Humanitarian Aid Operations in Republica Srpska during Operation Resolute 2

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SUMMARY: The humanitarian aid experience of a unit in Bosnia is described. Data are presented for primary care clinics undertaken, showing the range of conditions and age of patients seen. The role of the civilian aid agencies involved is described, together with recommendations for future training requirements for similar operations.

Introduction

16 Armoured Field Ambulance deployed on Operation Resolute at the beginning of April 1996. As late as February, when the unit's reconnaissance was carried out, humanitarian operations (G5) were considered to be 'mission creep' and discouraged because of the limited term for which troops were at that time considered likely to be available. During the final weeks of pre-deployment training it became apparent that there was a change afoot and that government funds were being made available to be channelled through the British element of the NATO Implementation Force (IFOR). Accordingly, a (double hatted) G5 Officer (author KE) was appointed and provisional ideas were 'brainstormed'. The unit was fortunate in having taken part in the first Exercise SHARP POINT in Kenya in early 1995 which had produced a degree of relevant experience and an enthusiasm for G5 projects (1). SHARP POINT was a vaccination programme for rural communities in remote areas, undertaken with the support of the Kenyan Ministry of Health and working within the framework of non-governmental organisations (NGO).

Despite the large amount of pre-Bosnia training, there was no part of it which provided any preparation for this aspect of the deployment. One of the reasons for writing this paper is to ensure that the lessons learnt should be available to other units in similar situations in the future.

On deployment it was confirmed that the Overseas Development Administration (ODA) had committed £4.7 million of government aid to Bosnia which would be used to finance low cost G5 projects initiated by British military units, and that humanitarian aid was now part of the mission.

Guidelines for the conduct of medical humanitarian aid were produced by COMARRC on 26 Mar 96 (2). In brief they stated that:

(i) any activity must not undermine the capability of support to IFOR
(ii) it must be done within the existing civil structure
(iii) it must be impartial to all factions
(iv) there must be no financial cost to IFOR
(v) there must be a specified handover date to the local community

The second criterion was crucial and is worth expanding on because it placed some restrictions on what the unit was able to do. It meant that no facility could be provided where it did not previously exist before the conflict, because that would create a dependency on NATO and leave a vacuum when it was withdrawn.

Humanitarian Aid Activity

The main location of 16 Armoured Field Ambulance, with its Medical Support Troop (MST), was Sipovo in central Bosnia, in the area known as the 'Anvil' from the shape formed by the Inter-Entity Boundary Line around it. The Anvil was formerly inhabited by a Bosnian Serb majority, over-run by the Army of the Bosnian Croats, Hrvatsko Vijece Obrale (HVO), in the autumn offensive of 1995 (the citizens of Sipovo fled on 9 September) and handed back to the Bosnian Serbs on 4 February 1996. In the process, anything of value in the area was looted or destroyed, including all the medical facilities. Medical sections were also deployed in the Federation area at Sanski Most, Gorni Vakuf and Vitez (Fig 1).

The unit started by creating a list of proposed projects for consideration by a G5 committee chaired by the Commanding Officer with OC MST, the unit Second in Command and the G5 Officer. The list included primary care clinics, vaccinations, basic surgical procedures, X-ray and laboratory services and dentistry.

The most obvious need within the Anvil was for primary health care clinics in the rural areas, and this aspect quickly became the G5 main effort. Meetings were immediately organised with the local authorities, the various NGOs providing humanitarian relief and the ODA representative. £250,000 of ODA funding was allocated to...
buy 24 WHO primary care starter packs containing basic medical equipment, of which 8 would be allocated to each of the factions. While speed was deemed of the essence by the ODA in order to enable the money to be committed before the date of the elections (14 Sep 96), the need to ensure full co-ordination with all agencies, the requirement for other resources such as engineering assessments of the cost of repair, and the limited unit manpower available, all rendered a quick fix solution impossible.

The first stage was to identify the 8 clinic locations. Given the degree of devastation in the Anvil this was relatively easy. It was done in conjunction with the G5 Liaison Officers of the Battle Groups (BG) who were already operating in the area and had a detailed knowledge of the infrastructure damage, and with the Civilian Military Co-operation (CIMIC) teams from 415 (US) Civil Affairs Battalion attached to the Brigade Headquarters. Most of the clinics needed extensive repair to their buildings, and make them weather proof using plastic sheeting and boards. An emergency surgical service was offered in the rural districts. An emergency surgical service was offered.

As there was inevitably a delay while assessments were made and project approval obtained from the chain of command and ODA, an immediate start was made by the unit to clear out rubble and clinical waste from the buildings, and make them weather proof using plastic sheeting and boards. Once the buildings were usable, clinics were started by 16 Armd Fd Amb personnel on a weekly or biweekly basis, according to need. Combat Medical Technicians documented and triaged the patients for the Medical, Nursing or Dental Officer to see, all working through interpreters or using sign language. Drugs were donated by Médècins Sans Frontières (MSF), who were happy to do so knowing that they would be going straight to the point of need.

