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Building Australia's defence relationships with Pacific Island nations through Enduring Health Civic Assistance (EHCA)

Michael C. Reade

Introduction

ADF policy for foreign 'Humanitarian Assistance' is limited to crisis response, including famine, natural disaster, terrorist events and war.¹ Equally, although engaged in numerous long-term development projects, the Australian Government Department of Foreign Affairs and Trade (DFAT) 'Humanitarian Strategy' is entirely focused on the preparation for, response to, and recovery from crises.² ADF policy recognises the 'Guidelines on the use of foreign military and civil defence assets in disaster relief' (the Oslo Guidelines), which prioritise a civilian response to overseas disaster relief, assigning military responsibilities only where there is no civilian alternative that can meet a critical humanitarian need.³ Introduced in their current form in 2007, the Oslo Guidelines have had a profound effect on ADF and Australian Government international engagement, leading to the creation and frequent deployment of civilian Australian Medical Assistance Teams (AUSMATs). The ADF essentially no longer contributes substantial medical support to HADR operations, with only two limited exceptions in the last

1 *The Military Contribution to Humanitarian Operations*, Australian Defence Doctrine Publications 3.20 (Canberra, Australia: Defence Publishing Services, 2013).

2 Department of Foreign Affairs and Trade, 'Humanitarian Strategy', Australian Government, <https://www.dfat.gov.au/about-us/publications/Pages/humanitarian-strategy>.

3 United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 'Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief — "Oslo Guidelines"', Revision 1.1 November 2007, UN MCDA Project, Civil-Military Coordination Section (Geneva, Switzerland: OCHA United Nations, 2007), <https://www.unocha.org/publication/oslo-guidelines-use-foreign-military-and-civil-defence-assets-disaster-relief>

decade: in response to an earthquake in Pakistan (2010)⁴ and a typhoon in the Philippines (2013)⁵.

In contrast, US military doctrine distinguishes non-disaster Humanitarian Civic Assistance (HCA) activities from HADR. HCA is development work that 'serves the basic economic and social needs of the host nation', 'promotes the security and foreign policy interests of the United States ... and the country in which the activities are to be performed' and enhances the 'operational readiness skills of the Service members who participate'.⁶ HCA activities are explicitly not characterised as foreign aid operations; rather they must be of benefit to both the host nation and the United States, and their primary purpose must be the training of US military personnel or the conduct of a military operation with another purpose. Examples of the types of project that can be funded are defined in policy:

- (1) medical, surgical, dental and veterinary care provided in areas of a country that are rural or are underserved, including education, training, and technical assistance related to the care provided, or
- (2) construction of rudimentary surface transportation systems, or
- (3) well drilling and construction of basic sanitation facilities, or
- (4) rudimentary construction and repair of public facilities.

Lacking equivalent policy to cover such activities, the ADF has, since 2007, arguably over-extrapolated the underlying principles of the Oslo Guidelines to mean that all forms of medical assistance to a foreign nation should be undertaken by civilian agencies. This paper argues that this has led to opportunities lost, and so proposes a health-focused HCA doctrine for the ADF that meets all the best-practice criteria built on US expertise. It further argues that the benefits of brief HCA engagements, such as those most commonly conducted by US teams, could be enhanced for both Australia and partner nations by deploying smaller teams, on rotation, to produce an enduring near-continuous presence of ADF personnel.

4 Sergei DeSilva-Ranasinghe, 'Operation Pakistan Assist 2: "The Most Successful Australian Deployment of a Combined Humanitarian Task Force"', *Feature Interview, Future Directions International*, 16 September 2011 <http://www.futuredirections.org.au/publication/operation-pakistan-assist-ii-the-most-successful-australian-deployment-of-a-combined-humanitarian-task-force/>.

5 Department of Foreign Affairs and Trade, 'Australia provides surgical hub in typhoon affected region', *News, speeches and media*, DFAT, 19 November 2013, <https://www.dfat.gov.au/news/news/Pages/australia-provides-surgical-hub-in-typhoon-affected-region>.

6 Department of Defense (USDOD), *Instruction DoDI 2205.02: Humanitarian and Civic Assistance (HCA) Activities*, 23 June 2014 [incorporating change 1, 22 May 2017] (Washington DC: US Department of Defense, 2017), available at <https://www.hsdl.org/?view&did=801360>

A history of Australian HADR operations in the Pacific

Table 1 outlines the major HADR operations conducted by Australia in the Pacific region in approximately the last 20 years. Notably, all four major HADR operations between 1998 and 2007 had a health focus and were centred on ADF medical assets, while none of the ten Pacific HADR operations since that time has had a substantial ADF health component. The role of ADF health assets has been demonstrably taken over by the civilian AUSMATs⁷, nonetheless supported by ADF logistic, transport and engineering elements. The AUSMATs are teams of doctors, nurses, paramedics, allied health professionals and logisticians who undergo one to two week blocks of training similar to that provided for Defence Health Reserve Officers, albeit without the same opportunities for attendance at subsequent collective training exercises to reinforce individual skills, build teams and develop leaders. Approximately 700 team members have been trained. Presumably noting the substantially reduced opportunity for HADR work within Defence, many ADF Reservists, including several senior officers, have volunteered for AUSMAT deployments in addition to their Defence service. Training and operational employment of the AUSMATs is coordinated by the National Critical Care and Trauma Response Centre, based in Darwin, which also maintains the equipment required to generate a light surgical capability and inpatient facility approximately the equivalent of a NATO Role 2 hospital. The AUSMATs fulfil Australia's obligation to provide a civilian-based HADR capability under the Oslo Guidelines and, although objective assessments of each of these deployments have not been published, there is general recognition in the Australian civilian disaster assistance professional community that these have been effective. These teams are staffed and equipped for brief (approx. one month) deployments, and there is an understanding that an enduring hospital effect could be more the domain of the ADF.

