



HANDBOOK



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COMMANDER'S GUIDE TO SUPPORT OPERATIONS AMONG



WEAPONIZED DISPLACED PERSONS, REFUGEES, AND EVACUEES

Lessons and Best Practices

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Foreword

The use of chemical and biological weapons on the battlefields of history is not a new phenomenon. Although this practice is contrary to international treaties and customs, it has not precluded the use of these weapons by state and non-state actors against military, political, or civilian targets. Chemical and biological weapons use during the Iran–Iraq war in the 1980s and the use of chemical weapons in Syria in 2013 demonstrate that our collective security is threatened by actors willing to defy the international community. The threat of chemical and biological weapons use is increased as these are relatively inexpensive to produce and can be delivered by a variety of methods, making them an asymmetric threat of catastrophic potential. The psychological, health, and logistical implications of displaced persons fleeing a real or perceived chemical, biological, radiological, nuclear, and enhanced conventional weapons (CBRNE) environment will create complex mission command and support requirements requiring innovative and agile responses.

The United Nations High Commissioner on Refugees estimated at the end of 2012 that there were more than 44 million refugees and displaced persons around the world, most of these forcibly displaced due to conflict. Populations trying to escape violence can rapidly exceed the capacity of receiving nations' capabilities to provide even rudimentary support. The purposeful introduction of a single biologically infectious person acting as a carrier, or the introduction of mass CBRNE casualties into a displaced person, refugee, and evacuee (DPRE) environment has the potential to create a medical, safety, and security calamity of some magnitude. Non-governmental agencies that traditionally respond to these types of humanitarian crises would be immediately constrained in their ability to help.

Responding to a crisis of the magnitude associated with the purposeful introduction of CBRNE casualties into a DPRE environment would almost certainly require military forces — particularly U.S. military forces — with the skills necessary to rapidly deploy for consequence management, and operate in what promises to be a very complex and chaotic environment. The ability to provide streamlined and integrated CBRNE and medical capabilities will be essential. Military forces will need to create the space necessary for aid agencies to operate and provide a synchronized interagency and intergovernmental response. Time between detection,

analysis, understanding, and deployment could be very short and predeployment training and planning timelines will be limited.

U.S. forces must be agile and innovative in responding to these types of crises. They must possess the ability to rapidly deploy and integrate CBRNE forces with the appropriate security and medical support personnel to effectively identify CBRNE threats, infected persons, and appropriate mitigation and response strategies. Forward positioning of medical capabilities should be considered and, because these types of threats have the potential to rapidly and dramatically increase casualties, effective mission command systems and technical reach back will be critical for the proper identification of agents, treatment of infected persons, hazard containment, and mitigation efforts.

The purposeful introduction of biologically infected persons or CBRNE casualties into the DPRE environment also has the potential to create a security calamity of some magnitude. The manifestation of these types of threats provides a complex and challenging situation for commanders and staffs at every echelon. The intent of this Center for Army Lessons Learned handbook on weaponized DPRES is to initiate the discussion necessary to enable our preparation to successfully operate across such a complex security situation.

A handwritten signature in black ink, appearing to read "James B. Burton". The signature is stylized and fluid, with a large loop at the end.

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Introduction

In our recent history, the U.S. military has conducted operations across the full spectrum of conflict. The most common characteristic has been the complex and ambiguous nature of the environment in which these operations have been conducted. Certain trends are global and enduring in such an environment, such as the use of improvised explosive devices and the inclusion of large groups of displaced persons. Some of those displaced persons will be victims of forced migration due to conflict, while others may be victims of voluntary migration as a result of desperate humanitarian hardships. Experience shows that these population groups are especially vulnerable and are usually in desperate need of basic necessities for survival. While advances in technology and industry have offered unparalleled opportunity, these same developments often highlight the enduring nature of displacement and the illusive nature of achieving long-term, durable solutions to this vexing problem.

In our previous Center for Army Lessons Learned handbook, *Commander's Guide to Supporting Refugees and Internally Displaced Persons*, we offered a collection of essays that discussed the fundamental challenges associated with the military's involvement in refugee operations. Included in the previous handbook were discussions about funding, security, planning considerations, civil-military interaction, and legal constraints.

For this edition, we focus our essays on a particularly daunting concern related to mass displaced populations — that of the weaponized displaced person, refugee, and evacuee (DPRE). The threat of a biologically or chemically infected person entering a large displaced persons camp — either purposefully or inadvertently — warrants serious and immediate study and is the topic for this edition. As in the previous volume, the articles are organized into common chapters for clarity and purpose.

It is our hope that this handbook will contribute to the body of knowledge in this field and will facilitate our collective understanding of how the military can effectively deal with the multitude of challenges associated with large numbers of displaced persons. Understanding the context of the issue is essential for all leaders; this handbook provides keen insight into the military's role in dealing with a unique refugee dilemma — the weaponized DPRE.

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Chapter 1

Medical Considerations for Weaponized Attacks on Displaced Persons, Refugees, and Evacuees

MAJ Chuck Douglas, MPH

Terrorism refers to the use or threat of force or violence against people or property. A bioterrorist attack releases viruses, bacteria, or other germs to cause illness or death. These biological agents are typically found in nature, but they can sometimes be made more harmful by increasing their ability to cause or spread disease or to resist medical treatment. Biological agents spread through the air and water or in food. They can be very hard to detect and they don't cause illness for several hours or days. Some agents can also be spread from person to person. Scientists worry that anthrax, botulism, and hemorrhagic fever viruses such as Ebola, plague, or smallpox could be used as biological agents. Biodefense involves medical measures to protect people against biological agents. This means medicines and vaccinations. It also means medical research and preparations to defend against bioterrorist attacks.

Centers for Disease Control and Prevention¹

Introduction

Internally displaced personnel (IDP) and refugee camps are places of outright danger and insecurity for refugees and aid workers.² Security threats come in many forms and might begin from outside a camp while people are fleeing, or within the confines of the camp. Threats historically include direct military attacks, armed raids by rebel groups or militants, violent crime, or abuse and intimidation.³ Displaced persons, refugees, and evacuees (DPREs) face a number of safety challenges and health risks while trying to escape political strife and war-torn regions of their country; having to encounter additional threats of attack by others increases their vulnerability. The evolution of technology increases these threats with the introduction of biological and chemical weapons in a form previously unseen. Such technology now allows enemy forces to use people as a potential weapon and carrier of biological and chemical hazards. Therefore, military commanders must consider the evolving threat of exploiting people to spread chaos and devastation.

New Type of Threat

Military commanders and aid organizations often expect such a threat to come in the form of conventional munitions that are chemically weaponized. This new threat is a weaponized DPRE — a person diseased

with a biological or chemical agent, who is sent into a camp with the intent to spread a deadly contaminant. This new threat can cause much greater destruction before the source is identified. A belligerent force might weaponize the person in order to undermine the safety and security of the camp and to force repatriation of the IDPs or refugees.⁴ How does a military unit effectively mitigate a weaponized DPRE with limited resources and time while protecting a population at risk? What are some of the medical considerations to help lessen the effects of such an attack?

Identifying a Weaponized DPRE Threat

As military commanders deal with the ever-changing situation within a country, they must also be aware of the likely sources for weaponizing a DPRE. Enemy combatants within a given region might have access to a limited type of chemical or biological agent that can be used against a DPRE population. Since a weaponized DPRE might use these means to spread disease, medical personnel and security forces working in and around a camp must have the ability to recognize the signs and symptoms of possible threats. Identification will likely be delayed until several people experience consistent symptoms. Constant vigilance of the site's general health is the basis for timely identification.

Recognizing the possible signs and infections is a start. By understanding the potential threats of certain agents, a military commander and his medical personnel can devise a plan to facilitate early detection in a camp. Routine monitoring during medical treatment operations should be coupled with a trends analysis of disease and illnesses. Identified spikes in outbreaks should be further examined to determine if the source is naturally occurring or if a possibility exists for intentional contamination. A weaponized DPRE will likely exhibit many of the same symptoms as some of the more common illnesses within a camp. Therefore, a comparison of endemic diseases and significant spikes of acute disorders might indicate a possible threat.



Figure 1-1. Medical personnel must anticipate a potential chemical or biological threat even when symptoms replicate a population’s pre-existing conditions and endemic diseases.

Photo source: United States Africa Command.⁵

Securing a Camp for Weaponized DPRE

The military is resourced to treat certain chemical and biological threats within their own ranks.⁶ Additional resources are normally required to treat a much larger population of refugees and aid workers. Coordination with key personnel within the camps is essential to prevent an attack from spreading. Team training begins with military personnel prior to deploying to support an operation in which DPRES are involved. These teams practice decontamination procedures, isolating personnel who have possible exposure, and also investigating the source of exposure. The overall medical plan should include these procedures, and embody security measures to control the flow of personnel through treatment, isolation, and identification of weaponized DPRES.⁷

Medical personnel must be prepared to treat a mass infection within the camp. Aid workers and security forces will likely be exposed as well. Medical planners must conduct a medical treatment analysis to determine the various populations that might require treatment and also to overcome shortfalls in proper treatment and widespread prevention of a weaponized DPRES. Contingency planning will consider the site location, density, and possible areas for isolating and treating a weaponized threat.

If a weaponized DPRE attack is effective, medical personnel must be able to prevent further spread of the attack while working closely with aid workers, camp leaders, and security forces to contain the problem.

Population Estimate and Health Assessment

Preparing medical personnel, aid workers, and security forces ahead of time is essential. Conducting a population estimate and health assessment provides vital information on population-at-risk size and vulnerable groups.⁸ By estimating the total number of refugees, a military commander can assess if a military medical team has the ability to treat and prevent the spread of a weaponized threat. Commanders must anticipate total casualty numbers in order to mitigate the threat at its earliest stages. If this is not properly coordinated, the spread of disease within the initial stages of attack can produce exponentially greater losses to both camp residents and aid workers.

Health assessments are another critical component of preparing for a possible weaponized DPRE situation. Military medical personnel must understand current disease and illness rates within a camp in order to recognize any irregular trends occurring from exposure to a weaponized DPRE. Disease rates may be difficult to determine if a weaponized DPRE contaminates a camp with an agent or disease that replicates another type of commonly occurring illness within the camp. Disease analysis must consider the potential for enemy use of a weaponized mechanism in order to differentiate a sanitation-related concern from a genuine attack.

Probable Sources of a Weaponized Threat

Identifying the probable type and scope of a chemical or biological threat is important in order to focus preliminary surveillance efforts. Potential threats can be identified. Potential threats can be identified by reviewing pre-existing chemical and biological weapons in the region, access to chemical and biological agents by enemy forces within the area, and the mode of transmission to larger groups within a camp.⁹ Medical personnel should identify potential sources of chemical or biological attacks to anticipate the impact on the health of a population at risk.

Brigade medical planners should collaborate with intelligence staff members to assess the likelihood of a belligerent force introducing a weaponized DPRE into a camp who possesses similar symptoms to many of the camps common diseases. Since diarrhea, respiratory infection, and malaria are some of the principle causes of death among DPRES, military personnel should understand the symptoms commonly associated with these maladies and compare such symptoms with probable chemical and biological agents an enemy force might introduce into a camp.



Figure 1-2. A man washes his hands in a Kobe refugee camp.¹⁰ This latrine and water source are shared by four families. A weaponized DPRE attack on vulnerable resources can cause widespread contamination before proper identification of the threat. Photo source: Negash, Meron Tsehaye. “Sanitation & Hygiene Efforts in Kobe Refugee Camp: Mohammed’s Story.”

Preventing Outbreaks

DPREs are not the only possible source for spreading a disease. DPREs might contaminate food and water sources in the camp in order to ensure rapid, widespread exposure. If a weaponized DPRE has access to these sources, a situation could rapidly deteriorate as the rest of the population consumes contaminated food and water. Physical security of these items is not only critical for equitable distribution; safeguarding these assets can mitigate against their use as sources of infection.

Utilizing Brigade Medical Teams

Medical personnel are capable of diagnosing and treating routine diseases found in an adult population. A weaponized DPRE attack can easily overwhelm a brigade’s organic medical capability while also placing medical team members at increased risk. If a weaponized DPRE successfully infects a significant portion of a population, a medical treatment team should be ready to protect itself against exposure while simultaneously providing care to infected personnel within the camp. The team must also quickly determine if the potential casualty rates will exceed its own capabilities. If this is the case, previous coordination with external

health care organizations, military medical units, and host nation medical capabilities can ensure proper coverage to a population suffering from widespread exposure.

Conclusion

A weaponized DPRE presents many challenges for military commanders and medical personnel. A synchronized effort between military forces, non-governmental organizations, and host nation personnel is essential to fully understand the potential threat and handle an attack. It is not enough simply to react to a threat once an outbreak has occurred. Proactive coordination prior to an actual attack is the only way to offset the widespread effects of a weaponized DPRE exposing a population of thousands to a biological or chemical attack. Understanding the extent of likely damage, preempting capability shortfalls, and having a rehearsed contingency plan involving the key players are necessary. If a weaponized DPRE is not identified and contained in a timely manner, the ensuing situation can reach catastrophic levels. Military commanders need to consider and prepare for this type of threat as a likely danger during future operations. In doing so, the key stakeholders can minimize the consequences of a weaponized DPRE attack and protect those who are already fleeing a situation in which they faced possible persecution or physical harm.

Endnotes

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Chapter 2

Protection Through Prevention: Defending At-Risk Displaced Person Populations Against Disease

MAJ Paul D. Lang, Medical Service

Your unit has been given the task of securing a displaced persons camp in Africa. This task includes protecting the camp population and your unit against natural and enemy-directed disease threats. The number of arrivals is increasing daily and the situation that has driven them to your camp has left many of the population undernourished, exhausted, and potentially sick. How do you protect them?



Figure 2-1. Securing a displaced persons camp in Africa.

Introduction

Complex situations calling for U.S. military involvement often include the presence of displaced persons, refugees, and evacuees (DPREs). Historically, populations involved in mass migration (such as the case of refugees and internally displaced persons [IDPs]) lack food, water, and medical care. This population will literally be sick and tired. The key

responsibilities of any organization operating camps established to assist this population must limit suffering and make every effort to limit disease within the camp. This becomes all the more serious in areas where an infected person could be used as a directed weapon against a camp.

Many diseases, even those occurring naturally in a given geographic area, can be very serious. As described in the above vignette, regions in Africa have many serious diseases such as the Ebola virus that could be utilized by actors focused on disruption and destabilization of a vulnerable population. Several tenets, when utilized in harmony, can assist planners and humanitarian aid providers to limit the threat and effects of disease on a camp. Whether directed by a third party or naturally occurring, disease is a part of all displaced civilian encampments and must be considered by any military planner faced with this dilemma. A well-informed unit, working with a simple, but effective plan rapidly employed, can have great impact on the levels of disease in a displaced persons camp.

Medical Threat Analysis

Understanding the operational environment is vital to a successful mission. One of the best ways to gain this understanding is through an extensive medical intelligence preparation of the battlefield. Department of Defense Instruction 6420.01 defines medical intelligence as the intelligence resulting from collection, evaluation, analysis, and interpretation of foreign medical, bio-scientific, and environmental information, which is of interest to strategic and medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors.¹

A detailed medical threat analysis provides knowledge and awareness of prevalent diseases and the prevention measures within a given area of operations. For example, in Africa some of the diseases of major concern could include Zaire Ebola hemorrhagic fever, Marburg hemorrhagic fever, and diarrheal diseases including cholera. Knowing the signs and symptoms of these illnesses and having a plan to deal with infected displaced persons arriving at a particular location can save lives. The first resource for medical threat analysis and applicable protection measures is a unit's medical section. In emergencies, the National Center for Medical Intelligence (NCMI) can also be utilized to develop medical threat and risk assessments for a particular area to support deploying units.² Understanding the environment is only the first step in protecting health; a unit will have to act quickly to mitigate threats from disease.

Speed is Vital

Rapid response is crucial in preventing disease and protecting displaced civilians. Populations within displaced civilian camps can increase sharply within a few weeks or months. Figure 2-2 shows the estimated population

at the Gambella camp in Ethiopia over the course of less than a year. The camp’s estimated population doubled between April and August.

