



# Overview of Overseas Humanitarian Assistance, Humanitarian and Civic Assistance, and Excess Property Programs



Measures of Effectiveness  
CDHAM Publication 02-01  
#MDA 905-99-M-0726



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# MDA 905-99-M-0726

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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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## Executive Summary

DoD is to be commended for the vision in undertaking a major assessment of some of its diverse programs for humanitarian assistance. As discussed in detail below, a major finding of this report series is that both military and civilian providers of humanitarian assistance, medical and otherwise, face similar challenges in measuring the effectiveness of their activities. This primarily involves determining what critical information needs to be collected and how to transform that information in a timely manner into management decisions that directly improve effectiveness. Decisions which determine the effectiveness of humanitarian assistance are required in both the immediate time frame, such as within the planning and execution of a particular project; and in the longer term, such as in managing humanitarian assistance programs regionally and over time.

Having the information, background and training to make wise and often difficult decisions among many competing priorities is the challenge in moving towards more effective humanitarian assistance. Information shortfalls currently range from incomplete documentation of humanitarian assistance projects in AARs to lack of analysis and synthesis. Unfortunately, at present, information is either not available or not utilized in many cases to change activities, focus, or priorities to more effective projects. Although creative, innovative, and effective humanitarian assistance projects have been successfully executed in selected cases, in other situations this is not the case even where many humanitarian assistance projects may have been conducted within a single country or region within a year or year-after-year for several decades.

In addition to the incomplete information records on DoD humanitarian assistance such as humanitarian and civic assistance (HCA), humanitarian assistance (HA), and excess property (EP) projects, the part time nature of personnel staffing of many of these humanitarian assistance programs also limits effectiveness. Both information and manpower shortfalls have probably limited the rate of evolution of many humanitarian assistance programs in the past. However, both the information and staffing issues are widely recognized. Solutions, ranging from information management support to manpower surveys and innovative staffing could be readily implemented. The need to measure and improve the effectiveness of humanitarian assistance projects and programs is widely recognized among participants, both DoD personnel as providers, and host nation representatives as beneficiaries or recipients. Thus, implementing policies and procedures that result in more effective humanitarian assistance projects and programs will be met by a highly receptive global audience, both military and foreign nationals.

Other major findings of this study relate to how information is utilized and how the effectiveness of humanitarian assistance, whether for training, humanitarian, or political values, can be measured and how improvements may be readily and significantly implemented by:

- applying existing Service training procedures to HCA and other humanitarian assistance missions,
- utilizing the logical framework process to describe quantifiable goals and outcomes in terms of 'before' and 'after' a humanitarian assistance project,
- considering other approaches in addition to the short term patient care focus that has monopolized military medical humanitarian assistance to date, and
- conducting humanitarian assistance activities within the guidelines outlined by the international consensus on minimum performance standards for humanitarian assistance, known as the SPHERE project.

Before discussing specific major findings, it is important to consider the scope of this study. Other than a GAO (Government Accounting Office) report of nearly a decade ago (which was limited to two geographic commands) an analysis of the effectiveness of humanitarian and civic assistance (HCA), humanitarian assistance (HA), and the donation of excess property (EP) (See Appendix B for information on these programs.) had not previously undertaken on the scale of this study.

In this study, 410 uniformed health care providers of all Services and diverse medical specialties were surveyed on their opinions and experiences about humanitarian service and its impact specifically on their thoughts about joining the military, remaining on active duty, and morale – important aspects of humanitarian service,

not considered in any previous study. An additional 215 DoD personnel, including 50 humanitarian assistance project and program managers were also surveyed using detailed questionnaires jointly developed with the Medical Staff Officer, Office of the Assistant Secretary of Defense, Special Operations and Low Intensity Conflict, now termed Stability Operations. Respondents were highly experienced military humanitarians, each having completed an average of 4 humanitarian assistance projects, and representing, in aggregate, nearly 1,000 military humanitarian assistance projects conducted in over 100 countries. We are not aware of any previous report of primary source information from humanitarian assistance projects on this global scale.

Nor are we aware of any previous reports on the opinions and experiences of the recipients of military humanitarian assistance, as was obtained from 8 host nations in this study. In this case respondents ranged from parents of infant patients, to host nation care providers, to government representatives.

We not only questioned both participants and recipients, but thoroughly combed the very diverse and somewhat obscure literature on humanitarian assistance, especially after action reports. Other than the DoDI 2205.3 specification regarding after action reports on HCAs, no formal reporting requirement for after action reports on humanitarian assistance projects was identified. Nevertheless, we obtained and analyzed over 100 such reports. While providing information on how military humanitarian assistance has been conducted, this review also pointed out abundant opportunities to improve project planning, host nation coordination, the reporting of essential elements of information, and the importance of developing quantifiable goals and objectives early in the planning for each project. In sum, this study, utilized all available sources of information in a comprehensive review of military humanitarian assistance, especially as conducted under HA, HCA, and EP sections of the OHDACA - Overseas Humanitarian, Disaster, and Civic Aid program.

Although the study focus was 'medical' or health-related humanitarian assistance, many findings regarding the need for better planning, training, information management, and applying common tools such as the logical framework process and SPHERE standards, are readily and fully applicable to all forms of military humanitarian assistance. Many observations are also applicable to humanitarian assistance as provided by organizations other than militaries.

The broad based, global approach of this study suggested the following findings regarding improving the effectiveness of military humanitarian assistance projects and programs. These findings fall into the broad categories of improving the collection and use of information and ensuring the measurement of the effectiveness of projects and programs for their statutory purposes: training value, bona fide humanitarian benefit, political value, as well as possible incentives to recruit and /or retain uniformed health care providers.

### **Information Resources:**

- While there is considerable published literature on disaster response, there are comparatively few published reports on deliberately planned theater engagement or stability operations projects such as humanitarian and civic assistance (HCA), humanitarian assistance (HA), or excess property (EP).
- Although after action reports (AARs) for humanitarian assistance projects are prepared and forwarded in many organizations, at present AARs vary widely in scope, detail, and utility. Humanitarian assistance project AARs are descriptive but often relay subjective information such as "great wartime readiness training." AARs often report measures of process, rather than effectiveness (e.g., the number of bandages used, or "over 18,608 vaccinations were given to 5,621 patients.") Other AARs, although limited in number, thoroughly document all aspects from pre-project planning to, in the case of medical projects, patient outcomes.
- Among the over 100 AARs reviewed, including those on HCA, HA, EP missions as well as other types of military humanitarian assistance projects, none answered all of the following simple questions: "Who provided the humanitarian assistance? What assistance was provided? When and where was it provided? How was it accomplished? Why was this important? And most importantly, what was the impact (i.e. so what?). Very few AARs mention measuring effectiveness.

- The humanitarian assistance project AARs that are written are difficult to obtain because at the DoD level there is no formal reporting requirement other than that specified for HCAs in DoDI 2205.3. Thus, a large amount of potentially valuable information that could contribute to the planning and execution of more effective humanitarian assistance is, at present, lost. This loss is not only to the commands who may be conducting other similar humanitarian projects, or possibly contingency operations in the future, but also to the larger military, medical, and international humanitarian relief communities.
- Despite the current shortfalls in the content and availability of AARs and in using such information to better manage humanitarian assistance projects, military personnel and host nation civilians alike quickly grasped the importance of measuring effectiveness when this subject was brought up in interviews and discussions. There is no shortage of interest, commitment, or understanding of the need for more effective humanitarian assistance. It would appear that the solution lies in additional time (i.e. personnel staffing resources) and specifically targeted training of military personnel in how to apply techniques for measuring effectiveness to DoD projects and programs.

### **Measuring effectiveness for training, humanitarian, political or other values**

Humanitarian assistance as conducted in HCA, HA, and EP projects is the cornerstone of the unified combatant commanders theater engagement or stability operations programs worldwide. A significant portion, conservatively estimated at between 1/3 to 1/2 of all such projects (depending on command and year) is medical or health-related. Military medical personnel are often 'ambassadors of American good will' providing numerous and important opportunities to enhance U.S. national interests and objectives abroad, to advance their own training and to provide quality health care that, in the vast majority of cases, would not otherwise be available to medically-underserved patients.

