SOLLIMS SAMPLER

Targeting Peace & Stability Operations Lessons & Best Practices

Volume 3 Issue 4

Medical Assistance / Health Services

PKSOI
U.S. Army Peacekeeping and Stability Operations Institute

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FOREWORD

Welcome to the October 2012 edition of the Stability Operations Lessons Learned and Information Management System (SOLLIMS) Lessons Learned "Sampler." The general structure of the "Sampler" includes (1) an **Introduction** that provides an operational or doctrinal perspective for the content, (2) the Sampler **"Quick Look"** that provides a short description of the topics included within the Sampler and a link to the full text, (3) the primary, topic-focused Stability Operations (SO)-related **Lessons Learned report**, and (4) links to **additional reports or other references** that are either related to the "focus" topic or that address current, real-world, SO-related challenges.

This lessons-learned compendium contains just a sample – thus the title of "Sampler" – of the observations, insights, and lessons related to **Medical Assistance / Health Services** available in the SOLLIMS data repository. These lessons are worth sharing with military commanders and their staffs, as well as civilian practitioners with a Stability Operations-related mission / function – those currently deployed into conflict environments, those planning to deploy, the institutional Army, policy makers, and other international civilian and military leaders at the national and theater level.

Lessons Format. Each lesson is provided in the following standard format:

- Title (Topic)
- Observation
- Discussion
- Recommendation
- Implications
- Event Description

The "Event Description" section provides context in that it identifies the source or event from which the lesson was developed. Occasionally you may also see a "Comments" section. This is used by the author to provide additional personal perspective on the lesson.

You will also note that a number is displayed in parentheses next to the title of each lesson. This number is hyper-linked to the actual lesson within the SOLLIMS database; click on the highlighted number to display the SOLLIMS data and to access any attachments (references, images, files) that are included with this lesson. Note, you must have an account and be logged into SOLLIMS in order to display the SOLLIMS data entry and access / download attachments.

If you have not registered on SOLLIMS, the links in the reports will take you to the login or the registration page. Take a brief moment to register for an account in order to take advantage of the many features of SOLLIMS and to access the stability operations related products referenced in the report.

We encourage you to take the time to provide us with your perspective on any given lesson in this report, or to the overall value of the "Sampler" as a reference for you and your unit/organization. **By using the "Perspectives" text entry box that is found at the end of each lesson – seen when you open the lesson in your browser – you can enter your own personal comments on the lesson**. We welcome your input. We encourage you to become a regular contributor to the SOLLIMS Community of Interest!

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At PKSOI we continually strive to improve the services and products we provide the global stability operations community. We invite you to use our web site at [http://pksoi.army.mil] and the many functions of the SOLLIMS online environment [https://sollims.pksoi.org] to help us identify issues and resolve problems. We welcome your comments and insights!

CAMP SHAHEEN, Afghanistan – Afghan National Army Surgeon General, Major General Dr. Sultan Gul Totakhil, addressed a room full of military healthcare officials during a Medical Leadership Conference held in Regional Command North. The 7th ANSF Medical Shura was assembled to give the medical community an opportunity to discuss future transition plans. US Navy Photo by Mass Communication Specialist 2nd Class Nicholas A. Garratt, 18 October 2011.

INTRODUCTION

Welcome to the October 2012 edition of the Peacekeeping and Stability Operations Institute (PKSOI) Lessons Learned "Sampler." The focus for this edition is on **Medical Assistance / Health Services**.

In the aftermath of a natural disaster or violent conflict, it is not uncommon to find that healthcare systems have collapsed, health information/records cannot be found, and communication systems have broken down. Other significant challenges frequently confronting health sector planners/practitioners include shortfalls in knowledge/understanding of the immediate healthcare needs of the population, low/reduced capacity of the host nation healthcare system to absorb external assistance, and a lack of synchronization among healthcare providers.

In the face of these challenges and the many other demands posed by humanitarian assistance/disaster relief (HA/DR) and post-conflict stability environments – where U.S./coalition forces and international organizations endeavor to meet the pressing medical needs of the indigenous population – U.S./coalition forces face the additional challenge of not interfering with, nor overshadowing, local medical authorities and practitioners:

> *Of note, medical care must be provided in partnership with host nation health care providers, whenever possible, to protect and sustain the host nation's long-term medical capacity. There is a frequent, unintended consequence of providing a Western standard of care when local doctors and pharmacists cannot compete with the free, high-quality health care and medications provided by well-meaning…medical forces. An initial medical assessment, conducted in consultation with local medical authorities who understand the local medical infrastructure, is essential in preventing the displacement of local practitioners.*
>
> *[Humanitarian Assistance and Disaster Relief Lessons Information Paper, Joint Center for Operational Analysis (JCOA), July 2011]*

Ensuring long-term sustainability of healthcare services is always a major issue for stability planners/practitioners: Which actors should be involved in planning and implementing health sector reform for the host nation? What expertise is needed? What should be the role of non-governmental organizations (NGOs), other international organizations, and the Diaspora? How can cooperation/ collaboration be facilitated? What should be done to lay a foundation for success for the host nation's Ministry of Health? How should success be measured?

This Sampler seeks to explore these and other questions about medical assistance and health services for HA/DR and post-conflict stability operations. Key thoughts and recommendations are captured in the **Conclusion** paragraph.

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Sampler "Quick Look" – Medical Assistance / Health Services

Click on [Read More ...] to go to Sampler topic.

- The ability to provide competent and appropriate "expeditionary medical services" is perhaps one of the most urgent and critical capabilities needed when responding to conflict-related crises or natural disasters… **[Read More ...]**

- It is possible to contribute successfully to the restoration of disrupted health services no matter the challenges. …"Investment" in health service development is essential – to alleviate suffering, contribute to the peace process, and provide long-term return in terms of equity, efficiency, and effectiveness of services. **[Read More ...]**

- During the 2010 earthquake relief operation in Haiti, a myriad of organizations carried out disaster relief roles, but no collective command and control structure was in place to manage the whole effort. **[Read More ...]**

- In general, medical logistics was a problem in Haiti; in addition, there was a significant lack of awareness – at the tactical, operational, and strategic levels – of what medical capabilities and capacities were available… **[Read More ...]**

- Good progress has been made in the field of Humanitarian Assistance and Disaster Relief (HA/DR) over the last several years. …Unfortunately, mega disasters, by definition, are not predictable. **[Read More ...]**

- The combined efforts of the UN's "Cluster Approach," the Pakistan Army, and international military forces provided relief and recovery efforts after the Pakistan earthquake of 8 October 2005. **[Read More ...]**

- Health sector reform efforts in Iraq during the 2003-2004 timeframe were largely unsuccessful. The U.S.-led coalition made minimal progress in building Iraqi healthcare capacity. **[Read More ...]**

- Nation-building efforts cannot be successful without adequate attention to health. …Seven case studies were used to analyze the effect of health on post-conflict reconstruction and development. **[Read More ...]**

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3 October 2012

Subject: SOLLIMS REPORT – MEDICAL ASSISTANCE / HEALTH SERVICES

1. GENERAL

A wide array of players – various U.S. Government (USG) civilian and military organizations, coalition partners, non-governmental organizations (NGOs) and other international actors, and host nation (HN) government authorities – are typically engaged in providing medical assistance and health services during both humanitarian assistance/disaster relief (HA/DR) operations and post-conflict stability operations. Their contributions are absolutely vital for restoring the social well-being of the host nation.

Reports from health practitioners – entered/stored in SOLLIMS – provide a great number of insights with regard to achievements and shortfalls in the provision of medical assistance / health services on recently conducted HA/DR and post-conflict stability operations. They also provide a range of recommendations for future operations. Samples of those reports/lessons are presented here.

2. OBSERVATIONS & RECOMMENDATIONS

a. TOPIC. Medical Services as Part of an Overall Stability Operations Strategy (758)

Observation.

