

Focus On....Managing Health Services Support to Military Operations.

**International Military Medical Engagement with the Indigenous Health Sector -
Civilian**

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Abstract

This is the twelfth in a series of occasional monographs that examine some of the principles and factors involved in managing health services support to military operations. This paper is the second of two that look at the engagement of international military medical services with the indigenous health sector. This paper will focus on the relationship between security forces, both international and indigenous, with the indigenous civilian health sector. The paper uses the term to refer to the population in the country to which international military forces have deployed. The paper will build upon a previous paper from my experiences in Afghanistan in 2006/7 and evidence from other Counter-Insurgency (COIN) campaigns cited in my MA thesis. It will focus on experiences and observations at the operational and tactical level from engagement with the Afghan civilian health sector in 2009/10. The paper will conclude by providing a practical description of medical engagement within the 'Shape-Clear-Hold-Build-Transfer' construct for COIN operations.

Introduction

This is the twelfth in a series of monographs that examine some of the principles and factors involved in managing health services support to military operations. This paper is the second of two that look at the engagement of international military medical services with the indigenous health sector. This paper will focus on the relationship between security forces, both international and indigenous, with the indigenous civilian health sector. The paper uses the term to refer to the population in the country to which international military forces have deployed. The paper will build upon a previous paper from my experiences in Afghanistan in 2006/7 and evidence from other Counter-Insurgency (COIN) campaigns cited in my MA thesis. It will focus on experiences and observations at the operational and tactical level from engagement with the Afghan civilian health sector in 2009/10. The paper will conclude by providing a practical description of medical engagement within the ‘Shape-Clear-Hold-Build-Transfer’ construct for COIN operations.

Background

My previous papers have demonstrated the inevitability of international military medical engagement with the indigenous civilian health sector on expeditionary operations (^{1, 2, 3}). The role of military forces in this engagement will be dependant on mandate ranging from an exclusively civilian-military relationship in a humanitarian assistance mission through to a ‘de minimis’ relationship during war-fighting limited only to fulfillment of

international obligations under the Geneva convention. There has been an increasing international acceptance of the requirement to establish a policy framework for this relationship based upon current operations in Iraq and Afghanistan (NATO policy, US DoD instruction, US interagency code of practice). This operational experience has emphasized the primacy of civilian actors and acknowledged the risk of harm resulting from military engagement with the civilian health sector. However, there is also agreement that insecurity is one of the leading causes of lack of access to health services and there may be occasions where the use of security forces medical capability is the last resort to enable the indigenous population to have access to health care. This may result in security forces providing protection for civilian health services or security forces directly providing health care through their own resources. Overall there is agreement that security forces health care systems, both international and indigenous, are legitimate stakeholders in the indigenous health sector and that communication and co-ordination between them and other players is essential to ensure effectiveness for the dependant civilian population.

The previous paper on international military medical engagement with indigenous security forces provided a framework for understanding the Afghan health sector at a macro level. The organizational structure of the public sector of the health care system in Afghanistan has been well described and will not be covered in detail in this paper ⁽⁴⁾. In summary there is a pyramidal system of public medical facilities starting from basic health posts, health clinics, district and regional hospitals and national referral hospitals. The majority of effort has been to increase access to healthcare through the Basic

Package of Health Services. It is important not to forget that Afghans should have primacy in their health system. Thus the provincial directors of public health are the government appointed health sector leaders at a local level. Many of these individuals are 'survivors' and have been local residents during all of the political turmoil of the last 25 years. They are well connected with strong formal and informal power possibly including communication links to insurgents. The director of the contractor providing the Basic Package of Health Services and the director of the provincial hospital are also highly important. These three individuals control the flow of money allocated by the Ministry of Public Health from national to district level. Nationally financial management is weak with substantial uncertainty over budget allocations and actual flow of funds. This is the main source of money to cover operating costs of hospital services. The international community is represented by the World Health Organisation (WHO), United Nations Office for the Co-ordination of Humanitarian Affairs (UNOCHA), United Nations Children's Fund (UNICEF) and the International Committee of the Red Cross (not all of whom are permanently resident in the South of Afghanistan). These are the main organizations for technical assistance though there is very little impact outside of Kabul. The United States Agency for International Development, the World Bank and the European Union are the biggest donors to the health sector. These are the main source of funding for the operating costs of the Basic Package of Health Services though each has their own mechanism for allocation of funds and managing contracts. Other national development agencies (e.g. Canadian International Development Agency) also support the health sector through local projects managed by their Provincial Reconstruction

