

## PLENARY SESSION II: DISASTER, HUMANITARIAN AND STABILITY OPERATIONS

## PL3

**MEDICAL PLANNING OF CHINESE ARMED FORCES IN WENCHUAN EARTHQUAKE RESCUE OPERATIONS**Shusen Guo <sup>1</sup>, Zhuoyi Yang <sup>1</sup>, Yanni Li & Li Ma <sup>1</sup><sup>1</sup> The Health Teaching and Research Division of Logistics Command, Academy of Chinese PLA, CHINA

This paper discusses the medical planning of Chinese Armed Forces during the Chinese Wenchuan Earthquake rescue operations. In the operations, the medical planning included ways to establish medical service system, means to prepare medical forces, ways to employ the medical forces, and the 4 phases of the rescue operations. The medical service systems were divided into 2 parts; the medical service command system, and the medical support system. The medical service command system consists of 4 levels; the stratagem, the campaign, the duty area and the tactics levels, The medical support system is made up of 3 levels. Each level, consists of medical treatment, prevention medicine, medical evacuation and medicine supply organizations. In the earthquake rescue operations, the medical troops were not only service units but also battle units, 'battling with the wounded, epidemic and infectious disease. There were two types of medical forces. One, belonged to military contingents, and the other was the force level called rapid response unit each with different missions. There were 5 mission areas in Wenchuan. Operations. In each area some medical forces were deployed. Some were field hospitals with 120 people each deployed in containers and tents. Some were medical units with 30 people each deployed near the front line. Some were deployed in inherent military hospitals. Others were dispersedly deployed, taking medical service to villages and houses. The medical rescue emphases were changed according to the phase of the rescuing operation. In the first 2 days after the earthquakes, the most important task was to deploy the medical forces and to carry out front line first-aid. In the 3rd to the 8th day, the most important task was to save lives and transfer the wounded. In the subsequent 9-29 days, the main work was to prevent infectious disease and epidemic. Cooperation between different medical organizations such as the PLA and the Armed Police and different medical areas was very important in the earthquake rescuing operations.

## PL4

**THE US MILITARY HEALTH SYSTEM'S ROLE IN STABILITY OPERATIONS**

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The US Department of Defense (DOD) is evolving to meet new security challenges in the 21st century. Today's challenges result from growing political, environmental, and economic instability in important areas of the globe that threaten national and global security. The US Department of Defense and the US Government have established a mandate to develop stability operations capabilities through official strategic and policy documents. Stability Operations consist of five main sectors which include: Medical Security Cooperation, Military-to-Military Security Cooperation, Humanitarian Assistance/Disaster Relief, Health Sector Stabilization, Health Sector Reconstruction. The DOD has conducted numerous Stability Operations over the past decades, and the Military health system (MHS) has provided significant support to these efforts, however DOD and the MHS have yet to systematically define the Stability Operations health/medical role, nor to fully embrace this role for the MHS through dedicated and focused organization, train, and equip efforts. Although many tasks in medical stability operations are best performed by international, U.S. Government, host nation, or civilian professionals, U.S. military forces, including medical, must be prepared to perform any and all tasks necessary to establish or maintain order and stability when civilians cannot do so. A Policy Committee has looked at the core competencies necessary for Medical Stability Operations. This didactic session will detail what are the core competencies for Medical Stability Operations and explain what prioritized gaps exist in current assets.

## PL5

**NATIONAL SURVEY OF DISASTER MEDICAL ASSISTANCE TEAM MEMBERS IN AUSTRALIA: IMPLICATIONS FOR DEPLOYMENT**

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**Background:** There have been significant international military, civilian and NGO Disaster Medical Assistance Team (DMAT) deployments in recent years. It is likely that calls for DMATs will continue. There have been few studies examining civilian DMAT deployments. This survey was part of a national program evaluating the Australian DMAT experience and examining potential models for future use in Australia.

**Methods:** An anonymous questionnaire was distributed via State and Territory representatives on the Australian Health Protection Committee, who identified DMAT members associated with Australian deployments from the 2004 Asian Tsunami disaster and forwarded the questionnaire.

**Results:** The response rate was around 50%. Most of the personnel had deployed to 2004 Asian Tsunami affected areas. Nearly one half of team members were medical personnel. The DMAT members were quite experienced. About two thirds of the respondents were male and about two-fifths had deployed previously with the military. About half of respondents felt that a military model suited DMAT deployments. The deployment of DMATs should be based on a full understanding of disaster epidemiology and realistic response times. Properly composed DMATs need to recognize what their capabilities are within this timeframe, and base their response on a needs assessment of the affected area/country. Prior planning is required to ensure the success of DMAT deployments and members should have appropriate training. More emphasis should be placed on welfare of personnel before deployment. Once in the field, there should be clear lines of communication between the team, the local coordination, and an operations centre as well as families and friends back home. DMATs should deploy with adequate equipment. The response should be self-sufficient with respect to both the team needs and their ability to provide care, for a minimum of 72 hours, but ideally for the duration of their stay. Team members also need to be adequately supported during and after the mission.

**Conclusion:** Australian civilian DMAT members had an overwhelmingly positive response to their deployment. A military model for DMATs was considered the more effective option. More research is needed to examine DMAT issues pre-, during and post-deployment as well as to further develop evidence-based standards for evaluating DMAT deployments.