U.S. Participants Perspectives on Military Medical Humanitarian Assistance

Measures of Effectiveness

CDHAM Publication 02-04
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Jeffrey E. Drifmeyer, PhD, MPH
LTC (Ret) MS USA

and

Craig H. Llewellyn, MD, MPH
COL (Ret) MC USA

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.

Center for Disaster and Humanitarian Assistance Medicine (CDHAM)
Dept. of Military & Emergency Medicine (MEM, Room C-1080)
Uniformed Services University of Health Sciences
4301 Jones Bridge Rd.
Bethesda, Maryland 20814-4799 USA

COL (Ret) Craig Llewellyn, M.D., MPH,
Director

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Executive Summary

The survey of 215 U.S. military personnel from all Services, including 50 who managed or led humanitarian assistance projects and 165 who participated (in many cases, in multiple missions) provided information useful in improving the effectiveness of DoD humanitarian assistance projects and programs, e.g.

- **Improve training for humanitarian missions.** (Among 50 humanitarian assistance project managers, 11 had no training, while 41 received only 'on-the-job' training* (which was undefined). The lack of specific training negatively impacts effectiveness.)
- **Expand the scope of projects beyond an often DoD-centric approach.** (Only 6 of all 215 respondents reported having been involved in humanitarian work with non-military organizations. This self-limited scope probably limits project effectiveness.)
- **Deploy personnel with their regularly assigned units to the greatest extent practicable.** (Of 50 project leaders who had led humanitarian assistance missions, only 21 did so with their regularly assigned units. The effect of unit cohesion on humanitarian missions was not specifically addressed, but effectiveness is typically greater with a cohesive team compared to a recently assembled group of individuals.)
- **Increase staffing and/or manpower devoted to humanitarian duties.** (Only 1 in 50 leaders had humanitarian assistance program management as their sole duty. For 30 of 50 (60%) humanitarian assistance was "one of several different duties." Half (26 of 50) spent less than 25% of their time on the humanitarian assistance programs for which they were responsible. The part time staffing limits effectiveness from the outset.)
- **Improve project planning and management.** (Summarized by respondents as, "no time for anything other than tasking missions, transferring funding, and making transportation arrangements." The lack of in-progress reviews, frequent project cancellation, and inadequate host nation contacts, both pre and post-project, limits project effectiveness.)
- **Expand the development of new types of humanitarian assistance missions rather than repeating the same kinds of missions year-after-year.** (The lack of reviews, internal or external, the DoD-centric focus, limited staff time, and often cursory management practices, all systemically limit project effectiveness.)
- **Focus beyond the short term.** (The DoD approach to humanitarian assistance can sometimes be summarized as "Get in, do as much as you can in a short amount of time, and get out." While this is understandable within the context of military contingency operations, it limits the effectiveness of DoD humanitarian assistance.)
- **Develop medical humanitarian assistance beyond patient care and excess property donations.** (Short-term projects, often conducted without need assessments, are not effective when conducted to the exclusion of a developmental, long-term approach.)

** in some cases, the numbers of responses may not equal the number of respondents as some questions went unanswered, or in other cases, elicited more than one response.*

