



# Humanitarian and Civic Assistance Projects and Military Training



Measures of Effectiveness  
CDHAM Publication 02-02  
#MDA 905-99-M-0726



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This program is in collaboration with the Henry M. Jackson Foundation  
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# A world center advancing medicine in humanitarian and disaster relief

**The mission** of the Center for Disaster and Humanitarian Assistance Medicine (CDHAM) is exactly what its name implies—to be the focal point for *medical* aspects of disaster relief and humanitarian assistance. Other centers—namely United States Pacific Command’s Center of Excellence in Disaster Management & Humanitarian Assistance, based in Hawaii, and the Center for Disaster Management and Humanitarian Assistance, based at both Tulane University and the University of South Florida in support of United States Southern Command—operate within the realm of humanitarian relief. However, they are focused on the broader issue of disaster management. By specializing in medicine and health-related topics worldwide, CDHAM compliments the work of these centers, as well as many other organizations that are improving the provision of relief and international health care.

**The origin** of CDHAM (pronounced “SID-am”) predates the current emphasis on military medical support of operations other than war by more than a decade. The CDHAM is organized within the Department of Military and Emergency Medicine at the Uniformed Services University of Health Sciences (USUHS). The Department Chair, along with the Dean, the President, and key faculty at the University, recognized early on the evolving role of military forces in shaping an uncertain world. CDHAM was formally established at USUHS by the Defense Appropriations Act of 1999 as the Department of Defense’s focal point for medicine in the non-traditional military operations and missions that have become more common in the new millennium.

**The role of CDHAM** extends beyond simply conducting studies. Our goal is to analyze, develop conclusions, determine lessons learned, and translate these into learning opportunities and improvement. Publications, lectures, symposia, and other media developed as a result of this work will become tools for educating graduate and medical students at USUHS, as well as advancing the broad spectrum of military medicine. CDHAM uses training, technology, and best management practices to improve military medicine capabilities and readiness for humanitarian missions, especially in partnership with the inter-Agency process, the international medical community, and the host nations’ medical infrastructure and beneficiary populations.

## Comments and questions are invited.

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# Contents

Executive Summary . . . . .	1
Overview of Military Humanitarian Assistance . . . . .	2
About Humanitarian and Civic Assistance (HCA) Projects . . . . .	3
Current Shortfalls: . . . . .	5
Lack of Documentation . . . . .	5
Lack of Utilization . . . . .	6
Source Materials . . . . .	8
Other Aspects of Humanitarian and Civic Assistance and Training . . . . .	10
Training Resulting from Military Deployments on Humanitarian Operations . . . . .	10
Specific Training Prior to Humanitarian Deployments . . . . .	10
Training Host-Nation Personnel . . . . .	12
Conclusions . . . . .	14
Clarifying Mission Objectives . . . . .	14
The Need for a Systematic Approach . . . . .	15
References . . . . .	17
Appendix: Brief summary of Title 10 section 401, Humanitarian and Civic Assistance . . . . .	24

# Tables

<b>Table 1:</b>	Graphic summary of the training, humanitarian, and political values of DoD humanitarian assistance programs . . . . .	18
<b>Table 2:</b>	Summary of Humanitarian Assistance After Action Reports with Comments on Training. . . . .	19-24

## Executive Summary

This report, one in a series on military humanitarian assistance, highlights the abundant opportunities for improving the training effectiveness of humanitarian and civic assistance (HCA) projects and programs. Current shortcomings are identified and suggestions for improvements provided. Shortcomings are primarily based on the lack of comprehensive reporting and analysis of the effectiveness of humanitarian and civic assistance (HCA) projects, especially for one of their statutory purposes: the training of U.S. personnel. Few after action reports (AARs) document training, even with basic information such as the number of personnel trained and the tasks or skills taught. In reviewing over 100 after action reports from DoD medical humanitarian assistance projects, (at least one-fourth of which were specifically identified as HCA projects), none compared the proficiency of military personnel in any skill before and after the mission.

Improving the training value of participating in military humanitarian and civic assistance projects could be as simple as marrying existing Service training programs with HCA deployments through the following:

- Incorporate existing Service mission essential tasks, training programs, tactics, techniques and procedures into HCA projects, and conversely, integrate the opportunity to participate in HCA projects into individual and unit training plans and schedules.
- Clearly state HCA project mission purposes, especially training objectives, and do so early in the planning stages. Share this information with all participants, including, to the extent feasible, host nation colleagues.
- Document educational and other outcomes from HCA projects, evaluating performance before and after the project and accomplishments against established Service training requirements, as well as international performance standards for humanitarian assistance.
- Expand the scope of medical HCAs beyond the current, common focus of short-term patient care. Include, where applicable, developmental and infrastructure-building aspects or projects, such as health education and training, sanitation, maternal child health, veterinary care and other public health projects. This will provide more effective and lasting humanitarian assistance, while offering deployment training opportunities to a wider range of DoD assets.
- Enhance pre-project training in the art and practice of conducting effective humanitarian assistance missions, such as HCAs. Ideally, specific training for key leaders if not all participants should be a prerequisite for project approval and funding.
- Utilizing the existing authority and format as specified in Dept. of Defense Instruction 2205.3, implementing mandatory after action reporting for HCAs (and all DoD humanitarian assistance projects), ideally in a standardized, easily retrievable format that supports post-project analysis to improve the effectiveness of future projects and training programs.

## Overview of Military Humanitarian Assistance

With the world's finest deployable medical system, an outstanding record of emergency care following disasters, and the turmoil in the new world order which continues to swell world populations of refugees and internally displaced persons, DoD is heavily engaged globally in providing humanitarian assistance. Often this assistance is in the form of medical or health-related relief. These assistance projects can provide political benefits to the donor nation, humanitarian care for beneficiaries in the host nation, and can offer training opportunities for both provider and host nation personnel. Situations in which DoD provides humanitarian assistance range from deliberately planned theatre engagement activities (now termed "theatre security cooperation"), to contingency operations, disaster relief, and complex human emergencies. These actions may be conducted unilaterally, bilaterally, or with coalition partners either as multi-national force or United Nations responses .

From these diverse kinds of military humanitarian assistance, the focus of the nine reports in this series is on three of the several distinct programs, managed by the Overseas Humanitarian, Disaster and Civic Aid (OHDACA) program. These are distinguished by their focus, funding, and oversight: the Humanitarian Assistance (HA), Excess Property (EP), and Humanitarian and Civic Assistance (HCA) programs. This report focuses specifically on HCA projects, (hereafter referred to as 'HCAs') which are provided for the training or operational readiness benefit to U.S. service members consistent with the political benefits to donor and host nation (see Table 1). For more information about military humanitarian assistance in general and these OHDACA programs please see the first report in this series titled, *Overview of Overseas Humanitarian Assistance, Humanitarian and Civic Assistance, and Excess Property Programs*.

Medical or health-related projects are among the most popular form of military humanitarian assistance. With over 200 deliberately planned humanitarian assistance OHDACA projects conducted worldwide, annually, health related projects account for approximately one-third to one-half of the total. With the rapid growth in global demands for humanitarian assistance of the past decade, participating in DoD humanitarian assistance missions has become a major workload for deploying forces, especially personnel and units of the military health system (MHS). In some areas this rapid growth has outpaced the development and application of specific joint medical doctrine, training, tactics, techniques or procedures for military humanitarian assistance.

