguish them from HCA operations. Pub 4-02 focuses on HA in disaster assistance. It states that HSS assistance for disaster requires a rapid assessment of damage to tailor the required HSS element [Ref. 26]. An assessment team should have a wide range of



specialties to conduct an accurate assessment. Although the name of the assessment team is not specifically stated in Pub 4-02, the U.S. currently uses a Disaster Assistance Response Team (DART) headed by the Office of U.S. Foreign Disaster Assistance (OFDA) of USAID. [Ref. 7]

Preventive medicine will play a key role in the relief effort. Disasters can disrupt sanitation control

<b>ASSESSMENT FACTORS IN MEDICAL HCA PLANNING</b>	
▶	Population demographics.
▶	General health of population.
▶	Sanitation and personal hygiene.
▶	Endemic diseases.
▶	Primary care capabilities.
▶	Infant mortality rates.
▶	Availability and accessibility of health care delivery systems and processes.
▶	Secondary and tertiary hospital facilities and supporting transportation capabilities.
▶	Education and training levels of health service support professionals and technicians.
▶	Local facilities for production of medical equipment and supplies.
▶	Political impact of providing care to the host nation population.
▶	Long-term requirements and the ability to provide continuity of care.

Table 3-5 [Ref. 26]

which can cause disease outbreaks. Therefore, a critical component of HSS is including the preventive medicine personnel in the planning.

**C. DoD INSTRUCTIONS AND DIRECTIVES PERTAINING TO IH/DRO**

**1. DoDD 2205.2: Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations, October 6, 1994, ASD (SO/LIC)**

This instruction establishes DoD policy and assigns responsibilities for conducting HCA activities. HCA operations must adhere to the criteria outlined in Table 3-1. These criteria are derived from Title 10 USC Sec. 401 and reiterated in DODD 2205.2 with a few additional detailed constraints. One of these details is that HCA activities are to be conducted with the approval of the host nation and local civilian authorities. U.S. commanders may engage in certain activities essential to the accomplishment of their military operation that result in incidental benefits to the local population, but are not considered to be activities under Title 10 USC Sec. 401. An example would be for a commander to build a road to get to a base camp. Expenses incurred as a result of HCA operations must be paid for out of funds specifically appropriated for HCA.

The Assistant Secretary of Defense for Special Operations and Low-Intensity Conflicts (ASD(SO/LIC)) acts as the program manager for the HCA program. ASD(SO/LIC) acts as

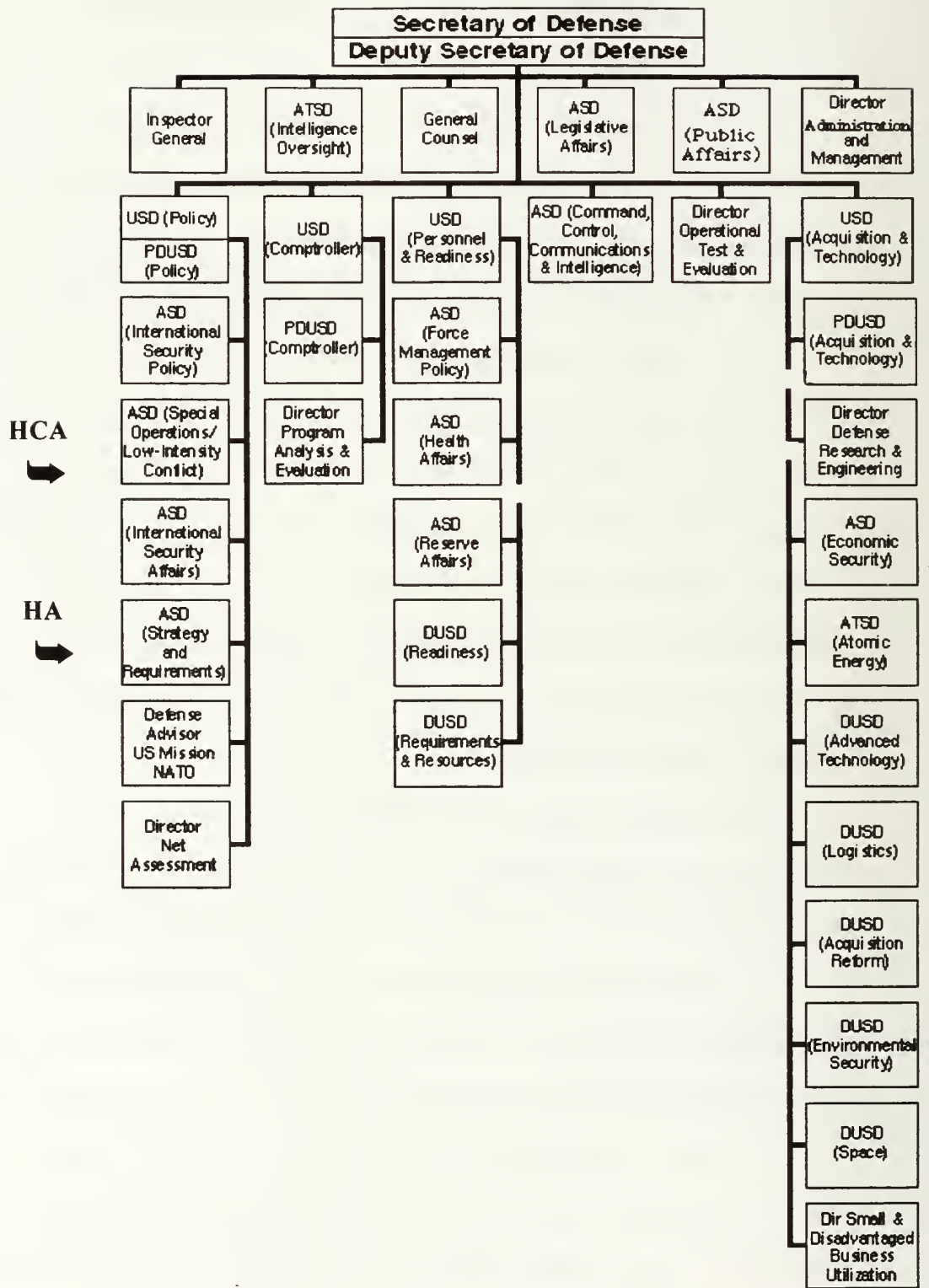


point of contact for HCA with other executive branch agencies.

The Assistant Secretary of Defense for Health Affairs, a component of USD (Personnel & Readiness), reviews and recommends to USD(P) changes to HCA that involve medical personnel and would enhance medical operational readiness skills. It should be noted that ASD (SO/LIC) is a component of USD (Policy). To gain a better understanding of the organization of the Office of the Secretary of Defense and its components involved in IH/DRO, Table 3-6 is provided.

