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ARMY MEDICAL SUPPORT IN OPERATIONS OTHER THAN WAR: OPPORTUNITY FOR CIVIL-MILITARY COOPERATION

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ABSTRACT

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The mission of the US Army Medical Department is to maintain the health of members of the Army, to conserve the Army's fighting strength, to prepare for health support to members of the Army in time of war, international conflict, or natural disaster and to provide health care for eligible personnel. This mission statement implies providing medical support for "operations other than war" (OOTW), such as peacekeeping, peace enforcement and humanitarian assistance. Military participation in OOTW has increased in recent years and some non-government organization (NGO) representatives have reported that military presence may be perceived as a collaborative action with their activities which in turn risks their political neutrality. Army officials on the other hand consistently conclude that better coordination and cooperation with civilian agencies is the key to success in these operations. This research will examine the relationships that have existed between Army Medical Department players and humanitarian aid organizations and it will attempt to illustrate that of all the military components in OOTW, AMEDD is the likely candidate to establish a template of cooperative efforts with civilian agencies.

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> The choice is about meeting, or not meeting, the challenges of a changed and changing world. The consequences of failure are simply too great.
>
> —MHS 2025 - Toward a New Enterprise

The subject of civilian and military working relationships in peace operations and humanitarian relief missions has been a significant topic of interest, debate, and consternation of late. Since the end of the Cold-War, the international community has been responding to a resounding number of conflicts that target civilians and result in humanitarian disasters and human rights violations. In virtually all of these conflicts, the response and intervention has involved components of the military, intergovernmental organizations (IGOs) and non-governmental organizations (NGOs), making it necessary for dialogue among all parties.[1] The ability of these diverse players to communicate and work well together in the spirit of cooperation is a key factor to the success of any peace operation or humanitarian assistance mission.

The United Nations is the most recognized IGO and the principal actor in peace operations. Since 1948, the UN has authorized fifty-five peacekeeping missions in over twenty-five locations around the world and as of this writing, fifteen operations are concurrently being conducted.[2] Since the end of the Cold-War, the United States military has frequently been called upon by the President to participate in these military operations other than war (MOOTW). In the past decade, new military doctrine that describes MOOTW and methods for planning and executing these missions has emerged, based on the realization that these operations are not about to disappear. Included in the new doctrine is the subject of military involvement in humanitarian assistance (HA) operations and the importance of HA to the success of any peace operation. According to FM 100-23-1, "HA is an important MOOTW that the US military is uniquely qualified to plan and execute. Unlike any other single organization, the military has the organizational structure, educated and trained personnel, essential equipment, rapid worldwide deployability, and ability to operate in austere physical environments."[3] Many civilian humanitarian assistance agencies might take exception to such a claim by the US military, but nonetheless, both military and civilian personnel will find themselves on the same stage, operating to relieve suffering and restore peace. And perhaps it is these relief missions that most critically require extensive communication and cooperation

between civilian and military parties; missions in which human life is at stake, and future survival may be at risk.

The Army Medical Department (AMEDD) is a key player in these missions and in virtually any of these military areas of operation (AO), a humanitarian NGO is or eventually will be present. Some coordination and communication between these parties is inevitable. This paper will briefly examine civil-military relations in OOTW, the role of AMEDD in OOTW and finally illustrate AMEDD's potential for setting the standard in civil-military cooperation.

BACKGROUND

The Army has assisted in disaster relief since just after the Civil War, when commanders were often called upon to respond to tornadoes, earthquakes, floods and disease. The art of medicine was still primitive at this time so it wasn't until the early 20th century, that Army medical assets became the nation's primary source of medical and public health aid in domestic disasters.[4] Following WWI, the Army found itself at odds with Congress over relief aid funding and in dispute with the Red Cross over authority in disaster operations. As a result, AMEDD participation in disaster relief declined significantly. After WWII, the creation of federal, state and private sector relief agencies further deterred AMEDD participation in disaster relief and AMEDD assistance was limited to instances only when these civilian agencies became overwhelmed. But after WWII, the United States began participating in disaster assistance overseas and although much of the coordination was orchestrated by these same civilian relief agencies, Army medical personnel were frequently called upon to render assistance.[5] It was during these times that perhaps the stage was being set for the establishment of civil-military relationships that would require solid coordination and cooperation in order to achieve the maximum benefit for those requiring assistance.