OHDACA projects, including HCAs, are managed by the humanitarian assistance program managers on the staffs of the unified combatant command staffs. The respective Service component staffs usually execute these humanitarian assistance projects within their respective areas of responsibility. Units and personnel involved may be from active, Reserve components or the National Guard, or varying combinations thereof. Integrating these projects into theatre security cooperation plans is the responsibility of Combatant Command humanitarian assistance program managers. Oversight for humanitarian assistance programs is with the Office of Stability Operations within the Office of the Assistant Secretary of Defense for Special Operations/Low-Intensity Conflict (ASD, SOLIC), which funded this study under the Overseas Humanitarian, Disaster and Civic Aid Program. While humanitarian assistance (HA) and excess property donation (EP) are funded by annual appropriations under OHDACA authority, HCAs, because they are for training are Service-funded –an important distinction .

The nature of medical humanitarian projects ranges widely, -from constructing hospitals under HA authority to donating excess medical supplies and equipment via EP projects. Perhaps the most common form of medical humanitarian assistance, however, is direct care of foreign patients as is often done during HCAs. This is reportedly a means to train military personnel, which cannot be accomplished in the U.S. although this has not been well documented as discussed below. The quality humanitarian health care provided during HCAs and other military humanitarian assistance projects has benefited reportedly tens to hundreds of thousands of host nation patients and provided training to hundreds or thousands of military personnel over the years, although exact summary statistics are not recorded.



Besides DoD, many other humanitarian organizations, such as private volunteer organizations, (PVOs), non-governmental organization (NGOs), and international organizations (IOs) also provide humanitarian assistance including medical and health care to the growing populations requiring assistance around the world. However, DoD humanitarian assistance often differs from that conducted by these other organizations. For example, medical humanitarian assistance provided by DoD is usually provided for very short periods of time, typically two weeks (see Table 2). (As discussed in another report in this series, this limited time span can result in continuity of care issues, when care providers move on to the next location or another mission.)

In addition to the period of time during which care is provided, humanitarian assistance as provided by personnel and units of the U.S. military, may also differ from that provided by PVOs, NGOs, and IOs in other important ways. For example, in the case of HCAs, DoD conducts humanitarian assistance missions for the express purpose of training military personnel. Conducting humanitarian assistance for the training benefit of the providers is a fundamental difference between military and civilian humanitarian assistance and is explored below.

## About Humanitarian and Civic Assistance (HCA) Projects

In addition to the acronym 'HCA', the corresponding section number of the statute is often used to refer to "401 projects". Because their purpose is training, HCAs are funded by the respective Services, unlike the other humanitarian assistance programs of the OHDACA program. This has resulted in large differences between organizations in both the philosophy and procedures for HCAs. Differences can be comparatively minor such as the frequency with which personnel deploy, to fundamental, such as differences about the value and benefits of undertaking such missions. For example, in some organizations, personnel are required to take personal leave to participate in humanitarian assistance missions, while in other organizations member participation is not only actively encouraged and fully funded but in some cases, mandatory for completion of requirements for medical residency and other formal military training programs. Presumably, if there are bona fide training benefits derived from participating in HCAs, these would transcend the Services, and perhaps medical specialties.

While OHDACA projects are generally conducted for a combination of three fundamental, statutory purposes: humanitarian relief, political benefit, and training value (see the first report in this series titled, *Overview of Overseas Humanitarian Assistance, Humanitarian and Civic Assistance, and Excess Property Programs*), HCAs focus on training opportunities for U. S. service members. These must be 'consistent with U.S. and host nation political interests', as specified by U.S. Code, Title 10, section 401 (see Appendix, and references; Department of Defense Directive Number 2205.2, October 6, 1994, Subject: Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations, and Department of Defense Instruction Number 2205.3, Jan 27, 1995, Subject: Implementing Procedures for the Humanitarian and Civic Assistance (HCA) Program).

For U.S. military medical personnel, the training opportunities of HCAs are reportedly increased by the large number of patients seen during a short period of time. Typically, patient workload during HCA or other military humanitarian assistance missions far exceed a normal caseload at a home duty station. Thus, there is a potential training benefit in the increased number of patients treated. Care for these host nation beneficiaries is often provided in an austere environment which reportedly simulates some of the conditions of combat casualty care, therein reportedly increasing the training value. However, anything beyond subject comments such as 'great wartime readiness training' is not reflected in the AARs on HCAs. This is problematic as Dept of Defense Instruction 2205.3 specifically requires an entry in the HCA, Unified Combatant Command After Action Report to address: "how the HCA activity promoted specific operational readiness and/or skills of members of the U.S. Armed Forces participating in the activity." Thus, although the enabling legislative authority and implementing instructions require that HCAs be conducted for their training or specific operational readiness benefit of military personnel, evidence of this is frequently absent from HCA AARs when they are prepared.

Another training benefit to military medical personnel often cited in HCA AARs is the opportunity to diagnose and treat tropical and other diseases not endemic or often seen among U.S patients. For example, diseases of potential military significance such as malaria, dengue fever, leishmaniasis, or even cutaneous anthrax may be found among patient beneficiaries of HCAs depending on the host nation. There is an important, but unquan-

tified, medical training benefit to seeing, diagnosing, and treating diseases of potential military significance which otherwise would only be seen in a medical textbook.

In addition to training U.S. personnel, HCAs are one of the few opportunities to expand or update medical training among host nation providers. In preparing to teach medical skills, for example, U.S. personnel may effectively reinforce their own understanding by teaching the classes. In medical HCAs, subjects such as basic first aid, sanitation, hygiene and maternal and child health would be effective both for their training value for MHS personnel and for their sustainable humanitarian value to host nation personnel. This kind of training offers great opportunity for long-term improvement of living conditions and the health of host nation citizens. It also offers a certain degree of effectiveness in positively impacting the greatest number of beneficiaries at the lowest cost. In the past HCA training has often only focused on the U.S. service members but recently, the aspect of training host nation providers along with service members has been incorporated and featured in several innovative HCAs. However, the full potential of the educational aspects of HCAs has yet to be explored for any participant, U.S. or host national. At present, important training and developmental opportunities may be missed by not documenting outcomes and by limiting the focus of HCAs to short-term patient care. Sometimes continuity of care issues are not adequately addressed in short term projects. Ideally, humanitarian assistance projects such as HCAs should be planned to last as long as required to accomplish stated, approved project objectives, including training. The duration and effectiveness of HCAs would thus be evidence-based, rather than arbitrary.

## Current Shortfalls

While HCAs and other humanitarian assistance projects have great potential training value, this has yet to be fully realized. Despite a number of creative HCAs, including some involving training of both U.S. and host nation civilians as well as military personnel, their effectiveness remains, for the most part, largely unquantified. Existing training procedures utilized throughout DoD have rarely been applied to HCA projects, and conversely, HCA training opportunities, with the single exception of the combined Army-Air Force ophthalmology residency training program, rarely gain entry into either individual career development plans or unit-training schedules. To date, linking Service training requirements, also known as mission essential tasks, with the training opportunities afforded by HCAs has not been routinely made. For example, among more than 100 after action reports from various DoD humanitarian assistance projects including HCAs, only 1 report specifically included 'mission essential tasks' a key element of military training as part of the HCA project (Singer, 2001).

In some cases, the information from humanitarian assistance projects like HCAs, simply hasn't been documented or made readily available, so key information remains unavailable when planning new projects. In other cases, the information (while incomplete), is available, but not readily, and remains unutilized. For more discussion on this issue of the collection and management of essential elements of information in military humanitarian assistance, please refer to the CDHAM report *Host Nation Participants Perspectives on Military Medical Humanitarian Assistance*. In essence, the shortcomings of the HCA reporting evaluation system can be divided into two fundamental causes: lack of documentation, and lack of utilization.

