INTRO
First of all, my thanks go to the conference organizers and other presenters for making this valuable opportunity available to all of us. Most certainly, it’s a new world, and an interconnected world. The tragedy experienced by Thailand and other nations struck by the tsunami was felt around the world. The universal response to the plight of those struck was astounding to all. That universal response does indeed show that we can achieve a new level, a new capability, in disaster response. History teaches us that there will be the occasion to call on that capability again. This meeting represents an opportunity to assure that we can match and over-match the tsunami response when…not if…we’re called upon to do it again.

OUTLINE OF TALK
Our topic is civilian-military cooperation in humanitarian health action based on our experience in tsunami relief, which the US military labeled “Operation Unified Assistance”. In keeping with the plan for these presentations, I’ll touch on 4 areas: Needs Assessment; Coordination; Filling gaps in population health needs; and Capacity building in stricken nations. I will then try to suggest a few opportunities to build or improve, in preparation for that inevitable “next time”

US Pacific Command is located in Hawaii and is the operational agent for the US military from the west coast of North America to Diego Garcia in the Indian Ocean. We coordinate military activities across that broad area and are the intermediary with Washington DC. My own office has responsibility for the medical portion of those activities. We first received word of the tsunami in Hawaii on Christmas afternoon. By the next morning, our full planning and operations staff had been recalled from vacation and had begun trying to figure out what had happened and how to help. That began about 2 ½ months of activity, extending until 16 MARCH when the hospital ship USNS MERCY departed Banda-Aceh.

Some observations from that activity:

NEEDS ASSESSMENT:
Early helicopter availability was extremely valuable. Sea basing the helicopters allowed them to go more places safely, and gave them a support base. Military assessment teams arrived early, but were of limited effectiveness because of difficult ground transportation. Further, the experience and skill level of these teams was limited. Among the first in the area were military infectious disease research doctors from our Navy medical research laboratory in Jakarta. Enthusiastic and familiar with the country, but not trained in assessment, their work verified the scope of the problem, but was not comprehensive. Helicopters from ships carried general medical personnel who provided situational awareness across a broader area, but still not in depth. Finally, comprehensive and actionable assessments were created by the combined teams of experts organized by WHO and transported by military helicopters to assess key areas. Food, water, and urgent medical evacuation were provided by the helicopters while conducting assessments, thus reducing overall deaths. One caveat about helicopters: during the earthquake relief effort in Nias, an Australian military helicopter crashed. It was carrying a medical team. Nine
were killed and 2 critically injured. Frankly, helicopter operations are dangerous. They must be conducted professionally and carefully, not ad hoc, and not on the cheap. They are expensive, complex machines that we should not expect many organizations to be able to support.

COORDINATION:
From USPACOM viewpoint, some innovative and effective things happened. The receptiveness of host nations to a large foreign presence was remarkable. It happened only because of long-standing relationships in the region. Coping with such a large foreign presence will remain a problem for all nations. Assuring the host nation has the lead, and clear veto authority, is important in this regard. Military relationships in the region have been developed through years of joint exercises and planning. This accelerated military coordination significantly. The availability of UN and OFDA liaison at headquarters and operational levels was very effective. Establishment of WHO as lead coordinator for medical efforts improved synergy and effectiveness. The organizational architecture of the military Combined Support Force headquarters provided a “Civilian – Military Operations Center”, and was useful to provide a location and means for broad coordination. Sharing medical intelligence and situational awareness was one key product of this ‘togetherness’. The organizational structure is complex, reflecting the multiple organizations with which it must interact. A streamlined, simplified structure that could be rapidly implemented would be of value. Rapidly establishing a combined air control center at Banda Aceh was an important effort. Also at an operational level, the immediate synergy we experienced between our EPMU and the IOM’s preventive medicine capabilities was of great value. Some things weren’t quite as good. The US military medical lead in Utapao lacked effective liaison with medical components of NGOs and IOs in Aceh. For example, when we tried to gain understanding of NGO preventive medicine capabilities present, we were unable to get a clear picture. Our typical military focus is on getting people and things in place as quickly as possible, making external communication and coordination with NGOs a second priority. This reduced speed and efficiency of coordination.

