Defense & Security Analysis
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/cdan20

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Available online: 22 Jul 2010

To cite this article: Natalie J. Webb & Anke Richter (2010): Strategy at the Crossroads: Medical Humanitarian Assistance Missions for Navy Hospital Ships, Defense & Security Analysis, 26:2, 161-179

To link to this article: http://dx.doi.org/10.1080/14751798.2010.488857

Defense & Security Analysis Vol. 26, No. 2, pp. 161–179, June 2010

Routledge
Taylor & Francis Group

Strategy at the Crossroads: Medical Humanitarian Assistance Missions for Navy Hospital Ships

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INTRODUCTION

Despite carrying out humanitarian assistance (HA) missions for decades, the US military has seen the demand for its HA capabilities skyrocket in response to the global war on terror and recent disasters such as the Indian Ocean Tsunami of 2004, Hurricane Katrina in 2005, and the Haiti earthquake of 2010.

> Beyond nation-building and counter-insurgency activities in Iraq and Afghanistan, the DoD and the US military has long been involved in providing humanitarian relief around the world. [. . .] Thanks to its logistical assets and global deployment, the Pentagon has unparallel capacity to respond quickly to natural disasters and to meet emergency relief needs in strife-torn countries.[1]

The superiority of Navy hospital ships in providing medical care and the ability of the ships to deploy to a great number of places in the world make them a desirable asset for combatant commanders and policymakers alike. Fortunately, these ships, the USNS *Mercy* (T-AH 19) in San Diego, CA, and USNS *Comfort* (T-AH 20) in Baltimore, MD, have not been called upon to function in their primary capacity as combat trauma hospitals for US marines and other military combatants in the past decade. Given the continued engagement of Navy hospital ships in HA missions, an ongoing question is how the leadership of government, defense, and the navy views the use of these assets.

Current government documents and operations statements suggest multiple priorities, desired outcomes, goals and actions for the ships. Based on the USNS *Mercy*'s website,[2] the ship has both a primary mission: "To provide rapid, flexible, and mobile acute medical and surgical services . . ."; and a secondary mission: "To provide mobile surgical hospital service for use by appropriate US Government agencies in disaster or humanitarian relief . . ." The official immediate priority is to be able to fully activate the

ISSN 1475-1798 print; 1475-1801 online/10/020161-19 © 2010 Taylor & Francis
DOI: 10.1080/14751798.2010.488857

ship as a Full Operational Status Echelon III Medical Treatment Facility within five days. The primary and secondary missions have a vastly different profile and scope: desired outcomes, goals and objectives, costs and performance measures are very different. Current goals, costs and performance measures come from the "primary" mission: the ability to treat and care for patients injured with conventional warfare injuries. Measures of expected workload from these types of injuries form the basis for all aspects of the mission, from planning through to execution and assessment.[3]

Humanitarian assistance missions, on the other hand, have stated objectives such as "improving health conditions," "generating soft power," "improving security and stability" and "contributing to capacity building." Combatant commanders and policymakers believe these missions provide direct and indirect benefits to the United States government, local communities, and affect a large number of stakeholders, a thought echoed by Patrick and Brown, who note successful missions would:

> Build effective and enduring local institutions that permit the state and society to realize long-term broadly shared economic growth, participatory governance, and social welfare.[4]

To pursue these objectives and benefits, planners need better guidance on the desired outcomes, and goals and, correspondingly, to be able to plan for them with appropriate staffing, equipment and other resource use plans. Costs of providing these missions will probably vary significantly from traditional missions (and are not well measured), and relevant performance measures are not well studied. To provide better guidance, plan for and efficiently and effectively execute hospital ship HA missions, leaders must decide what outcomes they desire, not only to vertically align with US government policy goals, but to support global efforts, intra-agency co-ordination and horizontal integration with stakeholders.

In the remainder of this article, the authors survey the literature on humanitarian assistance, foreign policy and military policy, identifying broad goals that define possible mission areas for hospital ships. Hospital ship medical HA missions are placed in the context of the many stakeholders who have opinions on and sometimes the ability to affect the success of the missions. Emphasis is placed on DoD and Navy planners to better understand important stakeholders, as the effectiveness and perception of hospital ship missions rely heavily on interactions between them. Specific studies and guidance on translating broad HA goals to more specific goals are then assessed, allowing recommendation of key strategies to achieving mission success and to plan, execute and evaluate better a mission's efficiency and effectiveness. The last section concludes.

LITERATURE REVIEW: FOREIGN AND DOD POLICY AND HUMANITARIAN ASSISTANCE

The United States increasingly finds itself expanding the role of its military through forms of humanitarian assistance. Brigety states that military operations are "often insufficient to achieve the strategic objectives of a given war."[5] He notes that investing

in a country's development today could prevent it from becoming a battlefield tomorrow. Consensus among US policymakers seems to be that HA missions strengthen US power and influence. They may generate soft power, which Nye defines as getting others to want what you want through the use of culture, values and institutions rather than forcing them to do what you want through the more traditional carrot and stick of diplomacy and force.[6] Correspondingly, the three "Ds" – diplomacy, development and defense – work together to achieve greater humanitarian effects and improve worldwide security.

By investing in worldwide development, the three Ds can help prevent conflicts and improve human conditions by improving the health status of citizens. In turn, these efforts may lead to the generation of soft power and improved security and stability within a region. The literature on health policy, soft (or smart) power, security and stability and US military policy documents provide the basis for understanding and achieving desired outcomes for hospital ship HA missions.

Health policy

With respect to health status and foreign policy, Kassalow suggests that the US government should "For reasons of narrow self-interest, enlightened self-interest, and humanitarian interests [. . .] consider health as an integral part in its foreign policy." Sloane *et al.* state:

> It is a common failure of the imagination to dismiss as a "soft" add-on to foreign policy American efforts to combat pestilence and ill-health elsewhere. In blunt truth, the United States benefits doubly from every victory won abroad, not only in the intangible form of goodwill but also in our own homeland defense against disease. [. . .] Foreign health assistance deserves a corresponding rank with other vital elements of diplomacy – security, trade, and development.[7]

Despite both researchers' and policy makers' acknowledgement of the importance of health to foreign policy, little research addresses if and how health and health care affect political stability and national security, and how to best work with stakeholders to affect better health outcomes.