### Lack of Documentation

Measuring effectiveness for training, humanitarian benefit or any other purpose requires an assessment of pre-existing conditions and post project follow-up to quantify changes, if any. Results need to be consistently documented in a standardized format that is clear and concise. A format for HCA after action reporting by the geographic Combatant Commands is specified in Dept. of Defense Instruction #2205.3. Although we analyzed numerous after action reports authored by the officers in charge of the particular project we did not obtain copies of the HCA AARs as specified in DoDI 2205.3. Whatever AAR format is eventually utilized (that prescribed in DoDI 2205.3 or an electronic prototype as outlined in the report in this series entitled, *Information Management for More Effective Military Humanitarian Assistance Projects & Programs*), it is essential that the key elements of information be readily accessible to authorized users. While many AARs very accurately document the details of a particular project, reports are far from consistent in what gets reported. They are not organized into a data base that is accessible. The present situation does not support analyses across projects, programs, geographic areas, or over time. Based on the responses of both U.S. participants and host nation representatives (see companion reports in this series entitled, *US Participants Perspectives on Military Medical Humanitarian Assistance* and *Host Nation Participants Perspectives on Military Medical Humanitarian Assistance*), pre- and post-project assessments are rarely conducted at the present in DoD humanitarian assistance projects such as HCAs.

With the exception of some component commands, guidelines or instructions on what information should be included in humanitarian assistance AARs is lacking except for the DoDI requirement discussed above (which is specific to HCAs). Other than organizational files for projects conducted by their subordinate units, there is no central repository for detailed information on humanitarian assistance projects or HCAs. Even where reports are prepared and forwarded, old files are periodically purged when personnel transfer or offices move, and the information is unfortunately lost. For example, information on years of extensive medical humanitarian involvement in Central and South America was lost when offices were closed in Panama and moved to Miami. The small collection of AARs on humanitarian assistance projects collected for this study (see *Humanitarian Assistance Bibliography: with some Annotations, After Action Reports, and Web Sites of Interest*) is an incomplete record of numerous DoD humanitarian assistance projects, and yet at the same time, probably represents the largest compilation of such information available anywhere. Clearly, assessing training, effec-

tiveness, or any other aspect of DoD humanitarian assistance would be improved by better record keeping. For HCAs the reporting requirement and specific format have been specified. How, when, or if this requirement has been implemented remains unclear.

Although over 200 humanitarian assistance projects, including HCAs, are conducted by the U.S. military annually under OHDACA programs, obtaining specific information about any of them is often problematic. The lack of information on the effectiveness of HCA missions for their statutory purpose— training—is particularly puzzling, since training is the hallmark of military preparedness.

In all Services, training is often repeated until performance meets or exceeds a specified standard, and is then documented in individual and unit training and proficiency records. Training is verified both by formal testing and informal on-the-job evaluations. Still later, refresher training is used to maintain or sharpen skills. Unfortunately, this well-defined and very familiar military training process has not been applied to HCAs, despite the fact that their statutory purpose is training.

This disconnect between HCAs and military training essentially stems from the lack of clearly defined requirements and/or enforcement. As mentioned, DoDI 2205.3 specifies an AAR format for HCAs but we were not able to find examples of such reports. We were unable to identify an overall DoD requirement for after action reports (AARs) on any other kind of humanitarian assistance projects besides HCAs. Nor did we find instructions on how to prepare project documentation. As an example of the incomplete documentation, many of the AARs we reviewed did not identify the specific authority under which the project was undertaken. Sometimes one can surmise that a particular project was probably an HCA, but in many AARs there is no indication if the authority for an overseas humanitarian assistance project was under one of the OHDACA programs, a TCA traditional unified combatant command activity, or one of the several other means by which military personnel may be deployed for humanitarian purposes. Obtaining information about an HCA or any other military humanitarian assistance project usually means requesting the information from individuals who were personally involved in each project. Eventually, through this process, over 100 AARs on a variety of humanitarian assistance projects were obtained and reviewed for the purpose of this study.

The lack of project documentation and analysis has also lead to repetition of similar kinds of projects year after year with little apparent determination if different kinds of projects might result in more effective training or humanitarian assistance. With a few notable exceptions, such as the Navy and the combined Army-Air Force ophthalmology residency programs, HCAs are often treated as unique, one-time events, missing opportunities to build on the experience of previous projects in the same region or field of medicine. This brings up another aspect of the problem, which is the lack of information utilization in an organized, analytical approach.

### **Lack of Utilization**

Despite the considerable investment represented by an HCA, the country teams and humanitarian assistance program managers at the Unified Combatant Command headquarters often define the scope, breadth, and goals of medical projects without the benefit of input by medical staff officers or review of prior projects. Planning of medical and health-related HCAs may include or omit input from medical subject matter experts, depending on different procedures and staffing in various organizations. Similarly, planning of HCAs may or may not include consultation with host nation representatives or others involved in humanitarian efforts, even in the same region.

In addition to inadequate information and inconsistent and/or incomplete planning efforts, medical humanitarian projects such as HCAs are often conducted on short notice, often by personnel who are not specifically trained for humanitarian assistance. Personnel are well trained and equipped to provide battlefield trauma care, but may not have any experience or training in humanitarian relief. Despite such challenges, participation in HCAs is almost invariably viewed very positively by participants.

At present, there is no active process for the formal review of HCAs. Training objectives are not stated, documented, modified, updated, or improved for use in the planning future HCAs. Rather, HCAs are

seemingly most often viewed as short-term, temporary duty or one-time deployments. In many such projects, training often appears an afterthought, and is not conducted in a manner consistent with training at a home duty station. In many cases, it is as if the familiar military training process and procedures are left behind when the individual or unit deploys on an HCA. Medical HCAs are widely described, but not documented, as essential medical readiness training.

Although this report focuses on only one of the many programs by which DoD provides humanitarian assistance worldwide, policy makers in other humanitarian programs and organizations also address many of these same issues raised in this study. The issue of what constitutes effective humanitarian assistance is also of vital concern to the many national and international organizations involved in humanitarian relief. For example, the United Nations Office for the Coordination of Humanitarian Assistance (UNOCHA) and many private volunteer organizations (PVOs) and non-governmental organizations (NGOs) also are concerned with the issues of accountability, evaluations, and the processes of 'lesson-learning' (UNOCHA, 1998, ALNAP, 2001). Like DoD, many humanitarian organizations are actively addressing how to better assess, evaluate and learn from past relief projects and how to apply these lessons constructively for more effective humanitarian assistance (ALNAP, 2001). Thus DoD is far from alone in this effort. The challenges faced by DoD in moving towards more effective humanitarian assistance and training are quite similar to those faced by the myriad other relief agencies. The solution to long range improvements in the effectiveness of training and humanitarian assistance lies in the close coordination, sharing of information, and other aspects of civil-military cooperation in which DoD should take an active and full role.

## Source Materials

Collected from a wide variety of medical humanitarian missions including HCAs, 100 AARs were reviewed; of which only 33 mention 'training' (Table 2). In many cases the type of humanitarian project was not identified in the report; thus in some cases we could not ascertain whether the project was an HA, HCA, or a mission under some other DoD humanitarian program. Reports included:

- At least 26 medical projects that were clearly identified as HCAs.
- 1 Partnership for Peace exercise in Moldavia.
- 1 USUHS medical student's trip report (Guatemala).
- 2 reports from Cameroon, one a MEDFLAG exercise, the other from Exercise Brilliant Lion.
- 1 Mobile Ophthalmologic Surgical Team (MOST) AAR for a New Horizons exercise in Peru (likely an HCA but not so identified).
- AARs from Operation Nectar Bend (Ethiopia), JTF-Bravo (Honduras), and Mexico.
- An undetermined number of military medical humanitarian assistance projects that did not identify in any way the authority under which they were conducted. Some of these could well have been HCAs but this could not be ascertained from the reports.