7 National Critical Care and Trauma Response Centre, 'AUSMAT' (web page), NCCTRC, <https://www.nationaltraumacentre.nt.gov.au/what-we-do/disaster-management/ausmat>.

Table 1. Major Australian HADR Operations in the Pacific since 1998⁸

Year	Location	Event	Response
1998	Aitape, PNG	Tsunami 2200+ killed immediately 500+ survivors with infected wounds, fractures, aspiration pneumonia	OP SHADDOCK. The ADF, augmented by NZ, US and civilian personnel, deployed a light field hospital to Vanimo, PNG, 3 days after the tsunami. 209 surgical operations performed in the ADF hospital in 10 days.
2004	Niue	Cyclone Heta, one killed, with substantial property loss destruction of the island's only hospital.	OP NIUE ASSIST. 17-person ADF medical team replaced local hospital primary care and minor surgical functions for two weeks.
2004–2005	Aceh, Indonesia	Earthquake 100km off northern Sumatra, causing tsunami that killed 230,000 people in 14 countries around the Indian Ocean.	OP SUMATRA ASSIST. 1100 ADF personnel deployed a surgical field hospital (staffed also by NZDF members) to Indonesia for 3 months. In this time, 3700 medical treatments were provided, along with 2530 aeromedical transports, and engineering works providing 4.7 million litres of potable water and clearance of 9000 m3 debris.
2005	Nias Island, Indonesia	Earthquake	OP SUMATRA ASSIST II. 570 medical treatments provided by an ADF medical facility, food distribution, water purification, engineering works. Nine ADF members killed in helicopter crash April 2005.
2009	Samoa and American Samoa	Earthquake and tsunami. 180 killed (+9 in Tonga) with major infrastructure damage	Australian civilian paramedics, doctors, nurses and rescue specialists. ADF response limited to logistic support and aeromedical evacuation.
2011	Tohoku, Japan	Earthquake and tsunami	Australian civilian rescue specialists. ADF response limited to logistic support.
2011	Christchurch, New Zealand	Earthquake. 185 killed. Major infrastructure damage.	Australian civilian police, medical and rescue teams. ADF response limited to logistic support.
2013	Honiara, Solomon Islands	Dengue Fever outbreak post tsunami	AUSMAT team deployed.
2013	Tacloban, Philippines	Cyclone Haiyan. 7415 deaths.	Initial ADF primary care medical response, along with extensive logistic and engineering support. AUSMAT team deployed to form the core Australian medical response.
2014	Solomon Islands	Floods	AUSMAT team deployed. ADF response limited to logistic support.
2015	Tanna, Vanuatu	Cyclone Pam	AUSMAT team deployed. ADF response limited to engineering, logistic and limited primary care support.
2016	Fiji	Cyclone Winston	AUSMAT team deployed. ADF response limited to engineering, logistic and limited primary care support.
2018	Sulawesi, Indonesia	Earthquake. 2000 killed, 4600 severely injured.	ADF response limited to logistic support.
2019	Apia, Samoa	Measles epidemic	AUSMAT team deployed.

8 Steven Bullard, *In Their Time of Need. Australia's Overseas Emergency Relief Operations, 1918–2006* (Cambridge, UK: Cambridge University Press, 2017), DOI: <https://doi.org/10.1017/9781108225441>.

The effectiveness—or ineffectiveness—of HADR as ‘soft power’ diplomacy

There is little doubt that the patients treated on each of these HADR operations derived benefit from Australia's contributions and that they remain grateful for this clinical care. However, disaster relief efforts have short-term effects and, as is apparent from Table 1, the health care component is frequently less important to the recipient nation than logistics and engineering assistance. Indeed, the World Health Organization publishes several recommendations for disaster assistance, amongst which is that ‘it is unlikely that medical personnel will be required from abroad’, and if they are, ‘the need for life-saving first aid and other immediate medical procedures is short-lived’.⁹ Long-term investment in disaster recovery, and in development in general, is usually of much greater benefit to an affected population. Consequently, even if the only goal is to enhance the social stability and physical wellbeing of Australia's Pacific neighbours, basing Australia's plan for future health engagement with Pacific Islands solely around a strategy of providing health-focused HADR whenever required—either military or civilian—would appear unwise.

However, the Australian Government recognises that engagement in the Pacific has goals that go beyond improving the living standards of our neighbours. Exercise of Australian influence through the use of ‘soft power’ diplomacy is explicitly recognised in the Australian Government's 2017 Foreign Policy White Paper¹⁰, which defines this concept as ‘the ability to influence the behaviour or thinking of others through the power of attraction and ideas’. Several examples are highlighted in this document, including the provision of scholarships allowing students from the Pacific to study in Australia, placement of Australian students in Indo-Pacific countries under the New Colombo Plan, scientific collaborations and international sporting competitions. Notably, no health projects are mentioned in this section of the document, and there is no mention of the soft power benefits of HADR. This might not be an error. While the US military has objectively documented increased support for its activities in Indonesia, the Philippines and Japan immediately after military HADR interventions, the same study noted ‘the up-and-down nature of US–Indonesia ties shows that HADR cooperation is not in itself enough to overcome all the problems that can plague a bilateral

9 Pan American Health Organization, *Humanitarian Assistance in Disaster Situations: A Guide for Effective Aid* (Washington DC: PAHO/WHO, 1999), <https://www.paho.org/disasters/dmddocuments/pedhuman.pdf>.

