The Psychological Impacts of the COVID-19 Pandemic on the U.S. Military

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Abstract: The U.S. government and Department of Defense (DOD) have plans to counter a pandemic and return the country to normal while reducing the impacts of the disease. These plans address psychological health, but only in a limited manner. The U.S. government and DOD's response to the COVID-19 pandemic has been primarily focused on containing the virus and reducing the number of deaths and damage to the economy, with very limited attention paid to the mental health impacts in both the population and military. Historical cases suggest that the psychological impacts can be wide-ranging and enduring if not treated properly and the country does not recover from the pandemic in a deliberate fashion. While some emerging research could suggest this for the U.S. population and military, researchers have not conducted specific studies into this particular field. Therefore, the U.S. military's mental health could be degraded by the COVID-19 pandemic and mitigation measures and may be degraded for a significant period of time, reducing its readiness and ability to aid in the government's response to the pandemic.

Keywords: pandemic, mental health, psychological health, COVID-19, SARS-CoV-2

Introduction

The COVID-19 pandemic has had an enormous impact on the world in every aspect.[1] The most notable effects are the physical health of the global population and the international economy. But these are not the

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only areas in which the pandemic is wreaking havoc. As many people are told to remain home and quarantine or isolate themselves to prevent or at least slow the spread of the virus, they are also incurring psychological impacts that are not receiving the same level of attention as the physical ones. This prioritization of physiological health and reducing the spread of the virus over psychological impacts is especially true of the U.S. military, which has continued its global movement of forces while instituting various mitigation measures throughout the pandemic.

The U.S. military must also prioritize its resources. Being one of many components of the government, the military is subject to the rules, regulations, and policies of the president and their administration. While this provides a vast array of resources for it to draw from, it also subjects the military to the many bureaucratic rules and procedures that characterize so much of the government today. One of the primary responsibilities of the military is to take care of its servicemembers: the children of American citizens. The great resources provided by the government ensure the military can do this. However, the bureaucracy of the government also creates challenges in the creation and implementation of policies and regulations, which are needed to use those resources. In an emergent situation such as a global pandemic, the military may not have the ability to simultaneously overcome the challenges associated with creating and implementing new policies and procedures while also maintaining its normal operational tempo and readiness to respond to crises. When COVID-19 became a consideration in everything the military did, accommodations for the pandemic took priority over other things, such as planned deployment and redeployment timelines and training schedules, which then suffered because of those adjustments.

U.S. military servicemembers are trained from day one to handle stress. The rationale is straightforward: combat is stressful and the military must be able to function effectively in combat; therefore, servicemembers must be trained to function effectively in stressful situations. This rationale is not only a basic tenet of being in the military, but it is also part of the challenge and one of the draws for young Americans—to be able to show they accepted and overcame the challenge of completing boot camp and becoming a member of the U.S. military. However, the resilience against stress developed during boot camp is not infinite. A common refrain heard throughout the Marine Corps when a less than ideal situation arises is that "they're Marines—they can handle it." While this is true and rarely will a Marine admit they are being overworked, they are not superhuman and do not have an unlimited capacity for handling stress. Fortunately, Marine Corps leadership acknowledges this and has equipped units and commanders with the tools to ensure their personnel and their families can endure challenging times continue to contribute to the mission throughout those times, and be ready for future assignments. Even though the government, the DOD, and the Marine Corps have plans and resources for handling a situation like this, they were inadequately prepared, and the plans were not implemented

to the best extent. As a result, the military's mental health could be degraded by the COVID-19 pandemic and mitigation measures and may be degraded for a significant period of time.

This degradation could have an impact on several different facets of the military, but in particular its readiness to execute its assigned missions. Medical readiness is an integral part of the military's readiness to deploy, and with both a global pandemic and a possible mental health crisis to contend with, this readiness could be significantly diminished. This is especially true during a global pandemic when the military's vast resources can be used to assist the government in its response, in which this degradation would be particularly detrimental. The impacts on the psychological health of the U.S. military could extend far beyond the servicemembers themselves and manifest in units that are not prepared to execute their missions in support of the government and in the defense of the nation.

This article seeks to examine how the COVID-19 pandemic and the measures implemented to mitigate its spread have impacted the mental health of the U.S. military. It will explore the plans and policies of the government at several echelons to determine if and how mental health was accounted for and if the government's response carried out those plans and policies as designed. It will then relate those findings to pandemic psychiatry as studied and described by experts. Historical examples will be used to determine if any parallels can be drawn and estimates made as to what COVID-19's psychological impact will be. The emerging research on COVID-19 will then be examined as well as how it could translate to the U.S. military. Finally, recommendations will be offered regarding how to better incorporate measures for maintaining the mental health of the military during a pandemic.

U.S. Government Guidance for Pandemic Response

The government has a comprehensive guide for responding to an influenza pandemic that was published by the Homeland Security Council in 2006, with the *National Strategy for Pandemic Influenza*.[2] Its nine chapters and three appendices describe a wide range of topics necessary for the prevention and control of a pandemic. While its focus is on what the U.S. government will do, it also outlines the actions that local governments will have to take in their own communities. It even states that "the center of gravity of the pandemic response, however, will be in communities."[3] Even though it acknowledges the primacy of local governments in fighting a pandemic, it covers the support the government will provide to the states, tribal nations, and communities that make up the United States.

This strategy addresses some psychological and psychosocial concerns, but it largely focuses on how they will impact the overall response to the pandemic, as opposed to individual concerns.[4] The strategy's guidance for planning for additional mental health care providers is tied into its guidance for all additional health care personnel, which is to use the Medical Reserve Corps and the

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) programs to ensure local governments are able to mobilize the personnel they need during a pandemic.[5] This shows its limited focus on psychological concerns and that they are lumped in with the other additional health care personnel who will be needed. It also provides limited guidance for organizations, businesses, schools, faith-based and community organizations, and families. However, this guidance is simply to ensure that psychological and psychosocial concerns are planned for as part of the overall response and does not provide specific instructions on what to plan for.

The strategy also affirms the need for quarantine and isolation as measures to restrict the spread of a pandemic.[6] It discusses the potential for quarantines to be imposed, especially for travelers, and that coordination will be required at the international level.[7] Further, it emphasizes the efficacy of quarantine in slowing the spread of a pandemic and that it will be part of a larger public health response to minimize the effects of the pandemic.[8] However, it does not address any of the potential ramifications of implementing quarantines, or any considerations for how to handle quarantines or those possible ramifications. If those who implement quarantines are not familiar with any of those considerations, this guidance would not be enough to ensure they are implemented properly.