The AARs reviewed reported on projects spanning the globe, representing a variety of commands and diverse medical specialties. These reports cover humanitarian assistance projects conducted by all Services in 18 countries, beginning in 1994 with the majority of reports from recent missions (1999-2000). Projects ranged in scope from assessments by 2-person teams of subject matter experts, to deployment of 90 person medical units. While highly dissimilar projects are lumped in this analysis, the process allowed an overview of DoD humanitarian projects, especially HCAs. (Most AARs were obtained from the authors, whose kind cooperation made this study possible. For a listing and brief synopsis of the AARs please see the final report in this series, entitled, *Humanitarian Assistance Bibliography: with some Annotations, After Action Reports, and Web Sites of Interest*).

In addition to reviewing humanitarian assistance project AARs, information was also obtained from voluntary surveys of DoD personnel from all Services who had participated in HCAs and other health-related humanitarian missions. Using standard questionnaires administered via personal and telephone interviews, posted on the worldwide web, ([www.tmed.usuhs.mil/mmhap/](http://www.tmed.usuhs.mil/mmhap/)), and via attendance at U.S. and international medical conferences; reports on the experiences of 215 DoD personnel in medical humanitarian assistance were directly obtained. Respondents included both leaders and participants in medical projects as well as some humanitarian assistance program managers and supporting staff officers. Their experiences included HCAs and other kinds of military humanitarian assistance. (For more information on the results of these surveys, please review the CDHAM reports *US Participants Perspectives on Military Medical Humanitarian Assistance* and *Host Nation Participants Perspectives on Military Medical Humanitarian Assistance*.)

The number of responses was limited, which is not uncommon in voluntary surveys. Nevertheless, 215 officers and enlisted personnel from a variety of medical specialties responded, including 165 who self-identified as 'participants', and 50 who self-identified as having management or leadership responsibilities in humanitarian projects such as HCAs. There was some limited crossover between survey forms; for example, a few respondents who had led multiple missions completed the participant survey, while a few others who were completing their first humanitarian mission used the management questionnaire, leaving many of the leadership questions blank. This crossover on which form to complete was rare, both survey forms included many of the same questions, and does not affect the findings.

The results of this survey of military personnel are an important primary source of information, providing participants views on experiences during humanitarian assistance projects that are not often forthcoming in AARs. Respondents had the opportunity to convey ideas that might otherwise never have been expressed in official reports. The survey was not a random sample of DoD personnel. Survey completion was voluntary by individuals with prior military humanitarian assistance project experience and sufficient interest to complete

rather lengthy questionnaires (e.g. either 63 or 130 questions, for participants, and managers, respectively). Thus, this was a targeted survey of military personnel, active-duty, Guard, and Reserves, with experience in DoD humanitarian projects, including HCAs.

Despite the limited sample size, the survey constitutes the largest, and perhaps only available compilation of individual and collective experiences of military personnel in conducting humanitarian missions, such as HCAs. Respondents included both patient care providers and allied health practitioners who were highly experienced in health-related humanitarian missions. Respondents on average, had each participated in 4 humanitarian assistance projects. In aggregate, their experience represents nearly 1,000 DoD humanitarian assistance projects conducted in over 100 countries. Highlights of the training aspects of these experiences are discussed below and summarized in Table 2.



## Other Training Aspects of Military Humanitarian Assistance

### Training Resulting from Military Deployments on Humanitarian Operations

While HCAs are unique among the many diverse forms of military humanitarian assistance in that their purpose is training, there are also important training benefits that can derive from other forms of military humanitarian assistance. Often the training benefit of humanitarian experiences might not appear in a project AAR, but surface years later. For example, based on her experiences as a military physician in remote Kurdish refugee camps, Julia Lynch, with support from the Uniformed Services University of Health Science (USUHS), spearheaded the development of a new short course providing training in military medical humanitarian assistance (Lynch et. al. 1999). In this example, the challenge of rapidly transitioning from a clinical practice to providing health care for the population of a refugee camp, spawned the development of this new short course. Clearly, Operation Provide Comfort was not an HCA, and the development of a training course was never part of the operational plan for relief efforts for Kurdish refugees. However, this military medical humanitarian assistance experience and the specific training that has been developed by a dedicated service member and her colleagues demonstrates the broad general training benefits that can arise from military humanitarian assistance deployments.

The recognition of the need for a short course in military medical humanitarian assistance and the years of development and refinement of the resulting course have now had a multiplicative effect. Other military medical humanitarian assistance courses have been developed (also with sponsorship from CDHAM, USUHS) creating a series of specialty-specific short courses on military medical humanitarian assistance. For example, existing military medical humanitarian assistance short courses include, but are not limited to: family practice nursing, dermatology, rehabilitative medicine, mental health, and veterinary public health. To improve the effectiveness of medical humanitarian assistance and training, several other courses remain to be developed including, but not limited to: preventive medicine, pharmacy support to humanitarian operations, and field medical logistics to cite a few.

In sum, HCAs and many other forms of military humanitarian assistance have potentially valuable training benefits to military personnel. Participation in a medical humanitarian mission spawned the recognition for needed military training and has resulted, years later, in improved training opportunities for providers who have not yet had the opportunity to deploy in a humanitarian capacity. This will, over time, greatly increase the effectiveness of medical HCAs and other humanitarian assistance projects by having them staffed by highly and specifically trained personnel.



## Specific Training Prior to Humanitarian Deployments

In addition to training while conducting HCAs, or in the example discussed above, training experiences during and after a humanitarian deployment, we were also interested in the training that military personnel received prior to undertaking humanitarian projects. In our survey of DoD personnel who had participated in humanitarian projects, only 13 of 215 respondents (6%) reported having received long-term (unspecified) training in humanitarian assistance. This limited training in humanitarian assistance has been noted in prior operations (Sharp et. al, 1994). Approximately one out of every four respondents in our survey reported receiving short-term training or participating in a conference on humanitarian relief. Our survey did not specifically define short and long-term training. 'Short-term' was interpreted as a course such as CHART<sup>1</sup> (Combined Humanitarian Assistance Response Training), or HELP<sup>2</sup> (Health Emergencies in Large Populations), the Joint Civil-Military Operations Course (Doan, 2001), or SOUTHCOM's Inter-Hands course<sup>3</sup>, which range from one to three weeks in length. Long-term training was interpreted as participation in an accredited certification or degree-granting program, such as a Masters of Public Health degree, with a concentration in international health or humanitarian assistance. The majority of survey respondents reported the only training they received prior to conducting a medical humanitarian mission was 'on-the-job'. Thus, while a growing cadre of Service members who participate in medical humanitarian projects have field experience they do not have the benefit of specific training in the subject before they participate in, lead or plan humanitarian assistance projects such as HCAs. Anecdotal reports were similar to those of our survey; a medical officer with humanitarian experiences on 6 continents indicated that no one with which he had served ever indicated having received any training for such missions (Tarantino, 2001). Service members are called to perform humanitarian missions regardless of whether they have been trained or not. The fact that untrained personnel conduct most HCAs and that training during the project is questionable, likely has adverse effects on the overall effectiveness of DoD humanitarian assistance.

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<sup>1</sup> CHART a one week course offered by the Center of Excellence in Disaster Management and Humanitarian Assistance, HQ, U.S. PACOM, focuses largely on military support to complex human emergencies especially as under United Nations resolutions. CHART is being improved and is considered as the entry level course for DoD personnel anticipating a humanitarian deployment.