The Chairman of the JCS has the responsibility to review, coordinate, and forward recommendations to USD (Policy) for approval of annual HCA execution plans proposed by the Unified Commands.

Commanders of Unified Combatant Commands are responsible for developing an annual execution plan for HCA activities within their Area Of Responsibility (AOR). To identify the Unified Commands and priority countries in their Areas of Responsibility (AOR), Table 3-7 is provided. The Unified Commands execute HCA activities in conjunction with military operations in their AORs. The Unified Commands are tasked to coordinate all details of HCA operations. An example would be to identify possible HCA projects and coordinate them with the indigenous



Date: March 1995

Table 3-6 [Ref. 23]

**UNIFIED COMMAND AREAS OF RESPONSIBILITY (AOR)**

**Priority Countries Identified by OSD (Global Affairs)**

<b>CENTCOM</b>	<b>USECOM</b>	<b>PACOM</b>	<b>SOUTHCOM</b>
Afghanistan	Albania	Cambodia	Guyana
Bahrain	Estonia	Laos	Belize
Djibouti	Hungary	Thailand	Panama
Egypt	Romania	Philippines	Peru
Eritrea	Bulgaria	Bangladesh	Ecuador
Ethiopia	Macedonia	Indonesia	El Salvador
Jordan	Lithuania	Soloman Is.	Guatemala
Iran	Lebanon	Tonga	Nicaragua
Iraq	Turkey	Fiji	Honduras
Kenya	Poland	Vanuatu	Suriname
Kuwait	Latvia	Papua N.G.	Costa Rica
Oman	Botswana	Maldives	Bolivia
Pakistan	Uganda	Mongolia	Paraguay
Qatar	Rwanda	Nepal	Brazil
Saudi Arabia	Angola	Madagascar	Chile
Seychelles	Ivory Coast	Western Samoa	Argentina
Somalia	Zimbabwe	Comoros	Uruguay
Sudan	Senegal		
	S. Africa		
	Malawi		
	Burundi		
	Ghana		
	Mauritania		

**Table 3-7 [ Ref. 24 ]**

country's government and military. This is done with the ambassador and the country team which includes DoD personnel.

**2. DoDI 2205.3: Implementing Procedures for the HCA Program, Jan 27, 1995, ASD (SO/LIC)**

This instruction implements policy, defines responsibilities, and prescribes procedures for the HCA Program under DoDD 2205.2. It basically reiterates DoDD 2205.2 with more detailed coordinating responsibilities.

DoDI 2205.3 states that before USD (Policy) issues final approval of the Unified Combatant Command Commander's proposed annual HCA activity plans, USD (Policy) shall ensure that plans are coordinated with, and have the concurrence of, the Secretaries of the Military Departments, the Assistant Secretaries of Defense for International Security Affairs, International Security Policy, Reserve Affairs, and Health Affairs, the General Counsel of the DoD, and the Comptroller of the DoD. USD(Policy) shall also obtain approval of the Department of State and the Agency for International Development (USAID).

HCA activities are paid for out of O&M funds budgeted by each military department. Each Unified Command falls under the budget authority of one of the Services. An example is that CENTCOM HCA is funded by Air Force O&M.

[Ref. 20]



**3. DoDD 5100.46: Foreign Disaster Relief, December 4, 1975, ASD (ISA)**

This directive states DoD policy for the employment of its resources in foreign disaster relief operations. It also assigns responsibilities for carrying out this policy.

Foreign disaster relief is defined as prompt aid which can be used to alleviate the suffering of foreign disaster victims. This includes humanitarian services, transportation, provision of food, clothing, medicines, bedding, and temporary shelter. This directive also provides for the furnishing of medical materiel, and medical and technical personnel. Disaster is defined as an act of nature such as an earthquake, or an act of man such as civil strife, epidemic or rioting.

The coordination of DoD disaster response starts with the Department of State determining that response is required. The Department of State contacts the ASD (International Security Affairs). ASD (ISA) gets the ball rolling by contacting the JCS. The JCS, depending on the magnitude of the disaster, will establish a Joint Task Force to handle the relief efforts.

**4. DoDD 5111.10: Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict (ASD(SO/LIC)), March 22, 1995.**

This directive establishes the responsibilities, functions, relationships, and authorities of ASD (SO/LIC).

In regards to IH/DRO, DoD Instructions 2205.2 established ASD(SO/LIC) as program manager of the HCA program. ASD (SO/LIC) was also responsible, as per this instruction, for humanitarian and disaster relief. In June of 1996, a new office was established called Peacekeeping and Humanitarian Assistance. This new office is within ASD (Strategy and Requirements) which is a component of USD (Policy) [Ref. 20]. This new office has assumed responsibility for HA operations, while ASD(SOLIC) maintains responsibility for HCA.

The control and coordination of IH/DRO within the DoD is in a dynamic state and continually evolving. The Office of Peacekeeping and Humanitarian Assistance does not have an Instruction regarding HA promulgated at this time. Mr. Claudio Lillienfeld, advisor for Policy Programs, ASD(Strategy And Requirements), indicates that they are currently writing an instruction [Ref.20].

Peacekeeping and Humanitarian Assistance is responsible for developing, coordinating, and overseeing the implementation of policy for DoD humanitarian assistance, foreign disaster relief, and DoD responses to migration emergencies such as the Cuban refugee crisis. This new office is also responsible for programming, planning, justifying, and executing the (OHDACA) appropriation, citing

Title 10 USC Sec. 2551. [Ref. 20]

#### **D. INTERAGENCY COORDINATION OF IH/DRO**

Conducting IH/DRO is a very complex operation not only in physically implementing an operation but overcoming the tremendous complexity of coordinating activities within the DoD, Department of State, U. S. Agency for International Development (USAID), the host government, United Nations, NGOs, and other players, depending on the operation. I will document the command relationships as outlined in a Center for Naval Analyses (CNA) study. The complex coordination for HCA and HA disaster relief operations will be outlined with text and figures.

##### **1. Command Relationships in Conducting IH/DRO**

One of the biggest problems in conducting and coordinating IH/DRO is establishing command relationships. There are three factors identified by the Center for Naval Analyses that make the traditional military chain of command to conduct IH/DRO insufficient [Ref. 27]. The first of these factors consists of a need for a closely coordinated U.S. government interagency response. The military does not have sole responsibility or authority to conduct IH/DRO and must interact with agencies outside the DoD.

A second factor is that these operations support the work of other groups involved, such as NGOs, international



organizations, and host governments.

Finally, involvement with the United Nations or a coalition of other governments adds another layer of complexity. [Ref. 27]

The command relationships within the U.S. government for conducting these operation were identified by the Center for Naval Analyses and are provided in Figure 3-1.