The Army involvement in foreign disaster assistance has obviously evolved since the end of WWII. The world has changed and as such, the strategic security environment has changed requiring the Army to respond to new and unique threats to our national security. To accommodate these changes, Army doctrine has been rewritten to address such responses that have come to be referred to as operations other than war (OOTW). Two examples of OOTW, peace operations and humanitarian assistance, are critical for today's Army in order to help create and sustain conditions that are necessary for peace. Peace operations include peacekeeping and peace enforcement activities and have become a fundamental mission in support of our national security strategy.[6] Humanitarian assistance (HA) operations are conducted to relieve or reduce the results of natural or man-made disasters or other endemic

conditions such as human pain, disease, hunger or privation that might present a serious threat to life.[7] Army forces generally conduct HA operations in conjunction with peace operations with the intent and purpose to supplement or complement the efforts of the host nation civilian authorities or agencies responsible for providing such assistance.[8] Additionally, HA operations are conducted by the Army under appropriate treaties, memorandums of understanding, US fiscal authority and foreign policy.[9]

Voluntary and private organizations have also responded to these changes in the world and to the emerging threats to peace, security and human dignity. By the middle of the twentieth century there existed an abundance of aid organizations throughout the world and today, the number of NGOs alone has swelled to over 16,000.[10]

By common definition, an NGO is, "a private, self-governing, not-for-profit organization dedicated to alleviating human suffering; and/or promoting education, health care, economic development, environmental protection, human rights, and conflict resolution; and/or encouraging the establishment of democratic institutions and civil society."[11] Furthermore, NGOs are typically associated with one of four functional categories; humanitarianism, human rights, civil society and democracy building, or conflict resolution.[12] Given this definition, it is understandable that the Army and NGOs will be participating in many of the same missions around the world.

MEDICAL SUPPORT IN OPERATIONS OTHER THAN WAR

All military operations call for the provision of medical support. Army medical support in OOTW can encompass a variety of missions. It may include civilian assistance in disaster relief, or medical support to US and coalition forces in a peacekeeping operation, or it may entail the distribution of medical supplies and actual provision of care in a HA operation. But history has shown that medical support in OOTW, even in the case of having a clear mission statement at the onset of an operation, tends to expand or fall victim to what is commonly referred to as "mission creep." This happens for a variety of reasons. One reason is that AMEDD personnel may become aware of the medical needs of the local civilian population or coalition forces. For example, during Operation Restore Hope, there was a tendency to want to use excess medical capacity for purposes that went beyond the original mission. AMEDD personnel were motivated to participate in the humanitarian relief effort and treat the Somali nationals. They saw an overwhelming medical need in the community and they saw it as a way to maintain their clinical proficiency.[13] Or the medical mission may expand at the request of outside agencies as was the case during United Nations Protection Force (UNPROFOR) in the Balkans. The medical

mission was to provide medical support to UN peacekeeping forces only. During the initial rotation, the Army strictly adhered to the mission and to the specific policy of not treating refugees as the situation was too fluid with constantly shifting ethnic alliances. Some AMEDD personnel did, however, submit requests to voluntarily treat refugees during their time off but their requests were denied. But soon after the Air Force took over the medical rotation, the US State Department and UN requested that they treat refugee children and adults in the Air Force hospitals.[14] This significant expansion to the medical mission has affected the other military services, as subsequent rotations to the AO have continued. These two examples illustrate how AMEDD can easily and quickly become involved in HA.

But regardless of how and why AMEDD participates in HA, the planning, preparation and execution for such missions can be critical to the success of the overall mission. The impact of the health threat as a contributing factor to social, political, and economic stability in both peace and other operational environments cannot be underestimated.[15] Typically these missions are conducted in regions where the host nation health care infrastructure has been destroyed and where there is a large number of refugees. Medical planning must consider factors such as the status of these refugees and the condition of any remaining host nation infrastructure. Planners must also consider the vulnerability of medical activities and resources during these operations as insurgents and/or terrorists may not recognize or acknowledge the implied protection of medical assets by the Geneva Convention.[16] Additionally, there are dilemmas associated with providing this type of humanitarian medical support during OOTW. For example, what level of care should be provided particularly when the host nation medical capabilities are so primitive? Should the Army treat a condition that is untreatable by the host nation? What is the best way to transfer care back to the community? And is it appropriate to provide a level of care that cannot be sustained once the Army departs?[17] Perhaps one of the most important and useful factors to consider in humanitarian assistance missions is the capabilities of the humanitarian NGOs that are present in the region.[18] The aforementioned factors and dilemmas facing AMEDD in HA are seemingly the same issues that humanitarian NGOs must grapple with and should be discussed and resolved to some degree by effective communication and coordination between AMEDD and the NGO personnel.