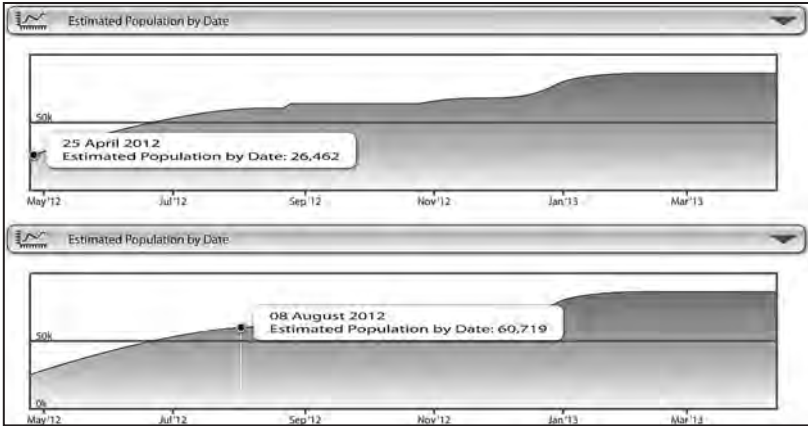


Figure 2-2. Growth of estimated population at Gambella Camp, Ethiopia, by date.

Often in the military, leaders would like long planning timelines and an opportunity to weigh and compare multiple courses of action. As is clear from the above numbers, time is not a luxury planners will often have in an event involving displaced persons. Speed, as it applies to disease prevention, is especially important. Preventing a disease is always preferred over treating the sick. The more rapid the response by military and civilian partners, the better the opportunity to mitigate the threat of disease and diminish camp mortality statistics. The speed of a response to mass displaced person incidents will be greatly assisted by the feasibility of the support plan; simplicity in any of these plans is imperative.

Keep it Simple

Any plan for preventing disease and protecting the population from the threat of sickness must be simple. Simplicity directly relates to both speed and the ability to facilitate transition. A military unit deployed in response to a problem often brings a level of capability that is not comparable to many non-governmental organizations (NGOs). Furthermore, military units often operate within nested levels of bureaucracy. Too rigid an organizational structure often leads to operations that are chaotic and waste time.³ These complicated operating mechanisms have the potential to impair any response to a displaced civilian event.

For example, identification of illness in the displaced person population during the registration process of any camp is a vital step in disease prevention. If an illness is missed in the registration process and appropriate treatment is not administered, the levels of disease in a camp

will undoubtedly rise. Military units must always review their methods to ensure personnel are thorough without the process being too complex. This simplicity also aids in the eventual transition to an NGO or other civilian organization to take over camp operations.

Facilitate Transition

Rarely, if ever, is the application of U.S. military personnel a strategic end state to a displaced persons incident. The purpose of military units involved with displaced persons should be to alleviate suffering, provide emergency care, and seek a viable government or civilian organization with which to transition. Within the international community are multiple NGOs and international organizations, which have a successful history of responding and supporting DP/RE camps. Many of these organizations, such as *Medicines' Sans Frontieres* (Doctors without Borders), focus on the health of displaced populations. Often these organizations are able to provide care to the refugee population without the stigma of a political agenda.

Military planners should consider prompt transition to professional organizations dedicated to helping the displaced population based on conditions. Early planning considerations for simplistic health surveillance systems enables civilian organizations to assume control with little interruption of health services and surveillance. An important consideration during transition is that once a non-military organization assumes responsibility, military presence may not be desired. Transition can be aided through early and thoughtful planning, with a mind to simplicity.

Conclusion

Military planners should plan and execute missions that involve displaced civilians differently than many operations within the spectrum of conflict. Plans so complex that they inhibit rapid execution, risk being overwhelmed by a significant displaced civilian population. This risk is exacerbated in an environment with serious endemic diseases, whether naturally occurring or enemy directed. Simplicity also allows for a smooth transition to a civilian entity in order to facilitate subject matter expertise to manage the crisis. It is highly likely that future operations will include refugees and IDPs. They are a population highly at risk for potentially lethal diseases; but through an informed and rapid approach, these risks can be mitigated.

Endnotes

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Chapter 3

Risk, Prevention, and Mitigation of Infected Displaced Persons

MAJ James M. Brown, Military Police

The 1995 movie “Outbreak” showed audiences the speed at which a disease can enter and spread within a population, and the extensive efforts that would be required to contain and control the risk to the population. While this movie represents a dramatized version of a deadly disease outbreak, its basic elements are drawn from events that combine to represent a plausible scenario, given the proper conditions.

Virulent and devastating disease presents significant risks to the safety and efficacy of military operations in an austere environment. Knowledge and understanding of the risk presented, the methods that are required to prevent exposure, and the steps to mitigate the danger of disease already present in a population are essential in working with a population at risk.

Risk

A single person or small group of individuals purposefully infected with an easily communicable disease, if given the opportunity to spread illness to uninfected persons, can quickly derail or end a relief effort. In the direst of cases, a deadly infection can rapidly spread through a camp, directly or indirectly affecting all those living or working within its boundaries. Significant impact can also arise from those instances in which the pathogen is not linked to extreme morbidity, but still affects the population. Independent of the illness that may be introduced, the emphasis on prevention is evident.

The use of biological weapons may be attractive to state and non-state actors alike. The potential of controlling an agent with the capacity to sicken or kill hundreds with minimal investment beyond its introduction to the target community is attractive.¹ The majority of agents employed as biological weapons are formulated to be delivered via traditional munitions, making them more accessible to state actors or, at the very least, those forces with established conventional arms capabilities.

While 170 nations have signed the Biological Weapons Treaty,² stockpiles of assembled biological munitions and virulent laboratory strains do exist and present the opportunity to be obtained by non-compliant parties. Some infectious agents may also be obtained from the environment, presenting an additional accessible source. A small number of these agents do not require a high level of sophistication to employ, making them able to be weaponized by those with even rudimentary laboratory skills.³

A Hybrid Threat

The threat is hybrid in nature, as biological agents may also be used directly or indirectly to target personnel assisting with the humanitarian effort. The potential effects upon stability operations include the morbidity and mortality of the affected populations, diminishment of the credibility of those involved in relief efforts, and significant logistical and force protection requirements. Given this spectrum of adverse outcomes, the role of disease must be understood and the impact anticipated.

Refugees and displaced persons are present throughout the world, with the relative level of regional crises in constant flux.⁴ While an exhaustive discussion would be required to focus on each area and the unique regional features, Africa in general presents an area of constant volatility⁵ and increased opportunity for access to potential agents. The highest concentration of non-signatories to the Biological Weapons Treaty is located within Africa⁶ and there are natural diseases present on the continent with the capability to be harnessed as potential weapons.⁷

Hemorrhagic fever from the Ebola or Marburg viruses,⁸ typhoid fever,⁹ cholera and other bacteria and parasites that can cause severe diarrhea,¹⁰ influenza,¹¹ and meningitis¹² are all potentially obtainable from existing patients within Africa and have the ability to be readily transmitted through close and direct human contact. Smallpox, while declared as eradicated in the wild in 1980,¹³ is believed to still pose a danger for re-introduction as a biological weapon¹⁴ and is easily transmissible through human-to-human contact.¹⁵

The pathogens that could be weaponized with the intent of spreading person-to-person through a closed population are diverse. Some cause death in almost all cases while others are often not fatal, but can result in significant short- or long-term disability. Transmission patterns and potential treatments differ in the list presented and the geographic location within a small region may make one illness more likely than another. Lastly, the sophistication, resources, and intent of the enemy are decisive factors in determining which agent may be confronted. While specific countermeasures employed against each agent will differ, there are common practices that may be employed to reduce the risk of a weaponized person inflicting harm upon humanitarian operations.

Prevention

Contact with diseased individuals is a necessary factor in disease transmission. This contact can include direct contact via touch, close proximity to aerosolized respiratory secretions, contact with bodily fluids, or potential contact with water or food sources that have been contaminated with infected human waste. While these modes of transmission differ, each can be mitigated by applying the appropriate contact precautions.

Develop information, plans, and training. Delineating which disease may be encountered and what barrier measure may be required begins with first becoming acquainted with the diseases prevalent within the assigned area of operations. Various governmental institutions, such as the Center for Disease Control (CDC), international organizations (such as the World Health Organization), non-governmental organizations, and host nation agencies can provide valuable information in regard to regionally specific threats and potential risk factors for exposure. This information can be acted on during the planning of operations and used to target preventive immunizations, develop protocols, and identify equipment requirements before encountering a refugee or displaced person. If time permits, training among the medical and force protection staff also can be conducted before deployment with an emphasis on enduring vigilance and surveillance.

Prevention continues with initial screening of all current camp inhabitants and ongoing screening as the population expands. Any existing infrastructure should be inspected for cleanliness and assessed for the potential to exacerbate the risk in harboring or spreading disease. Latrines, trash accumulation points, and water sources should receive initial focus and measures enacted rapidly when indicated. Preventive medicine and engineering teams can provide the best guidance for camp improvements or re-siting of the camp, should conditions warrant. Additional attention should be directed at healthcare facilities. Given the varied modes for potential disease transmission, plans for sanitary interaction, patient separation, waste disposal, and general patient flow must be made.

Prevention measures must be continued throughout the duration of humanitarian operations. The initial intelligence that drives protective posture selection must be shared and resulting actions synchronized with other components and agencies active in humanitarian relief. A camp must be established or improved in a manner that further limits the risk of disease spreading and all agencies active within its borders must be cognizant of the preventive standards in place. Medical care, facility engineering, field sanitation, force protection, and mortuary affairs must be synchronized to establish and maintain an environment that limits the potential for disease to spread, while providing dignified assistance to the population.

Mitigation

The incubation time of a particular disease will impact the onset of symptoms relative to the time at which the disease was contracted. While protective measures, such as those discussed previously, are typically stressed when initially encountering displaced persons and refugees, vigilance must be maintained, as symptoms may only arise at a later point in time. Even the most stringent of protective measures and screening may

not be adequate to prevent the arrival of disease within a camp. At this point prevention remains vital, although mitigation measures must rise to equal importance.

A weaponized refugee or displaced person would likely fulfill the medical rules of engagement and be eligible for care, using recent criteria established in Afghanistan as a guideline. Care for these individuals must be appropriate, dignified, and complete, yet also comply with the goals of risk mitigation. Care must be rendered in a manner that is safe and limits exposure to the remainder of the camp and its supporting staff. Pursuit of this goal will maintain the conditions required to sustain safe operations while providing optimal care.

Treatment

Medical treatment must be tailored to the illness encountered. As discussed previously, a number of agents may be utilized to weaponize a person and each will be met with varying degrees of success during treatment. Just as prevention measures were important to assess early in an operation, potential treatment requirements must also be pre-planned based on available intelligence. Medical staffing, Class VIII medical supply specifications, medical facilities, biohazard disposal, nutritional support requirements, and remains processing gain enhanced importance once a disease appears in a camp.

Independent of what the outcome may be for the patient, proper alignment of these factors in the context of mitigation will be vital to stem the spread of illness. Hemorrhagic fevers are almost universally fatal and mitigation does not end until the remains are properly processed.¹⁶ Diarrheal illnesses are typically not fatal, but can increase demands for intravenous fluids, waste handling, and barrier protection materials for health care workers.¹⁷ Typhoid,¹⁸ meningitis,¹⁹ and influenza²⁰ patients experience varying degrees of mortality and each poses unique treatment and containment considerations. These examples illustrate the need for those providing health care, facilities management, field sanitation, and protection to be aware of the differences that may be encountered in the treatment and mitigation phases if disease manifests in a camp.

Conclusion

A weaponized displaced person or refugee is an ominous prospect in the conduct of military or humanitarian operations. A number of possible diseases could be harnessed to this end and while sharing some universal characteristics, each presents unique challenges. Preparation is essential in appreciating the risk presented, prevention measures that may be available, and mitigation measures should illness arise. Commanders must develop subject matter experts within their teams and formulate an integrated and feasible plan to address each of these during operations.

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Chapter 4

Preventing Slow Extinction: Combating the Use of Weaponized Displaced Persons, Refugees, and Evacuees to Inflict Generational Genocide

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Introduction

In June 1994, at the height of the killings during the genocide of the Tutsi in Rwanda, HIV-infected Hutu men purposely went into homes to rape Tutsi women with the sole intention of infecting as many Tutsi women as possible with HIV.¹ As one survivor recalls, “[T]he soldier told me that he was HIV positive and he was going to rape me to infect me with HIV. That way I would then infect my future sexual partners and any children I bore as well with HIV and eventually kill off all Tutsis in the future.”²

For months and perhaps even years before, Hutu propagandists had said Tutsi women were inferior to Hutu women, working for the Tutsi cause, and labeled as evil seductresses. This “existence of hate propaganda which targeted Tutsi women supports the argument that the sexual violence was not merely a side effect of the conflict but rather an integral part of the genocidal campaign.”³

Why? Why during a genocidal campaign would soldiers be given a mission not to kill women, but instead rape and infect them with HIV, if the intent was to completely eradicate the Tutsis from the face of the planet? The answer: generational genocide through infectious disease.

International Efforts to Combat Genocide

Any decent person that possesses a shred of morality views genocide as reprehensible, unconscionable, and debased. It’s the reason why the United Nations passed the Convention on the Prevention and Punishment of the Crime of Genocide in 1948. It’s also one of the bases for forming the International Coalition for the Responsibility to Protect and the Responsibility to Protect Report of 2001. The international community cries out in one united voice, “Never again!” It stands to reason, therefore, that the world is prepared to do whatever it can to prevent genocide on the scale of Armenia in 1915, the Holocaust in 1945, or Rwanda of 1994 from ever happening again.

Nevertheless, there will always be people who desire to get rid of their enemies by wiping an ethnic or religious group from the face of the earth. One only needs to listen to the rhetoric of leaders like then-President Mahmoud Ahmadinejad from Iran to know that to be the case.⁴ While it is entirely possible that the world may never again witness genocidal killing at

the rate of 8,000 per day as it did in Rwanda, genocide could still occur, just done over decades instead of days. Just like the HIV-infected Hutu soldier raping Tutsi women, and thereby engaging in ethnic cleansing, which spans a generation, the same could be accomplished through infecting refugees with a type of human sterilization virus or through infecting a refugee camps' food source with a sterilization gene.

Not Science Fiction

Weaponizing a displaced person, refugee, or evacuee (DPRE) with a highly infectious disease, or emplacing a sterilization gene into a food source meant to infect an entire population sounds like something out of a science fiction novel or thriller movie. However, the frightening reality is that the technology exists today. In 2001, the Epicyte Corporation was granted exclusive patent rights for a technique to produce therapeutic antibodies from corn and other crops. Using a technology called "biopharming," Epicyte estimated that a "single acre of genetically engineered corn could produce the same quantity of drugs as a typical multimillion-dollar factory."⁵ During the research phase, scientists were able to isolate a rare class of human antibodies that attack sperm and spliced its gene into corn. Dubbed "contraceptive corn," the ramifications of its use ran the full spectrum from birth control to stemming population growth.⁶

For some who believe the world is already overcrowded, this type of biotechnology is enticing. But it is not without risk. Entire ethnic populations already run the risk of extinction by the end of the millennium simply because of the low birth rate of females.⁷

Hence, without any "help" from sterilization measures, a country like Bosnia-Herzegovina could cease to exist in as little as 600 years. So the idea that a country, through forced sterilization and genocide "from the inside out," could wipe out its hated enemy's population by the time their grandchildren or great grandchildren have reached adulthood may become extremely palatable. The question is not if this type of genocide and biowarfare can happen, but rather when will it happen? Therefore, doctrine should be written to describe how to combat it.