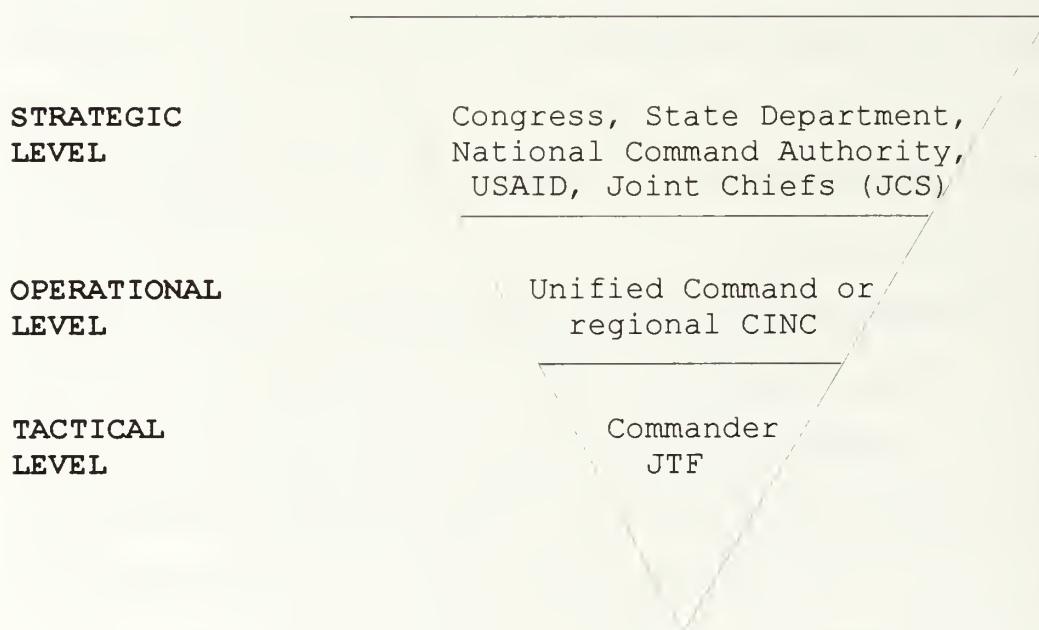


Figure 3-1 [Ref. 27]

At the strategic level coordination, not command, is essential. The USAID Administrator serves as the President's Special Coordinator for International Disaster Assistance. Therefore, the burden of coordination falls on the Administrator of USAID. The lead agency is not defined at the other levels. Consequently, the CINC is the de facto leader at the operational level. The CINC must communicate regularly both up and down the chain of command to ensure that policy promulgated at the top becomes an operational reality with the CJTF.

The Mission Statement outlines the purpose and scope of a future mission. The responsibility for planning IH/DRO passes from the NCA to the JCS to a CINC and finally the JTF. A CNA report stated that each group writes its own slightly different Mission Statement [Ref. 28]. The resulting mission can end up being different from what was originally intended from the top. This would create problems in coordination.

This is especially true for IH/DRO because there is a lack of established doctrine and success is not as clearly defined as in war-fighting [Ref. 28]. The report recommended that all levels should examine Mission Statement wording for ambiguous language. It stated that the military should standardize language and develop Measures Of

Effectiveness (MOE) for IH/DRO.

## **2. Coordination of Foreign Disaster Relief And Humanitarian Assistance**

The CINCs carry out IH/DRO in support of State Department objectives. The CINC, therefore, transforms national-level policy into action. There are three phases associated with conducting disaster management operations [Ref. 29: p. 443]. Phase I is Deployment and Assessment, Phase II is Responses, and Phase III is Transition and Redeployment.

### **a. Phase I: Deployment and Assessment**

The process is started with the host nation requesting assistance through the U.S. Ambassador. The Ambassador, with the assistance of the embassy's country team, develops a recommendation to submit to the State Department. If the State Department declares a disaster, it will determine the policy for the relief effort. This State Department effort is developed by the USAID and its coordinating Office of Foreign Disaster Assistance (OFDA).

OFDA will coordinate the U.S. government disaster relief responses, procure supplies, transportation, and coordinate assistance with NGOs and other international organizations such as the Red Cross. OFDA can deploy the Disaster Assistance Response Team (DART) into the area to

assess needs. OFDA usually requests DoD equipment and transportation in the early stages of a disaster. [Ref. 29]

**b. Phase II: Responses**

After the DoD receives the request to provide assistance from OFDA the CJCS oversees the military logistics response to the crisis. After receiving policy from the strategic command level, the regional CINC organizes, plans, and initiates the action. This is the point where the CINC develops the Mission Statement that outlines the purpose and objectives of the mission. The Joint Task Force (JTF) carries out the objectives of the mission statement. The CINC uses the Humanitarian Assistance Survey Team (HAST), to assess the mortality, injury, illness, infrastructure and overall status of the disaster area. The Unified Command medical operations staff provides medical teams with current host country health information. The response time is critical in disasters to reduce the loss of life. The Strategic Disaster plan gives the CINC 2 hours to determine military support availability after DoD notification. The HAST must be deployed in 12 hours and relief must be in the disaster area within 48 to 72 hours.

**C. Phase III: Transition and Redeployment**

This phase starts after immediate life saving

efforts have been accomplished and rehabilitation begins. Phase III ends when the objectives outlined in the Mission Statement have been achieved. The JTF then disbands and returns home. Assistance continues under the direction of the U.S. Ambassador and OFDA representatives.

A review of coordination for disaster relief is provided in Figure 3-2.

### **3. Coordination and Approval of HCA**

The coordination and levels of approval for the HCA program were provided earlier in Chapter Three with a review of DoD Directive 2205.2 and DoD Instruction 2205.3. A summary of the approval levels and interagency coordination are provided in Figure 3-3. Figure 3-3 was provided by the USCENTCOM Humanitarian Assistance Survey Team (HAST). This diagram is typical of the coordination and interagency involvement with HCA in the five Unified Commands that conduct HCA operations. The five commands are USCENTCOM, USECOM, USPACOM, USACOM, and USSOUTHCOM. [Ref. 24]

