

HUMANITARIAN ASPECTS OF HEALTH SUPPORT IN OPERATIONS OTHER THAN WAR

by

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Abstract

The decade of the 1990's proved to be very busy for health personnel serving in the Australian defence Force (ADF). During this time, they deployed to areas as far away as Africa, after the genocide in 1994, and areas closer to home.

There have been missions in Indonesia, Bougainville and Papua New Guinea. In more current times, the most significant deployment has been to East Timor where health personnel remain today. Furthermore, there have been a number of deployments on short missions to various areas within Australia's strategic area of interest. Every mission has a mission statement. In all cases involving health personnel, the statement outlines their primary tasking, which will be the provision of health support to the troops in force. The secondary tasking, which inevitably follows, is the provision of health support to the local community from within any spare capacity. It is this spare capacity that this article will discuss. The primary focuses of this article are what care should be provided and the limitations of such care, how health should be provided, what training is required for health personnel who will provide this care, and the policies that are required to be in place to monitor this care.

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INTRODUCTION

The decade of the 1990s heralded the way for operational deployments for Australian Defence Force (ADF) health personnel. During this time they deployed as far away in Rwanda in Africa following the genocide of some 500,000 to one million killed in 1994 to areas closer to home. Missions were also undertaken in Indonesia in 1997, providing famine relief, and in Papua New Guinea in 1998 following the Tsunami where some 4,000 people were killed. Further, since 1997 ADF Health personnel continue to serve in Bougainville providing health care to members of the Peace Monitoring Group. Again in 1999 ADF health personnel were deployed to East Timor where they remain today as part of the United Nations Transition Authority in East Timor (UNTAET). In between times there have been a number of deployments on short missions to various areas within Australia's strategic area of interest.

WHY PROVIDE HUMANITARIAN ASSISTANCE?

Military contingents will normally be self sufficient with respect to medical care, and will often bring with them what appears to local populations to be large medical structures and resources. Military contingents will not generally deploy for humanitarian purposes, but rather to provide care for their own and associated personnel such as the provision of health support to the mission. Where populations are medically at risk in the case of the aftermath of conflicts, natural and man made disasters and so forth, lack of access to these military medical facilities may and often does generate local resentment. So why provide humanitarian assistance?

The main reason for the provision of health care services to disaster or conflict affected populations are to prevent excess mortality and morbidity. ¹ ADF health personnel, like colleagues around the world, are unable to stand by and not render assistance to those in need. There will always be the argument that 'we' as health care providers have a moral obligation to assist those who are injured and that it is offensive in the extreme to go into a country where there is such a need and not provide medical assistance. Further, it is a justification of their existence lest they would possibly become bored and frustrated. Whilst the provision of humanitarian health support is commendable it must be in line with the mission statement and be aligned with the requirements of the host nation. Therefore, when health support is provided by deployed ADF assets it is to be provided from surge capacity and is not to compromise the health support primary mission.

GUIDELINES FOR THE PROVISION OF HUMANITARIAN ASSISTANCE

There are numerous examples abounding as to health staff as good intentioned as they are who have provided treatment to local populations in association with their own professional mores.^{2,3} The provision of humanitarian assistance should conform to international humanitarian protocols such as International Committee of the Red Cross (ICRC). Acts performed in a life and limb-threatening emergencies will always be justified however, it is inappropriate arrogance to assume that anything that Western health care has to offer their less developed neighbours is progress.

It is imperative that the focus remains on the standard of care provided to the local population and should conform with the level of health care in that country. Practicable health care should be provided from existing local facilities and assistance should be provided to the local health infrastructure to rebuild a sustainment capacity for the local population.

It is important to involve early participation of existing local health authorities and remaining qualified health professionals of the affected population. This will assist in the alleviation of human suffering brought about by conflict or disaster through the protection of life with dignity in ways that supports achievable recovery. Cognizance of the culture of the host country is imperative so that the intervention of health care compliments and does not interrupt or disrupt their culture.

For example, when Australia deployed health personnel to Rwanda in 1994, the medical/surgical ward holding policy for the admission of the local population was no more than 6 beds of the 25-ward. The Intensive Care Unit (ICU) was 1 bed out of a 4- bed ICU be allocated. The in- patient holding policy was 24-48 hours post operative stay in the medical/surgical ward. For ICU patients the holding policy was continuing care until the patient was fit for transfer to the Non Government Organisation (NGO) ward.

In reality, very few Rwandan patients admitted to the Australia Hospital were ever transferred within the time frame of the stated policy. Understandably, medical staff who had spent many hours working on these patients were reluctant to send these patients back into the local health care arena for fear that their patient management would be changed or ignored. Further, in the NGO wards infection rates were high, there was no running water and an unreliable power source. Drug therapy was suspect and it was perceived that only 'doom and gloom' awaited these patients.

Frequently, Rwandan patients spent considerable time in the care of Australian health care personnel. Although these patients by and large were grateful for the care they were receiving some problems did arise. The provision of care within the Australia facility was vastly different from that of the local hospital. This changed the expectation local patients had regarding the health care they should receive. Many patients became institutionalised, and the family traditions regarding the provision of nursing support to their relative started to change. It is the custom in many countries that the patient's family will stay in hospital with the patient. Obviously, inpatient care in the Australian Hospital involved the provision of all care, so very quickly we started to see changes to their local customs. The patient's family saw no need to supply food or water for the patient, or wash their clothes. Further, the family member as well as the patient was always sure of a good meal, and staff had to be vigilant to prevent the remainder of the family joining the meal queue over meal times.