The clinics continued to be run by the unit while work on repairing the buildings progressed and the starter packs were procured. Eventually they were all handed back to the local authorities, with due pomp and ceremony and media coverage, prior to the unit's return to the UK.

Data Collection

At the end of each clinic the reasons for consulting were recorded on the form at Figure 2. The principal aim of collecting these data was to show the case mix of those presenting, in order to tailor medical supplies to meet the actual need. Accordingly, each significant complaint was recorded, and not just the presenting complaint. A complaint was considered significant if medication was necessary, or an intervention was made such as referral. Total numbers of patients were recorded separately, as each patient might have more than one condition recorded on the health data collection form. The data were recorded by the senior medical assistant administering the clinic, and collated each month.

Three clinics were identified to receive WHO starter packs, having already sufficient local staff to run them. Members of the unit were involved in running five others. One was in the Federation Area near Sanski Most and run in conjunction with a local doctor. A second was run by the Regimental Medical Officer of 1st Battalion the Worcestershire and Sherwood Foresters Regiment near Mrkonjic Grad, with one of the 16 Armd Fd Amb nursing officers. Data from these clinics are not presented in this paper. Three clinics were run entirely by 16 Armd Fd Amb and only those data are presented here. The data were entered into a Microsoft Excel spreadsheet which was used for producing the charts.

Other G5 Activity

While the primary care clinics were the unit's main humanitarian aid priority, it was active in many other fields and constantly alert to new areas of need, medical or otherwise. Help was given to the local medical authorities to reintroduce vaccination programmes in the rural districts. An emergency surgical service was offered.
to the local community, normally by referral from the local doctors. As an example of the extent of this activity, during the month of August 5 civilians were admitted and 25 seen as outpatients. Significant numbers of mainly acute injuries were seen, many from the thriving forestry industry. More ambitious plans to provide day case surgery for elective procedures had to be abandoned because they did not meet with COMARRC's criteria; there being no surgical facility in the immediate area prior to the conflict. Health and hygiene and technical advice were provided to the Salvation Army soup kitchens and help with the distribution of their aid. Clothing and toys collected by the unit's families were distributed to needy children. Parties and sports events were organised for the local kindergarten. The local

school playground was cleared of rubbish, scrap vehicles and oil, their basketball goals renovated and new football goals made.

**Non-Governmental Organisations**

Liaison between IFOR and the medical NGOs was essential. The military and civil agencies had their own chain of command and areas of responsibility which rarely coincided. Co-ordination was vital to prevent duplication of effort and highlight areas receiving insufficient medical aid. Similarly, with medical units in the Divisional Area of Operations from the United Kingdom (three), Canada, Czechoslovakia, Malaysia and the Netherlands, it was equally important that their efforts should be co-ordinated. This was achieved through the forum of a monthly Medical Deep Operations Group meeting. The role of

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**G5 PROJECTS - MONTHLY HEALTH DATA COLLECTION FORM**

<table>
<thead>
<tr>
<th>Code</th>
<th>Event</th>
<th>Under 5 yrs</th>
<th>5 - 16 yrs</th>
<th>16 - 50 yrs</th>
<th>50 - 65 yrs</th>
<th>Over 65 yrs</th>
<th>Ref to Civ facilities</th>
<th>Ref to IFOR facilities</th>
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<tbody>
<tr>
<td>(a)</td>
<td>1. Cardiovascular (incl hypertension)</td>
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<td>2. Respiratory Dis other than asthma</td>
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<td>3. Asthma</td>
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<td>4. Intestinal infectious disease</td>
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<td>5. Dyspepsia</td>
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<td>6. Contraception, Gynae and preg</td>
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<td>7. Urinary Tract Infections</td>
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<td>8. Syphilis and other STDs</td>
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<td>9. Neurological</td>
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<td>10. Headache</td>
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<td>11. Mental disorders</td>
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<td>12. Alcohol related problems</td>
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<td>13. Eye Disorders</td>
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<td>14. Cataracts</td>
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<td>15. ENT problems</td>
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<td>16. Dental</td>
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<td>17. Dermatological problems</td>
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<td>19. OA and RA</td>
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<td>20. Other musculoskeletal</td>
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<td>21. Major Injuries</td>
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<td>22. Minor Injuries</td>
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<td>23. Other disease</td>
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</tbody>
</table>

**TOTAL SEEN**

Fig 2. Data collection form used in G5 primary care clinics.
the principal NGOs involved in providing medical humanitarian aid is summarised below.

**World Health Organisation**

The WHO is the lead organisation for medical humanitarian aid operations and was thus responsible for overall co-ordination of NGOs working in this area. It was done through fortnightly meetings which were attended by the G5 Officer. WHO also serves as a clearing house for new NGOs coming into country so that they can be directed to the area most appropriate to the type of care being offered with the minimum of delay, and alerts them to potential problems. In order to obtain an overview of health care provision, the WHO conducted a detailed survey of the whole of Bosnia Herzegovina in the summer of 1996. Much of the work for this survey was carried out by IFOR medical personnel. WHO has a set of pre defined medical kits for a variety of circumstances, and their primary care kits proved a ready means to equip facilities.