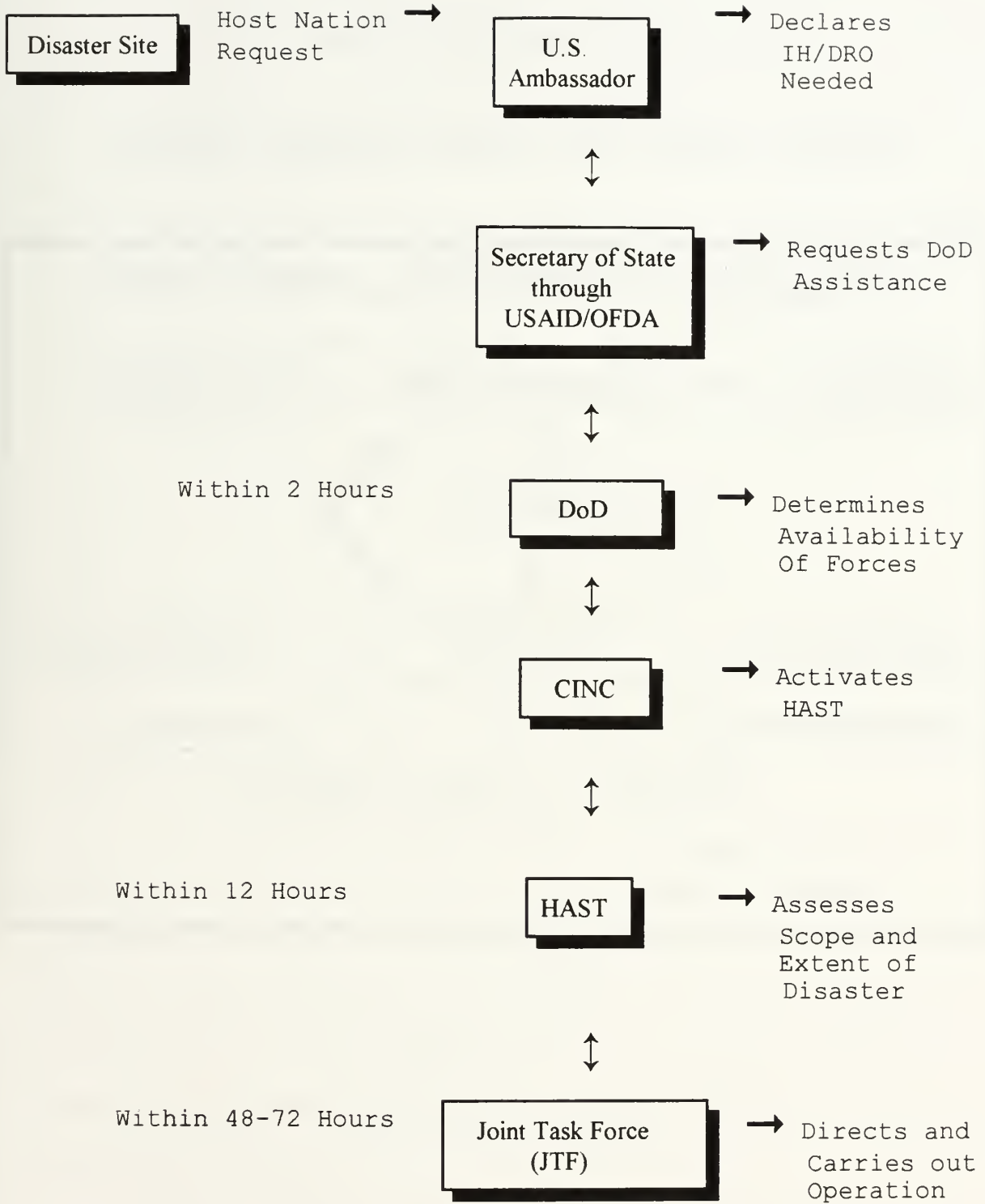


Figure 3-2 [Ref. 29]



UNIFIED COMMAND HCA PROJECT APPROVAL PROCESS

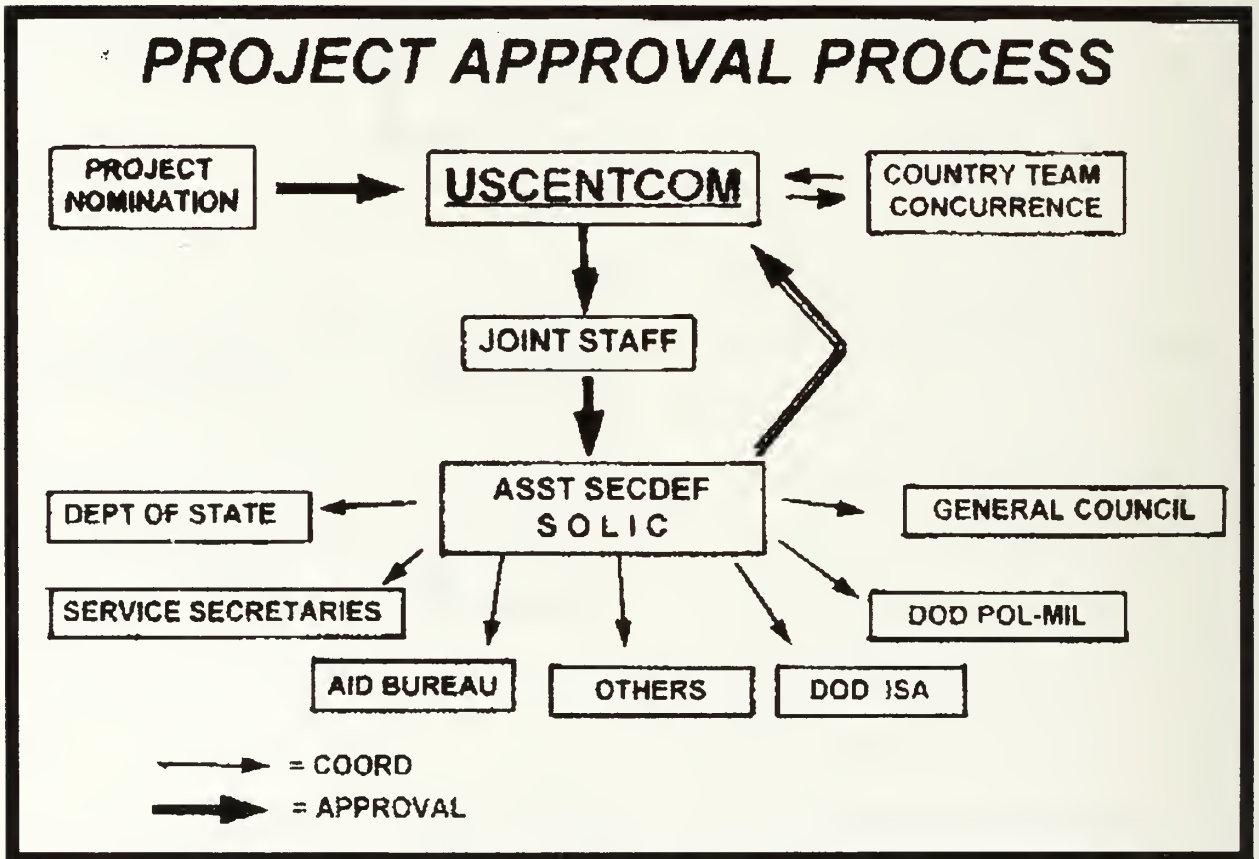


Figure 3-3 [Ref. 30]

#### IV. PLANNING AND EXECUTING IH/DRO

Chapter IV will review the two distinct types of Humanitarian missions.