<sup>2</sup> HELP., of two to three weeks duration, this course sponsored by the International Committee of the Red Cross (ICRC) is usually given annually at Johns Hopkins University and the University of Hawaii focusing specifically on the health concerns of, and support to humanitarian emergencies involving large populations of refugees or displaced civilians

<sup>3</sup> Inter-Hands, a week long course designed by the staff of HQ. US SOUTHCOM specifically addresses the cooperation of military assets with civilian providers of humanitarian relief within the context of the cultures of Central and South America.

## Training Host-Nation Personnel

While HCAs are for the training benefit of U.S. service personnel, it is also quite feasible and desirable to train host nation personnel. For example, our surveys of host nation personnel inquired whether health education classes were taught as part of the DoD humanitarian assistance project. Surprisingly, despite the nearly universal need for health education in developing countries, no host nation participants reported even a single class in maternal and child health, or oral rehydration therapy. One respondent (each) reported training in oral hygiene, first aid, and general nutrition. Two reported training in food and/or water sanitation, hand washing and hygienic waste disposal, and five participated in classes on disease prevention. Training in these and similar topics can have a tremendous health impact where medical and public health infrastructure is often lacking or inadequate.

Highly effective health training can be accomplished at a fraction of the cost of the short-term acute care projects that to date nearly monopolize DoD medical humanitarian assistance. Many more host nation citizens could have the quality of their lives improved substantially if the emphasis was placed on training for what is sustainable within the context of the host nation medical infrastructure. This would also offer the possibility of expanding training opportunities to a broader base of DoD personnel. Instead of surgical and medical care providers conducting the majority of HCAs, a broader base of DoD personnel and units could be involved, including for example, from medical assets; more preventive medicine, veterinary, family practice or community health nursing experts. From other-than-medical units, engineering units such as well drilling teams can be highly effective providing lasting benefits at minimal cost, while accomplishing training that is often not possible at home duty stations. Effective HCA projects should take full advantage of opportunities to provide appropriate basic health education and training in topics such as: first aid, maternal child health, and other public health related topics.

Training inappropriate for the host nation should not be provided or allowed. For example, a recent AAR noted that training for host nation personnel were provided via a prepared lecture on the surgical separation of conjoined twins. While the material presented was no doubt fascinating, one wonders about the effectiveness of such training given the extremely low occurrence of conjoined live births and the even lower probability that such a complex surgical procedure would ever be undertaken in a remote location in a developing country. When no classes are given in maternal child health or oral rehydration therapy, and instead, lectures are given on highly complex, extreme surgical procedures, the effectiveness of training benefits to host nation recipients is suspect.

Obviously, effective training of host national during military humanitarian assistance projects such as HCAs works best when host nation personnel are closely and fully engaged in project planning and execution. Training materials must be technically correct, presented in the native language, and appropriate in the context of their medical system, economy, culture, values, and needs. To cite another example, the first ever contact between the American military and the armed forces of Moldova occurred in the spring of 1997 in a Partnership for Peace exercise (Suraj, 1998). This training exercise involved response to a hypothetical earthquake scenario in which U.S. Army helicopters and U.S. Air force C-130 aircraft transport simulated patients from earthquake-affected areas to medical treatment facilities.

While such training in a mass casualty drill is common in U.S. military training exercises, is this training appropriate for Moldova? The specifics of the training, the medical capabilities, and ground transportation network of Moldova would have to be known; but the requirement in many lesser-developed (and developed) countries after an earthquake or other disaster is not so much for aero medical evacuation of victims to some distant treatment facility as it is for first aid skills among local first responders. Local resources and capabilities will have far greater impact on saving lives than aero medical evacuation and a distant medical treatment facility (de Ville, 2000). We do not know when or if the Moldavian military personnel were consulted in the planning stages of this training exercise, nor do we know whether they have the resources for costly rotary and fixed wing aero medical patient evacuation aircraft and systems. Even if the resources were available and the training successful, does training in expensive, high technology patient evacuation post-disaster effectively

address Moldavian health care needs? Is aero medical patient evacuation the most important and most effective means for post-disaster preparedness in a newly independent state?

As stated, any training provided to host nation personnel in conjunction with military humanitarian assistance must be appropriate within the context of their culture, assessed and prioritized health needs, and medical capabilities and infrastructure. Have the Moldavians subsequently expended scarce resources to emulate U.S. military patient evacuation capabilities? How many DoD humanitarian projects have exported Western or military medical practices to the host country without fully considering the host nation's needs, capabilities, and interests or whether the technologies and practices involved are appropriate or effective? Some argue that inappropriate interventions do more harm than good (Smith & Llewellyn, 1992, de Ville, 2001). HCAs and other DoD medical humanitarian projects must include comprehensive assessments of host country needs and priorities during the initial planning stage, coupled with documentation of measured post-project outcomes.

The appropriateness of U.S. humanitarian responses and how military personnel train host nation personnel remains an important, unresolved issue in DoD humanitarian assistance. Referring to medical civic action programs in Vietnam, USAF Major General Lansdale noted:

*"...too often they (U.S. units) want to run their own programs at the expense of national ones and to adopt a 'let me do it for you' stance [which was] damaging to long term...improvement in the host country. They regularly stifle local initiatives and too often endeavor to convert the program of foreign nationals into mirror images of themselves."*

*(Smith & Llewellyn, 1992).*

Applying this perspective to the example project in Moldova, was the purpose of the exercise to train U.S. aeromedical evacuation personnel by deploying them to a new country, or was the purpose to improve the post-disaster capabilities of this newly independent state? Was either task accomplished effectively? These questions cannot be readily answered due to incomplete reporting, but wonders if such questions were considered in the planning stages? They should be in HCAs and other military humanitarian assistance projects.

Clearly, HCAs and other forms of DoD humanitarian assistance offer great training potential to both provider and beneficiary alike. However, to result in effective training, humanitarian, or political benefits for either donor or recipient, humanitarian assistance projects such as HCAs must necessarily involve close and detailed coordination and planning involving all parties concerned, especially host nation representatives. These discussions (clearly more than single meeting is required) must incorporate outcome measures, comprehensive after action reporting and careful and impartial review. Objective and thorough analysis, followed by feedback of information into the planning process, budget cycles, training calendars, theatre security cooperation plans must occur on the U.S. side. Similar entries into host nation plans, budgets, objectives and priorities must also occur and will improve the effectiveness of military humanitarian assistance projects such as HCAs. This detailed planning and coordination process is directly applicable to HCAs as well as other forms of military humanitarian assistance whether for training, humanitarian, or political benefits to donor or recipient.

## Conclusions

### Clarifying Mission Objectives

The information shortfall and lack of documentation of training and effectiveness contribute to an apparently widespread lack of understanding of the purpose(s) of humanitarian assistance projects such as HCAs, even among direct participants. For example, without prior training specific to humanitarian missions, and absent centralized review of project AARs, many HCAs are apparently conducted without an understanding by project leaders or participants that the deployment is for their training benefit and humanitarian relief secondarily. For example, participant comments such as, *“while the purpose is to render humanitarian assistance, the mission also served as a valuable training exercise,”* are found in many HCA AARs. Similarly, the comment, *“war readiness training was also a significant portion of the mission”* is found in report after report. However, there is no discussion of what war readiness training involved or how it improved.

The inclusion of the same general subjective statements, word-for-word in multiple AARs spanning years suggests that training is often an afterthought and that planning and evaluation of training benefits, if conducted at all, are not documented. The statutory purposes of medical and other kinds of HCAs as well as other kinds of military humanitarian assistance must be clear to all parties involved, and forms the basis for measuring effectiveness.

DoD personnel, from program managers and project leaders to participants should clearly understand the mission, purpose, and criteria for success, outcome measures, and priorities of each humanitarian assistance mission. These should be documented in writing during early planning meetings and clearly communicated to all parties involved, including host nation personnel. In addition to specific training on how to conduct effective HCAs and the military training therein, copies of section 401 should be provided to each command or unit as part of the formal HCA project approval and funding process to make the process completely clear.

