Operation Provide Comfort

A Cry for Help—The Military Role in Humanitarian Aid

Lt Col Joseph M. Harmon III*

A detailed description of the preparation for and actual deployment to Turkey of the military medical team that assisted in the operation Provide Comfort.

There is a lesson for the US Army hidden amidst the success of the Operation Desert Shield/Storm campaigns. It is one that has little to do with the lessons learned from the war itself, but rather focuses on a mission that was an outgrowth of the Persian Gulf War—the use of military forces to provide humanitarian aid on an international scale. The future use of US military forces for operations such as Provide Comfort is hard to ignore, and will almost certainly include medical personnel in a variety of roles. Considerable discussion and professional debate on this type of mission seems appropriate given the potential for future involvement. The purpose of this article is to review the health service support of Operation Provide Comfort and, more importantly, to suggest its application to similar operations in the future.

Operation Provide Comfort, the coalition effort to aid the Kurdish refugees that fled from northern Iraq into southeastern Turkey, combined a multinational military and civilian force into an international relief effort while simultaneously conducting defensive combat operations to ensure the safety of the refugees and coalition members. US Army medical personnel played a key role in the operation from the outset, and gained invaluable experience in the process.

Operation Provide Comfort (OPC) was initiated on April 6, 1991. The Commander in Chief, US European Command (CINCEUCOM) was designated the supported CINC and began to build a combined task force from assets in Central Europe, the United Kingdom, and Turkey. US Army Europe's 7th Medical Command was tasked to deploy the initial medical survey team to assess the medical situation confronting the Kurds in southeastern Turkey and northern Iraq. The six-member team—physician/team chief, operations officer, physician assistant, logistics officer, and two medical NCOs—deployed on April 8, 1991 to linkup in-country with the Disaster Assistance Survey Team (DAST) formed by EUCOM, the Office of Federal Disaster Assistance (OFDA), and civilian relief agencies.

One of the first things that became apparent to the team upon arrival at Incirlik Air Base, Turkey, was the overwhelming size of the area of operations (AO) (Fig 1). The AO covered 83,028 square miles, greater than the area of the State of Kansas. The Combined Task Force (CTF) headquarters at Incirlik Air Base in the west was 491 miles from the Humanitarian Service Support Bases (HSSB) at Yuksekova in the east. The distance from Diyarbakir, Turkey in the north to Dihok, Iraq in the south was 169 miles (Fig 2). Compounding the distance problem was the extremely rugged,

