

## Observations on Health in the 2003 War with Iraq: Part III: Lessons learned

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### Lessons Learned

#### PRELUDE TO WAR

In the prelude to the 2003 war with Iraq, described in Part I of this series,<sup>1</sup> the U.S. Department of Defense (DoD) insisted on control over relief efforts. In doing so, the DoD marginalized the traditional international relief organizations (IROs), specifically the UN, UN Agencies, and numerous NGOs whom they perceived as inefficient.<sup>2</sup> The US Government organizational chart (Figure 1) depicts the relationships between the Office of Reconstruction and Humanitarian Assistance (ORHA), a Pentagon office coordinating Iraq's relief and reconstruction, with other agencies. ORHA was the central authority overseeing the efforts of the Coalition Forces (US, UK, Australia, Poland, Denmark,

Spain and Iraqi Kurdish Militia) to provide humanitarian relief during the “immediate relief phase” of the crisis. ORHA was in charge of both operational and policy requirements in the areas of humanitarian relief, reconstruction, national and local governance, and external affairs. In time ORHA’s authority in Iraq was transferred to the Coalition Provisional Authority, which was to become the overall name for the joint civilian-military presence in Iraq.

Immediate relief during a humanitarian crisis refers to the provision of basic life-saving aid including emergency health care, water and sanitation, and food, fuel and shelter as well as the re-habilitation of the public health infrastructure needed to ensure access to essential health services. In late 2002 the DoD initially planned for a humanitarian catastrophe in Iraq but by the start of hostilities thinking had changed and it was assumed that the war would be short and there would be no major humanitarian crisis. DoD planners also assumed that reconstruction could be accomplished by the private sector, funded by oil revenues and supported by a cooperative Iraqi population.

## **OUTCOME**

As described in Part II <sup>3</sup> many of the predicted disasters did not occur. The conflict did not displace large numbers of people within the country nor create a flood of refugees across its borders. Nor did the fighting cause extensive damage to highways, bridges, power stations, and other civil infrastructure, reports of which were often confirmed by western and international media embedded with coalition forces. In addition, chemical and biologic weapons, which US officials had said might be used, now appear not to have been available.

But unexpected complications did occur. Widespread looting and social disorder that had not been anticipated by the DoD planners led to the destruction of public facilities and the disruption of essential public services. In many areas, hospitals, clinics, public health departments, laboratories and administrative offices were ransacked causing the collapse of the Iraqi public health system.<sup>4-8</sup> In addition, the disruption of such essential services as electricity and water, police and judiciary, public transportation and communication systems, made it impossible for patients to obtain health care and for health workers to perform their jobs.<sup>9,10</sup> Much of the emergency supplies pre-positioned

before the war, such as antibiotics, intravenous fluids, and wound dressings, which were suitable for emergencies, were not in great demand. Instead, the need was for drugs to treat chronic diseases of the largely urban population, such as cardiovascular drugs, and the critical diagnostic and therapeutic equipment needed to refurbish the looted laboratories and hospitals.

The resulting chaos confirmed that the US military-led relief operation had “relatively untested capacities,”<sup>11</sup> and lacked the expertise and resources for a complicated humanitarian effort. Clearly US planners had been wrong to assume they would not need the help of the United Nations and international relief organizations (IROs) to restore security and public services after the war.

Complex humanitarian crises, meaning crises which unlike most natural disasters involve a complicated political situation, usually involving, if not war, high levels of violence are becoming more common, as was seen in Somalia, the Former Yugoslavia, East Timor, Kosovo, Sierra Leone and Liberia to name but a few. As a result, IROs are being forced to work more closely with military forces. If such cooperation is necessary, what lessons can be learned from recent experience in Iraq? Where did the Coalition’s approach succeed and where did it fail?

#### **MISSION, PERFORMANCE, LESSON, COMMENT**

##### **DoD’s Humanitarian Planning Team (HPT)**

**Mission:** The HPT consisted of a small number of military and US Government agency personnel instructed by DoD to conduct pre-war planning of the humanitarian response and coordinate that response during the conflict, including any response needed to cope with the use of weapons of mass destruction.

**Performance:** The HPT insisted on authority over IROs and claimed to be the official ‘liaison’ for the US government. The HPT staff, however, appeared to be unaware of the functions, charter, and capabilities of IROs. This led some in the IRO community to believe that the planning for war was a hoax bent on convincing the Saddam regime to leave Iraq, and therefore were hesitant to go further in their own planning. HPT, citing security, also withheld its plans from other military, governmental and civilian agencies working on humanitarian relief. IROs were already reluctant to work with the DoD, fearing their cooperation with the military of a belligerent nation would compromise their

policy of neutrality.<sup>12,13</sup> The HPT's insistence on control alienated the IROs further; its penchant for secrecy caused confusion and denied IROs crucial information needed for planning. The HPT's insistence that all liaison contacts go through its staff prevented non-military US humanitarian agencies, such as USAID which has a long history of serving as a liaison between the government and neutral IROs, from salvaging the situation.