For HCAs, the authorizing legislation clearly requires that two of the three traditional values for humanitarian assistance be identified: (a) ‘security interests’, and (b) ‘operational readiness skills’ (i.e. political and training values). Curiously, humanitarian benefits are not specifically mentioned other than in the title of the program, ‘humanitarian and civic assistance’. Thus, naming a training and political program ‘humanitarian’ may be part of the confusion. Many medical HCA AARs document the humanitarian benefits to the host nation populous without mentioning political value at all, and only mentioning training in vague comments such as ‘great wartime readiness training’. HCA project effectiveness should be evaluated on the basis for which these projects are approved, funded and conducted: training and political values. This is not to say that HCAs do not have humanitarian benefits, or that humanitarian benefits are not important. Certainly, the direct humanitarian benefit to hundreds and thousands of patients for which care is provided even in a single HCA project contribute significantly to the political benefit of the project. However, at present HCA projects and reports variously document humanitarian benefits while training and political benefits are not recorded.

## The Need for a System to Evaluate the Effectiveness of HCAs

Attaining demonstrable training, humanitarian, or political benefits in HCAs and other military humanitarian assistance projects requires careful planning, including a formal determination of when stated project goals are met. Without these deliberate decisions, one would not know when a project is finished. For example, in military training there is usually some form of proficiency test, whether written or performance based. If the desired or required proficiency or skills have not been mastered the training continues. Similarly, in HCAs stated goals and objectives should be met. Essential aspects of improving HCA project effectiveness for training or any other purpose include implementing:

- 1 outcome measures
- 2 comprehensive after action reporting
- 3 review, analysis, and feedback of information into the planning process, budget cycles, and training calendars

Unfortunately, with incomplete reporting and the lack of outcome data, there are, at present, few apparent efforts to learn from, or improve upon prior missions. There is insufficient information to evaluate the overall effectiveness of the HCA program, from either training or political perspectives. Are HCA projects an effective means of training MHS personnel in critical wartime medical readiness skills? Some would agree, but it is not possible to demonstrate conclusively when a majority of the AARs reviewed do not even mention the word 'training', and the balance (with few exceptions) usually treat training superficially (e.g. "all training objectives were met.")

Despite dozens of HCA missions annually, some within programs spanning decades, few systematic, standardized approaches to training within humanitarian missions have developed. A notable exception is the combined U.S. Army and Air Force ophthalmology residency program based at Wilford Hall in San Antonio, Texas. In this program, military physicians undergoing medical resident specialty training are required to participate in an overseas humanitarian ophthalmologic mission, and then later in their studies, lead an overseas humanitarian mission as a senior resident (Waller, personal communication; Ward, personal communication). This residency program successfully combines the humanitarian, training, and political benefits of humanitarian assistance such as HCAs, and could provide useful insight into how to make HCAs and other humanitarian projects more effective, -either as training platforms or for other benefits. (A number of ophthalmology HCA AARs were kindly provided by officials of this combined residency training program (Waller, and Ward, personal communications) and are included in the Annotated Bibliography report.)

Without a systematic approach, a great deal of useful information on health conditions and needs in various countries, as well as training, is currently unavailable to the military and international medical communities. Instead of undertaking humanitarian projects without the benefit of prior coordination, or doing the same kind of humanitarian projects year after year, the planning and prioritization should be based on a careful balancing of military capabilities, training requirements, and assets available against the prioritized requirements of the host nation. Review and analysis of past initiatives is necessary to determine what actions proved most effective. Analysis of AARs over time, or regionally should lead not only to more effective HCAs and humanitarian assistance in general, but to better theatre security cooperation plans. It should also lead to scholarly contributions to the literature in international health, post-disaster medicine, and other fields, which DoD should actively encourage.

These improvements in the effectiveness of HCA projects can be met in part by offering and requiring specific training prior to mission approval and funding. Virtually every other mission or task performed by military personnel requires individual and unit training, proficiency testing for training validation, and training exercises. It is inconsistent to expect that complex humanitarian projects, medical or otherwise, can be undertaken without the benefit of prior training. Despite the lack of specific training in humanitarian operations, survey respondents nevertheless described themselves as 'well-prepared,' both militarily and medically. In our survey of humanitarian project leaders, a strong majority (39 out of 50) expressed interest in future humanitarian assistance training.

In this careful balancing of DoD capabilities and host nation priorities for humanitarian assistance care must be taken to ensure that planning incorporates specific quantifiable objectives that can be met within the time and other constraints imposed. For example, to date DoD medical humanitarian projects such as HCAs are almost invariably patient-care based and typically involve seeing as many patients as possible in a short period of time. Projects are typically conducted in two weeks or less, which sometimes does not allow adequate follow-up for post-operative care. The performance of as many medical procedures as possible in a short amount of time and then departing is not necessarily effective training or humanitarian assistance and could be unethical as many participants and leaders have noted in HCA AARs. Clearly, standards of care by health providers and international standards for performance in humanitarian assistance are integral to effective DoD medical humanitarian assistance and training.

A compromise in the multiple factors that determine the optimum length of a humanitarian project is required. Project duration will not necessarily be the same for all types of humanitarian missions. For instance, while an ophthalmology-focused HCA might be conducted in two weeks, a public health oriented project would likely take a longer period of time, or may require repeated visits to accomplish. Certainly, training and project schedules should allow sufficient flexibility for successful completion of all tasks, both training and humanitarian. To leave without measuring project results or completing training or patient treatment is ineffective and should be discontinued.

Military medical humanitarian projects employ, not surprisingly, existing deployable military medical capabilities, which are designed, equipped, staffed, and trained for combat trauma care—not humanitarian and civic assistance. While this presents obstacles in planning, sending untrained personnel on medical humanitarian missions in lesser-developed countries has been described as providing essential medical and military training. However, the nature of the training provided, who is trained, and indications of improved readiness or skills as a result of this training remains elusive. Typically in HCAs, surgical specialties from ophthalmology to orthopedics treat complex cases, often in numbers far exceeding normal workloads. This heavy caseload is often performed under austere or difficult conditions, which is said to simulate combat trauma care. For training on large numbers of surgical procedures in a limited time span, under less than optimal conditions, HCAs probably have no equal. Present information on the value of such training experiences however, is subjective, as they remain undocumented and have not been evaluated. What AARs can be obtained suggest that similar projects are often conducted again and again, rather than using previous project experiences to improve effectiveness.

Measuring the effectiveness of the humanitarian assistance or training requires an assessment of pre-existing conditions and post project follow-up to quantify changes, if any. Based on responses of both U.S. participants and host nation representatives, pre- and post-project assessments are missing from many DoD humanitarian projects. While such assessments require additional time, travel, and expense, they are essential. HCAs and other humanitarian projects should not be executed without them. Pre-project assessments are essential, if for no other reason than to understand the demographics, medical conditions, and health needs of the host nation population, which are often quite different than those of U.S. patients (Blount et. al., 1991).

Despite current shortfalls, some highly creative innovative programs involving medical training and HCAs have been developed and conducted for a number of years. These have evolved and have a sufficient track record in terms of time or numbers of missions, to warrant further study as potential models for broader application. For example, the extensive overseas humanitarian assistance-based residency training programs in ophthalmology could provide lessons for other medical specialties, residency programs, or enlisted specialist training. Similarly, a particularly noteworthy innovation involved specific military-civilian cooperation in jointly conducting a successful HCA in Guatemala (also in ophthalmology). This project effectively demonstrated the broadened training benefits of including U.S. civilian providers, so that both military and civilian as well as host nation personnel are trained. The training and other benefits of these successful HCAs should be effectively marketed both DoD wide and to the international medical and humanitarian relief communities. This would create bona fide humanitarian benefits as well as the lasting political good will resulting from enduring and enhanced international professional medical training and collaboration.