Teams (PRTs). In addition to these large donors there may be smaller aid organizations operating locally.

The Afghan security force medical services are also likely to be influential as they often care for local civilians, and, dependant on the security situation, they may also undertake private practice. As described previously, the international military are also important local stakeholders funding development projects – usually on a capital basis. The ‘for-profit’ private sector is the final element of the health sector. This is a poorly understood but critical element of the Afghan health system with the majority of health encounters occurring privately, particularly for adults and in rural areas. The majority of Afghan healthcare workers working for the public sector also have private practice sometimes including a financial interest in local private pharmacies. Like many developing countries, this is an essential mechanism for salary supplementation as the basic government salary is inadequate compared to the cost of living and the social status of physicians. This relationship can add complexity in the application of ‘western’ standards of governance with migration of donated equipment and medications from public into privately owned facilities. Local governance is a complex mix of tribal affiliation, patronage and coercion. Accessing international money is a key source of power, especially if this can be linked to controlling the market price by monopolizing supply. This is most relevant for the management of capital projects at the local level. This can cause significant tension between local representatives demanding medical facilities that cannot be justified or sustained within the resources available. The Ministry of Public

Health has recommended that all donations should be as public as possible and made within the oversight of MoPH representatives.

Military Engagement

At the macro level, the surge in military forces in Afghanistan that occurred from mid-2009 was accompanied by a surge in development resources – both surges mainly originating from the United States. The surge in development resources was based upon the hypothesis that counter-insurgency campaigns should be grounded upon winning the consent of the indigenous population. The increase in developmental assistance was aimed to show the commitment of the international community and the effectiveness of the government of Afghanistan to the Afghan population. There is a finite limit to the number of Afghan educated technocrats who are competent to manage development projects. There is also a finite limit to the number of interpreters who can both facilitate international civilian engagement with the Afghan community but also facilitate the partnership between international military forces and their Afghan military counterparts. This, compounded with the threats by the insurgents to those who work with government institutions, has created a challenging market for Afghan human capacity. Future capacity will only be delivered by extending access to education and this will take many years to have a significant impact. The developmental challenge in Afghanistan has been to convert these resources into practical improvements in the quality of life at community level, especially in the vulnerable rural communities most exposed to the threats from insurgents.

The endstate for civilian sector reconstruction and development is for an Afghan to provide culturally and clinically appropriate health care for an Afghan. Where possible, the international military role in the civilian health sector is to do nothing. There will be occasions where international military medical units have obligations under the Geneva convention and medical ethics to provide emergency medical care to Afghans. These circumstances are covered under 'medical rules of eligibility' or MRE. This has been discussed in more detail in the paper on the execution of military operations.

My previous papers have cited the inevitable engagement of international military medical forces with the indigenous civilian health sector. This enthusiasm needs to be directed at a policy level to ensure the most effective outcomes from this engagement. International military forces are likely to have the maximum impact at a local level by accessing communities that cannot be reached by civilian agencies. The civil-military Provincial Reconstruction Team (PRT) was created to bring together security and development expertise to improve quality of life for Afghan civilians. The expectation is that security will transfer to Afghan forces and that development programmes will transition to the provision of basic services by Afghan institutions under local governance. At the local level, the key grievance is insecurity. This is followed by lack of employment, access to health services and education. The meaning of personal security is very different to a civilian healthcare worker from a different tribe to the local population living in a rented apartment traveling to work in private taxis compared an international soldier encased in body armour, travelling in a heavily armoured vehicle, living in a