The ability to provide competent and appropriate "expeditionary medical services" is perhaps one of the most urgent and critical capabilities needed when responding to conflict-related crises or natural disasters – when large numbers of people are displaced or injured by violence, earthquakes, hurricanes, flooding, tsunamis, etc. In these situations, the host nation, region, or town can be so devastated by the events that essential services are either overwhelmed or become incapacitated. Where robust and modern medical services never truly existed (in some 3rd world countries) – when medical personnel themselves are also among the casualties, and when medical care facilities are significantly destroyed – then the provision of medical services becomes one of the most critical aspects of any stability operations strategy. Time is of the essence during these Humanitarian Assistance/Disaster Relief Operations (HA/DR) – to save lives, alleviate suffering, and prevent additional morbidity or mortality from environmental exposures or infectious diseases. There are significant

challenges to both military medical support elements and civilian non-governmental organizations (NGOs) in being able to provide critical care to the indigenous population. For military medical teams and units – e.g., Combat Support Hospitals – their normal mission is to provide force health protection for the "kinetic" force. Because of this, the local populace may see these medical providers as being aligned more with military intelligence activity and the warfighters. However, as recently reiterated by the Department of Defense, medical HA/DR and other stability operations are now just as important as offensive and defensive operations in the core competencies of the military. For the NGOs, many seek to distance themselves from close association with military forces – to include such "vanilla" activities as having medical supplies delivered by military assets, moving with military forces for local security, or regularly conversing with military patrols in their area. Otherwise, groups such as Al Qaeda (AQ), the Taliban, or other opposing forces can use these passive events to show that NGOs are in league with the military and can then become targets for the insurgents. The result – the populace will not trust NGOs nor will they use the available medical services and facilities. For both military and NGO medical providers, another precept of medical stability operations is to work closely with the host nation (HN) so that priorities are identified, medical support activities are properly coordinated, and HN Ministry of Health programs and services are not disparaged or undermined by the short-term stability operation. Another challenge, particularly in Middle Eastern regions, is understanding the culture as it relates to the medical treatment of women, children, and prisoners/detainees – a very touchy subject. Expect/anticipate that, at best, only female medical personnel will be able to talk to, perform triage for, or treat the indigenous female population.

Discussion.

Security of medical care personnel and facilities must always be kept in mind. Terrorists/insurgents often seek soft targets (those that are not as well-armed as combat units). They like to disrupt HA/DR missions or kill medical or NGO providers/personnel. Example: during the initial UN mission in Iraq, a Vehicle Borne Improvised Explosive Device hit the UN headquarters and killed the head of the UN team. Result: the rest of the UN mission packed up and went home. The overall security plan for stability operations personnel and facilities must always include an ongoing evaluation of security risks and the protection of expeditionary medical services and personnel – without being intrusive. Over emphasis on security requirements or responding with excessive military force can leave the impression that medical services are not there as a priority for the people and can even result in the local populace fearing and fleeing from medical elements.

Immediately after a major disaster, essential medical services are vitally needed to save lives and to prevent more suffering. Failure to provide adequate essential medical services not only brings down the overall standard of living and

wellness of the population, but can also result in a loss of confidence and dissatisfaction with the HN government. (Failure/inability to care for their basic needs can result in a decline in governance and order.)

Expeditionary/emergency medical care: Need to have military expeditionary medical support (EMEDs) forces available 7x24. When responding to a humanitarian crisis – tsunami, flood, etc. – EMEDs forces should deploy within 48-72 hours. They must be nominally self-sufficient for 7-10 days.

When designing a stability operations/expeditionary medical support concept, priority of effort should be determined and coordinated by the HN. Emergency medical services are needed during the early part of a major HA/DR operation, followed by general preventive medicine, public health, hygiene & sanitation, training & education, and building or improving partner capacity.

Special challenges: How to interact with/provide care for women and children / maternal and child health. Mothers are very central characters in many cultures, having control of family, influencing the children/daughters. By training the mothers how to provide basic medical/health care, it results in training of the children and the family.

With regard to providing medical care for detainees/prisoners, it is important to show respect for the Rule of Law and instill professionalism in the detention cadre - for dealing with the most vulnerable, disenfranchised, and often the most reviled segment of the population. Yet some of these detainees may, in the future, become the military, political, or business leaders of the HN. Must be careful to show respect for cultural issues. Don't antagonize the individual, family, community, or local leadership. Ensure application of acceptable humanitarian principles and adherence to Geneva Conventions. This also applies to treatment of combatants and non-combatants in general.

In disaster response situations, there is a tendency for the populace to move away from the disaster site(s) – e.g., flooded areas. Expect massive migrations. Need to be prepared to run/administer refugee communities / internally displaced person (IDP) camps. Expect externally displaced person (EDP) camps in neighboring countries. The people are now located where there are no preventive medical services, no infrastructure, and no professional care givers

Priority of effort: 1) potable water – used for both drinking and cleaning; without this expect a large number of cases of gastrointestinal disorders; 2) disposal of garbage, human waste, and black/brown water [black = sewage/human waste; brown = post-cleaning body and food]; 3) teach good personal hygiene and infection control; and, 4) provide proper and adequate/appropriate shelter, food, and water – e.g., after Hurricane Katrina, relief agencies provided trailers as shelter/homes – but, they were not connected to any sewage system and did not

have electrical power or water; might have been better off with communal toilets and tent shower & bath facilities.

Importance of strategic communication (STRATCOMM): letting people know where to go to get medical attention/care; ensuring that people know who is providing services so that AQ/Taliban cannot discredit or claim credit; countering negative STRATCOMM being broadcast by AQ/Taliban. Use social media as part of STRATCOMM operations. Inform the populace on matters of public health, preventive medicine, hygiene, and warnings about epidemics.

Recommendation.

1. When designing a stability operations/expeditionary medical support concept, the priority of effort should be: emergency/essential medical services, general preventive medicine, public health, hygiene & sanitation, training & education, and improving or building partner capacity. Always work and coordinate with the HN Ministry of Health.

2. Understand and disseminate to medical care givers the cultural nuances related to caring for women and children.

3. Teach detention cadres and medical care givers the professionalism needed to care for prisoners/detainees to ensure respect for the Rule of Law.

4. Use social media to inform the populace of the types of medical care facilities, capabilities, locations, missions, etc. Social media can be useful to help connect patients with medical providers.

5. Respect NGOs and other civilian medical providers' desires to be non-affiliated with warfighters. Any interpretation by the population that the medical service personnel or NGOs are part of the warfighting element can jeopardize the care givers themselves, as well as spread mistrust among the populace.

6. Avoid any activity that creates the perception by the people that the medical services are more a part of “military operations” than a true concern for the health and welfare of the people. Medical services provided by the military or NGOs must be done in close coordination with the HN. Medical services provided by the military or NGOs must not overshadow the HN Ministry of Health because this can ultimately result in a lack of confidence in the government – as well as dependence on a standard of care that might not be sustainable once the expeditionary medical services have departed.

Implications.

Failure to adhere to the concepts and principles outlined in this observation may not only jeopardize the success of medical services in stability operations, but

also the success of the overall strategy for the region, province, etc. On the other hand, successful implementation of medical services can be a tremendous positive influence on the populace, enhancing the probability that other stability operations objectives will be more easily realized and aid in winning the "hearts and minds" of the people.

Event Description.

Extracted from notes taken during live interview with COL Roberto Nang by Mr. Dan French, Chief, Lessons Learned Branch, PKSOI, on 3 June 2011. COL Nang served as Senior Medical Advisor at PKSOI from September 2010 to July 2012. His previous assignments included commanding a medical support and evacuation company in Somalia in 1993, leading a Preventive Medicine team in support of the Nicaraguan Ministry of Health in 1998 following Hurricane Mitch, serving as Division Surgeon for the 1st Cavalry Division 2002-2005 with duty in Iraq, and commanding the 31st Combat Support Hospital 2007-2008 in support of detainee operations in Iraq. Interview is available upon request (MP3 format).

Comments.

Although costly to maintain and train, the ability to quickly deploy expeditionary medical capacity – medical personnel, equipment, and mobile facilities – is vital in this dynamic geo-political world where stability operations are just as important as offensive and defensive operations. The USAF EMEDs program; the light, modular, expeditionary field hospitals of the Army; and, the ship hospitals of the Navy are the right steps in the evolving world of medical stability operations.

Return to "Quick Look"

b. TOPIC. Delivering Health Services in Conflict-affected States (648)

Observation.

It is possible to contribute successfully to the restoration of disrupted health services no matter the challenges. Conflict-affected fragile states typically have the worst health care systems in the world – requiring significant resourcing. "Investment" in health service development is essential – to alleviate suffering, contribute to the peace process, and provide long-term return in terms of equity, efficiency, and effectiveness of services.

Discussion.

Sometimes, transitions from war to peace are brought about by specific, tangible events, such as a peace agreement, or the outright military victory of one side

over the other. In other cases, such as Somalia and the Democratic Republic of the Congo, the process evolves slowly and erratically, and the explicit features of a post-conflict situation only emerge later. Decision-makers are faced with an array of post-conflict situations: poor information base; health actors with a knowledge gap; newcomers not understanding context, language, culture, or history; health sector lacking capacity; uncertain financial, political, and administrative future; uncertain external support; peace-building taking precedence over other competing concerns; fear of relapse of war; conflicting agendas from powerful players; and, urgency to address immediate needs.

Donors should tailor interventions to context, maintain a long-term focus on governance and state-building, and manage transition and hand-over sensitively. Efforts at the national government level need to be balanced with programs linked to local authorities and communities. The quality and availability of essential services, such as health care and primary education, are key measures of governance. Inadequate service delivery therefore is a clear symptom of state fragility. Fragile states also suffer from other deficits of governance, such as political instability and lack of territorial integrity. These deficits hinder efforts to establish the accountability mechanisms between state and citizens that are necessary for effective health service delivery.