10 Department of Foreign Affairs and Trade (DFAT), *2017 Foreign Policy White Paper* (Canberra: Commonwealth of Australia, November 2017), available in pdf format at <https://www.dfat.gov.au/sites/default/files/2017-foreign-policy-white-paper.pdf>

relationship. Gratitude and admiration may fade with time'.¹¹ HADR operations offer brief opportunities for intense, usually positive, publicity. However, there is almost never an opportunity to form an enduring relationship with individuals or institutions in a host country and, hence, little opportunity to 'influence the behaviour or thinking of others'.

Accordingly, while HADR, including a health component in circumstances when this is appropriate, will continue to be an essential contribution by Australia to the physical and social security of Pacific nations, it should not be a focus of military health assets or the primary means by which Australia plans to exercise soft power diplomacy. Alternative employment of ADF health assets offers greater potential benefit.

US military HCA projects

Table 2 lists several examples of health-focused projects undertaken under the US military HCA program, the legal authority for which is contained in Title 10, Section 401 of the US Code (abbreviated as '10 U.S.C. 401 operations', or 'Section 401 appropriations'), for which detailed conditions are defined in US Department of Defense Instruction 2205.02.¹² The primary purpose of funding under 10 U.S.C. 401 must be to train US Armed Forces personnel. The US military first allocated funds under this mechanism in the 1980s. As a result of operational experience in Iraq and Afghanistan, similar projects, with operational rather than primarily training objectives, can now also be funded under the Combatant Commanders Initiative Fund and US Special Operations Command project funding. ADF members will be most familiar with Exercise Pacific Partnership, as Australia has contributed to each of these exercises since their inception in 2006. Average annual global HCA expenditure grew from US\$47 million in 2004 to US\$109 million in 2010, supporting approximately 200 activities per year.¹³ Detailed guidance for operational planners is freely available.¹⁴ Surprisingly, few formal evaluations of these programs have been made.¹⁵

11 David Capie, 'The United States and Humanitarian Assistance and Disaster Relief (HADR) in East Asia: Connecting Coercive and Non-Coercive Uses of Military Power', *The Journal of Strategic Studies* 38, 3 (2015): 309–331. DOI: doi.org/10.1080/01402390.2014.1002914

12 Humanitarian and Civic Assistance (HCA) Activities, DoDI 2205.02.

13 Michael Baxter and Charles Beadling, 'A Review of the Role of the U.S. Military in Nonemergency Health Engagement', *Military Medicine* 178, no. 11 (Nov 2013):1231–40.

14 'Navy Humanitarian and Civic Assistance Operations', US Navy Judge Advocate General's Corps, 3 Nov 2009, [https://www.jag.navy.mil/distrib/instructions/NTTP%203-57.3Humanitarian_and_Civic_Assistance_Ops_\(Nov2009\).pdf](https://www.jag.navy.mil/distrib/instructions/NTTP%203-57.3Humanitarian_and_Civic_Assistance_Ops_(Nov2009).pdf) or <https://usnwc.libguides.com/c.php?g=866733&p=6228504>

15 Erik J. Reaves, Kenneth W. Schor, and Frederick M. Burkle, Jr., '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* 2, no. 4 (Dec 2008):230–6, DOI: doi.org/10.1097/DMP.0b013e31818d3c80

Table 2. Examples of US military Humanitarian Civic Assistance (HCA) projects

Year	Location	Description
2006–present ¹⁶	EX PACIFIC PARTNERSHIP Various locations throughout the Pacific	<p>Aim: to improve US interoperability with Pacific military forces during disaster relief operations</p> <p>Method: Usually, but not always, involves the deployment of a US hospital or amphibious warfare ship to several developing countries in the Pacific, providing medical, dental, veterinary and engineering assistance during brief (approx. 1 week) port visits.</p> <p>This is the largest US military medical HCA activity, e.g. in 2011, the USS Cleveland treated 38,000 patients in five countries.</p>
2011 ¹⁷	Trinidad	<p>Aim: to enhance relationship with the government of Trinidad</p> <p>Method: Introduction of a new method for treating cataracts by a visiting US Army team at a Trinidad government hospital, resulting in enduring improved service provision and long-term partnership between a US civilian university, US Army Reserve unit and Trinidad civilian hospital.</p>
2004 ¹⁸	Senegal	<p>Aim: To enhance relationship with the government of Senegal and knowledge of its armed forces</p> <p>Method: 60 US Navy personnel deployed to a military clinic in Senegal for 12 days, augmenting local clinicians in providing treatment for 6200 patients.</p>
2007–present ¹⁹	OP PACIFIC ANGEL	<p>Aim: Enhance relationship with partner nations</p> <p>Method: Build capacity in host nation health, dental, veterinary and engineering sectors by short-term (approx. 1-2 week) deployments of subject matter experts to work in host-nation facilities.</p>
2007–present ²⁰	OP CONTINUING PROMISE	<p>Aim: Enhance relationship with partner nations</p> <p>Method: Deployment of US hospital, amphibious warfare or Expeditionary Fast Transport Ship to several developing countries in Central and South America, providing medical, dental, veterinary and engineering assistance during brief (approx. 1 week) port visits.</p>

16 Erik J. Reaves, Michael Termini, and Frederick M. Burkle, 'Reshaping US Navy Pacific Response in Mitigating Disaster Risk in South Pacific Island Nations: Adopting Community-Based Disaster Cycle Management', *Prehospital and Disaster Medicine* 29, no. 1 (2014), DOI:10.1017/S1049023X13009138.