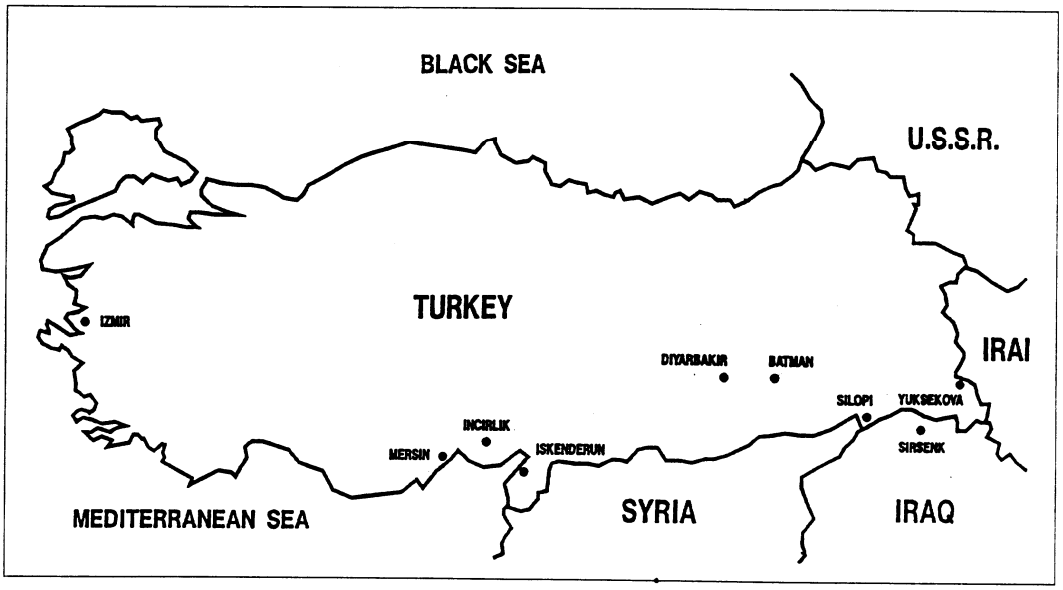

Figure 1. Geographic locations of camp sites assisted by operation Provide Comfort.

*Chief, Current Operations, 7th Medical Command, APO AE 09403.

mountainous terrain throughout the region which required almost total dependence on aircraft for the movement of relief supplies and personnel.

Although variable throughout the operation, the size of the Kurdish refugee population was estimated between 360,000 to 760,000 civilians who had fled their homes to escape the attacking Iraqi Army, and were clinging to life on the mountain cliffs along the border between Turkey and Iraq. Reconnaissance flights had identified 43 separate locations and eight major camp sites (Fig 3). All were enduring harsh weather conditions and suffering from a critical lack of potable water, food, shelter, sanitation, and medical care. They had fled their homes with all they could carry and driven as far into the mountains as their vehicles would take them. When they could no longer drive, they got out and walked, carrying each other and their possessions on their backs. They went as high as they could climb until stopped by either the mountain terrain or the Turkish Army. There on the side of dozens of mountain cliffs they waited for the world to help.

The initial estimates of the size of the refugee population and their condition were provided by international relief agencies working the area, and the international press. The medical survey team used this preliminary data as a starting point, but requested CTF authorization to visit each of the known camp locations to conduct an assessment of the medical priorities in each of the camps. This request was repeatedly denied by CTF due to their concerns about the safety and security of the team in the camps, and ultimately resulted in the initial medical support plan being developed without the benefit of an onsite medical survey. The medical survey team was not allowed to visit any camp until it had been secured by the 10th Special Forces Group (ABN), who had operational control of the camp areas. The intent of Iraqi forces in the area, numbering more than eight divisions, as well as the terrorist threat from Kurdish extremists of the PKK and Peshmerge guerilla factions, made for a very unstable situation. Mines and booby traps left from Saddam Hussein's operations in the area exacerbated the situation. This conflict between the humanitarian aid mission and the unstable security situation was not satisfactorily resolved until coalition ground combat forces had cleared and occupied the 50km x 150km security zone in northern Iraq. Even though it was a humanitarian aid mission, the security situation was never clear enough to allow the aid teams, other than armed Special Forces Detachments, to operate freely in the mountain camps. The security of the force was never compromised to achieve humanitarian objectives.