Some characteristics of health sectors in states emerging from protracted crises:

- Many of the weaknesses observed in post-conflict health sectors actually pre-date the crisis.
- In most cases, conflict has served to exacerbate the problems of an already fragile health sector.
- In some cases, conflict has resulted in a smaller health service workforce; in other situations, the workforce has grown but lesser-skilled workers have been enrolled into the health sector to meet demand.
- Health sectors respond to crisis in many ways. Because of external funding, ease of access to funds/resources in some cases, and better security conditions, islands of relative privilege may emerge in areas where deprivation is rife.
- Thanks to the presence of humanitarian actors, areas affected by violence may be better served than other comparatively peaceful ones. By that same token, refugees may have access to better health services than people who remained in country / in their local communities.

Efforts to improve service delivery within fragile states face challenges specific to this context. In particular, the socio-political environment may not be conducive to usual foreign assistance initiatives – owing to social fragmentation, governments lacking capacity and legitimacy, and poor relations between citizens and state. Some particular challenges that arise in this situation are:

- Recognizing path dependencies: Interventions will create path dependencies and must be designed with the specific local context in mind.
- Building accountable governance: While this is common in any context, within fragile states external aid can sometimes have the negative effect of further alienating the state from its citizens and undermining its ability to build capacity organically.
- Understanding access constraints: Social fragmentation can leave many groups marginalized, particularly the poor. Understanding these constraints is necessary for designing appropriate interventions.
- Improving women's well-being and opportunities: Women play an important role in promoting social cohesion and reducing conflict. They must be provided with sufficient opportunities and security to participate fully in society.

In facing these challenges, donors must make strategic choices in determining their engagement with fragile states on service delivery. Specifically, they must decide on their method of delivering the aid, the instruments they intend to use, and the priorities they will focus on, given limited resources. These choices and the context in which they are made have several policy implications for donors:

- Tailoring interventions to context: Donors should do contextual analyses and mapping of service realities in order to acquaint themselves with the country situation and to help them design more robust indicators for monitoring short- and long-term progress. In selecting their means and degrees of engagement, donors should seek to strike an appropriate balance, based on risk/benefit analyses of the political realities of different service sectors.
- Long-term focus on governance and state-building: Donors face an ethical challenge in fragile states between achieving short-term improvements in service delivery and establishing a foundation for long-term improvement in governance. To attain both of these goals, donors must be engaged at multiple levels of government within a fragile state, working to promote a mixture of community-driven and nationally-organized programs.
- Managing transition and hand-over: Different fragile state settings require different transition strategies. In stabilizing settings, donors should work with the government to accelerate the transition of service provision from external and non-state actors back to state mechanisms. Deteriorating settings, on the other hand, necessitate a decision on whether or not to engage with the government. If the decision made is to not engage with the government, a strategy focused on community and locally-led service delivery may be most effective.

Main actors involved in the health care sector are as follows: Official funding agencies (bilateral and multilateral donors); informal funding agencies (e.g., charities and private contributors); government (central and local authorities);

rebels; United Nations (UN) agencies; international transitional authorities and peace-keepers; military (indigenous and foreign armies); non-governmental organizations (NGOs), international and local special programs (e.g., the Polio Eradication Initiative); private for-profit entrepreneurs (e.g., health care facilities, laboratories, training outlets, suppliers, etc.); and, users of health services.

Recommendation.

1. Adopt a sector-wide appraisal of the factors affecting health service delivery.

2. Repair existing, damaged health management systems whenever possible, before or instead of rushing to introduce new ones.

3. Do not develop recovery plans without realistic assessments and sound forecasts of available resources and capacity.

4. Recognize that certain structural changes caused by a deep, protracted crisis are irreversible.

5. "Align" – as far as feasible – donor procedures, systems, and approaches with host nation systems.

6. Introduce aid management tools, such as trust funds and pools that oblige participants to harmonize their activities.

7. Establish aid coordination mechanisms, even in the absence of a recognized central government.

8. Conduct comprehensive planning for health sector operations as early as possible.

9. Invest early in the systemic analysis of the health sector and health service delivery.

10. Introduce measure to address deep-rooted systemic distortions. Such distortions may include biases toward tertiary hospitals and curative treatment, an under-skilled workforce, and perverse incentives.

11. Introduce rational and progressive drug management systems.

12. Introduce standardizations and common policies.

Implications.

- Donors will need a long-term focus on governance and state building. Short-term efforts typically concentrate on ensuring essential health services for those

in urgent need. The key for donors is to strengthen public health institutions for sustained development.

- Decision points will include whether a state can be a viable aid partner and what appropriate level of alignment and engagement should take place. If the state/central government is not a willing partner, then possible entry points include certain ministries, regional/local governments, and/or the public sector. However, the central government will have to be involved, to some degree, as long as there is some capacity for policy and program coordination.

- Donors will need to carefully consider the political dimension in their programs. Health sector work should support the objectives of state building and help reduce conflict. A phased transition strategy should rebuild healthcare services. An example of this phased strategy is as follows: 1) emergency re-establishment of services; 2) establishing policy framework and planning; 3) hand-over to host nation and capacity development initiated; and, 4) hand-over completed.

- Intervening nations and international organizations will have to be flexible as the fragile state undergoes fluctuations in stability and crisis. Donors will need to adapt aid to the situation – whether to reinforce the government or certain private institutions or a combination of the two.

- Health service strategists and planner need to be realistic about a sustainable health care system. A fragile or post-conflict state will already be marked by distress, lack of basic resources, poverty, and operational constraints. Sustainability should be examined in terms of technical, financial, and political dimensions. At the strategic and operational levels, goals and objectives must be set so that practitioners can achieve them at modest levels in early phases. As experience and capacity grows, practitioners can achieve higher standards and goals.

Event Description.

This observation is based on the following two documents:

- Background paper "Health Service Delivery in Post-Conflict States," from the High-Level Forum on the Health Millennium Development Goals (MDG), held 14-15 November 2005 in Paris, France.
- OECD/DAC Discussion paper "Service Delivery in Fragile Situations: Key Concepts, Findings and Lessons," by the Organization for Economic Cooperation and Development (OECD), May 2008, based on the work of the Development Assistance Committee (DAC), which is the principal body through which the OECD deals with issues related to cooperation with developing countries.

c. TOPIC. "Whole of International Community" for Foreign Disaster Relief (700)

Observation.

During the 2010 earthquake relief operation in Haiti, a myriad of organizations carried out disaster relief roles, but no collective command and control structure was in place to manage the whole effort. The U.S. Agency for International Development (USAID) served as the lead agent for the United States, however, it relied heavily on the supporting effort provided by the U.S. military to manage the effort. The U.S. military's Joint Task Force-Haiti (JTF-Haiti) was the driving force for planning and delivering relief in the initial/emergency phase of the operation. Additionally, JTF-Haiti took a lead role in organizing and synchronizing a large part of subsequent (post-emergency) relief efforts through a number of innovations in partnering, coordinating, communicating, and building unity of effort among the participating organizations. In a disaster relief operation of this magnitude, such work to gain a "whole of international community" approach is invaluable for gaining efficiencies, saving lives, and mitigating suffering.

Discussion.

The devastation in Haiti resulting from the 7.0 magnitude earthquake of 12 January 2010 prompted the longest and largest U.S. military effort in a foreign disaster relief operation. At the peak of Operation Unified Response, in February 2010, JTF-Haiti was comprised of over 22,000 service members, 58 aircraft, and 23 ships. Within just two days of the disaster, on 14 January, the headquarters for JTF-Haiti was established by U.S. Southern Command (SOUTHCOM) – to conduct humanitarian assistance and foreign disaster relief operations in support of the lead federal agency, USAID.

JTF-Haiti assumed responsibility for all U.S. forces and began directing activities to assist in providing timely relief. The Department of Defense (DoD) ordered elements of the Global Response Force (the XVIII Airborne Corps assault command post, 2nd Brigade/82nd Airborne Division, and 58 rotary-wing and fixed-wing aircraft) and the USS Carl Vinson, USS Bataan, USS Nassau, and USS Carter Hall to the JTF-Haiti mission. These forces, along with personnel from the SOUTHCOM staff, the Joint Force Special Operations Component, and the 3rd Expeditionary Sustainment Command, provided the crux of JTF-Haiti's assets.

In the initial emergency phase, the 2nd Brigade/82nd Airborne, under the direction of the JTF-Haiti headquarters (the core of which was the XVIII Airborne

Corps assault command post) conducted and supported continual humanitarian aid distribution missions (interagency missions) in the heaviest impacted areas of Port-au-Prince. 16 distribution sites were established to provide food, water, and medical care – for well over 1 million people. On 20 January, the U.S. Navy hospital ship ***USNS Comfort***, equipped with surgical operating teams and orthopedic surgeons, arrived and began conducting round-the-clock medical support.