Humanitarian health care is provided by military medical personnel and units that are designed, equipped, staffed, and trained to provide combat casualty care and health service support to military operations; not necessarily humanitarian care. Although many medical, surgical, and other aspects are similar, there are also fundamental and significant differences in health care needs and delivery to military personnel compared to the beneficiaries of humanitarian assistance. For example, the usual military patient population is young, largely male, well nourished, fully immunized, physically fit, and has had ready and frequent access to comprehensive health care services including preventive and curative medical, surgical, dental, mental health and a range of other social support services. On the other hand, many patients encountered in humanitarian assistance operations often represent the high risk segments of disrupted societies, i.e. the young, elderly, and those with pre-existing serious health and medical conditions. Humanitarian assistance health care beneficiaries include high proportions of females and children, often unaccompanied. Many patients suffer from varying combinations of malnutrition, chronic diseases, and microbial and parasitic infections. Often they have had little or infrequent access to even rudimentary health care services. Patients are often first seen by care providers after homes, livelihoods, and societal support systems have been totally disrupted or destroyed, and family members killed. They may have been deliberate targets of violence, abuse, and long term ethnic, religious, or sexual discrimination. Sometimes they have been shuttled from one camp to another for extended periods of time, often with less than adequate food, water, shelter or rest.

Thus, the provision of humanitarian health care is quite different from that with which most providers, military and civilian are most familiar. The difficulties of medical humanitarian assistance are exacerbated not only by austere, post-disaster, or sometimes hostile situations, but by the absence of some support functions normally associated with military medicine. For example, DoD's sophisticated and effective global patient evacuation systems, medical diagnostic laboratories, and medical logistics may not be available to health care providers in humanitarian assistance missions. Of course, language barriers, societal mores, and differing cultural views on Western medicine introduce further complications. Nevertheless, through hard work, innovation, creativity, and dedication military medical and other personnel have gained considerable experience in providing a wide range of health care and other humanitarian services for reportedly hundreds of thousands of patients worldwide.

Just as there are significant differences in the health care needs of different patient populations, there are also fundamental differences between the perspectives of military and civilian providers of humanitarian assistance. Such differences especially among those untrained or inexperienced in humanitarian assistance may limit, at least initially, the effectiveness of projects. For example, private volunteer organizations (PVOs) often take a long-term, developmental approach to humanitarian relief, while military humanitarians, while no less altruistic, often find themselves constrained by mission, security, and other considerations, to a shorter term, or 'quick fix' approach. Neither approach is necessarily 'right' or 'wrong' and both can have effective applications in given humanitarian situations. The differences in these approaches need not necessarily limit the effectiveness of humanitarian assistance. For militaries providing humanitarian assistance, constraints such as limited time and force protection issues require additional planning for the humanitarian assistance to be effective.

Some programs such as HCAs, while 'humanitarian' in name, are for a different primary purpose: the express training benefit of the providers, although they may have secondary, but nevertheless important, humanitarian benefits. Because of training shortfalls (discussed below), the after action reports on military humanitarian assistance projects such as HCAs often reflect participant's confusion on why the humanitarian assistance mission is being conducted. For example, an AAR on an HCA may describe how humanitarian assistance "touched the lives" of beneficiaries yet fails to mention training. Similarly, AARs on an HA mission may mention that "great wartime readiness training was conducted," while omitting any discussion of humanitarian benefits. To maximize effectiveness, humanitarian assistance projects should be conducted and evaluated based on the clear, unambiguous mission statements that are fully consistent with their statutory authority.

Considering the number of DoD personnel involved in humanitarian assistance, there are comparatively few formal training programs for military personnel in humanitarian assistance in general, and fewer still on the specific requirements and detailed aspects of HA, HCA, and EP programs in particular.

There are minor differences in the manner in which humanitarian assistance programs such as HCA, HA, and EP have been implemented by the respective commands. While creativity is encouraged, it is also essential that lessons learned and success stories be shared and ideally, promulgated DoD-wide. For example, the current practice of some commands to link HCA, HA, and EP authorities and funding in a synergistic approach to provide comprehensive, highly effective humanitarian assistance projects is to be commended. Perhaps this synergistic approach to planning and executing more effective humanitarian assistance could be adopted by others.

While there are different priorities and policies within geographic Commands executing HCA, HA, & EP projects, there are also common findings that have a direct bearing on the effectiveness of these programs. For example, a somewhat surprising finding was the very 'part-time' nature of staff support to these programs in many commands worldwide. A 60% majority (30 of 50) of personnel tasked with project execution or program management authority have many other duties and responsibilities in addition to humanitarian assistance. The result is that managing humanitarian assistance projects and programs is in many cases a part time effort. For example, as many as 1/2 of the military personnel with humanitarian assistance project or program management responsibility spent less than 1/4 of their duty time on humanitarian assistance tasks. Despite the dedication, creativity, and hard work of those involved, when personnel support is often part-time in nature, program effectiveness is limited from the outset.

There are also marked differences in the manner in which humanitarian service is viewed by the Services. For example, the U.S. Air Force has created a new career field, international health specialist, and actively promotes the participation of their personnel in humanitarian assistance, language, and other training related to international affairs. On the other hand, the U.S. Navy often requires its personnel be on personal leave status in order to participate in a humanitarian assistance mission. While unique Service requirements and considerations are fully recognized, if humanitarian assistance missions have training or other values to Service members, these would, presumably, transcend Service personnel policies.

Many medical humanitarian assistance projects are undertaken with limited or no medical staff support in the

planning stages, again reportedly due to staffing shortfalls.

The nature of these findings should not be surprising. Related findings were reported from two geographic commands by the GAO in 1993. Although changes in office functions and publications have been made in the interim, some of the key findings of this prior assessment remain valid today, i.e. the need to: establish long term goals so progress could be measured; consider the ability of the host nation to maintain projects, assess host country needs, and their ability to sustain a project once U.S. assistance is completed. From our review of over 100 humanitarian assistance project AARs subsequent to the GAO study, these key and essential functions (assessing needs, establishing goals and ensuring sustainability) pointed out by the GAO are still not routinely performed in the conduct of HCA, HA, and EP projects today.

In addition to concerns about the part-time nature of the staffing of these programs, we noted that humanitarian assistance projects under a variety of programs were often defined, planned, and executed based largely or even solely on the prior experience (or in some cases, lack thereof) of the individual(s) involved. The lack of specific training in humanitarian assistance prior to assuming a leadership role (either as an officer in charge of a project or a staff officer in charge of executing program limits effectiveness. For example, among 50 humanitarian assistance project and program managers, 11 reported 'no training' whatsoever, while 41 reported receiving only 'on-the-job' training. The results of limited training opportunities specific to humanitarian assistance duties and responsibilities are several. For instance, many military personnel consult only their immediate chain of command, failing to consider or even contact any of the many PVOs, non-governmental organizations (NGOs) or international organizations (IOs) which often have ready sources of detailed information, if not direct experience operating in the area of interest in a particular DoD project. Without specific training in humanitarian assistance, personnel have only their personal experience on which to rely and may not understand how to obtain, consider, and utilize information from a much broader base than the familiar DoD sources

Another result of limited training specific to humanitarian assistance is that projects are often planned and executed based largely on what was done in the past, rather than on an assessment of host nation needs or priorities. In medical humanitarian assistance for example, this results in short-term acute patient care constituting the vast majority of all medical humanitarian assistance. Typically, as many patients as possible are screened or treated in a short amount of time (usually a few days) then the providers re-deploy, sometimes without adequate follow up for care provided and with no subsequent contacts with anyone from the host nation. This unfortunately can run counter to quality health care, completion of training, cementing the political and national benefits, and effectiveness.

While there is no end to unmet health care needs worldwide, more effective humanitarian assistance would result from incorporating a broader perspective beyond a short term acute care approach. For example, public health based humanitarian assistance could positively affect the health of an entire population of a village rather than the few patients lucky enough to have received care, even if not completed during the typically short visits of U.S. personnel. The benefits, for example, of potable water, improved medical or other infrastructure, or health education may extend for years compared to a few hours or days of acute care medical humanitarian assistance.

While the enabling authorities for HA, HCA, and EP programs specify the eligibility of indigent, civilian host nation patients for care by U.S. military personnel, in some rare cases medical humanitarian assistance after action reports describe the care as having been provided in host nation military hospitals on non-indigent patients that were pre-selected for care by the U.S. military by some host nation officials.