**Lesson:** The HPT was unprepared and ill suited to the task. As a result the HPT did not work with the IROs to effectively harness their abilities and failed to appreciate the critical role they have in humanitarian assistance, in transition to sustainable development and reconstruction and to civilian control as the military exits.

Judging from the experience in Iraq, it would be best to keep the military out of the liaison business as much as possible and leave this task to agencies that have traditionally handled humanitarian crises, such as, in the case of the USA, the Office for Foreign Disaster Assistance (OFDA). OFDA and its Disaster Assistance Response Teams (DARTs) and the State Department's Bureau of Population, Refugees and Migration (BPRM) have extensive experience with relief operations and liaison duties between civilian and military agencies. Indeed, over the years, OFDA and similar agencies such as UK's Department for International Development (DFID) have served as effective liaisons even between military officials of a belligerent party and the IRO community. Such liaisons are particularly crucial in the role where military officers must understand how IROs operate to provide security and security communications to their organizations.

If, however, the military officials, such as the US DoD, are going to continue to insist on control, the military needs to improve its knowledge of how IROs work. It must build up a cadre of Civil Affairs officers seasoned in complex emergencies, knowledgeable about public health and formally trained to work with IROs. Liaison must stress equal representation of the views from both sides, ensure that those in authority understand the mission, charter and capacity of the organization, and utilize only experienced professionals to complete the tasks.<sup>14</sup>

**DoD's Office of Reconstruction and Humanitarian Assistance (ORHA)**

**Mission:** ORHA was established to provide a humanitarian assistance operating and coordination structure for the DoD. ORHA, on deployment to Kuwait and into Iraq, also planned to convene coordination and technical committees at national and local levels, set broad policies and identify priorities for US Government humanitarian activities, and support development of a donor coordination mechanism and facilitation of NGO registration.

**Performance:** ORHA was primarily staffed by policy experts who had limited practical field experience in relief operations, and were unfamiliar with critical issues surrounding field assessments. They did not have experience with multi-agency or multi-sectoral (humanitarian sectors of health, water and sanitation, shelter, food, and fuel) decision-making which was essential in understanding, for example, the diverse health roles and responsibilities across UN Agencies, NGOs and the military. Lastly, ORHA did not recognize the need to separate politics from relief, and more broadly politics from public health. Pre-ORHA planning by the DART, UN Agencies, and NGOs strongly emphasized a decentralized public health approach to health governance. However, planning by ORHA emphasized a Baghdad centric approach that has remained to this day. Over the objections of many Iraqis there was a rush to name an Iraqi interim Minister of Health, who was later dismissed for not renouncing his connection to the Baathist party. Optics (what looks good) often predominated over substance.

**Lesson:** Again, the job of coordination should remain with agencies who know how to do this. The mission assigned to ORHA has traditionally been handled by State Department's Agency for International development (USIAD) and their OFDA/DART assets. During pre-conflict planning it was USAID that provided for grants to UNICEF, WHO, and for an NGO consortium for health, water and sanitation that proved crucial during the war and the weeks immediately following the conflict. The ORHA, however, challenged such multi-agency support grants questioning their political appropriateness and worth. Only as security worsened and health and water and sanitation delays occurred did ORHA seek the UN as a partner. Whereas many ORHA personnel were well meaning, they lacked requisite relief experience and expertise. People in leadership positions must have previous humanitarian, and both multi-agency and multi-sectoral policy and operational experience. In addition, the humanitarian community has stressed

for years the need to minimize bureaucracy to ensure the efficient delivery of relief. ORHA was an additional layer of bureaucracy designed to be a substitute for existing US agencies and was not successful in adding value to the relief process, failed to serve, and generally impeded, immediate relief actions

### **DoD's Civil Affairs Units**

**Mission:** Civil Affairs Units are military units that work with US military commanders and local civil authorities to lessen the impact of military operations on civilians during peace and war. Civil affairs specialists are trained to systematically identify critical services and infrastructure needed by local citizens in war and disaster situations.