The Civil-Military Operations Center or CMOC provides the venue for just such communication and coordination. As Andre Natsios states, “The most practical mechanism for ensuring that some coherent strategic design and planning does take place is the system of civil military operations centers (CMOC), developed to establish and maintain operational contact among the military and humanitarian participants in a complex operations.”[19] The CMOC is

established to encourage sharing of information and coordination of resources in order to avoid duplication of efforts. This can be of particular importance to military and civilian health care providers in resolving the aforementioned dilemmas regarding the provision of health care to a host nation populace. But is this coordination taking place?

CIVIL-MILITARY RELATIONSHIPS

According to The Center for Army Lessons Learned (CALL), the mission of a CMOC is to coordinate the military and civilian aspects of a humanitarian assistance effort by providing the linkage between the military commander and other governmental and non-governmental organizations (NGOs)."[20] A CMOC does not necessarily need to be a building or any type of physical structure. In fact, Chris Seiple suggests that a CMOC might simply be a process that occurs, perhaps in the form of a professional relationship or informal, meaningful, and productive communication, where the result is a cooperative effort.[21]

The first true case study of civil-military relationships and the concept of a CMOC come out of Northern Iraq during Operation Provide Comfort (OPC). After the Gulf War, hundreds of thousands of Kurds fled from northern Iraq to the mountains of southeastern Turkey. But despite distribution of food and the provision of emergency aid, the sanitary conditions of the camps and the overall humanitarian situation rapidly deteriorated. When Turkey requested assistance, the US responded with 12,000 troops (other allied forces responded as well) with a threefold mission to 1) alleviate suffering in the mountain camps, 2) repatriate the refugees from the mountains to a camp in northern Iraq more conducive to providing assistance, and 3) finally return the refugees to their original villages. The overall goal of the operation was to successfully achieve the aforementioned missions and then conduct a transfer of humanitarian efforts over to the NGOs.[22] During OPC, these two groups of people, soldiers and NGO civilians who had no experience with each another were forced to come together and collaborate in this extremely complex humanitarian emergency. According to numerous accounts, much of the success of this operation can be best attributed to the continuous communication and cooperation among the military and civilian agencies.[23]

This spirit of cooperation and desire to work cooperatively in these emergency situations is not, however, a natural phenomenon between military personnel and NGOs. There are people of the opinion in both camps that humanitarian issues are the responsibility of the humanitarian community, and not the military. Andrew Natsios writes that even after responding to five complex humanitarian emergencies there are those in the rank and file that remain uncomfortable participating in these missions. He goes on to imply that many in uniform are

unsure why they are given duties that they have not even been trained to perform.[24] In keeping with good order and discipline, no one in uniform will publicly denounce the participation in HA, but it is understood that there are varying opinions. The "war-fighters" maintain that the purpose of the Army is to fight and win the nation's wars and as one observer notes, "military officers trained to have that mindset [war-fighter] will inevitably find HA operations to be a secondary activity."[25] Operation Support Hope illustrates well the military's concerns with involvement in HA. In July of 1994, tribal conflict in Rwanda had resulted in a mass exodus of refugees to neighboring Zaire, creating one of the worst ever humanitarian crises. After a plea for assistance from the UN High Commissioner for Refugees (UNHCR), the US promised a massive relief effort and due to the nature of assistance requested, i.e., security, water management and logistic services, most of the support would need to be provided by the military. Unfortunately, the military did not hide its reluctance to support this mission. Then-Chairman of the Joint Chiefs of Staff, General John M. Shalikashvili is reported to have said, "We have a capacity like almost no one else to help with tragedies of a magnitude like we're witnessing now in Rwanda. But we also at the same time need to strengthen the United Nations so they can do more on their own without always having to call upon us or we don't have to play as large a part."[26] Despite this initial reluctance, the US military did respond and the military's contributions to this crisis are credited for saving thousands of lives.