The medical survey team concentrated its initial efforts on the immediate objectives of stopping the dying and suffering and stabilizing the population in the camps. A series of assessment questionnaires was developed for use by the Special Forces teams in the camps to determine the priority of medical need in each camp. The team was aided in this by the addition of two preventive medicine experts from the US Navy, Europe's Environmental Preventive Medicine Unit #7 in Naples, Italy, and the guidance of the OFDA panel of medical and disaster experts flown in from the United States to lead the overall effort. The lack of a support infrastructure or distribution system in the camps was making it extremely difficult for aid to get to the most needy. The tremendous airdrop of food and shelter being flown to the camps each day needed to be focused. After briefing each of the Special Forces teams prior to their deployment into the camps, the medical survey team, which had by now become the Combined Task Force Surgeon and staff, turned its attention to the development of a medical task force to support the refugees and the coalition. The medical concept of operation called for a dual track system capable of handling the refugee's initial needs, medical supply support sustainment, and transition of their care to international and private volunteer relief agencies. Coalition forces, on the other hand, required routine and emergency medical treatment, hospitalization, and evacuation to definitive care as required. Twelve nations responded with military medical forces to support the coalition (Fig 4), while more than 50 international and private volunteer relief agencies pushed into the camps to begin the process of sustaining the refugees for a long term stay. A natural division of labor was possible with the military medical forces, as each combat unit had its own unit level medical support, and 50% of the 12 nations had either hospitalization capability, evacuation, or both. These forces were primarily distributed in support of national combat forces throughout the security zone, with the additional mission of refugee support in their areas of operation. Placement of the relief agencies proved to be an awesome task. Most had significant experience from previous international relief efforts and a clear sense of what it was their organizations wanted to accomplish. While all were motivated by a sincere desire to help the Kurdish refugees, they were unaccustomed to working within the confines of a coordinated team effort and were zealously independent in thought and deed. Nonethelees, a cooperative spirit prevailed, and agencies with particular skills or experience were assigned tasks and areas of responsibility within the camps and the security zone. The assumption of responsibility by the United Nations High Commissioner for Refugees (UNHCR) as the umbrella under which all civilian relief agencies would work, proved to be an excellent way to organize and orchestrate the critical contributions of so many diverse agencies. This "assumption of command" by UNHCR was a major step in the transition from military to civilian control of Operation Provide Comfort.

As responses to the assessment questionnaires began to come in from

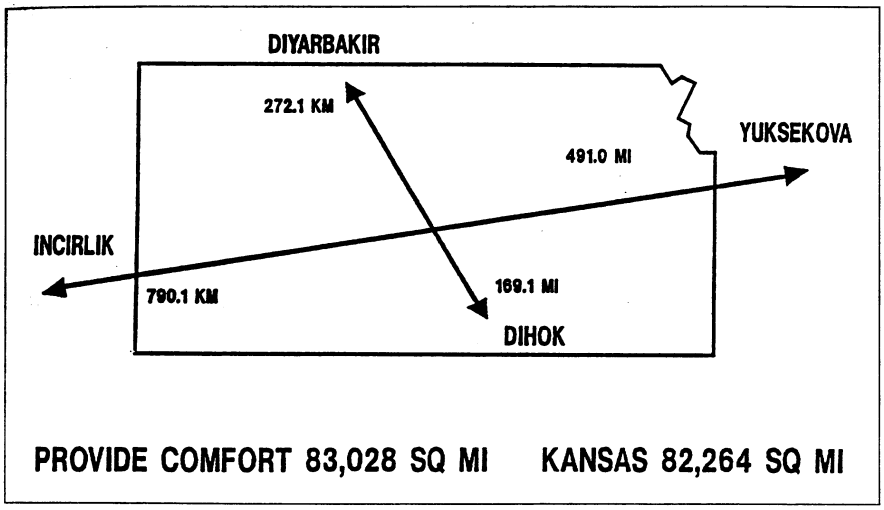

Figure 2. AOR maximum dimensions.

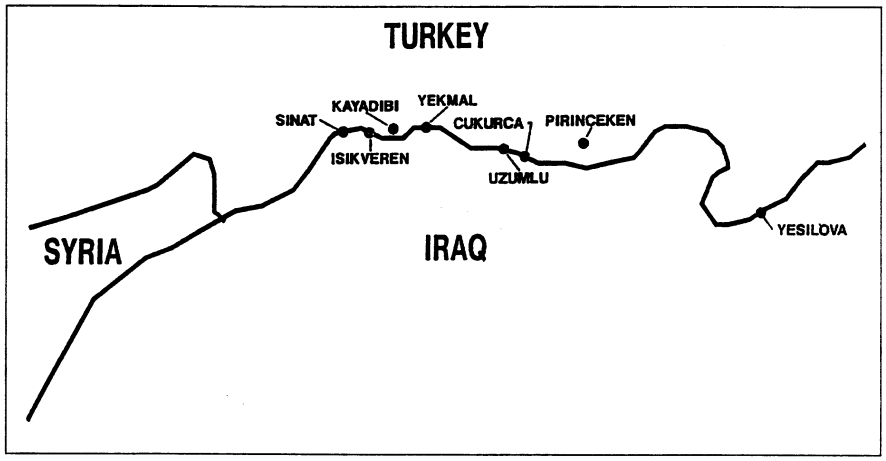

Figure 3. The refugees were collected in 43 separate locations and eight major camp sites.