Despite the challenges of multiple duties and limited opportunities for training, a majority of uniformed members highly value their humanitarian service experiences. Many of the more than 625 personally formally surveyed in this study and many others contacted informally expressed great interest in conducting additional humanitarian assistance missions. Many respondents used the survey forms to volunteer to conduct humanitarian assistance missions, 'anytime, anywhere'. If there was any frustration with the requirements or hardships of overseas humanitarian assistance, it was usually in not having been able to deploy as frequently as many participants would like, or to return post-project for follow up. Nearly half, 198 of 410 military medical

personnel (48%) indicated that the opportunity to participate in a humanitarian assistance mission was a factor in their decision to join a uniformed service. Just over 60%, 254 of 410 indicated that the opportunity to participate in a humanitarian assistance mission was a factor in their decision to remain in uniform. These preliminary findings on the recruitment and retention aspects of humanitarian assistance suggest this additional 'purpose' of these programs beyond the traditional; training, humanitarian, and political values for the HCA, HA, and EP programs.

While the perspectives of Commands and participants in providing humanitarian assistance are important, HA, HCA, and EP projects have, unfortunately, often failed to adequately consider the input of host nation officials. Host nation needs, interests, or priorities for humanitarian assistance are often not considered, or if obtained, are done so late in the project planning that they are often not effectively addressed. In questioning the recipients of military humanitarian assistance, 25 of 38 foreign respondents who had recently and directly participated in such projects indicated that the U.S personnel 'told' them rather than 'asked' them what the project would entail. A disturbing 15 of these 38 respondents did not have the opportunity to meet visiting DoD personnel until the humanitarian assistance was underway –hardly a sound basis for effective political or other benefits from humanitarian assistance. Only 1 of 38 reported that any information or data was collected on health conditions before the project began and then compared to conditions after project completion. By not obtaining the input or opinions of host nation personnel (those who often know best), the effectiveness of military humanitarian assistance projects is limited by the sometimes narrow focus and the often limited experience of those deployed on short notice for short periods of time.

The challenges faced by DoD in actively working towards more effective humanitarian assistance are mirrored within many PVO, NGO, and IOs. The global humanitarian relief community, both military and civilian, is actively working on developing better means of measuring effectiveness of humanitarian assistance projects and programs. (see particularly: Humanitarian Action: Learning from Evaluation, Annual Report, 2001, ALNAP)

In this ongoing effort by many diverse organizations to improve the effectiveness of humanitarian assistance, there are readily available tools and techniques that have been repeatedly demonstrated to improve effectiveness. For example, a technique termed the logical framework process has been used by the American Red Cross, European Union, Australian government and many other organizations in setting goals, objectives, and measuring outputs for humanitarian activities that are based on inputs in the given scenario or situation. This process, applied extensively by diverse organizations worldwide, is readily adaptable to DoD humanitarian assistance programs, such as HA, HCA, and EP and with training, would result in improved effectiveness.

Another readily available resource that could be used to quickly improve the effectiveness of DoD humanitarian assistance would be to ensure that all such missions are planned and conducted in accordance with the international consensus standards for minimum performance of humanitarian assistance known as the SPHERE project.

## Key Recommendations

### Information Management:

- Enforce the existing requirement of (DODI # 2205.3, dated Jan 27, 1995) to report essential elements of information in a standardized format, (entitled HCA Unified Combatant Command After Action Report Format). Alternatively, adopt the use of user-friendly electronic after action reporting format as discussed in the report in this series, entitled, *Information Management for More Effective Military Humanitarian Assistance Projects & Programs*.
- Expand this existing standardized reporting requirement and format to include other forms of humanitarian assistance such as under HA and EP programs.
- Establish a central repository for after action reports, so that they are accessible to authorized users. Require the use of information from prior projects in the planning and documentation of HCA, HA, and EP projects. (The AARs utilized in the conduct of this study are available for official use in the Learning Resource Center, Uniformed Services University of Health Sciences.)

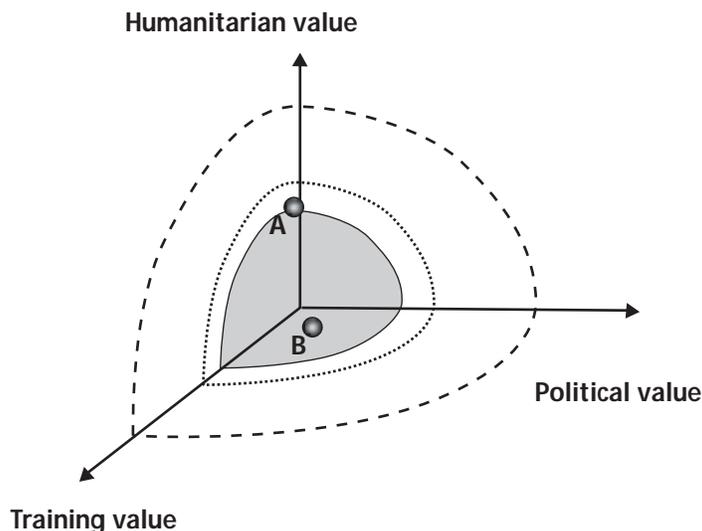
**Project & Program Effectiveness:**

- Conduct manpower surveys to ensure that staffing of program management and subject matter expertise/staff support is adequate for the considerable workload of humanitarian missions.
- Ensure targeted training specific to humanitarian assistance duties and responsibilities is available, ideally prior to an individual service member's assumption of duty as a humanitarian assistance project officer, or a program manager serving on one of the unified combatant commanders staffs. Training should enable the planning, conduct, and evaluation of HA, HCA, and EP projects and programs for measured effectiveness.
- Capitalize to the extent practicable, on the recruitment and retention value of humanitarian service opportunities as a means of addressing Service personnel staffing and professional development programs.
- To the extent practicable, align Service personnel policies to optimize the training and other values of humanitarian service opportunities.
- Ensure adequate pre-project planning that incorporates host nation input and perspective on goals, objectives, means, and all aspects of a humanitarian assistance project. Follow this up with post-project review and analysis and document the measured effectiveness of the project.
- Adopt or adapt proven means of improving the effectiveness of humanitarian assistance such as the logical framework process and the SPHERE project minimum standards of performance in humanitarian assistance to DoD programs.
- Measure the effectiveness of DoD humanitarian assistance projects against the specific regulatory purpose(s) for the programs. While secondary benefits are important, these should not be confused with the primary purpose of a project. Ensure participating Service members recognize the different purposes of HA and HCA projects, for example. Ensure projects are conducted and evaluated according to their statutory purpose(s). Likewise, ensure compliance with program requirements for patient eligibility during medical humanitarian assistance.
- Provide trained DoD personnel, working in close collaboration with other providers of humanitarian assistance and host nation representatives, using effective information management tools to provide HA, HCA, and EP project and programs of documented effectiveness.
- Directly link the specific results of humanitarian assistance projects to their training value, humanitarian benefits, and political value to the host nation and United States, especially those of a long term or developmental nature.

## Introduction

Webster’s definition of humanitarian assistance, in approximation, would be any support, aid or assistance that is offered out of concern to improve the welfare of mankind. The United States Department of Defense (DoD) conducts a wide variety of overseas operations, many of which are humanitarian in nature. During the past decade DoD humanitarian assistance missions have increased in frequency and diversity. However, DoD humanitarian assistance is a unique activity, differing from that conducted by other organizations in multiple aspects. For this reason, it is essential that the fundamentally different perspectives of various organizations involved in humanitarian assistance be recognized and mutually appreciated.

Humanitarian assistance conducted by the U.S. military is often done so for reasons that are different than those of civilian organizations, even though superficially activities performed are the same or similar. To draw an analogy from the world of sports, the situation is not unlike the game of football. In Europe, the word means a soccer match, while in the United States it is a completely different game—American football. Although participants in both sports kick a ball in an attempt to score points, the players, rules, strategy and even the ball are completely different. Similarly, in humanitarian assistance, military providers participate for their own training benefit and for political reasons of the sponsoring government, in addition to humanitarian reasons (Figure 1). Distinguishing between military and civilian perspectives and terminology is essential to developing more effective programs.



**Figure 1:** This diagram shows the three fundamental purposes (training, political and humanitarian) of Department of Defense humanitarian assistance as the axes of a three dimensional graph. Humanitarian assistance missions vary in respective values, and would accordingly be plotted as individual points in space. For example, point A represents a mission with low training and political value, but high humanitarian value, and would therefore plot further out from the origin than would another mission (point B) with low training, political and humanitarian value. The relative importance of different humanitarian missions can be visually compared according to their position on the graph, reflecting their overall value.