As one of the major departments of the government, the DOD has its own pandemic response plan for pandemic influenza that was published in September 2006. It has three primary goals: to provide planning guidance on how the DOD will prepare and respond to the pandemic and its internal effects on the department; how the DOD will support the overall response by the government; and how it will address other security concerns, such as humanitarian relief operations that may come about as a result of the pandemic.[9] In those three realms, it further identifies 13 priority action areas on which it will focus its efforts. Already at the DOD level, the department is acknowledging the vast scope of the response and what it needs to do to be fully prepared for a pandemic. Because the DOD acknowledges that it might not be able to fully complete all of the tasks set forth in the *National Strategy for Pandemic Influenza*, it has set internal priorities for what it will plan for. The highest priority is protecting the health and safety of personnel and resources; then determining and maintaining essential functions in a pandemic, supporting federal, state, and local governments in their response; and finally effective communications. In these priorities, it recognizes quarantine as a measure that will be used to help contain and mitigate the spread of the pandemic. The plan first refers to quarantine as something the DOD will have to help civil authorities enforce as part of the broader national response. It also mentions that military commanders may need to implement quarantines and isolation strategies to contain and limit the spread of a pandemic on base.

The DOD plan only refers to mental health twice, which reveals that mental health is not a serious consideration in the plan. Therefore, it immediately

goes to the bottom of the list of priorities and will not receive an adequate amount of attention, funding, or research. This leads directly to the type of situation the DOD is in now, with little to no data on how a pandemic will impact the mental health of the military. For the tasks to its various subordinate elements, the DOD tasks the military departments and agencies to ensure the "installation commanders plan for mental health and chaplain support for emergency workers."[10] Then, in the section detailing how to maintain continuity of operation, when describing the reconstitution phase and returning to normal operations, an organization must "consider providing counseling and other mental health and social services resources."[11] While it is at least acknowledged as something the DOD may have to deal with, it does not appear to be a serious concern. The focus is more on the installations and ensuring they can support the operating forces and maintain operational capability. Even though the DOD recommends mental health care planning for the supporting establishment, it appears to be an afterthought and not something seriously considered for any other subordinate element.

Marine Corps Order (MCO) 6220.1, USMC Pandemic Influenza (PI) Response Plan, signed on 6 November 2009, goes into a little more detail than the DOD and government plans, as it has a narrower focus than either of them. It outlines the key tasks for the Marine Corps during each of the DOD phases of response and identifies the installations as the center of gravity for the Corps' response. The installations being the main effort instead of the operating forces is different from what one would expect because the mission is to prepare for, respond to, and recover from PI, which would have a much greater impact on the operating forces.[12] Also, the operating forces are the primary concern of readiness and component for responding to crises, so the installations would act in support of them. The second half of the mission statement states that the Marine Corps will support government efforts, which would make sense for the installations to do, in supporting the local communities. This shows that the Corps has a slightly more detailed plan, but it is still generic and only broadly addresses mental health readiness and response for the force.

The Marine Corps plan provides much more detail about planning for quarantine and isolation. It describes a variety of measures that need to be considered, such as security, basic needs, and transportation. It also specifically mentions the need to plan for mental health support for those subject to quarantine or isolation. Not only does it identify the need for psychological support for potential patients but also for emergency workers, as it acknowledges the additional strain they will be under working during a pandemic. Additionally, the MCO lays out a PI preparedness and response planning checklist for its medical treatment facilities (MTFs). While this is specific to the MTFs, it could be used by other subordinate units to ensure they cover all the necessary tasks when creating their own PI response plans.

The U.S. government overall has a framework for how it would respond to a global pandemic and try to reduce its impact on the American popula-

tion. While some plans are more detailed than others, especially in the realm of mental health, they all account for it and acknowledge it is something that needs to be planned for. However, as with all plans, they are only effective if implemented properly, which for a large organization like the government, is not always possible.

The U.S. Government's Response to COVID-19

The wide variety of accounts describing the government response to COVID-19 makes it difficult to succinctly depict it here. Fortunately, the Government Accountability Office (GAO) was charged with overseeing the implementation and execution of the money allocated as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and they have published bimonthly reports on its execution starting in June 2020.[13] These reports are freely available to the public and go into detail about how effectively the government has implemented the COVID-19 relief acts passed by Congress. Even though the reports focus primarily on how funds have been obligated and expended, they still provide some insight into how effective the whole-of-government response has been.

GAO published its most recent report on 28 January 2021, and the report highlights several areas that the organization found to be delinquent in previous reports, which still were not adequately addressed.[14] Further, it identifies 13 new recommendations for executive action the government should take to improve the nation's response to the pandemic.[15] As with the pandemic response plans described above, psychological and behavioral health were mentioned only a few times in more than 500 pages of text. This further shows the lack of attention to mental health from the government and how it was more focused on reducing the spread of the virus than on other health impacts from it.

One of the instances about psychological health focuses on the use of telehealth by the Department of Veterans Affairs (VA) to avoid face-to-face visits with their patients. This is one of the positive aspects of the report, in that the VA was already familiar with using telehealth to provide care to veterans, and with additional funding, it was able to expand that care without unneeded risk to the providers or the patients.[16] This shows that at least one aspect of the government was dealing with mental health issues, and they had some success.

Another instance where psychological health was deliberately accounted for as part of the CARES Act was additional resources to "mitigate the negative psychosocial impact of social isolation."[17] While the act provided $50 million for this initiative, it is only for Aging and Disability Resource Centers as part of the Older Americans Act of 1965, which means none of it went to the U.S. military.[18]

The CARES Act funded various aspects of the Department of Health and Human Services (HHS), including the Substance Abuse and Mental Health Services Administration, which was appropriated $425 million.[19] As with the amount spent on the Aging and Disability Resource Centers, it seems like a lot,

but it is only 0.17 percent of the total amount appropriated to HHS.[20] Also, with mental health services sharing the funding with substance abuse services, one cannot be sure which aspect received more attention, substance abuse or mental health.

The GAO report acknowledges that its findings are incomplete and lists 103 areas in which it has ongoing work.[21] Of these areas, several are noteworthy in that they will provide future information relevant to this topic. They include the military health system response to COVID-19, impacts on DOD maintenance depots, and behavioral health impacts. This at least shows that GAO understands the limitations of its work and is trying to gain a more complete picture of the impact of COVID-19.

As with the U.S. government response plans, it makes sense that the priority is on the physical health of the population, so much of the focus was on developing a vaccine. However, the impacts of a pandemic go far beyond that and can have lasting impacts elsewhere as well. With pandemics being a part of human history, they have been studied and written about before, such as in Mark Honigsbaum's *A History of the Great Influenza Pandemics*, Andrew T. Price-Smith's C*ontagion and Chaos*, and Nathan Wolfe's *The Viral Storm*.[22] Two specific examples have some commonalities with the COVID-19 pandemic. The 1918 flu and the Ebola outbreak in western Africa in 2013–14 each have some commonality to the COVID-19 pandemic, which make them useful cases to determine how COVID-19 may impact the U.S. military.

Historical Examples of Pandemics

Humans have dealt with pandemics for thousands of years, and while each is unique, they all share similar qualities. These commonalities enable the world's health experts to plan and prepare and try to ensure the next pandemic is less impactful than the last.

