Special Article

The Impact of Providing Medical Assistance to Local People of Medical Unit of The Royal Thai Army Task Force in East Timor

Piyapan Cheeranont MD*

** Department of Surgery, Phramongkutklao Hospital, Bangkok, Thailand*

The Royal Thai Army deployed a large troop overseas to join the United Nation Peace Operation in East Timor in October 1999. The operations included recovering peace, providing security and humanitarian assistance in the area of operations in Baucau and Viqueque. Our level 2 medical unit provided medical assistance to the Timoreses by opening consultation at our medical unit and sending mobile clinics into remote areas. This mission made Thailand uphold its good reputation and good relationship with the Timoreses. To reduce any conflicts and to ensure a high success of UN peacekeeping missions, enhancing a collaborative work and relationship with the NGO who previously pursued health service activities in that area are needed. Additionally, concerning negative impacts to the local people should be considered after implementation of the health service system. They had to adapt themselves to the limitation of their own local health service after the humanitarian assistance was over. There is a need to improve the training of military personnel with internationally accepted guidelines and they understand their potential roles within armed forces and improve the coverage of humanitarian needs for the next mission.

Keywords: *Peace operation, Royal Thai Army, Impact, Timorese, Humanitarian assistance*

J Med Assoc Thai 2009; 92 (Suppl 1): S135-9
Full text. e-Journal: *http://www.mat.or.th/journal*

After occupying East Timor for more than 20 years, Indonesia was pressured on by the world community to propose the East Timorese to choose either autonomy within Indonesia or transition to independence. A ballot held on 30th August 1999 showed that 98% of registered voters went to the polls with 75.5% voted for independence.

After the ballot, pro-Indonesia local armed group called Militia terrorized people and forced 250,000 East Timoreses and the UN staff to leave East Timor. This chaos made the UN security council authorize the International Force in East Timor (INTERFFT) and deployed to East Timor in September 1999 with an UN mandate in order to provide security and maintain law and order throughout the territory of East Timor.

The Royal Thai government, after receiving requests from both the Australian government and Indonesian government, decided to send a troop to join the INTERFET in September 1999 and the main troop, the Royal Thai Army task force in East Timor (RTA TFET), deployed to the area of operation in Baucau, the second largest town of East Timor, and Viqueque in October 1999. RTA TEFT consisted of the 31st Infantry Regiment King's Guard and its 3rd Battalion, which was a rapid deploying force and other supporting units such as a special force team, psychological operation team, engineer platoon, helicopters teams and a medical unit. RTA TFET started the mission, which consisted of recovering peace and providing security in the area of operation by first deploying troops which covered a responsible area and then delivering assistance to make confidence for the Timoreses, guarding important places and UN properties such as airfields and seaports, conducting foot and vehicle patrolling, setting up check points on roads and communities, and conducting reconnaissance in remote areas by air, land and sea.

For the mission of protecting and supporting the UN task, the RTA TFET assisted the UN workers giving a return preparation for returnees, providing

Correspondence to: Cheeranont P, Department of Surgery, Phramongkutklao Hospital, 315 Rajavithi Rd, Rajathevi, Bangkok 10400, Thailand. Phone: 0-2354-7600 ext. 93124, E-mail: piyapan84@hotmail.com

security for the convoys and returnees during processes of screening and vaccination at the transit area.

This operation was the first time over the past 50 years (after the Korean War) that the Royal Thai Military sent a large troop overseas to support the UN peace operation. It seemed that we had done good work and received a good reputation, especially in providing humanitarian medical relief. However, this work in providing medical care for the Timorese people had created some problems and impacts in local public health that we might not have expected. The purpose of this article aimed to summarize the author's personal experiences in East Timor for improving our work in providing humanitarian assistance for the next mission.