17 Maela C. Haims, Herbert C. Duber, and L. P. Chang, 'Enhancing the Effectiveness of the U.S. Army's Participation in Medical Diplomacy: Implications from a Case Study in Trinidad', *Military Medicine* 179, no. 6 (2014).

18 Norman L. Johnson, Martin J. Livingston and Thomas S. Novak, 'A Cost Analysis of Training Expenses Versus the Value of Medical Care Provided During West Africa Training Cruise 2004: Senegal', *Military Medicine* 171, no. 12 (2006).

19 Mikaley Kline, 'Pacific Angel Provides Aid, Builds Partnerships Throughout Indo-Pacific Communities', Pacific Air Forces Public Affairs, 30 Sept 2019, PACAF, <https://www.pacaf.af.mil/News/Article-Display/Article/1975329/pacific-angel-provides-aid-builds-partnerships-throughout-indo-pacific-communit/>.

20 US Southern Command, 'Continuing Promise 2018' (web page), *Media, Special Coverage*, <https://www.southcom.mil/Media/Special-Coverage/Continuing-Promise-2018/>.

A common feature of most HCA projects is their average duration in each location of approximately one to two weeks. The short-term gains achieved by such projects compared to the potentially greater enduring beneficial effects—to all parties—of much longer-term engagement of health professionals has been noted by many. For example, the Director of the Global Health Program at the US Uniformed Services University noted ‘hospital ship cruises and (short-duration health HCA operations) establish access, foster individual relationships and engender goodwill. But they do not do much to build capacity, and ... it is unclear how long the goodwill might endure. The relationships are very short-lived.’²¹ In an insightful comparison of short vs long-term engagements, the globally recognised success of Cuban doctors sent to work for two year deployments in developing countries has been noted.²² However, even this approach was found to be flawed, as the Cuban doctors were sent primarily to deliver services not available in the host developing countries—all of which were lost when the Cuban economy contracted and the doctors withdrew. The optimal model proposed is one in which US military clinicians would work alongside local health professionals, assisting them to develop their own skills and infrastructure. Implicit in this development assistance model is the understanding that improvements take months to years, and so cannot be accomplished with visits of only two weeks.

Examples of enduring US military global health engagement projects

The best examples of enduring US military engagements with developing partner nations are the five Overseas Medical Research Laboratories of the US Army and Navy, located in Thailand, Kenya, Cambodia, Peru and, until 2016, Egypt.²³ The first of these was founded in 1946, and each focuses on epidemiology, treatment and vaccine development for infectious diseases relevant to their local geographic areas. When the program was first established, the core scientific staff were from the US military, with locally employed staff mostly employed in supporting roles; however, more recently this balance has shifted, with most of the scientific output now driven by host-nation scientists and doctors. The largest laboratory is the US Army Medical Research Unit–Kenya, which employs 600 local staff and only 15 US military staff and two US civilians, at a total annual cost to the US Government of only US\$36.3 million. The US Overseas Medical

21 Bradley J. Boetig, ‘Bilateral Institutional Relationships: A New Mission for U.S. Dod Medical Capabilities in Support of Health Diplomacy’, *Military Medicine* 177, no. 7 (July 2012): 763–5.

22 Asad Moten, Daniel Schafer and Edwin K. Burkett, ‘Global Health Engagement and the Department of Defense as a Vehicle for Security and Sustainable Global Health’, *Military Medicine* 183, no. 1–2 (Jan/Feb 2018) DOI: doi.org/10.1093/milmed/usx044.

23 James B. Peake et al., ‘The Defense Department’s Enduring Contributions to Global Health’, ed. Center for Strategic and International Studies (Washington, DC: Center for Strategic and International Studies, 2011).

Research Laboratories boast several major medical and scientific achievements, including development of the first effective malaria and HIV vaccines, and detection of the first cases of H1N1 influenza during the 2009 pandemic. Less obvious achievements have been training generations of host-nation physicians and scientists in infectious diseases, ethical research governance and in negotiating appropriate relationships with sponsoring pharmaceutical companies. The diplomatic effectiveness of the laboratories was evident in 1967 in Egypt, when all US Government representatives were expelled from the country due to US support for Israel in the Six-Day War. The single exception was US Navy Medical Research Unit 3 in Cairo, which remained open and acted as a de facto US Embassy for several years. The value of a mutually beneficial medical and scientific engagement to the soft power engagement between the US and these developing countries was clearly evident.