The most recent global disease comparable to COVID-19 was the 1918 influenza pandemic. Even though that occurred more than a century ago, it shares many similarities with COVID-19. While the disease itself is similar to COVID-19, the world in which it infected was very different. The global community was in the midst of World War I, which cast a great shadow over the challenges associated with the pandemic. As the war was at the forefront of everyone's minds, the flu was an afterthought, and people could not be bothered with it.[23] With the lack of concern and inability of the federal government to coordinate a response, communities across the United States implemented measures sporadically and therefore with mixed results.[24] Some of the most common intervention measures were the closures of public spaces where people could gather and the banning of public gatherings in general.[25] These measures were not only the most common but also seemed to have the greatest impact. These interventions were not just implemented in civil society but military bases employed them as well. They attempted to reduce the spread of the disease through prohibiting mass gatherings and prepared for its inevitable arrival on

base by designating certain areas as overflow hospital beds and quarantining units and areas of camps to prevent them from being infected. One of the notable impacts of the 1918 flu was its effect on the psychological health of the U.S. military. As if the death toll was not enough, with more people killed by the flu than in battle during World War I, and it also increased absenteeism and reduced the morale of the armed forces.[26] With the military simultaneously fighting a war overseas and fighting to keep the troops healthy, it simply could not keep up with both. Even though the U.S. military was not engaged in a conflict of the same scale as World War I when COVID-19 began to spread, it could have some similar psychological impacts.

The 2013–14 Ebola outbreak in western Africa also provides some insight into the potential psychological impacts of COVID-19 on the U.S. military because U.S. servicemembers were deployed to support the U.S. response. Because of the high profile of the mission, the publicity it received, and the high mortality rate, military leaders took many precautions to prevent the disease from returning to the United States. One of those measures was to quarantine the entire force that deployed to western Africa.[27] The unique nature of the situation allowed researchers to conduct a study on their mental health and attitudes toward their leadership while they were in quarantine. Because of the size of the unit and their ability to prepare, psychological impacts were minimal, with the most noticeable challenge being sleep problems.[28] However, this is difficult to extrapolate to the scale of COVID-19. With the entire global force needing to be quarantined after return from deployments, bases across the country needed additional space to do that. Also, servicemembers did not deploy in anticipation of being quarantined on their return, as those deploying in support of the Ebola response did. This expectation management for the troops and their families can have a significant effect. In the same vein, the leadership was fully prepared and could prepare their subordinates for what they would go through when they returned. Unfortunately, military leaders were not as fortunate when returning from deployments during COVID-19 and had to adjust in the midst of their returns to ensure their units were properly cared for. Other key differences that make for a challenging comparison include the transmissibility and mortality rates of the viruses, the many unknowns surrounding COVID-19—especially early in the pandemic—and the scale of the outbreaks. These differences make any comparison challenging and show the rareness of a pandemic like COVID-19.

These historical examples provide some insight into the potential psychological impacts of COVID-19. From the 1918 flu, researchers know that psychological health problems in the military contributed to several challenges the military faced.[29] The Ebola outbreak showed that well-informed and prepared leadership can make a significant difference in the mental health of their units. These findings can inform the hypotheses and research questions of current researchers. While research has been sparse up to this point, there are some relevant studies that can serve as a starting point.

Emerging Research

At this time, researchers have not specifically investigated the psychological impacts of COVID-19 on the U.S. military. The sudden onset and dispersion of the disease prevented any trials from being initiated immediately, so nothing has been published to date. However, as the world enters its second year of the pandemic, those types of studies may begin to emerge.[30] Therefore, the research examined here can only allude to potential impacts on the U.S. military and its readiness to respond to crisis and how further research could be conducted.

Studies on the U.S. population and other groups have been conducted and provide some insight into the possible impacts on the military. Because the armed forces are a representation of the nation, similar patterns may emerge in the military as have arisen in the civilian population. Four studies of adults in the United States are the most relevant and provide some insight into the larger impact of COVID-19 on the mental health of the population.

The first study compares the prevalence of anxiety and depressive symptoms from 2019 and 2020.[31] Researchers used the National Health Interview Survey (NHIS) and Household Pulse Survey (HPS) to collect responses five times: from January–June 2019 they used the NHIS, and from the end of April through the end of May 2020 they used the HPS in four iterations, in total collecting 336,525 responses across the five periods.[32] They did not have any data on the demographics of the respondents, only that they are adults in the United States. They found that the respondents were more than three times as likely to screen positive for depressive disorders, anxiety disorders, or both, and more than one in three screening positive for both during the pandemic in April and May 2020 than in 2019.[33] Even though the survey looked at a small percentage of the population and the demographics cannot be compared to the military because they are unknown, this study does indicate that, in general, the U.S. population was in a deteriorated mental health state during the pandemic, and this could translate to the military population as well, but more research is required on military populations specifically to verify that.

The next relevant study examines depressive symptoms in U.S. adults before and during the COVID-19 pandemic. The researchers used data from the COVID-19 and Life Stressors Impact on Mental Health and Well-being study, conducted from 31 March to 13 April 2020, for their assessment during the pandemic, and the National Health and Nutrition Examination Survey, conducted from 2017 to 2018, for their estimates before the pandemic.[34] The sample size was much smaller in this study, with 1,441 respondents during COVID-19 and 5,065 before the pandemic. However, the study does break out more specific demographic information, with quantities and percentages tied to gender, age, race, education, marital status, household income, and household savings. This allows for a somewhat more detailed analysis of the results, but with fewer participants, it is less likely to be generalizable to the greater population. However, in each of these categories, the prevalence of depressive symptoms was higher during COVID-19 than before.[35] Also, across the subject

group, the prevalence of depressive symptoms was three times higher during the pandemic than before. As with the first study, these results could translate to the military community as well, but more research is required to verify that.

The third study examined the reporting of depression in adults in the United States, again comparing information from before the pandemic to information collected during it. As with the other studies, the participants completed surveys in March and April 2020, with 6,819 responding, and these results were compared to the National Health and Nutrition Examination Survey (NHANES) taken in 2017–18, which had 5,075 respondents.[36] The researchers also examined NHANES data from 2007–18 to assess any potential trends in the data. They further collected data on the participants' demographics, including age, gender, race, education, and household income. Again, with such a small sample size, it is difficult to make any concrete conclusions, but the results show a similar pattern as the other studies. Compared to 2017–18, when 8.7 percent of U.S. adults reported depressive symptoms, 10.6 percent reported symptoms in March 2020 and 14.4 percent in April 2020.[37] As this was the very beginning of the pandemic, it is hard to determine if that trend continued or how it changed throughout the pandemic, but the initial results are significant, especially since they echo those of the other two studies shown.

Finally, researchers conducted a similar comparison of data from April 2018 and April 2020 to determine the prevalence of psychological distress and loneliness among U.S. adults. The researchers used the Johns Hopkins COVID-19 Civic Life and Public Health Survey compared to a National Health Interview Survey (NHIS) conducted in April 2018.[38] Overall, they had fewer respondents in 2020 with 1,468, but 25,417 from the NHIS in 2018. They did collect similar demographic data as the other studies and maintained a similar distribution across the U.S. population. Further, their results echo those of the other studies, with 3.9 percent reporting symptoms of serious psychological distress in 2018 and 13.6 percent in 2020.[39] One factor to consider in this study was that the symptoms were highest among adults 18–29 years old, which is the same age range as almost three-quarters of the active-duty military, which could be cause for concern.[40] However, the results cannot directly be translated to the U.S. military as many other factors are at play.