Summary of Recommendations

- **Implement comprehensive, specific training for humanitarian missions,** both in military subjects, and specialty specific medical education.
- **Shift the focus from short-term patient care projects to longer term comprehensive, integrated projects** based on host nation assessments of prioritized needs and a developmental approach. Focus especially on capacity and capability-building projects such as public health interventions, medical training, and infrastructure improvements.
- **Task humanitarian missions to existing DoD units** to the extent practicable, rather than ad-hoc groups of individuals assembled for short-term temporary duty. Where additional subject matter expertise is required, attach individual experts to units, preferably before the deployment, so that a cohesive unit approach is the basis for project execution.
- **Conduct manpower surveys** where humanitarian assistance management is provided.
- **Ensure adequate staffing by trained personnel** to support the dynamics of high visibility multi-million dollar overseas humanitarian assistance.
- **Establish a means for regular periodic evaluations, ideally independently, of proposed DoD humanitarian projects** (e.g. external review board or steering committee). This should include pre-project approval and funding as well as project after action review of outcomes and effectiveness. This external review function could be accomplished by including representatives from DoD Centers of Excellence in Humanitarian Assistance and similar experts from other-than-DoD organizations including academia.
- **Utilize to the extent practicable the Civil-Military Operations Center (CMOC)** process for civil-military cooperation. Now limited to contingency operations, the CMOC process could be extended to deliberately planned humanitarian engagement activities.
- **Explore and promulgate the 'synergy of collaboration' approach** linking military and civilian resources and experts in planning and executing medical humanitarian missions. Meaning, utilize to the maximum extent practical, civilian health care providers, whether host nation representatives or expatriates, in closely coordinated projects. This not only reduces requirements for DoD personnel, but also provides the in-country coordination and participation necessary to improving the effectiveness of DoD projects and programs.

Fortunately, participants and managers alike often expressed a very clear understanding of these issues and an equally clear interest in improving project outcomes. Despite any difficulties involved, participation in humanitarian missions is nearly universally viewed quite positively. Half of the managers (26 of 50) would welcome additional tours of duty in humanitarian assistance.

Study Methods

In separate reports in this series, we discuss the very limited documentation in the published literature on the hundreds of humanitarian projects conducted annually by DoD personnel worldwide. Even unpublished sources are limited, as many humanitarian projects do not necessarily result in after action reports. In cases where after action reports are prepared, these are not easily accessed due to the absence of a central repository or information management system. The limitations on available information restrict the ability to assess effectiveness or complete many other tasks consistent with program review and best management practices.

However, even if the literature was robust and after action reporting comprehensive, it is important to directly obtain the opinions, ideas, and experiences of DoD personnel involved in humanitarian relief projects. We queried both providers of humanitarian relief, especially health care, as well as the recipients or beneficiaries of these projects. This report focuses on military providers' perspectives. (Another report in this series, *Host Nation Participants' Perspectives on Military Medical Humanitarian Assistance* focuses on the recipients or beneficiaries.) Information from these diverse sources was obtained by several means, but the primary data gathering was accomplished using standard survey forms. Standardized questionnaires were administered to both recipients and providers. For military personnel participating in overseas humanitarian assistance the survey forms were quite comprehensive. The questionnaire for participants had 63 questions, while the form for humanitarian assistance managers also had these basic questions, but added many additional questions about their project management experiences and leadership functions, totaling some 130 questions in all. Both forms included free text responses such as, "What is the best (and worst) aspect of participating in a humanitarian assistance mission?" Questionnaires were administered by direct contact, distribution through unit leaders, attendance at military medical conferences, via the web (http://tmed.usuhs.mil/mmhap), and through telephone inquiries. Responses (215) were obtained from DoD personnel, 165 from those self-identified as 'participants', and the balance from those self-identified as having management responsibilities. Respondents included; leaders and participants in medical projects, some humanitarian assistance program managers, and supporting staff officers. Participants included officers and enlisted personnel from all Services and a wide variety of medical specialties.

Among the U.S. respondents there was some limited crossover between which survey form was completed. For example, some respondents who had been on multiple missions in a leadership capacity completed the participant survey. Others who had participated in their first mission used the management questionnaire, but left many of the leadership questions blank. Many of the questions on the two surveys were identical, but the longer management survey added questions concerning leadership functions. This crossover on which form was completed was rare and did not affect study findings.

Although the number of respondents was limited, they did provide views which are simply not expressed elsewhere. Respondents had the opportunity to convey ideas and opinions that might otherwise never be voiced. We are not aware of any prior opinion surveys of participants in DoD humanitarian assistance projects. The following discussion focuses on the providers of DoD humanitarian care, with emphasis on medical projects, although participants and leaders experiences on projects of a non-medical nature were not excluded. We focus on those who completed the very detailed humanitarian assistance project management survey (numbering some 130 questions). These respondents included both personnel serving as humanitarian assistance program managers, and those who were leaders or officers in charge of specific humanitarian assistance projects.