**Performance:** Civil affairs planned and acted with professionalism and good will. They worked well with the IROs. The IROs were fully aware of the critical role the units had as an instrument of the occupying power in restoring essential services.<sup>15,16</sup> Civil Affairs Units, consisting of 96% Reserve forces, however, were under-supported, under-manned, under-prepared and under-utilized for the responsibilities they faced. Specifically, in health, they lacked needed public health expertise. For a short, but crucial period of time health officials had to depend on reports, often based on rumor, from non-public health military personnel within Iraq. Civil Affairs units, which were on the scene, were unfortunately not trained in health assessment.

**Lesson:** Civil Affairs Units should have gone through extensive training with standardized health assessment forms and assurance of a two-way communication link with public health experts in the rear. Rapid assessment, survey and surveillance requirements in humanitarian operations demand a coordinated effort by WHO.

Civil Affairs Units require more personnel with specific training and tools in public health assessment. DoD needs additional active duty units, if not, they are at risk of losing this valuable resource thru attrition. A call for a major increase in active duty civil affairs units, first endorsed after Somalia in 1993, never materialized.<sup>17,18</sup> It is critical, given the excellent track record of civil affairs assets in World War II, that the lesson here is not so much what skills, training and levels of presence are necessary as much as they need to be relearned.

### **Humanitarian Operations Center (HOC)**

***Mission:*** The HOC was established by DoD under Kuwaiti Government sponsorship to provide a foundation for civil-military communication and coordination.

***Performance:*** For many military this was the first time they had ever engaged with IROs. Again, as with the HPT, there was too much secrecy and initial interest by IROs to participate was minimal. Pre-conflict planning did not recognize the impact that delays in obtaining a permissive clearance from the HOC to cross into Iraq from Kuwait would have on the health assessment process. With time this situation improved. However, as the war evolved and IRO staff moved into Iraq, the HOC failed to provide good 'threat trend' and security analysis information on which the IROs depend when operating in conflict to protect staff. In addition, once conventional combat activities were over, the evolving guerrilla type of warfare became a major challenge to the HOC military intelligence system.

***Lesson:*** HOCs need to be able to adjust to evolving operational and security requirements, and must be prepared to provide this non-battle intelligence and communication as an equal priority. What IROs consider critical to daily security decision making, program and living locations, and the hiring and safety of national and expatriate staff differ from that of the military. For some in the NGO community the failure of the military to be as 'interested and sensitive' to these non-traditional security concerns of the IROs underscored any lingering mistrust they had in the motives of the military. IROs, who employed their own security personnel, attempted to fill in the intelligence and security planning gaps through their own assessments. The responsibility of the occupying forces must be equally responsive to maintaining security for humanitarian efforts. It would be useful for military intelligence and security elements to work and learn from experienced IRO security personnel who come from a different operational background.

#### **Disaster Assistance Response Team (DART)**

***Mission:*** USAID/OFDA's Disaster Assistance Response Team (DART) is, in most natural, technological and humanitarian emergencies, the operational on-site arm of OFDA. The DART is primarily involved in assessment, coordination of technical assistance, development of project proposals, and in the procurement of materiel.

**Performance:** Because of internal battles between DoD and the US State Department it was not clear who would lead the humanitarian effort. This controversy in Washington over policy, authority, budget and operational independence of the DART was not resolved before deployment causing great confusion in the field. The consequences to staff time and relationships were often wasteful and damaging. Nevertheless, the DART was very effective and efficient in developing and monitoring relief programs especially in southern and northern Iraq.

**Lesson:** The US Government operational lead for relief should remain with the DART. It is worrisome that DoD does not recognize and support the critical advantages of having the DART function as a neutral ambassador for humanitarian assistance as the U.S. Congress intended under the Foreign Assistance Act (amended 1961). A military-led model runs the risk of sidestepping both OFDA and the DART and sets one standard for humanitarian assistance for war and another for natural disasters. Arguably, the DART fulfills an essential role as an impartial broker to the IROs that must be maintained. The military should learn to work with the DART and similar agencies and not try to replace them.

### **International Relief Organizations (IROs)**

**Mission:** International organizations such as UN Agencies and non-governmental organizations (NGOs), included here collectively as IROs, share an established framework of humanitarian relief expertise for people forcibly displaced or otherwise affected by conflict, natural disaster and oppression. In Iraq the IROs addressed issues related to immediate assistance and protection of populations in need as well as operations, security and coordination of relief response.

**Performance:** What limited preparation was done by IROs occurred in an informational vacuum. They also suffered from inadequate funding. As a result, they were unable to respond swiftly. However, the pre-conflict 10-year experience of WHO and UNICEF in Iraq proved to be invaluable in jump-starting the health and water and sanitation systems.<sup>19</sup> Despite poor funding, WHO training of Iraqi nationals in surveillance and outbreak control, and the stockpiling of pharmaceuticals and emergency therapeutic centers by UNICEF proved life-saving. Many others remained in a 'catch-up' mode that delayed their ability to optimize their early participation.