While these studies do not point directly to the U.S. military being more depressed or suffering serious psychological distress because of the pandemic, they are indicative of what the nation as a whole is experiencing. Many factors prevent this from translating to impacts on the military population, but it is an important point to consider. Further, even if the servicemembers are not suffering from increased levels of depression, anxiety, or psychological distress, their families and friends are the civilian population who are dealing with those issues, which can take a toll as well. All of these factors must be considered when determining if COVID-19 has had an impact and to what extent and how it can have an impact further in the future.

Impacts on the U.S. Military

Even though COVID-19 has been spreading through the United States for more than a year, research pertaining to the psychological effects on the U.S. military is ongoing and inconclusive. This is because the data that have been collected are still being analyzed by psychologists and researchers.[41] Because of the sudden onset of the pandemic, many military psychologists were not entirely prepared to collect, handle, or analyze the data as soon as it was available. This has made developing hypotheses, results, and theories based on that data very difficult. At the same time, more data are being collected as the pandemic continues. While psychologists have begun analyzing the data that have been collected, and some results have been published, it will take time for the behavioral health community to reach a consensus on how the pandemic has impacted different parts of the population.[42] As the country and the world get the pandemic under control, this will change and research will be published to show the various psychological impacts it had on the global population—specifically the military. With vaccine distribution increasing every day and fewer and fewer people being infected, this will hopefully occur sometime this year.[43] However, as psychological impacts are not always identified or manifest immediately, mental health specialists will continue to deal with the effects.

The potential impacts on the military will likely echo those described above in the research conducted thus far. However, this is difficult to determine due to several factors that make the military unique. First, military training is designed to prepare servicemembers for stressful situations so they can function effectively in combat. This creates resiliency, which in general reduces the amount of mental health challenges encountered by military forces. Next, military leadership is trained to be engaged and involved with their subordinates, more so than is expected in a traditional occupation. This additional level of care further enhances their resiliency and gives them another layer of support beyond what the average citizen has. Those in the military also have a variety of resources available to them if they encounter mental health challenges. Not only is the chain of command used to handle low-level issues, but it also enables servicemembers to seek other sources of support, such as chaplains, behavioral health specialists, and psychologists. These resources are available throughout the military and its health system, which is free to access by all servicemembers. However, as indicated by the studies of the general U.S. population, the military demographic could be more prone to depression or psychological distress due to the pandemic. This is because of the age range in which most servicemembers fall. Further, as the military population is drawn from the greater U.S. population, their families, friends, and loved ones are likely to suffer from mental health challenges during the pandemic. Even though servicemembers may not be directly impacted, their concern for their loved ones and potential inability to support them because they are stationed far from home could have a negative impact. Ultimately, it will take time for psychologists and researchers

to study the impacts of COVID-19 on the U.S. military, but as it has affected the American and global population, it will likely have an effect on the military population as well.

Recommendations

As the COVID-19 pandemic is the first global pandemic to occur in more than a century, much can be learned from it that will enable better preparations for the future. Even as COVID-19 still infects people across the globe, many recommendations can be implemented now to maintain the psychological health of the U.S. military until the pandemic is over. The *Textbook of Disaster Psychiatry* has a host of recommendations to ensure proper preparation for a pandemic, but the ones that stand out the most are communication with the public and leadership on education and preparedness for a pandemic.[44] For the DOD and U.S. military, these can be implemented easily, as they have a captive audience and take developing leaders very seriously. As shown earlier, the federal government, DOD, and Marine Corps all have pandemic response plans, even though they may not be current. As the DOD already practices and trains for a variety of other disaster responses, adding pandemics to that should not be a significant challenge. Problems may arise because a pandemic can last months or years and a drill cannot last that long as it would impede regular operations. However, military units regularly train for several weeks at a time so they could implement a training schedule in which they jump ahead in the timeline from the pandemic's onset to its peak and finally to later response and recovery. With the military capturing many lessons learned during COVID-19, it has the ability to incorporate them into its plans and policies now while they are still fresh.

As mental health is only briefly mentioned in the government and DOD's plans, they both would benefit from expanding these sections to better account for the impact of mental health on pandemic preparedness, response, and recovery. The DOD has instructions on maintaining psychological health in military operations, and while it is only 10 pages long, the DOD *Implementation Plan for Pandemic Influenza* does not reference it at all.[45] Even this modest step would at least indicate that the DOD recognizes that operational stress will be a factor during a pandemic, and it needs to be properly planned for at all levels.

The same is also true for the Marine Corps' Pandemic Influenza Response Plan.[46] While it does more than the DOD plan in terms of highlighting the need for mental health and psychological support, it also does not refer to its own Combat Operational Stress Control (COSC) program.[47] The Marine Corps Order on COSC is much more detailed than the DOD instruction and provides a framework for subordinate units to establish and implement their own programs. Again, if the Marine Corps' Pandemic Influenza Response Plan referred to its own COSC program, it would at least indicate that it acknowledges it is necessary to plan to maintain the psychological health of the force

during a pandemic. It could go further by writing some of those details into the Pandemic Influenza Response Plan and indicating where COSC teams would be best incorporated into the planning and execution of the Pandemic Influenza Response Plan.

Finally, even though some studies have already been conducted on the civilian population, the DOD should conduct or sponsor research focused on the military population and especially those who were directly affected by the pandemic. This includes not only those who supported pandemic response operations but also those whose training and deployments were impacted. As the pandemic is now entering its second year, this will include a large portion of the force, but the possible ramifications are great enough that a large scope for the research is necessary.[48] It will be difficult to collect specific data on the units and personnel who deployed and redeployed during the first year of the pandemic, but the regular data collected during that time can at least inform and provide some indication of any changes in the mental health of the force during that time. Military psychiatrists can use that information to develop research plans now so that in the future, when another pandemic occurs, they can begin collecting data immediately to get a better indication of how it is impacting the military.

Because the DOD already has instructions for maintaining psychological health in military operations, it has a baseline to work from in incorporating that into other policies. The challenge will be for the leadership in ensuring it is not overlooked. As military servicemembers are trained to handle stress in combat situations, it makes sense that their leaders would assume they can handle stress in other situations as well. The challenge is in finding a balance between how much psychological health should be emphasized without making it seem like the entire DOD is stressed out. Engaged leadership is a large part of this, and ensuring leaders have the training and resources they need to appropriately handle any concerns is critical as well. Especially in unusual situations, such as a pandemic, leaders need to be more engaged with their troops and ensure they can execute their mission effectively. Even though the focus will be on the mission, just as much focus needs to be on the servicemembers and how they are managing the stress associated with a novel situation. As long as military leaders are engaged and aware of the mental health of their subordinates, they should be able to identify any potential risk factors as soon as they appear, ensure their subordinates are able to get the care they need, and employ measures to ensure the psychological health of the force is maintained so they are ready to execute their mission to the best of their abilities.