Results & Discussion

It is illustrative to look briefly at the demographics of the fifty responses to the management survey. These leaders included five civilians and forty-five military personnel, the majority of which were officers, representing the Army, Navy, Air Force and Coast Guard. Forty-two of the military managers were active-duty, two were reservists, and one was from the National Guard. Eighteen were military physicians, and a dozen more were other types of health care providers ranging from a special operations medical sergeant and an independent duty corpsmen to epidemiologists. The balance were line officers of varying backgrounds, including civil affairs officers, and those serving as military attachés at U.S. embassies, i.e. members of the country teams that are so important in planning and executing humanitarian projects.

On average, managers had slightly over 16 years Service experience. Nineteen had volunteered for and/or requested a humanitarian assignment. These managers were evenly divided among those with and without prior humanitarian experience. Among those who had completed humanitarian projects, they had a wealth of experience. Respondents had each conducted, on average, nearly five humanitarian assistance projects. The majority of experiences derived from DoD activities and projects. While experienced by virtue of having completed projects, personnel were not specifically trained. Eleven reported having had no training whatsoever related to humanitarian assistance (HA), while forty-one reported 'on-the-job' training (undefined). This training shortfall is not due to lack of interest as thirty-nine of fifty expressed interest in future humanitarian assistance training. As for future training, respondents preferred a short-term humanitarian assistance course of 1 to 2 weeks duration. Only 6 of all 215 respondents reported having done HA work with non-military organizations. This narrow DoD- centric focus and limited training of those managing and leading humanitarian assistance projects could limit effectiveness. This seems particularly true in terms of considering new ideas or approaches utilized by humanitarian organizations other than DoD in conducting humanitarian projects.

The nature of these project managers' humanitarian deployment experience was not anticipated. Surprisingly, the norm in humanitarian missions was not to deploy with one's regularly assigned unit. The majority of those deploying were sent as individual augmentees, or as part of a small augmentation team. Only about 40% (21 of 50) reported having led the unit to which they were regularly assigned on a humanitarian mission. Overall, the participation in a majority of humanitarian assistance projects is by individuals, or small augmentation teams rather than regularly assigned units. Groups of individuals, gathered on short notice, no matter how proficient in their individual fields of expertise, are not likely to be as effective as cohesive units that regularly train and serve together as a team. The effect of the lack of unit integrity in conducting medical humanitarian missions remains to be explored. The impact of unit versus individual ad-hoc assignments to humanitarian projects warrants further study. For example, is there a difference in outcomes or effectiveness between projects that are executed by organized units, such as Special Forces "A" teams, versus projects completed by individuals on temporary assignment for that mission? Specific details on how humanitarian projects are staffed can have a major impact on their effectiveness, and should be examined in a subsequent study.

The majority of humanitarian assistance project leaders and program managers, despite their great interest and dedication, had surprisingly little time to devote to humanitarian duties. Only 1 in 50 respondents indicated that humanitarian assistance program management was their sole duty. Only 2 of 50 reported spending even half of their duty time on humanitarian assistance tasks. A 60% majority (30 of 50) had humanitarian assistance management as "one of several different duties." Similarly a majority, 32 of 50, reported spending less than half of their time working on humanitarian assistance duties. Approximately half (26 of 50) of all respondents spent less than 25% of their time on the humanitarian assistance programs for which they were responsible. This very limited time spent by leaders of projects and managers of humanitarian assistance programs cannot help but negatively affect many aspects of humanitarian programs, especially their effectiveness. What amounts to, in many cases, part time staffing of humanitarian programs has adverse impacts on all aspects of the projects from planning, through execution, to completion and follow-up. For example, when time is currently not available for even rudimentary documentation of projects, more complex tasks like management reviews and measuring effectiveness often do not appear to occur in many cases. As long as

humanitarian assistance project and program management is viewed as 'one of several duties,' with commitments of less than 25% of their time from half of the DoD personnel involved, effectiveness will remain limited. Several respondents described their programs as, *'no time' for anything other than tasking the missions, transferring the funding, and making transportation arrangements.* In such situations it should not be too surprising that documentation and follow up is largely absent, and that the effectiveness of these considerable DoD humanitarian efforts remains largely unknown.