Tribal Conflict

Members of the Kalash tribe live in small remote villages deep in the valleys of the Khyber-Pakhtunkhwa province of Pakistan. They are a population of less than 6,000 members, and theirs is the only known polytheistic culture remaining in an Islamic-dominated country. Their animistic beliefs play a highly significant and spiritual role in their daily lives. As part of their religious tradition, sacrifices are offered and festivals held to give thanks for the abundant resources of their three valleys.⁸

But living in a country which is 97-percent Muslim threatens their way of life. Throughout the years, various tribes have tried to destroy the Kalash people and eradicate what they consider to be a religious abomination in Pakistan. With such a small, isolated population, it would be easy to introduce a sterilization virus into their food source as described in the section above, which could eradicate this ethnic population from the inside. The Kalash people would cease to exist in less than 25 years. Generational genocide could occur and the international community would never know.

How should the international community respond once it learns that a government is trying to destroy an ethnic portion of its population through sterilization? According to the Convention on the Prevention and Punishment of the Crime of Genocide of 1948, Article 2(d) defines genocide as “imposing measures intended to prevent births within the group.”⁹ Infiltrating infected food into a society which has the potential to render all who eat it sterile would definitely qualify under this definition. Likewise, the Responsibility to Protect Report of 2001 states that “where a population is suffering serious harm, as a result of internal war, insurgency, repression or state failure, and the state in question is unwilling or unable to halt or avert it, then it becomes the responsibility of the international community to act in its place.”¹⁰ The fact that a government would do this to people within its own borders requires the international community to take action.

CARE for the Problem

Nevertheless, given the nature of the virus and how it is implemented, a responding nation’s (or coalition) military intervention force must ensure the mission is done carefully and prudently. It requires careful planning across all the warfighting functions, and spelled out through the mnemonic acronym — CARE:

- C – Contain the area.
- A – Assess the ongoing situation.
- R – Respond to the crisis.
- E – Endure until eradication.

Contain the Area

Of primary concern in a situation where a virus knows no distinction between friend and foe is the fact that a military commander must first take into account the safety and security of his unit with respect to force health protection. Here the protection warfighting function is crucial, as “the key to preventive and protective care is information — the capacity to anticipate the current and true health environment and the proper delivery of information to the affected human population.”¹¹ Once it has been determined how the virus is being administered, whether through human transmission or a food source, it is imperative that the virus be isolated

and those who are already infected quarantined. Additionally, it would be important in the beginning of the mission that Soldiers eat only food issued to them through approved supply systems while force health protection teams inspect the food coming into the camps or villages.

Such an undertaking requires a whole-of-nation approach. The U.S. military has personnel assigned to health services as veterinarians and public health doctors. The government could provide inspectors from the Food and Drug Administration and the Centers for Disease Control and Prevention, as well as partnering with non-governmental organizations (NGOs) such as the World Food Program or CARE International to distribute food.

Assess the Ongoing Situation

During the mission analysis phase, it is imperative that the commander accurately define the problem and maintain a running estimate of the situation. Ensuring that food sources are safe and there is no further outbreak of disease require constant monitoring.

Effective monitoring depends not just on knowing what to monitor, but equally on knowing how best to collect the necessary data, having the capacity to do so together with the ability to analyze it, mechanisms to properly record and usefully report on information received, and finally, the ability to use it to adjust programs and interventions.¹²

Just as commanders are the central figures in mission command, the same is true for this type of mission. Of critical importance is putting together a team that is expert in containing and eradicating the virus, and providing ongoing care for the victims.¹³

Respond to the Crisis

Responding to a crisis of this type will encompass all six tenets of unified land operations: flexibility, integration, lethality, adaptability, depth, and synchronization. Because of the unknown nature of the virus, how it spreads, and how it can be contained, flexible plans will enable units to adapt quickly to changing circumstances. This type of mission can be expected to encompass a larger Joint, interagency, and multinational effort. Integrating U.S. Army capabilities with agencies or other forces already on the ground or in country for a long time prior to a unit's arrival creates shared understanding and purpose. Even if that means that all the military brings to the situation is its lethality to ensure security of the contained area of camp so NGOs and United Nations personnel can do their work, this symbiotic relationship builds a foundation for ongoing stability operations.¹⁴ A weaponized DPRE crisis must be approached with a plan that is adaptable, synchronized, and able to be accomplished over protracted periods of time and purpose. Moreover, commanders must be comfortable

with ambiguity and uncertainty, possess a willingness to accept prudent risk, and be able to rapidly adjust operations as the situation dictates.¹⁵

Endure Until Eradication

Perhaps more than any other principle, this one poses the most difficult to sustain because of its requirement for longevity in support. Our nation's doctrine seeks to use the military effectively in order to create conditions for favorable conflict resolution. Yet this type of crisis has the potential of continuing on for many years. Consequently, transitioning to civilian control must be accomplished with an understanding that the mission may require unconventional approaches to ongoing care.

The fact that this mission involves risk to those who render support by being exposed to the virus themselves may require volunteers who understand, and are willing to assume the risk in order to work directly with the population. This may include having to think broadly when it comes to finding NGOs that actually will work within the contaminated area. For example, working with an organization like the Medical Missionaries of Mary, which focuses on health and nutrition services as well as trauma counseling, would be low risk due to the requirement of the sisters in the mission to take vows of chastity and celibacy as part of their calling to be nurses with the organization.¹⁶

Conclusion

These four principles require a responding nation's military to "think outside the box." Situations like these are "likely to be complex 'wicked problems' with a variety of intertwined geographic, political, military/security, economic, social, infrastructural, and informational factors, and an effective mission analysis will address all these particularities and challenges."¹⁰ Therefore, a commander who has been given the mission to respond to this type of situation is only limited by his imagination on what course of action will successfully end the atrocity.

No one wants to think that something like this could ever happen. God willing, it never will. But the problem of evil in the world requires that our nation and our military be prudent in planning for even the most unlikely of events. Indifference to inconvenient truths will always result in calamities that could have been avoided or, in the least, mitigated. To say as a civilized nation, "[n]ever again will genocide occur on our watch" and then simply hope it never will happen again, places too much trust in humanity which, time and time again, astonishes us at the depths of its depravity. Creating a human sterilization virus and infecting a refugee or adding it to a food source is definitely on par with such debasement. In the event that it does happen, a mission to combat this requires careful planning, fully integrating all military operations with the efforts of interagency and multinational partners. This will require a whole-of-nation approach, realizing that its

success depends on the willingness of the international community to stare evil in the face and do whatever it takes to combat its wickedness.

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Chapter 5
Weaponized DPREs:
A Potential Threat to the Army's Ethical Climate
and Organizational Culture
MAJ Deb Case, Adjutant General

We must carry the war into every corner the enemy happens to carry it: to his home, to his centers of entertainment; a total war. It is necessary to prevent him from having a moment of peace, a quiet moment outside his barracks or even inside; we must attack him wherever he may be; make him feel like a cornered beast wherever he may move. Then his moral fiber shall begin to decline. He will even become more beastly, but we shall notice how the signs of decadence begin to appear.¹

– Che Guevara, “Message to the Tricontinental”

Introduction

The United States Army prides itself on being a values-based organization entrusted “to support and defend the Constitution and to do so in a way that upholds U.S. law and American values.”² This is a source of pride and strength for the Army. Nevertheless, it is possible that our greatest strength could become our greatest weakness in the hands of a skilled propagandist. The internal and external perception of the Army’s virtue could become a target for an adversary unable to defeat it through conventional means, but able to inflict damage through messaging tactics. An adversary who does not respect international conventions could employ unconventional or illegal tactics in order to provoke responses that erode the respect and trust the Army enjoys. As the quote above shows, our enemies have long been prepared to do whatever is necessary.

It can be difficult to ensure that a professional Army balances the ethical application of violence with its responsibility to achieve its mission. This is particularly true in cases where the mission is not one of defending against aggression, but one that involves peacekeeping, humanitarian, or stability operations. The Pentagon’s recent decision to send troops to the Middle East to help deliver aid to refugees is a good example.³ It places an institution required and entrusted to use violence on behalf of its society in a position to enforce humanitarian standards on behalf of another. We need to consider the possible unconventional or illegal ways that forces hostile to the United States or to the refugees may target this type of operation.

One dangerous possibility involves a number of these displaced persons, refugees, or evacuees (DPRE) being infected with a disease with a high

mortality rate. Imagine, too, that these refugees are deliberately infected; in effect, they are weaponized.

The Weaponized DPRE: Persons of Interest

The purpose of this discussion is not to make obvious claims about the danger of biological weapons or the physical effects of using such weapons. The focus is the psychological chaos that could occur and the ways in which our adversary may use this environment as a means of bringing about conditions that incubate a different kind of illness in our own force. We might consider two possible cases. The first is the case where our forces are involved in a militarized dispute inside another country. In this case, it is possible that refugees are analogous to human shields, used as a means of protection by opposition forces. In this scenario the care for refugees can easily disrupt the primary combat mission by overburdening combat activity with critical humanitarian considerations. The weaponizing of the DPRES in such a case would be for the tactical purpose of physically disrupting our military operations in order for the adversary to achieve their own goals.

There is another case — the strictly humanitarian mission — and this is the one I want to consider more closely. It is this type of case where the weaponized DPRE is most dangerous to the profession. This biological threat represents a far more subtle danger whereby the motivation to protect could easily manifest, as it has in different times and places in history, in destructive behavior towards a population. In other words, the strategic goal in this type of case may be not only to discredit the U.S. Army, but even worse, to get the Army to overreact toward a segment of the population. A similar perversion of honorable motives occurred during the Inquisition. Philip Zimbardo, the social psychologist who created the Stanford Prison Experiment and served as an expert witness in the Abu Ghraib trials, notes that “the terrible paradox of the Inquisition is that the ardent and often sincere desire to combat evil generated evil on a grander scale than the world had ever seen.”⁴

Because we are an Army who relies heavily on the law, rules, and conventions to inform our sense of right and wrong, it may be difficult to recognize the incremental deterioration of our own values. This is particularly true in the case of the weaponized DPRE, because while they are noncombatants and should be treated as such, they do present a threat. Because of this, they will require special care and expert knowledge to ensure they receive the normal protections of refugees or internally displaced persons. At present, current Army doctrine falls short in segregating, managing, and safeguarding populations outside of internees and detainees. Furthermore, even if we were to treat them as detainees or as hostile civilians, we have not updated that doctrine in the last 12 years, even after abuses at Abu Ghraib exposed a serious need for revision.⁵

The World We Inherit

Protocols and conventions governing treatment of refugees include the 1951 Convention Relating to the Status of Refugees and the 1967 Protocol Relating to the Status of Refugees. These binding legal documents define who qualifies as a refugee and outline the rights afforded this population. However, there are three fundamental problems that make enforcement difficult. First, there is no mechanism for consistent enforcement. Because these standards are a matter of treaty law and customary law, and because implementation relies on the signatory nations' own laws, the framework for determining the rights of each individual is, at best, inconsistent. Others, such as the United Nations High Commissioner for Refugees (UNHCR) Operational Protection in Camps and Settlements offer little more than best practices that are similarly difficult to enforce.⁶

Second, these protocols are not well known. Many refugees do not know their rights under these two key documents. Third, the vagueness of some of the language leaves much for commanders to figure out. While education can help commanders and their staffs understand the law, the protocols often need context and legal interpretation. If commanders choose to use their discretion instead of seeking legal advice, minor violations could make the environment ripe for more serious violations later. This is particularly likely in cases where commanders are overburdened.

It is not always clear what DPRE rights must be enforced, but it becomes less so when the pragmatic challenges of identification, quarantine, and treatment processes for infected DPRES surface. Segregation of the affected population may be required. This will require all persons to undergo some type of screening process to identify symptoms of contamination or infection. This will possibly subject the refugee population to screenings that require a curtailment of basic or perceived rights or at least small violations of privacy that appear disrespectful.

There may be issues regarding lack of identification documentation and registration that complicate the ability to record and register illnesses to the proper individual. Once identification is complete and refugees are properly registered, they may also have to be made physically identifiable. This type of identification becomes a critical feature of preventing the spread of disease, particularly if the population is large, and especially in cases where the physical manifestations of the disease are not apparent. The length of the incubation period will also affect the classification of individuals where there are multiple diseases to be managed. This tagging may employ arm brassards, special identification tags, patches, or uniforms. While some kind of protective clothing would be ideal, funding limitations may make this option unlikely.

Quarantine

Depending on the nature of the contagion(s), it is likely that segregation or quarantine will be necessary. Quarantine and segregation have different connotations, but the practical distinctions are not clear, particularly to a regular Soldier. The World Health Organization (WHO) has a Global Alert & Response Network that establishes guidelines for responding to threats from communicable diseases.⁷ The United States is a signatory to these regulations, but it is unclear if the Army has integrated any of the guidelines and procedures into its doctrine.⁸ Army internee and detainment doctrine and regulations do not address quarantine issues and they receive meager coverage in Chapter 5 of the Army's field manual on the Law of Land Warfare (last updated in 1956).⁹



Figure 5-1. Quarantine station at Point Nepean, Melbourne, Australia, in use from the mid-1800s until the 1970s.

While this manual does cover a modest number of rights and limitations, it does not cover the additional concerns associated with treating the sick. For instance, there will be additional security requirements, both to keep people in and to keep family members out of quarantine areas. Additionally, medical supplies will require closer safeguard, as will water- and food-storage locations. It is important to note that additional personnel may not

be available to fill these additional security requirements. The relationship between these additional security requirements and the ethical treatment of quarantined individuals highlights the problematic nature of the weaponized DPRE. While it will be necessary to provide additional security to safeguard the quarantined, this can give the appearance of a detention or internee camp instead of an area of safety and asylum.

Medical Care

Lastly, medical treatment will be necessary. Treatment may include anything from screenings and vaccinations to medication and preparation of the deceased for proper disposal. Based on the culture of the population, this may cause initial resistance. In addition, a proper male-to-female ratio for medical providers is important. During the initial stages of a biological disaster this may not be practical, or we may not prioritize this over the security requirements. The resolution would reveal a hierarchy of values that could cause tension both with refugees and care providers from non-governmental organizations, even though the UNHCR acknowledges that “Government policy and practice may directly restrict the enjoyment by refugees or other persons of concern of their rights, for example, curtailing freedom of movement. . . . Resource constraints may restrict the availability of services and such constraints may necessitate difficult choices such as prioritizing health care over education. Rights may even appear to conflict.”¹⁰ The handling of the dying or deceased will also be an equally sensitive issue. We must be certain to dispose of bodies with the utmost discretion, so as not to generate additional fear of disease or of the diseased.



Figure 5-2. Emergency hospital ward in Kansas during the 1918 influenza outbreak. (<http://bldgblog.blogspot.com/2009/10/isolation-or-quarantine-interview-with.html>. Accessed 18 May 2013.)

Cultural Concerns

One of the guiding principles of the WHO in responding to crises requiring quarantine is that they “will proceed with full respect for ethical standards, human rights, national and local laws, cultural sensitivities and traditions.”¹¹ It would be prudent to follow this guidance as much as possible as well as the guidelines in the WHO’s “toolkit for behavioral and social communication in outbreak response.”¹² It may be difficult for grief- and panic-stricken individuals to act rationally. On the part of the refugee population, it is difficult to reconcile the use of force or aggression with protection or good will. Likewise, it could be difficult for Soldiers to maintain the humanitarian nature of the mission if faced with a possibly disruptive, hostile crowd made more anxious with fear. This may lead to curfews, detention, punishment, isolation, and other restrictive measures.

This is perhaps the first hint of the strategic success of the weaponized DPRE for the skilled opposition. The perceived ethical concerns that arise in this situation could affect public perceptions about the operation as well as international relations, especially given the added component of media coverage. Additionally, given the U.S. Army’s traditional role as a combat force, perceived violations of rights could strain relations with humanitarian organizations who will inherit the operational environment when military forces depart.