Among the military assets that are regularly used for humanitarian assistance are the units and personnel of the DoD Military Health System (MHS). The MHS provides humanitarian assistance in response to situations ranging from contingency operations, disaster relief, and complex human emergencies to deliberately planned theatre engagement activities. Medical and other forms of military humanitarian assistance may also be conducted with coalition partners as a multi-national force, or as a United Nations response. While military medical humanitarian assistance often includes patient care, it may also involve a wide variety of other projects, including construction or renovation of clinics and hospitals, or donation of medical supplies and equipment that is excess to the needs of the DoD.

This report is the first in a series examining the effectiveness of Overseas Humanitarian, Disaster, and Civic Aid (OHDACA, pronounced “oh-DA-ka”). However, the focus of these reports is on only those programs involving direct action by DoD personnel, specifically humanitarian and civic assistance (HCA), humanitarian assistance (HA), and excess property donations (EP). In the past, projects under any of these three programs have also been termed ‘engagement activities,’ although other terms, ‘theatre security cooperation’ or ‘stability operations’ are also now used. Whatever the label, these programs form an important means by which the DoD implements and influences the national security strategy abroad. OHDACA demining activities are discussed elsewhere (Center for Casualty Care Research, 2000).

This report specifically describes DoD humanitarian assistance, how it differs in fundamental ways from that provided by civilian practitioners, the various humanitarian assistance programs employed by DoD, and explains many of the acronyms used. Other reports of this series include:

- Humanitarian and Civic Assistance Projects and Military Training
- Measuring the Effectiveness of Department of Defense Humanitarian Assistance
- US Participants Perspectives on Military Medical Humanitarian Assistance
- Host Nation Participants Perspectives on Military Medical Humanitarian Assistance
- Information Management for More Effective Military Humanitarian Assistance Projects & Programs
- Measuring the Effectiveness of Humanitarian Assistance other than Department of Defense Providers
- Humanitarian Service: Recruitment & Retention Effects Among Uniformed Services Medical Personnel
- Humanitarian Assistance Bibliography: with some Annotations, After Action Reports, and Web Sites of Interest

Consistent with CDHAM’s mission, the focus in this series of reports is on the medical aspects of humanitarian assistance. The considerable extent and growth of the DoD involvement in humanitarian assistance medicine and in other areas reflects many important innovations, but also opportunities for improvement. The analyses and findings in this report series are intended to provide a basis for increasing the effectiveness of DoD humanitarian assistance projects and programs.

## Organizational Context for U.S. Dept. of Defense Humanitarian Assistance

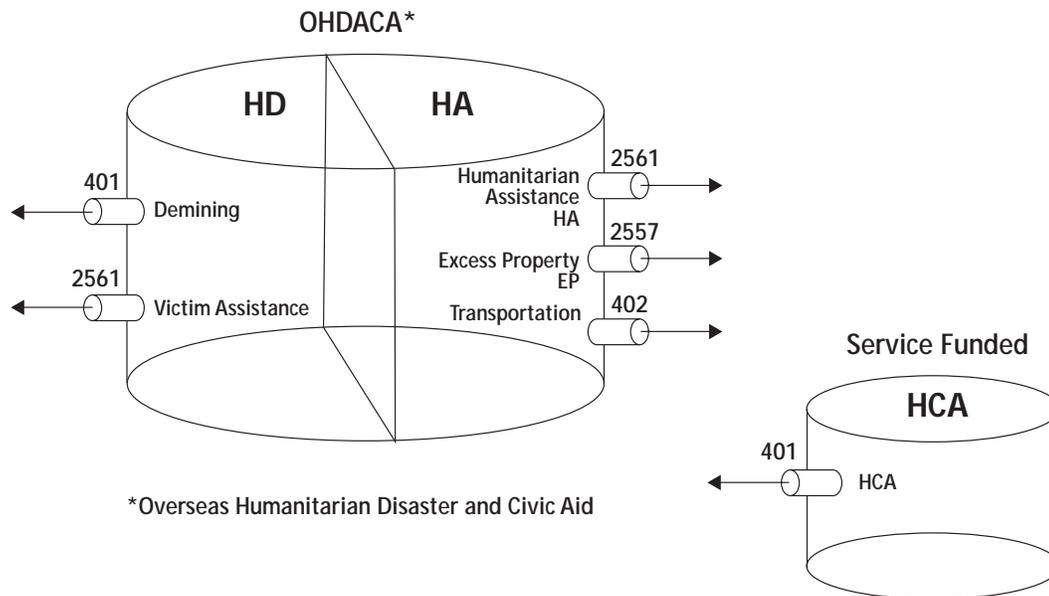
The two fundamental processes by which the DoD deploys personnel outside the continental U.S. for the purpose of humanitarian assistance are through contingency deployments and deliberately planned engagement activities (Figure 2), through which DoD attempts shape world events in accordance with U.S. national security interests and military strategy. The deliberately planned humanitarian assistance programs include humanitarian and civic assistance (HCA) which are for the training benefit of U.S. personnel consistent with the political interests of the U.S. and the host nation, Humanitarian Assistance (HA) which are for bona-fide humanitarian need of civilian personnel in rural or underserved areas, and Excess Property donations (EP) by which non-lethal supplies and equipment excess to the needs of DoD is donated to meet humanitarian needs of host nation civilian organizations. Together, these programs result in approximately 200 DoD humanitarian assistance projects annually.



**Figure 2:** This diagram represents some of the programs by which the DoD provides global humanitarian assistance, both via deliberately planned theatre security cooperation and in contingency operations. Regardless of the particular program, projects are undertaken with the intent of influencing world events according to the national interests of the United States, according to the statutory authority of each particular program.

An explanation of DoD terms and their context is in order, as there are several DoD humanitarian programs and many more acronyms. Some terms have multiple uses or may have different meanings, depending upon the context, both within and outside DoD. As mentioned previously, under the DoD Overseas Humanitarian, Disaster and Civic Aid Program (OHDACA), there are three principal programs: humanitarian and civic assistance (HCA, section 401), Humanitarian Assistance (HA, formerly 2551, now section 2561), and Excess Property (EP, section 2557). Specific definitions and guidelines regarding these projects have been excerpted and included in Appendix B of this report. In addition to the acronyms 'HA', 'HCA', and 'EP', the respective section numbers (e.g. "401") may refer to projects under these programs (see Figure 3). Caution is advised in using the term, 'humanitarian assistance' as it widely refers to the general relief of human suffering (as defined by Webster at the outset), but also refers to a specific, statutory OHDACA program (section 2561).

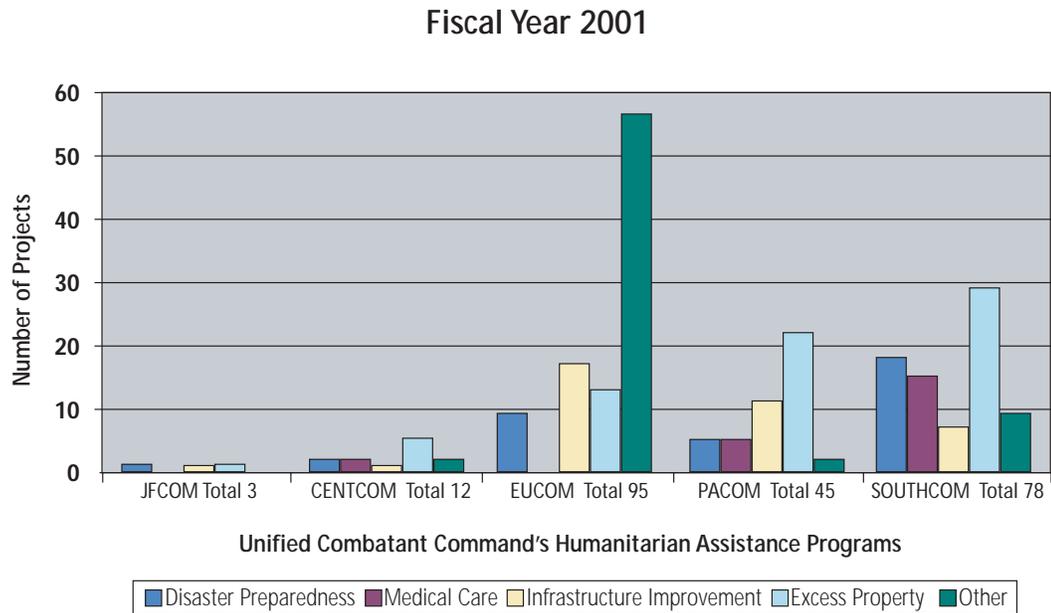
## DoD Humanitarian Assistance Programs



**Figure 3:** This diagram represents the various DoD humanitarian assistance programs as holding tanks, wherein funding is allocated and dispersed to the various programs. Program numbers are printed directly above each of the “spouts” that drain the tanks. Accordingly, monies allocated for humanitarian assistance via HA and EP projects are separate from those allocated for demining and victim assistance, although each of these is overseen by the OHDACA. All activities performed under the HCA program are funded directly by individual Service branches, and may include both HCA and demining.