Because of the rapid deployment of the DoD Global Response Force, JTF-Haiti helped avert a major food and water crisis. Although more than 230,000 people died from the earthquake, the abundant and superior medical assistance provided by the U.S. military and the international community saved thousands of lives.

From the outset, JTF-Haiti planners and leaders worked alongside counterparts from the United Nations Stabilization Mission in Haiti (MINUSTAH), USAID, and non-governmental organizations (NGOs). Together they developed plans for protecting internally displaced persons (IDPs) in makeshift camp – who were at great risk of further disaster due to the impending hurricane season and potential flooding. In February and early March, JTF-Haiti elements conducted comprehensive infrastructure assessments and then executed various engineering projects – with the UN and NGOs – to mitigate the risk and reduce the number of people requiring relocation. Then, from mid-March through mid-May, JTF-Haiti supported the Haitian government and UN, USAID, and NGO partners by relocating IDPs from sites still at risk to transitional resettlement sites.

JTF-Haiti's Maritime Component Command, comprised of the 22nd and 24th Marine Expeditionary Units, conducted relief missions outside Port-au-Prince, to the west and to the north. Using the flexibility inherent in amphibious forces, these units brought relief to thousands of Haitians in the outlying regions.

Although the deployment of U.S. military forces and U.S. resources was quick and effective, it was not always efficient. The most significant challenge to the U.S. military – and to the international community – was logistics. Three specific areas presented major challenges to JTF-Haiti's logistical operations (and those of the international players):

- "Incomplete situational awareness" at the outset made it difficult to determine requirements and priorities for providing relief and delivering supplies.
- The "lack of a unified and integrated logistics command and control structure" led to gaps in reception, staging, and movement of forces, equipment, and supplies into Haiti. Logistics staffs were not always aware of many non-military activities and cargos.
- The "initial reliance on the one single airport" (Toussaint Louverture International Airport) for throughput, created the need to validate and

prioritize all flights (including international flights) to ensure that only the most critical cargo landed.

JTF-Haiti had a proven logistical system to manage its own requirements; however, it was not designed for managing external flights, requirements, cargo, etc. In spite of this challenge, however, JTF-Haiti's airmen were able to increase flights at the international airport from 13 per day (pre-quake) to a peak of 150 per day. However, even this capacity fell short of the demand. SOUTHCOM's 12th Air Force, in coordination with the UN, then developed a system of time-slots and priorities – driven by the Haitian government – that at least served to meet Haiti's major requirements on a day-to-day basis.

The earthquake had rendered both of the two main piers of the Port-au-Prince seaport as "unusable." JTF-Haiti, with assistance from U.S. Transportation Command, quickly established a Joint Logistics Over-the-Shore capability to bring supplies in from the sea. This doubled the number of shipping containers received in Haiti from pre-quake numbers. Also, JTF-Haiti established a temporary port capability at the Port-au-Prince seaport through the use of two contracted Crowley barges. This further enhanced the flow of supplies into Haiti and reduced some pressure on the international airport.

From the beginning, the focus of JTF-Haiti was to save lives and mitigate suffering. Security – to protect the people from gangs, looting, and acts of violence – was also an initial concern. However, JTF-Haiti's close working relationship with MINUSTAH and the cooperation and professionalism by MINUSTAH in conducting security operations enabled the JTF to focus its efforts on humanitarian assistance operations. In the first few days following the earthquake, General Keen and the MINUSTAH force commander, Major General Peixoto (Brazil), discussed the necessity and a concept for a safe and secure environment. Bringing their staffs together on this issue ensured that priorities and workloads were aligned. It enabled MINUSTAH to provide the requisite security, while JTF-Haiti could then focus on delivery of food, water, and emergency medical care. Regular meetings between forces contributed to unity of effort and mission accomplishment.

Another excellent example of partnering was the development and execution of the first major food distribution plan for Operation Unified Response. JTF-Haiti, the World Food Program, MINUSTAH, and various UN agencies contributed to this effort through joint and combined planning. The locations for 16 food distribution sites throughout Port-au-Prince and its surrounding communities were mapped out, requirements determined, and concepts of operation written, and then these critical sites were rapidly established and supported – for initial deliveries and sustained distribution. Through these nodes, and through the teamwork and communication between these partners (prompted and facilitated by JTF-Haiti), more than two million Haitians received much-needed food and water on a regular basis.

JTF-Haiti's "Humanitarian Assistance Coordination Center" was the key node for facilitating the coordination and collaboration between JTF-Haiti and its partners. This coordination center (manned by 30 military personnel, including one general officer) pulled together and tracked the efforts of JTF-Haiti, MINUSTAH forces, the UN humanitarian community, USAID, and numerous NGOs. The center, as well as the bulk of JTF-Haiti, operated on unclassified information systems and used commercially available programs/tools to build a humanitarian assistance Common Operating Picture – shared with all participants.

On the information front, Facebook and Twitter were also used, not only to collect and disseminate information, but also to counter possible misinformation. JTF public affairs personnel used cameras on their cell phones to "Twitpic" key activities and then post them on Twitter and on JTF's Facebook page. JTF-Haiti's Joint Information and Interagency Center also contributed to the JTF's information management and communication efforts. One of the key products from this center was daily talking points – which provided the overall communication goal, target audiences, themes, and top-line messages.

Although the U.S. administration had issued guidance that the Haitian relief effort was to be a unified whole-of-government effort with USAID as the federal lead agency, the roles, responsibilities, authorities, and required capabilities of USAID and other players were not clearly defined. There were no specifications on subordinate relationships or divisions of labor. USAID had too few personnel on the ground to form and lead the robust planning that was required early on for a crisis of this size and scope. Therefore, JTF-Haiti provided a number of planners to USAID to assist on the complex initial planning effort.

The close proximity of JTF-Haiti to the U.S. Embassy was a key factor for facilitating the desired whole-of-government response. The JTF established its headquarters next to the American embassy, which was close to the MINUSTAH headquarters. This physical co-location greatly simplified coordination, collaboration, and communication. Staff working relationships were quickly developed, and these relationships paid dividends throughout the operation. Additionally, liaison officers provided to/from JTF-Haiti also greatly benefited communication and unity of effort.

Initially, the JTF commanders and staff did not fully appreciate the number of humanitarian organizations that had been in Haiti since before the earthquake. There had been over 1,000 NGOs working with the UN Office of Coordination and Humanitarian Assistance in Haiti. However, within the first couple weeks, JTF leaders quickly teamed with the UN Coordination Support Committee to develop UN-approved coordination processes – in which requirements were raised, validated, and passed to the appropriate organizations. JTF leaders also worked to coordinate requirements and activities within the UN "cluster system" to further ensure unity of effort.

In the first few weeks, it became apparent that the biggest challenge facing the Haitian government was IDPs – especially those who had set up spontaneous settlements in areas prone to flooding. At the strategic level, the JTF and USAID worked closely with the UN and the Haitian government to develop an IDP strategy. Soon thereafter, JTF engineering projects were carried out – which mitigated the risks for camps that had been assessed as likely to experience flooding during the rainy season (9 major camps). Also, approximately 6,000 people at other camps/sites needed to be moved to safer ground. To complete the operation, the JTF provided the requisite engineering support, transportation assets, and civil affairs teams in a UN-led effort, and the endangered people were moved to safety. Various other relief efforts continued well after this IDP protection/relocation project – and the partnering and unity of effort prompted by JTF-Haiti's innovations continued to enhance success.

Recommendation.

The authors of the article "Foreign Disaster Response: Joint Task Force-Haiti Observations" – Lieutenant General P.K. (Ken) Keen and three Army officers who served in JTF-Haiti – provide the following recommendations that the U.S. military, interagency, the UN, and the international community can apply for future disaster responses:

1. Develop a more robust and capable disaster response assessment and initial life-saving response team. The Global Response Force was invaluable, but greater situational awareness was needed to set priorities and drive logistics.

2. Have combatant commands maintain a JTF-capable force (with Joint logistics capabilities adaptable to external requirements), trained and ready to deploy in support of a foreign disaster relief operation with the Global Response Force.

3. Develop an international disaster response framework for nations to deploy civilian and military capability to respond to disasters – a framework that allows inclusion in planning, logistics, and information systems.

4. Conduct exercises (with U.S. agencies, partner nations, and the UN) to develop relationships and refine processes and systems.

5. Codify the use of coordination centers like the U.S. JTF-Haiti Humanitarian Assistance Coordination Center and the UN Coordination Support Committee; make them adaptable to any existing partner-nation center.

6. Develop and codify unclassified information-sharing tools like JTF-Haiti's humanitarian assistance Common Operating Picture; make them adaptable to any partner-nation's existing system.

7. Examine how best to integrate and support the NGOs and the public/private sector in support of humanitarian assistance/foreign disaster relief. Consider integration in both assessment teams and response teams.

8. Tackle the internally displaced persons challenge immediately. Identify IDP issues and develop appropriate solutions.

Implications.