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**Table 1.** *The differing humanitarian, training, and political values of Overseas Humanitarian Demining and Civic Aid programs: humanitarian assistance (HA), Humanitarian and Civic Assistance (HCA), and Excess Property (EP) donations. Properly planned and executed projects of all types can positively support U.S. policy interests and objectives overseas. Poorly planned they can do more harm than good. For improved effectiveness it is essential that the primary purposes of projects under different programs not be confused. For example, HCA projects are for the operational readiness training value to U.S. military personnel, consistent with the security interests of the U.S. and the host nation. Humanitarian benefits, while often substantial and important, are nevertheless secondary to HCA missions.*

Type of Project	HUMANITARIAN VALUE	TRAINING VALUE	POLITICAL VALUE
HA (humanitarian assistance)	++	N/A	+
HCA (humanitarian and civic assistance)	N/A	++	+
EP (excess property)	+	N/A	+



**Table 2.** Of 100 medical humanitarian assistance AARs reviewed, these reports discuss ‘training’ as noted above. For comparison purposes during the current and preceding two fiscal years, a total of 671 humanitarian assistance projects were approved un der OHDACA programs. Not all of these were HCAs for training, nor were all medical projects. Humanitarian assistance project AARs are a substantial and potentially valuable source of information that at present are not being effectively captured or utilized by DoD to evaluate the effectiveness of either training, humanitarian or political benefits.

Country	Duration/ Time	Command	Project	Unit	# U.S. personnel	# Host Nation Patients	Training Comments
Ethiopia	30 days June 94	U.S. Army Surgeon General	Operation Nectar Bend	Physical Therapy Consult	15	111 evals, 1607 procedure	“The mission was very rewarding and challenging. Learning to adapt to an austere environment was invaluable.”
Peru	10 days Dec. 97	Wilford Hall Medical Center	MOST deploy Pisco, Peru	59th MDW MOST, Mobile Ophtham. Surgical Team	5	0	“...Canceling and rescheduling... delays by Peruvian Customs in clearing equipment led to cancellation. Lack of communication... resulted in many broken promises...”
Sri Lanka	12 days Aug. 97		Operation Becker Serum VII		2	N/A	“Whenever possible, a training schedule should be established and agreed upon by all parties prior to deployment”
Honduras	14 days Jan. 98	Brooke Army Medical Center	AAR, Eye Surgical Team	Eye Surgical Team	11	Screen 700, 59 cases	“War-readiness training. Few other experiences currently available with DoD provide ophthalmic surgeon technicians, anesthesiologists and residents the primitive, austere and realistic conditions imposed in a war environment than humanitarian missions to Honduras. Surgeons operating in primitive environments with limited supplies and the pressure of 10 cases/day. All eye care specialists enhance their ability to triage, diagnosis, and treat ocular problems in a hostile environment, attempting to provide sight restoring surgery for the greatest number in a short period of time.”
Guinea	14 days Mar. 98	HQ EUCOM	MEDFLAG 98-1	Joint US Forces stationed in Europe	78	Med: 2031 Dent: 399 Opt: 427	“All training objectives were met, US Forces exercised their medical/ dental skills in both classroom and real world scenarios”
Honduras	14 days April 98	Wilford Hall Medical Center	TOPS, Training Ophthalmic Personnel Service	59th MDW	12	555 pts, 94 surgeries 51 referrals	“Few other experiences currently available within the DoD provide ophthalmic surgeons, technicians, anesthesiologists and residents the primitive, austere and realistic conditions imposed in a war environment than humanitarian missions to Honduras. Surgeons operating in primitive environments with limited supplies and the pressure of 10 cases/day. All eye care specialists enhance their ability to triage, diagnosis, and treat ocular problems in a hostile environment, attempting to provide sight restoring surgery for the greatest number in a short period of time.”

**Table 2 (continued)**

Country	Duration/ Time	Command	Project	Unit	# U.S. Personnel	# Host Nation Patients	Training Comments
Easter Island, Chile	14 days April - May 98	Wilford Hall Medical Center	MOST	59th MDW, MOST	9	360 pt visits, 22 surgeries 19 pts	"War readiness training was also a significant portion of the mission. This short notice exercise resulted in more productivity in patient evaluations, medication distribution, surgical procedures as well as refractions and eyeglasses distribution than many previous deployments several times its size."
Peru	14 days June 98	Wilford Hall Medical Center	MOST Deployment New Horizons 98	59th MDW, MOST	17	532 screened, 36 surgeries	"The ability... to perform surgery in a location without running water or electricity is a testament to the versatility... and provided invaluable war-readiness training."
Zimbabwe	15 days July 98	HQ EUCOM	Flintlock 98	3rd Special Forces Group	14		"U.S. Forces enhanced their medical skills by affording Zimbabweans an opportunity to participate in the outreach programs."
Nicaragua	13 days Aug. 98	Wilford Hall Medical Center	MOST Deploy Matagalpa	59th MDW MOST	5	Outpatient 580 Surgeries 56	"War readiness training was also a significant portion of this mission... Deployments of the MOST are ideal war skills training for ophthalmologists. The opportunity to plan and execute such a mission is readiness in its purest sense, and fits the expeditionary force mode perfectly. A hands-on short course would supplement this experience and improve war readiness."
Peru	14 days Aug. 98	Wilford Hall Medical Center	MOST Deploy Pisco	59th MDW MOST	7	1560 pt. visits 83 surgeries	"...Readiness training for the deployed team and the support personnel..."
El Salvador	15 days Sept. 98	Wilford Hall Medical Center	HCA- El Salvador	59th MDW	6	96 surgeries	"I believe that this high intensity surgical experience in a third world setting has strengthened my medical readiness capabilities."
Zimbabwe			Flintlock IIB	3rd Special Forces Group			"The HCA promoted special operational readiness skills, exercise team process, enhance subordinate member skills, and participate in OCONUS deployment."
Honduras	14 days Feb. 99	Wilford Hall Medical Center	Plastic Surgery Mission Soto Cano AB	59th MDW US-based USAF, Plastic Surgeons	7	204 evaluated 38 procedure	"The extensive planning, along with the successful execution of such missions, benefits the Air Force through improving readiness mobility and medical logistics skills of all involved."