Operation Sea Signal was a pure Humanitarian Assistance operation referred to by CENTCOM HAST as HA (other).

Operation Sea Signal was a large scale operation involving a large contingent of DoD medical assets that are typical of these operations. Humanitarian Assistance operations are emergent in nature and therefore not as definitively preplanned and budgeted for as HCA operations.

Operation Eager Tiger was typical of a small scale Humanitarian Civic Assistance operation that was short in duration and is part of the Joint Chiefs of Staff (JCS) Nation Assistance Program.

While no two of these distinct types of operations are exactly the same, the intent of this chapter is to give insight into types of planning and execution problems faced while conducting IH/DRO. Two officers involved in these operations were interviewed to give their personal point of view on the conduct and outcome of the operation in which they were involved.

Major D. Randall Ziss, USAF, is the Director of Pharmacy of the 6th Medical Group, located at MacDill AFB,

Tampa, FL. He deployed with the 6th Air Transportable Hospital (ATH) in support of Operation Sea Signal. He was interviewed and provided valuable insight into Operation Sea Signal [Ref. 33]. LtCol. James Rodgers, USAF, MC, FS, is Commander, Medical Services Flight of the 6th Medical Group. Col. Rodgers was interviewed concerning his participation in operation Eager Tiger, conducted in Jordan from April to May 1996 [Ref. 34]. He provided candid opinions and suggestions for future HCA operations involving DoD medical assets.

#### **A. OPERATION SEA SIGNAL (HUMANITARIAN ASSISTANCE)**

This review will focus on the participation of the U.S. Air Force 6th Air Transportable Hospital (ATH) in Operation Sea Signal from 8 September to 8 December 1994 [Ref. 31].

##### **1. Synopsis of Mission**

Operation Sea Signal was an operation designated to provide Humanitarian Assistance to the thousands of Haitian and Cuban migrants desperately trying to gain access to the United States. These migrants were detained and cared for in temporary camps located on the U.S. Navy base in Guantanamo Bay, Cuba. The regional CINC, USACOM, established Joint Task Force 160 to respond to the crisis.

The purpose of the 6th ATH involvement in Operation Sea Signal was to provide Echelon I and II medical care and emergency dental care to Haitian and Cuban migrants. They

also provided care to non-migrant personnel, primarily Joint Task Force (JTF) 160 personnel. The mission of the medical component was detailed in Annex Q to JTF-160 OPLAN 1-94, Medical Service. OPLANS are developed and utilized to delineate JTF component responsibilities and objectives. Echelons of care above those available in Guantanamo Bay were considered for Medevac to facilities in the United States in accordance with Annex Q.

Other medical players in Operation Sea Signal were Guantanamo Bay Naval Hospital, 59th USAF ATH, and the U.S. Army 147th MEDLOG Company to provide logistical support [Ref. 32].

## **2. 6TH ATH Capabilities**

The 6TH ATH was capable of providing the full spectrum of general surgical procedures not requiring specialized radiological equipment. Elective surgical procedures were avoided unless there was a threat to life, limb, or eyesight. The 6th ATH is a 50 bed medical/surgical facility. The ATH was modified to accommodate 57 inpatients and provide outpatient care to as many as 20,000. If needed, the 6th ATH could expand to 100 inpatient beds.

## **3. Chain of Command**

Operationally, the 6th ATH reported directly to the JTF Surgeon. For administrative matters such as billeting,

personnel actions, and rotations, the chain of command started with the Air Force Forces (deployed) Commander. This is typical of chain of command in Joint Task Force elements for IH/DRO [Ref. 33]. The 6th ATH Bioenvironmental Engineering and Military Public Health personnel were integrated into the JTF Preventive Medicine Team. Again these personnel reported operationally to the JTF Team Chief and administratively back to the 6th ATH.

#### **4. Operations**

In preparation for deployment to Guantanamo Bay, the 6th ATH made changes to their normal load out of medicines and equipment due to the nature of the mission. Obviously the battlefield mission scenario was de-emphasized and additional medications needed for Humanitarian Assistance were added to their Table of Allowances or Formulary.<sup>4</sup> Medical conditions found in third world areas and tropical diseases were emphasized in planning for expected cases.

Medical care was provided by sending in teams to the migrant camps. Patients were initially screened in the camps and then transported to the ATH if required. Initially, the majority of care was directed to patients with malaria, diseases, and injuries caused by exposure

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<sup>4</sup> The formulary is a list of authorized medications that are carried by a hospital pharmacy.

while at sea. When camps were fully established, a systematic approach to medical care was initiated. All Haitian migrants were immunized for a variety of diseases. A high incidence of Pulmonary Tuberculosis, HIV and dental problems was found.

### **5. Manpower**

A normal staff of 147 personnel was augmented by 42 personnel from Wilford Hall Medical Center and 3rd Medical Group from Elmendorf AFB, Alaska. These additional personnel were there to meet the demand of contingency operations and additional obstetrical and pediatric taskings. Naval Dental officers and technicians were added to provide dental care.

The unit consistently included 165 to 200 members. Assigned personnel deployed from active Air Force, Air Force Guard and Reserve units from several states and bases. The average was 67 percent active Air Force, 3 percent Active Navy, and 30 percent Guard and Reserve assigned during the three month period. The staff usually consisted of six family practitioners, two obstetricians, two pediatricians, five internal medicine and infectious disease specialists, one general surgeon, two radiologists, two nurse anesthetists, two pediatric nurse practitioners, four dentists, and numerous technicians and support personnel.



[Ref. 31]

## 6. Productivity

During the period of 8 September to 8 December 1994, the 6th ATH averaged per month, 24,007 outpatient visits, 164 admissions, 567 inpatient days, 16 operations, 28 newborns, 50 well baby checks, 1,568 X-rays, 6,417 laboratory procedures, and 6,192 prescriptions. The unit accomplished 49,771 immunizations in August alone. A rough estimate of operation costs was developed by Major Ziss, and exhibited in Table 4-1.

<b>OPERATION SEA SIGNAL COSTS</b>	
▶	<b>\$250,000/day</b> for food consisting mainly of rice and beans.
▶	<b>\$60,000/week</b> and <b>\$1.5 Million</b> total for medication.
▶	<b>\$1 Million</b> for vaccinations.
▶	<b>\$35,000/day</b> for ship billeting. Ships were chartered to alleviate the U.S. personnel billeting shortage.
▶	<b>\$2 Million/day</b> total cost (est.).