Conclusion

The U.S. government has a robust plan for responding to pandemics but does not go far enough in addressing the potential mental health challenges. Its response has been inadequate and needs to be reevaluated to ensure the same mistakes are not repeated. Further, as researchers analyze and publish their findings,

the true mental health impacts will emerge and better inform any modifications to the current plans and policies and future pandemic response efforts.

Fortunately, many of the tools required for a more comprehensive response already exist in the DOD, but they are only applied to those who are preparing for a deployment, deployed, or have recently returned from a deployment. This overlooks the many other things the military does in support of the government and its citizens. Simply applying the tools the military and government already have to the many other contingency and response plans of the DOD would be a step forward in ensuring military personnel have the mental health support they need in all situations. With further research, those plans can be developed more and specialized so that the right support is provided to the right people at the right time.

The COVID-19 pandemic has created many opportunities to learn and improve how the global population will respond to the next one. The information collected can be used to improve the various plans and policies to reduce people's loss and suffering. While scientists cannot predict when the next pandemic will strike, they can implement some of the lessons they have learned during this one. It will require more research to determine the best way forward, but it will prove its worth in ensuring a better response to the next one.

Endnotes

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Guided by Experience
A Comparative Analysis of the U.S. Military Responses to Natural Disasters in Haiti (2010 and 2021)

Christopher Davis, PhD

Abstract: In 2010 and 2021, Haiti was struck by a massive earthquake and both times it left the nation in the grips of a humanitarian crisis. The U.S. military responded to both events with a large-scale, interorganizational relief effort to provide aid to the affected areas. Though the disaster in 2010 created unprecedented challenges, the U.S. Southern Command met those challenges and applied their lessons to its response to the 2021 earthquake 11 years later.
Keywords: earthquake, Haiti, U.S. Southern Command, SOUTHCOM, humanitarian relief effort, Operation Unified Response, Joint Task Force-Haiti

Natural Disasters and Political Instability in Haiti

On 14 August 2021, the old axiom of "history repeats itself" was keenly and painfully felt by earthquake-stricken Haiti.[1] Without having yet fully recovered from the earthquake that hit Port-au-Prince on 12 January 2010, Haiti once again found itself crippled by the same natural disaster less than 80 miles from where the previous one had struck. As this situation 11 years later demonstrates, there is an important caveat that gets left out of that old axiom: when repeating itself, history never performs a precise reenactment. The 2010 7.0-magnitude earthquake struck within 15 miles of the urban capital of Port-au-Prince while the 2021 7.2-magnitude earthquake struck hardest

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against the more rural areas of the Tiburon Peninsula.[2] Furthermore, early relief efforts in 2021 were hindered, and the devastation compounded, by Tropical Storm Grace, which made landfall on Haiti a mere two days after the earthquake.[3]

The goal of this article is to provide a comparative analysis of the U.S. military's coordinated responses to the Haitian earthquake disasters of 2010 and 2021. In doing so, it will demonstrate how the U.S. military took the lessons learned from the challenges it faced in 2010, launching the largest humanitarian aid operation the Department of Defense (DOD) had ever undertaken and applied them when a similar event recurred in 2021. This comparison is made using available studies of two events that, while separated by time, are linked by both their location and similar circumstances. As the 7.2 earthquake along the Tiburon Peninsula in 2021 is still a relatively recent event, there are far fewer studies of its coordination and impact in comparison to that of the 2010 Operation Unified Response. As further studies will no doubt come, and with it greater scrutiny of the U.S. military response to the 2021 earthquake, this article seeks to provide a preliminary assessment of what the 2021 operation successfully drew from the experience of 2010.

One important difference in 2021 that made the situation even more problematic than in 2010 was that the natural disasters of the earthquake and Hurricane Grace came during the midst of one of the greatest political crises in Haiti's long and troubled history. On 7 July 2021, Haitian president Jovenel Moise was assassinated in his home by masked gunmen whose motivations and goals are still under investigation.[4] A controversial figure in Haitian politics, Moise's ruling by decree, debates about when his term limit as president ended (or would have ended), and his dissolution of a majority of the Haitian legislature left Haiti in a constitutional crisis with an unclear path of succession to the presidency.[5] Prime Minister Ariel Henry, appointed just days prior to Moise's assassination, has since taken the role of acting president of Haiti, and elections, which were scheduled for November and have since been delayed.[6] As the question of authority has lingered within the Haitian government, overall government authority within Port-au-Prince has progressively eroded in the wake of these political and natural disasters as various gangs in the capital vie for control.

The political situation in Haiti as well as the increasing power of the gangs as the authority in the capital continue to be an ongoing situation without a clear solution. Previous experiences of the United States using the military to restore order in the wake of political turmoil, such as the U.S. intervention in 1915 after the assassination of Jean Vilbrun Guillaume Sam, offer more guidance on how best to avoid past missteps than a course of action in addressing Haiti's destabilization. For problems not related to internal Haitian politics, however, recent history provides clearer advice. Regardless of the problems related to the political situation in Haiti, the U.S. military, in their response to the 2021 earthquake, used lessons learned from previous experience to effectively

respond to a natural disaster. The successes and problems encountered during Operation Unified Response in 2010 provided valuable experience that Joint Task Force-Haiti learned from and applied in 2021.

Operation Unified Response

It was immediately apparent in the aftermath of the 2010 earthquake that a natural and humanitarian disaster of that magnitude required a coordinated response across multiple military branches and U.S. aid organizations. Responsible for military-to-military relationships (both among U.S. military branches and foreign partner militaries in the region) in an area encompassing Central America, South America, and the Caribbean, the U.S. Southern Command (SOUTHCOM) was positioned to coordinate and execute such a response.[7] The U.S. Agency for International Development's (USAID) Office of U.S. Foreign Disaster Assistance was the lead agency of the U.S. whole-of-government response to the Haiti earthquake, but the sheer magnitude of the disaster required the manpower and resources of the Department of Defense.[8] The DOD already had in place the expeditionary emergency medicine units, vertical lift capability, command and control communications, and logistics that Haiti would need to manage the situation.[9] Unfortunately, Haiti's relief needs were extreme in the aftermath of the earthquake, giving SOUTHCOM the challenge of determining how to respond to an unprecedented humanitarian crisis. In a country often given the unenviable label of being the poorest country in the Western Hemisphere, the Haitian capital of Port-au-Prince, home to approximately 700,000 people in a hilly terrain that easily lent itself to post-quake landslides, had just been dealt a knockout punch in the form of more than 200,000 dead, another 300,000 wounded, and massive damage to private residences, government buildings, and infrastructure.[10]