protected fort. The goal is to achieve freedom of movement so that the population can move to health facilities or that civilian health care workers (either indigenous or international) can reach the population. According to the Director of Public Health for Kandahar, security is achieved when local village elders provide him assurance that his healthcare workers will be protected to work in community clinics. Security may best be achieved by recognizing that health actors may be negotiating with parties to the conflict to avoid targeting the civilian health system. A good example of this is the Afghan element of the Global Polio Eradication Campaign. The senior immunization coordinators have negotiated with as many parties to conflict as possible to recognize the impartiality of the vaccinators and to give them unimpeded access to the civilian community.

Activities

Current military doctrine for COIN is summarized in the mnemonic Shape-Clear-Hold-Build (to which some commentators have added 'transfer')⁽⁵⁾. Conceptually, security operations start by 'shaping' the environment to both build relationships with the indigenous population and also define and then reduce the opposition. The 'clear' phase is the surge of tactical operations to physically remove opposition forces from the area. 'Hold' is the transition from military operations to police-led security operations to ensure the population is protected from the opposition. This includes the (re)establishment of local governance. 'Build' is the execution phase of reconstruction and development in order to demonstrate to the population the benefits of supporting the

instruments of government and go gain their consent. 'Transition' is the transfer of governance and security from international security forces to indigenous security forces. This is not a linear process but requires selection of each of these activities according to the context. Ideally planning should be 'backwards' with agreement between stakeholders (most particularly indigenous representatives of governance) of what the 'transition' looks like and the resources required to achieve the entire process. Within RC(S) this process was built around District Stabilisation Plans that were developed at District level between community representatives, PRTs and international agencies. There is no benefit to the indigenous population if, having suffered the inevitable damage associated with the 'clear' phase, the security forces are not able to sustain the hold and the opposition forces return. The biggest challenge is to mobilise the civilian sector to deliver practical improvements in quality of life to the indigenous civilian population during the early stages of the 'hold'. This is the period when military forces may have a role in development activities – where money can be considered as a 'weapon system'⁶.

As described earlier, lack of access to health services is often a key grievance. The following text was provided by a Medical Officer at a ISAF Forward Operating Base.

There are currently no formal medical facilities of any sort in the local area. Afghan civilians travel to the bazaar or the district hospital. They report that the facilities are poor and that they feel poorly treated by the 'doctors' in the bazaar. They often think that they are being short changed with poor advice or expensive drugs that do not work. Often travel to the District Hospital is difficult because of Taliban road blocks. There

used to be a functioning government clinic 6 kilometers to the north but this was destroyed by ISAF bombing following being occupied by the Taliban 2 years ago. We have put forward a proposal to the District Stabilisation team for a local clinic but this is currently stalled at the level of the District Health Officer and has not appeared in the most recent version of the District Stabilisation Plan. There is no evidence of current public health activity in the area though some local children have had a limited number of vaccinations.

We run a clinic from 0900 to 1200 every day and frequently treat local nationals. We see many babies with pyrexias and D&V, many toddlers with burns and minor injuries. Many of the men have upper gastrointestinal symptoms, as well as the ubiquitous lower back pain and leg aches from working in the fields. Some have presented with advanced conditions beyond treatment. Treating Afghan civilians is very rewarding, as well as educational for the medics. It also provides a vital link to the people, building trust and goodwill, to the extent that many will share other information with us. Children will often come on their own, with young ones brought in by their older siblings or sometimes their father.

Care of Afghan women is done by senior female family members only. Only in the gravest of circumstances will adult females (over the age of twelve) be taken to the District Hospital. A recent example is of a woman who was a victim of an IED within 500 metres of the gate. She was driven by family members through one of our checkpoints to the District Hospital and declined emergency treatment by ISAF forces. No women have

been seen in the FOB. It would bring dishonour on a woman if she were to enter. We have seen women on two occasions in the compound opposite the front gate at the request of their husband.