A selective history of Australian civilian health HCA projects in the Pacific

Australian civilian institutions have built a good name for Australia through medical engagement in the Pacific over the last century. The number of projects is so large that any attempt to be comprehensive would almost certainly still omit major contributors, and therefore only a representative sample is presented here. The Australian Government Indo-Pacific Centre for Health Security recently reported on the 'State of the Region 2019', identifying numerous infectious disease threats, infrastructure in each country to combat these, and detailing co-operative strategies for improvement that involve international organisations, Australian Government programs, corporations and host-nation institutions.²⁴ More specifically, since 1995, the Royal Australasian College of Surgeons Pacific Islands and Papua New Guinea Programs, with the support of DFAT and other Australian specialist medical colleges, have been sending visiting medical teams to undertake direct clinical care, medical education including postgraduate examinations, clinical governance and workforce planning assistance. While each of these team visits are brief, they recur at frequent intervals, building trust amongst individuals. The Australian Society of Anaesthetists sponsors senior trainees and consultants to work in Fiji or East Timor for three months each, providing both direct clinical care and teaching to local anaesthetists and technicians. Papua New Guinea (PNG) has the highest Maternal Mortality Ratio in the Pacific. From 2012 to 2013, DFAT sponsored the University of Technology, Sydney to place 11 midwife facilitators and two obstetricians in PNG hospitals

²⁴ Melanie Bannister-Tyrrell et al., 'Health Security in the Indo-Pacific: State of the Region 2019', Indo-Pacific Centre for Health Security (Canberra: DFAT, Australian Government, 2019).

to provide clinical care and teaching. Substantial progress in the professionalisation of midwifery practice was documented at the completion of the project.²⁵ The University of Melbourne Department of Psychiatry has partnered with the only psychiatric hospital in Fiji, St Giles Hospital, in a 10-week exchange clinical training program for Australian and Fijian clinicians, and to develop training resources and research collaboration.²⁶ Operation Smile is a US-based organisation of plastic surgeons who undertake brief (1–2 weeks) visits worldwide to correct craniofacial deformities. An Australian-based subsidiary has operated since 1999.²⁷ Similarly, the Sydney-based Open Heart International has operated on patients with mostly congenital heart disease (but also burns and ophthalmology patients) throughout the Pacific and elsewhere since 1985, with 200 deployments and 7,399 patients treated.²⁸ Each of these programs describes its desire to build the local capacity of the host-nation health facilities, but the objective evidence that this has been achieved is sometimes not present in published material. In some cases, this is understandable, as the resources required to maintain a service such as cardiothoracic surgery in the absence of the visiting team are greater than is present in many of the host-nation hospitals. These projects therefore represent a mix of direct aid and capacity-building work, but they all have built Australian clinicians and their supporters a good reputation amongst our Pacific neighbours, which must be carefully maintained.

ADF capacity-building health projects in the Pacific

The ADF has recognised for many years the value of collaborative engagements with Pacific partners in areas other than health. Examples include Exercise Crux de Sud and Exercise Mhanuu (HADR and security assistance exercises hosted by New Caledonia), and ADF Support to the Pacific Island Forum through activities such as Operation Solania (maritime surveillance in the Pacific to protect fisheries and other resources). Each builds relationships at the government and military level, but none provides a lasting health effect. There is one outstanding exception: the series of enduring health projects throughout the Asia–Pacific region led by the ADF Malaria and Infectious Disease Institute (ADF MIDI).²⁹

25 Amanda Neill, Caroline Homer, Michele Rumsey and Mary Killilo, *Papua New Guinea Maternal and Child Health Initiative Phase II: Final Report*, DFAT WHO CC UTS, 30 June 2016, <https://dfat.gov.au/about-us/publications/Pages/png-maternal-and-child-health-initiative-phase-2-final-report.pdf>.

26 'Fiji–Melbourne Alliance for Mental Health', Asia Australia Mental Health, <https://aamh.edu.au/post-program/fiji/>.

27 'Operation Smile' (webpage), <https://www.operationssmile.org/>.

28 *Open Heart International Annual Review 2018–2019*, Open Heart International, Wahroonga, NSW https://ohi.org.au/wp-content/uploads/2018-2019_Annual_Review.pdf.

29 Until 2017, the ADF MIDI was known as the Australian Army Malaria Institute. See G.D. Shanks et al., 'Army Malaria Institute—Its evolution and achievements fifth decade: 2006–2015', *Journal of Military and Veterans Health* 24, no. 1 (2016).

Numerous research projects co-funded by the World Health Organization, US Department of Defense and National Institutes of Health, DFAT and private industry throughout the region have in recent years been augmented by reinvigorated training relationships with military and civilian colleagues in PNG, Solomon Islands and Vanuatu. Although the primary mission of the ADF MIDI is to provide ADF members with the best possible protection against malaria and other vector-borne diseases, the collaborative relationships built with both the armed forces and civilian institutions of partner nations are an excellent example of the potential for enduring health projects to achieve positive influence for Australia in our region.

ADF operational health readiness requirement

The ADF provides ab initio training for its medics at an 18-month course at the Army School of Health, but for all other health professions it relies on civilian universities and hospitals to provide the bulk of clinical training for both Permanent and Reserve personnel. Military-specific expertise in penetrating trauma and tropical diseases of military relevance is acquired on short courses and through experience on major exercises. However, none of these Defence training activities provide experience with 'real' patients, leaving a substantial training gap. The Australian civilian hospital system provides few opportunities for training that mirrors the scope of practice required in ADF deployed Role 2E hospitals.³⁰ Civilian clinicians now work in a system that is reliant on sub-specialisation, advanced technology and minimally-invasive surgery, none of which is available on military deployment. ADF Role 2E hospitals have no CT scanner, no endoscopic instruments, and no sub-specialist surgeons (such as neurosurgeons) or physicians (such as specialists in infectious diseases). Consequently, the ADF must seek a different employment model that engages its clinicians in a way that better prepares them for military deployment.