Table 4-1 [Ref. 32]

## 7. Observations

Medical resupply was provided initially by the home unit, the 6th Medical Group, MacDill AFB, via a weekly C-12 US Special Operations Command (USSOCOM) flight, which was coordinated by medical logistics personnel. Medical

personnel associated with the operation indicated that the resupply pipeline was not sufficient to keep up with the needs of the ATH [Ref. 33]. The priority system was abused and a backlog of transport quickly developed. When a critical item was needed, a 6th ATH member would call the flight line and literally have certain items segregated for urgent transport. No differentiation was made between medical supplies and repair parts. Hence important drugs would get the same expediency as wood for housing.

No formal logistics effort was established prior to commencing the operation. In mid September 1994, the 6th ATH was directed to use the 147th US Army MEDLOG company as its "depot" for all medical supplies. However, the 147th was not properly stocked to meet their requirements [Ref. 31]. The 147th had not established adequate resupply lines and was not properly stocked until late October 1994. It is critical that MEDLOG companies need to be in the area of operation, properly stocked, and have a dependable resupply line established before medical operations begin.

Another problem was that the 6th ATH not only treated the Cuban and Haitian migrants but also the U.N., Red Cross, and other agencies that did not bring their own medical care capacity. The 6th ATH even treated the ACLU members who were there to, "protect the rights of the

migrants." The Task Force also had to feed and provide scarce shelter to these other groups. Some of the best accommodations were provided to these agencies' senior officials, to the dismay of the military members providing relief. Joint Task Force planners need to take these additional agencies into account in future operations.

It was discovered that the stress level for DoD medical personnel providing relief peaked at three months. The after action report stated that personnel rotations rarely occurred on time. This was not good for morale.

A policy was established to rotate high stress billets such as linguists, chaplains, and medics. These were people who had close, day to day contact with the migrants. The migrants were irritable and dealing with them was, at times, not a pleasurable experience [Ref. 33]. This policy should be followed in similar future operations.

## **B. OPERATION EAGER TIGER (HCA)**

Operation Eager Tiger was executed by DoD medical personnel as an asset of USCENTCOM. The majority of these personnel were attached to the 6th Medical Group, Air Combat Command, MacDill AFB, Tampa, FL. They were to provide Humanitarian Medical Assistance in partnership with a Jordanian medical team. The operation occurred between 29

April and 14 May 1996, with 12 days in Jordan.

### 1. Synopsis of Mission

The objective of the medical HCA operation was to provide assistance to the Jordanian medical team providing health screenings and medical care to school children and civilians in northern and southern Jordan. The team was to perform complete physicals and associated lab work. A large amount of equipment was transported from MacDill AFB with the team. Table 4-2 details the items utilized. This list served the team well and could be used by medical teams in the future for similar HCA missions.

<b>HCA TEAM EQUIPMENT</b>
Echocardiography machine
Abdominal ultrasound machine
Electrocardiogram (EKG) machine
Automatic Refractor Meter
Microscope (later determined not needed)
85 Line items of medical supplies and medications
Preventative medicine educational materials
Portable generators and transformers with extension cables

**Table 4-2** [Ref. 35]

During the twelve days in Jordan the team worked five days, traveled seven days, and had four non work days. The team screened five schools, three in southern Jordan, and two in the north.

## **2. Medical Team Capabilities**

The team had the capability to perform procedures inherent in physical screening. There were no surgical capabilities, as that was not within the scope of this HCA mission. They used the equipment in Table 4-2 to give comprehensive exams to the school children. Any major medical problems discovered upon examination were relayed to the Jordanian team members for treatment at a local hospital.

## **3. Operations and Productivity**

The joint medical team visited three schools in southern Jordan near Al-Quara and two schools in northern Jordan near Al-Mafraq. During the five work days, the team screened 2,383 students and teachers and performed 6,790 procedures [Ref. 35].

A medical record, vital statistics, blood pressure, physical exam, and eye exam were performed on all students. Further testing was required on identified eye and abdominal problems by automated refraction and the ultra sound machine. The EKG machine was utilized for identified heart murmurs. A total of 720 prescriptions were filled for minor ailments. Preventative medicine handouts on smoking cessation, dental care, drug and alcohol abuse, sexually transmitted diseases, first aid, and hearing conservation

were presented.

#### 4. Manpower

The combined team consisted of twenty-six medical personnel. Table 4-3 identifies the specialties of each country's team members.

<b>USAF 6th Medical Group MacDill, AFB</b>	<b>Jordanian Royal Medical Services</b>
Internal Medicine, Commander	Family Physician, Commander
Radiologist	Family Physician(2)
Medical Administrator	Ophthalmologist
Pediatrician	Medical Supply Officer
Family Practice Physician	Lab Technician (2)
Bioenvironmental Engineer	Practical Nurse (3)
Nurse	Driver
Medical Tech	
Cardiopulmonary Tech	
Medical Maintenance	
Medical Technician (2)	

**Table 4-3** [Ref. 35]

#### 5. Observations

It must be reiterated that problems encountered on this specific operation are not necessarily encountered on every Medical HCA operation. These observations are presented to demonstrate the types of problems encountered by U.S. personnel in coordinating with the host country's medical



team. The After Action report submitted by the U.S. team commander stated that all objectives of the operation were achieved and the operation was highly successful. The success of the mission was based on objectives set in predeployment planning correspondence and the opinion of the U.S. team commander.

**a. HCA Planning Problems**

The team departed Shaw AFB and arrived at Marka International Airport, Amman, Jordan. Because the Jordanians thought the team was landing in Azraq, they were not met by a Jordanian representative in Amman.

The Pre-Deployment Site Survey (PDSS) is used to set the itinerary, and to establish billeting and travel arrangements for the mission. The U.S. HCA team leader attended only the initial PDSS in January 1996.

Upon arrival, the Jordanians did not have a clear idea of a work plan, despite prior communications with the HCA team. It was later determined that the Jordanians who attended the PDSS in January, prior to the mission, were not the same individuals who participated in the actual HCA project. There was obviously poor communication between the two Jordanian parties. A firm itinerary was never laid out by the Jordanians, only vague ideas of when and where the team could work. The Jordanians planned to have the HCA

team work through 13 May 96 and depart on 14 May 96. This was contrary to the earlier planned departure of 12 May 96.

This indicates that no matter how well the U.S. team has planned before commencing the operation, the host nation's lack of coordination could cause problems and must be anticipated.

#### **b. Execution Problems**

The U.S. team commander contracted severe diarrhea on the sixth day of the operation. However, the team was prepared and had the necessary medication for treatment. The team noted that it is critical for team members to drink bottled water and insist on it being provided if their own stocks are depleted.

