

country of origin. These may be significantly different from that of the host country. Rare, re-emerging, and vaccine-preventable diseases may appear. During transit and while settling in the host countries, migrants will encounter the health risks specific for that epidemiological area.

Migration health received special attention in 2007. Though the EU still has no harmonized migration health policy, the Schengen protocol has no human public health part, and the training of law-enforcement bodies have no detailed warnings on occupational health hazards and ways of prevention in relation to the first contact with migrants.

Military corps on peacekeeping or humanitarian missions may meet people with significantly different health backgrounds and morbidity profiles than those of the country of operation. Both military medical service providers and other participants should be trained and prepared on how to cope with this new, rapidly growing phenomenon.

Keywords: health; humanitarian; migrant; migration; military

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CIMIR or CIMIC, Time to End the Humanitarian Confusion?

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Military forces are measured by their ability to hurt, not by their ability to help. Their historical rationale has been either for protection (defence) or aggression (annexation). Concomitantly, modern military forces comprise all systems to sustain their operations, and therefore, also to assist in humanitarian needs and health action in crisis. Consequently, Civilian-Military Relations (CIMIR) covers a wide range of contact and interphasing, some positive and some negative. The support for the tsunami victims of 26 December 2004 and earthquake victims in Pakistan in 2005 exemplifies the positive contribution. The oppression, as seen in many states under military rules, signals the opposite. Further, the significant difference between a drafted military army and a professional army must be understood.

The term Civilian-Military Cooperation (CIMIC), currently widely used in NATO, is, in this context, confusing. It was originally defined as a “non-lethal combat support weapon”, serving the objective of the troops through activities for “winning hearts and minds”. As such, humanitarian needs are not first priority. In other settings, e.g., peace-keeping operations, parts of military forces are involved in collaborative, well-conceived, and sustainable projects, purely addressing the defined needs of the population. The anesthesia capacity building project in Afghanistan and the MEDCAPS (one day healthcare support to random villages) are both healthcare support, but based on very different philosophies. The anesthesia project is done in collaboration with the World Health Organization and the Ministry of Public Health. MEDCAPS seem more like CIMIC.

Consequently, CIMIR is not purely “black or white”. It also covers all shades of “gray”. As such, CIMIC is but one part of CIMIR and should not be understood as humanitarian assistance *per se*, but should be conceptualized as only one activity

under the larger umbrella of CIMIR. Civilian-Military Relations fathoms cooperation = sharing goals, coordination = sharing processes, and collaboration = sharing resources.

All military forces, including NATO Allies, must elaborate and fine tune its terminology, e.g., CIMIC must not be allowed a stand-alone position, as it will jeopardize otherwise fruitful collaboration both with civilian operational entities as well as recipients and/or supported countries.

Keywords: civilian-military; cooperation; humanitarian; terminology

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Health Systems for Peace and Security

US Navy Asthma Care Practices as Reported by Primary Care and Acute Care Providers

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Introduction: Healthcare system implementation of asthma clinical practice guidelines (CPG) has been challenging.

Methods: To understand the current status of asthma care in the US Navy, medical providers completed an anonymous questionnaire. Questions explored compliance with guideline recommendations including inhaled steroid use, asthma action plans, and spirometry.

Results: A total of 337 providers completed the questionnaire (67% were physicians). For newly diagnosed, mild, persistent asthma, 70% of primary care providers (PCPs) prescribed an inhaled steroid as recommended by guidelines; 70% of acute care physicians would start an inhaled steroid in the acute care setting. The asthma action plan use varied significantly by patient age: 68% of PCPs reported use in the majority of children; only 38% used plans regularly for adults. Action plan use varied by location (medical center > hospital > free-standing clinic) and support staff availability (PCPs with <1.5 support staff were less likely to use action plans). Only 40% of PCPs used spirometry to monitor at least half their asthmatics. Facility type (medical center = hospital > free-standing clinic) and spirometer availability were factors. More support staff trained in patient education tasks was the #1 improvement deemed most likely to enhance asthma care.

Conclusions: Asthma CPG compliance remains low. Identifying barriers to optimal asthma care will be important to managing this chronic disease.

Keywords: action plan; asthma; care; guidelines; US Navy

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