If a disaster response framework is not developed to accommodate a "whole of international community" approach, and if exercises (involving U.S. agencies, partner nations, and the UN) are not conducted to clarify and develop relationships and to refine processes and systems, then USAID, DoD, State and others will be building support in an ad hoc manner – rather than a systematic/ practiced manner for quickly delivering and efficiently sustaining relief to disaster victims.

Event Description.

This observation is based on the article "Foreign Disaster Response: Joint Task Force-Haiti Observations," by Lieutenant General P.K. (Ken) Keen and Lieutenant Colonels Matthew G. Elledge, Charles W. Nolan, and Jennifer L. Kimmey (U.S. Army), Military Review, November-December 2010.

Comments.

- A related article, which discusses the use of new (unclassified) information systems to improve information-sharing and management during disaster relief operations is "Haiti Earthquake: Breaking New Ground in the Humanitarian Information Landscape," U.S. Department of State - Humanitarian Information Unit, July 2010. See SOLLIMS Lesson 681 for article and associated lessons.

- SOLLIMS should be taken under consideration by combatant commands and JTFs for meeting recommendation #6 above (i.e., Develop and codify unclassified information-sharing tools like JTF-Haiti's humanitarian assistance Common Operating Picture; make them adaptable to any partner-nation's existing system).

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d. TOPIC. HA/DR Haiti - Jan 2010: Medical Issues (629)

Observation.

In general, medical logistics was a problem in Haiti; in addition, there was a significant lack of awareness – at the tactical, operational and strategic levels – of what medical capabilities and capacities were available – e.g., computed axial tomography (CAT scan), magnetic resonance imaging (MRI), beds, treatment facilities, etc.

Discussion.

There was no organized way to determine what supplies were available in the main logistics caches that grew up at the port and throughout the area. In "pallet city" nothing was clearly marked to show – what is this? to whom does it belong? where is it supposed to go? Additionally, there was often no way to move large amounts of supplies once they had been located

Over time, a Joint Logistics Center (JLC) developed. Unfortunately, however, capabilities did not mature as rapidly as were needed. There was no logistics Common Operating Picture to lay out who was doing what and where supplies were supposed to go.

Although a Humanitarian Affairs Coordination Cell (HACC) developed, it focused mainly at the tactical level. No one was really looking long-term. No medical regulatory body was established to identify the capabilities of each medical facility, track patient management/flow, or manage medical logistics (MEDLOG). The approach was very ad hoc.

Available medical units were not under a central control element – e.g., the medical units that came in with the brigade from the 82d Airborne Division stayed with the divisional troops and under control of a military command. There was a need to better understand/clarify the role of DoD/U.S. military medical elements in support of the Humanitarian Assistance/Disaster Relief (HA/DR) operation.

Recommendation.

1. Consider working medical coordination from a central regulatory body. The medical regulatory body should disseminate a medical Common Operating Picture to all medical players as quickly as possible. The medical regulatory body should have control of all medical capabilities, units, and supplies. Effectiveness is often more important than efficiency.

2. The medical regulatory body may or may not be part of the HACC; do what makes the most sense and what will provide the most responsive medical care for the disaster victims.

3. Use commercial-off-the-shelf (COTS) handheld radios for medical operations when infrastructure cannot support more sophisticated devices. Distribution needs to include non-U.S. medical facilities and activities to better support medical communications in the disaster relief environment

4. Integrate medical logistics into the overall HA/DR logistics concept and its designated storage sites. Provide access to movement capabilities and materiel handling/management capabilities. Work to establish priorities and mark pallets to support rapid location, identification, and distribution of medical supplies.

Implications.

- Inability for medical units, facilities, and sites to communicate with either a central regulatory body or one another will lead to ineffective HA/DR medical operations.

- Efficiency vs. effectiveness. Not every patient requires medical evacuation to sea-based facilities (e.g., the USNS Comfort). If there is a medical Common Operating Picture, it would be possible to get the right help quicker and much more effectively.

Event Description.

Lesson content is based on notes taken during the Joint Center for Operational Analysis (JCOA)-sponsored Haiti Lessons Learned Working Group held at Headquarters, U.S. Joint Forces Command (JFCOM), Suffolk, VA, 23-24 March 2010. The working group was conducted in the format of facilitated discussions; there were no formal presentations made by any of the attendees. The discussions were structured around seven focus areas developed by JCOA. These included:

- Gaining Situational Awareness
- Forming the JTF / Command & Control
- Force Protection / Global Force Management
- Expeditionary Logistics / Sea-basing
- Information Operations / STRATCOMM
- Interagency / NGO Partnerships
- Medical

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e. TOPIC. Haiti Earthquake & Mega Disasters Overwhelm HN Governance, Essential Services & HA/DR JIIM Process (743)

Observation.

Good progress has been made in the field of Humanitarian Assistance and Disaster Relief (HA/DR) over the last several years. More and more, U.S. government agencies [especially the U.S. Agency for International Development/ Office of U.S. Foreign Disaster Assistance (USAID/OFDA)], other foreign government organizations (GOs), Department of Defense (DoD), the United Nations (UN), and non-governmental organizations (NGOs) have increased communications and coordination to increase synchronization and efficiencies during HA/DR operations. Cluster meetings – the gathering of various GOs and NGOs to identify humanitarian needs and priorities to better coordinate and focus relief efforts – and relief websites help to update relief efforts and iteratively identify ongoing needs of the community that the GOs/NGOs work to address, often on a real time basis. Keys to successful HA/DR operations have been: prioritization of needs and directory guidance of relief efforts by the host nation; determination of HA/DR objectives, endpoints, and when to transition from the operation; ***and, adaptable, modular, and rapidly deployable medical capabilities to meet the specific needs created by the disaster***. Unfortunately, mega disasters, by definition, are not predictable. Despite the best efforts of relief organizations in planning for them, the tremendous Black Swan (an unexpected, rare, catastrophic event that devastates and disrupts systems) impacting Haiti in January 2010 overwhelmed host nation (HN) governance, essential services, and even the Joint, Interagency, Intergovernmental, and Multinational (JIIM) coordination of relief efforts.

Discussion.

The Haiti earthquake of 12 January 2010 was a Black Swan disaster. The magnitude of suffering caused by natural phenomena is related not only to the strength of a tornado, hurricane, or earthquake, but also by its proximity and impact on a population, infrastructure, governance, and essential services. The 7.0 magnitude earthquake was unprecedented in its havoc. Originating 10-16 miles from the center of the capital, Port Au Prince (with a population of over 2 million), it destroyed most of the poorly constructed buildings and homes and disrupted government and essential services. The Haitian government, in February 2010, estimated that the quake had killed over 230,000 people, injured over 250,000, and left homeless 1,000,000. Infrastructure damage was so extensive that government services and essential services (electricity, potable water, sewage, etc.) were devastated.

Over 6,000 GOs and NGOS responded to the disaster, and there were several important lessons learned. The Cluster meetings were conducted only in English, which proved problematic, and Cluster leaders did not routinely

coordinate with Haitian medical or government officials. Although the human toll of injured and ill was enormous, relief agencies needed to set objectives and endpoints to properly transition and end their missions. As a result of their not setting objectives/endpoints, several weeks after the disaster and after treatment had been completed for those people immediately injured by the earthquake, Haitian local and central government officials continued to request the presence of relief clinics and hospitals for sustained operations. Many organizations then felt compelled to remain far beyond what would have been reasonable HA/DR objectives and endpoints. Lastly, although the U.S. Army, Air Force, and Navy are moving to establish more modular, adaptable, rapidly deployable medical packages, when a Black Swan disaster occurs, there are important medical capabilities that only robust level 3 or 4 hospitals are able to provide.

Note: A Black Swan event is described by Nassim Taleb in his book, "The Black Swan: The Impact of the Highly Improbable," published in 2007. A Black Swan is a rare event, but its impact is so overwhelming that it can systematically disrupt organizations and systems. Part of the Black Swan discussion is that we rely too much on our limited negative experiential history (non-occurrence of the event). Thus, we continuously underestimate the likelihood of Black Swans. We also tend to underestimate their magnitude or scope. Lastly, Black Swans are often rationalized after they occur by “expert analysts” who never predicted them.

Recommendation.

1. Given the massive disruption of Haitian government and essential services, and the importance of Cluster meetings as nodes for managing services, Cluster meetings should have been held both in English and in French/Creole. Haitian medical and government representatives should have been invited to the Cluster meetings to determine priorities of need for relief efforts.

2. It is important that the initial tenets of HA/DR efforts be identified and noted beforehand to the HN government and local leaders, i.e., to save lives, take care of those injured or ill, and to prevent further pain and suffering.

3. Once the initial casualties are medically treated, it is important to convey and prepare the end-point of relief efforts and the transition back to HN government and HN medical services. Otherwise, relief agencies' missions could become open-ended to the detriment of the HN government and its need to rebuild, increase capacity, and provide essential services.

Implications.