**International Committee of the Red Cross**

The ICRC has been active in the Former Republic of Yugoslavia (FRY) since 1992 and works to 7 principles: humanity, impartiality, neutrality, independence, voluntary service, unity and universality. Their projects fell into 3 categories: medical aid, reconstruction and human rights. Liaison was important to prevent duplication of effort, though the ICRC field workers were anxious not to be seen to be working too closely with IFOR lest it compromise their neutrality.

**Médecins Sans Frontières**

MSF has also been in the FRY since 1992. Their normal priority is to respond to emergencies following natural disaster or war. In the FRY MSF concentrated on the supply of drugs to medical facilities, including an insulin programme. The co-operation between IFOR and MSF was particularly valuable as they provided the drugs used in clinics run by the military, in the knowledge that aid provided would reach the target population. MSF continued to supply the clinics after they had been handed back to the local medical authorities.

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**Figure 3. Total cases seen at three G5 clinics by disease classification.**

**Figure 4. Age distribution of patients seen at three G5 clinics.**

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### Results

During the course of the unit's tour in Bosnia, 1587 people were seen in the three clinics run from the unit's main location in Sipovo. The numbers attending these clinics at Strojice, Pljeva and Jezero are summarised in Table 1.

It was the experience with each clinic that the first week produced few attenders, but that the second and subsequent weeks were full. The clinics at Strojice and Jezero remained busy to the end, but Pljeva declined for the last two sessions. This may have been due to increased tension at this time, being the lead in to the all Bosnia elections. However, it is more likely that the release of information in mid August that the clinics were to be handed over to the local medical authorities was the reason.

### Table 1

**Attendance at G5 primary care clinics. (Figures in brackets are the number of dental cases within the total).**

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strojice</td>
<td>68 (9)</td>
<td>224 (43)</td>
<td>136 (18)</td>
<td>148 (9)</td>
<td>82 (17)</td>
<td>N/A</td>
<td>Started 22 Apr. Handed over to local health authorities 21 Aug.</td>
</tr>
<tr>
<td>Pljeva</td>
<td>N/A</td>
<td>3</td>
<td>76 (20)</td>
<td>114 (34)</td>
<td>95 (16)</td>
<td>10</td>
<td>Started 29 May Handed over to local authorities 18 Sep.</td>
</tr>
<tr>
<td>Jezero</td>
<td>N/A</td>
<td>92 (2)</td>
<td>82 (6)</td>
<td>89 (2)</td>
<td>71 (1)</td>
<td>N/A</td>
<td>Started 10 May. Handed over to local health authorities 29 Aug.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>68 (9)</td>
<td>319 (45)</td>
<td>294 (44)</td>
<td>351 (45)</td>
<td>248 (34)</td>
<td>10</td>
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</tr>
</tbody>
</table>
An analysis of significant presenting complaints is at Figure 3. This shows that the largest single group had some form of cardiovascular disease, principally hypertension. There were significant numbers with angina, old myocardial infarcts and strokes. The second largest group was those with musculoskeletal problems; if combined with patients with arthritis this group is the most significant in terms of numbers, a reflection of the age of the population visiting the clinics.

The age distribution of cases presenting to each clinic is shown at Figure 4. The emphasis was particularly on the older age groups, especially in Strojice. Indeed the impression gained while running the clinics was of a different population in Strojice compared to the other two clinics. Whereas those attending at Pljeva and Jezero were generally those living in towns, albeit having been refugees, many of those attending the Strojice clinic travelled large distances from their farms and small holdings. Many of the older people at Strojice wore traditional peasant costume, which was not seen at all in Jezero or Pljeva, where modern European dress was worn universally.

Dental cases depended on whether the dental surgeon was available to visit the clinic. The unit was fortunate to have a second dental officer attached as the resuscitation officer for the MST. This allowed one or other of the dentists to carry out G5 work, provided that neither was on leave, given that the unit’s first priority throughout was the clinical care of IFOR troops.

Discussion

The experience of 16 Armd Fd Amb and other NATO medical units in Bosnia has shown that, despite lack of specific training, the current organisation and equipment and level of basic expertise gives units the flexibility to undertake humanitarian operations as a secondary task. It emphasised the need to work closely to achieve the long term viability of the primary care clinics, though much can still be done without specific finance. The importance of collecting data from such projects cannot be emphasised enough, if only to define the resources which might be required in similar circumstances in the future. A number of deficiencies were identified in the standard MSF drug scales which were tailored to the needs of third world conditions.

Following the end of the cold war it is likely that the involvement of British forces in operations other than war will continue to expand, and with it the relative importance of medical humanitarian aid opportunities. Many practical lessons have been learnt and a small body of expertise developed. It is important that those lessons are preserved in order to minimise time and effort wasted in reinventing the wheel every time units deploy. A database of personnel with relevant experience should be maintained so that they can be called upon to give specific briefings to units as part of their special to arm training, particularly to the nominated G5 Officers. The high calibre of officers required to fill such posts successfully cannot be over-emphasised.
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