DoD humanitarian programs are funded by annual appropriations, with the exception of HCA projects; since their purpose is training, HCA projects are funded separately by the Services using operations and maintenance funds (see the report in this series titled *Humanitarian and Civic Assistance Projects and Military Training*). However, execution of all programs is decentralized. The humanitarian assistance program managers on the staffs of the geographic Unified Combatant Commands execute these programs within their specific areas of responsibility. The Office of the Assistant Secretary of Defense, Special Operations and Low Intensity Conflict (SO/LIC) which funded this study, has oversight of humanitarian assistance programs.

As mentioned, HCA, HA, EP, and other kinds of humanitarian programs constitute a major portion of each theatre security cooperation plan. Specific projects include both medical and non-medical activities. Many humanitarian projects listed as engineering or infrastructure development also include significant medical aspects (Figure 4). For example, European Command’s infrastructure development projects in the Balkans involved new construction or substantial renovation of some 70 hospitals and clinics in the past two years. Although listed as engineering projects, such projects will undoubtedly have a major impact on host nation medical care.



**Figure 4:** This graph shows the relative number of humanitarian assistance projects by unified combatant command during Fiscal Year 2001. It is important to note that some projects, such as those listed under Infrastructure Improvement, can have an indirect effect on the medical care of host nation citizens. For FY 1999 and 2000, please see Appendix A.

For a variety of reasons, medical or health-related projects are among the most popular form of humanitarian assistance. The importance of medicine in overseas humanitarian assistance under these programs is far greater than it may seem on preliminary examination. For example as shown in Fig. 4 direct 'medical care' accounted for 20 of 231 projects. Similarly, table 1 shows medical expenditures at \$2.5M of the total \$27.1M. Thus, one might estimate that approximately 10% of DoD overseas humanitarian efforts under these programs are health related. In reality, we conservatively estimate that the more accurate estimate is between one-third and one-half of all OHDACA projects are medical or health-related. This is because many other humanitarian projects not necessarily categorized as 'medical' are in fact, health related. For example, many of EP (excess property) projects involve donations of excess medical supplies and equipment. In many cases, such donation are an important means of allowing health clinics and other facilities to be established, to advance their capabilities, or even to remain in operation. Thus, although listed as EP vice 'medical,' such property donation projects should also be considered as improvements to host nation medical capabilities. Similarly, many projects categorized as engineering or infrastructure development are also health-related. For example building a new, or reconstructing an existing clinic, hospital or other health care facility clearly involved engineering, but when the construction is completed the lasting impact will hopefully be improved host nation medical capabilities. Of course the number of direct medical projects, and the number of EP, engineering or other projects that ultimately involve health-related activities varies slightly by year and geographic region.

Whatever the standard, be it number of projects, patients treated, personnel trained and involved, or funds expended (Table 1), providing international humanitarian assistance is a historic mission of the military that has taken on a renewed importance. Although DoD involvement in humanitarian assistance may be small compared to the role of major international donor agencies, its significance has steadily increased in budget size and the scope of United States foreign relations.

To provide further appreciation for the magnitude of DoD humanitarian assistance programs, for fiscal

year 2001, DoD approved 237 specific projects in over 100 different countries (Table 2). This year and these projects are representative of the OHDACA annual program.

Type Project	JFCOM	CENTCOM	EUCOM	PACOM	SOUTHCOM	Total
Disaster Preparedness	\$73,050	\$200,000	\$965,000	\$455,000	\$1,660,000	\$3,343,050
Medical Care	\$0	\$266,000	\$0	\$550,000	\$1,735,000	\$2,551,000
Infrastructure Improvement	\$245,000	\$93,900	\$1,635,000	\$1,500,000	\$1,040,000	\$4,513,900
Other	\$0	\$200,000	\$8,161,000	\$90,000	\$550,000	\$9,001,000
Excess Property	\$30,000	\$270,000	\$325,000	\$1,999,000	\$2,530,000	\$5,154,000
Program Management	\$50,000	\$200,000	\$1,800,000	\$425,000	\$90,000	\$2,565,000
<b>Total:</b>	<b>\$398,050</b>	<b>\$1,229,900</b>	<b>\$12,886,000</b>	<b>\$5,009,000</b>	<b>\$7,605,000</b>	<b>\$27,127,950</b>

**Table 1:** Project expenditures by type and command for fiscal year 2001. For FY 2000 and 1999, please see Appendix A. Command acronyms are: CENTCOM for U.S. Central Command, EUCOM for U.S. European Command, PACOM for U.S. Pacific Command, and JFCOM for U.S. Joint Forces Command.

Type Project	Humanitarian Projects	Excess Medical Property Donations	Medical or Health-Related Projects	Disaster Response Projects	Countries Receiving Projects
CENTCOM	13	4	2	2	6
EUCOM	96	45	0	14*	50
SOUTHCOM	79	18	12	29**	29
PACOM	46	14	5	5	20
JFCOM	3(+1 deferred)	-	1	-	3
<b>Total:</b>	<b>237</b>	<b>81</b>	<b>20</b>	<b>51</b>	<b>108</b>

\* Of which 13 are the top priorities of all 96 approved projects

\*\* Of which 14 are the top priorities

**Table 2:** Humanitarian Assistance Projects (HA, HCA & EP) approved for Title 10 Funding during Fiscal Year 2001, according to unified combatant commands. Command acronyms are: CENTCOM for U.S. Central Command, EUCOM for U.S. European Command, PACOM for U.S. Pacific Command, and JFCOM for U.S. Joint Forces Command.

For the prior year there were 254 projects, of which 72 were medical, and an additional 57 involved donation of excess medical supplies and equipment. In all, for the current and preceding two fiscal years, 671 different projects were approved and funded for a total of just under \$70 million (see Appendix). These humanitarian programs are managed regionally by the CINCs, where they are an integral part of theatre security cooperation extending and expanding U.S. influence abroad. The programs of even a single command are ambitious: U.S. Southern Command received approximately \$6.2 million for 147 projects in fiscal year 2001, and requested just over \$8M for 165 projects in fiscal year 2002 (Blanchette, 2001).

Whether testing new weapons, doctrine, or leaders, overseas deployments have been widely used as a means for improving military readiness. Among the several programs for DoD humanitarian assistance, the HCA program is unique in specifically recognizing that overseas deployments provide training otherwise not possible in the U.S. For example, in medical HCA projects, justification statements frequently cite the unique training opportunities, such as the diagnosis and treatment of tropical diseases, or performing surgeries and other care under austere, 'field' conditions. Medical HCA missions can also provide the opportunity to care for far greater numbers of patients in a shorter amount of time than would be seen at home duty stations.

Recently, global humanitarian demands seem to have expanded somewhat more rapidly than the DoD doctrine and training systems that support these diverse missions. Because of this, MHS personnel sometimes find themselves in situations for which they have not been specifically trained. For example, consider a young military physician, perhaps a general medical officer, on his or her initial tour of duty. In an operational deployment with a joint task force, he or she may (on very short notice) serve as the sole medical officer for a refugee camp. The setting may be austere, lacking ready access to many of the supporting functions of the MHS to which the physician is accustomed. Medical logistics, laboratories or patient evacuation services may be non-existent. A short-term course addressing such training needs, Military Medical Humanitarian Assistance, Pediatrics, has recently become the model for other specialty-specific short courses under USUHS and CDHAM sponsorship.<sup>1</sup>

Deployed MHS personnel are caring for patients by the hundreds or thousands from diverse cultures with unique health care needs. To provide some sense of the magnitude of these programs, in just one Unified Combatant Command's area of responsibility (Central & South America), for the period FY 1991-96, MHS personnel provided care for a reported 848,000 host nation medical patients, 160,000 dental patients, and 353,000 animals (Fortune, 1996). In medical humanitarian assistance projects, the military staffing may range from a handful of personnel sent as augmentees, to entire medical units deployed for training. With current global issues such as the increasing world population of refugees and displaced persons, multinationalism, and terrorism, the lessons learned during humanitarian assistance missions should be used to increase readiness and effectiveness, better preparing the MHS for the future.