Drifmeyer and Llewellyn conducted perhaps the most comprehensive study of whether medical missions improve health conditions over time.[8] They noted that humanitarian and civic assistance (HCA) projects and program results have little foundation in the literature. Their results show that the US does no follow-up with patients to assess their long-term health status, projects were almost never linked to previous projects, and stakeholders providing identical or similar services rarely worked together or shared information. While it seems reasonable to argue that providing medical care is morally right and should positively affect not only the recipients of care, but US image, security and stability, there is little or no proof that military medical missions generate these desired outcomes.

Research offers several steps for the US to undertake to provide more effective health outcomes through foreign policy. For example, Kassalow suggests US officials:

1. Conduct policy research and analysis to determine how health and health care affect political stability in countries of clear US interest.
2. Assess health risks in countries deemed critical to US national security and determine effective interventions.
3. Work with the World Health Organization to identify projects in which investments in improving and maintaining health can spur development.
4. Support research for vaccine and other health technology.[9]

In addition Drifmeyer and Llewellyn set out explicit recommendations for more effective military humanitarian assistance missions including implementing regulations, training, tactics, techniques, and procedure manuals for HA, ensuring military HA projects are thoroughly co-ordinated with other health care providers, and using measures of effectiveness as a condition of project approval and funding.[10] To date, however, few recommendations appear to have been implemented in military policy. Hospital ship medical HA missions do not have stated and measurable desired outcomes and goals, thus planners cannot staff, equip or resource in line with desired HA outcomes, nor can they appropriately capture costs that would allow assessment of the effectiveness and efficiency of the missions. Drifmeyer and Llewellyn specifically note that process measures for providing relief should not be confused with outcome measures of effectiveness. Rather than recording the number of immunizations given, mission commanders should measure and comment on the prevention or reduction of vaccine-preventable infectious diseases.[11]

Yet, to this day, hospital ships (and likely other) medical HA mission commanders continue to record patients seen, surgeries performed, immunizations given and related process measures; they continue to staff, equip, and resource medical HA missions as if they were combat support missions, they do not track longer-term health or reputational effects from the missions, and they do not collect data that would allow cost-effectiveness analyses of the missions.

Soft power

Soft power, as defined above, describes a way to attract and persuade others, rather than coerce them. Soft power helps obtain desired outcomes in development, disaster or other situations where military force is not an option.[12] It can be seen as an augmentation of power – an intangible force that helps achieve broader goals in the long run and can help foster security and stability – and can be obtained by:

> . . . Investing in global public goods – providing things people and governments in all quarters of the world want but cannot attain in the absence of leadership by the strongest country. Development, public health and coping with climate change are good examples.[13]

Although not yet measured well in the literature, researchers clearly believe providing public health services increases power and influence in the world. As McInnes notes, "[t]he promotion of global health may reap dividends in promoting the

image held of the West by others."[14] In addition to providing goodwill, medical HA missions allow the US to reassure its allies of the US's intent to support them.

More recently, the term "smart power" suggests the need to better combine traditional and "soft" or "soft power" operations:

> There remains a lack of strategic vision for how to integrate soft and hard power into "smart power" to address current and future challenges. [The Smart Power Initiative] seeks to engage in a national dialogue on the best way to draw to America's side the support of friends and allies in the pursuit of its national security interests.[15]

On the surface, hospital ship HA missions seem to be a perfect way to use American values and institutions to show others that we want to help them improve their quality of life. The "goodwill" or soft power benefits should come along with improving health conditions; thus, employing military assets in a strategy of soft or smart power could provide long-term security benefits. As Drifmeyer and Llewellyn noted, however, little preparation and no process collects needed data to verify whether health conditions are improved long term, much less whether soft power generation lasts beyond the mission.[16]

One might ask why the DoD has begun to take on activities more typically defined as "developmental" and "diplomatic." Specific to the hospital ships, their technical superiority, their lack of use as combat support platforms and the change in the world security environment after 9/11 explain much of the demand. Another explanation lies with the DoD's large number of personnel. In comparison, the DoD employs approximately 1.33 million uniformed members; the Department of State employs about 6,500 Foreign Service officers, and USAID, about 2,000.[17] As Kilcullen aptly notes, "there are substantially more people employed as musicians in defense bands than in the entire Foreign Service."[18] Patrick and Brown suggest the DoD's growing involvement in these activities probably comes from a "chronic US failure to invest in critical civilian dimensions of state-building [leaving] DoD and its Combatant Commands to fill the void."[19] Defense Secretary Robert Gates recently suggested the US strengthen its capacity to use soft power and integrate it with hard power by increasing funding for the State Department and other agencies that increase diplomatic, economic assistance and communications efforts,[20] suggesting that integration requires great co-operation and changes in funding among organizations. To date, roles and missions for various government agencies in providing the three Ds are not clear.

Health outcomes (perhaps arguably) do improve immediately following a mission. The only effort to assess overall mission effectiveness to date was one *post-hoc* public opinion survey conducted by the polling organization Terror Free Tomorrow, which assessed the Mercy mission to Bangladesh and Indonesia.[21] The study demonstrated the powerful potential returns to reputation these missions have, proving them capable of reversing anti-Western attitudes and beliefs.[22] While this was an excellent survey and a good means to measure one facet of the impact of the HA missions, no standardized or formalized process exists to assess this or other facets of HA missions, and no follow-on surveys appear to be forthcoming.

Without continuing measures of health outcomes and perceptions of US policy as a result of these missions, there is no way of knowing if soft power continues or how fast it declines. As Kickbusch notes, soft power can be short-lived and easy to destroy.[23] If seen as manipulative or done with the intent to achieve a US government goal not related to humanitarian assistance or disaster relief, soft power generated may rapidly evaporate. While soft power continues to be advocated, empirical evidence has not shown that military medical missions can and do generate it; nor do leaders or mission personnel set goals that can be assessed or collect data to help evaluate outcomes over time. As US foreign policy evolves, the hard questions on whether and how assets such as the hospital ships generate lasting effects for public health and soft power, will continue. Thus, it becomes doubly important to understand the outcomes hospital ships can affect as well as their costs, in order to properly evaluate alternative ways to generate the health, power and security benefits desired.