When a Black Swan disaster occurs, as in the case of Haiti (but also in 1st world countries, like the recent earthquake, tsunami, and nuclear plant disaster experienced by Japan on 11 March 2011), there can be such overwhelming destruction and damage that HN government and essential services are widely

disrupted. Even with the loss of electricity, the internet, and email, it is vitally important that Cluster meetings are conducted with at least one HN official in attendance. Massive disasters can so devastate clinics and hospitals that in addition to smaller, modular, and rapidly deployable clinics/hospitals, there is usually a need for the slower deploying, but higher capacity, level 3 and/or 4 hospitals.

Event Description.

These observations were taken from discussions that took place during the U.S. Navy/United States Institute of Peace (USIP)-sponsored NGO Conference, held 24 January 2011 in Washington, D.C. Specifically, observations were based on the first three discussions, led by: 1) Joel Charney, Vice President of Human Policy, Interaction, speaking on "The Haiti Earthquake" and how it was overwhelming in its devastation; 2) Kate Legates, OFDA, speaking on the moves to modular, adaptable, expeditionary medical systems; and, 3) Captain Colleen Gallagher, USN, Captain of the USNS Comfort, speaking on the many medical issues that the Navy encountered while providing assistance and relief for Haiti after the earthquake.

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f. TOPIC. Using the Cluster Approach during the Pakistan Earthquake (643)

Observation.

The combined efforts of the UN's "Cluster Approach," the Pakistan Army, and international military forces provided relief and recovery efforts after the Pakistan earthquake of 8 October 2005. The different entities developed reasonably good partnerships despite the earthquake zone being in an area with military forces, militants, and insurgents involved in current conflicts in the region.

Discussion.

A large magnitude earthquake occurred on 8 October 2005 in Pakistan that resulted in approximately 73,000 deaths, 125,000 injuries, 3.5 million people homeless, and 600,000 destroyed homes. Because no disaster response organization existed in Pakistan, the government directed the Pakistan Army to take charge of relief operations. An Army general was appointed to lead a Federal Relief Commission (FRC). The FRC was intended to coordinate and integrate all relief efforts – from the military and civilian sides. The United States and NATO provided military forces with transportation, medical, and engineering capabilities. On the international side, a United Nations Disaster Assessment

and Coordination (UNDAC) team worked with the Pakistan government, international donors, and UN agencies to develop an emergency response plan.

The decision was made to adopt and pilot the "Cluster Approach," whereby different UN agencies were appointed to lead different sectoral and thematic coordination clusters that operated in four "humanitarian hubs" within the earthquake zone and supported the FRC and Army headquarters in Pakistan's capital, Islamabad. "Cluster coordination meetings" were held in the field hubs, as well as in Islamabad. A "Cluster Heads forum" was established, and this became the strategic decision- making body for the international community's relief efforts.

Points of consideration that were worked during this operation:

- The role of the Cluster Heads
    - Cluster Head forum interaction with the UN Country Team (UNCT) and Inter-Agency Standing Committee (IASC) country team [team/forum involving key UN and non-UN humanitarian partners]
    - Strategic decisions and authority

- "Non-interfering coordination"
    - Military could not task NGOs and UN agencies
    - Military covered gaps in humanitarian actions
    - Some NGOs felt there was a lack of decision-making because they were not "tasked"
    - NGOs remained unaware of how much they were coordinated by "non-interference"

The relief phase was to be transitioned to the reconstruction phase – with the FRC's responsibilities taken over by the Earthquake Reconstruction and Rehabilitation Authority (ERRA). The ERRA was technically a civilian entity, but was still run by Pakistan military officers. The UN Office for the Coordinator of Humanitarian Affairs (OCHA) had been responsible for the relief efforts on the international side during the relief phase. OCHA handed off responsibilities to the United Nations Development Programme (UNDP) for the reconstruction phase. The ERRA and the IASC jointly developed an Early Recovery Plan (ERP) designed to minimize gaps between relief and reconstruction. During the transition, some of the NGOs and Clusters closed down permanently and transitioned to "working groups." The overall perception was that the "Cluster Approach" worked better than previous humanitarian emergency coordination mechanisms.

Recommendation.

1. Get strong HN government "buy-in" and, preferably, align HN government and UN structures to facilitate personal and institutional relationships.

2. Do not double-hat people.

3. Cluster coordinators must have coordination expertise more so than sectoral expertise.

4. Must undertake joint analysis and cross-sector analysis. The "Cluster Heads forum" should do this.

5. Joint, not shared, decision-making should be facilitated by the Clusters.

6. Get base-line data if possible, but if not, agree on key assumptions and move on.

7. Clarify roles of: UNCT, IASC, Cluster Heads, and senior NGOs.

8. Develop procedures for coordinating the efforts of NGOs. Determine whether or not the International Council of Voluntary Agencies (ICVA) should have a field presence in major operations.

9. Set up Clusters as early as possible. When transitioning from relief to reconstruction, keep the Clusters open, rather than closing them down and transitioning to "working groups."

10. Develop the Early Recovery Plan (ERP) early.

11. Allow key personal relationships to flourish, and be flexible with human resources.

12. The Pakistan Army provided a platform/control center for all humanitarian organizations. The Army developed coordination mechanisms to track NGO efforts. The military covered operations in remote areas, while NGOs worked in high visibility and accessible areas. The military minimized duplication of effort and emphasized "non-interference."

13. The decision-making process in Clusters needs to be improved. Two distinct Cluster meetings should be held: one meeting for information-sharing and a separate meeting for coordination and planning.

Implications.

- The Pakistan humanitarian effort illustrates how compromises have to be made when the overriding concern is humanitarian assistance. The government and military forces may allow help from insurgent and militant groups. This is a big step in separating humanitarian priorities from political/military priorities.

- Expect that military forces will provide most of the immediate humanitarian assistance and disaster relief because they can quickly mobilize and deploy with large numbers of personnel. Despite concerns, military forces can adapt and work successfully with civilian organizations using an integrated approach. In Pakistan, the only organization large enough and capable enough to handle a disaster of this magnitude was the Pakistan Army. The Pakistan NGOs did not have the capacity to lead, organize, and execute relief/recovery efforts.

- Despite recommendations, a military force does not have to establish a standing organization ready to conduct humanitarian assistance/disaster relief. The Pakistan Army did not have an established organization or office, but by default was made the lead agency in charge of relief/recovery efforts; it capably handled this responsibility.

- Military organizations will have to emphasize neutrality when conducting humanitarian efforts in a conflict area. This is difficult when there are militant and insurgent groups operating in the same area, also conducting relief and recovery efforts. Work may have to be shared or cooperatively managed with groups that are the antithesis of your group or organization.

- In a situation like the Pakistan earthquake relief operation, HN military organizations will have to open up to international and national organizations. The Pakistan Army had to do this despite being a closed institution. It had to become a facilitator for humanitarian organizations and civilians.

Event Description.

This observation is based on the brief "Lessons Learned on the Introduction of the Cluster Approach: Pakistan Earthquake," by the Office of the United Nations Recovery Coordinator (UNORC), January 2007, and the study "Perceptions of the Pakistan Earthquake Response," by Andrew Wilder, Feinstein International Center (Tufts University), February 2008. [Links to these documents are unavailable; however, a related document is: "The Evolving Cluster Approach in the Aftermath of the Pakistan Earthquake: an NGO perspective," ActionAid International, 21 April 2006.

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g. TOPIC. Involving the Right Players in Health Sector Reform (882)

Observation.

Health sector reform efforts in Iraq during the 2003-2004 timeframe were largely unsuccessful. The U.S.-led coalition made minimal progress in building Iraqi

healthcare capacity. It missed a key opportunity to develop an implementation plan for the newly developed vision/strategy for the Iraqi health sector. Although the coalition faced enormous obstacles when it set out to reform the Iraqi health care sector, the real downfall of its efforts stemmed from taking a unilateral approach and not involving the right players.

Discussion.

In August 2003, the U.S.-led coalition in Iraq made a prudent attempt to bring all health sector stakeholders together to discuss reconstruction ideas for the Iraqi health sector. Stakeholders included representatives from the coalition, the United Nations (UN), non-governmental organizations (NGOs), the World Bank, and the Iraqi Ministry of Health. However, a terrorist attack on the UN headquarters in Baghdad resulted in the UN closing its offices in Iraq and truncating its role in post-conflict reconstruction for years to come.

Another major obstacle to the coalition's effort to reform the Iraqi health sector was the lack of knowledgeable national healthcare officials and managers to work with - owing to de-Baathification actions. Through de-Baathification, members of the top four ranks of the Baath party were removed from the civil service, including the Ministry of Health. De-Baathification also dissolved both the national security apparatus and the Iraqi Army. Stand-down of the Iraqi Army immediately deprived the country of almost 20 percent of its national healthcare capacity. Shortfalls in security forces led to looting, violence, and destruction of property at numerous healthcare facilities, warehouses, and medical offices. As a consequence, numerous international organizations and NGOs reduced their presence at healthcare facilities because of security concerns.