The part time nature of staffing humanitarian assistance projects and programs should not be allowed to negatively impact the speed with which changes are implemented. Additional time and/or staffing will be needed to make programs more effective. Given the high visibility of overseas humanitarian assistance projects, the considerable resources involved, including the commitment of DoD manpower, the part-time nature of current management in the majority of cases should be addressed. Comprehensive manpower surveys are highly recommended to review required and recommended staffing levels at all commands tasked with humanitarian assistance project planning, execution, or oversight. Manpower surveys have been effectively used in some commands and organizations to do this –document workload and justify personnel authorizations. In other organizations this has not yet happened. This results in a wide disparity in staffing levels of humanitarian assistance programs. For example, in organizations where a manpower survey was conducted one finds full time government civilian employees staffing each of the programs, Humanitarian and Civic Assistance (HCA), Humanitarian Assistance (HA), and Excess Property (EP). In other organizations, sometimes a single individual is responsible for all three programs (and others), and may be on temporary assignment.

Respondents were also questioned about their experiences planning and conducting humanitarian missions, eliciting scaled responses with 1 being strongly disagree, 2 disagree, 3 neutral, 4 agree, to 5, strongly agree. Managers were surprisingly neutral (2.9) on whether any kind of in progress review (IPR) was conducted during project planning. While IPRs are common throughout DoD, they do not appear to be routinely used in humanitarian programs. The rarity of IPRs while projects are in the planning stages may account, in part, for the observation that about one third of these managers (16 of 50) have had humanitarian assistance projects canceled. The leading reason for humanitarian assistance project termination prior to execution was cancellation by the host country. Other reasons for cancellations included funding, scheduling, and staffing issues. The fact that one-third of these managers have had projects canceled probably relates to the lack of adequate time allocated for planning and the limited application of standard management practices such as IPRs. With the considerable time and energy invested in projects that are subsequently canceled, the current process is not as effective as it could be.

The limited contact that managers make outside DoD also hinders effectiveness. Managers were much more likely to communicate within DoD or Department of State authorities than with any PVOs, or NGOs or even host country officials. Higher headquarters within DoD and the country team at the U.S. Embassy were the most likely to be consulted. Least likely to be contacted in planning and managing humanitarian projects were international organizations, including the United Nations (UN), the World Health Organization (WHO), academic sources, and Private Volunteer Organizations (PVOs), and Non-Governmental Organizations (NGOs). Some of the lowest scores on the entire survey were in response to this series of questions. Most DoD personnel planning projects simply do not contact some of the very humanitarian organizations that might be able to provide valuable up-to-date information on: health needs of the country, other ongoing medical humanitarian projects, or similar information that would potentially readily allow DoD projects to be much more effective. In those DoD humanitarian assistance projects where contact with other-than-DoD agencies has been made, these organizations often offer not only essential information, but also considerable resources. For example, from corporate sponsorship to professional societies, these other-than-DoD agencies are often ready, willing, and able to donate everything from medical supplies and equipment to staff participation. Many organizations outside DoD have a tremendous interest in contributing to, or participating in, some aspect of humanitarian assistance projects. DoD has utilized such humanitarian resources effectively but only done so on rare occasions to date. These other-than-DoD contacts and participants could prove to be tremendous resource multipliers, greatly increasing the effectiveness of DoD humanitarian assistance with minimal costs. Often the

only cost to DoD is the time required to complete the necessary coordination, which as discussed above, on part time staffing and management can be problematic at this time.