Public health system in East Timor

After the INTERFFT troops deployed to East Timor and established security, the UN staff came back to continue their work. Subsequently, groups of experts from the UN and NGO's surveyed and evaluated status of public health system there. There was a conclusion that the public health system established by the Indonesians in East Timor was centralization, similar to those of Indonesia's system. This included small health centers called "Peus Kissmass", opened in every village and all were run by nurse aids, who graduated from a nursing school in Dili. After all the Indonesian doctors and medical personnel left East Timor, there were only 18 Timorese doctors. Most of the primary health care was handed over by these nurse aids and all the medical support, medicines, medical supplies, doctors and other medical personnel were supported by the UN and NGO's. After that, a committee called the Interim Health Authority (IHA) of East Timor, consisting of experts from the UN, senior Timorese doctors and medical personnel was set up. Their duties were to plan and develop a public health system in East Timor. After the IHA finished surveying the public health status in East Timor, it was found that the public health system developed by Indonesia for East Timor was too large. Like other new countries, East Timor could not provide enough budget and resources to support every Peus Kissmas and salaries payment to all the Timorese health workers because Timorese people asked for no-charged services. To make East Timor able to help itself, the public health system needed to be down-sized, opening only some Peus Kissmas and employing only half of all Timorese health workers. The IHA set up a minimal standard for health service that there must have been a kind of health services (fixed clinic or mobile clinic that ran regularly, might have been 2 to 3 times a week) in a distance not more than 10 kilometers from every village and the IHA assigned the biggest NGO's who took care of the health service in each town to set up plans for health care systems for those towns (from an unpublished report of Joint Working Group on Health Services in a workshop for minimum standards for health services in Timor Loro Sae in Dili on February 2000.).

In Baucau, Medecins Sans Frontieres (MSF) was the NGO that provided and took care of health service**s**. They handed over Baucau hospital, running health centers and mobile clinics throughout Bancau area. In planning for health care system of Baucau, the MSF followed the minimal standard and many heath centers had to be closed later and half of Timorese health workers were out of work, which lead to conflict among them.

Medical unit of the RTA TFET

The medical unit of the RTA TFET consisted of 6 doctors (3 surgeons, 1 internal medicine physician, 1 anesthetist and 1 preventive medicine physician as well as 1 flight surgeon), 1 dentist and other medical officers and medics who worked as laboratory technicians, x-ray technicians, dental assistants and nurse aids. A field hospital was set up, which was equivalent to a level 2 medical unit of the UN, consisting of a 30 beds ward, 2 bed intensive care unit, one operating room with an anesthetic machine, one electrical dental unit, basic laboratory facilities and an x-ray machine. Our mission was to provide medical care to peace keeping force (PKF) soldiers and other The UN personnel in the area of operation. In addition, we provided medical care to the Timorese people by opening consultation at our medical unit and sending mobile clinics in to remote area**s**. From November 1999 to July 2000, there were totally 36,790 Timorese patients who received medical care at our units (4,088 patients a month). A total of 95 mobile clinics (10 mobile clinics a month) were sent and 13,282 Timorese patients received service at mobile clinics (approximately 140 patients per each clinic).

Problems and impacts

On the starting of our mission, our task force deployed to Baucau rather late, after other UN agencies and NGO's about 2-3 weeks. At that time, these organizations had already started working for relief and humanitarian assistance for Timoreses in every field, especially health care, which the MSF was

handing over and taking care of. As we were assigned by the Royal Thai Army to provide support for Timoreses in every field, especially medical care, we planned and declared to run mobile clinics for the Timoreses. We were objected by the MSF because providing medical care to the Timorese was not our mandate and we would create new needs among the Timorese people. Moreover, the MSF gave us a list of villages that they planned to run mobile clinics and asked us not to run our mobile clinics in those villages. Finally, we decided to run mobile clinics although we were objected at the beginning by the MSF. After we provided medical care to the Timoreses for a month, medicines ran out. As a result, we had to stop all our clinics for 2 months and started again after receiving additional medicines from Thailand. Nearly all medicines and medical supplies for humanitarian assistance were donated from Thailand.