In the face of these obstacles, the coalition aggressively initiated health sector reform, but operated in a void of expertise. It was missing the key expertise from indigenous personnel (Baath Party members) and the critical knowledge/ understanding gained by UN agencies from decades-long work in Iraq (especially by the World Health Organization) about Iraq's healthcare institutions, systems, and needs. The coalition essentially took a unilateral approach, primarily utilizing its own staffs and a number of Iraqi exiles. In fact, the coalition relied heavily on the Iraqi Diaspora to determine how the Ministry of Health should be restructured and manned, but these expatriates actually had very limited knowledge of the existing Iraqi health sector, its operating procedures, and healthcare issues. Most expatriates had spent at least 25 years outside Iraq. The involvement of these individuals was largely resented by Iraqis working within the health sector, who viewed the expatriates as outsiders and not representative of Iraqi interests. A lack of cooperation became commonplace within the Ministry of Health.

In their efforts to reform/improve the Iraqi health sector, coalition military units and civilian agency representatives wisely scheduled visits to healthcare facilities throughout the country for the purpose of conducting "needs assessments."

However, repeat visits to the same facilities often took place – without prior coordination and without delivery of tangible benefits to meet previously identified needs. Consequently, local healthcare professionals often became disillusioned and grew to believe that their time was being wasted. At many facilities, Iraqi staffs stopped cooperating. Copies of the needs assessments were not left behind with the local staffs, nor were they provided to the Ministry of Health – precluding development of a national data repository, which could have been used by all parties to view, track, and address health sector requirements.

The coalition did initiate a key step toward building host nation healthcare capacity and setting the Ministry of Health up for long-term success. It brought the United States Agency for International Development (USAID) together with the Ministry of Health to map out a long-term strategy in conjunction with donors. USAID and the Ministry of Health arranged seven workshops over the Oct 2003 - Jan 2004 timeframe for this purpose, with various donors, NGOs, and Iraqi healthcare representatives participating. They addressed such areas as a national health information system, women's health, nursing, nursing education, pharmaceutical and medical supplies procurement and distribution, facilities master planning, and a national health account.

Their efforts produced a "vision document" – a comprehensive strategic vision for health sector reform, with goals, objectives, and priorities. However, the "vision document" did not include an implementation plan to help the Ministry of Health select, prioritize, design, and implement projects to meet the goals and objectives and outlined in the document. To compensate for this oversight, the coalition provided short-term training for the ministry staff on ways to develop an implementation plan, but this approach was limited and failed to incorporate the members from the workshops. Meanwhile, the coalition attempted to transition certain hospitals, health clinics, and facility construction projects over to Iraqi control. However, since many of the projects were coalition-driven and had not included Iraqi buy-in when the projects were initiated, no one on the Iraqi side would agree to take ownership and commit to carry the projects through to completion.

Another example of failing to involve the host nation occurred with the transfer of coalition field hospitals. The Iraqi Ministry of Defense had requested the transfer of a number of medical facilities so that Iraqi forces/staffs could continue to provide medical services in certain regions. The coalition decided that only three specific field hospitals would be transferred: at Fallujah, Mosul, and Salah Al-Deen. However, those locations were not a priority for the Iraqis. A series of meetings ensued – between the Ministry of Health, the Ministry of Defense, coalition authorities, and the U.S. Embassy – as the coalition sought to figure out a way to gain Iraqi staffing and have them make use of those three specific field hospitals. Although the facilities were transferred to the Iraqis, they ended up going unstaffed and unused.

On the positive side, the transfer of 16 smaller military health clinics went exceedingly well after representatives from the Iraqi Ministry of Defense had been allowed to participate on all 16 transition planning teams. Iraqi representatives were able to directly interact with the American clinical staffs, learn how the clinics had been managed, and identify what gaps/specialties needed to be filled. They then worked with local officials to gain the requisite staffing, and the clinics were seamlessly kept open and operating. This instance illustrates the importance of gaining host nation involvement and commitment at the outset, which generally was lacking in Iraqi health sector reform efforts throughout in the 2003-2004 timeframe.

Recommendation.

1. Health sector reform planners should attempt to gain a good understanding of the host nation's healthcare history, how the health ministry and healthcare institutions were operating pre-conflict, and what relationships existed between healthcare institutions and their partners (international organizations, NGOs, etc.). Reform planners should conduct a comprehensive needs assessment of the entire health sector – from the national to the local level – and ensure that results are placed in a national data repository at the Ministry of Health.

2. Heath sector reform planners should develop a long-term national health strategy – in close collaboration with host nation officials. Along with the strategy, planners/partners should develop a comprehensive implementation plan to select and prioritize regional and local projects. Projects should be aligned with national health strategy goals and should be sustainable by the host nation.

3. Along with USAID representatives, the coalition/intervening authorities should maximize the use of subject matter experts from international organizations and NGOs, as well as knowledgeable indigenous personnel with history/ experience at the health ministry and at healthcare facilities – when working on health sector reforms, national health strategy, and the implementation plan.

4. Health sector reform planners should establish procedures and systems early on for integrated ("whole of health sector") planning, as well as for continuous information-sharing with host nation partners.

5. Health sector reform planners/practitioners should use caution when involving the Diaspora. Depending on how long these people have been living abroad, they may be out of touch with the latest developments/issues in host nation healthcare. Also, their involvement may raise the sensitivities of local nationals, who might view them as outsiders and not representative of their interests.

Implications.

If coalition/intervening authorities fail to develop an overarching long-term national health strategy and an implementation plan – working hand-in-hand with host nation personnel and drawing upon the expertise of key international organizations and NGOs – then health care reform efforts will likely be inadequate, disjointed, and short-lived.

Event Description.

This lesson is based on the article "Post-Conflict Reconstruction in the Health Sector: Host Nation Perspective," by Shakir Jawad (AL-ainachi), MD; Maysaa Mahmood, PhD; Ali Al Ameri, MD; and, Gregg Nakano, MALD. This article is found in "Transitions: Issues, Challenges and Solutions in International Assistance," PKSOI, 18 Aug 2011.

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h. TOPIC. Securing Health: Lessons from Nation-building Missions (633)

Observation.

Nation-building efforts cannot be successful without adequate attention to health. Health has an important effect, positive and negative, on security. It is inter-related with other areas of nation-building, such as reconstruction and development.

Discussion.

Seven case studies were used to analyze the effect of health on post-conflict reconstruction and development. The case studies included the immediate post-World War II period (Germany and Japan); the 1990s (Somalia, Haiti, and Kosovo); and the post-9-11 conflicts (Afghanistan and Iraq). Success in the health sector can be defined as improvements in water and sanitation conditions, infectious disease rates, mortality and morbidity rates, and food and nutrition conditions during the course of reconstruction. In broader terms, success can also be viewed as how rebuilding public health has affected other areas of nation-building, such as security, economic stabilization, and infrastructure.

There are several variables that contribute to success in rebuilding public health and health care delivery systems. One set of variables is: coordination and planning prior to the post-conflict period. Coordination and planning may be required between different agencies over space and time. Coordination and planning may also be needed within the same agency at different points in time.

Another set of variables is: infrastructure and resource variables. Infrastructure and resource variables describe the levels of effort devoted to improving health and the enabling conditions that allow progress to be made in building infrastructure.

The variables that were described can be used to show the outcomes from rebuilding health in post-conflict countries. The cases of Germany and Japan were most successful; Kosovo and Iraq were mixed cases; Haiti, Somalia, and Afghanistan were the least successful. The least successful countries had poor infrastructure before the conflict or their infrastructure was severely damaged by the conflict. In these countries, overall coordination and planning efforts were also poor or inadequate; the health status of the population was poor; the health care system functioned poorly; and, security was insufficient to support the nation-building effort. Haiti's, Somalia's, and Afghanistan's health care systems relied on non-governmental organizations (NGOs) and international aid even before their respective conflicts.

Kosovo and Iraq were examples where nation-building efforts had good infrastructure and resources, but poor coordination and planning. Reconstruction began with a damaged but operational infrastructure and a system that did not rely on external support. Since nation-building efforts were plagued by a lack of security, the infrastructures were not as stable as those of Japan or Germany. Kosovo and Iraq also experienced multiple challenges within the coordination and planning dimension variables.

Germany and Japan, on the other hand, were examples of countries that had very good coordination and planning, as well as adequate infrastructure and resourcing. These two countries had a high level of security and a damaged yet still functional infrastructure. Owing in large part to these variables, success was more readily achieved – in rebuilding public health and health care delivery systems, as well as in nation-building.

Recommendation.

1. Health as an independent variable. Health programs should be designed to gain support for the host country, because eventually political authority shifts to local control. As part of the reconstruction effort, the health programs must have activities that are clearly visible to the host country citizens. Close attention is needed to coordinate the sequence of health steps taken during three broad, sequenced phases: immediate post-conflict; reconstruction; and consolidation. Three considerations that should take priority are as follows: 1) plan for clinical consequences arising after the use of weapons of mass destructions; 2) quickly address potential outbreak or actual outbreak of communicable diseases; and, 3) quickly provide basic public health needs, such as food and sanitation.