In addition to the staff time required to facilitate necessary coordination, education of DoD participants is needed. To be more effective, personnel planning humanitarian assistance projects must be involved in training and procedures whereby planners gain an appreciation and understanding of the importance of contacting others in the international medical and humanitarian relief communities. Better planning is required in order to conduct more effective humanitarian operations. Relying almost exclusively on internal DoD sources to the near complete exclusion of other views and information from contacts outside the military sets a very narrow focus for DoD humanitarian assistance activities. An inward, DoD-centric focus systemically limits, from the outset, the potential effectiveness of humanitarian assistance projects and programs because it fundamentally affects the manner in which projects are first defined and how they are subsequently executed. The narrow focus of DoD and the lack of coordination with either host nation or other-than-DoD humanitarian organizations may explain, at least in part, the claim of some PVOs and NGOs that the military often does more harm than good in some humanitarian assistance operations, or that the military should not even be involved in international humanitarian relief.

In terms of information resources used by DoD personnel in planning humanitarian assistance, project leaders were most likely to ask their supervisor or co-workers and least likely to refer to either Service or Joint doctrine publications. While networking among colleagues can be highly effective, in cases where individuals have limited experience or training it can also lead to projects that are not as soundly based on either current doctrine or lessons learned as desired for effective projects. It can also lead to the same kinds of projects being proposed and conducted year-after-year. Sometimes this has occurred without the benefit of any periodic review to determine if the planned activities are effective. Project managers were also not likely to use available medical intelligence sources, either classified or unclassified. Again, the failure to utilize readily available information has adverse effects. In this case not only is project effectiveness adversely affected, but the infrequent use of readily available medical intelligence could result in critical force protection shortfalls that might place project participants at undue risk. For example, without advance information on the health conditions or disease threats in the host nation, project planners do not know what priorities are held by host nation officials or any requirements for personnel protection measures for those conducting the mission.

Despite the shortfall in specific humanitarian assistance training and in consulting appropriate sources of information, managers reported that they felt well prepared in the military aspects of humanitarian missions. A clear majority of respondents had received all of the following: statement of Commander's intent, information on cultural "do's and don'ts" for the host nation, the project mission statement, rules of engagement, and understood the chain of command for the project. Similarly, managers felt they were well prepared for the medical aspects of their projects. Most reported having obtained some information on the host nation's health problems, endemic diseases, basic health statistics, and medical organizations and infrastructure. On the same scale previously described, the statements, "I was well prepared as a health care professional," and "I was well prepared as a military service member" were scored as 3.8, and 4.1, respectively.

The disparity in the previously discussed narrow, internal focus of DoD humanitarian assistance projects and the perception of participating DoD personnel considering themselves well prepared militarily and medically is worthy of further study. Despite their reported individual preparedness on their specific projects, both militarily and medically, project manager's felt less well prepared on other broader aspects of humanitarian engagement activities. A broad-based training program could be essential in ensuring that individual perceptions of being well prepared matched the realities of new and different missions that involve many different international participants. This would prepare DoD personnel for more effective humanitarian missions.

Of the various kinds of medical humanitarian activities respondents had managed, there was a clear predominance of activities such as: direct patient care, donation of medical supplies and equipment, and health education. Activities such as 'building medical capacity' and 'improving health care infrastructure' however were less often included in projects. This focus on patient care, training, and equipment donations likely reflects the short-term nature of the vast majority of DoD humanitarian medical missions, and is a major influence on effectiveness.