COUNTRY/CARE	OUTPATIENT	HOSPITAL	EVACUATION
AUSTRALIA	X		
BELGIUM	X		
CANADA	X		X
FRANCE	X	X*	X
GERMANY	X		
ITALY	X	X*	X
LUXEMBOURG	X		
NETHERLANDS	X	X	
SPAIN	X	X*	X
TURKEY	X		
UNITED KINGDOM	X	X*	X
UNITED STATES	X	X*	X

= SURGERY

Figure 4. Military Health Care Support.

the SF teams in the camps, a clear picture of the medical requirements emerged. Malnutrition and diarrheal diseases were the major contributing factors to the morbidity and mortality rates. As could be expected, the hardest hit groups were the very young and the old. Infant mortality was especially high and was targeted for immediate relief. Clean water became the most critical item of supply for the camps. Oral rehydration salts were used throughout the camps to stop the diarrhea. Education classes for mothers, and special feeding programs for mothers and their infants, began to turn the tide. Within one month of initiating this program, the infant mortality rate had fallen to levels normal for the area. Camp sanitation also received high priority, and the SF teams, civil affairs, medics, and engineers worked diligently to establish proper sanitation in the camps. This effort was supported by the camp leadership which had been reestablished by the SF teams. As relief supplies continued to pour into the camps, less acute medical problems were treated and the medical personnel began to see more patients with chronic long term illness.

With the immediate objectives met, the coalition turned its attention to the resettlement of the refugee population at temporary sites in northern Iraq. The establishment of a secure, sustainable environment was the key to getting the Kurdish people out of the mountains before the summer drought made their position untenable. Joint Task Force Bravo (JTF-B), with the majority of coalition combat forces assigned, was given the mission of providing this safety zone and relocating the refugees out of the mountain camps.

JTF-B began by establishing, and then expanding, the security zone north of the 36th parallel in Iraq. Most of the Kurdish refugees had left homes in this area, and were not anxious to return and face the Iraqi army. The Kurdish leaders were insistent that they would not leave the mountain camps unless the coalition could

guarantee their safety. JTF-B concentrated on securing the key cities within the security zone and then all the territory in between. Coordination of coalition intent with the Iraqi military leadership, overflights by coalition combat aircraft, and the presence of maneuver forces on the ground all contributed to the success of this effort without any major confrontations between coalition and Iraqi forces. The disposition of Iraqi forces on April 7, 1991 as shown in (Fig 5) was replaced by coalition forces arrayed as shown in (Fig 6). All Iraqi forces were withdrawn south of the 36th parallel to areas south of the key provincial city of Dihok. While working to clear the security zone, JTF-B also began construction of three transit centers for the temporary resettlement of the refugees. Each center was designed to replicate the clan and family structure of the people and to be self-sustaining. Each was built with the help of Kurdish men and scheduled to house 25,000. The centers were initially supported by coalition military forces, but quick turnover to international relief agencies proved highly successful. As centers were readied for occupation, all manner of trucks and busses were contracted to bring the Kurds out of the mountains and into the centers. As each group arrived, they were medically screened, treated, and assigned to a section of the center. Many of the people simply returned to their homes rather than the centers. Others used the centers until they were able to reconstruct their homes. Assets of the Combined Task Force were brought into the city of Zahko, and later Dihok, to reestablish essential city services such as power, water, schools, and medical clinics and hospitals. This effort increased the pace of the return of the Kurdish people to their homes and obviated the need for lengthy transit center operations. In keeping with the original intent of the operation, military forces continued to expedite the handover of functions to their civilian aid counterparts.