Security and stability

"Security and stability" tends to be used to mean affecting particular outcomes in a defense setting. Security and stability operations are those direct actions designed to promote social and political stability within an area by enhancing the host populations' health, well-being, access to essential services and the possibilities for economic growth.[24] The goals of security and stability operations may overlap with some of the goals of HA missions, each possibly generating soft power. The authors note, however, that security and stability operations and the generation of soft or smart power are different concepts. The terms are not interchangeable and represent part of the discussion of the exact uses the US has intended for and hopes to achieve with its military humanitarian assistance missions. No research to date provides evidence that hospital ship HA missions increase security and stability, and, as previously noted, very few begin to tie reputational or other effects to the missions. This may represent another avenue for future research into the long-term effects of medical HA missions.

US MILITARY POLICY AND HA

Humanitarian assistance as a military strategy has received more attention, and guidance has become more specific, in recent years. In 1994, DoD Directive 2205.2 defined the conditions for using humanitarian assistance in military operations. This directive and current authority for humanitarian civil assistance missions come from Title 10, USC. 401, Humanitarian and Civic Assistance Provided in Conjunction with Military Operations.[25] These programs include civil engineering projects, explosive ordinance disposal, programs to promote civil governance, and medical missions. Activities receive funding through the Overseas Humanitarian Disaster and Civic Action (OHDCA) appropriation, which funds the Humanitarian Assistance Program, the Humanitarian Mine Action Program, and Foreign Disaster Relief and Emergency Response.[26] These projects are "justified by their humanitarian benefit, training value, or for political reasons (e.g. 'showing the flag')."[27]

As planners began to view humanitarian assistance missions as viable and important adjuncts to military force, the role of HA in US policy evolved. The DoD now directs

planners that HA missions take at least equal priority to combat missions.[28] The Office of the Assistant Secretary of Defense–Global Security Affairs, Policy Guidance for FY08 Overseas Humanitarian Assistance, 2007, states that the,

> Highest priority for DoD senior leadership is to take action in the global war on terrorism (GWOT) using security cooperation tools such as HA missions where their activities are best integrated into regional security cooperation planning.[29]

Similarly, DoD Directive 3000.05, Military Support for Stability, Security, Transition, and Reconstruction (SSTR) Operations, 28 November 2005, states the DoD must give stability operations "priority comparable to combat operations."[30] These operations – HA provided by DoD during stability operations and theater engagement under the Overseas Humanitarian, Disaster, and Civic Aid (OHDACA) program – "are conducted to help establish order that advances US interests and values."[31] Several other DoD strategic doctrine documents, including the 2006 Quadrennial Defense Review (Department of Defense 2006), Cooperative Strategy for 21st Century Seapower and Forward from the Sea, also state HA missions take at least equal priority.[32]

As noted, HA missions are only one tool among many that may improve health and basic living conditions, generate soft power, and increase security and stability. HA is considered a flexible deterrent option, one of a range of military options available to combatant commanders. According to the Naval War College, flexible deterrent options are, "[. . .] designed to be used in groups that maximize integrated results from all the political, informational, economic, and military instruments of national power."[33]

US MILITARY HA GUIDANCE

Today, a multitude of documents provides guidance on HA goals. Starting at the top, the 2006 QDR lists four priorities for national defense. The third priority, to shape choices of countries at strategic crossroads, is most likely to guide the use of humanitarian assistance missions. The 2006 QDR also identifies four lessons (broad goals), three of which are directly relevant to HA activities, including the need to build partnership capacity and enabling partners to do more for themselves; shifting towards preventative measures; and increasing the freedom of action of the US and its allies.[34] Additional information is provided in the Office of the Assistant Secretary of Defense's Overseas Humanitarian Assistance Policy Guidance for Fiscal Year 2008, which states that humanitarian assistance missions should aim to achieve the following security goals:

- improve DoD visibility, access, and influence in a partner nation or region;
- generate long-term positive public relations and goodwill for DoD;
- promote interoperability and coalition-building with foreign military and civilian counterparts;
- enhance the legitimacy of the host nation by improving its capacity to provide essential services; and

- improve basic living conditions of the civilian populace in a country or region susceptible to terrorist or insurgent influence.[35]

While certainly laudable, these goals remain broad and vague. Looking to the combatant commands does not offer a clearer picture. A briefing on 23 September 2007 on the new African command (AFRICOM) illustrates the breadth, depth, and vagueness of US policy goals. In the brief, a Rear Admiral on the AFRICOM Transition Team stated the following goals:

- An African continent that knows liberty, peace, stability, and increasing prosperity.
- Fragile states strengthened; decreased likelihood of failed states; all territory under the control of effective democracies.
- Economic development and democratic governance allow African states to take the lead in addressing African challenges.
- Africans possess stronger capabilities; increased regional capacity to support post-conflict transformations and conduct peacekeeping/disaster response operations.
- Adversaries deterred or defeated; terrorism defeated throughout Africa and its ideology rejected and opposed by Africans.
- Regional access assured; lines of cooperation remain open; flow of strategic resources unimpeded.
- Vital interests and key infrastructure of US/partner nations protected; attacks against US and partner nations prevented.[36]

Clearly these goals encompass many issues outside traditional military policy, and many are stated goals of other government and international organizations such as the State Department, United States Agency for International Development (USAID), and the United Nations (UN). These agencies focus their expertise and resources on economic and political development and their personnel may be better qualified and be more likely to achieve the goals in the long run. While the DoD has received and spent an increasing and significant amount of funding on humanitarian assistance and other non-traditional activities, and the role of the DoD continues to evolve, it is not clear how hospital ships fit into US goals for national security.

The myriad of worthy, but in many instances vague, goals create a difficult situation for planners determining whether to undertake a hospital ship medical HA mission and assessing whether a mission was successful. The policy goals the authors have highlighted are non-measurable and non-verifiable (i.e., "terrorism defeated throughout Africa and its ideology rejected and opposed by Africans.") Those executing HA missions are currently faced with tasks that represent a clear shift for the military from its traditional roles, are guided by too many directives and too many goals that are not well-defined, have little empirical or theoretical basis from which to organize and manage, and may be operating outside of their traditional realms of expertise.