These common medical humanitarian assistance activities such as direct patient care may also simply reflect the kinds of actions with which the participants are most familiar. It is perhaps human nature to continue doing the familiar rather than attempting new activities, especially when the location has changed to an unfamiliar overseas and different cultural setting. On the 1 to 5 scale, the highest rankings to the statement: "I would like to manage the following types of activities: _____" were: "patient care," 4.2 (non-disaster situations being preferred over patient care post-disaster 4.0) and "donation of medical supplies and equipment," 4.2. Scoring lower in terms of preferred activities were: "building host nation medical capacity" (3.7), "improving future health care infrastructure" (3.5), or "environmental health or sanitation" projects (3.4).

Without specific training in medical humanitarian assistance activities, health care providers tend to do what they know best: take care of patients. This is also reflected in the responses to questions about the kinds of medical HA missions that were easiest and which were most difficult. Although comments are quite diverse, activities such as excess property donations are mentioned as easiest while building infrastructure, 'most difficult.' This relates to the time scale in which most DoD efforts have been planned. As long as projects are scheduled as short-term activities, activities such as 'build infrastructure and host nation capacity' do not often get incorporated into planning DoD humanitarian assistance projects.

These observations raise the issue: Are DoD humanitarian assistance projects for the benefit of what is most needed by the host nation, or for what providers can most readily provide? Who defines the scope and focus of a military humanitarian assistance project determines, in large measure, its effectiveness. Managers felt strongly that projects are worthwhile for the host nation population, scoring 4.8, and as a show of support by the U.S., 4.8, but that humanitarian assistance projects were of somewhat less value as either a military or medical training activity, both aspects scored at 4.4.

In terms of measuring project value and effectiveness, although most project managers reported contacting the country team in conducting humanitarian assistance projects, far fewer reported doing so upon project completion. Information feed-back to the country team with the results of the project must be completed in order to measure effectiveness. An after action report based on quantified outcomes and not simply impressions, should be prepared. Ideally, an oral out-briefing should also be provided to both the country team and to the sponsoring command. These briefings and reports are completed in some units and component commands, however the procedures are by no means a uniform practice or policy. Again, post-project sharing of information, especially outcomes, is an essential step towards measuring effectiveness. This is certainly understood among many project and program managers that responded. When asked, 'what would you like to accomplish in humanitarian assistance but have not yet been able to do?' several replied, *"Return for outcome data."*

Respondents were also asked for their opinions on project effectiveness, even without formal measures. Although clearly subjective and based on small numbers, one finds in their remarks their clear understanding of the need for follow-up information and formal measures to gauge project outcomes. For example, to our question, "what kinds of medical HA projects are the least effective?" responses included: *"Med Caps where follow up of patients can not be completed," "those without adequate follow up," "those where host nation specialists do not participate," and "sporadic random 'photo op' type outpatient clinics."* Clearly, many project leaders fully understand and appreciate the need for more effective humanitarian assistance. At the present time they simply lack the tools, procedures, training, and time in which to accomplish what is widely recognized is required. Certainly, this widespread recognition of the need to implement the means to measure outcomes and effectiveness is encouraging and will speed its timely implementation.

Participation in medical HA missions is widely viewed quite positively, half (twenty-six of fifty) of the managers said they would welcome or volunteer for additional tours of duty in humanitarian assistance. Of all 215 respondents only 1 reported that they would not welcome additional medical humanitarian assistance assignments. For involvement in future projects, there was a strong preference for field or project work, with staff planning, headquarters, or teaching opportunities being less popular activities among respondents supporting humanitarian assistance projects.

To attempt to profile a hypothetical 'typical' HA medical project leader (based on this survey); as mentioned previously, the individual is a mid career officer with some 16 years active duty service, having conducted five humanitarian missions and gladly volunteering to do more. Although well experienced within DoD, only rarely do they have any experience outside of DoD. They have not had any formal training in the field, but would be interested in attending a short course or conference for this purpose. While they feel that they are well prepared both militarily and medically to conduct humanitarian missions, they do not feel that they are trained to do so.