**Table 2 (continued)**

Country	Duration/ Time	Command	Project	Unit	# U.S. Personnel	# Host Nation Patients	Training Comments
Honduras	13 days Feb. - Mar. 99	Wilford Hall Medical Center	Orthopedic AAR	59th MDW		70 pts. eval 48 surg pts.	"MEDEL training objectives achieved: Mostly, the experience of a surgical deployment into an austere environment proved to be the most beneficial."
Honduras	14 days Apr. - May 99	Wilford Hall Medical Center	AAR, HCA Medical Mission MD92507: 601BF Honduras	59th MDW	10	969 pt visits 78 surgeries on 75 pts	"War readiness training was also a significant portion of this mission, allowing an opportunity to improve our capacity for rapid response to an acute war time need..."
Ecuador	14 days June 99	Wilford Hall Medical Center	AAR, MOST Deploy, Cuenca	59th MDW MOST	8	970 pts visits 128 surgeries on 101 pts.	"Also, the role of the MOST deployment as a real-time war readiness exercise cannot be overemphasized... What a great way to hone the skill of the military medical corps."
Botswana	14 days July 99	HQ, EUCOM	Flintlock IIB	96th Civil Affairs Bn	26		"U.S. Forces reinforced military medical skills and afforded unique opportunities to diagnose and treat diseases that are rare in CONUS."
Honduras		Wilford Hall Medical Center	Pediatric Orthopedic in the Third World	59th MDW, US-based USAF	10	204 evacuated 29 surgeries	"Benefits: training... in deployed medical assets, and training in treatment of severe musculoskeletal infections."
Latvia	14 days June- July 99	HQ, EUCOM	MEDCEUR 99-2	US Navy Rota, Naples, USNR	90		"... Provided another successful facet... with Baltic nations, reinforced interoperability between U.S. and Latvian military medical specialists."
Malawi	16 days Aug. 99	HQ, EUCOM	Silver Eagle, JCET	3rd Special Forces Group	14		"... Personnel received valuable hands on experience in tropical diseases diagnosis and treatment... Specifically trained U.S. Forces in many of the soldier's Mission Essential Tasks."
Russia	10 days Sept. 99	HQ PACOM	AAR, HA Ecology Project, Far East	USAF Team		N/A	"All the way from planning the effort to working under field conditions in a foreign environment, team members received significant training benefits."
Cameroon	14 days Sept. 99	HQ EUCOM USAFE	AAR, Brilliant Lion/ MEDFLAG-00-1	86th Airlift Wing	192	19,035 pts. 43 surgical	"The mission presented realistic training for medical personnel in providing health care in an austere environment"

**Table 2 (continued)**

Country	Duration/ Time	Command	Project	Unit	# U.S. Personnel	# Host Nation Patients	Training Comments
Cameroon	14 days Sept. 99	HQ EUCOM	AAR, MEDFLAG-00-1	86th Wing USAFE	10	N/A	"Combined training with host nation, mass casualty response training and medical civic action"
Peru	14 days Sept. 99	Wilford Hall Medical Center	HCA, AAR MOST	59th MDW, MOST	6	2493 pt visits, 95 surgeries	"METL training objective achieved: USAF ophthalmologist and ophthalmic technician performed eye examinations and surgical procedures in an unfamiliar environment with all equipment and supplies carried in by the team. This scenario simulated conditions of an ophthalmic deployment for armed conflicts or for response to a natural disaster."
Tanzania	10 days Sept. 99	HQ EUCOM	MEDFLAG 99-2	Joint US Forces stationed in Europe	75		"Developed a common understanding of military interoperability... U.S. Forces medical personnel gained valuable hands-on experience while bringing much-needed assistance."
Costa Rica	Nov. 99	Wilford Hall Medical Center (WHMC)	MOST Deploy, Puerto Limon	59th MDW, MOST		162 pt. visits, 20 evacuated 6 surgery cases	"The mission of the MOST was to medically and surgically evaluate and treat ophthalmic disorders of the indigent population. War readiness training was also a significant portion of the mission."
Guatemala	11 days Feb. 00	Navy Medical Center San Diego	Navy Medical Readiness Training, Playa Grande	NMCS	11 & 45 Civ	1300 evaluation & 333 surgeries	"Objectives: Provide real world training opportunities, & to exercise projected equipment loads, and other specialized gear prior to its use in future military medical field operations. It was not a simulated situation or a class... it was real life with real surgeries, patients and all the problems and issues that go along with these. Real-life situations such as this provide the best training possible"
?	?	MARFO RPAC	Memo, Marine Corps lessons learned, Exercise Natural Fire 00	USMC Brigade Service Support Gp. 1st Marine Expedi- tionary Brigade			"Many issues were approached concerning training that should have been scheduled prior to attachment. Medical officers need to set up a definite schedule of training for Corpsmen prior to exercise. Deployment to the host nation was during the ONLY month that they expect rain. This greatly inhibited transportation."

**Table 2 (continued)**

Country	Duration/ Time	Command	Project	Unit	# U.S. Personnel	# Host Nation Patients	Training Comments
Nicaragua	8 days Aug. 00	Wilford Hall Medical Center	Medical AAR, New Horizons Exercise 2000	59th MDW	17	5359 pts	"The mission demonstrated an excellent training opportunity for both staff and residents/fellows. The ration of 1 trainee / 1 staff is ideal... Corporate donation of \$8K"
Senegal	Sept. - Nov 00	HQ EUCOM	Senegal Brigade, Africa Crisis Response	96th Civil Affairs Bn (Airborne) Co E			"Lost training time due to: lack of supplies, language barrier, no student handouts, and excessive VIP visits (1+days out of 4 day exercise)"

**Summary**

Country	Duration/ Time	Command	Project	Unit	Training Comments Summarization
31 projects in at least 18 nations, worldwide but mostly Africa (II) Central & S. America (15)	From 94 - late 00, most 99, from 8-30 days duration, but by far most common is 14 day	Combatant Commands & Medical Centers, mostly WHMC & EUCOM	operations, exercises, and small unit deploy, especially HCA missions	Army, Navy, USAF, Marines, Special Forces personnel, at least 484 in total, ranging from 2 to 90 person units (average 15) saw a total of > 17,578 patients (average 1034) performing some kind of surgery on total of >1352 (average 80)	Usually great training, subjectively and objectively, but often only described in very general terms of experience operating in austere environments overseas, typically poor or no documentation. Training mission typically secondary to humanitarian one.

## Appendix: Brief Summary of Title 10 Section 401

### 401 Humanitarian & civic assistance provided in conjunction with military operations

- (a) (1) Under regulations prescribed by Sec Def, the Sec. of a military Dept. may carry out humanitarian and civic assistance activities in conjunction with authorized military operations if the Secretary determines that the activities will promote:
  - a) The security interests of the U.S. and the Host nation, and
  - b) The specific operational readiness skills of the members of the armed forces who participate in the activities.
- (2) Humanitarian and civic assistance activities carried out under this section shall complement, and may not duplicate, any other form of social or economic assistance which may be provided to the country concerned by another department or agency of the United States. Such activities shall serve the basic economic and social needs of the people of the country concerned.
- (3) Humanitarian and civic assistance may not be provided under this section (directly or indirectly) to any individual, group, or organization engaged in military or paramilitary activity.
- (4) The Sec Def shall ensure that no member of the armed forces, while providing assistance under this section
  - a) engages in the physical detection, lifting or destroying of landmines, or
  - b) provides such assistance as part of the military operation that does not involve the armed forces
- (b) (1) Humanitarian and civic assistance may not be provided under this section to any foreign country unless the Secretary of State specifically approves the provision of such assistance.
- (c) (1) Expenses incurred, as a direct result of providing humanitarian and civic assistance under this section to a foreign country shall be paid for out of funds specially appropriated for such purpose.
- (2) Expenses covered by para (1) include the following expenses incurred in providing assistance:
  - (A) Travel, transportation, and subsistence expenses of Dept. of Defense personnel providing such assistance
  - (B) The cost of any equipment, services, or supplies acquired for the purpose of carrying out or supporting the activities that are to be transferred or otherwise furnished to a foreign country
- (3) The cost of equipment, services, and supplies provided in any fiscal year, as part of a military operation that does not involve the Armed forces may not exceed \$5 million
- (d) The Sec Def shall submit a report not later than March 1 of each year on activities carried out under this section during the preceding fiscal year.
- (e) The term “humanitarian and civic assistance” means any of the following:
  - (1) Medical, dental and veterinary care provided in areas of a country that are rural or are underserved by medical dental, and veterinary professionals respectively
  - (2) Construction of rudimentary surface transportation systems
  - (3) Well-drilling and construction of basic sanitation facilities
  - (4) Rudimentary construction and repair of public facilities
  - (5) Detection and clearance of landmines, including activities relating to the furnishing of education, training, and technical assistance with respect to the detection and clearance of landmines