In the other camp, the NGO camp, it is easy to find civilian sentiment that emphatically and very publicly opposes any military presence in HA. According to Evans and Sahnoun, military intervention should be the last resort and even then, the force should be of minimal proportion with the specific expressed intent of stopping human suffering.[27] Hardliners such as Joelle Tanguy, US Executive Director of Médecins Sans Frontières (MSF or Doctor's Without Borders), a prominent humanitarian NGO, see military humanitarianism as an oxymoron and Tanguy insists that humanitarian and military work must be carried out independently.[28] Tanguy's organization has even appealed to the UN Defense Committee for the complete elimination of any military presence in HA and for genuine debate on the future use of forces in their regions of engagement.[29] Likewise, Larry Minear prescribes to NATO's conclusion that the primary function of military troops is to provide security and that hands-on humanitarian activities by the military are envisioned only in exceptional cases. And even then, these activities should be in collaboration with humanitarian agencies and civil authorities.[30] Yet other civilian humanitarians understand that military involvement in HA is inevitable but still have concerns regarding a cooperative relationship. For example, soon after relief operations in Kosovo, a UNHCR evaluation suggested that while the military is in deed best equipped to

render assistance for large numbers of refugees, it can also put refugees at undue risk by abruptly terminating that support if and when military priorities change.[31] This evaluation was based on a perception that refugees, having become accustomed to a certain level of care and assistance were left "high and dry" when the military was required to redirect its resources. Perhaps proper communication and coordination between the military and civilian agencies could have resulted in contingency plans for such circumstances, and thereby may have prevented such disruption of assistance to the refugees.

Another concern regarding any relationship with the military during HA is the issue of neutrality. Many humanitarian NGOs adhere to a doctrine of neutrality and fear that any relationship or appearance of cooperation with the military will compromise their neutrality. According to Lindenburg and Bryant, the work of NGOs should be based on the principles of neutrality, impartiality and independence.[32] Discussion of these principles has been cause for debate within the NGO community, but none dispute that the International Committee of the Red Cross (ICRC) is the most successful in maintaining true neutrality while responding to complex humanitarian emergencies. Many NGOs make the claim that the ability of an organization to demonstrate impartiality is tied to their financial and political independence. But according to Natsios, neutrality is admirable, but not a necessary condition of humanitarian operations. In fact, it is becoming increasingly more difficult to maintain neutrality in many of today's complex humanitarian emergencies.[33] Some NGOs now prescribe to this thinking and advocate taking "sides" in these conflicts. "They believe that one group in a conflict has a more just cause than the other."[34] Natsios goes on to explain that humanitarian work in a state controlled by a repressive regime may even prolong the life of those regimes. NGOs may then be actually negating their supposed neutral policy and in fact aiding and abetting the cause of the crisis. This has become the subject of much discussion in recent years; in fact, an entire book by Mary B. Anderson focuses on the assertion that, "international aid given in a conflict setting should not feed into and exacerbate the conflict."[35] Thus some NGOs have abandoned any pretense of absolute neutrality in favor of independence.[36]

In addition to the debate about military involvement in HA and NGO concerns over their neutrality, there are considerable cultural barriers to overcome as well before civilian and military cooperation becomes genuine. As some suggest, the military and civilian components of HA missions simply just don't understand each other. They speak different languages, operate under very different command structures and work toward different end-states. This vignette from one of the AMEDD officers that just returned from Afghanistan clearly illustrates the existing misconceptions between NGOs and the military.

> We had many NGOs tour our hospital and the general reaction was amazement that we were actually caring, smart people trying to do a good job. We cared for hundreds of Afghans, mostly mine victims, and many, many of them were children. We saw thousands in our MEDCAPS. The NGOs generally then expressed interest in working with us, but none of those projects came to fruition.[37]

Generally, the military sees NGOs as unorganized, unprepared and undisciplined while NGOs see the military as rigid, controlling warriors that have no concern for the civilian populations being affected by their actions.[38]

Ironically these two groups, regardless of how they perceive each other, actually need each other. The military comes fully manned and equipped to respond to any complex humanitarian emergency and NGOs often request support from the military. As Steve Henthorne has said, "The military has assets that most NGOs can only dream about!"[39] When NGOs comprehend the tremendous capabilities of the US military, with its unique warfighting and humanitarian abilities, they become more receptive to increased interagency operations.[40] Likewise, NGOs typically have a long standing presence and relationship with the local community and they enjoy a strong inter-NGO connection that allows for quick affiliation with indigenous agencies and the sharing of a wealth of information and expertise. In a nutshell, NGOs are innovative and dedicated; the military is well equipped and organized.