Seeing Afghan civilians is justified for the reasons above. There is no local health system to undermine and we are careful not to affect our capacity to care for ISAF or ANA. It does not alter local health beliefs or give false hope as the locals are more canny than they are given credit for. The vast majority have very genuine problems. They are happy to take advice rather than medication and willingly listen to health education such as managing infants with feeding problems or D&V. The often used technique of 'fobbing people off' with vitamins or tic-tacs is not needed. They fully understand the limitations of what we can do here and are happy to be advised to seek more specialist care.

At first glance military units may believe that the solution is MEDCAPs and building clinics. The term MEDCAP has moved away from the original concept of a 'medical civil action programme' developed during the Vietnam War into a descriptions of on-off, non-emergency primary healthcare clinics provided by ISAF forces within an ISAF security envelope. There is very clear evidence of the ineffectiveness of MEDCAPS in anything other than the extreme short-term (⁷). As a result, the construction or refurbishment of BPHS facilities or schools are often selected as PRT development projects. However buildings are not health capabilities and the military role in improving access to health services should be considered within the wider 'Shape-Clear-Hold-Build-Transfer (SCHBT)' construct. The slide at Figure 1 illustrates the spectrum of

relationships between security forces and health providers according to the security environment. This illustrates the goal of ‘An Afghan caring for an Afghan’ using Afghan civilian medical services. There may be occasions where this cannot be achieved because of security or resource constraints and so the options may have to move to the left of the slide. As described in the narrative from a medical officer cited above, there may be occasions where there is no alternative to ISAF providing both medical services and security. However this should always be considered to be the short-term solution to meeting an urgent healthcare need and there should be a plan to move the relationships to the right of the slide. This fits within the SCHBT construct.

Figure 1 Supporting Development

SUPPORTING DEVELOPMENT



Goal : Afghan to care for Afghan



Security	ISAF	ISAF	ANSF	ANSF	Not required	
Medical Care	ISAF	ANSF	ANSF	MoPH <small>Mobile clinic</small>	NGO BPHS	MoPH BPHS



Key
ISAF – International Security Assistance Force
ANSF – Afghan National Security Force
MoPH – Ministry of Public Health personnel
NGO – Non-Government Organisation
BPHS – Basic Package of Health Services

Increasing
 Local, Afghan security
 Local health capability
 Decreasing
 International involvement

SHAPE. Military medical representatives should be actively engaged with representatives from the indigenous health sector during the formulation of the District Stabilisation Plan. At the local level, this ensures that the location, capability and capacity of the civilian health facilities are known and that this information can be compared with the reported community’s grievances. It may be appropriate to use military transport (e.g. helicopters) to assist Afghan or international civilians to visit Districts in order to conduct ‘health shuras’. The most important outcome for the security forces medical services is to agree the roles and responsibilities for the management of civilian casualties that may

occur during the surge of security operations during the Clear phase, continuously stressing civilian primacy. As a last resort, it may involve acceptance of civilian casualties into the military medical system, both Afghan and international, and should include agreement on hand-off arrangements back into the civilian health sector. Figure 2 illustrates two of the many co-ordination meetings amongst the health sector stakeholders in Kandahar City.

Figure 2 Enabling Governance of the Afghan Health Sector

ENABLING GOVERNANCE OF AFGHAN HEALTH SECTOR

Figure 2 RC (South) News Volume 4, Issue 3

Medical care in the Kandahar City region

Story and photo by Sgt. Aaron L. Rosencrans, RC (South) Media Support Center

KANDAHAR, Afghanistan (November 20) - Representatives from three hospitals met at Camp Hero's Kandahar Regional Military Hospital (KRMH) on Nov. 17 to enhance communication and cooperation between medical facilities in the Kandahar City area.

While the leaders were conducting the meeting, Afghan surgeons were performing their first complex orthopedic surgery with minimal assistance from ISAF mentors. The surgeons treated an Afghan man whose leg was injured in a car accident. The surgery marked a milestone in the rapid improvement of the infrastructure and level of care at the KRMH.