Just as the U.S. government promised the Haitian people a whole-of-government response, SOUTHCOM provided likewise. Operation Unified Response began immediately with resources from every branch of the U.S. military concentrated within Joint Task Force-Haiti under the command of Lieutenant General Paul K. Keen.[11] One of the first challenges that SOUTHCOM faced in responding to the earthquake was access to get personnel and materiel into the city, as the significant damage to Port-au-Prince's infrastructure included the airport and seaport. Nevertheless, within 48 hours after the earthquake, Army paratroopers from the 2d Brigade Combat Team, 82d Airborne Division, were on the ground distributing food, water, and medical care.[12] Furthermore, until the Toussaint Louverture International Airport could be made operational again, the Air Force Special Operations Command (AFSOC) 623d Air and Space Operations Center (AFSOC) used its proximity at Hulbert Field, Florida, to set up an initial command and control station.[13] As SOUTHCOM took the lead in military operations for Unified Response, the 12th Air Force (Air Forces Southern) became the air component of the operation. Based farther away at Davis-Monthan Air Force Base, Arizona,

command and control had then shifted to the 612th Air Operations Center (AOC) to manage flight planning and airspace coordination for the incoming aid to Haiti.[14]

As SOUTHCOM assessed the overall situation and how best to address it, it established a series of operational phases to relieve and restore the affected area. Phase I (emergency response) involved search and rescue teams for emergency aid, establishing situational awareness, deploying initial forces, and setting up port operations. Phase II (relief phase) established medical support; distribution of food, water, and aid; and reestablished critical infrastructure and shelters. Phase III (restoration) redeployed U.S. military assets as the need for humanitarian relief decreased, shifting the continuation of relief and infrastructure reconstruction to other government and nongovernmental organizations. Phase IV (stabilization) worked to reestablish legitimate civil authority and provide basic services to the Haitian people, and phase V (recovery) involved long-term support to the Haitian government to rebuild its infrastructure and ability to provide basic services.[15] The direct involvement of U.S. military forces in the relief-based phases I and II successively diminished through the recovery-based phases III–V as they took on increasingly supportive roles, because the ultimate goal in any foreign aid situation is to save lives and provide that nation with the means to regain self-sufficiency. However, as we will see later in this assessment, providing relief to Haiti and Haiti's recovery from this disaster are separate and distinct issues.

Initially reliant on air units to restore the infrastructure to the air and sea ports, additional aid then came by sea. The Navy participated in flying relief supplies to accessible points in Haiti and airdropping supplies in others. The Navy also established field hospitals, provided medical assistance aboard the USNS *Comfort* (T-AH 40), and landed the 22d and 24th Marine Expeditionary Units to carry out amphibious relief missions.[16] Some of the ships involved in the relief effort included USS *Carl Vinson* (CVN 70), USS *Higgins* (DDG 76), USS *Underwood* (FFG 36), USS *Normandy* (CG 60), USS *Bataan* (LHD 5), USS *Carter Hall* (LSD 50), USS *Fort McHenry* (LSD 43), USS *Bunker Hill* (CG 52), USNS *Grasp* (T-ARS 51), USNS *Henson* (T-AGS 63), USS *Gunston Hall* (LSD 44), USS *Nassau* (LHA 4), USS *Mesa Verde* (LPD 19), and USS *Ashland* (LSD 48). During the course of Operation Unified Response just USS *Carl Vinson*'s air wing distributed more than 1.1 million pounds of aid and 19 of its helicopters flew more than 1,000 hours and evacuated 435 patients.[17] With the combined efforts of SOUTHCOM, USAID, and other international organizations, relief efforts were assembled quickly and carried out vital lifesaving and order-restoring missions as Operation Unified Response continued until 24 March 2010. By 17 February, the American Forces Press Service reported that the need for U.S. military forces was diminishing, indicating that conditions for SOUTHCOM's phase III had been met. Lieutenant General Keen had informed Pentagon reporters that the peak of 20,000 U.S. troops that had been deployed to Haiti since the operation began had been reduced to 13,000

(with 7,000 of these being on the ground) as their work thus far had allowed for greater civilian partner capabilities.[18]

Assessments of Unified Response

In the months that followed after the conclusion of Operation Unified Response, U.S. officials praised the success of the U.S. military in bringing relief to earthquake-stricken Haiti. In *House Resolution 1066*, Congressman Ike Skelton (D-MO) commended SOUTHCOM and Lieutenant General Keen's conduct of the operation as "immediate, focusing on life saving and assessment, humanitarian assistance, and disaster relief and evacuation operations" and that "all those involved in Operation Unified Response deserve our utmost thanks and praise for their efforts to save lives and restore hope in Haiti."[19] Additional praise was bestowed on 28 March 2011 when USAID gave its final report on the U.S. government response to the Haiti earthquake. In their independent review, the evaluation team from Macfadden described the actions of SOUTHCOM's Joint Task Force-Haiti as pivotal in saving many lives and that the

> vital services such as airport management; seaport repair; road clearance to deliver essential humanitarian material; airlift and sealift capabilities to bring in critically needed relief supplies; organizational capacity to manage the supply chain; aerial reconnaissance; and manpower and equipment to support HADR operations, logistics, and security, could not have been accomplished by any other international or host country agency.[20]

Nevertheless, not all of the assessments that followed were free of critique and, while praise is certainly due for this operation, the assessments require attention as often they—more than accolades—are necessary for greater improvement. Despite the vital relief efforts carried out by the U.S. military in Haiti during the course of Operation Unified Response, the assessment of the U.S. Government Accountability Office (GAO) determined that the operation faced challenges that would need to be addressed for potentially similar events in the future. Simply put, the findings of the GAO were that SOUTHCOM had been unprepared to respond to a disaster of that magnitude. This is certainly understandable as SOUTHCOM found itself in an unprecedented situation of responding to a massive natural disaster in the capital city of a nation among those least equipped to deal with a natural disaster. Operation Unified Response, therefore, represented the largest disaster relief effort that the DOD had ever conducted and required 24-hour, 7-days-per-week operations over an extended period.[21] Among the challenges covered in the report were organizational weaknesses, planning issues, and logistical issues. The critiques of this assessment gain further weight as they were echoed by those central in carrying out the operation. In a self-assessment written by Lieutenant General Keen,

Lieutenant Colonel Matthew Elledge, Lieutenant Colonel Charles Nolan, and Lieutenant Colonel Jennifer Kimmey, they state that the most significant challenge that they faced in the initial stages of the operation was logistics in the form of incomplete situational awareness, absence of a unified and integrated logistics command and control structure, and reliance on the only airport into Haiti through which to funnel all personnel and resources.[22] While the issue of the airport was a factor outside of SOUTHCOM's control, leaders in Joint Task Force-Haiti recognized that they were hindered early on by a logistical system designed primarily for internal support for their own forces rather than on external support for humanitarian assistance and disaster relief.[23]