STEPS TOWARD IMPROVED UNITY OF EFFORTS

In May of 1994 after an extensive inter-agency review of our nation's peacekeeping policies and programs, then-President Clinton signed Presidential Decision Directive (PDD) 25 that addressed six major issues of reform and improvement. This PDD followed peace operations in Somalia, Iraq, Rwanda, Bosnia, and Haiti during which funding, command and control, protection of peacekeepers and overall support were questionable and often chaotic. PDD 25 provided a comprehensive policy framework for OOTW by addressing such items as the requirement for rigorous standards of review prior to US involvement in these operations, the reduction of cost, and the need for improving UN and US management of operations. In addressing the management issue, PDD 25 proposed a United Nations Peace Operations Training Program to be aimed at commanders and other military and civilian personnel participating in peace operations. Specifically, "the US is prepared to offer to help create and establish a training program, participate in peacekeeping training efforts and offer the use of US facilities for training purposes."[41] Three years later, in May of 1997, President Clinton signed PDD 56, which further emphasized the importance of civilian and military integration to the

success of complex contingency operations. This PDD put the Pentagon, State Department, and other agencies on notice to create training and education programs for participants of such operations. Additionally this directive called for the development of political-military implementation plans, rehearsal of such plans and comprehensive after-action reviews following each operation.[42] Unfortunately, as Rowan Scarborough reported in December of 1999 in the Washington Times, little had been done in two and a half years in response to that directive. Mr. Scarborough's article revealed that a Pentagon-financed study concluded, "The spirit and intent of PDD 56 directed-training is not being followed."[43] But finally, today we can find numerous forums for military and civilian training in the complexities of these peace operations and in the tools and techniques for effective coordination. In particular, there are many available resources for training in humanitarian assistance responses.

For example, the Military Division of the UN Department of Peacekeeping Operations (USDPKO) provides extensive resources for both military and civilian personnel involved in humanitarian assistance through the Training and Evaluation Service (TES). Also, the UN Office for the Coordination of Humanitarian Affairs (OCHA) offers numerous courses and seminars, described via a Humanitarian Assistance Training Inventory (HATI). Of note is the UN Civilian Military Coordination (UN-CMCoord) Courses offered by the Emergency Services Branch, Military and Civil Defense Unit (ESB/MCDU). This course is generally conducted eight times annually at various locations around the world.[44] And finally, the Combined Humanitarian Assistance Response Training (CHART), sponsored by the Center of Excellence in Disaster Management and Humanitarian Assistance, has been developed to prepare US and foreign military personnel for service in multi-force theaters of operation and to function in concert with civilian relief organizations. This training is offered numerous times a year throughout the US and is accredited by the Accreditation Council for Continuing Medical Education.[45]

In addition to these training opportunities, numerous handbooks and other publications have surfaced to further assist civilian and military cooperation and corroboration in the field. In August of 1998 USAID published a revised version of the Field Operating Guide (FOG) for Disaster Assessment and Response that serves as a handbook of "how-to's" for civilian disaster assistance personnel. The FOG includes an entire section on the military, outlining command structure, rank structure, and pertinent military capabilities as well as the procedure for requesting specific types of military support, such as transportation, etc[46]. Two years later the US Institute of Peace published a similar reference entitled Guide to IGOs, NGOs and the Military in Peace and Relief Operations. This handbook was written with the intent to be used

by individuals of the title organizations in order to assist them in better understanding each other's mission, culture, organizational structure and the like.[47]

These opportunities for training and dialogue as well as the distribution of helpful publications amongst civilian and military personnel involved in humanitarian relief are evidence of a desire to improve efforts on behalf of those in need. There are cynics who question the motivation behind these efforts, however, and even make claims that these dialogues have more to do with preserving humanitarian independence, rather than improving collaborative efforts.[48] But generally it seems that those who have participated agree on the importance of learning about their counterparts and improving their inter-operability and ultimately ensuring the most effective use of military and civilian assets in support of all types of humanitarian operations.