Medical operations continued to keep pace with the security operations and the need for refugee support during their transition from the mountain camps to the transit centers. A massive measles immunization campaign was conducted by US medical personnel in cooperation with UNICEF and the Center for Disease Control. Thousands of children were vaccinated during this program. Preventive medicine disease investigation prevented the outbreak of debilitating diseases among the refugees and the coalition forces. Veterinary support ensured the wholesomeness of food for the relief effort and the dining facilities of the coalition forces. The emergency medical treatment and surgical capability of coalition hospital units were tested on several occasions by the arrival of medical evacuation helicopters with critically injured or ill service members. Motor vehicle accidents, gunshot wounds, and mine explosions were all treated by an exceptional staff of multinational physicians, nurses, and medics. Every soldier, sailor, airman, or marine received outstanding care under extremely arduous circumstances.

Although not originally intended to treat local national personnel, this emergency medical system also provided life saving care to a number of Turkish, Kurdish, and Iraqi citizens during this deployment. The medical logistics system was an extremely successful operation supported from the US Army Medical Materiel Center, Europe (USAMMCE) in Pirmasens, Germany. Although each nation's medical forces utilized national lines of communication for medical resupply, the ability of the forward deployed medical logistics detachments from USAMMCE to meet immediate operational requirements supported every unit in the operation. Medical supply support for the civilian relief agencies was also coordinated through the medical logistics detachments at Incirlik and Silopi. Contributions of medical supplies from more than 30 nations created a significant warehousing and inventory control challenge. Utilizing five huge Rubbhall tents donated by the Norwegian government, and supplementing them with a maintenance tent and five GP medium tents of their own, the detachment at Silopi created an enormous medical depot of relief supplies. A computerized inventory system enabled the detachment to store and issue items from USAMMCE in support of the coalition forces, excess medical material from Operation Desert Storm, and the multitude of items donated from around the world.

As quickly as this operation was put together, the logisticians were even more efficient in training their civilian colleagues on the operation of their system and the transition of the entire warehouse complex and its contents to United Nations control. The operation of a separate and distinct medical supply system proved its invaluable worth to the relief effort and the coalition. CTF logistical planners did not need to worry about medical logistics and its priority cargo as they wrestled with all other classes of supply, maintenance, and transportation. Although hard to convince at the beginning of the operation, the efficiency and responsiveness of the Class VIII system won over new converts from the logistics community.

Medical evacuation procedures proved to be the long pole in the tent for medical operators and unit commanders alike. Communication was never adequate to allow for prompt MEDEVAC response. Maneuver forces have come to rely almost exclusively on tactical satellite (TACSAT) communication, yet no MEDEVAC unit in the US Army has that capability. Abortive attempts to relay MEDEVAC requests through multiple command layers proved totally unsatisfactory. It was also surprising to learn that senior US commanders either do not know, or choose to ignore, standardized request formats. Information received by the MEDEVAC operations staff was consistently incomplete, inaccurate, and frequently misrepresented the patient's actual condition.

Many times the unit could not give an accurate location for the patient pickup, and with so many calls filtered through organizational layers, the inevitable duplication of effort occurred when a MEDEVAC would launch in response to a mission already in progress by another MEDEVAC or aircraft of opportunity. Without hesitation, every call for assistance was answered with the launch of an aircraft. The situation improved markedly when attempts to obtain a TACSAT were successful and a loaner was obtained from the US Air Force. This did not, however, correct the command impression that MEDEVAC was unresponsive. As a result, MEDEVAC aircraft were field sited at Zahko in support of JTF-B and at Sirsenk in support of the British task force. The communication failure also contributed to the fury of the debate over command and control of MEDEVAC aircraft. Suffice it to say that the issue of how to best command and control medical air ambulances is alive and well in the US Army aviation community. During Provide Comfort, the senior medical authority, the CTF Surgeon, retained doctrinal control over the use of medical air ambulances to perform medical missions. The assistance of a US Air Force Aeromedical Evacuation Liaison Team (AELT) as part of the evacuation system was of great benefit to all patients from the coalition. Transition from rotary wing air ambulance to fixed wing evacuation was coordinated to take place at the reopened airfield at Sirsenk (Fig 6) for direct flight to Incirlik Air Base. At this point, US personnel were treated at Incirlik Air Base Hospital or evacuated to Germany. Members from other coalition nations entered national evacuation channels upon arrival at Incirlik.