When Abstinence is Not an Option

Unlike the physical effects of a biological threat, the threat of undermining or perverting our values and using them against us may be difficult to detect. To defend against this threat we must acknowledge that it could happen. This is plausible given that our enemy for the last 10 years manipulated our sense of virtue in ways that, at the same time, undermine its application. If it is true that “People around the world recognize the American Soldier as a symbol of the United States just as they do the White House or the Washington Monument,” it is imperative that we develop the professional knowledge and expertise to maintain that symbolic value in the face of challenging missions and uncertain environments.¹³ That expertise must incorporate studies and observations that originate from sources that are not Army-centric. To have the discussion now and consider the possibilities I have proposed here is not to write presumptuously or prematurely about issues that have not affected us, but to apply smaller, past lessons to avoid the cost of a larger one. We must confront our vulnerabilities before someone else does.

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Chapter 6

Weapons of Mass Destruction and the Humanitarian Aid Response: An All Hands Approach to a Global Threat

MAJ Laurie Godin, Medical Service

“There is no technical solution to this problem of biological warfare. It needs an ethical, human, and moral solution if it’s going to happen at all....” Then he paused and said, “But would an ethical or moral solution appeal to a sociopath?”

— Nobel Laureate Joshua Lederberg¹

Introduction

Bioterrorism is a growing concern for the international community. Although terrorists who attempt to buy nuclear materials often make the news, officials who have reviewed classified intelligence believe that terrorists are more likely to strike with a biological agent than a nuclear weapon.² If the idea of using a biological weapon by terrorists was not abhorrent enough, the purposeful use of this same type of weapon on a displaced person, refugee, and evacuee (DPRE) camp would create a political and economic nightmare for the sovereignty of a nation, its economy, and public health infrastructure. A terrorist attack on a vulnerable population would also create enormous challenges among the international medical community with respect to surveillance, containment, and treatment. The following essay will explore motivations of terrorists to use biological weapons as a means of attack, current international structures and authorities for intervening in a weaponized DPRE incident, and medical interventions from the Department of Defense (DOD) necessary to control the environment.

The Problem

The use of communicable diseases and biological weapons by terrorists to date has not been a common occurrence. The problem is one day there will be, but only limited discussion or preparation by security officials, medical personnel, and the international community will have taken place. Central to the problem of bioterrorism is how government organizations, international organizations, non-governmental organizations (NGOs), state and non-state actors, and the DOD would develop or implement an inter-cooperative process to secure porous borders where little or no global public health measures, titles, or authorities exist.

Terrorism and Motivation

Joint Publication 1-02, *Department of Defense Dictionary of Military and Associated Terms*, defines terrorism as “the calculated use of unlawful violence or threat of unlawful violence to inculcate fear; intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological.”³ These motivating factors could lead to the use of bioterrorism as the means to attack and infect an already vulnerable refugee population. The use of bio-weapons would instill fear into an already psychologically damaged populace, as well as have significant second- and third-order effects on the public health infrastructure of the nation and global health of the world.

To further highlight the importance of understanding terrorism and the use of biological contaminants to infect a DPRE population, one must recognize that DPRES are vulnerable targets. DPRES routinely lack the support systems required to protect the affected population. One of the National Security Strategy (NSS) essential tasks is to prevent our enemies from threatening the United States, its allies, and friends with weapons of mass destruction.⁴ U.S. foreign policy remains focused on counterterrorism, and is a central tenet of the NSS.⁵ The motives behind why a terrorist might choose to target a vulnerable population such as DPRES with a biological weapon are complex. There should be a common and accurate understanding of bioterrorism, a standardized international biosecurity effort, and multinational nonproliferation agreements.⁶

The National Strategy for Countering Biological Threats highlights the use of biological weapons by state or non-state actors. The use of bio-weapons presents significant challenges not only for the United States, but the world as a whole.⁷ It is a distinct possibility that an attack on a DPRES population would not be detected and the ability to prevent and control an attack would be limited. Therefore, a comprehensive approach among the international community for surveillance, containment, and treatment is necessary for the prevention of such biological terrorist attacks.

Virus Detection

One of the central difficulties with biological agents is detection. This is because in many cases biological agents do not cause illness for several hours or days. The difficulty also lies in the variety of delivery methods and means by which the agent can be spread. Biological contaminants can be spread through air, water, food, livestock, and person-to-person, all of which pose significant challenges to the international community. A comprehensive global bio-defense program is needed that is capable of transnational surveillance, containment, and treatment to protect the people.

The Centers for Disease Control recommends that bio-defense programs involve medical measures to protect people against biological agents. This

requires medicines and vaccinations as well as medical research, planning, and preparation to defend against bioterrorist attacks.⁸ Bioterrorism lethality of diseases such as smallpox, severe acute respiratory syndrome, pandemic flu, cholera, infectious tuberculosis, plague, and hemorrhagic fever would take a considerable amount of medical resources to manage and alleviate human suffering. This is even more problematic in a DPRE camp that lacks the security and structure to contain such a catastrophe. There are currently no global quarantine measures, formal regulations, or legal authorities for nations that lack the public health infrastructure to contain such an incident.

The Role of the Department of Defense

It is with the upmost certainty that the DOD would be expected to play a role in foreign disaster relief, working to survey, contain, and treat biological agents in a DPRE camp. However, the DOD cannot be alone in the defense of a DPRE camp. Cooperation and understanding among the interagency, interdepartmental, international community, NGOs, and private citizens are necessary to combat the host of issues biological contamination would bring to a DPRE camp. The good news is that a variety of frameworks exist to assist in the operational and tactical picture in containing the threat.

Doctrinal Tools in Use by Other Agencies

As the humanitarian space evolves and more actors become involved with the delivery of humanitarian aid, it is of equal importance that the DOD is aware of existing tools and frameworks that reside among the international community.⁹ There will be instances where host nations will not want to be involved in containing a biological contaminant. They may not have the capability to assist or may lack the capacity to combat a deadly threat. Therefore, it is imperative that the DOD appreciate the humanitarian space so the commander can better visualize, describe, and direct forces to solve the problem of a weaponized DPRE.

Much like the National Incident Management System that provides a common framework that organizations use to integrate into existing response networks, there are many tools and frameworks in the international arena of which military planners should be aware. The United Nations (UN) Cluster Approach,¹⁰ The Interagency Conflict Assessment Framework (ICAF),¹¹ The Department of Defense Support to Foreign Disaster,¹² and The SPHERE Project¹³ all provide a level of organization designed to assist in combating human suffering; identifying gaps in humanitarian response; and working to prepare, prevent, respond, mitigate, recover, and reconstruct efforts.

The UN Cluster Approach was instituted as part of a UN Humanitarian Reform Agenda in 2005, which sought to increase effectiveness, coordination, and leadership and enhance partnerships during a

humanitarian crisis across UN agencies, NGOs, and international organizations.¹⁴ The Cluster Approach has two focus levels, a global level, and the country level. At the global level, clusters are established in 11 key areas: logistics, nutrition, emergency shelter, camp management and coordination, health, protection, food security, emergency telecommunication, early recovery, education, and sanitation, water, and hygiene. At the country level, clusters are normally established for a major emergency and may or may not include all portions of the 11 global clusters. At the country level, where a coordination group already functions with clear leadership, no new leadership would be required for that area.¹⁵

The ICAF has two main objectives. The first purpose is to develop a common understanding of the relevant issues across participating U.S. Government departments and agencies. The second is to identify what the different agencies can bring to the response. It is not an authoritative document; rather it is a tool that is utilized to inform, establish goals, design or reshape activities, and implement or revise programs and resources.¹⁶

The Department of Defense Support to Foreign Disaster Relief is a handbook designed for Joint task force and below commanders. It provides the broader mission of humanitarian assistance for military functional areas. As outlined in the handbook, medical personnel face unique challenges in a disaster, and must be prepared to provide both support to military and, if directed, to civilians.¹⁷ The handbook outlines planning and execution considerations for medical planners.

The Sphere Project is a handbook that introduces considerations for quality and accountability among NGOs within the humanitarian charter and minimum standards in the humanitarian response domain. The handbook describes in detail the core and minimum standards for delivering humanitarian aid in four key life-saving sectors. These standards have become the “de facto agreed upon” standards by the world’s leading NGOs and humanitarian providers.

Ultimately, these conceptual frameworks provide aid workers and the military with resources that will assist in facilitating cooperation and understanding of the organizations’ culture and requirements when working in a complex environment.

Medical Intervention

In a complex emergency such as a biological or other attack on a DPRE camp, the need for civilian and military cooperation is among the greatest. Medical intervention for the force protection of all concerned will be critically stressed. The speed at which a pandemic can spread with today’s modern forms of travel and the availability of correct pharmaceuticals for treatment create enormous challenges for civilian and military medical practitioners. As part of a larger bio-defense program, it is imperative the

DOD medical community be synchronized with international organizations, NGOs, and interagency partners. DOD assets may not always be available and the access to those assets may be delayed due to competing operational requirements, shortfalls in staffing, and availability of immunizations and other medical resources. Additionally, the deployment and the setup of medical resources is a lengthy process and could take days and weeks before medical capabilities are fully established.¹⁸

Conclusion

The gathering and effective employment of the recourses necessary to combat a biological contaminant in a refugee camp would take a tremendous amount of effort and cooperation among interagency, international organizations, and NGO partners. A containment strategy that is codified by authoritative documents and a comprehensive global bio-defense program to alleviate human suffering and secure its borders are required. If the DOD finds itself responsible for reacting to a biological crisis, it must do so with speed and decisiveness. While contingency planning and training among the medical community are imperative for efficiently and effectively dealing with a bio-crisis, equally important are the relationships established among the international community.

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Chapter 7

Understanding Organizational Culture: Nongovernmental Organizations and Communication Barriers

MAJ Christine Lancia, Military Police

In today's reality, aid workers and soldiers at times have little choice but to re-explore their relationship and improvise best ways possible for some degree of potential interaction, while simultaneously responding to the emergency at hand.¹

— **John Holmes, United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator**

Introduction

Department of Defense Instruction 3000.05 established stability operations as a core function of the U.S. military and directed that forces be prepared to act as the lead agency “until such time as it is feasible to transition lead responsibility to other U.S. Government agencies, foreign governments and security forces, or international governmental organizations.” A primary task of stability operations is to provide humanitarian assistance, a long standing mission and primary function of nongovernmental organizations (NGO) and private voluntary organizations.

The dual mission has the possibility to strain the relationship between the military and these humanitarian organizations, especially when placed in a challenging situation involving a rapidly spreading epidemic within a refugee camp. This interdependent relationship is vital and necessary to contain a widespread disease of an unknown source. Through shared understanding of organizational culture and deliberate initiatives to establish mechanisms of communication, these organizations can come together in mutual collaboration to respond swiftly and alleviate human suffering.

Organizational Culture

When military and NGO personnel come into contact, there is often that initial phase of frustration and curiosity that emerges from two very different cultures.² When tensions are high and parties are working in an environment of the unfamiliar, the military and NGOs may have dissimilar methods and objectives, all of which can contribute to misunderstandings. The Center for Disaster Management and Humanitarian Assistance illustrates the differences between military and NGO cultures³ (see Figure 7-1).

Figure 7-1: Organizational Culture	
<u>NGO</u> Independent	<u>Military</u> Highly disciplined
Decentralized authority	Hierarchical command
On-the-job training	Extensive branch training
Few doctrinal publications	Doctrinal publications
Long Term Perspective	"End state" approach
Field Experience	Combat experience

While the description is streamlined, it is an easily understandable visualization of the challenges that may be encountered while planning and collaborating with humanitarian organizations. Understanding organizational cultures provides valuable insight that will be useful during the initial phase of operations. The ability to quickly develop interpersonal relationships among the various actors will allow a more rapid transition to the collaboration stage. This is critical to the development of successful courses of actions to isolate and contain the disease or contamination.

An easy way to remember these organizational culture differences is with the acronyms C3A and C3I.⁴ NGOs build their structure and operating processes on cooperation, coordination, consensus, and assessment (C3A), while the military is grounded in command, control, communication, and intelligence (C3I). These characteristics of both organizations are generalized to illustrate the possible perceptions that exist between both parties. If this relationship is handled improperly, the humanitarian relief community can be alienated by a perception that, contrary to its philosophical ideals, it is considered no more than an intelligence source by the military.⁵ To prevent any misunderstanding, education and emotional intelligence is critical to maintaining open dialogue and fostering trust.

Organizational culture is ultimately created by the personnel within the group. Military personnel must acknowledge the people working for many of these NGOs. Aid workers come from all types of backgrounds, cultures, and educational levels. A majority of NGO personnel are recent graduates of advanced degree programs, professionals, well-travelled and multilingual, and even former military personnel.⁶ A key point that must be highlighted in a discussion of culture differences between NGOs and the military is that

NGO personnel, in general, want to be there. In contrast, typically military personnel have been ordered to be there. NGO personnel are driven by ideology, religion, charity, sense of purpose, and numerous other factors. This is not to say that military personnel are not driven by these or similar reasons; it is just a matter of being ordered versus volunteering.

In 2004, the Inter-Agency Standing Committee (IASC) of the United Nations (UN) published guidelines and principles for humanitarian practitioners to assist with civil-military relations during complex emergencies. The list below is a summary of those guidelines:⁷

- The concepts of humanity, neutrality, and impartiality are the core principles guiding most NGOs during humanitarian operations.
- NGOs must maintain its ability to obtain access to all vulnerable populations.
- Humanitarian operations using military assets must maintain civilian character.⁸
- A clear distinction must be maintained from military operations.
- NGOs prefer to maintain the lead role in humanitarian assistance operations and must not implement tasks or policy on behalf of military forces.
- Respect local culture and custom.
- The use of military assets, armed escorts, and Joint operations is the last resort option.
- Requests for the use of military assets must be made by the humanitarian/resident coordinator.⁹
- NGOs must avoid reliance on resources and support provided by the military.



Figure 7-2. IASC guidelines provide principles for humanitarian practitioners during complex cultural emergencies.

While not all NGO personnel will follow or abide by these published UN guidelines, one must remember that these principles are just that, guidelines. Reproducing these guidelines here provides the shared understanding and education for military planners of how NGOs may approach its mission and interactions with military actors. Effective civilian-military collaboration starts with developing shared objectives, a unity of purpose, and a relationship of shared trust.

Communication

In working through solutions to a situation that has elevated stress and fear among all actors involved, information sharing and consistent communication will effectively foster the right conditions to move toward recovery. For information to flow across these community divides, members must identify with a mission larger than their own organization's goals.¹⁰ Both the military and NGOs must attempt to pursue common goals and minimize competition, and even more so when working in an environment of the unknown. At the tactical level, the Civil-Military Operation Center (CMOC) is the keystone to facilitate communication.

Civil-Military Operations Center

The CMOC is normally comprised of civil affairs officers and other interagency representatives. When established, its role is to plan and facilitate coordination between U.S. military forces, indigenous populations and institutions, the private sector, intergovernmental organizations, nongovernmental organizations, multinational forces, and other governmental agencies in support of the Joint force commander (see Joint Publication [JP] 3-57). The challenge is that not all NGOs will be physically co-located with the CMOC and additional mechanisms for communication must be established.

Other Communication Mechanisms

While face-to-face interactions are ideal in a humanitarian crisis, it is usually not feasible. An effective way to communication with NGOs within an area of operations is through brokers, such as a representative from the United States Agency for International Development and/or political advisor. At the operational level, liaison can be made through the Disaster Assistance Response Team), civil-military coordination officer (CMCoord), or U.S. Embassy Country Team.

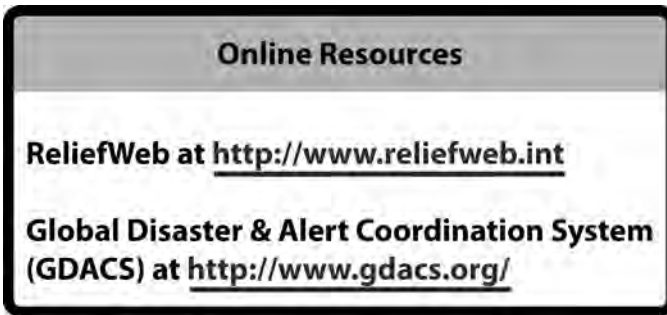


Figure 7-3. Online resources for NGOs.