Having several other duties besides humanitarian assistance, many project leaders typically devote less than one-half or even one-fourth of their time to the actual humanitarian assistance missions. Some devote as little as 5% of their time to humanitarian assistance. When planning a humanitarian mission they may contact a supervisor, co-workers, personnel at higher headquarters in the DoD chain of command, or sometimes members of the country team. They are not inclined however to consult medical intelligence sources. Nor do they contact any resources outside DoD such as host nation officials, international organizations such as the United Nations, World Health Organization, nor any PVOs or NGOs. They also are not likely to conduct an in-progress review while planning projects. Combining the lack of contact with host nations representatives, and a lack of detailed planning may account, at least in part, for a relatively high likelihood (1 in 3) that a given humanitarian assistance project will be canceled.

Although often frustrated by too little time to prepare for the missions, managers find them highly rewarding personally and professionally, and volunteer for additional humanitarian assistance projects. Typically, specific project activities involve tasks such as patient care and donation of excess property, and the projects are generally short-term. Only rarely do personnel engage in anything longer term than the duration of their own short deployments. Very few re-contact anyone in the host country with which they worked, and fewer still write any kind of after action report, or out-brief the country team or their higher headquarters upon project completion. Publication of findings is rare and will likely document process measures such as numbers of patients seen, or short-tons of supplies transported rather than providing any information on the outcomes, impact, or effectiveness of the project for its humanitarian, training, or political values.

Often the DoD assets available or a provider's perceptions or interests define humanitarian assistance project scope rather than an assessment of host country needs. With little specific training in humanitarian assistance, many participants simply tend to do what they know best. In the case of medical projects this usually means taking care of patients. DoD should develop new kinds of humanitarian missions such as helping host nation medical colleagues improve their capacity and capabilities, and otherwise build the infrastructure so that host nations become less dependent upon foreign assistance. Obviously, such missions are more complex, and probably longer term than short-term patient care visits. The focus should shift from minimally planned, short-term projects executed by personnel who, while highly motivated and enthusiastic, are not specifically trained. The goal should be to conduct comprehensively planned, longer-term developmental efforts conducted by trained personnel in a coordinated civil-military cooperative approach. For medical humanitarian assistance for example, this shift might target public health interventions rather than individual patient care encounters as an important means by which DoD can improve the effectiveness of overseas medical humanitarian engagement programs.

Table

Table 1. Selected Comments of DoD Participants in Military Medical Humanitarian Assistance Projects.

- **“Move away from the "band aid" programs,** (direct medical care on a short term basis) **towards more sustainable projects.”**
- “Whatever we accomplish must be in concert with the locals' usual way of life. We need to learn more from the locals and **not always assume that Western Civilization knows best.”**
- “More funding to NGOs and less military participation or **adequately supply the military with the necessary manpower and finances to tackle this new mission effectively.”**
- **“Standardize joint doctrine** for size and composition of task force…”
- **“Better define goals** that are sometimes poorly defined in terms of what recipients want and what will be of lasting benefit to them.”
- “In a non-disaster shelter, these people need engineers to improve their infrastructure, educators to teach them healthy lifestyles, and lots of time to change societal norms. **They really don't need medical care.”**
- “All teams…**required to report their findings/ accomplishments** via a conference or website to help others learn and hopefully avoid their mistakes!”
- **“Should focus on more long-term impact** in some cases. Medical missions tend to be directed at giving Tylenol or Motrin when focusing on immunizations for children would have greater impact. Information exchange and medical equipment exchange also have the capability of lending long-term medical impact.”
- **“I strongly recommend that short-term efforts (e.g. 2 weeks in country) of treating local people be abolished. Expectations are raised and greater damage is done than good. *It is vital that health care personnel be involved in the planning of the mission from the beginning.”***
- “We need to **develop specific operational planning for each global region to meet the demands and requirements of diverse cultures.** Select a pool of healthcare providers with expertise in customs/language of each region, create teaching guidelines to educate our young airmen/officers in Humanitarian Assistance (HA)/Military Operations other than War (MOOTW) as we get more involved in these operations.”

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