The relationship between the MSF and our team got better later after we provided helicopters 3 times to evacuate the MSF's patients from Viqueque to Baucau. We had set up together a plan for mass casualty incidence in Baucau. Moreover, a better relationship was established when the MSF's surgeon got sick-leave and MSF transferred 3 Timorese patients to us for emergency operations.

The mandate about providing humanitarian assistance that we received from the International Force HQ (INTERFET) was unclear. After changing into The United Nation Transitional Administration in East Timor Peace Keeping Force (UNTAET PKF), the mission about humanitarian assistance in Standing Operations Procedure was defined clearly that "Humanitarian assistance (HA) may be under taken within the capacity of the health element, however, it must not be detrimental to the UNTAET health support. All HA support is to be in conjunction with the local health administrator and the NGO responsible for health care in that area"[1]. In fact, the commander and all the staff in our task force had made "Mission Creep" (when a unit attempts to do more than is allowed in the current mandate and mission).

The benefits for providing medical care to the Timoreses was not only to make friends and good relations with the Timoreses but also lead to the security and safety for our soldiers. To serve this purpose, villages that we planned to send mobile clinics to were the villages that provided our interest in security, such as the villages that our military units were located in or those that were located around our units or along our transport and logistic routes. The frequency of sending mobile clinics to each village was irregular and usually were not more than 3 months at a time. Though the activities of mobile clinics were not as frequent as we could, this could efficiently make Thai soldiers become popular among the Timorese

This method of mobile clinic could efficiently favor and make a good relationship with the Timorese that was an effective psychological operation. Moreover, our work in providing medical care to Timoreses created some problems. According to the health system down-sizing plan, Peus Kissmass in many villages were closed. The villagers had more troubles in travelling to meet health service and felt displeased. Our mobile clinics might have made these Timoreses not to adjust themselves and made the MSF put more effort in implementation of the proper health service system for them.

The clinic that was opened at our medical unit in task force HQ was very popular among the Timorese with 100-200 patients per day because of high capabilities of 6 specialists with good equipments. However, all these capabilities were for the PKF soldiers and the UN staff. These practices might have created dependency among the Timoreses and problems for them when we left at the end of the mission.

In the treatment of some diseases, we didn't use medicines in the National Essential Drugs List or follow national guideline such as treatment of Falciparum malaria. The recommended guidelines from The World Heath Organization (WHO) for the treatment of Falciparum malaria in East Timorese people was Fansidar. However, we could not provide Fansidar from Thailand because we had stopped using it for a long time. Thus, we had to prescribe Quinine and Doxycycline to treat Falciparum malaria in Timoreses which was criticized by not following the national guidelines.

Discussion and Recommendations

From a review of US military forces' relief operations in Kurdish crisis in 1991, Bangladesh cyclone in 1991 and famine and civil strife in Somalia, 1992-1993, Shape et al[2,3] made the conclusion that the military field medical services have some advantages in high level of medical and dental readiness because they have complete competent doctors and personnel, full equipment and medical supplies and can rapidly be deployed. But all these capabilities are prepared for soldiers that are usually healthy young adults who were injured in battle. This orientation may be appropriate after some sudden impact disasters, such

as earthquakes or during armed conflict, when immediate trauma care is a critical need. But most of Humanitarian crisis that involve refugees or displaced persons, the affected people are mostly children and women and most common causes of death among them are measles, diarrhea, respiratory infection and malaria. In this case**,** the deployable military medical facilities seemed not suitable for this mission because they have minimal quantities of medications recommended by the WHO for disaster-affected populations, such as oral re-hydration salts, pediatric supplies, some common antibiotics and vaccines. Few military health care providers have training in the diagnosis and management in field conditions of the acute medical problems that are common in many refugees and displaced populations, particularly among women and children. Moreover, military medical facilities may undermine local capabilities and create dependency among local population.