The Jordanians did not provide an adequate truck for the HCA team material. The team had to go to great lengths to demonstrate they needed a larger vehicle, despite earlier communication of the size and weight of the equipment.

The Jordanian team was annoyed by the U.S. team insistence on taking the time to properly handle and package their equipment each day after working. The Jordanians displayed a nonchalant manner toward their own equipment and supplies. Some of the Jordanians supplies were damaged by their haphazard stowage in their truck.

The hosts expected HCA team members to pass out small gifts and toys to children. Also, the Jordanians were offended that the team did not present them with a plaque at the end of the mission.

The Jordanians did not supply enough interpreters. Communication was difficult when English speaking Jordanian doctors were not present.

Female members of the HCA team were not treated equally to their male counterparts. The majority of the Jordanian team, especially the enlisted men, treated the U.S. female HCA team members with subservience. This resulted in resentment by the female members toward the Jordanians.

Cultural differences must be briefed prior to commencing an operation so that HCA team members are prepared to deal with them.

The Jordanians were very concerned about how much money they were going to receive and how much of their equipment requests the team could accommodate. It appeared that the Jordanians looked at the mission as a way to get the \$75,000 in medications earmarked for the operation, not as a medically focused mission. A full 80 percent of the material went to their clinic after the operation was concluded [Ref. 34]. LtCol. Rodgers, the HCA team

commander, stated, "the Jordanian Officers were rather up front about it and were not as enthusiastic as the U.S. HCA team members about providing medical care to the children" [Ref. 34].

There were significant problems that were overcome with determination by U.S. team members and the mission achieved all stated objectives. All medical team members must be briefed about these types of problems and understand the cultural, logistical, and political realities in the host country before commencing a medical HCA operation. These potential problems can be overcome with professionalism and a thorough understanding of the stated objectives and political objectives of HCA operations.



## V. CONCLUSIONS

Chapter five will provide an overview of what was found in research. Section A will answer the main thesis question and Section B will answer the subsidiary research questions. Recommendations for further research will be presented in Section C.

**A. PRIMARY THESIS QUESTION: *What is the current structure for planning, coordinating and budgeting for IH/DRO and the use of DoD medical assets in these operations?***

**1. Planning IH/DRO**

The primary entity responsible for planning and executing IH/DRO is the Unified Combatant Command. The Unified Commands that conduct IH/DRO are USCENTCOM, USECOM, USPACOM, USSOUTHCOM, USACOM, and in some situations SOCOM. With the exception of Special Operations Command (SOCOM), each Unified Command is responsible for a geographic Area of Responsibility or AOR.

When a mission is identified by the State Department, the Unified Command tasked to execute the mission establishes a Joint Task Force. This Joint Task Force develops an OPLAN or Operation Plan that establishes mission objectives and JTF component responsibilities. For example, JTF 160 was established in 1994 to execute operation SEA SIGNAL to handle the Cuban and Haitian migration crisis. This Joint Task Force utilized JTF-160 OPLAN to carry out





the mission.

To clarify the AORs for the Unified Commands Figure 5-1 is provided. The AOR of U.S. Atlantic Command (USACOM) is the darker shaded region in Figure 5-1.

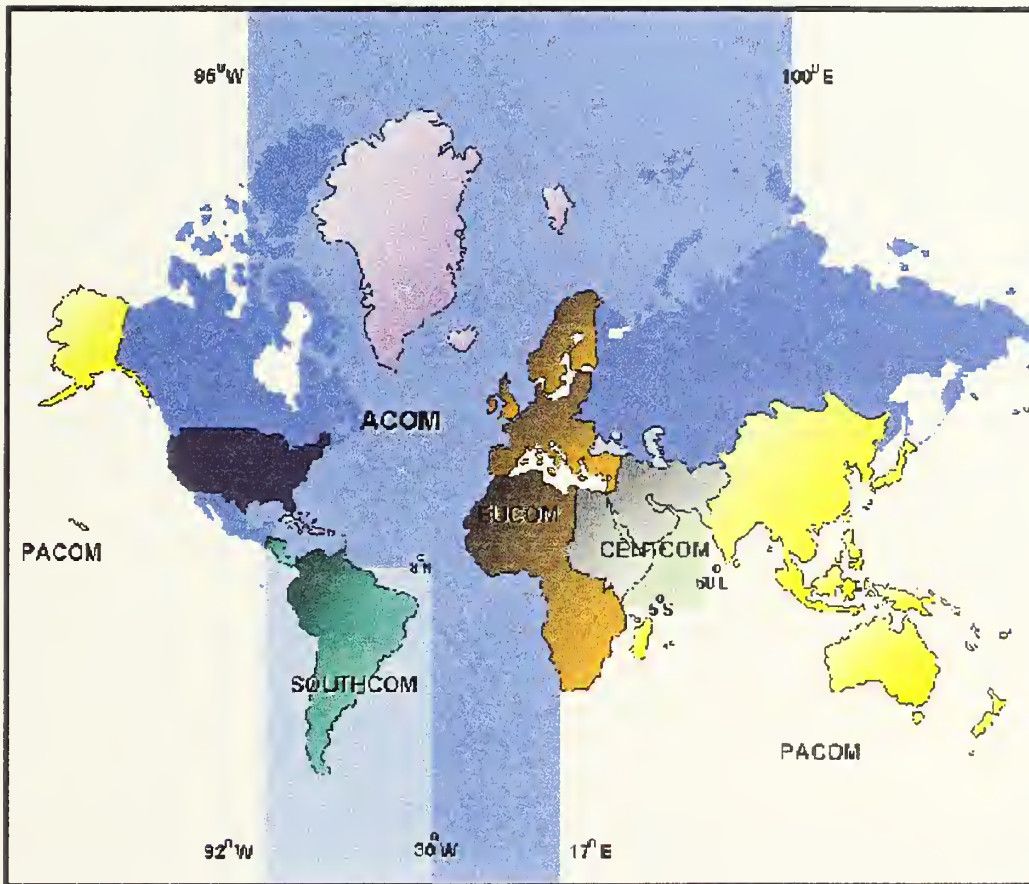


Figure 5-1 [Ref. 23]



## **2. Coordination of IH/DRO**

The coordination of IH/DRO was outlined in chapter III. The major players conducting IH/DRO are the DoD, Department of State, U.S. Agency for International Development (USAID), and its Office Of Foreign Disaster Assistance (OFDA), the host government, the United Nations, and NGOs.

The usual progression of a IH/DRO mission is this: a disaster occurs, the host country asks the U.S. ambassador for assistance, and the ambassador declares that assistance is required. The State Department will request DoD assistance through the U.S. Agency for International Development (USAID). The DoD will activate a Humanitarian Assistance Survey team to assess scope and extent of disaster. The data is relayed to the Unified Command which has responsibility over the geographic area of the disaster site. The Unified Command establishes a Joint Task Force to render assistance.