AMEDD AND NGO PERSPECTIVES IN HA

By virtue of their profession and their intrinsic calling to provide aid to the sick, perhaps it is the medical personnel participating in complex humanitarian emergencies that are the most likely to successfully communicate and coordinate with their counterparts. Dr. Lincoln Chin of the Rockefeller Foundation spoke recently during a presentation at Harvard Medical School and remarked that good health and human survival are ultimate goals of any human security agenda and as such, medical workers must cooperate, operate alongside or integrate with other actor groups, each with its own mandate. He went on to discuss the vital importance of public and private healthcare provider partnerships.[49] Similarly, the Military Health System 2025 study states that health related capabilities are frequently the critical success factors of disaster relief and humanitarian assistance missions.[50] Considering these two viewpoints one can derive that health care providers, whether in uniform or civilian clothes, want the same outcome in a humanitarian assistance operation. Parallels are easily drawn between the role of the Army Medical Department (AMEDD) in humanitarian assistance operations and the missions of NGOs such as Partners in Health (PIH), Médecins Sans Frontières/Doctors Without Borders (MSF), and International Medical Corps (IMC). For example, the mission of IMC is "to improve the quality of life through health interventions and related activities that build local capacity."[51] The MSF mission is "to deliver emergency medical relief to populations threatened by armed conflict, civil strife, epidemics, or natural and man-made disasters."[52] PIH simply aims to "tackle health crises that can't be solved and does whatever it takes to solve them."[53] All four of these organizations have an ultimate goal of providing the tools and resources necessary to assist the host nation in developing a viable and sustainable health care infrastructure. Perhaps for these

reasons, it has been observed during humanitarian assistance operations that military medical personnel are able to maintain a professional rapport with NGOs while the NGOs reject other military players.

But in spite of these similarities, shared visions, and perceived cooperation, history has shown that the medical community during humanitarian assistance operations has experienced some difficult challenges. For example, during Operation Provide Comfort humanitarian NGOs were arriving at numerous entry points of a Kurdish refugee camp and setting up their operation without any prior coordination with UNHCR or the military task force. In the meantime, the Army medical assets were receiving orders from various sources; therefore initial efforts to assist the refugees were not appropriately directed toward rehydration, starvation and sanitation which were the immediate medical threats in the mountain camps. Perhaps with dialogue, coordination and planning in the CMOC at Zakho between the Army medical personnel and the NGOs, this situation could have been quickly and easily resolved. As one after action report states, "doctrine and training relative to the interface between civilian volunteer medical organizations and US military medical personnel need to be developed and implemented. The lack of interface was a perpetual source of control problems that adversely affected treatment coverage and optimal use of available medical assets."[54]

Army medical assistance in a humanitarian operation is governed by US and international law as well as medical rules of engagement (ROEs). These laws and rules dictate and define the scope of medical care that can be delivered by US medical forces operating in any deployed environment but they also ensure that medical forces are utilized properly and do not become over extended in secondary missions or tasks that compromise their ability to support the primary mission.[55] For example, the Army may provide medical services to a host nation that complements but does not duplicate any other assistance being provided.[56] An example of this was demonstrated in 1994 during a humanitarian mission in Haiti. Operation Uphold Democracy was a mission to restore and support the legitimate government of President Aristide in Haiti. The health services support plan of Joint Task Force 190 (JTF 190) called for no medical support to the Haitian people except in extreme emergencies. Care for the civilian population was strictly the responsibility of the local authorities, IOs, and NGOs. However, in the spirit of civil-military cooperation, the JTF Surgeon worked closely with various relief agencies and helped to establish procedures for the medical treatment of Haitians in civilian facilities. Additionally, AMEDD deployed the Army's first ever Health Facility Assessment Team (HFAT) to inspect local medical facilities in Haiti. Over time, the two HFATs became increasingly sophisticated and were able to identify and inspect sites for potential conversion to

medical treatment facilities. AMEDD proved successful in identifying medical conditions and resources that could then be addressed by NGOs and other civilian agencies that were present.[57] From both a medical standpoint and a civil-military coordination stand point, this operation was extremely successful. By assisting the NGOs and other medical resources on the ground, the AMEDD assets of JTF 190 were able to perform within the limits of their stated mission as well as lay the groundwork for the development of a competent civil infrastructure.