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## Some Differences Between Military and Civilian Humanitarian Assistance

In virtually every contingency operation involving US military forces, the primary responsibility of deploying medical units and personnel is the care of U.S. service members and other eligible beneficiaries. In fact, many operational orders, plans, and directives read, “Care of U.S. Forces only.” However, in some peace keeping operations, permissive environments, or as missions evolve, medical care of a humanitarian nature is provided, as has occurred repeatedly in operational deployments over the past decade. For example, care of displaced persons, refugees or victims of land mine injury—particularly to save life, limb or eyesight— is authorized and provided. While there are several reasons why humanitarian care by military personnel can extend beyond the initial mission, it’s important to note that the principal reason medical assets and capabilities are present in a contingency operation is to provide care for deployed military forces, not necessarily to provide humanitarian assistance. In contrast, many civilian organizations have medical humanitarian assistance as their sole purpose.

In considering the humanitarian assistance provided by the DoD, it is essential to understand the specific authority and funding sources. For example, under Title 10 U.S. Code section 401, DoD annually conducts dozens of humanitarian and civic assistance (HCA) projects around the world. Although these include engineering projects such as construction or repair of schools, orphanages, and health clinics, a large percentage of HCA projects have involved health care. The health care provided to thousands of patients is certainly humanitarian in nature, but the purpose, statutory authority, and funding for overseas deployments of U.S. military personnel under the HCA program is for their training benefit and the furtherance of the political interests of the U.S. and host nation. Humanitarian benefits, while important, remain secondary to the training and political purposes of the mission. In contrast, many private volunteer organizations (PVOs) and non-governmental organizations (NGOs) might not consider training as a justification for sending their personnel to a foreign country to provide humanitarian assistance. Thus, military and civilian providers of humanitarian assistance may be present in a given locale for far different reasons.

In addition to the differences in authority and funding between military and civilian-provided humanitarian assistance, the individuals providing care also have different perspectives. Both military and civilian humanitarian assistance include elements of altruism, and the people performing these missions are genuinely concerned for helping those in need. However, one important difference between them is that, although many military personnel joined the Services voluntarily, often subsequently volunteering repeatedly for humanitarian missions, their participation is under military orders. Regardless of how terrible the conditions in a humanitarian assistance mission may be, they cannot leave without violating those orders. Military personnel do not have the option of deciding on which humanitarian missions they will deploy. Typically their orders to deploy are on very short notice; sometimes only a few days or even hours are all the time allowed between notification and getting on an aircraft for some distant country.

Another basic difference between military and civilian healthcare providers of humanitarian assistance is that military personnel are trained, equipped, and deployed specifically to provide care usually to U.S. service members in combat, hostile, or emergency response situations. Until recently, DoD medical personnel were not specifically trained nor equipped to provide humanitarian assistance. The MHS, its capabilities, and vast array of equipment are geared toward combat casualty care, and humanitarian assistance is often an “extra duty” for which personnel have only recently begun to be trained. Civilian providers, on the other hand, are often specifically trained for care of refugees or other elements of the host nation population.

Humanitarian assistance by the MHS is often provided for a patient population far different than for which it is trained and equipped, i.e. the largely male, young, healthy, highly physically fit, fully immunized, and well nourished military cadre. In contrast, in humanitarian assistance the patients range from neo-natal and pediatric to geriatric, and often include a high proportion of females, as males are deceased or away engaged in conflict. These patients are often malnourished, suffering from multiple endemic diseases or infections, and likely have had little or no medical or dental care throughout their lives. Commonly they are displaced from their homes by long distances and/or periods of time. Many have suffered a variety of trauma and abuses, ranging from rape to ethnic cleansing, with marked effects on mental health status, coping, and support

mechanisms. Military personnel dealing with these populations and the attendant complex health care and humanitarian issues are not given the time, nor access to the same level of training and specific preparation (i.e. language, culture immersion) that other organizations, such as the Peace Corps, offer their civilian volunteers.

The duration of humanitarian assistance missions also differs markedly between DoD and civilian providers. Military personnel provide humanitarian assistance for comparatively short periods of time, over which they have no control. The report in this series titled *Humanitarian and Civic Assistance Projects and Military Training* examines over 100 after action reports on humanitarian assistance projects. We found that the average duration of these missions was just two weeks (including travel time). Compare this very short time frame with the perspective of many PVO and NGO humanitarian assistance workers who may toil for years in a given locale or country. While some PVO and NGO staff members voluntarily remain overseas for long periods of time, military personnel are ordered into and out of countries over very short periods of time, over which they have no control.

The experiences of 215 military personnel who had deployed on an average of 4 humanitarian missions each to a total of over 100 host countries is discussed in the report in this series titled *US Participants Perspectives on Military Medical Humanitarian Assistance*. Recent surveys have shown that, regardless of the hardships involved, humanitarian assistance missions are a significant factor in military personnel recruitment and retention. Nearly half of 410 uniformed medical personnel surveyed indicated that the opportunity to provide humanitarian assistance was a factor in their joining the military as discussed in the report in this series titled *Humanitarian Service: Recruitment and Retention Effects among Uniformed Services Medical Personnel*. Collectively, the survey responses of over 600 uniformed personnel in these two surveys represent information and perspectives on DoD humanitarian experiences not previously reported. Similarly, the responses of host nation representatives from eight countries are discussed in *Host Nation Participants Perspectives on Military Medical Humanitarian Assistance*, the first-ever analysis of what recipients think about DoD humanitarian assistance.

Overall, DoD provides humanitarian assistance via a wide variety of mechanisms, under the broad categories of contingency operations and deliberate planning. While the resulting humanitarian benefits are considerable, especially in medicine and health care, they are not necessarily well documented. In some military operations, humanitarian assistance may be secondary to the primary purpose of the military presence. Humanitarian assistance may be provided in conjunction with care of U.S. service members, or for training, or political or national security interests. Thus, the kinds of projects labeled by DoD as 'humanitarian assistance' may bear little resemblance to what many in the international relief community understand by the same name.<sup>2</sup>

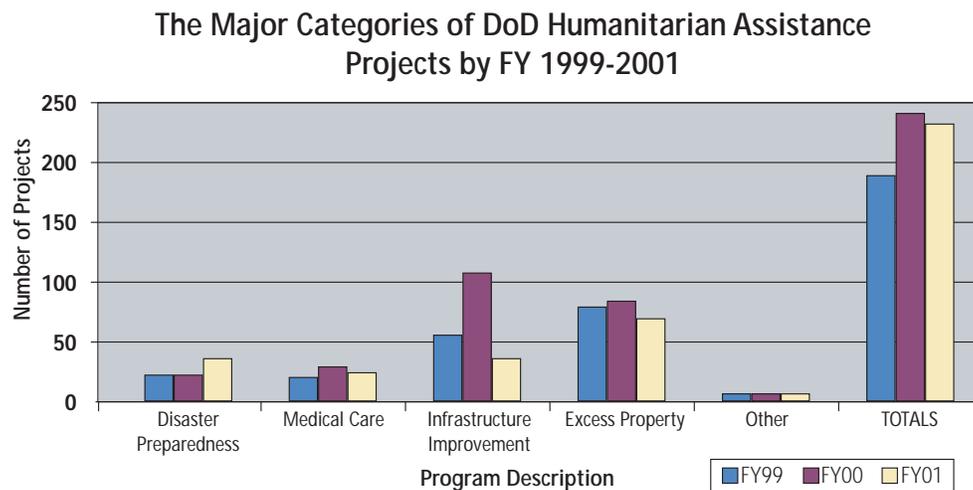
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<sup>2</sup> For additional information on the comparative perspectives of military and civilian providers of humanitarian assistance, see the International Federation of the Red Cross & Red Crescent Societies, "Can Military Interventions and Humanitarian Action Coexist?", Chapter 2, World Disaster Report, 1997, pp. 23-24.

## Humanitarian Assistance: A Historic Mission of Renewed Importance

A number of contributions have been published on the historic role of military medicine in disaster relief and humanitarian assistance in contingency operations, particularly over the past decade. However, there is comparatively little literature examining military medical humanitarian assistance as provided under the deliberately planned projects executed under HA, HCA, and EP programs. The expenditure of considerable resources in conducting more than 200 humanitarian assistance projects annually worldwide warrants this review of their effectiveness, with the goal of improving the effectiveness of future missions.