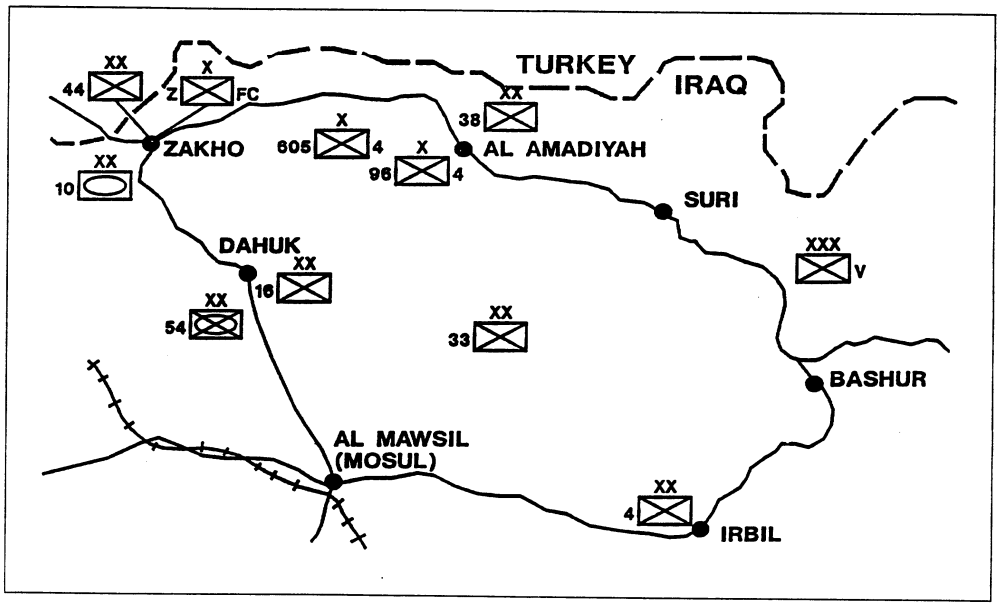

Figure 5. Iraqi forces—situation on Apr 7, 1991.