If the primary desired outcome of HA medical missions is improved medical care for local populations, and secondary desired outcomes are the improvement or increase in

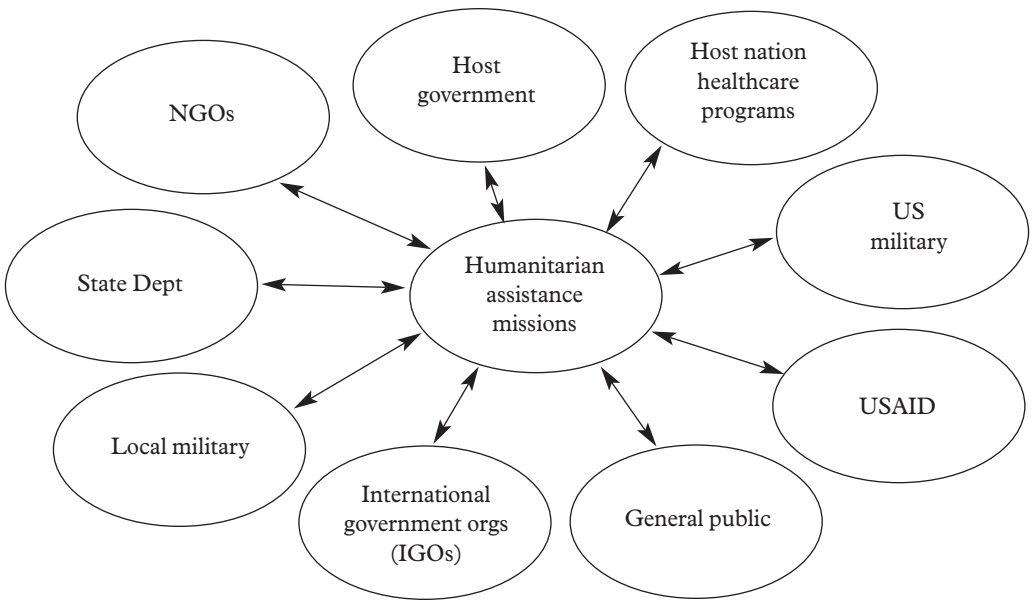
soft power, security and stability, planners must first design goals, objectives, and performance and cost measures that allow them to assess whether desired outcomes are achieved, and at what cost. They must better understand and work with important stakeholders to best use their resources, best direct their efforts and best achieve desired outcomes. In the next section, the authors discuss stakeholders important to navy hospital ship HA missions.

STAKEHOLDERS AND HUMANITARIAN ASSISTANCE

Many agencies and organizations play a role in humanitarian assistance efforts to increase the stability and security in a country or region and to ease human suffering.[37] Figure 1 shows some of the most important stakeholders who have the ability to influence the goals of military humanitarian assistance missions and can impact whether or not these missions are deemed a "success." To set clear and explicit goals, navy leaders should consider the roles and missions of the other complementary and/or competing stakeholders. Major stakeholders in humanitarian assistance include the US State Department, USAID, host government(s), international governmental organizations (IGOs), non -governmental/non-profit organizations (NGOs), local militaries, local health care organizations, and the public (general, host specific, and international).

To ensure that the DoD does not waste resources or complicate the provisions of foreign aid, the Policy Guidance for FY08 Overseas Humanitarian Assistance, 2007, states that "HA missions should complement, but not duplicate or replace, the work of other US government agencies, or other host nation authorities, international organizations, or local or international NGOs."[38]

Figure 1: Stakeholders in Humanitarian Assistance



The guidance discusses complementary goals relating to stakeholders, accountability, sustainability, effectiveness, and reporting, and states that HA projects should be complementary to US government development plans carried out by USAID and the Department of State. Changes in the relationships between these actors pose important questions.

Wheeler and Harmer stress that constructive discussion and agreement on core issues of responsibility and competence, as well as strategic engagement among defense and humanitarian organizations can improve understanding and provide better outcomes.[39] Partnerships between military forces and USAID are becoming more prevalent, leading to the need for greater co-ordination. The State Department and USAID clearly have a large role in co-ordinating and continuing development and other foreign aid in most countries in the world, and can provide information to combatant commanders and hospital ship planners to better integrate their respective missions.

Despite guidance to avoid duplication of effort, each stakeholder or group can act independently in light of its view of its own role in providing humanitarian and other assistance. The Department of State and USAID base their actions on the Secretary of State's direction and priorities for both organizations. Together, their strategic plan supports the policy positions set forth by the president, showing how they will implement US foreign policy and development assistance programs. In co-ordination with the State Department, USAID provides economic and humanitarian assistance in more than 100 countries and spent $23.53 billion on (non-military) foreign assistance in 2006. US military leaders set goals based on the directions and priorities of the Secretary of Defense. The Secretary of Defense creates the DoD's strategic plan to support the policy positions set forth by the President, just as the Secretary of State does. For decades, the State Department and DoD have worked in synergy on foreign affairs; at times with defense taking a more proactive role.

The debate on the military's future role continues: Should the military be used to ensure security with traditional military assets, training and strategies or should it (at least partially) move towards lower-intensity types of assets, training, and strategies, to include greater use of humanitarian assistance?

> Either way, however, it seems clear that, as long as the United States is involved in the world arena, military and foreign policy will remain inextricably linked and that the Defense Department will continue to be a major factor in both the policy process and the conduct of American affairs abroad.[40]

As Figure 1 suggests, the roles of the military in humanitarian assistance are not clear, and sit somewhat outside the traditional domain of stakeholders and providers of HA. No matter what a leader's view on assistance and how to generate soft power, security and stability, understanding of and negotiation with State Department, Congress, and National Security Council personnel will be critical in achieving US policy goals. Drifmeyer and Llewellyn illustrate some of the differing perspectives of and measures of effectiveness for participants in military HA projects. For example, host governments may have a multitude of expectations and goals arising when request-

ing or accepting humanitarian assistance. They may hope for additional materials or funds, may have political agendas, and frequently have some degree of suspicion or concern about partnering with the US.[41] Local militaries, as well, will likely have expectations or hopes regarding additional equipment, training, and perhaps funding, as a result of US aid work in their countries. While DoD goals for an HA mission should not be dictated by the host country and its military, an understanding of their needs and desires may be helpful in planning a mission that will be welcomed by the host country and result in better living conditions and increased soft power. In addition, clear communication from DoD officials as to US goals and desired outcomes with regard to both host country and other in-country governmental agencies will help the host country popularize the aid within their nation.