Army doctrine states that while the immediate goal of support operations is to relieve hardship and suffering, the ultimate goal is to create conditions necessary for civilian follow-on operations. Transferring activities to civil authorities and withdrawing Army forces is a clear indication that life in that state is returning to normal and that the Army has successfully completed its mission.[58] To be clear, a humanitarian assistance operation cannot successfully conclude unless the organizations that are in place can operate effectively long after the military has departed. According to some, Operation Support Hope proved to be a clear example of how successful the military can be in these HA missions using these guidelines. The Joint Task Force in Rwanda saved lives, protected its troops and then transferred the mission over to the appropriate civilian agencies; the task force experienced no mission creep and executed a successful exit strategy.[59]

Unfortunately, the events in Rwanda did not unfold so neatly for MSF. Under the "watch" of MSF, the aid that was intended for the victims actually gave power to the perpetrators of the genocide being committed in the refugee camps. MSF aid workers were faced with the decision of whether to remain in the camps and continue to provide medical care or to leave in the hopes of eliminating any assistance they were providing to the perpetrators.[60] This paradox of humanitarian assistance and ethical dilemma for NGOs remains a topic of continued debate in the NGO community.

Operations in Somalia presented a different kind of challenge for the Army. AMEDD assets were initially tasked to provide comprehensive medical support to the US peace enforcement forces and emergency medical support to coalition forces. It was understood that the mission did not call for providing health care services to Somalia nationals, refugees or any civilian relief workers. But as discussed earlier, for the better part of 1993, some AMEDD personnel did in fact provide medical care to Somalis and this angered the NGOs that were present. NGOs are often "threatened" by Army medical capabilities, afraid that the Army will take over their mission or that it will establish a level of care that they cannot maintain once the Army leaves.[61] Furthermore, while the NGOs were appreciative and took full advantage of the logistical resources that the Army provided, they in turn were critical of the Army's failure to

provide protection to the civilians that were distributing humanitarian aid and in late 1993, NGOs questioned the Army's cessation of all but emergency medical care to Somalis. Little, if any coordination was made between the AMEDD assets and NGOs in the area, therefore the NGOs failed to realize that as tension in the region rose and the number of U. S. casualties increased, there was growing resentment among the Army medical staff at having to treat Somali patients. Given these circumstances and lack of communication between these parties, it is no surprise that according to Dr. John Hammock, Professor, Tufts University, "the root of NGO conflict and controversy with military intervention in humanitarian assistance can be traced back to operations in Somalia."[62]

For the most part, reports coming out of Afghanistan indicate that Operation Enduring Freedom may prove to be a civil-military cooperation success story. Interestingly, over a year ago, Nicolas de Torrente, Executive Director of MSF-USA delivered a congressional briefing in which he voiced his concerns regarding military action and the effects on the civilian population of Afghanistan. Prior to September 11th, 2001, MSF had been in Afghanistan for over twenty years providing humanitarian assistance, but their activities were suspended shortly after 9/11 due to uncertainty about security in the region. His briefing, in essence, was a plea for help in re-establishing the MSF mission in Afghanistan and a request for assurance that a clear distinction would be made between the military action and the humanitarian efforts.[63] A year later, as sustainment and development efforts are well under way, there were numerous favorable reports of the work being done by the military and NGOs alike in the region. The Director of Planning at the Afghan Health Ministry was interviewed in December of 2002 and reportedly was very pleased with the NGOs and their work in assisting the Afghans in regaining their own medical infrastructure capabilities. Likewise he praised the US Army for the medical and veterinary care being provided, evidence that the top priorities of the AMEDD elements, TF44, in Afghanistan were being realized.[64] The goal of TF44 has been to educate the local people on taking care of themselves and to generate initiatives to create a local health care system. This would seem to be in concert with humanitarian NGO pursuits; however, some anti-military sentiments remain.