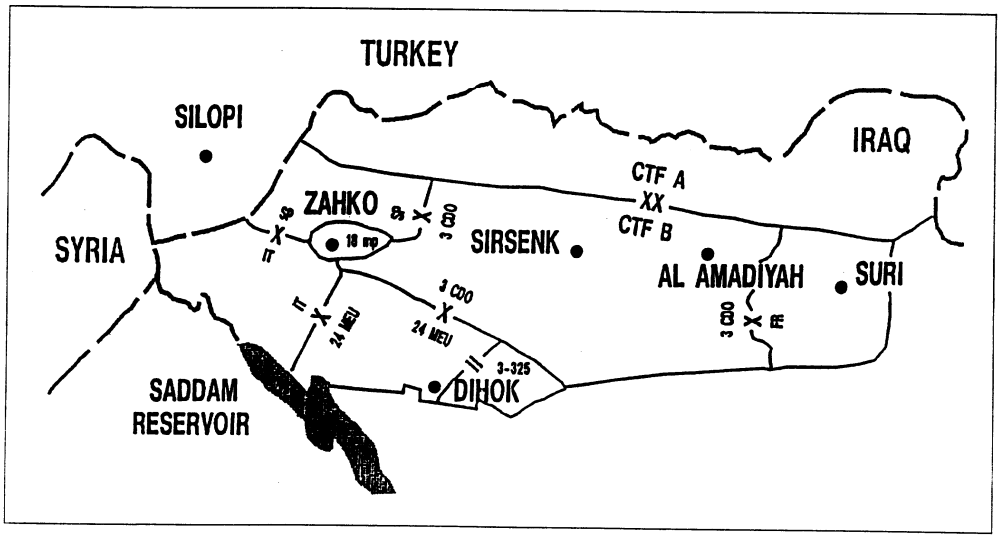

Figure 6. Security disposition of forces.

Operation Provide Comfort I ceased operations on or about July 15, 1991 when the security zone had been assured and the transition of humanitarian aid from the military to international relief agencies was complete. The magnitude of the task is still a shock after the fact. It was the largest humanitarian relief effort ever undertaken. Military elements were projected over 10,000 miles to make an immediate stand against the pitiful plight of the Kurdish people. A multinational, multi-agency effort was synchronized into a team capable of meeting the most stringent demands. Thousands were saved, thousands more resettled. Yet, the relief effort continues, as Provide Comfort passes through phase after phase of subsequent operations. The question to be asked is, whether the US military will be utilized in future operations of this nature, and if so, how?

As surely as the Kurdish child asked "Mister, will you help me?" the US military can expect the cry for help at home and abroad. The provision of humanitarian aid has followed every recent US combat operation since the 1983 invasion of Grenada, and has

even created its own operational niche. In operations from Hurricane Hugo in South Carolina and the Virgin Islands, to Bangladesh and most recently the hurricanes in Florida, Louisiana, and Hawaii, the military has demonstrated its supremacy in moving quickly and expertly in response to natural disasters. Military forces have also been instrumental in meeting national foreign policy objectives in the former USSR, Eastern Europe, and Africa by providing tons of food and medical supplies to struggling nations. There is clearly a Congressional move afoot to keep the military decisively engaged in these types of operations in the foreseeable future. The appropriateness of utilizing US military forces for humanitarian aid operations will ultimately be decided by our senior political and military leadership. Understanding the potential missions and planning to support them will enable the military to meet these challenges if directed to do so.

Potential military involvement in humanitarian aid is likely to be found in one of three roles:

(1) Humanitarian aid as a by-product of traditional military operations.

(2) Humanitarian aid as an element of US national foreign policy.

(3) Humanitarian aid in response to a disaster at home or overseas. Each role could be independent or mutually supportive. Each may require the deployment of combat forces as well as comabt support and service support assets. Medical, military police, engineer, and civil affairs personnel will be key players. A combination of active and reserve components may be necessary. International and private volunteer relief organizations may be required. The potential scenarios are endless.

Supporting thousands of displaced civilians and prisoners of war with shelter, food, and medical care is a historic example of the military's role in humanitarian aid. It is a mission common to most military operations, and one which has led to an increased emphasis on civil-military operations during recent campaigns such as Operations Just Cause and Desert Storm. In fact, during these two most recent examples, it was the volume of aid and the speed with which operations transitioned from combat to humanitarian relief that most surprised our military leadership. In Panama, commanders saw the end of most fighting within the first 72 hours of the operation, only to be confronted with the huge task of reorganizing and revitalizing Panama's entire infrastructure. Almost none of the Army hospitals deployed to Desert Storm ever saw a combat casualty, but devoted their considerable assets and expertise to the treatment of displaced civilians and prisoners of war. Awareness of these historical precedents should require planners, especially Army medical planners, to anticipate the need for supplies and services not normally associated with combat operations. Examples would be the increased need for women and child care products and specialists, and the need for evacuation and patient flow patterns that do not interfere with the casualty system.