A strong case can be made for reform in the IRO community. In humanitarian missions important inefficiencies remain unsettled. The Office of the Coordination of Humanitarian Affairs (OCHA) staffs, with UN Agencies, operations centers during conflict with seasoned experts in emergency care. Whereas a strong WHO emergency response and surveillance team was sent to Kuwait during the prelude to the war, it was questioned whether this expertise could be sustained during the immediate relief phase by existing WHO country and regional organization personnel.

**Lesson:** The IROs possess years of humanitarian experience, understand critical cross-cultural issues, can work in a lateral multi-agency environment, and maintain relief-related and field tested resources such as emergency health kits. Their expertise cannot be replaced. By marginalizing the IROs and favoring a private sector that was not yet functioning ORHA lost valuable time in turning around the collapsing health system. The operational tempo and tenor of emergency missions requires that WHO commit to educate and train multiple emergency response teams to supplement country teams and WHO Regional Organizations during a conflict, provide country wide surveillance and health program coordination, and maintain the functions of a ministry of health when one no longer exists.

**Comment:** The military needs to learn how to work in lateral decision-making operations with IROs.<sup>20</sup> The IROs have participated in various political-military-humanitarian models, all having limited success.<sup>21</sup> Controversy centers on the appropriateness of combatants assuming traditional roles of IROs such as community projects and food distribution. In future US military-led operations it is doubtful that the IROs will be marginalized as they were in Iraq. That being said, much work must be done in asserting and educating for the roles that are done best by the IROs. Somehow, in the planning for Iraq, these IRO capacities were lost to either history or politics. The private sector is not the answer nor is the continuance of business as usual for the IROs. The IRO's strength is in understanding the cross-cultural nuances and politics of working in an international environment. The IRO community will benefit by combining this with better management, personnel, staffing, training and technical competencies and capacities.

## **The Media**

**Mission:** Many Western and international media resources were embedded with coalition forces during the conduct of the war.

**Performance:** The media, embedded with the military, was preoccupied with the conduct of the war. Once combat was over, there was no plan for the media to engage with the relief community. The media often remained pre-occupied with rumors of epidemics, participated in exaggerating the gravity of reports of communicable diseases and impatiently failed to understand the process of disease investigation and outbreak control.

**Lesson:** This was the first time the media had embedded with the military. The combat was over quickly and a gap phase occurred which offered an unmet opportunity for the humanitarian community and the military to engage the media in the importance of the immediate recovery of the public health laboratories and departments. Accurate media portrayal of the public health situation is critical. It would serve the humanitarian community well to educate and possibly embed the media in future humanitarian operations. As a critical purveyor of public health information the media needs to reach a wider audience that includes the local populations.

**Comment:** The media has always been a major factor in humanitarian missions. Their participation often influences political decisions to intervene, as well as in informing the world of operational successes and failures. In Iraq, the media was essential in getting out the word a collapsing health care system. However, their unfamiliarity with public health priorities and the manner in which decisions are made temporarily served to exaggerate outbreaks to the level of 'epidemics' and contributed to a 'panic press' mentality.

### **Chemical, biologic radiation, nuclear, and explosive (CBRNE) response management**

**Performance:** There was a limited number of adequately trained CBRNE support staff, equipment and procedural knowledge. Overall, health professionals serving the humanitarian community were not trained to deal with a CBRNE event. Evacuation from the area was the only operational strategy, one which would have severely compromised optimum management.

**Lesson:** Future complex humanitarian emergencies may require IROs to train their staff in CBRNE risk assessment and response planning before deployment, and to remain

operational during a conflict only if optimal protective, decontamination and isolation assets were available.

**Comment:** DART training was broad and first thought by some to be wasteful. Specifically, because two DART members were ambushed early on in Baghdad, the training in anti-terrorism security, security assessments and security communications in adverse environments proved life-saving. In addition, all DART personnel received mandatory CBRNE training before deployment and some IROs were trained while in Kuwait and Jordan. Primarily, personnel were trained to care for decontaminated chemical and non-contagious bioagent cases but lacked protective gear, and facilities for decontamination or isolation. The International Committee of the Red Cross (ICRC) remained in Iraq during the conflict and were most at risk had a WMD event occurred. Events such as the bombing in Mombassa, the potential for a CBRNE event during a conflict along the India-Pakistan border, and veiled threats of biological agents by terrorist groups indicate that risks to IROs and the civilian populations they serve remain real.<sup>22</sup>

## **DISCUSSION**

Iraq, a developed country, entered the war with four distinctly different regions (north, south, central and Baghdad). Each region varied politically, ethnically and religiously, and had widely different needs and capacities for health and health services. The public health infrastructure had suffered long term decay, especially in the south and east. Public health advances and support were lacking. Whereas, Iraq's health labor force consists of competent health workers well versed in curative care they were not necessarily able in public health and preventive medicine.