When the time finally came for patient transfer, both they and their families were reluctant to move. This was not helped by the reluctance displayed from local nursing staff with regards to continuing with their ongoing care. The local staff saw that as we had commenced care it was our responsibility to continue it. So the patient was disadvantaged within his own cultural health care environment. For both the patient and their families they were left floundering to gain some normality in their lives. As health professionals, we must learn 'how things are done' within the culture we are treating and be prepared to work within these parameters.

Health logistics must also be considered when humanitarian assistance is offered from surge capacity. If the medical contingent is not resourced for this function then health personnel will need to source stores and equipment external to their supply chain, because the United Nations (UN) does not sanction the provision of humanitarian assistance to local populations. The reason for this UN policy is based on the risk of compensation payments following the provision of such care to local populations. This has been a problem for the UN in the past as they have received in claims from previous operations. The alternate source of health stores may be sought from NGOs such as Pharmaceutical Sans Frontiers (PSF). PSF is a

French NGO involved in the provision of basic pharmaceutical services to third world countries. These humanitarian stores are ideal for primary health care, however, the range of stores provided by PSF will not adequately support the humanitarian services being provided at level 3 facilities. The relationship with PSF will most probably be by a local arrangement, and when planning for operations where health personnel are involved health logistics must be considered.

The Defence Health Services Branch where I work has developed a policy for the provision of humanitarian support. It covers many of the issues I have already addressed and recommends the following: (1) as a guide, up to 25% of beds may be allocated for the humanitarian task and (2) an accepted length of bed stay in a medical or surgical ward should not exceed 5 days. In the case of ICU patients only patients who require invasive respiratory support should be admitted. They should only be given a 24- hour trial of life.

When humanitarian assistance is included in a mission statement ADF health personnel are to be fully aware of the nature of humanitarian assistance that will be provided and the limitations that will apply.

There will always be a need to have policy guidance for without this health support personnel do not know the required range of procedures they are able to perform, nor will the health logistic staff be able to quantify the health materiel required to perform the tasks. The capability to perform a particular procedure should not be a function of logistic reactivity but rather a function of proactive health planning and clinical directives.

PREPARATION OF HEALTH PERSONNEL FOR HUMANITARIAN SUPPORT

On deployments such as Rwanda, the patient population resembled that found in acute hospital care in Australia. ADF hospitals do not have a casemix that deals with trauma and seriously ill patients. The lack of routine exposure to acutely ill patients is a major disadvantage associated with the current arrangements and this will not change, so it is a basically fit clientele aged 18 –55 years of age which find there way into an ADF hospitals. Further, it is routine practice in Australia to refer acute patients or those requiring specialist treatment to civilian facilities. As a result many of the procedures and skills required for operations are not practised on a daily basis in ADF Military hospitals.

Australia's return from Africa in 1995 a strategic alliance between field units and major civilian teaching/ trauma hospitals was set up as a way of overcoming this. The strategic alliance provides the opportunity for service personnel to work in civilian hospitals in selected areas such as accident and emergency, intensive care units, trauma centres, which are relevant to combat casualty care on a routine basis. In return, the civilian hospital does provide a broad range of both outpatient and inpatient services to the dependent military population.

However, there is also a requirement to train health personnel with regards to what I have named humanitarian work practices. By this, I mean the understanding and practice of how to provide care in a humanitarian setting, which covers many of the issues I have previously mentioned. The focus should be on the wide gamut of primary health care, cultural understanding, drug therapies and patient management practices in association with developing countries. Health personnel at all levels should be provided with this information. For ADF health personnel, it means expanding their knowledge base into areas outside of the trauma model into areas of obstetrics, feeding regimes, infectious diseases and the like. In concert with this expanded education requirement is the appreciation that the level of care provided must accord to host countries standards. Every effort must be afforded to prevent the provision of services, which cannot be maintained or sustained.

CONCLUSIONS

Throughout this article, I have endeavoured to provide you with an overview for the provision of humanitarian health support to operations other than war by giving an outline of policy and educational requirements to undertake such care. I have utilized personnel experiences, which have shaped my approach to humanitarian assistance, to highlight the lessons learnt from my time on active service in Rwanda.

Humanitarian health assistance is always an issue for military operations. It is an issue that must be actively managed. Attempts avoid the issue by ordering military health services not to provide humanitarian health assistance have not been not been successful in Western military forces.⁴ I have highlighted some examples earlier in this presentation.

The scope of this paper was to explain the current guidance for humanitarian health assistance by ADF health services and how we got there. It has raised lessons learned from operations and discussed key issues that must be addressed.

Throughout this paper, I have introduced to you the way that humanitarian assistance by ADF health service participation is used in operations other than war. It is hoped that the issues discussed here may be of some assistance to you all. It is never easy to arrive into a host nation and to have to “sit on our hands”; however, with prior preparation and planning, humanitarian health support to a nation in need can be a positive experience for the nation when assistance provided to the local infrastructure to rebuild sustainment capacity for the local population. When health personnel have policy guidance which provides the flexibility for the commander on the ground, it removes the many and varied complexities which surround the provision of such care. When the operation is finished, we need to be able to know as professionals that the greatest good was provided for the greatest number of local patients. Perhaps the most positive aspect we leave behind is a legacy of leaning and a feeling of well-being to those to whom we provide care.

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