A principle of military involvement in disaster relief, however, is to be engaged for a short time, mainly during the emergency phase, and then to transfer relief efforts to others. The military has to realize inappropriateness and limitation of military medical care and accept that civilian relief organizations are better prepared to provide most relief services, particularly after the emergency phase when the focus shifts to redeveloping sustainable medical care and alter human services. The military should not be a replacement for, or a competitor of, humanitarian and development organizations that in many respects are better prepared for humanitarian relief, especially beyond the emergency phase. In the author's opinion, providing medical care to make favor to local people should be done with caution and should be in conjunction with the NGO responsible for health care in the area. There is a need to improve the training of military personnel in internationally accepted practices and in international law and conventions regarding humanitarian assistance and they can understand the potential roles of armed forces in humanitarian assistance.

In conclusion, these observations provide more understanding of the situation during humanitarian assistance in East Timor which could help in preparing the potential roles of armed forces for future relief missions.

References

1. United Nations Transitional Administration in East Timor Peace Keeping Force (UNTAET PKF). Health cell. Standing operation procedures for medical units. Dili: UNTAET PKF HQ; March 2000.
2. Sharp TW, Yip R, Malone JD. US military forces and emergency international humanitarian assistance. Observations and recommendations from three recent missions. JAMA 1994; 272: 86-90.
3. Sharp TW, Luz GA, Gaydos JC. Military support of relief: a cautionary review. In: Leaning J, Briggs SM, Chen LC, editors. Humanitarian crises: the medical and public health response. Cambridge: Harvard University Press; 1999: 273-91.

ผลกระทบของการให้ความช่วยเหลือทางการแพทย์แก่ประชาชนชาวติมอร์ตะวันออกของกองกำลังเฉพาะกิจกองทัพบกไทย

ปิยพันธุ์ ชีรานนท์

กองทัพบกไทยได้ส่งกองกำลังเพื่อสนับสนุนปฏิบัติการเพื่อสันติภาพของสหประชาชาติในติมอร์ตะวันออก ในเดือนตุลาคม พ.ศ. 2542 การปฏิบัติการนี้ประกอบด้วยการฟื้นฟูความสงบ เสริมสร้างความมั่นคง ปลอดภัย และให้ความช่วยเหลือด้านมนุษยธรรมในพื้นที่ปฏิบัติการที่เมืองเบาเกาและวิเคเค หน่วยแพทย์ ระดับ 2 ของกองกำลังของกองทัพบกไทยได้ให้ความช่วยเหลือทางการแพทย์แก่ประชาชนชาวติมอร์โดยการเปิดบริการตรวจโรคในที่ตั้งและส่งหน่วยแพทย์เคลื่อนที่ไปให้บริการในที่ห่างไกล ถึงแม้ผลงานนี้ทำให้ทหารไทยมีความสัมพันธ์อันดีกับประชาชนชาวติมอร์และสร้างชื่อเสียงให้กับประเทศไทยเป็นอย่างมาก เพื่อให้เกิดผลสำเร็จของงานสูงสุดและลดความขัดแย้งระหว่างหน่วยงาน ควรมีการประสานงานและมีความร่วมมือกันระหว่างการปฏิบัติการเพื่อสันติภาพของสหประชาชาติกับองค์กรเอกชนที่ทำหน้าที่ดูแลบริการด้านสาธารณสุขในพื้นที่ นอกจากนี้การให้ความช่วยเหลือของหน่วยแพทย์นี้อาจก่อให้เกิดผลกระทบต่อระบบสาธารณสุขในพื้นที่โดยที่ไม่ได้คาดการณ์ไว้ อาจทำให้คนพื้นเมืองไม่ยอมปรับตนเองและเกิดปัญหาในการวางระบบสาธารณสุขที่เหมาะสม จึงมีความจำเป็นที่จะต้องปรับปรุงการฝึกอบรมของกำลังพลของกองทัพในเรื่องการปฏิบัติอันเป็นที่ยอมรับของสากล เพื่อให้เกิดความเข้าใจในบทบาทของกองทัพ และมีการปรับปรุงการปฏิบัติการให้ความช่วยเหลือด้านมนุษยธรรมในภารกิจต่อไปในอนาคตให้ดีขึ้น