How did the DoD—especially the Military Health System—find itself in a position that has been described as the ‘global 911’? Causative factors are numerous, complex, and include: evolving national security considerations brought on by post-Cold War changing world order, population growth, climatic change, the emergence of new diseases and re-emergence of old ones, and the political opinions that change with successive administrations on the role and missions of the United States military. Regardless of the reasons, the net result is that DoD has experienced rapid growth in humanitarian deployments (Figure 5). This type of mission, however, is not without historical precedent for the military.



**Figure 5:** This graph illustrates the number of humanitarian assistance projects annually between fiscal year 1999 and fiscal year 2001, under the HA, HCA and EP programs.

Since early history, militaries have provided assistance for the purpose of training, for humanitarian reasons, and for political interests. Among the earliest recorded accounts is that of Pliny the Elder (Pliny Letters) who deployed his fleet to rescue Pompeii’s residents, only to lose the fleet, and his life, in the attempt. Early in the history of the United States of America, military officers were involved in humanitarianism. The journals of Lewis and Clark outlined three goals for dealing with the Native Americans: 1) conduct health and demographic surveys, 2) practice disease prevention, and 3) provide patient care (Callahan, 2001). In the U.S. Civil War, “healthcare and medications were provided to families of indigent volunteers, displaced civilians, and refugees.” (Barnes, 1870-1888).

Overseas humanitarian care by the U.S. military continued into the 20th century. The “Armed Forces Aid to Korea” program collected over \$3.5 million, while volunteer Army physicians and nurses performed 320,000 medical procedures for Koreans (Naythons, 1993). Later, in Vietnam, Navy and Vietnamese medical personnel provided daily care for an average of 250 outpatients, admitting about 100 children monthly from the local medically-underserved population (Burkle, 1970).

In addition to providing humanitarian care, military units serving outside their own country have long been an important means of political influence. A century ago, the Great White Fleet circumnavigated the globe to 'show the flag'. Today, U. S. influence is extended worldwide by military medical personnel providing care for thousands. Medical humanitarian assistance can also open doors to closed nations. Former U.S. Ambassador to Somalia, R.B. Oakley, described situations where, "...medical personnel serve as ambassadors of American goodwill.... Military medical teams are often welcomed by nations who would not accept other forms of U.S. assistance" (Oakley, 1996).

Particularly since the fall of the Berlin wall, the number of military humanitarian assistance missions has increased dramatically. A steady stream of headlines has chronicled: "Operation Provide Comfort" involving caring for Kurdish refugees in Northern Iraq; "Operation Sea Angel" where Marine forces afloat suddenly had to respond to devastating flooding in Bangladesh; Operations "Restore Hope" and "Support Hope" in Somalia and Rwanda, respectively; Operations "Uphold Democracy" and later "Restore Democracy" in Haiti; the reconstructive humanitarian assistance following the horrors of ethnic cleansing in the Balkans; and now "Operation Enduring Freedom." Although these contingency operations have been prominent in the headlines during most of the past decade, they represent only one of several processes by which DoD provides overseas humanitarian assistance.

In terms of the number of projects, number of countries, population for which humanitarian assistance is provided, or the number of U.S. personnel involved, deliberately planned humanitarian assistance projects rival the more publicized contingency operations. These forms of humanitarian assistance, now often referred to as 'theatre security cooperation,' remain largely undocumented in the literature, even within DoD reports.

## Evaluating Effectiveness

Although there are exceptions within some commands and selected medical residency training programs, many DoD humanitarian assistance projects are treated as unique events, without consideration of what has been accomplished previously in a given country or locale. There is often poor documentation of project outcomes. Military providers ask their host nation colleagues for input only infrequently as discussed in the series report *Host Nation Participants Perspectives on Military Medical Humanitarian Assistance*. Rather than involving host nation officials in the planning of humanitarian assistance, by the time they are consulted, humanitarian care often has already begun. When it is completed, there is virtually no post-project follow up. Finding after action reports or any documentation of project outcomes is problematic.

Whether for training, humanitarian, political, or any other value, in order to measure effectiveness, progress toward a defined outcome or goal must be documented and measured. Ideally, evaluations should be conducted within an established procedure, such as the logical framework process employed effectively by the American Red Cross<sup>3</sup>. Additionally, evaluations should be conducted against known standards, just as military training is evaluated according to standards. In this case, the international consensus minimum standards for humanitarian assistance, as outlined in the SPHERE<sup>4</sup> project, are recommended. These issues are discussed further in the report in this series titled, *Measuring the Effectiveness of Humanitarian Assistance other than Department of Defense Providers*.

Clearly the requirements of diverse missions complicate the straightforward application of one information management system. What is key is that there is a methodology to capture critical information, whether costs or patient outcomes, in a consistent and straightforward manner. Further discussion of these issues is included in the report *Information Management for More Effective Military Humanitarian Assistance Projects & Programs*, where prototype software after-action reporting system for humanitarian assistance missions is proposed. Implementing better information collection, retrieval, and analysis is absolutely essential to more effective humanitarian assistance.

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<sup>3</sup> For more information reference the following:

European Commission, 1993; Manual on Project Cycle Management: Integrated Approach and Logical Framework, pp. 22-24

AusGuidelines: The logical framework approach. [www.usaid.gov/ausguide/ausguidelines/1.html](http://www.usaid.gov/ausguide/ausguidelines/1.html)

<sup>4</sup> The Sphere Project, Humanitarian Charter and Minimum Standards in Disaster Response, Oxfam Publishing, 244 Banbury Rd. Oxford, OX2 7DZ, UK ISBN 0-85598-445-7

## Summary

Despite ample historic precedent, and an extensive and growing involvement of DoD assets, particularly medical units and personnel, the record of humanitarian assistance project outcomes is incomplete. An analysis of their effectiveness has not previously been undertaken on the programmatic scale that this series of reports attempts. In this regard, DoD is not unlike the myriad private volunteer, non-governmental, and international organizations that also provide humanitarian care worldwide. Many of these organizations are likewise struggling with how to collect key project management information in the midst of famine, flood, or plague, and how to translate data into decision support systems that facilitate management decisions and more effective projects. The important collaborative work of multiple organizations over the course of several years in pulling together the internationally recognized minimum standards of performance in humanitarian assistance represented by the SPHERE Project is a good example. The global community of humanitarian assistance providers mutually recognized the need for more effective humanitarian assistance. Similarly, the logical framework process employed by the American Red Cross and others is another example of improved management tools for more effective humanitarian assistance project and programs. The importance and applicability of the SPHERE standards, the logical framework process, and an information management system are three key and essential components of more effective humanitarian assistance programs which DoD should adopt or adapt.

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- Dr. David Richards who implemented the software which made analysis of the responses to the many questions on the standard survey questionnaire possible.
- Dr. Linda Spencer contributed significantly to the discussion on the logical framework and the Sphere Project consensus standards.
- Dr. Doug Ehrhardt facilitated development of the prototype standardized after action report and automated information management system.
- Mr. Raul Sotomayor traveled to Central America, employing his expertise to gather host nation information.
- Dr. Darrell Singer voluntarily traveled to Africa to collect host nation data from past military medical humanitarian assistance missions in Botswana and Zimbabwe.
- Ms. Michelle Shirley assisted with the collection and entry of survey response data.

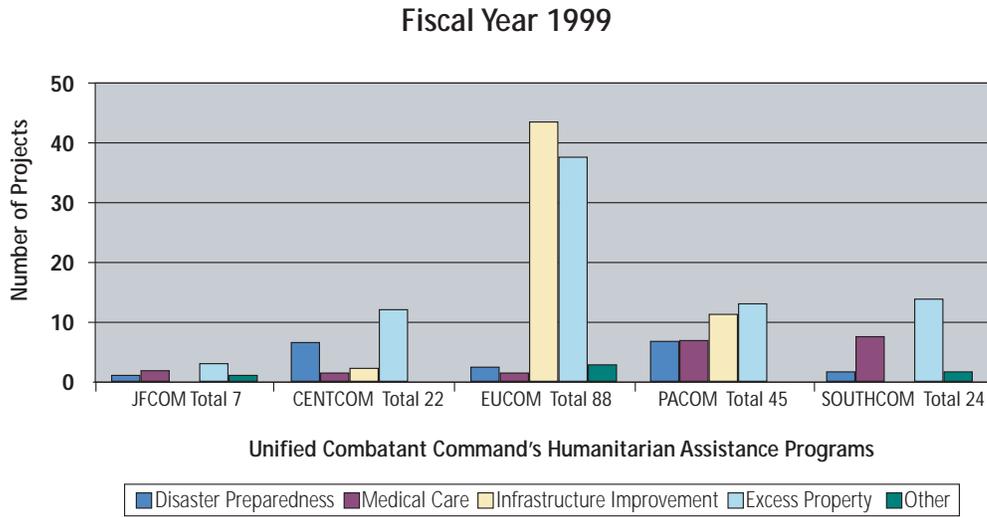
Special thanks to the many staff officers, military and civilian, who work diligently to annually design, plan, and execute hundreds of medical humanitarian engagement activities worldwide. Your cooperation and frank discussion provided valuable insight to the day-to-day functioning of complex programs. Your voluntary completion of lengthy survey questions has provided valuable insight on your substantial experiences.