Following the drawdown of military operations in the Middle East, the ADF has struggled to engage its clinical workforce in duties that genuinely enhance clinical operational readiness. Fewer than 40 per cent of Army's SERCAT 5 (Reserve) medical officers worked their mandated 20 training days in FY 2018–19. Most Army SERCAT 7 (Regular) clinical staff do not meet the criteria for Tier 1 readiness³¹, due to difficulties in securing time for placements in civilian hospitals. By developing an enduring medical engagement program in the Indo-Pacific region, the ADF would significantly enhance its engagement with current and prospec-

30 Kyle Bender, 'Training War-Time Surgeons in a Peace-Time ADF', 2019 *AMMA Conference Abstracts, Journal of Military and Veterans' Health* 27, no. 4 (2019): 27–76.

31 'Clinical Readiness Standards for Army Health Services Personnel', *Army Standing Instruction (Personnel)* Part 8, Chapter 9 (2019).

tive clinicians, and their competency, in an operationally relevant environment. The workforce available to undertake such an activity is large: Army has 835 SERCAT 5 and 1,562 SERCAT 7 clinicians; Navy has 212 Reserve (SERCAT 3 & 5) clinicians and 388 in SERCAT 7; RAAF has 378 in SERCAT 7 and 426 in its Reserve (SERCAT 3, 4 and 5)—making a potential workforce of approximately 3,800. Employing an element of this workforce in continuous clinical operations in a relevant environment would not only place the ADF in the best possible position to deploy a surgical capability in support of operations when next required, but it would additionally provide greater certainty to health planners that this would indeed be possible.

The ‘humanitarian’ controversy

Before making any proposals for an evolution in ADF doctrine, it is essential to recognise differing perspectives on the use of the term ‘humanitarian’. ADF and DFAT documents make extensive use of this word, albeit limited to the context of crisis response. Quoting DFAT, ‘humanitarian action... is designed to save lives, alleviate suffering and maintain human dignity during and in the aftermath of conflict, disasters and other humanitarian crises, as well as to prevent and strengthen preparedness for the occurrence of such situations’.³² The four ‘humanitarian principles’ defined by the United Nations, International Committee of the Red Cross and others, are ‘humanity, impartiality, neutrality and independence’.³³ Most non-government organisations consider military forces, and indeed even civilian government agencies such as AUSMAT, incapable of delivering ‘humanitarian’ aid as defined by these principles because they are inherently not independent (of government) and might not be impartial or neutral under all circumstances. Any proposed ADF project that did not exclusively aim to deliver health care for the benefit of recipients, but incorporated training and diplomatic outcomes as well, would be liable to criticism for misappropriation of the term—as indeed have been the US HCA programs. Therefore, the term should be avoided.

A proposal for the ADF: Enduring Health Civic Assistance (EHCA)

This paper proposes a novel concept, *Enduring Health Civic Assistance*, that would enhance ADF capability, exercise beneficent Australian soft power, and build the health capacity of Pacific nations in a respectful and collaborative man-

³² DFAT *Humanitarian Strategy* (n. 2).

³³ OCHA, ‘Humanitarian Principle’, United Nations https://www.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf.

ner. Teams of 4–6 ADF clinicians would work in a host-nation hospital for periods of four weeks each, with rotations of teams such that there would be a near-continuous presence throughout the year. Composition of the teams would be guided by the requirements of the host hospitals but, given the most critical capability constraints in many Pacific Island countries, this is likely to mean a focus on surgery, anaesthesia and emergency medicine. However, given the high prevalence of tropical and other infectious diseases, dental morbidity, complex obstetrics and untreated chronic illness, there would be ample scope for essentially all ADF medical, dental, nursing and allied health specialties. The complex logistic and organisational challenges of the health systems of many Pacific nations also suggest valuable potential work by ADF pharmacists and health General Service Officers.

Several key relationships would need to be built to make such a program possible. The host-nation hospital clinicians and executive team would need to identify service delivery and training priorities and contribute to the detailed planning of the program. All health professionals would need to be registered to practise in the host country, which would be considerably assisted if the relevant professional boards agreed to recognise Australian qualifications and registration. Procedures for clinical governance and medical indemnity would need to be agreed, and there would need to be a mechanism for the host hospital to approve the scope of practice of visiting ADF clinicians. The host-nation Ministry of Health would ideally oversee the project and, as this would be a military endeavour, ideally clinicians from the health service of the host-nation's armed forces would participate alongside visiting ADF members. Mechanisms for formal evaluation of the project should be established, including the extent to which the host nations' capabilities would be enhanced upon the withdrawal of the ADF team. A formal public relations plan should be agreed with the host nation from the outset, highlighting the collaborative nature and mutual benefit of the endeavour and making the specific point that the project is not an 'aid program', as traditionally understood.

Relevance of EHCA to HADR, using COVID-19 as an example

While Australian medical HADR tasks will almost certainly remain the primary responsibility of AUSMAT, relationships fostered by Defence EHCA projects could potentially facilitate the effectiveness of an Australian whole-of-government disaster response in the Pacific. A topical example is to consider how Australia might respond to a Pacific Island nation overwhelmed by COVID-19 patients. Although the AUSMATs are focused exclusively on HADR, they have no enduring presence in any overseas country. How much more rapid and effective might an

Australian response be if, during planning and execution, we could draw upon a cohort of ADF members with detailed knowledge of the host-nation health system, contemporaneous health intelligence from those deployed, and personal influence with clinicians from the host nation? Even if the Australian HADR response were to be entirely from AUSMAT, an in situ Defence EHCA team could assist the host nation make valuable preparations to ensure the greatest value was extracted from this response.