Taking each of the challenges highlighted in the GAO assessment in turn, the organizational weakness indicated in the report was that the Haiti earthquake presented a situation outside of SOUTHCOM's core mission at that time. While SOUTHCOM was organized to meet regional challenges such as building partner nation military capabilities and providing humanitarian assistance, GAO determined that SOUTHCOM had not been organized with contingencies in place for disaster relief efforts and needed to be reorganized for such an event.[24] This in turn leads into GAO's conclusion that SOUTHCOM's response suffered from planning issues. Specifically, GAO determined that the command structure of SOUTHCOM lacked a division to address planning for future operations and had suboptimized some of the core functions that were necessary to respond to a large-scale contingency such as the events of 12 January 2010.[25] One of these core functions included logistics, which presented a series of issues that SOUTHCOM had to quickly overcome. The absence of this core function caused relief effort planning difficulties in the areas of supply, maintenance, deployment distribution, health support, engineering, logistics services, and contract support.[26] With the massive combined response force assembled by SOUTHCOM for this operation, these issues meant that the operation started with a lack of cohesion necessary for a force that size to be effective. Intercommunication across various components was strained as different components, such as Joint Task Force-Haiti, were organized under different structures within SOUTHCOM, and initial organization was further hindered by a lack of augmentation plan to produce the personnel necessary for such a large contingency.[27]

While SOUTHCOM faced understandable challenges in responding to an unprecedented disaster at the onset, it also addressed and overcame these issues with impressive speed. Much of this can be attributed to using SOUTHCOM's core mission successes of building and maintaining partnerships in the region to reorganize and meet its objectives. SOUTHCOM received more than 500 augmentees to its existing approximately 800 personnel, including an entire staff office from U.S. Northern Command (NORTHCOM), and 40 augmentees from seven agencies and four international organizations were also integrated into the planning and operations through its preexisting interagency and international partnerships.[28] Another asset SOUTHCOM was able

to employ to swiftly address these initial challenges was flexibility. Though U.S. military leaders started out Operation Unified Response with little direction and situational awareness, they were given significant latitude in their ability to demonstrate and exercise initiative, which allowed Lieutenant General Keen to determine initial requirements and use verbal orders of the commander.[29] This informal approach streamlined force selection and assignment generation resulting in a high volume of personnel and resources able to respond more quickly.[30] While the absence of organizational preparedness for large contingencies was cited as an initial hindrance, SOUTHCOM quickly turned the hindrance into an asset. Without a plan in place that may have called for a more rigid response, SOUTHCOM adapted as needed to the situation and used its preexisting assets accordingly.

It is perhaps fair to say that the disaster of 12 January 2010 was something for which no one could have been fully prepared. As mentioned earlier, this was an event where a massive earthquake struck one of the world's nations that was least equipped to deal with it. The U.S. military response was swift and effective given the scope of the devastation, injuries, and loss of life that had just been inflicted on a regional neighbor. It is also worth noting that in 2010 the U.S. military was still engaged in combat operations in both Iraq and Afghanistan, and that resources were swiftly and effectively shifted away from these theaters to support a large, immediate, and unexpected humanitarian relief effort speaks to the versatility of U.S. forces.[31] Though adaptability served SOUTHCOM in the initial organization of Operation Unified Response, it was nevertheless agreed that organizational restructuring to provide for future planning for large contingencies was something that needed to be done. Based on the recommendations of GAO, SOUTHCOM established the future operations division, which was tasked with elevating functions such as logistics and communications between DOD stakeholders that was absent at the onset of the operation. Additionally, this reorganization required an update of SOUTHCOM's organization of functions.[32] Follow-up reporting by GAO confirms that SOUTHCOM completed this update in the form of Southern Command Pamphlet 0103-Organization and Functions Manual as of 15 June 2012.[33]

The U.S. military committed a large amount of personnel and resources to bring relief to Haiti in the aftermath of 12 January that, at its peak on 1 February, consisted of more than 22,000 servicemembers, 58 aircraft, and 23 ships.[34] When Operation Unified Response ended by 24 March, the hope of Haitians and the international community who responded to the disaster was that out of the chaos of the earthquake could emerge a new beginning for the beleaguered nation. Haiti and the United States have shared a troubled history, where chronic political instability in Haiti and U.S. military interventions in response to it have strained relations. Many Haitians were suspicious of U.S. intentions in deploying such a large force once again to their capital, but there were also many who welcomed U.S. assistance as a chance to rebuild better than before. However, the U.S. military leadership in Haiti during the operation was

cautious in its optimism about the long-term impact of its efforts, pointing out the relief is not the same as recovery.[35] While the U.S. military provided vital relief in the form of distributing medical aid, food, water, and rebuilding key points of infrastructure in Port-au-Prince, there were still systemic problems within Haiti that had preceded the earthquake and were only exacerbated by it in the years that followed. Political corruption in Port-au-Prince tied up post-quake foreign aid that was meant for national recovery, and other geopolitical events in the Caribbean in later years brought the political and economic problems Haiti faced to a boiling point.[36] U.S. military and humanitarian intervention in 2010 could not solve these problems for Haiti. What SOUTHCOM could and did do was prepare, based on its experience in 2010, for the other major problem Haiti has over which the U.S. military (nor anyone else) has no control: that Haiti, located where the Caribbean and North American tectonic plates meet, would someday have another major earthquake.

Haiti's 2021 Disasters

When, on 14 August 2021, the nation of Haiti once again suffered an earthquake of a slightly higher magnitude of 7.2, it was the latest in a series of disasters that had recently struck that nation.[37] However, for the most part, the disasters that preceded 14 August had been a result of human actions. While Haiti has a long history of political and economic turmoil, the current crisis finds its genesis the in the suspension of the PetroCaribe program in 2019. Beginning in 2005, in hopes of extending its influence and courting potential anti-American allies in the Caribbean, under President Hugo Chavez, Venezuela instituted the PetroCaribe program. Under this program, Venezuela loaned oil to participating nations at a low interest rate and deferred payment on 40 percent of the oil purchased for up to 25 years, which in turn allowed those nations to sell the oil elsewhere to use the proceeds for social programs and development.[38] However, the worldwide price of oil had sharply declined since 2005 and by 2019, Venezuela's economy had collapsed and the PetroCaribe program was suspended. If the suspension of the program, which Haiti had participated in, did not cause enough problems in cutting off the flow of both oil and future revenue from oil sells, by 2019 it became clear that the Haitian government during the course of the program had not been using that revenue as intended.[39] While the Haitian government claimed to have used the $4 billion raised between 2008 and 2016 for hundreds of post-2010 earthquake infrastructure and health care programs, suspicion over the negligible progress in these areas resulted in a 2017 commission of the Haitian Senate determining that government coffers had been misreported, exchange rates had been adjusted, and more than half of all government contracts for these projects had been awarded outside of official bidding processes.[40]

Then-Haitian president Jovenel Moise's involvement in the PetroCaribe scandal in and of itself had made him a controversial figure. Riots over the resulting fuel shortage and mismanagement of government funds were com-

pounded as Moise's presidential term presented a constitutional crisis. Though the Haitian Constitution states that the president serves a five-year term, which officially ran out for Moise in February 2021, Moise refused to step down on the grounds that an interim government had technically occupied his first year in office.[41] Opponents of Moise accused him of placing himself as a dictator and, as Moise ruled increasingly by decree, fuel shortages persisted, and various factions within the Haitian government and elites used gangs to enforce their will against their opponents. Finally, the added strain of the COVID-19 pandemic in Haiti in the summer of 2021 was a powder keg.[42] Then on 7 July, that powder keg exploded when masked gunman entered President Moise's home in the middle of the night and carried out his assassination.[43]