The Agency Coordinating Body for Afghan Relief (ACBAR) recently drafted a policy brief of concerns and recommendations regarding civil-military relations in Afghanistan and in it declared that NGOs in the region are concerned that the Joint Regional Teams (JRTs) that have been established will deflect the military focus from security to assistance. The brief goes on to say that the military should not refer to its participation in assistance as humanitarian as it is a misnomer and that NGOs are better suited to provide assistance and reconstruction. The

ACBAR brief goes so far as to claim that military assistance is far too costly, that it is provided by inexperienced military reservists and that local communities that accept military assistance are put at risk.[65] Fortunately, this is not the opinion of everyone. On the heels of the ACBAR draft was a report by Dr. Joseph Collins, Deputy Assistant Secretary of Defense for Stability Operations that described successful civil-military coordination and cooperative efforts between the Defense Department, State Department, USAID, UN and 150 NGOs in Afghanistan that have resulted in rebuilt schools, medical clinics and veterinary services.[66]

So the underlying debate regarding US Military participation in humanitarian operations lives on, but as Ian Johnstone put it so well during a recent debate of the issue, "As the dividing line between peace operations, humanitarian assistance and humanitarian intervention blurs, so must peacekeepers, NGOs and military forces find new ways to work in an integrated fashion."[67] The AMEDD recognizes the importance of this integration and has worked extensively on finding ways to improve the dialogue with humanitarian NGOs. In an Army War College research paper, a senior military medical officer explained that effective medical support in OOTW demands medical unity of effort, and is a principle of OOTW that has been lacking in many recent military medical operations. This officer participated in the Joint Medical Wargame 2000 (JMWG) and she explained that the game revealed, unsurprisingly, the importance of developing global partnerships and the use of medical assets of allies, coalition partners and NGOs alike. She goes on to endorse a concept that originated during an AMEDD Army After Next (AAN) exercise in 1998, the concept of a Medical Foreign Area Officer to serve as a conduit to such unity.[68] This recommendation did not fall on deaf ears and is one of the initiatives identified in an extensive report dubbed, Military Health Service (MHS) 2025.

MHS 2025 is the culmination of a four-year study conducted by a group of joint military health care visionaries to address future social, economic, technologic and military advances and the subsequent implications for military health.[69] The result of this study is a list of thirty-five recommendations, one of which is to improve military health service's capabilities for relationship building and collaboration with other organizations. The concept of a Foreign Area Medical Specialist (FAMS) as it was coined in MHS 2025, is discussed as a potential means to improve such capability. The study also examined the possibility of a Virtual University of Peace Support Operation (VUPSO) as an interactive training platform for US and allied military medical personnel as well as international humanitarian aide workers. VUPSO would be a collaborative effort between the military, International Red Cross and World Health Organization and would include such valuable training as language, culture, and regional specific health topics.[70] While the Army Medical Department realizes that support in OOTW often results in

partial unit deployments and some degradation of its ability to provide peacetime health care to soldiers and their families, all of which has a negative affect on readiness and overall mission performance, it also recognizes the positive effect that participation in these operations has on the clinical and operational abilities of AMEDD personnel. The Office of the Army Surgeon General has been tasked to produce an AMEDD International Strategic Plan that will be a valuable document addressing these and similar issues, specifically the civil-military coordination that must occur in order to maximize our efforts in achieving national strategic objectives.[71]

CONCLUSION

The topic of civil-military relations will continue to be debated until all agencies engaged in the debate have a clear understanding and appreciation for the mission, capabilities, constraints and vision of one another. The Army Medical Department and humanitarian NGOs that similarly provide medical support during operations in which humanitarian relief is required should be in the best position to put this debate aside. Both entities have the health and welfare of fellow human beings foremost in their concerns. And while putting aside issues of neutrality, funding, and independence, their capabilities and limitations remarkably complement one another's. While the AMEDD is well trained and equipped to perform extensive and thorough assessments of existing host nation medical capabilities, NGOs are intimately familiar with regional customs, cultures, and language to ease the process. While the AMEDD has the wide range of medical expertise and resources to address a myriad of medical conditions, the NGOs have an extensive inter-NGO network to facilitate a continuum of care. If the efforts are put forth as addressed in MHS 2025, the USAID FOG, UCHA and perhaps the pending AMEDD International Strategic Plan, then the efficient and successful delivery of medical care during humanitarian operations and other OOTW could soon set the example of a significant civil-military corroboration that successfully contributes to achieving international strategic objectives.

WORD COUNT: 6,616

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