Special thanks to MAJ Robert Mott, formerly Medical Staff Officer, Office of the Assistant Secretary of Defense, Special Operations and Low Intensity Conflict, whose untiring interest and support was instrumental in making this study possible, and to his successor, LCDR Dave Tarantino, who follows closely in that tradition.

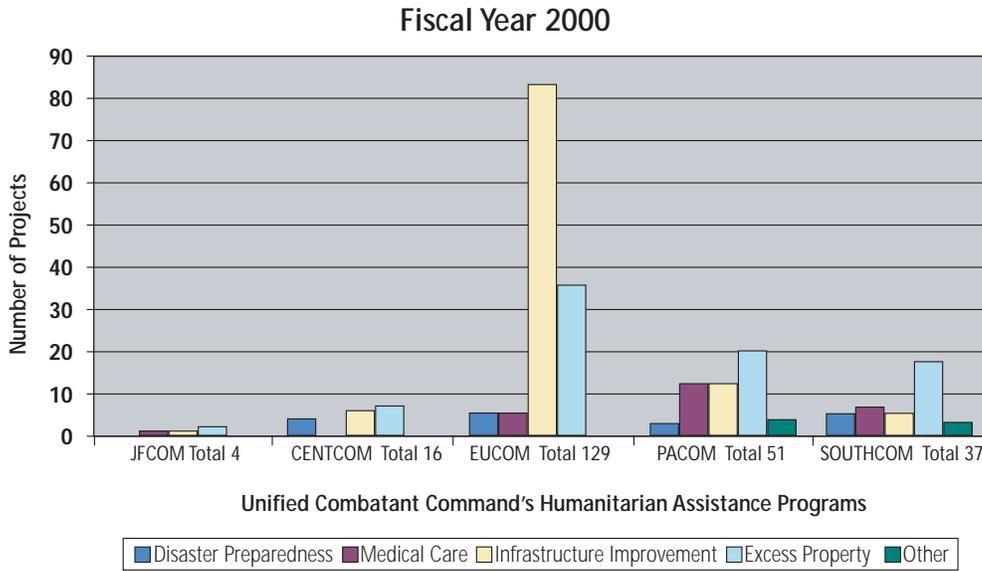
Finally, thanks also to the hundreds of medical personnel of all ranks, specialties, and Services who, often on short notice, with austere resources, under the most trying or dangerous of circumstances, persevere and extend the benefits of quality health care to their fellow man, often when they need it most. Your unselfish efforts in providing quality medical care under the most arduous of conditions have saved countless lives, cured diseases, restored sight, limbs and other functions for thousands of patients who would otherwise not receive care. The lives of others are improved by your selfless service.

LTC (Ret) Jeff Drifmeyer, PhD, MPH  
Special Project Officer, CDHAM

### Appendix A: Figures and Tables for 1999 and 2000



**Figure 6:** This graph shows the relative number of humanitarian assistance projects by unified combatant command's during Fiscal Year 1999



**Figure 7:** This graph shows the relative number of humanitarian assistance projects by unified combatant commands during Fiscal Year 2000

Type Project	JFCOM	CENTCOM	EUCOM	PACOM	SOUTHCOM	Total
Disaster Preparedness	\$123,200	\$754,930	\$375,000	\$228,000	\$350,000	\$1,831,130
Medical Care	\$207,000	\$75,000	\$75,000	\$305,000	\$1,150,000	\$1,812,000
Infrastructure Improvement	\$0	\$670,000	\$5,438,000	\$1,045,000	\$0	\$7,153,000
Other	\$57,000	\$0	\$85,000	\$907,000	\$30,000	\$1,079,000
Excess Property	\$210,000	\$397,500	\$1,010,000	\$965,000	\$1,245,000	\$3,827,500
Program Management	\$48,673	\$160,000	\$1,700,000	\$500,000	\$75,000	\$2,483,000
<b>Total:</b>	<b>\$645,873</b>	<b>\$2,057,430</b>	<b>\$8,683,000</b>	<b>\$3,950,000</b>	<b>\$2,850,000</b>	<b>\$18,186,303</b>

**Table 3:** Project expenditures by type and command for fiscal year 1999. Command acronyms are: CENTCOM for U.S. Central Command, EUCOM for U.S. European Command, PACOM for U.S. Pacific Command, and JFCOM for U.S. Joint Forces Command.

Type Project	JFCOM	CENTCOM	EUCOM	PACOM	SOUTHCOM	Total
Disaster Preparedness	\$83,400	\$386,582	\$370,000	\$195,000	\$525,000	\$1,559,982
Medical Care	\$0	\$0	\$501,000	\$1,175,000	\$995,000	\$2,671,000
Infrastructure Improvement	\$245,000	\$1,270,600	\$8,857,000	\$910,000	\$345,000	\$11,627,600
Other	\$0	\$0	\$0	\$250,000	\$490,000	\$740,000
Excess Property	\$105,000	\$200,500	\$1,043,000	\$1,515,000	\$2,110,000	\$4,973,500
Program Management	\$49,000	\$200,000	\$1,809,000	\$425,000	\$75,000	\$2,558,000
<b>Total:</b>	<b>\$482,400</b>	<b>\$2,057,682</b>	<b>\$12,580,000</b>	<b>\$4,470,000</b>	<b>\$4,454,000</b>	<b>\$24,044,082</b>

**Table 4:** Project expenditures by type and command for fiscal year 2000. Command acronyms are: CENTCOM for U.S. Central Command, EUCOM for U.S. European Command, PACOM for U.S. Pacific Command, and JFCOM for U.S. Joint Forces Command.

## Appendix B: Definitions and Summaries of Title 10 Programs

### I. Section 2557: Excess Property (EP)

- A. Excess nonlethal supplies, humanitarian relief.
- B. Sec Def may make available for humanitarian relief purposes any nonlethal excess supplies of the DoD.
- C. Excess supplies made available for humanitarian relief...shall be transferred to the Sec of State, who shall be responsible for the distribution of such supplies.
- D. Definition of nonlethal excess property: (excess, and not a weapon, ammo or other equipment or material that is designed to inflict serious bodily harm or death.)

### II. Section 2561: Humanitarian Assistance (HA)

- A. "...funds authorized....shall be used for the purpose of providing transportation of humanitarian relief and for other humanitarian purposes worldwide."
- B. funds remain available until expended.
- C. annual reporting to Congress required.
- D. Relief to unauthorized countries requires specific report to Congress, not less than 15 days PRIOR to shipments as amended: transportation by most economical means, military or civilian, to include aircraft and personnel of the Reserve components.

### III. Section 401: Humanitarian civic assistance (HCA)

- A. 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:
  - 1. The security interests of the U.S. and the Host nation, and
  - 2. The specific operational readiness skills of the members of the armed forces who participate in the activities.
- B. 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 other department or agency of the United States. Such activities shall serve the basic economic and social needs of the people of the country concerned.
- C. Humanitarian and civic assistance may not be provided under this section (directly or indirectly) to any individual, group, organization engaged in military or paramilitary activity.
- D. The Sec Def shall ensure that no member of the armed forces, while providing assistance under this sections engages in the physical detection, lifting or destroying of landmines, or provides such assistance as part of the military operation that does not involve the armed forces.
- E. 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.
- F. Expenses incurred, as a directed 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.

- G. Expenses covered by para (1) include the following expenses incurred in providing assistance:
  - 1. Travel, transportation, and subsistence expenses of Dept of Defense personnel providing such assistance.
  - 2. 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.
- H. 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 exceeded \$5 million.
- I. 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.
- J. 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 under served 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.