To make matters worse, Moise's previous actions and assassination left the Haitian presidency with no clear path to succession. Under the Haitian Constitution, the Supreme Court president would succeed the president or, if barring that possibility, the prime minister could be appointed by Parliament.[44] However, the same week of Moise's assassination, the Supreme Court president died from COVID-19, and an official appointment of the prime minister from acting president to president was not possible as Moise had dissolved the Haitian legislature in 2020.[45] After some debate, it was agreed that Prime Minister Ariel Henry would serve in the role of acting president until elections can be held at some currently undetermined point in the future.[46] Political uncertainty, heightened social unrest in the wake of the assassination, and the increasing power of the gangs once used by government members and elites now emboldened to act on their own authority had brought Haiti to the threshold of chaos.

Joint Task Force-Haiti, 2021

The last thing Haiti needed at this point was another natural disaster, let alone successive natural disasters. Just days after a 7.2 magnitude earthquake hit the Tiburon Peninsula, tropical storm Grace arrived to immediately hinder recovery efforts. With the government in Port-au-Prince in an even weaker state than it was in 2010 to deal with a natural disaster, if there was a silver lining in this scenario it was that this earthquake had occurred farther away from the capital, causing less causalities and infrastructure damage. Nevertheless, Haiti still needed outside assistance and the United States once again provided a whole-of-government response to the devastation. Utilizing the future planning lessons learned from 2010 and able to augment force capability based on domestic and foreign partnerships, SOUTHCOM quickly established a new Joint Task Force-Haiti (JTF-Haiti) to provide DOD support to the USAID Disaster Assistance Response Team (DART).[47] JTF-Haiti, led by Rear Admiral Keith B. Davids, consisted of SOUTHCOM units from the U.S. Navy, Marine Corps, Army, and Air Force in partnership with British, French, and Dutch forces.[48] Additional support was provided by the U.S. Coast Guard, which began rescue operations and aid delivery within the first 24 hours after the earthquake.[49]

The operations of JTF-Haiti lasted from 15 August until 2 September

2021, demonstrating both how swiftly SOUTHCOM responded with a ready relief force and how quickly those relief efforts were carried out. In a total of 671 missions throughout the course of JTF-Haiti's operation, six ships, 19 helicopters, and eight transport aircraft succeeded in delivering a total of 587,950 pounds of food, water, medicine, and supplies to the devastated areas and assisted or rescued 477 people.[50] Especially noteworthy are the contributions of Joint Task Force-Bravo (JTF-B), which delivered 340,740 pounds out of the total aid provided by JTF-Haiti and included food, shelter, blankets, tents, tarps, water purifiers, generators, and an entire mobile medical hospital for affected communities.[51] At the time of this article, less than a year has passed since the 2021 Haiti earthquake and the work of JTF-Haiti in response to it. Fewer assessments have been made as of yet in comparison to the ones made of Operation Unified Response occurring 11 years earlier. While there are likely to be more reviews and analyses of JTF-Haiti in the future, there are preliminary takeaways that are immediately apparent with the information currently in hand.

JTF-Haiti Assessments and Conclusions

In this preliminary assessment comparing the U.S. military response to the 2010 and 2021 earthquakes in Haiti, initial information indicates that SOUTHCOM was able to prepare and execute Joint Task Force-Haiti in 2021 with even greater speed and efficiency than it had in 2010. As stated at the beginning of this article, there is an inherent challenge in making comparisons between two natural disaster events, because even similar disasters are not exactly alike. The 2021 Haiti earthquake resulted in more than 2,000 deaths, 12,000 injuries, and 150,000 homes destroyed.[52] While these losses were certainly tragic, the more rural location of this earthquake did not produce casualties in the hundreds of thousands that its more urban-centered predecessor did in 2010. In the face of the devastation of Port-au-Prince in January 2010, SOUTHCOM's relief response was impressive despite early organizational, logistical, and planning gaps for such a large contingency. In the absence of a clear plan of how to respond to a large disaster, SOUTHCOM relied on its strengths of adaptability and preestablished regional partnerships to quickly assemble the combined force necessary to aid Haiti in its darkest hour. The fact that SOUTHCOM was able to rapidly respond and engage in the largest disaster relief operation ever conducted by the DOD at a time when the United States was engaged in two wars on the other side of the world deserves praise.

In contrast, JTF-Haiti in 2021 did not require as much time, personnel, and resources to provide relief to affected Haitians, but it is clear that SOUTHCOM and JTF-Haiti took the lessons learned from 2010 to produce an even more efficient response. Partnerships with the U.S. Coast Guard, foreign military allies, and nongovernmental organizations (NGOs) were immediately called on for a rapidly coordinated response to provide aid to Haiti, the first of which arrived in less than 24 hours. Having addressed its absence in future large contingency planning after 2010, SOUTHCOM was prepared

to respond to such an event when history (imperfectly) repeated itself. While the devastation of the 2021 earthquake was thankfully not as extreme as that of 2010, SOUTHCOM, having already demonstrated its ability to respond to the unforeseen, showed it is even better prepared now that large disaster contingencies are in place. Based on Haiti's geographic position along a fault line and often within the pathway of seasonal hurricanes and tropical storms, such contingency planning will no doubt continue to be tested in the future.

Furthermore, while SOUTHCOM has reportedly made the recommended organizational changes to enhance their ability to render humanitarian aid to neighbors such as Haiti, Haiti has gone through even greater changes since 2010, but not for the better. At present, gangs in the capital of Port-au-Prince arguably exert greater authority than the Haitian government. The future of the current acting presidential administration is anything but clear, and none of the issues Haitians have faced during the last few years have been resolved or even eased by this point. This fact has been reinforced as recently as New Year's Day 2022, when Acting President Henry was forced to flee from the northern city of Gonaives amid a shootout between his security forces and an armed group that had previously warned him against entering the city.[53] As of February 2022, it has been reported that there are currently more than 200 gangs operating in Port-au-Prince, demonstrating exponential growth when compared to the roughly three dozen known gangs recorded in 2004.[54] Of the 2021 disasters Haiti has endured, a natural disaster was the only one that could clearly and cleanly be addressed by a U.S. military response. At a time when Haiti was in an even weaker position to respond politically to a natural disaster than in 2010, the U.S. military provided disaster relief, saving lives and providing aid. But, as stated before, relief is not recovery. Experience obtained from U.S. interventions in Haiti make it unclear what role if any the U.S. military could or should play in response to Haiti's internal political and social disasters, but experience has also provided a much clearer picture of the vital role the U.S. military can play in providing relief from natural disasters in Haiti and elsewhere.

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