Criteria for appropriate capacity building in Civic Assistance programs

Many civilian aid programs of the 20th century created what has become known as a 'donor-recipient aid trap', in which the economic priorities of less developed countries became tailored around the continued receipt of external assistance, such as donations of food, equipment or personnel. This is acknowledged to have created a persisting culture of dependence rather than encouraging self-reliance. US military doctrine recognises this potential problem and lists several requirements for successful HCA projects, all of which should be met by this proposal.³⁴ These include ensuring 'that the project does not drastically exceed the standard of care already provided by the host nation' (it explicitly would not); it must not 'discredit national and local governance' (it would work within these constructs by registering ADF officers with local boards and by empowering local hospital authorities in the clinical governance of ADF practitioners); and it must not cause economic displacement of local providers (it would not; rather it would assist them in their work). The project must have the approval of the Ambassador or High Commissioner and be coordinated with existing civilian development assistance programs.

The former administrator of the US Agency for International Development defined 'Nine Principles of Reconstruction and Development' by which a project such as this might be assessed.³⁵ These are:

1. *Ownership. A country must drive its own development needs and priorities, and projects must build on the leadership, participation and commitment of a country and its people.* The project must be developed in close collaboration with host-nation colleagues and fill clear, evidence-based needs as articulated by them. It must empower the existing leadership structures within the host-nation hospital by making it clear that ADF clinicians are coming to learn from their expertise, not to dispense aid.

³⁴ *Humanitarian and Civic Assistance (HCA) Activities*, DoDI 2205.02.

³⁵ A.S. Natsios, 'The Nine Principles of Reconstruction and Development', *Parameters* 35, no. 3 (2005).

2. *Capacity building. Strengthen local institutions, transfer technical skills and promote appropriate policies.* There will be no attempt to replace local institutions or to introduce new clinical services. Rather, ADF clinicians would augment the existing workforce in delivering their current level of service, at times allowing them time for professional development leave. While the primary intent is not that ADF clinicians will teach host-nation colleagues, there will no doubt be opportunities for a two-way exchange of skills.
3. *Sustainability.* Funding for clinician salaries will come from the training budgets already allocated. Funding for travel and incidentals would be low and could come either from funds allocated to enhancing cooperation and interoperability between the ADF and the defence forces of partner nations if their health staff were integrated into the project or from the A\$1.4 billion allocated to development projects by the Australian Government as part of the 'Pacific Step-Up'.³⁶
4. *Selectivity. Allocate resources based on need, local commitment and foreign policy interests.* The Australian Government has identified several countries of strategic importance as part of the 'Pacific Step-Up'. PNG is the most populated Pacific nation next to Australia (8.6 million) and is of great strategic interest to Australia, receiving A\$600 million in aid in FY 2019–20, along with close Defence cooperation including frequent combined land exercises in East Sepik Province and naval exercises from Lombrum Naval Base on Manus Island. Fiji (880,000), Solomon Islands (650,000) and Vanuatu (300,000) are the next three most populous Pacific nations after New Zealand, all with longstanding defence, cultural and business ties with Australia and of strategic significance given their proximity and availability of port facilities. Each has a sufficiently developed and busy hospital system to support a project such as that proposed.
5. *Assessment. Conduct careful research, adapt best practices and design for local conditions.* A thorough assessment must be made of the operational conditions required for the project to succeed, through on-site visits and subsequent engagement between ADF and host-nation officials. The ADF has conducted frequent exercises in each of these countries and has an ongoing Defence Cooperation Program presence that could facilitate local contacts and logistics.
6. *Results. Direct resources to achieve clearly defined, measurable and strategically focused objectives.* The main immediate objective from an ADF per-

³⁶ Pacific Step-Up' (webpage), Department of Foreign Affairs and Trade, <https://dfat.gov.au/geo/pacific/pages/the-pacific.aspx>.

spective is increased engagement of clinicians in a relevant operational environment, which will be quantified readily by reporting numbers and types of patients treated. Longer-term objectives are enhanced relationships between the two countries, and augmented capability of the host-nation health system, which must be quantified by indicators of success defined at the start of the project.

7. *Partnership. Collaborate closely with governments, communities, donors, non-profit organisations, the private sector, international organisations and universities.* Any project must be coordinated with DFAT and any of its existing programs in the host nation, including (for example) those of the Royal Australasian College of Surgeons described above.
8. *Flexibility. Adjust to changing conditions, take advantage of opportunities and maximise efficiency.* The project must be responsive to changing circumstances. For example, if the quantity or nature of clinical work in the host-nation hospital is not as projected, there must be the option to move the ADF team to a more suitable location. The composition of the team must be able to change in response to the requirements of the host nation—for example, to cover periods of leave of specific host-nation clinicians, the ADF might agree to send an officer of a particular speciality between certain dates.
9. *Accountability. Design accountability and transparency into systems and build effective checks and balances to guard against corruption.* Mechanisms for clinical governance of ADF clinicians must be agreed with the Director of Medical Services of the host-nation hospital, including direct oversight by a senior ADF clinician who would have the authority to remove an ADF officer from the deployment immediately if this is required. Principles of rostering must be agreed that will ensure ADF clinicians do not take over only the less pleasant aspects of the work of host-nation doctors, such as after-hours on call, but rather that all will share an equal patient load. The clear intent is that the ADF clinicians are deploying to learn from their host-nation colleagues, not to teach them or replace them.