The planning for and immediate relief phase of humanitarian assistance played out differently than expected. There was a serious gap between the projected consequences of the war and what really happened. This was primarily due to unexpected organizational, operational, and political events. All have an impact on how immediate relief was practiced in Iraq.

Severe looting should have been expected. Looting had occurred after the first Gulf War in Bashra in the south and in Dohuk in the north. International relief workers had

predicted that looting would occur but their warnings either never reached high echelon levels or were not heeded. This was symptomatic of a lack of military-civilian communications at levels that would have made sharing these concerns possible and credible.

Re-establishing security must take precedence over replacing looted equipment and supplies. Once security allows access, the first priority is always to rehabilitate the public health infrastructure and to identify unique vulnerable populations, such as elderly on chronic disease medications, who need special attention. The DART, UNICEF and WHO rapidly worked to re-establish core public health functions: first surveillance, then disease control measures such as vaccination, outbreak control, and a reliable public health laboratory. Attention to other problems came slowly. It may never be known how many perished from removal of access to their chronic disease medications or access to diagnostic and therapeutic equipment such as dialysis, cardiac monitors, and defibrillators.

Lack of pre-war intergovernmental agency communications had its consequences. When multi-sectoral and multi-agency participants fail to plan and work in a coordinated fashion mistakes will be made. The military remained 'vertical' in planning as the international organization strived for a broader 'lateral' consensus planning process. What is lacking in strategies and sharing of information between the DoD and IROs in a military-led relief operation must be the focus in the future of transparent civil-military exercises and training that takes place before the emergency. Exercise scenarios should promote the advantages of lateral communications among agencies especially those that share sector responsibilities such as health and water and sanitation.

In a crisis, the vulnerable civilian population can be large, constantly moving, with too few health workers available especially during the immediate relief phase. Early access of the IROs to the civilian population is critical. With an expanded military-led model can military Reserve forces be expected to have the required skill sets for assessments and response? Can public health surveillance, critical to mitigating mortality and morbidity, be preserved during conflict? Historically, surveillance during conflict has never been fully supported and remains a gap area. In a military-led model the current

civil affairs assets cannot fulfill all the assessment and surveillance requirements.

Whatever the outcome, authority to coordinate surveillance should fall to WHO.

Lessons learned suggest that relief operations remain the purview of a reformed but traditional humanitarian community. Specifically, in the US case, an unencumbered USAID/OFDA should remain the lead agency for relief. If the DoD insists on again taking the lead they must do it right. If the military-led humanitarian response<sup>23</sup> is to be attempted in the future then critical questions remain unanswered: It has been suggested that future health related humanitarian actions of the US Government will be expanded and led by DoD Civil Affairs Units (with new DART-like functions) with uniformed officers of the US Public Health Services's Commissioned Officer Corps providing immediate response before transitioning to private contractors. Do these personnel have the appropriate multi-sectoral mix required of humanitarian operations? What transition and exit strategies will exist and who will participate? Will there be accountability for actions, and who will monitor these? This past decade minimum standards in disaster response and humanitarian assistance, called the Sphere Project, were developed for use by the IROs and donor agencies.<sup>24</sup> Will these standards be followed by the new military-led model? And, can surveillance and response be reliable in an environment where security impedes the access of the occupying force to the civilian population they are entrusted to protect, and if not what does this mean to vulnerable populations caught up in war and conflict?

## CONCLUSIONS

The lessons from this experience will have an impact on how relief operations in complex humanitarian crises will be executed in the future. Specifically, relief should be left to those agencies that know how to do it. If the military insists on control, it must learn what IROs do and develop the capabilities, from leadership to robust Civil Affairs units, to provide the services, such as assessments and threat trends, which they need. IROs must decide how they are going to relate to the military. If they are going to work with them, they need to decide on the ground rules and then work to build relationships and the prerequisite lateral communications capabilities with the military to avoid the problems experienced in Iraq. Lastly, public health must be seen, by a broader

humanitarian community including the military, as a critical strategic and security issue that takes precedence over politics. In relief operations public health and humanitarian actions are paramount and must never be driven by political motives and ideologies.

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# Figure 1: U.S. Government Organizational Chart