Additionally, virtual communication will likely serve as the primary means of communication with NGOs. E-mail, Skype, and web-based coordination centers can provide real-time information exchanges while simultaneously allowing the NGOs to maintain its humanitarian space and impartiality. Two significant open-source resources are ReliefWeb and Global Disaster and Alert Coordination System (GDACS). ReliefWeb is an online gateway to timely, reliable, and relevant information (documents and maps) on humanitarian emergencies and disasters.¹¹ GDACS is a cooperation framework to improve alerts, information exchanges and coordination in disasters. Words have meaning, and to communicate effectively, both organizations must understand each other's vocabulary. Just like military tactical tasks mean something specific, NGOs maintain its own definition

and meanings of terms. The most common cause of misunderstanding is the terms of coordination and cooperation. For the military, the term coordination implies integration, whereas for NGOs, coordination is dialogue and interaction. Listed in Figure 7-4 are UN definitions that will benefit military planners and tactical leaders when communicating with NGOs.

<p style="text-align: center;">Range of Civil-Military Relationships Defined by the United Nations</p> <p>Co-existence: Minimizing competition and de-conflicting operations.</p> <p>Cooperation: Focuses on improving effectiveness and efficiency of combined efforts.</p> <p>Collaboration: Combined efforts with shared resources.</p> <p>Coordination: Essential dialogue and interaction of shared responsibility to foster co-existence, cooperation, or collaborative efforts.</p> <p style="text-align: right;">— UN Civil-Military Guidelines and Reference for Complex Emergencies, 2008</p>
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Figure 7-4. UN definitions.

Conclusion

When faced with a spreading disease of an unknown source, both the military and NGOs have valuable tools and experience to bring to the fight. The military's equipment and intelligence capability is essential to protect aid workers and first responders while simultaneously striving to find the cause of the epidemic. Additionally, NGOs bring experience, knowledge in health services, and humanitarian aid resources to the situation. There have been numerous successful civil-military coordination achievements and the partnership continues to grow positively. There are differences and challenges associated with organizational culture differences between NGOs and the military, which can affect communication in a highly stressful operating environment. Through understanding partners' principles and guidelines, collaboration can take place while seamlessly working hand-in-hand to achieve a common goal. Additionally, proven communication techniques and procedures, specifically, the importance of virtual communication, are recognized as vital tools for maintaining coordination between the military and NGOs within the area of operation.

Key Definitions and Terms

Nongovernmental Organizations (NGO). NGO refers to a private, self-governing, not-for-profit organization dedicated to alleviating human suffering; promoting education, health care, economic development,

environmental protection, human rights, and conflict resolution; and encouraging the establishment of democratic institutions and civil society.¹²

United Nations Humanitarian Civil-Military Coordination (UN-CMCoord). The essential dialogue and interaction between civilian and military actors in humanitarian emergencies that is necessary to protect and promote humanitarian principles, avoid competition, minimize inconsistency, and when appropriate, pursue common goals. Basic strategies range from co-existence to cooperation.¹³

Humanitarian Information Center (HIC). The UN often sets up a humanitarian information center that also serves as a central coordination point. Many times NGOs are either required or voluntarily register with a HIC to keep updated on meetings, regional news, and developments. HICs are normally located in central activity areas, often close to UN offices or where the international community stakes out an unofficial headquarters.¹⁴

Humanitarian Assistance Coordination Center (HACC). A temporary center established by a geographic combatant commander to assist with interagency coordination and planning. A HACC operates during the early planning and coordination stages of foreign humanitarian assistance operations by providing the link between the geographic combatant commander and other United States Government agencies, nongovernmental organizations, and international and regional organizations at the strategic level. (JP 1-02. SOURCE: JP 3-29).

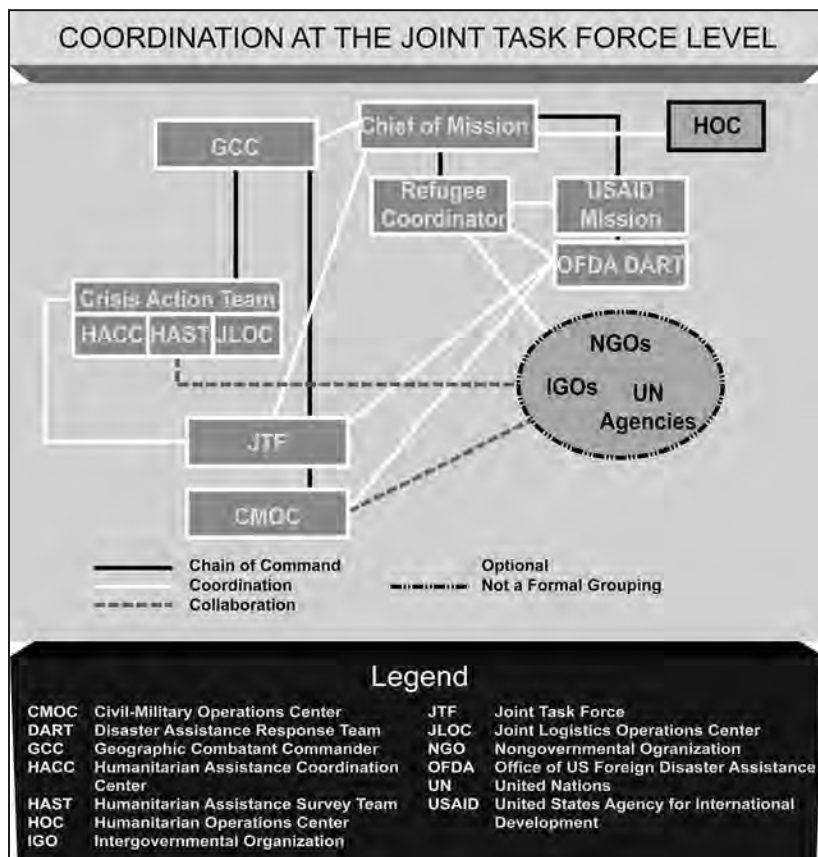


Figure 7-5. Interagency coordination during humanitarian assistance operations. (JP 3-29, Annex 1, *Foreign Humanitarian Assistance*.)

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Chapter 8

The Tool Kit: Information Dissemination in a Weaponized Displaced Persons Relief Effort

MAJ Steve Kitchens, Psychological Operations

Introduction

If there were an intentional effort to infect a refugee or displaced person and send them into a displaced persons, refugees, and evacuees (DPREs) camp, the rapid pace at which panic and rumor could spread would be difficult, if not impossible, to contain. The reasons for this can be surmised by comments from the authors of a recent Washington Times article. Jill Bellamy van Aalst, Clare Lopez, and Reza Kahlihi state, “biological weapons are silent until they explode into epidemics or pandemics. Genetically modified, weaponized biological agents would pose threats for which there are no known medical countermeasures. Calculating kill ratios and controlling strikes as with chemical weapons and nuclear weapons are nearly impossible with biological weapons.”¹

Confusion can become the norm when coupled with the interests of some people to use information as a powerful tool for controlling populations. The following quote by author Jacques Ellul describes the dangerous effects of leaving the handling of information, which he calls propaganda, up for grabs by anyone. He states, “Propaganda is most effective and most dangerous within a group....because its clash with facts is least noticed on the inside.”²

Extraordinary Communication Skills Needed

Weaponized displaced persons relief efforts require extraordinary skill coupled with highly developed planning skills in order to handle the delicate information dissemination challenges necessary for an effective response. A greater military capacity for juggling the nuances involved in information handling during weaponized DPRE relief efforts is required in order to conduct complex planning, identify critical target audiences, and mobilize available enablers for the proper handling of information. Adding credence to this claim for the requisite skill in handling information is the fact that information dissemination is considered a specific protection issue for refugees by the United Nations Refugee Agency of the United Nations High Commission for Refugees (UNHCR). By this it is meant that the quality and accuracy of information to and from refugees directly relate to their safety while in the conditions of a refugee camp.

To offer some insight into how this is acted out in context, the reference guide of good practices in the protection of refugees, titled *Operational Protection in Camps and Settlements*, states:

In practical terms, information is power and the more information shared with refugees about issues of concern to them, the more involved, engaged and empowered they will be. Accurate, up-to-date information assists them to make informed choices and decisions. Sharing information with the refugee community demonstrates trust, openness and respect for them and their ability to make sound decisions on the basis of the information presented.³

There must be a deliberate effort to manage the quality of information, not just as an additional task but as an imperative to ensure more harm is not done to the refugees. One cannot underestimate the importance of the handling of information as a specific protection issue by professionals with special skills. The Universal Declaration of Human Rights supports this claim in Article 19, where it stresses that, “Everyone has the right to freedom of opinion and expression; this right includes the right to opinions without interference and to seek, receive, and impart information and ideas through any media and regardless of frontiers.”⁴ The question is not how important proper handling of information is to refugee relief efforts and weaponized DPRE in particular, but what particular skills are most important to accomplish this vital task.

Planning

The first set of skills required in the military’s capacity for juggling the nuances involved in information handling during Weaponized DPRE relief efforts is the ability to conduct complex planning. Inherent in joint military planning is the idea of a recursive feedback process that allows for adjustments when new information comes forth to feed the evolution of a proper understanding of the problem. Joint Publication 5-0, *Joint Operation Planning*, states, “Operational design requires the commander to encourage discourse and leverage dialogue and collaboration to identify and solve complex, ill-defined problems.” It goes on to say, “[t]his requires continuous assessment and reflection that challenge the understanding of the existing problems and the relevance of actions addressing the problem.”⁵ It is safe to assume that a weaponized DPRE effort would qualify as a complex, ill-defined problem.

Personnel in the military with knowledge of how to handle the information challenges that would be present in this type of operation will also understand the need for an iterative process requiring constant feedback. One of the most important functions that this iterative process serves is the development of messages and themes that resonate among the refugee

populace. Proper assessment of the narrative that should be created, with its corresponding themes and messages to be disseminated, are a result of an accurate understanding of the actual problem.

The use of this planning method by individuals capable of effectively managing the plan is just the beginning of success. The follow-through implementation of the information dissemination plan is just as critical. The same UNHCR article mentioned earlier alludes to this fact when it states, “[a] carefully planned and ongoing information dissemination programme that keeps refugees informed of issues, projects, and changes will directly improve the protection of refugees. Refugees will know where to go for help and how to access services.”⁶ Comments from a successful communications effort during the North Atlantic Treaty Organization (NATO) Operation Allied Harbor help to emphasize the value of a deliberate integrated effort. The author states, “[t]he success of this tight collaboration was very evident — flyers and posters were produced quickly, information bulletins were produced on a weekly basis, and coordinated messages were broadcasted through all available mediums.”⁷

While the planning skillset appears to be the nexus around which most quality information efforts hinge, additional tasks are essential to achieve the full breadth of the potential that a properly handled information campaign could have toward resolving a difficult weaponized DPRE problem.

Targeting

The second set of skills required in a greater military capacity for juggling the nuances involved in information handling during weaponized DPRE relief efforts is the ability to identify critical target audiences. Understanding which audiences to target should begin by understanding how they use information. Authors Amy R. West and Lydia W. Wanbugu aptly describe how information is handled with groups, as well as those with the ability to withhold information.

“The phenomenon of information dissemination and communication flows is linked to that of power. When information flow is severely restricted, there are few means to check fact against fiction or to verify ‘truth’ from several sources. In these circumstances, information takes on even greater significance.... The tighter the rein is held on the very human need to communicate and exchange information, the more desperate will be the means by which it is attained.”⁸

Authors West and Wanbugu go on to say, “a little knowledge possessed by a few, delivered to a traumatized and desperate many, is both dangerous and irresponsible.”⁹ Obviously, with what we know about how information can be used as a tool to gain power and control populations, it becomes imperative that we make hard decisions on what particular groups need to

be influenced, what message we will use in the process, and how we can assess the results. To be effective we must consider all audiences, both internal and external. We also must be conscious of the connections between these audiences and prudent in our application of efforts to affect their behaviors.

In this endeavor we can take a cue from an interesting article discussing how to break the will of an insurgency. MAJ Chuck Ergenbright, a U.S. Army Green Beret, offers insight into targeting the will of an insurgency that must also be considered by relief workers in determining the leverage points available to them with various audiences.

Usually through a series of circumstances, where large portions of the population lose confidence in the state's ability to provide for basic needs or no longer identifies with the state's ideology, a political space becomes contested. In this environment, these circumstances or ideological discrepancies become so great that individuals are compelled to act. In most cases, this decision to act resulted from a cost versus benefit analysis conducted by the individual.¹⁰

— MAJ Chuck Ergenbright

Usually through a series of circumstances, where large portions of the population lose confidence in the state's ability to provide for basic needs or no longer identifies with the state's ideology, a political space becomes contested. In this environment, these circumstances or ideological discrepancies become so great that individuals are compelled to act. In most cases, this decision to act resulted from a cost versus benefit analysis conducted by the individual.

Although we are not dealing with exactly the same influences upon refugees as what can be found among insurgents, it is valuable to consider that refugees conduct their own cost-benefit analysis in terms of what they get from supporting various influencers. They might be torn between supporting those who are trying to uphold camp standards vs. aligning themselves with a gang because the gang can provide for their needs. This challenge needs to be addressed and not simply bandaged.

A deliberate targeting effort allows for the inclusion of audiences that can carry the message developed in the planning process to refugees through a reverberating ripple process. Choosing the right actors to carry the message is as important as building coalitions with those who can help and eliminating those who will do more harm than good. While proper planning with accurate targeting will have powerful second and third order effects on an information dissemination program, the additional quality that experienced personnel bring to the table is knowledge of the military capabilities available that can be applied to the problem.

Capabilities Integration

The third reason a greater military capacity for juggling the nuances involved in information handling during weaponized DPRE relief efforts is required is to be able to mobilize all available information capabilities. While public affairs officers (PAOs) perform a critical role, using them exclusively as the lead integrator for an information campaign would prove inadequate. PAOs play an informing educational role for various audiences, but their skillset and legal duties may require them to stay within boundaries that hinder the full potential of the power of information.

In an article written by a PAO concerning refugee operations, MAJ Corey Schultz states, “The Department of Defense should ensure that a PAO is assigned to brigade-size units, in order to . . . manage media, combat misinformation, and inform interested publics.”¹¹ These are all important aspects of information management, but may not address all the additional information challenges that will need to be addressed in a weaponized DPRE event. The need for a broader approach to information management is evident in the inform and influence capabilities outlined in Field Manual 3-13.¹² The difference comes with the integrating function that must be performed by an individual skilled in the coordination of all influence efforts.

Oversight of the various mediums by which information is flowing in a refugee camp, and in particular under conditions of duress such as weaponized DPRE, is required to synergize the collective effects that are available. Individual capabilities and efforts that are not synchronized with the other mediums at best accomplish a stove-piped effect and at worst cause information fratricide.

Final Thoughts

In the final analysis, a weaponized DPRE effort presents a complex, ill-defined problem.¹³ Success requires the ability to accurately target multiple actors that have the most informational impact. It also requires the ability to synchronize available information media able to provide the command message through the use of a broad range of capabilities. A key ingredient required for success in exercising information as a protection principle to DPRE efforts is the ability to harness the power of multiple media, plan in a complex environment, and then provide constant monitoring of the message.

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Chapter 9

Displaced Person Camps and the Potential for Weaponized Disease Attacks

MAJ Joseph Hoffman, Engineer

Introduction

What is meant by a weaponized displaced person event? Put simply, it is the purposeful act of infecting someone with a virus or disease, such as smallpox. The person infected may be an unwilling or unknowing participant to this purposeful infection. The infected or weaponized person is then sent into a displaced person camp in order to cause harm or death to others within that camp. Further harm can ensue if that infected person moves from one location to another, either a different camp or population center. Spread in this manner, the virus or disease can cause a possible epidemic. This is not to say that anyone will utilize this type of warfare, but the potential does exist. We must understand this potential and take appropriate steps to protect and respond properly to just such an event.