Potential concerns

Several potential concerns can be anticipated and mitigated:

1. *Creating an unsustainable and undesirable dependency on the ADF.* Dependency can be avoided in several ways. First, no clinical service would be introduced that is not already provided in the host-nation hospital. Unlike visiting civilian specialist teams that perform, for example, cleft palate surgery or cardiac surgery, ADF clinicians would only undertake the type of proce-

dures that are already performed in the host-nation hospital. Second, each rotation would comprise clinicians of different specialties, each present for only one month, so although the ADF presence would endure, no clinical specialty would always be present. Third, ADF clinicians would be forbidden from bringing equipment or consumables, avoiding the possibility that the hospital would replace its own medical supply chain with this source of free health materiel. Fourth, ADF clinicians would receive thorough training that their role was to work in partnership with host-nation clinicians, not to replace them. Fifth, the ADF would never take a leadership role within the host-nation hospital; consistent personal and public relations messaging would reflect the reality that their presence was as an adjunct to the excellent health services that existed before they arrived. The ADF has experience of successfully achieving this type of collaborative engagement without creating dependency, albeit on a smaller and less formalised scale, using essentially these rules. ADF clinicians performed surgery in the Solomon Islands National Referral Hospital, Honiara, during Operation Anode, and in Moleana Hospital, East Timor, during Operation Citadel to the mutual benefit of all involved.

2. *Inability of the ADF to support the project indefinitely.* Deployment rotations of one month are compatible with maintenance of a private practice and with the military leave provisions of Australian civilian public hospitals. Provision of 'real' clinical work, as opposed to training scenarios with little clinical fidelity, would be expected to increase the number of competent clinicians wishing to deploy through augmented recruiting and retention. Even were this not to eventuate, it is difficult to argue that from the approximately 3,800 existing ADF clinicians approximately 10 annual rotations of four to six personnel (i.e. 40 to 60 per year, or approx. 1–1.5% of the total) would be unsustainable. Should ADF operational requirements necessitate cessation of deployment of certain types of clinician (e.g. surgeons or general practitioners) for prolonged periods, the enduring relationship could be maintained in professions in which the ADF retained spare capacity. It is unlikely that every ADF health profession, including health General Service Officers, would be required simultaneously on operations elsewhere.
3. *Personal risk to ADF clinicians.* PNG has the highest prevalence of HIV in the Pacific, with a prevalence in the adult (15–49 years) population estimated to be 0.8%.³⁷ This is eight times higher than Australia, but less than one-twentieth that of South Africa and only double that of the USA. The incidence of tuberculosis (TB) in PNG is 333 per 100,000, the highest in the Pacific and

37 'HIV and AIDS Estimates: Papua New Guinea 2018' (Geneva, Switzerland: UNAIDS Secretariat, 2019), <https://www.unaids.org/en/regionscountries/countries/papuanewguinea>.

amongst the highest on the world.³⁸ However, TB can be avoided by careful respiratory precautions. Trauma from interpersonal violence is the greatest risk to civilians. Advice from Pacific Island military colleagues is that ADF personnel in uniform would be protected by their association with host-nation military forces.

4. *Reputational and legal risk to the ADF in case of adverse events.* ADF clinicians registered in some Pacific Island countries (such as PNG) are covered by professional indemnity insurance provided by their governments, or else must have individual practitioner insurance as a condition of their registration (e.g. doctors in the Solomon Islands and Fiji). Additionally, the Status of Forces Agreements that exist between Australia and most Pacific Island nations outlines the legal responsibilities of each nation with respect to civil claims made involving members of the ADF acting in an official capacity, as would be the case for clinicians working in this program. In brief, the host-nation legal system adjudicates any claim, and the host-nation government must pay any financial damages. These must in turn be reimbursed by Australia. In addition to any financial consequences, adverse outcomes to any patient treated by an ADF clinician might cast the ADF in a negative light. This risk would be lessened by the team nature of the work involved and the close working relationship with host-nation clinicians. Further, it should be noted that decades of Australian civilian medical aid experience in the Pacific, combined with careful ADF team selection, suggest the risk of a negative outcome is substantially less than the likelihood of benefit.
5. *Displacement of trust in local clinicians amongst the host-nation civilian population.* It is possible that ADF clinicians might be incorrectly perceived as being more competent than their host-nation colleagues simply by virtue of their training in a developed country. Hence their presence in the hospital or clinic might erode confidence in local practitioners. This perception would be fought at every opportunity by reinforcing to patients that the intent of the ADF team is to 'learn from the experts' in tropical disease and penetrating trauma.

Naturally, before any commitment to a program of this nature could be made, detailed consideration of operationally sensitive projected competing priorities and the fitness and availability of the ADF's employed clinicians would have to be assessed.

38 Paul Aia et al., 'Epidemiology of Tuberculosis in Papua New Guinea: Analysis of Case Notification and Treatment-Outcome Data, 2008–2016', *Western Pacific Surveillance and Response Journal* 9, no. 2 (June 2018): 9–19, DOI: doi.org/10.5365/wpsar.2018.9.1.006.

Conclusion

Australia's capability to staff a Role 2E hospital, in the South Pacific or elsewhere, relies mainly on clinicians whose experience is almost exclusively in large developed-world hospitals that treat few patients with penetrating trauma or tropical diseases. The health services of our nearest neighbours are overstretched in treating exactly these conditions in hospitals that very closely resemble an ADF Role 2E facility. Australia has a clearly articulated foreign policy objective to work more closely with Pacific neighbours to enhance regional security. *Enduring Health Civic Assistance* presents an invaluable opportunity to achieve substantial outcome benefit for both Australia and the Pacific.