Military support of humanitarian aid as an element of national foreign policy is a role of extraordinary potential. The significant changes in the former USSR and Eastern Europe within the last two years have exploded our military and political strategy of a bipolar concept. A new strategy has emerged as a regional focus on contingencies and crisis action, rather than a massive East vs. West orientation. As fledgling democracies struggle for survival in Eastern Europe and Africa, a myriad of opportunities to positively influence the outcomes is presented for humanitarian intervention. Some, such as the US European Command's MEDFLAG and US South ern Command's MEDRETE programs, build upon existing security assistance arrangements with host countries to offer medical and engineering humanitarian and civic assistance. The donation of excess food, medical supplies, and equipment is controlled by Department of Defense, Global Affairs in coordination with the Department of State. Recent operations such as Provide Hope and Provide Promise demonstrate the resolve of the United States to make a contribution on behalf of freedom throughout the world. The unique blend of deployability and capability inherent in military medical and engineer units make them well suited to support these operations. Excellent experience in both collective and individual training is available to units participating in these missions, as was recently demonstrated by the combined medical/engineer team from US Army, Europe that deployed to the Republic of Georgia. Working together with the host nation, this team shipped, installed and trained hospital staffs on the use of excess contingency hospital equipment. At least two other hospital equipment donations to former Soviet Republics are already in the planning stages.

The military's role in disaster relief has a long history, as witnessed by the number of operations for which the Humanitarian Service Medal has been awarded. The ability to react as a first responder with immense life

Lt Col Joseph M. Harmon III, MS, *who is presently the Chief, Current Operations, 7th Medical Command, Germany, received a BS degree from Middle Tennessee State University, and an MS degree from the University of Tennessee at Chattanooga. His military schooling included the NATO Staff Officer Course, the Command and General Staff College, the Medical Department Officer Advanced Course and the Infantry Officer Basic Course. The colonel's major assignments include the following positions: Chief, Current Operations, 7th Medical Comand, Heildelberg, Germany; Medical Operations Officer, XVIII Airborne Corps, Fort Bragg, NC; Executive Officer, Joint Task Force Bravo Medical Element, Palmerola, Honduras; and Battalion Operations Officer, 82d Airborne Division, Fort Bragg, NC. Lt Col Harmon has been a member of five humanitarian/civic assistance teams going to Honduras, Egypt, Panama, Turkey and Prague. He has given a number of well-received talks on the subject at various professional meetings.*

saving and sustaining capability cannot be matched. The military is best suited as an immediate reaction force to buy time for civilian agencies to mobilize their personnel and resources for the long term effort of disaster recovery. The forward deployed, regional focus of the active component, warrants the argument that they could be utilized to respond to specific disaster situations in their region. Whether or not this action would harm readiness is sure to be the subject of much debate. My opinion is that it would enhance readiness, especially in combat support and service support units, if viewed from the top as a fully supported training event.

The Pentagon has had a difficult task persuading Congress to drawdown the Reserve Components, and is now faced with a reserve structure that exceeds mission requirements. Why not take that surplus, reorganize it, and use it to provide initial disaster relief within the United States? This seems especially appropriate for the National Guard which already has a priority state mission. Utilization of these resources at home could lead to better public understanding and support for the military and its budgetary requirements. The potential training value for the Guard in deployment and support operations would be excellent. The USAR, home to many medical, engineering, and civil affairs units, would also benefit from this new training orientation in the leaner years ahead. Past experience gained by these RC units in Central America and Africa could be applied to battle tasks required of the unit, and assist in the development of new training opportunities.

New times call for new solutions. Opportunities abound to use the military's capabilities in non-traditional ways. It is essential that US policymakers keep uppermost in their minds the fact that the military's primary role is to fight and win wars to ensure our national defense and policy objectives. The three humanitarian aid roles presented here offer enhanced training and readiness through the execution of mission essential tasks for combat, combat support, and combat service support units. It is applicable to the Total Force, at home and around the world. It presents the United States with another tool for influencing the world. We have the technology, but do we have the will? ●