Humanitarian Crises, Population Displacement and Epidemic Diseases

Recent events have thrown the age-old association of humanitarian crises, population displacement, and epidemic diseases into sharp focus. The revolutionary waves of protests and wars that are known collectively as the Arab Spring have resulted in the geographical displacement of hundreds of thousands of people over the past two years. In 2012 alone, the Syrian uprising prompted the exodus of more than half a million people to the neighboring countries of Turkey, Lebanon, Jordan, and Iraq. The United Nations High Commissioner for Refugees (UNHCR) is expecting this number to double in the coming months.



Figure 9-1. A camp for the internally displaced in Haiti that was established in the aftermath of the catastrophic earthquake on 12 January 2010. Poor living conditions promoted the spread of a major epidemic of cholera in Haiti later in that year.

Source: CDC/Lt. Cmdr. Gary Brunette.

Environmental disasters have also added to the impact of displaced persons. Over a million people were displaced by the Haiti earthquake in 2010, while a similar number were displaced by the triple disaster of earthquake, tsunami, and nuclear accident in Japan during 2011. These and similar events have had infectious disease-related consequences for the displaced populations and, in some instances, for the populations into which they have fled. A high threat exists when looking at the potential risk of loss of human life if a weaponized virus or disease such as smallpox is utilized. Having properly prepared civilian and military forces will be necessary for the protection of displaced persons, non-governmental organizations (NGOs), and military personnel. There is no perfect plan or guidance that can eliminate the potential threat of this type of attack occurring. But proper planning can lower the risk and impact if such an event does occur, as well as provide quicker response to an identified attack, thereby saving lives.

Planning Considerations

In order to prepare for the possible use of a weaponized virus or disease such as smallpox within the confines of a displaced persons camp, contingency plans should be developed and be put in place to provide a guideline for success. The following are considerations for any contingency planning:

Communication. Good communications must exist between all organizations openly and constantly to ensure any identification of viruses

or diseases is provided to everyone. Communication sharing can provide a heightened awareness of potential threats throughout the area, to include other countries or states that could be at risk. Communication is an essential key to success, and with all missions, a must to provide essential information.

Communication with the outside world is also important to ensure everyone is aware of the situation, and protects those who are moving into the area by empowering them with the most up to date information. Open communication helps maintain government interest, keeps organizational support flowing, and provides continuous reports on progress for historical data. Communication needs to flow quickly and efficiently within the organizations at the point of support, the displaced persons camps.

To provide a good flow of information within supporting organizations, a well-defined and understood command structure should be developed; it should also be documented for future use to provide other organizations with a template for success. The civil-military operations center is a coordination center that can be established and tailored to assist the commander's civil-military operations. Several sites are available on both the NGO and military sides that provide guideline templates for information operations and command structures.

Immunizations. Immunization of all displaced persons within a camp must continue to occur, while respecting religious and cultural beliefs of all involved. Immunization tracking is required to ensure the maximum possible participation. Just because there has not been an outbreak in a long time period does not mean it cannot occur again. Being proactive and protecting against a future possible outbreak can assist in lowering the likelihood of another future attack of this kind, which is an important goal.

Security and separation during in- and out-processing. A system to ensure separation of those newly arriving into a camp needs to be further developed to ensure new arrivals are not exposing camps to potential dangers, while also ensuring those arriving do not feel segregated or unwanted. Separating those within a displaced persons camp may be necessary to protect the vulnerable. The separation of groups within the camp can provide a safer environment, and should be conducted as soon as possible to reduce security risks. Separating personnel within the camp is a way to protect those most vulnerable, and help identify those with ill intent. A good source of information available to assist in the security within a camp and settlement is provided in the UNHCR Reference Guide entitled, *Operational Protection in Camps and Settlements*, which can be accessed at <http://www.unhcr.org/448d6c122.html>.

Identification system providing a history of vaccinations and previous locations of internally displaced personnel. Tracking of personnel in and out of camps is vital. A process that provides the ability to track immunizations previously given and movement trends from one camp to another is vital in providing necessary data used for identifying where a particular virus may have come from, as well as who may be at risk. The current systems that are being utilized for registration and tracking displaced persons at a camp location consist of paper tracking.

Tracking by way of paperwork is the most cost effective process currently available, but several issues are associated with this type of system. The loss of paperwork by administrators at the camps, as well as by the displaced personnel themselves, adds to the difficulty in a long term tracking system. A more viable and durable system needs to be developed and implemented. A movement to a passport-type system, and later to a digital system needs to occur. Due to expense and time, it is difficult to implement a fully functioning database; but this is not impossible, and in time can be achieved. The U.S. military has developed and used several systems in the past, from identification card production systems, to digital identification and filing systems. These systems could be modified and used to assist NGOs in conducting a more efficient and long term identification and tracking system. The use of these systems should be considered during the planning stages for support of displaced person camp operations, as well as close coordination between NGOs and military personnel.

Disease awareness training programs for responders and participants.

It is vital for all medical and support personnel involved to understand how to identify symptoms associated with a virus or common disease such as smallpox. As part of this training, Soldiers should be taught the proper procedures to prevent the spread of the disease or virus and thus prevent a possible epidemic. It is not only important to identify, but also to understand how to contain and fight the spread of the virus without exposing oneself to danger. Training and full understanding of what is being battled is the difference between success and failure.

Obtaining and then training a competent staff. It is important to ensure those working to assist, whether civilian or military, understand the customs, traditions, and beliefs of those they are assisting. It is also vital to ensure those working together in camps have a good understanding of a chain of command and work toward a common goal in order to achieve the ultimate end state: eradication of the identified virus and safety of all involved.

Conclusion

Displaced persons camps exist in many areas throughout the world. Having a plan of action on how to work within these camps is vital to the protection of Soldiers, NGOs, and the host nation populace alike. Without procedures in place, a weaponized disease attack within a displaced persons camp could have catastrophic consequences. Without a plan to identify the sick, provide the necessary security of those in need, and communicate the dangers and protective measures to the surrounding populace, a weaponized disease could spread rapidly and kill many. Therefore, it is essential to continually improve the processes within displaced persons camps, and work toward an increase of protection against weaponized viruses/diseases. The guidelines suggested here provide information on mitigating the effects of a biological attack on displaced person camps by the use of weaponized diseases. It is important to understand that these guidelines are simply that, and by no means encompass every aspect of protecting displaced person camps from a weaponized disease attack. A primary goal should be to one day implement a solid and tested system to protect displaced persons from this type of attack; until then, the best actions to take are those laid out in guidelines from previous experiences, and the available military and NGO references.

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Chapter 10

Mitigating Risks of Deliberate Biological Contamination

MAJ Christian C. Neels, Engineer

Introduction

The effects of a biological agent being introduced to a refugee or internally displaced persons (IDPs) camp may not be immediately detected, as an incubation period usually exists prior to symptoms being identified. “One of the first indicators of a biological weapons attack could be disease outbreaks.”¹ This chapter will identify existing procedural and legal difficulties for combating the spread of viruses and disease and provide recommendations to mitigate disease impacts.

Legal Issues

Under a variety of United Nations documents relating to the treatment of refugees and IDPs, starting with the Convention Relating to the Status of Refugees adopted in 1951, hereafter referred to as the 1951 Convention, host nations (HN) have a responsibility to accept, assist, and protect persons seeking or granted asylum under a specified set of conditions. Within the 1951 Convention is Article 26, the *Right of Refugee Movement*. Under this article, “[e]ach Contracting State shall accord to refugees lawfully in its territory the right to choose their place of residence and to move freely within its territory subject to any regulations applicable to aliens generally in the same circumstances.” Holding refugees and displaced persons in detention-type facilities is also to be avoided. Under the 1979 Convention on Asylum, No.44, “If necessary, detention may be resorted to only on grounds prescribed by law to verify identity,” determine refugee status, destruction or fraudulent documentation, or to protect national security or public order.

HNs, when a signatory to the 1951 Convention and/or later related refugee and IDP conventions and agreements, can face significant challenges in restricting refugee and IDP population movement prior to identification of a bioterrorism event. Unrestricted movement permitted by legal agreements complicates HN efforts to identify possible infected persons, determine the location of the initial case of illness, and record the spread of the illness. These challenges, if not quickly addressed, can lead to rapid and uncontrollable increase of the infected population over a much larger geographical area. The 1951 Convention and subsequent related agreements also provide a variety of other refugee integration requirements for the HN, which may increase risk of virus and disease transmission.

Viruses and Bacteria

A variety of viruses and bacteria can be used as biological weapons to deliberately infect targeted population groups, to disrupt and spread fear in targeted governments and their populations. Table 10-1 lists several biological agents and typical incubation periods² identified by the U.S. Center for Disease Control and Prevention that could be used as potential weapons.

Biological Agent	Typical Incubation Period
Smallpox	7-17 Days
Anthrax	7-10 Days
Botulism	0-10 Days
Plague	1-6 Days
Tularemia	3-5 Days
Hemorrhagic Fevers *Includes Ebola and Margurg Virus	0-10 Days

Table 10-1. Biological Agent vs. Incubation.

A majority of viruses and bacteria have an incubation period of 1–10 days. This means an infected person may not show any signs or symptoms for over a week. These infected person(s) may spread the illness to others while in crowded conditions of refugee and IDP camps.

Urban Refugees and Displaced Persons

A majority of people often reside in urban areas and look to re-establish themselves in cities when becoming displaced as a refugee, and to a lesser extent, an IDP. “The United Nations High Commissioner for Refugees (UNHCR) estimates that 58 percent of refugees are located within cities, compared to one-third living in camps,” in rural areas.³ In a scenario where a biological contaminant is introduced via a refugee or displaced person, the virus or disease can quickly be introduced to a much larger population when compared to a rural setting. Within urban centers, refugee and IDP populations also may experience difficulty in identifying available support. This could increase the risk of further spreading a biological agent and preventing medical support for those already infected.⁴

Recommendations

Under Article 2 of the 1951 Convention, “[e]very refugee has duties to the country in which he finds himself, which require in particular that he conform to its laws and regulations as well as to measures taken for the maintenance of public order.” In order to prevent the spread of illness due to bioterrorism, HN must apply measures to maintain public order and national security. Detailed reception of refugees and IDPs who have crossed a border or arrived in an area is essential. Reception camps (RCs) should be established within the borders of the host nation accepting the refugees or displaced persons, near the border and a minimum of 15 kilometers away from urban areas. Security forces should secure reception camps in order to protect the refugees from violence from across the recognized border. Host nation authorities must ensure displaced persons are directed or transported to designated camps, and remain there until transferred to long-term camps or integrated into HN populations.

Camps should be constructed with the typical grid layout, separated with fencing on each side, no less than 100 meters apart. Personnel within separated grids should be segregated by arrival date in order to prevent virus or biological agents from infecting multiple arrival-date groups. Temporary lighting will be necessary between grids, along with security personnel. Security between grids should prevent intermingling and cross contamination if viruses or diseases exist.

Additional life support requirements will need to be coordinated. Construction of temporary housing may or may not be completed by the HN or other agencies, but may not be required. The UNHCR Emergency Handbook recommends, “[r]efugees should build their own shelter, with organizational and material support, as prefabricated or special emergency shelter has not proved to be a practical option for controlling costs or cultural grounds.”⁵ However, construction of latrines, emplacement of grids, security measures, and facilities for security personnel are necessary and will increase construction requirements. Additionally, camps must be located where water and food can easily be provided for anticipated displaced persons.

Within the reception camps a detailed health screening should be conducted after Day 10. Unlike the immediate health screening conducted when displaced personnel initially arrived, this detailed health screen is looking for signs and symptoms of the most common viruses or diseases that are common to the area or likely to be used as biological weapons. The selection of this time is due to typical incubation periods observed by the CDC. Under the 1969 International Health Regulations, these longer duration health screenings are allowed as additional health screening measures for long-term residence to reduce the burden on the country’s health services.⁶

Outside the camps, security checkpoints should be located along transition roadways in order to prevent persons from bypassing reception areas. After the completion of the prescribed reception time period and due to their reduced risk of spreading a virus or disease, refugees and IDPs should be led or transported to longer-term facilities or integrated into the local population. Outbreaks, if it does occur, will be confined to specific areas of reception camps and special coordination and treatment can be arranged for that population group.

Conclusion

Authoritarian regimes and radical organizations opposed to globalization and democracy are failing. Advancements in technology have increased the access and capabilities of these regimes and radical groups to produce biological weapons, while associated costs for these programs have fallen. Under the threat of losing power and facing an opposition group seizing power or being tried by international courts for crimes, persons and regimes with access to biological weapons not previously available may use these types of weapons to remain in power or gain influence. Security, enforcement of reception camp medical standards, and improvements in the design for displaced persons camps can reduce the effectiveness of these weapons and help protect vulnerable populations.

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Chapter 11

Security Considerations: Principles to Consider while Handling Displaced Persons, Refugees, and Evacuees in a Weapons of Mass Destruction-Affected Environment

MAJ Rodney Johnson, Military Police

Introduction

Quick decisions are often needed during refugee operations, decisions which, if not based on the best available information, may risk or jeopardize the lives and welfare of many people. Camp sites must be established, shelters must be constructed, and access routes may need to be built to enable delivery of food supplies. But the bottom line is people must be fed and provided with the basic needs for survival. Many, but by no means all, such decisions are in some way linked with the environment, either directly or indirectly.

The numbers of displaced persons and refugees around the world are increasingly becoming an issue; countries are finding it difficult to handle these rising numbers. The Office of the United Nations High Commissioner for Refugees (UNHCR) reported there were almost 10 million refugees and 14.7 million internally displaced persons (IDPs) in 2012.¹ Natural disasters, political strife, and conflict have driven people around the world into becoming internally and externally displaced. These countries find themselves struggling to provide medical aid, food and water, and other resources for these individuals.

However, this is only part of the problem. Security for refugees and IDPs is also a high priority. This chapter will look at the security challenges which a military commander or humanitarian organization must consider within a camp that has been affected by a biological weapon of mass destruction, disease, or famine. It will provide military commanders a brief overview of security aspects that normally would not be considered except for the biological weapon circumstances. The considerations are not new, but will require commanders to take risk within certain areas due to limited resources.

Security Concerns

Effective law and order are imperative and becomes the primary task for military policing when operating a displaced person, refugee, and evacuee (DRPE) camp. Law and order for refugees require a police organization that is efficient and effective and upholds human rights and the rule of law.

Non-governmental organizations (NGOs) or international organizations (IOs) cannot effectively provide assistance without security enforcement. In the instance of a camp that has been affected by a biological threat, security enforcement may present concerns that NGOs, IOs, as well as a military organization, may not be accustomed to. All these organizations must prioritize security enforcement inside and outside the camps for both the aid workers and refugees and ensure that those who have suffered violence are not further victimized.



Figure 11-1. Unloading supplies while maintaining security enforcement.

Security Objectives and Principles

U.S. military police bring a great deal of civil support operations capabilities and are sensitive to the human needs of individuals that are displaced. However, the primary objective of refugee or IDP operations is to minimize or reduce crime and violence, restore humanitarian confidence, and allow the start of desperately needed humanitarian programs. In cases where there is no military policing force available, the primary objectives should not change.

The key requirements a commander or NGO must address are the following:

- Protect refugees and IDPs from combat or operational violence.
- Prevent and control the outbreak of disease.
- Relieve human suffering.

In the situation of a camp that has been affected by the spread of a biological hazard, a commander must consider the issues above, and must also look at security of the population. Of immediate concern is the population which will possibly contain a large percentage of females, children, and elderly individuals.

First, with an identified spread of disease, a segregation plan must be established. A segregation plan can be defined as separating individuals based on geographical, cultural, religious, medical, or security criteria while in a collocated environment. This plan is important to the security and health of the population, as the spread of illness within a camp can be rapid. This may place great strain on the commander's resources needed for security purposes, in part because in order to keep the illness quarantined, enforced isolation of the contaminated individuals must be imposed. This may cause issues when only parts of the family are affected. Mothers and fathers who are affected may have other family members that are not.