2. Impact of other sectors on Health. Health conditions are deeply impacted by other sectors, including security, basic infrastructure, education, governance, and economic stabilization. The health sector is particularly sensitive to security in at least two ways: 1) direct effects, such as the inability of patients to visit doctors, and 2) indirect effects, such as the inability of health care facilities to function properly.

3. Coordination. Expect to coordinate and plan health efforts with many international and non-governmental organizations involving possibly hundreds of different projects. This is the reality in the current operating environment. Two steps can be used to help improve coordination: 1) establish and support a lead host county agency/organization/system for health, and 2) learn from and replicate successful on-the-ground organizational innovations.

4. Sustainability and the "Tipping Point". Health sector reform must encourage long-term sustainability. The "tipping point" refers to the time at which the government and private sector are able to provide significant health care to most of the country without external assistance. This host country capacity helps ensure that health conditions will continue to improve once external actors leave. Certain actions can be taken to help the host country sustain itself: 1) train indigenous personnel, and 2) be aware of, and train international health personnel on, the host country cultural and social norms and health capacities.

5. Exit strategies. It is difficult to ensure success in rebuilding health programs by leaving (ending support) too early. The case studies examined showed that no effort to rebuild health programs after major combat achieved success in less than five years. Exiting requires a functioning health care system that has at least reached the "tipping point."

6. Performance Metrics. Health programs should emphasize outcomes as a measure of success. Some key health program outcome measures include: life expectancy rate, birth rate, death rate, infant mortality rate, infectious disease rate, and malnutrition status.

Implications.

- The pre-operation planning process will be the critical aspect of health reconstruction, particularly in the current operating environment where reconstruction takes place under tight time constraints and limited resources. A sample planning process for health reconstruction is as follows: preparation; political consensus on health objectives and scope; establishment of coordination system by lead actor; long-term vision for health; prioritized sectors and cross-cutting issues; overall nation-building analysis; time requirements; costing; planning document; team composition refined; implementation and assessments; and, lessons learned. The order and timing of these basic steps can be changed according to the situation.

- Health sector stakeholders must not be wed to rigid plans and must have flexibility built into programs and plans – to change as the situation dictates or as modifications to the overall reconstruction and development plan are developed. Stakeholders must develop sound objectives and outcomes and ensure the plan supports the specified outcomes.

- Health reconstruction plans stand a better chance of success if consensus is sought among stakeholders. A health program or plan should include most, if not all, stakeholders' issues and capabilities. This enables broader consensus to the plan. No single organization or agency has the capability to completely provide all of the necessary health resources: health professionals, specialists, planners, administrators, logisticians, equipment suppliers, and so on.

- Health sector personnel will need to work closely with host nation counterparts and stakeholders from other reconstruction sectors. The health reconstruction plan will have to be integrated into the larger reconstruction and development plan. Case studies have shown that many other variables, besides those related to health sector planning, will affect the outcome.

- If the health reconstruction plan is not adequately coordinated with health community stakeholders and other reconstruction sectors, there may be adverse planning impacts and operational outcomes. Important issues and capabilities may be missed during planning which could affect the desired endstate. The deliberate planning process and effective coordination must be conducted prior to personnel conducting operations in the host country.

- Without integrated planning, the formulated objectives and outcomes will not include essential inputs or agreements from some of the health organizations and stakeholders. It is important to include the major health sector actors and organizations so that issues can be identified, solutions developed, and actions synchronized before a mission or operation. The major health organizations and stakeholders have the clout, expertise, and resources needed to support health initiatives and long-term programs.

Event Description.

This observation is based on chapter nine of the RAND monograph, “Securing Health: Lessons from Nation-Building Missions,” by lead authors Seth G. Jones, Lee H. Hilbourne, C. Ross Anthony, et al., March 2006. The purpose of the research was to analyze the activities that countries, international institutions, and non-governmental organizations undertake in rebuilding public health and health care delivery systems after major conflict. In addition, this monograph outlines key principles for the success of such reconstruction efforts and identifies lessons learned for future nation-building operations. The findings are based on an examination of seven nation-building cases. Chapter nine (“Evaluating Health Reconstruction”) summarizes the major lessons learned from

the case studies. The RAND monograph can be accessed at the following link: http://www.rand.org/pubs/monographs/2006/RAND_MG321.pdf

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3. CONCLUSION

Medical assistance and health services are absolutely essential for restoring the social well-being of a nation in the aftermath of disaster or conflict. In health sector activities, is imperative that contributing players – i.e., USG civilian and military organizations, coalition partners, NGOs and other international actors, and HN government authorities – gain an awareness of each other's capabilities and contributions early on, and that they cooperate/collaborate in both planning and execution.

Key lessons for health services in stability operations:

- Treat those with the most immediate health risks while restoring basic health services for the broader population.
- Support a sustainable health care system for the population.
- Work closely with host nation health authorities and affected populations to ensure that critical needs are met.
- Respond appropriately and adequately to victims of sexual and gender-based violence.
- Restore communication systems and information systems that support the health sector – especially for providing health information to the public.
- Invest early in a comprehensive assessment of the host nation's health sector and health service delivery.
- Repair existing, damaged health management systems whenever possible, rather than rush to introduce new ones.
- Establish a coordination center to facilitate cooperation among partners during HA/DR operations – e.g., U.S. JTF-Haiti Humanitarian Assistance Coordination Center, UN Coordination Support Committee, etc.
- Utilize unclassified information-sharing tools/platforms (e.g., APAN, HARMONIEWeb, SOLLIMS, etc.) – open to coalition civilian and military actors, NGOs and other international actors, and HN government civilian and military actors – for sharing health sector information.
- Develop a Common Operating Picture (COP) of immediate medical needs and display this COP on the designated information-sharing platform.
- Ensure that medical supplies are adequately prioritized and programmed during logistics planning – to facilitate rapid location, identification, and distribution during operations.

- Establish and maintain a comprehensive national repository of healthcare information (requirements, resources, services, projects, priorities, etc.) – resident at the host nation's Ministry of Health.
- Coordinate continuously with host nation authorities on developing and updating priorities for health services, as well as on developing and tracking plans for the transition of health sector management and health service delivery to host nation control.
- Work with host nation authorities on developing their long-term national health strategy and an associated implementation plan. Include expertise from international organizations and NGOs. Incorporate performance metrics into the plan.
- Respect NGOs and other civilian medical providers' desires to be non-affiliated with warfighters.
- Avoid any activity that creates the perception by the people that medical services are more a part of "military operations" than a true concern for the health and welfare of the people.
- Understand the cultural nuances related to working with women and children in the host nation; educate medical care-givers appropriately.
- Acknowledge the importance of addressing psychological as well as physical needs, and develop programs to address this challenge.
- Consider using social media to inform the population of medical care facilities, locations, and services.
- Establish aid management systems, such as trust funds and pools that oblige donors to harmonize and track their activities.

Through wider dissemination of the aforementioned lessons on health services, through their inclusion in training events and leader education programs, and through senior leader emphasis, significant impacts can be made during planning and execution of future HA/DR and post-conflict stability operations – to the benefit of host nation societies.

4. COMMAND POC

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Related Documents, References, and Links

- "The United States Government Global Health Initiative Strategy Document," the United States Government, 10 February 2011
- "New Perspectives in Health Systems Strengthening: Lessons Learned for Building Stronger, Smarter Systems," United States Agency for International Development (USAID), 17 July 2012
- "The Health System Assessment Approach: A How-To Manual," USAID, May 2012
- "From Humanitarian Assistance and Post-Conflict Assistance to Health System Strengthening in Fragile States: Clarifying the Transition and the Role of NGOs," USAID, 4 December 2008
- "Department of Defense Support to Foreign Disaster Relief (Handbook for JTF Commanders and Below)," Headquarters, U.S. Southern Command, 13 July 2011
- "Humanitarian Assistance and Disaster Relief Lessons Learned Information Paper," Joint Center for Operational Analysis (JCOA), July 2011
- "Guiding Principles for Stabilization and Reconstruction," United States Institute of Peace (USIP) and United States Army Peacekeeping and Stability Operations Institute (PKSOI), October 2009
- "Responding to Natural Disaster: Neglected Dimensions of Preparedness and Their Consequences," The Centre for International Governance Innovation (CIGI), 20 July 2012. This work is licensed under a Creative Commons Attribution - Noncommercial - No Derivatives License. See www.creativecommons.org/licenses/by-nc-nd/3.0/
- "Haiti HA/DR Community of Practice," SOLLIMS
- "HealthSystems20/20," USAID
- "Joint Publication 4-02: Health Service Support," Joint Staff, 26 July 2012

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