## **3. Budgeting for IH/DRO**

The budgeting for Humanitarian Assistance has been and will continue to be a problem into the foreseeable future. The OHDACA appropriation identified in Chapter II is one mechanism utilized to pay for HA operations. It is exceedingly difficult to budget for operations when their occurrence and magnitude cannot be anticipated.

Large scale IH/DROs rely on the movement of funds within existing O&M accounts. If the operation is long in duration, it has been necessary to ask for supplemental appropriations or reprogramming of appropriated funds to cover the costs.

## **B. SUBSIDIARY RESEARCH QUESTIONS**

### **1. What IH/DRO have we conducted in the past utilizing DoD medical assets and what were the results?**

The research presented in Chapter II demonstrated that the U.S. DoD has been conducting IH/DRO since before the cold war era. We have conducted numerous operations in providing disaster relief as a result of natural or manmade disasters. Examples of these types of operations are in Chapter II.

The Humanitarian Civic Action program had its beginnings in the Korean War with the Armed Forces Assistance to Korea (AFAK) program. This was one of the first nation building programs similar to HCA which is part of the JCS Nation Assistance Program.

The success of past operations is hard to quantify. It is very important to first identify objectives of the operation in order to know they have been achieved and the assets can be removed. This can be a problem, as demonstrated in Operation Provide Comfort in Somalia. Objectives were vague and mission creep lead to problems for

the DoD personnel conducting the operation.

**2. What are the current federal laws, military doctrine, and interrelationships between government agencies that coordinate and execute IH/DRO involving medical assets?**

There are various sections of Title 10 U.S. Code that allow DoD participation in IH/DRO. The most pertinent sections are 401, 402, 2547, and 2551. A detailed review of these sections of Title 10 is provided in Chapter III.

Doctrine on IH/DRO is widely acknowledged to be lacking. Two JCS pubs, 3-07 and 4-02, provide limited doctrine for conducting IH/DRO. JCS Pub 3-07 is entitled Joint Doctrine for Military Operations Other Than War and JCS Pub 4-02 is entitled Doctrine for Health Services Support in Joint Operations. The Naval Doctrine Command is currently developing doctrine covering naval participation in IH/DROs.

The complex web of interrelationships among U.S. government agencies that conduct IH/DRO is reviewed in detail in Chapter III.

The command relationships among U.S. government agencies that coordinate to conduct IH/DRO can best be represented as an inverted pyramid with the strategic level on the top, the operational level in the middle, and the tactical level at the bottom. The strategic level makes the decision to proceed with the operation and scope of the



proposed operation. The strategic level is made up of Congress, the State Department, the National Command Authority, the U.S. Agency for International Development in its capacity as the President's coordinator of international disaster assistance, and the Joint Chiefs of Staff (JCS).

The operational level is filled by the regional CINC who is responsible for contingency planning in its Area of Responsibility (AOR). The regional Unified Command will stand up a Joint Task Force (JTF) to execute the IH/DRO after the strategic level has made a decision.

The tactical level, at the bottom layer of this inverted pyramid, executes the operation. The Commander of the Joint Task Force (CJTF) is responsible for the conduct of U.S. forces in the theater of operation.

Agencies outside the U.S. government, and outside the inverted pyramid model, add a greater degree of complexity to the coordination of assets to conduct IH/DRO. These outside agencies consist of coalition forces, the United Nations, the host government, NGOs, and other participants depending on the operation.

**3. How do we plan for contingencies that require the use of medical assets at the Unified Command level and how much does it cost?**

There are no formal detailed contingency plans for each type of IH/DRO mission. Each mission is inherently unique,

resulting in ad hoc planning to suit the details of each mission. A problem with this ad hoc planning is that corporate knowledge is lost when personnel involved in these operations rotate to other billets. It is the Unified Commands' responsibility to maintain detailed lessons learned so that errors are not repeated. The Joint Uniform Lessons Learned System (JULLS), helps in this regard. This question is addressed in detail in Chapter IV.

**4. What are the current trends for the use of military medical assets for IH/DRO?**

DoD medical assets have been, and will continue to be a vital component in conducting IH/DRO, whether they are purely humanitarian disaster relief or Humanitarian Civic Action (HCA) program operations.

Organizations such as the Center of Excellence in Disaster Management and Humanitarian Assistance, Tripler Army Medical Center, will significantly enhance the capability and efficiency of units conducting IH/DRO. This COE provides education, training, and research in these types of operations. By consolidating professional expertise and study of IH/DRO in one location, "corporate knowledge" is aggregated and can be accessed by all commands that conduct IH/DRO.

A recent development in medical Humanitarian Assistance Programs involves the Special Operations Command (USSOCOM).

USSOCOM has proposed to develop Medical Humanitarian Assistance programs for each Regional Combatant Unified Command's authorized countries. This proposal was made at the Overseas Humanitarian, Disaster and Civic Aid (OHDACA) Appropriation Conference on 15, May 1996 to the Office of the Assistant Secretary of Defense for Peacekeeping and Humanitarian Assistance [Ref. 36]. USSOCOM requested that OASD Peacekeeping and Humanitarian Assistance provide USCINCSOC \$.5 Million under sections 2547 and 2552 of Title 10 to send Special Operations personnel to each regional Unified Command and to host a HA Program Conference. The team sent to the Unified Commands would develop a SOF Medical Humanitarian Assistance Program (HAP) tailored for each geographic region in accordance with the CINC's strategy.

This program can be used for SOF and conventional medical teams to conduct HA projects. The team would coordinate with the Country Team and host nation ministries of Health and Defense. Following approval of the developed plans by the Regional CINCS and USCINCSOC, they would be forwarded to JCS and OSD for review. USSOCOM envisions twenty to thirty HA medical country plans to be developed during FY97.

The planning and coordination for employment of DoD medical assets in IH/DRO is in a constant state of evolution and change. As outlined in Chapter I, the mission is likely to grow and place a greater burden on the DoD's diminishing assets. We must have a thorough understanding of how we coordinate and conduct IH/DRO and constantly strive for improvement and efficiency in the conduct of these operations.

### **C. SUGGESTIONS FOR FURTHER RESEARCH**

1. What efficiencies could be gained by consolidation of all DoD IH/DRO planning and operational control into one joint command?

2. How could SOCCOM's proposal to develop medical Humanitarian Assistance programs for each regional Unified Combatant Command help the DoD medical community prepare for participation in IH/DRO?

3. How can the DoD medical community change current training guidance to better prepare for participation in IH/DRO without diminishing the core competency of combat casualty treatment?



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