A second security concern that a commander may have to focus on is the issue of combatants within the camp. Armed combatants must be immediately disarmed and disbanded within the camp, and the area of operation must be considered a weapons-free zone except for the military. Segregation applies for the combatants as well. These individuals may have to be separated and protected from reprisal violence. A camp is similar to a community as it applies to security; the camp requires proactive policing and the investigation of crimes. This approach will ultimately help to reduce instances of crime and violence, restore humanitarian confidence, and allow for the start of desperately needed humanitarian programs.

Moreover, those in charge of the camps must make a diligent effort to register and issue identification cards to dislocated persons for accurate accountability. This measure will help to determine the size of the police force needed and will assist with logistical requirements. If identification cards are not available, military units can use enemy prisoner of war capture tags (Department of Defense Form 2745) to obtain and record data such as gender, age, special health considerations, and family members.

A camp must be divided into groups as much as possible. Groups can be made up of single parents, the elderly without family, orphans under the age of 16, and so on. Every consideration should be taken to group single females away from single males without separating families.

Security Considerations for Females

Female patrols are important to maintain female privacy and respect. Creating privacy in camps is a positive action, but it must be balanced with security. Camp security should include entry points and traffic control points for vehicles and pedestrians to prevent infiltrators who want to exploit women and children. Units should also train females within the host nation security force to assist with gender-based crimes. Some patrols can be of a mixed gender to efficiently meet the needs of the people.

If available, it is beneficial to coordinate with engineers to provide construction capability and assist with developing road networks to provide freedom of movement for continuous patrolling, since this will generate a deterrent effect. Lighting in dead space and along roads during periods of limited visibility also supports security efforts. Lighting should be placed both internally to the camp and externally around the perimeter to increase effective surveillance.

Overcrowding in camps is a common occurrence, especially until additional facilities become available. However, if the security force is not very large, the key is to discourage criminal activity through active patrols, adequate lighting, and investigations.

Safety of Security Force

During an event of this nature, the safety of Soldiers or policing forces must also be taken into consideration. Based on the type of weapons of mass destruction (WMD) threat, the appropriate personal protective equipment must be worn at all times. This requirement must also be put in place for the aid workers. The requirement will reduce the possibility of the work force being contaminated.

Conclusion

Commanders who are responsible for the establishment or operation of a DRPE camp have a difficult mission, which will become much more difficult in a camp or among refugees that have been infected with a biological or other WMD. The camp is already at risk from external violence, and will now have to deal with an internal threat as well. Inside the camp, violence is likely to take place as the social structure breaks down and those without protection are victimized by those that may be part of a stronger social network.

Although the doctrine on how to prepare, secure, and provide for a DPPE camp may be limited, commanders have the necessary tools to better visualize, understand, and describe their environment.

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Chapter 12

Minimum Standards of Water, Sanitation, and Hygiene for a Displaced Person, Refugee, and Evacuee Camp and Its Role in Reducing or Preventing the Spread of Infectious Diseases

MAJ Jennifer Karim, Logistics Officer

Introduction

Planning for the establishment of a displaced person, refugee, and evacuee (DPRE) camp requires consideration of numerous logistical aspects. Many references are available that outline the minimum standards of essential life support elements required to provide adequate life support. In an attempt to standardize and provide adequate living conditions and care for DPRES, there are some international guidelines to which both local governments and the international community should adhere.

A large influx of DPRES at one time may hinder the rate and level of care that a local government or international organizations may be able to provide. To make matters worse, the displaced persons camp could be affected by an infectious disease, which will require additional resources to mitigate. This chapter discusses recommendations from the “Sphere Project” regarding the minimum standards of water, sanitation, and hygiene for displaced persons or refugee camps and how achieving those standards assists in preventing or reducing the affects of an infectious disease.

Clean Water Prevents and Stops Disease

An adequate amount of potable water is necessary to prevent death from dehydration, to reduce risk of water-related disease, and to provide for consumption, cooking, and domestic hygiene requirements.¹ A majority of the health problems in DPRE camps are caused by inadequate hygiene linked to insufficient water and consumption of contaminated water.² The following considerations are critical in providing minimum water requirement for a DPRE camp:

- Identify appropriate water source for the situation.
- Consider the quantity of water needed and the environmental impact on the sources.
- Prioritize and meet the requirements of the affected population.
- Plan for an average quantity of 15 liters of water (for drinking, cooking, and personal hygiene) per person per day.³

See Figure 12-1 for a breakdown of quantities. Further guidance for each of these considerations may be attained from the Sphere Project Handbook.

Basic survival water needs

Survival needs: water intake (drinking and food)	2.5-3 litres per day	Depends on the climate and individual physiology
Basic hygiene practices	2-6 litres per day	Depends on social and cultural norms
Basic cooking needs	3-6 litres per day	Depends on food type and social and cultural norms
Total basic water needs	7.5-15 litres per day	

Figure 12-1. Basic survival water needs (Sphere Project).

Water Must be Treated Before Use

In addition to meeting the above recommended water supply requirements, it is imperative that the water be treated before consumption. This is especially critical when dealing with known contaminated water. The Sphere Project Handbook recommends that contaminated water undergo water treatment with disinfectant with a chlorine residual of above 1mg/l. (Figure 12-2 depicts the water treatment process in accordance with the Sphere Project.) Reverse osmosis water purification units may be used to meet this need. Additionally, in the event that household-level water treatment is implemented, the users must be properly trained on the treatment procedures and the water quality must be monitored.⁴ The final step is ensuring the internally displace persons or refugees have adequate facilities to collect, store, and use sufficient quantities of water for the basic needs.⁵

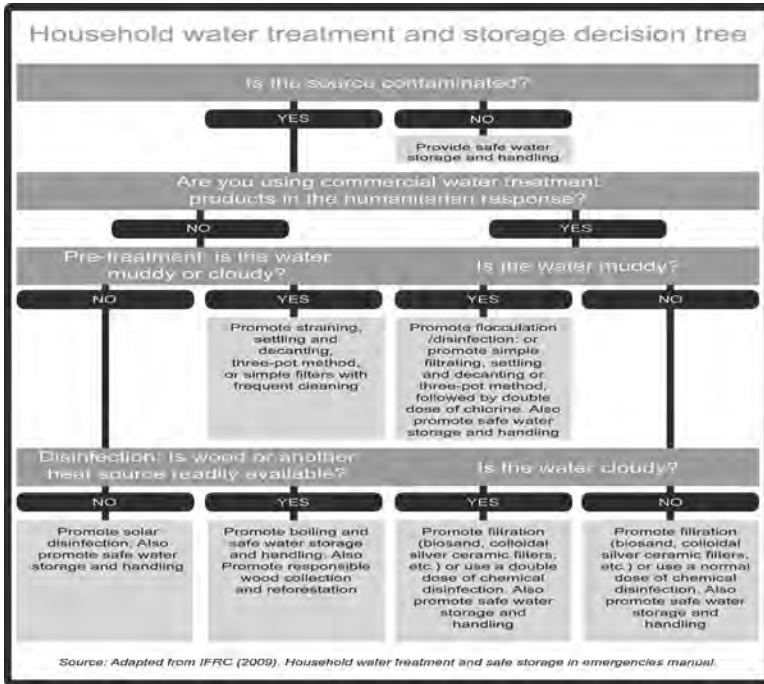


Figure 12-2. Household water treatment and storage decision tree (Sphere Project).

Critical Need for Good Sanitation

Most DPRE camps lack adequate sanitation due to the high population in a confined area. Additionally, not all countries practice and/or adhere to the same standards of sanitation as the United States. That said, any biological agent introduced into a refugee camp can quickly spread due to inadequate sanitation. It is extremely crucial to educate camp inhabitants and aid workers on proper sanitation immediately following the establishment of the camp. The UNHCR “*A Guidance for UNHCR Field Operations on Water and Sanitation Services*” provides several good practices for promoting adequate sanitation and hygiene in DPRE camps.

Enforcement of the following practices will help achieve and sustain the minimum standards for adequate sanitation and hygiene as well as prevent and/or mitigate the impact caused by the use of infection from biological agents:

- Use of safe water sources.
- Adoption of behavior to minimize contamination of water sources, especially from nearby sanitation facilities, animals, and chemical storage (i.e., community hygiene).
- Solid waste from health centers should be incinerated; liquid waste should be disposed of in soak away pits.
- All possible mosquito breeding areas should be drained of standing water.
- Household hygiene, including safe water collection strategies, are in place.
- Safe food preparation and storage practices (e.g., vegetables and fruits should be washed with safe water, and food should be properly covered).
- Kitchen utensils washed with clean water after use and stored in a clean place.
- Household (domestic) waste water should be disposed of properly.
- Regular hygienic cleaning of water and disposal containers in latrines.
- All feces, especially those of babies, young children and sick people disposed of using solid waste dump pits designed for this purpose.
- Personal hygiene, including washing hands after using the latrine, before feeding, eating and preparing food.
- Use of sanitary excreta disposal facilities at all times.⁶

The Sphere Project also provides additional information on adequate sanitation and proper hygiene.

Conclusion

Planning for the essential needs DPRE camps is complex because the total numbers of displaced persons coming to the camp and the rate of their arrival are not easily predictable. Therefore, an immediate and thorough assessment of the camp is vital as it helps determine requirements necessary for sustaining the population. Access to clean water and early education on sanitation are critical to the prevention of the spread of infectious diseases. The average death rates in a DPRE camp tend to be higher than in the surrounding community for many reasons. However, chief among these reasons are inadequate clean water and the lack of a sound sanitation

plan. The death rate could further be exacerbated by the introduction of an infectious disease. The recommendations discussed can assist in mitigating the effects of biological agents on water and sanitation.

Additional Sources

- Environmental Aid at USAID; <http://www.ehproject.org/>.
- Manuals on drilling, groundwater, sanitation: <http://www.lifewater.ca/manuals.htm>.
- PAHO website on water and sanitation issues in natural disasters: <http://www.disaster-info.net/watermitigation/i/links.html>.
- Refugee Camp Planning and Construction Handbook: Air Force Handbook 10-222, Vol 22: <http://www.dtic.mil/cgi-bin/GetTRDoc?Location=U2&doc=GetTRDoc.pdf&AD=ADA423967>.

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2. *Ibid.*, pg 97.
3. *Ibid.*, pg 97-98.
4. *Ibid.*, pg 100.
5. *Ibid.*, pg 103.
6. UNHCR, *A Guide for UNHCR Field Operations on Water and Sanitation Services* (Geneva, Switzerland: 2008), 18-19.

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Chapter 13

Integrating Female Engagement Teams into DPRE Operations

MAJ Maria Rodriguez, Military Police

Introduction

Internally displaced persons (IDPs) and refugees are prevalent all over the world. No continent is immune to the large numbers of individuals fleeing their homes from violence, oppression, or natural disasters. These overwhelming numbers make it difficult for receiving countries to support them, and often governments are not equipped to stand up formal camps and resort to establishing ad hoc settlements that often become permanent. These impromptu sites generally lack proper sanitation systems as well as adequate potable water for the inhabitants. The lack of common systems generates a host of problems. Water borne diseases like cholera and hepatitis A are common in internally displaced person, refugee, and evacuee (DPRE) camps. Dysentery, caused by parasites that live in water contaminated by the feces of sick individuals, is also common in camps.

Camp residents often use the same water source to drink from, bath in, and defecate in. This situation enables the rapid spread of bacteria and disease. Although highly discouraged, this situation is too often the norm. A cholera epidemic inside a DPRE camp can quickly convert an overcrowded refugee camp into a crisis. Cholera has a two-hour to five-day incubation period. This incubation period can allow an infected victim to infect other family and camp members unknowingly.¹

In September 2012, the United Nations High Commissioner for Refugees (UNHCR) reported an outbreak of jaundice caused by the hepatitis E virus, among refugees in the Dabaab camp in northern Kenya. Overcrowding, poor sanitation facilities, and lack of good hygiene practices were determined as the causes of the outbreak.² This chapter will outline how fully trained and qualified female engagement team (FET) members can be used to mitigate biological water-borne diseases from inhabiting a human host, promote gender equality, and ensure equal access of all women and children to protection and assistance inside DPRE camps.

History

The U.S. Army Female Engagement Team developed from a need in Iraq and Afghanistan to engage the indigenous female population that cultural sensitivities prohibited male service members from engaging. The U.S. Army developed the program based on the success of the Marine Lioness and Female Engagement Team programs and the U.S. Special Operations Command (SOCOM) Cultural Support Teams.

Prior to 2010, a formal training support package had not been established, which forced deploying units to develop their own selection criteria and pre-deployment training. Inexperienced trainers, unclear guidance, and ambiguous FET objectives often led to confusion and ineffective employment of FETs at the tactical and operational level. In 2011, the Vice Chief of Staff of the Army issued a directive that formalized FET training. Immediately thereafter, the Center for Army Lessons Learned (CALL) published a FET Commanders Guide and a training support program (TSP). This program ensured standardized training across all active FETs deployed to theater, and was available to deploying units.

Capabilities and Experiences

In the last 10 years, FETs have served as mentors, teachers, and role models for women in Iraq and Afghanistan. Both Iraq and Afghanistan FETs have developed programs to encourage and empower women. Engagement team members assisted in developing systems to protect village women and children from violence and engaged with government and non-government organizations (NGO) to advance economic and agricultural development. Teams were also able to engage female or children informants without drawing much attention. Information programs such as the Combined Information Data Network Exchange provided analysis capability. Engagement teams also performed other security tasks.

FETs performed searches at entry control points to mitigate the transport of illegal and harmful materials by women used as “mules” and assisted during cordon and search operations. Members were able to address specific protection challenges confronting women and children in villages and provincial district centers, and provide appropriate mitigation procedures. FETs provided an array of medical support and education that included women and infant health classes, providing basic first aid, facilitating special support needed by pregnant and lactating mothers, and assisting in establishing mobile clinics with assistance from other foreign military, joint, interagency, intergovernmental organizations and NGO support.

FET After Operations Iraqi and Enduring Freedom

Engagement team skill sets do not have to go stagnant as the drawdown continues in Afghanistan and engagement team members return to their primary jobs. Female engagement team capabilities should be effectively utilized in DPRE operations. Women and children comprise over half of the residents in IDP and refugee camps. FETs’ unique capabilities to engage this population can significantly decrease biological viruses from spreading through education and empowerment programs.

Displaced women and girls are extremely vulnerable to violence in armed conflicts, and they remain the main target for murder, systematic rape, trafficking, and forced pregnancy as a form of race extinction or intimidation.

Local militias target and recruit among this vulnerable population for suicide bombers, drug mules, and informants. The female population as a whole has special needs specific to their gender that often another female can understand, such as women's health and infant care. Rape victims often feel more comfortable speaking with or seeking medical attention from a female after an attack. FETs can provide for those needs, especially if they have military police or medics on the team with experience in working these situations.

FET Considerations Prior to Deployment

Mission Command/Task Organization

The command should identify clear mission command authorities. This will reduce misuse of FET assets and focus efforts across the area of operation. One recommendation is to maintain mission command authority with the supported brigade. The brigade would be responsible for the delineation of roles and responsibilities, as well as clear and concise guidance nested with the brigade lines of effort. The brigade should task organize teams depending on special skills and personalities that are best suited for mission success.

Training

A "re-greening" of current fully trained and qualified engagement team personnel must occur. This training should consist of a condensed version of the current FET TSP. The brigade FET Program OIC should screen and evaluate potential FET members using the criteria listed in the TSP. If time permits, interested females could attend the SOCOM resident course at Fort Bragg, NC. If team members are unable to attend the resident course, they should be trained using current TSP qualified trainers.

Additional Training

Engagement team members can train in a variety of tasks to become more effective. Although each FET member is an expert in her military occupation specialty (MOS), she must be comfortable performing tasks not specific to her MOS. Pre-deployment training should also consist of training in various types of reporting systems they may encounter. These include but are not limited to information-assessment tools, information-gathering techniques, legal constraints, and the rules of engagement. Other training events should include combat lifesaver course, self-defense combatives, convoy training, driver training in various vehicles, communications training, Blue Force Tracker training, and working with other agencies.

FETs should also train using various primitive but effective water purification techniques that rely on using local assets in order to mitigate water borne diseases.