GAP FILLING
Understanding gaps require ongoing analysis since specifics change from day to day. However, we had to try to predict them as we planned what capabilities to put on MERCY before sailing, knowing they would not arrive until a month later. Our reasoning went like this: Requirements a month after the tsunami struck would be a combination of disaster relief needs from the tsunami, and humanitarian assistance needs related to the health status existing before the tsunami. There would be a sequence of health risks: acute trauma, which we would not be there in time to help; then thirst and hunger, which we hoped to be able to help with our first arriving ships and aircraft. Next would be illnesses associated with crowding and inadequate sanitation: waterborne and airborne diseases such as dysentery and measles. There would also be wound infections and tetanus. As the insect population reappeared a month or two after the salt-water inundation, insect borne diseases such as malaria and dengue would increase. Throughout, the sequelae of untreated injury and pre-existing chronic problems would surface. We hoped to be able to do something about all these. Working with IO and NGO
experts to develop such projections this would have helped predict likely healthcare delivery needs. However the healthcare gap is not only in healthcare delivery. “An ounce of prevention is worth a pound of cure”. Gaps in disease prevention must be identified and plugged. This was a problem for us, first because we had difficulty understanding what the NGO preventive medicine capabilities were, and second because we had difficulty moving our own capabilities into place. This is an opportunity area to improve military and NGO/IO synergies. Engineering and medical repair capabilities also were gaps to be plugged. Engineering teams from the ships worked daily to do everything from cleaning out mud and laying water pipe to repairing electrical generators and medical equipment.

CAPACITY BUILDING
There were several valuable efforts. Engineering and medical repair were mentioned. This helped locally but was not broadly coordinated. Training was an important ‘leave behind’. The best example is “train the trainer” training conducted with UNICEF for mental health care. 1200 people were trained in mental health support. In time, these will have trained as many as 50,000 in northern Sumatra, a significant step toward restoring capacity. Similar training for nurses was conducted, helping to restore nursing capacity. US military ability to commit to long-term capacity building efforts is limited. We conduct a “theater security cooperation program” which carries out limited scope HA projects in concert with military exercises with host nation forces. The strategic focus is not on capacity building however and is not coordinated with USAID, IO, and NGO plans.

This summary points out a few specific suggestions based on observations above:

- Sea based helicopters and early air control capability. Develop standard civ-mil procedures for this.
- Sea bases, especially hospital ships, will not always be available. Is IO (or NGO) sponsorship of such feasible?
- Enhanced training of military assessment teams. Can this be done with IOs/NGOs?
- Combined civil-military assessment teams. Develop standard civ-mil procedures for this.
- Early, helicopter-delivered food and water saved lives and accelerated assessment. Develop standard civ-mil procedures for this.
- Host nation lead in control of response efforts is key and must be recognized as an inherent part of HA/DR response.
- Regional HA/DR response planning and exercises including civilian and military sectors. Can WHO sponsor such?
- Military HA/DR planning should include an interagency coordination group as a standard.
- For the US military, UN and OFDA liaison officers at both headquarters and local level should be standard.
- A lead medical coordinator should be established early.
• US military HA/DR headquarters architecture should be simple and assure early integration and communication with IO/NGO/host nation/foreign military coordinators.
• Improved sharing of situational awareness and medical intelligence should be planned.
• Military – civilian preventive medicine integration should occur early.
• Engineering and medical repair capabilities should be provided and coordinated.
• Training of host nation personnel should be provided.
• Military capacity building planning should integrate with USAID/IO/NGO as well as host nation.

Thank you to WHO and to the government of Thailand for the chance to participate in this conference. I can assure you that the US military recognizes it has an opportunity to learn many lessons from the tsunami response experience. I suspect that is true for us all. Now we must assure that we take advantage of the opportunity, that we build together on our shared experience, that we meet the new standard we’ve set for ourselves, and that we work together to prepare for the inevitable next time.
USNS MERCY Medical Capabilities

- Ancillary Support
- Medical Services
- Public Health Services
- Mental Health Services
- Trauma, Surgical and Emergency Services
- Surgical Services
- Veterinary Services

US Interagency Relationships

- President
- SECDEF
- SECSTATE
- CJCS
- Ambassador
- Combined Support Force
- Coordinator/CMDR
- NGO, Int’l Orgs, Intl. Other
- CSG TH
- CSG SL
- CSG ID
- OFDA / DART
- US Embassies in the Region
- Other US Agencies (USAID, etc.)
- Special Representative of the UN Secretary General
- Other Nations
- NGOs / PVOs
- Other UN
- USAID
- Agency for International Development
- Other USGA
- Ambassadors
- NGOs / PVOs
- Other UN
- CJCS
- SECDEF
- SECSTATE
- USAID
- Agency for International Development
- Other USGA
- Ambassadors
- NGOs / PVOs
- Other UN