International organizations and non-governmental/non-profit organization (NGO) leaders also have expectations and goals related to the relationship between the international stakeholder and the country receiving aid. International organizations make up a relatively large and diverse group: they may be international non-profit organizations such as the International Committee of the Red Cross (ICRC) and Médecins Sans Frontiéres (Doctors without Borders); multinational corporations such as The Coca-Cola Company; religious groups such as Operation Blessing International and Church World Service, combining missionary work with humanitarian assistance projects; and intergovernmental organizations (IGOs) such as the UN, European Union and World Trade Organization. International non-profit organizations granted $7.29 billion USD in 2006, $4.57 billion of which came from the US alone. Each of these organizations has a different set of desired outcomes and goals when conducting HA work.

Even if the organizations' leaders choose to align themselves with the United Nation's Millennium Development Goals, the goals are broad enough to allow many different approaches to achieving them. This group of stakeholders may also have different views on US military humanitarian assistance. Some may wish to establish a relationship with the US military by participating as a partner on an HA mission, or by allowing military forces to provide security for their operations. Others may not be interested in partnering with the US military but in undertaking their own humanitarian assistance work independently. They may view US government "help" as a hindrance or unnecessary force in the region, perhaps causing security issues for their personnel by discrediting their nonpartisan status.[42]

Some research indicates that the US government may be seen as a "wolf in sheep's clothing," suggesting to other nations that US defense and development agendas are merging with a defense agenda.[43] These goals may or may not be made explicit in US policy, but stated or otherwise, they influence international participation in and perception of humanitarian assistance missions and the generation of soft power.

Indigenous NGOs and local health care (government or private) organizations also have goals for medical HA missions, and are essential for providing the long-term, follow-up delivery of health care operations started or enhanced by the military mission. One of the greatest pitfalls with medical HA missions is the mismatch of the level of care provided by well-intentioned planners and the level of follow-on care available to the individuals once the medical HA mission leaves the area.[44] While the US

has the capability to provide world-class medical treatments, especially in the realm of surgery, there are questions about what happens after the ship leaves. What is the long-term prognosis of the patients seen? Does the country have follow-up care for surgeries, medications, etc.? Does it have the basic sanitation and clean water needed to maintain better health? How were patients selected? How do we know that work started will be continued? Alignment of the goals of military planners with the goals of indigenous healthcare providers may mitigate some of the issues surrounding level of care.

Finally, the public's perceptions, actions, and desires can impact the goals of HA missions. As Etzioni notes, "a nation can choose to disregard global public opinion. However, such disregard will have real costs."[45] "The public" is a broad term; there are several important components within this group. First, the US public, which funds these missions through its taxes, wants to know the missions "do good," and wants assurance that funds are being wisely spent. The global community judges the actions of the US and the US military by its perceptions of how effective the humanitarian missions are and their (relative) costs to the host country. In addition, the global community weighs actions against possible motives, trying to assess the true intent and desired outcome of any mission outside US borders. Finally, the public in the host country influences its government's views on whether or not the mission has been a success, and may have agendas, expectations and desired outcomes that influence other actions within the country.

In sum, a myriad of organizations and leaders view themselves as stakeholders in the humanitarian assistance missions conducted by the US military. Clearly, it may not be possible or advisable to please all of them or align with their interests. Important for navy planners is to be conscious of the disparate forces influencing HA missions, making a conscious choice of the strategic alignments to pursue. As they have in past operations, but perhaps increasingly so as DoD moves into more preventive actions, DoD and Navy planners should be willing, allow time for, and devote resources to better understanding important stakeholders and how to interact with them to achieve better outcomes. Integrated planning can result in both vertical alignment of goals with higher-level DoD desired outcomes, and horizontal alignment with the desired outcomes of the US government and other stakeholders. As Casey *et al.* note, cross-organizational awareness can avoid situations where people with clear goals and the motivation to achieve them plow ahead, creating unintended negative consequences for others.[46]

DESIRED OUTCOMES, SPECIFIC GOALS AND MEASURES FOR HOSPITAL SHIPS

Several researchers have begun to offer suggestions on how to tie broader goals to performance targets (measures of the impact) of humanitarian programs. Nelson *et al.* provide general guidelines for measuring effectiveness of HA operations.[47] The Center for Disaster and Humanitarian Assistance Medicine (CDHAM), Reaves *et al.*, and Bonventre all provide suggestions to begin to assess outcomes of the missions.[48] Drifmeyer and Llewellyn's list of planning and evaluation questions for HA medical missions offers an exhaustive list of ideas for any planner, or any stakeholder, to begin to understand how to measure and direct desired outcomes of medical HA missions.[49]

Recent events suggest the DoD is moving towards HA operations that use impact assessments to guide current and future actions.[50] Reaves *et al.* note the importance of readiness assessments (to undertake HA missions)[51] and Hoffman *et al.* state that outcome selection is essential in assuring "strong diplomatic partnerships with recipient HNs [host nations] and ensure mutually favorable HA program results."[52] As in the case of all good performance targets, Reaves et al. note that outcome states should include "the population affected location, percent change or quantity desired in indicators and duration (over what period of time change is expected)."[53]

Again, once goals and desired outcomes are defined, these studies provide excellent guidance on how to begin to measure performance in the HA context. They offer a good starting point for ideas, but require additional thoughts on implementation, data collection, cost analysis and other analyses to help align hospital ship HA missions with desired outcomes of policy. The authors suggest focusing on a few broad objectives for US military medical HA missions, then limiting them to attainable and reasonable specific goals and desired outcomes for hospital ship medical HA missions:

- To improve country-specific basic medical conditions that are needed and sustainable (supported by US, allied or other stakeholder groups) to include providing essential medical care, training local medical personnel, and transferring equipment and medications, where appropriate and useful.
- To strengthen the ability of a country to govern itself by allowing government to provide essential health care.
- To positively influence public perception of the US and the US military.
- To strengthen ties with a country or region to include increasing military co-operation from/within a region or country.