Interpreter Utilization

The pool of interpreters is often small and FETs are usually left short of support or sharing one across multiple teams. It is imperative that the command provide dedicated interpreters to FET missions. A dedicated interpreter enhances cohesive teams' stability and credibility. To mitigate interpreter shortages, parent units could utilize the Defense Language Institute in Monterey, CA, to reinforce cultural and basic language concepts.

FET Role in Establishing Secure DPRE Camps

Female engagement teams can perform various tasks while assisting a unit in establishing a secure DPRE camp. Their ability to engage women, children, and the elderly make them vital members of a medical or security assessment team. Their observations and engagements with the camp population help close gaps in camp and security assessments that male service members are often unable to address. They can also provide information to engineer or civil affairs units to complete the sewage, water, electricity, academics, trash, medical, safety, and other assessment; they can assist NGOs with gaps in their participatory self-assessment tool, and logisticians with logistics estimates.

FET Role in Operational DPRE Camps

The FETs most effective role will be performing basic instruction. The teaching of basic hand washing and personal hygiene classes must take place in camps to minimize disease, illness, and deaths. Engagement teams enable discussion and influence gender considerations that can strengthen security in DPRE camp organization. They recommend actions that will protect female heads of household and ensure adequate security to protect women from the risk of sexual violence. Engagement teams can help in acquiring extra provisions of medical supplies, and arranging for psychosocial counseling to support women and girls who may have been victims of sexual violence. Other instruction could include various methods of garbage disposal to prevent biological containments from entering food or water sources. They can also teach effective use of garbage for agricultural purposes. Training in identification and treatment of illnesses is another important area that engagement teams can address.

FET Database

Dr. LisaRe Brooks Babin, Ph.D., research psychologist at the U.S. Army Research Institute for Behavioral and Social Sciences at Fort Leavenworth, KS, has visibility on the Department of the Army FET database. The database lists formally trained FET personnel with the "G3F FET"

professional development skill identifier (PDSI). However, the database does not accurately portray the actual numbers of female soldiers trained. According to Dr. Babin, “the discrepancies are due mostly to technical and paperwork errors impeding the process of assigning the PDSI to all trained FET members.”³ Dr. Babin explained that the database can be used in future operations when the U.S. Army is prepared to select fully trained, qualified, and experienced female Soldiers to become trainers or engage in stability or peacekeeping operations.⁴

The G3F FET Course PDSI is not listed on an Enlisted Record Brief or Officer Record Brief. As of November 2012, FET training is not listed in the schools drop-down menu when updating a Soldier’s record brief. This is a challenge when attempting to identify a female with this invaluable experience and operational knowledge. A centralized database would increase visibility of trained personnel, and would reduce short notice operations that might limit training opportunities. It is imperative that engagement team members have the opportunity to train while in garrison to maintain their proficiency in various fields. Developing a comprehensive training plan throughout the garrison phase can multiply their effectiveness tremendously.

FET Security

Supported units have routinely transported FETs to an operational site to conduct a concurrent mission at that or a nearby location. A small element of the convoy, usually a three-man team, will also serve as the FET’s security team, if not needed on the other mission. Leaving engagement team members alone with the women, children, or elderly men they are there to engage with is very common. This creates a lack of security for the engagement team. The ideal situation is for FETs to have a dedicated external security component during missions. If possible, an all-female team made up of other FETs could form the security element. However, due to the limited number of FET personnel, having all-female security teams may not be feasible.

FET Equipment Requirements

FETs should have a long rifle and a side arm for close quarter engagements, not one or the other. The teams should be equipped with their own vehicle to minimize being “bumped” from missions due to lack of seats. FETs must also be equipped with hand held radios to ensure mission command and keep teams abreast of changing environment and/or security issues.



Figure 13-1. A 3-21 FET medic engages local children in Pajwa'i District, Afghanistan 2011.



Figure 13-2. Two 3-21 FET members interact with local boys in Pajwa'i District, Afghanistan 2012.



Figure 13-3. A 3-21 FET member poses with a young Afghan girl after discussing water purification options for her village elders in Pajwa'i District, Afghanistan 2011.

Conclusion

A sense of accomplishment and successful contribution is a common sentiment that is echoed by many former FET members. The FETs can continue utilizing their skills in different operational environments, especially in displaced person and refugee operations, where women and children are often a forgotten voice lost in the shadows of opposing factions. Their keen observation skills, knack to easily engage vulnerable populations, and ability to take immediate actions can minimize some of the debilitating diseases or causes of violence that plague DPRE camps.

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Chapter 14

Leadership: A Cure for Fear and Uncertainty

MAJ Andy Whitford, Armor

Introduction

Encountering a deadly infectious disease will commonly provoke fear and uncertainty. The experience of “Magic” Johnson’s struggle to play in the National Basketball Association after testing positive for the human immunodeficiency virus (HIV) is indicative of the fear that can occur when the risk of disease is present in the workplace. While Johnson’s disease did not spread to any other player, the fear of infection dominated players’ interactions with him.¹ Fear of disease is a normal human reaction, and the small threat of exposure to the acquired immune deficiency syndrome (AIDS) and the fear it provoked provides insight into what the effect of what a much more easily spread disease might have in the underdeveloped world.

The Operational Environment

The specter of disease haunts the future operational environment and the conduct of unified land operations. Large scale pandemics can destabilize governments, provoke shortages, and drive violence as people compete for increasingly scarce resources.² One of the recurring challenges in the operational environment has been displaced persons. As the nation’s primary land force, the U.S. Army will be confronted with an increasingly chaotic and complicated world where the twin challenges of deadly disease and displaced persons, refugees, and evacuees (DPRE) will be common components of the operational environment. One of the most challenging scenarios that the U.S. Army might face in a future operation would be an enemy force deliberately infecting a refugee population with a highly infectious disease. This could be done for the purpose of genocide, destabilization, or as a way of attacking United States and coalition forces.³

Soldiers would need to be well equipped and well led to rapidly respond to this dynamic and highly challenging environment and accomplish their mission. The basis of any U.S. Army unit’s successful response to a crisis of this magnitude would be leadership in accordance with the principles of mission command and Army leadership doctrine. This chapter lays out some ideas on how specific techniques of leadership in accordance with mission command might be applied in a scenario involving “weaponized refugees” at brigade level and below.

Leadership

Army Doctrine Reference Publication (ADRP) 6-22, *Army Leadership*, defines leadership as “the process of influencing people by providing

purpose, direction, and motivation to accomplish the mission and improve the organization.”⁴ Leadership skills are required to lead not only subordinates, but also influence civilians in their operational environment in order to aid in mission accomplishment. Leaders in a complex, joint, interagency, and multi-national environment that combines austerity, disease, and DPRES must be prepared to comfort, persuade, educate, control, and lead a wide group of actors with varying goals and methods.⁵ These actors will include other government agencies, private and non-governmental volunteer organizations, and host nation and allied governments. Leaders must determine how much they can influence these actors while appreciating that many of them will resist, either actively or passively, cooperating with United States forces.

The Human Domain

In this environment, conventional forces could learn a few things from special operations forces (SOF). The realm of the commander and the Soldier in stability operations that involve disease and DPRES is primarily what SOF refers to as the “human domain.” A proposed “7th” warfighting function that would “institutionalize the capabilities and skills necessary to work with host nations, regional partners and indigenous populations” might be a useful method or way of thinking for a commander in terms of organizing his/her staff, unit, and planning to leverage the expertise of the relevant local government, non-governmental organization (NGO), international governmental organization (IGO), and other government agency actors.⁶ Commanders must inform their subordinates about the nature and tendencies of these groups and then rehearse “actions on contact” with various NGOs in training in order that Soldiers have a good understanding of the best practices involved in military-NGO interactions.

Part of the underlying skill of a professional Soldier is learning to deal with uncertainty. Pre-deployment training must stress adaptability in the face of a rapidly changing operational environment. This adaptability, however, must be rooted in a clear understanding both of commander’s intent and the best practices for dealing with both refugees and disease. This approach of mission command means that commanders must spend time before and during the deployment with their staff and subordinates gaining the shared understanding of this combination of intent and technique, and then communicating, supervising, learning best practices, and then rapidly disseminating that information which will be key for unit success.⁷

Leading Soldiers in this environment requires the commander to emphasize pre-deployment preparation and presence during the deployment. Leaders must educate Soldiers about the complexities of the operational environment that may contain infected refugees. Commanders have dealt with the effects of disease on Soldiers and civilians since the founding of

the Army.⁸ Training for this eventuality must be part of the training for decisive action that combines offense, defense, and stability operations.

An Uncertain Environment

A hallmark of an operation involving weaponized refugees will be uncertainty. A training scenario for helping leaders deal with uncertainty may stress the identification of the problem, development of a solution, and then evaluation of the technique selected. Leaders and trainers must be willing to promote an environment of uncertainty. This type of training will allow trainees to function in situations where the limits of their professional knowledge are revealed, and leaders to function in a chaotic environment where their actions are based on judgment.⁹

Knowledge about the possible infectious diseases endemic to an area of operations (AOs) should be part of any pre-deployment cultural awareness training. Information management systems that provide for the rapid and accurate flow of information about the disease and the proper preventive measures to counter it must be a priority within the unit. Additionally, leaders must be out sharing the dangers of the environment. The greater the uncertainty, the more clearly a commander must be out sharing his intent and making sure that the best practices for the environment are being disseminated.¹⁰

Working with Partners

Brigade and battalion commanders must establish effective civil-military operation centers (CMOCs), staff them with their most qualified and capable personnel, and give them responsibility for interfacing with the multitude of NGOs, IGOs, private voluntary organizations, and other agencies in the operational environment. Community outreach efforts utilizing military information support operations and key leader engagements both to the refugee and surrounding community will be instrumental to providing accurate information, staying attuned to the atmospherics in the community, and laying the groundwork for future success.

Medical Integration

Commanders must also task organize their staffs to account for the unique challenges of this environment. One change that might be useful is to task organize a medical capability with the protection cell to ensure that U.S. force protection measures account for the deadly consequences of disease in the operational environment. The medical community needs to have a presence in the CMOC to link their expertise with the information the CMOC is gathering from the local community and other actors in the area of operations. An element from the sustainment cell will also need to be in the CMOC to get the most up-to-date understanding of the changing nature of the AO and to allow the cell to anticipate changing logistical

requirements. For example, a weaponized refugee population may require not just a surge in Class VIII medical supplies, but also great amounts of Class III(B) fuel in order to power generators that produce electricity or provide other combustibles to burn hazardous and contaminated materiel.

Security Considerations

An infected refugee camp might also be the focus of attacks from the surrounding population. A series of direct and indirect attacks from the local population or the force that infected the refugees in the first place might force the infected refugees to either try and escape or turn on U.S. and coalition forces. These attacks would both spread the disease and accelerate the crisis that had already caused the refugee situation. To prevent this, DPRE camps — in particular those that are isolating the infected — must be constructed to provide protection from external threats and contain a population that might attempt to escape.

Ideally, these camps would be secured by host nation forces. This could be supplemented with advisors with experience in guarding secure sites during Operations Iraqi Freedom and Enduring Freedom. However, an escalation of the threat from external actors, a mass attempt by other refugees to gain access to the infected population, or a desire of the infected to break out of their isolation could force Soldiers to either defend the camp or use force to contain the infected.¹¹ Commanders must provide maximum clarity about the rules of engagement in order to both promote the safety of all the actors in the operational environment and aid Soldiers in the split-second decision making required in a turbulent stability operation.¹²

Counseling Support for Soldiers

Lastly, given the level of suffering and trauma Soldiers will most likely be exposed to in this environment, commanders must ensure they deploy with enough chaplains and behavioral specialists to aid in preserving or restoring Soldiers' morale. Similarly, a Soldier or unit returning from this operation must be treated as if they had endured a high intensity or counterinsurgency-centric deployment based solely on the trauma and suffering they would have witnessed. In fact, given the unfamiliarity of the experience and the level of violence Soldiers are likely to witness, commanders and leaders should encourage their subordinates and peers to seek post-deployment help.¹³ One measure to legitimize this stability mission as the equivalent of a mission that primarily focused on offensive operations would be to award those who participated in it the right to wear the appropriate right shoulder sleeve insignia in accordance with Army Regulation 670-1. This would be an appropriate tribute, not just to the difficulty of the operation, but also to the courage of the Soldiers there in facing a dire threat in service of a greater good.

Recommendations

A thorough grounding in the fundamentals of good leadership and understanding the principles of mission command up and down the brigade will be essential for commanders and units. The past 13 years of combat and stability operations in Iraq and Afghanistan have shown that trying to bring stability to a country is extremely difficult. Encountering an environment where weaponized refugees have been introduced into the situation will be a massively destabilizing event. Thorough preparation for uncertainty through pre-deployment training, an adherence to the principles of mission command, and planning for post-deployment assistance to Soldiers will go a long way toward successfully accomplishing the mission.

Endnotes

1. Moisse, Katie, “*Magic Johnson’s HIV Announcement Resonates 21 Years Later,*” accessed April 16, 2013, <http://abcnews.go.com/Health/magic-johnsons-hiv-announcement-resonates-21-years/story?id=17618361#.UWysAMrpyRM>.
2. For the story of the chaos of an earlier pandemic, see John M Barry, *The Great Influenza: The Epic Story of the Deadliest Plague in History* (New York: Viking, 2004).
3. Creating refugee populations can be genocidal in intent without the help of disease. See Erin Patrick, “*Intent to Destroy: The Genocidal Impact of Forced Migration in Darfur, Sudan,*” *Journal of Refugee Studies* 18, no. 4 (December 2005): 410–29, doi:10.1093/refuge/fei038. For an earlier example of how forced movement of civilians can both trigger and exacerbate genocide, see Donald Bloxham, *The Great Game of Genocide: Imperialism, Nationalism, and the Destruction of the Ottoman Armenians* (Oxford: Oxford University Press, 2005).
4. U.S. Army, ADRP 6-22, *Army Leadership* (Washington, D.C.: Government Printing Office, 2012), 1–1.
5. Werker, Eric and Ahmed, Faisal, “*What Do Nongovernmental Organizations Do?*” *Journal of Economic Perspectives* 22, no. 2 (Spring 2008): 73–92.
6. The proposal for a 7th warfighting function is currently a joint venture of the Army Capabilities Integration Center and the Special Operations Center of Excellence. MG Bennet S. Sacolick and BG Wayne W. Grigsby, *Special Operations/Conventional Forces Interdependence: A Critical Role in ‘Prevent, Shape, Win’*. http://www.ansa.org/publications/armymagazine/archive/2012/06/Documents/Sacolick_0612.pdf, Accessed 15 April 2013.
7. U.S. Army, ADRP 6-0, *Mission Command* (Washington, D.C.: Government Printing Office, 2012), 2–1.
8. Becker, Ann, “*Smallpox in Washington’s Army: Strategic Implications of the Disease during the American Revolutionary War,*” *Journal of Military History* 68, no. 2 (April 2004): 381–430.
9. Light, Donald, “*Uncertainty and Control in Professional Training,*” *Journal of Health and Social Behavior* 20, no. 4 (December 1979): 313.

10. U.S. Army, ADRP 6-22, *Army Leadership*, 6–3. The methods of leadership this entails are participation and rational persuasion.
11. The Battle of Rorke’s Drift is one of the clearest examples of the dangers of locating a hospital too close to a perimeter. For more on this battle, see Ian Knight, *Rorke’s Drift, 1879: “Pinned Like Rats in a Hole”* (London: Osprey, 1996).
12. For an example of this need for clarity in the rules of engagement, see Jason Linkins, “*Petraeus: Rules Of Engagement To Be ‘Clarified,’ Not Changed,*” Huffington Post, July 8, 2010, http://www.huffingtonpost.com/2010/07/08/petraeus-rules-of-engagem_n_639273.html.
13. Greene-Shortridge, Tiffany M.; Britt, Thomas W.; and Castro, Carl Andrew, “*The Stigma of Mental Health Problems in the Military,*” *Military Medicine* 172, no. 2 (February 2007): 157–61.

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