Senior staff from the KRMH, Kandahar's Mirwais Hospital and Kandahar Airfield's Hospital participated in the conference. They discussed issues including the levels of care provided at each facility, and how to more efficiently transfer patients to the hospitals.

Afghan National Army Col. Abdul Basir, Commanding Officer of the KRMH, commented on the improvements at the Camp Hero facility. He said the hospital started operating in an old school in the area, providing whatever care they

could with the limited space and resources they had. The hospital did not have a proper operating room, or enough supplies to adequately treat their patients - Afghan National Security Forces and local residents.

Two years later, Col. Basir's physicians have modern technology, proper facilities, and a new 50-bed facility, which will allow the hospital to care for a larger number of patients.

"I am very proud of the level of training that we currently have...the future looks very promising,"

Colonel Abdul Basir

"We've been here for quite a lot of time and covered a lot of issues," he said. "I think the most important thing to take away from this meeting is we need to do it again and continue to do so in the future."

KANDAHAR MAJOR INCIDENT PLANNING





Col. Martin Reichselt (left) and other ISAF medical staff meet with Col. Abdul Basir (center) at the ANA's Kandahar Regional Military Hospital.

The information about civilian medical facilities can be compared with the Provincial Director of Public Health's Plan in order to discuss the factors influencing the community's access to health services and ways to mitigate the shortfall. This process can lead to agreement on the priority for refurbishment of clinics and confirmation of the availability of manpower and operating costs once the buildings are ready for use. It may be appropriate to use military money, such as US Commanders' Emergency Relief Programme (CERP), as funding for capital investment. This may require military engineer reconnaissance to establish the statement of work and the submission of funding applications into a military contracting process.

CLEAR. The focus of this phase is the emergency care of casualties from conflict. It may be necessary to remind the operational planners of their duties under the Geneva Convention, particularly to avoid targeting known healthcare facilities. There will need to be close co-operation across the health sector to ensure all casualties are transported to the most appropriate health facility for both immediate and long-term care. An example was the facilitation of safe passage of casualties across military lines brokered by the ICRC during OP MOSHTARAK in Feb 2010. This generated discussion over the authority of both international forces and Afghan forces to screen these casualties to identify wounded insurgents. It was emphasized that all casualties have right of access to medical care independent of allegiance but the Afghan security forces have the authority to detain them whilst in medical care for further investigation. It may be necessary to provide military support to provision of emergency medical supplies to the civilian

sector, ideally by assisting with the transport of previously earmarked resources or by emergency donation.

HOLD. During the Hold phase, there may be a gap between the imposition of military control and the ability of the civilian sector to establish routine medical services. During this period it may be necessary to provide access to healthcare using temporary, mobile services. Ideally this should be done using civilian capacity which would have been agreed with the Provincial Director of Public Health during the planning in the Shape phase. If there is obvious unmet need that is undermining confidence in the security operation, there may be a case for military medical services providing this medical care for the civilian population following the model shown in Figure XX. Ideally this should be done using Afghan forces but may require international military assistance. All cases of military involvement should be planned as a bridge to a civilian solution and both the necessity and method should be agreed with the civilian sector prior to military involvement. Military forces should use this period to assess the planned location of clinics in order to confirm the reconstruction and development requirements within the health sector element of the District Stabilisation Plan.

BUILD and TRANSFER. Ideally there would be no international military medical engagement during the Build and Transfer phase because the implementation of the District Stabilisation Plan would have been handed back to civilian leadership. In reality there should be continuing dialogue between all the health sector stakeholders to ensure co-ordination and co-operation. There may be scope for the international military medical

community to continue to assist the civilian health sector through training and education programmes, access to capital investment or other capacity building activities.

Conclusion

This paper has described the macro construct for the engagement of international military medical forces with the Afghan health system alongside other national and international stakeholders. It describes some of the realities of healthcare delivery in Afghanistan including the complexity of the public/private market at a local level. The paper closes by examining the roles of military medical services in the ‘Shape-Clear-Hold-Build-Transfer’ construct for COIN operations.

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