In order to make progress in towards these objectives, the authors specifically recommend:

1. Formulating hospital ship mission goals that "shape choices of countries at strategic crossroads" and are in line with medical outcomes ships can affect

Leaders must formulate mission goals in line with OHDACA, the 2006 QDR, and specific country information. The authors believe hospital ships will be most effective when their missions "shape choices of countries at strategic crossroads"[54] and focus specifically on the medical outcomes mission personnel can effect. In essence, leaders should try to help countries help themselves. As the Chinese proverb says, "Give a man a fish and he will eat for a day. Teach a man to fish and he will eat for the rest of his life." Hospital ships can make substantial contributions to capacity building, and therefore security, stability and soft power, by working with other stakeholders to teach countries how to improve their basic living conditions through better medical care.

2. Planning for medical humanitarian assistance missions rather than combat support missions, focusing on basic country healthcare requirements

Given the importance attached to humanitarian assistance missions in current national security policies, the authors suggest navy leaders reverse the primary and secondary

missions and revisit the issues of what services, equipment and resources to provide, and staffing and supplying the ships. Currently, combat support medical needs guide the staffing, equipment, and medications supplied for hospital ship missions. Because planning and execution is based on professional and technological platform capability, "success" can be at least partially claimed when hospital ship billets are filled with "correct personnel".[55] When planning for a combat support mission, personnel plan for self-sufficiency; for an HA mission, other factors such as co-ordination, communication and advance planning outside the military become more important. In addition, the region of deployment likely varies depending on whether the ship's mission is combat or HA, which also has implications for supplying the ship and readying its staff. Preparing for combat operations implies that the ship's ability to take on a humanitarian assistance mission will be compromised.

Cooperman and Houde specifically address manning for hospital ship HA missions.[56] They suggest that to effectively use DoD medical assets, medical planners follow a country-centric planning approach, identifying basic country healthcare requirements and intervention control programs to achieve meaningful long-range outcomes.[57] Their suggestions also apply to other resources used to produce the missions. To date, no studies address equipment and medication needs for hospital ship medical HA missions, nor do they address procedures used on board ship for these missions. Supplies for medical HA missions should differ from those supplied for traditional missions. Currently, equipment, medications and other supplies for hospital ship HA missions come from available (government or private) or donated US materials (and are valued at US retail prices!). These are distributed sometimes despite the fact that they may not be appropriate given the local health status or system, nor maintained or continued over time.

Rather than staffing and equipping under this legacy, planners should make better use of the many data sources such as the World Health Organization (WHO), United Nations International Children's Fund (UNICEF), and individual Country Co-operation Strategies available from WHO, that can inform planners about core medical services appropriate to the mission environment. Cooperman and Houde advocate aligning HA mission operations to support a country's progress towards the United Nations Millennium Development Goals (MDGs).[58] These goals include reducing child mortality, improving maternal health, achieving universal access to reproductive health, combating HIV/AIDS, malaria and other diseases, and increasing the number of people with access to safe drinking water and basic sanitation. The United Nations member states (189 countries) have agreed to try to achieve these eight MDGs by the year 2015.[59] The authors recommend these issues be studied thoroughly once data to allow country- and region-specific needs are analyzed.

3. Better addressing, planning for and evaluating interactions with stakeholders

Because partner agencies (other militaries, non-governmental organizations or host country participants) increasingly take larger and more active roles, hospital ship planners should make every attempt to include these important stakeholders in their planning, execution and evaluation processes. Examples where better co-ordination

could have resulted in better outcomes abound. On recent missions, for example, planners knew the numbers of embarked NGO and Allied volunteers at each port of call, but did not know if these were the "best" or "optimal" numbers to have on board, nor whether their specialties could be used. (Some participant satisfaction surveys indicated that given the issues of port accessibility, more volunteers were on board than could be effectively used to provide services.)[60]

These issues impact mission effectiveness in many ways including medical care provided, strategic partnerships with allied militaries and NGOs, and overall impact of the mission on the host nation(s); thus, greater interaction with host nation, State Department, USAID, NGO and other important stakeholders can help ensure better long-term effects of the missions. Additionally, survey or other instruments to help evaluate important stakeholder interactions and jointly-produced services should be employed.

4. Formulating and implementing procedures for collecting data on outcomes, costs, stakeholder involvement, and long-term reputational effects (soft or smart power)

Currently, the information collected by hospital ships does not allow assessment of the effectiveness of HA missions. Ship personnel collect data on the number of patients seen at each location (port of call) by ICD-9 (international classification of diseases) category. They collect information on the number of surgeries, medical procedures, and dental procedures, as well as donations of equipment and supplies (such as glasses). While important, these data contain no details about the patient populations reached, nor any means to estimate impacts on these populations. Similarly, while information is gathered about the number of training sessions provided and the number of attendees at these sessions, demographics on the trainees and the population whom the trainees serve are unknown. All of these measures are estimates of outputs – services and goods provided – but do not address their impact, the outcome of these efforts.

Leaders must plan collection and evaluation methods for specific information on outcomes and costs. For example, if improving long-term health is the goal, navy leaders should plan to monitor country-specific information on health before, during, and after (for a considerable time) a mission. They should compare the information with MDGs and examine the programs already being undertaken by stakeholders. They should work closely with USAID and the State Department to co-ordinate efforts. They should then plan and track actions in terms of their alignment with country-specific and Millennium Development goals. Finally, they should track information on long-term prognosis of patients seen (to assess overall indicators such as maternal health or child mortality improvements) including measures of follow-up care for (and costs of) surgeries, medications, access to clean water, etc.; demographic information on trainees, on equipment donated, and any activity that has consequences for the host country's medical system in the long run. These types of measures show tangible positive outcomes to health conditions. Collected with cost data, they would allow leaders to compare the costs and benefits of providing services using hospital ships, and allow decision-makers to compare the cost and effectiveness of using other types of medical assets to those of hospital ships.

With respect to intangible outcomes, hospital ship missions (by attending to needed health care) help the US send a signal within the host nation, regionally, and even globally, that the DoD and the US government respond to humanitarian needs and have an interest in the well-being of those in need. Indirect benefits (gains in soft power, for example) to US interests may arise in many ways. Possibilities and, accordingly, things to be tracked, include development of a populace's confidence in its national government's ability to provide essential services; public opinion of US policy over time; and collaboration and coalition building among US military and foreign military and civilian counterparts (including access and interoperability measures). Although difficult, measuring public and government responses through the media, surveys, counting access received, military support or local organizations involved and other methods, can provide data on the impact of hospital ship HA missions over time.

CONCLUSIONS AND POLICY RECOMMENDATIONS

US and DoD policy do not set clear goals for navy hospital ships. Due to their technological superiority, lack of use as combat support platforms, large numbers of personnel and the change in the world security environment in recent years, hospital ships have seen a considerable increase in demand for their ability to provide humanitarian assistance and disaster relief. What must follow is the integration of policy and direction from the DoD and other government planners to the State Department, USAID, and other important stakeholders. Navy planners must be conscious of the disparate forces influencing hospital ship HA missions and must be willing to devote time and resources to better understanding stakeholders, outcomes they can effect, and how to pursue them most effectively and efficiently.

Keys to success include formulating hospital ship mission goals that shape choices of countries at strategic crossroads, but are constrained to medical needs in a given country or area, and outcomes hospital ships can affect; planning for medical HA missions rather than combat support missions, to include reversing the primary and secondary missions of the hospital ships; better addressing, planning for and evaluating interactions with important stakeholders; and formulating and implementing procedures for collecting data on outcomes, costs, stakeholder involvement and long-term reputational effects of the missions. This will require changes to staffing, equipment, supplies and procedures on board hospital ships and refocusing on outcomes or impacts achieved, over time. A change in philosophy, plus well-crafted and communicated goals and priorities for the use of hospital ships are essential if the ships are to achieve desired policy outcomes.

NOTES

1. S. Patrick and K. Brown, *The Pentagon and Global Development: Making Sense of the DoD's Expanding Role*, Washington DC: Social Sciences Research Network, 2007, p. 7.
2. From http://www.mercy.navy.mil/index.htm.
3. K. Cooperman and L. Houde, *A Strategic Approach to Humanitarian Medical Military Manpower Planning,* Monterey, CA: Naval Postgraduate School, 2008.
4. Patrick and Brown, *op. cit.*, p. 14.

5. Reuben Brigety, "Striking the Appropriate Balance: The Defense Department's Expanding Role in Foreign Assistance", *Testimony of Dr. Reuben E. Brigety, II Before the Committee on Foreign Affairs, US House of Representatives,* Washington DC, 18 March 2009, p. 1.
6. Joseph Nye, "Soft Power: The Means to Success in World Politics", *Public Affairs*, 2004.
7. Harvey I. Sloane, Edward J. Burger and Richard G. Farmer, "Making Friends and Saving Lives", *World Policy Journal*, Winter 2001/2002, p. 2.
8. J. Drifmeyer and C. Llewellyn, "Military Training and Humanitarian and Civic Assistance", *Military Medicine*, 2004.
9. J. Drifmeyer and C. Llewellyn, "Military Training and Humanitarian and Civic Assistance", *op. cit.*, p. 162. Also, Jordan S. Kassalow, *Why Health is Important to US Foreign Policy,* Milbank Memroail Fund Report, New York: The Council on Foreign Relations, 2001, p. 4.
10. J. Drifmeyer and C. Llewellyn, "Toward More Effective Humanitarian Assistance", *Military Medicine*, 2004, pp. 161–168.
11. J. Drifmeyer and C. Llewellyn, *Military Medicine*, *op. cit.*, p. 162.
12. Joseph Nye, *Soft Power*, *op. cit.*,
13. Joseph Nye, "Smart Power", *New Perspectives Quarterly*, 2009.
14. C. J. McInnes, "Looking Beyond the National Interest: Reconstructing the Debate on Health and Foreign Policy", *Medical Journal of Australia*, 2004, pp. 168–170.
15. Center for Strategic and International Studies, *CSIS Commission on Smart Power: A Smarter, More Secure America.*, Washington DC: The CSIS Press, 2007.
16. J. Drifmeyer and C. Llewellyn, "Overview of Overseas Humanitarian, Disaster and Civic Aid Programs", *Military Medicine*, 2003, pp. 975–980.
17. DoD figures taken from National Defense Budget Estimates for 2008, Office of the Undersecretary of Defense (Comptroller), March 2007; other figures from Wikipedia, 27 October 2008.
18. D. Kilcullen, "Lieutenant Colonel David Kilcullen of the Australian Army, a senior advisor to General David Petraeus, Commander of the Multinational Force in Iraq", 2005, http://usinfo.state.gov/journals/itps/0507/ijpe/kilcullen.htm.
19. Patrick and Brown, *op. cit*.
20. Nye, *Smart Power*, *op. cit.*, p. 1.
21. The authors note that the Naval Health Research Center studied the 2006 *Mercy* deployment and reported its findings in a PowerPoint presentation. Other DoD and DoD-contractor presentations may exist; the authors have seen several, but have not seen final reports.
22. E. D. McGrady and D. Strauss, *USNS Mercy Humanitarian Deployment: What is the Meaning of Naval Engagement?*, Alexandria, VA: Center for Naval Analysis, 2007.
23. I. Kickbusch, "Influence and Opportunity: Reflections on the US Role in Global Public Health", *Health Affairs*, Vol. 21, 2002, pp. 131–141.
24. D. Nathanson, *Security and Stability Operations Measures of Effectiveness*, Providence, RI: Naval War College, 2005.
25. From the US Code Online via GPO Access, http://wais.access.gpo.gov, laws in effect as of 3 January 2006. Also, P. Darrell, "Use of Operations and Maintenance Funds During Deployment: An Informative Overview of the Use of O&M Funds During an Overseas Deployment, Exercise or Other Military Operation", *Entrepreneur.com*, 2006.
26. Serafino, *The Department of Defense Role in Foreign Assistance: Background, Major Issues, and Options for Congress*, Washington DC: Congressional Research Service, 2008; R. Margesson, *International Crisis and Disasters: US Humanitarian Assistance, Budget Trends, and Issues for Congress*, Washington DC: Congressional Research Service, 2007; DoD Security Cooperation Agency, *Overseas Humanitarian, Disaster, and Civic Aid (ODHDCA)*, Washington DC: Department of Defense Security Cooperation Agency, 2005.
27. J. Drifmeyer and C. Llewellyn, "Overview of Overseas Humanitarian, Disaster and Civic Aid Programs", *Military Medicine*, 200, p. 7.
28. HA efforts encompass many activities with an overall goal of relieving human suffering. This

general use differs from the specific use from Title 10. Following the lead of Drifmeyer and Llewellyn (2003), the authors use the general term "humanitarian assistance" when discussing broad goals and activities, and use the abbreviation "HA" when referring to the statutory program.

29. The Office of the Assistant Secretary of Defense-Global Security Affairs, Policy Guidance for FY08 Overseas Humanitarian Assistance, 2007.
30. DoD Directive 3000.05, *Military Support for Stability, Security, Transition, and Reconstruction (SSTR) Operations*, 28 November 2005, p. 2.
31. *Ibid*.
32. Department of Defense, *Quadrennial Defense Review*, Washington DC: United States Congress, 2006; Cooperative Strategy for 21st Century: Seapower and Forward from the Sea.
33. Naval War College, *Joint Doctrine for Campaign Planning*, Newport, RI: Naval War College, 2006, p. A-1.
34. Office of the Assistance Secretary of Defense for Health Affairs, *Policy to Improve Military Treatment Facility (MTF) Primary Care Manager Enrollment Capacity*, Washington DC: Department of Defense, 2007, pp. 2–3.
35. *Ibid*.
36. R. Moeller, "*Powerpoint Presentation by AFRICOM Transition Team*", Washington DC, 2008.
37. Ed. McGrady and D. Strauss, *op. cit*.
38. *Policy Guidance for FY08 Overseas Humanitarian Assistance*, 2007.
39. V. Wheeler and A. Harmer, *Resetting the Rules of Engagement: Trends and Issues in Military-humanitarian Relations*, HPG Research Briefing, London: Humanitarian Policy Group, Overseas Development Institute, 2006, p. 1.
40. http://www.americanforeignrelations.com, p. 3.
41. Center for Naval Analysis, 2006.
42. For example, Médecins Sans Frontiéres (Doctors without Borders), withdrew from Afghanistan after nine of its employees were killed. Its leaders cited their fears that their security was compromised by appearing to have anything in common with security and military forces.
43. M. Malan, "AFRICOM: A Wolf in Sheep's Clothing?", Testimony by Mark Malan before the Subcommittee on African Affairs, Committee on Foreign Relations, US Senate, at the hearing entitled "Exploring the US Africa Command and a New Strategic Relationship with Africa", Washington DC: Refugees International, 1 August 2007.
44. Cooperman, *op. cit*.
45. Amatai Etzioni, *Security First: For a Muscular, Moral Foreign Policy*, New Haven, CT: Yale University Press, 2007, p. 5.
46. W. Casey, W. Peck, N. J. Webb and P. Quast, "Are We Driving Strategic Results or Metric Mania?", *International Public Management Review*, 2008, pp. 90–106.
47. J. Nelson, S. Newett, J. Dworken, K. McGrady and K. LaMon, *Measures of Effectiveness for Humanitarian Assistance Operations*, Alexandria, VA: Center for Naval Analyses, 1996.
48. The Center for Disaster and Humanitarian Assistance Medicine (CDHAM) Center for Disaster and Humanitarian Assistance Medicine (CDHAM), *Measuring the Effectiveness of Humanitarian Assistance other than Department of Defense Providers*, Bethesda, MD: CDHAM, 2007; CDHAM, *Measuring the Effectiveness of Department of Defense Humanitarian Assistance*, Bethesda, MD: CDHAM, 2003; E. J. Reaves, K. W. Schor and F. M. Burkle, "Implementation of Evidence-based Humanitarian Programs in Military-led Missions: Part II. The Impact Assessment Model", *Disaster Medicine and Public Health Preparedness*, 2008, pp. 237–244; E. J. Reaves, K. W. Schor, and F. M. Burkle, "Implementation of Evidence-based Humanitarian Programs in Military-led Missions: Part I. Qualitative Gap Analysis of Current Military and International Aid Programs", *Disaster Medicine and Public Health Preparedness*, 2008, pp. 230–236; and E. Bonventre, "Monitoring and Evaluation of

Department of Defense Humanitarian Assistance Programs", *Military Review*, 2008, pp. 123–129.
49. J. Drifmeyer and C. Llewellyn, "Overview of Overseas Humanitarian, Disaster and Civic Aid Programs", *Military Medicine*, 2003, Tables 2 and 3, pp. 13–14.
50. A 2008 conference hosted by the Partnership Strategy Office on DoD HA began the process of getting combatant commanders and their staffs, USAID, State Department and others to discuss desired outcomes and how to measure them using an impact assessment modeling technique, Reaves, *Implementation of Evidence*, *op. cit*, p. 239.
51. *Ibid*.
52. C. A. Hofmann, L. Roberts and J. Shoham, *et al.*, "Measuring the Impact of Humanitarian Aid: A Review of Current Practice", *Humanitarian Policy Group Research Briefing Website*, 21 November 2006, http://www.odi.org.uk/hpg/papers/hpgbrief15.pdf.
53. Reaves, *Implementation of Evidence*, *op. cit.*, p. 4.
54. Department of Defense, *Quadrennial Defense Review*, Washington DC: United States Congress, 2006.
55. The operational plan (OPLAN) for both ships adjusts manpower requirements and authorizations for each platform allocated to each vessel (Levy and Miller, 1998).
56. Cooperman and Houde, *op. cit.*
57. Cooperman and Houde, *op. cit*. present this suggestion in the context of optimizing manpower resources; however, their work applies to a more comprehensive view of overall operational effectiveness.
58. *Ibid.*
59. For more on MDG, see OECD Development Co-operation Directorate webpage at: http://www.oecd.org/about/0,2337,en_2649_34585_1_1_1_1_1,00.html. For more on MDG Indicators, see http://mdgs.un.org/unsd/mdg/Default.aspx.
60. D. Strauss, *Input to COMPACFLT Assessment of USNS Mercy's Humanitarian Operation: Drivers for HA from the Sea*, Alexandria, VA: Center for Naval Analysis, 2007.