ORIGINAL PAPERS

ROLES FOR INTERNATIONAL MILITARY MEDICAL SERVICES IN STABILITY OPERATIONS (RECONSTRUCTION AND DEVELOPMENT)

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Abstract

This is the last in a series of three papers that provide a discussion on the wider roles of military medical forces in stability operations. It examines the framework for civil-military co-operation in humanitarian operations and complex emergencies. It then introduces the non-military components of 'stability' operations and examines the military role in reconstruction and development. The paper examines the potential capabilities of military medical services in providing medical support for non-military populations, Village Medical Outreach Programmes and medical infrastructure projects.

Introduction

Since the Gulf War of 1990, the employment of military forces has changed from that of protecting against direct threats to national interests to that of promoting national and international stability. Two previous papers have considered the impact of stability operations on health service support to military forces and the role of military medical services in security sector reform. Military operations in Iraq and the Balkans extended the traditional role of military medical services from that of provision of medical services to national military forces to include humanitarian medical support to civilian populations. This paper examines the role of military medical services in supporting civilian populations and discusses the organisational capabilities required to meet this mission.

Background

During the 1990s, international military forces have been used to support interventions in 'complex, humanitarian emergencies' in Bosnia, Kosovo, Rwanda, Somalia and Haiti. A complex emergency, as defined by the Inter-Agency Standing Committee of the United Nations (IASC), is *"a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country programme."* In this new operational environment military forces have been used to create security and stability to enable the restoration of civil order and a political process. This has resulted in a new interest in the civil-military interaction and a requirement for direct military involvement with International Agencies (IAs), such as the United Nations, and with Non-Government Organisations (NGOs) such as the International Committee of the Red Cross. Military forces have seen the potential value of 'civil-action programmes' as means to engender support for their activities by the local civilian population. This has become more than pure 'humanitarian assistance' in that the purpose is to achieve support for political and military objectives rather than solely saving lives and alleviate suffering of a crisis-affected population. The military approach to operations in Iraq and Afghanistan has further reinforced the use of military capability in direct support of the local population through the use of civil-military Provincial Reconstruction Teams (PRTs) as a channel for the expenditure of national funds on development projects. Thus military commanders have taken a more direct interest in the role of civil-military co-operation (CIMIC).

The language of military operations has also changed to include a new phase of a military campaign: 'stability operations'. This is defined as *'military and civilian activities conducted across the spectrum from peace to conflict to establish or maintain order in States and regions'* (1). It includes stabilization, security, reconstruction and transition operations, which lead to sustainable peace. Campaign objectives in this new environment include developments along diplomatic, information, military and economic themes (DIME). The military medical services can provide support to civilian communities by replacing or supplementing the existing local health facilities and assisting with the regeneration or development of local health systems coordinated with local authorities, local communities, International Agencies (IAs) and non-Governmental Organisations (NGOs). Thus the output of military medical services extends from purely medical support issues to effects which impact on the total force mission (2).

The strengths and weakness of military forces for humanitarian operations are well rehearsed. These include strengths in: command and control, deployability, logisitics, sustainability, security, discipline, and integration. Weaknesses include: political short-termism, expense, political rather than institutional humanitarianism, and an emphasis on military rather than local needs (e.g. food rations). The increasing casualty toll amongst humanitarian organisations has also led to a demand for an explicit separation between military forces and humanitarians in order to create 'humanitarian space' between parties to a conflict in which the needs of civilian non-combatants can be met. UN humanitarian agencies and other humanitarian NGOs rely primarily upon their neutrality for security and use negotiation rather than implied military capability as the principal means of gaining safe access to the affected population. This contrasts with the diplomatic and military view that regards the integration of all themes as the key to creating sufficient support amongst the local population to drive out those who oppose the restoration of

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security and stability. Furthermore military medical forces also have obligations under the Geneva convention and other ethical frameworks to also ensure separation between military health services and military objectives.

The United Nations has published a number of international guidelines that represent consensus in the reconciliation of these cultural conflicts in humanitarian emergencies. UN General Assembly Resolution 46/182 states that humanitarian assistance must be provided in accordance with the principles of humanity, neutrality and impartiality. For the first, human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women and the elderly. The dignity and rights of all victims must be respected and protected. Humanitarian assistance must be neutral and provided without engaging in hostilities or taking sides in any political, religious or ideological conflict. Finally, humanitarian assistance must be provided without discrimination as to ethnic origin, gender, nationality, political opinions, race or religion. UN guidelines for the use of military and civil defence forces in complex emergencies limit such involvement to situations where there is no comparable civilian alternative and only the use of military assets can meet a critical humanitarian need (3). Humanitarian assistance for the relief of the suffering must be guided solely by needs and priority must be given to the most urgent cases of distress. The use of military and civil defence resources should under no circumstances undermine the perceived neutrality or impartiality of the humanitarian actors, nor jeopardize current or future access to affected populations. The UN cautions *'while motivation for this (involvement in civil affairs by military forces) can be purely humanitarian and needs based, assistance can also be motivated by a desire to legitimize missions, gain intelligence, and/or enhance protection of forces. Unilateral support of this nature can be inappropriate, lack longevity, and can disrupt assistance that forms part of a coherent immediate and long term programme'.*

Operational experience in Kurdistan, the Balkans, Afghanistan, Iraq and Somalia have necessitated various forms of civil-military coordination for humanitarian operations and have led to an erosion of the separation between the humanitarian and the military space. This led to the publication of a series of principles by the United Nations to bind both parties in the civil-military relationship in a complex emergency (4,5).

However these guidelines are restricted to the civil-military interaction in the 'humanitarian assistance' phase of a complex emergency. Experience in Iraq and Afghanistan has shown that the 'humanitarian' community and the 'military' community have to remain engaged as a complex emergency transitions into a counter-insurgency campaign (waged on behalf of a legitimate political framework) within national plans for reconstruction and development. After the immediate tasks of provision of security, restoration of essential services, and supporting humanitarian needs are met, the international community must shift the campaign to the development of indigenous capacity to secure essential services, a viable market economy, rule of law, democratic institutions, and a robust civil society. In this respect, military forces will be operating within the framework of national and international legitimacy and thus are an integral element of the multi-dimensional solution to the complex emergency.

Natsios (6) has proposed nine principles for Reconstruction and Development, comprising ownership, capacity building, sustainability, selectivity, assessment, results, partnership, flexibility, and accountability. These are based on the extensive experience of USAID working alongside the US military in a number of complex emergencies. Table 1 shows both the UN principles and Natsios' principles. Both lists promote an ethical framework for military involvement with indigenous civilian communities within the context of a continuum of military operations from combat through stability operations towards restored and functioning nation states.

according to IASC(4)	*according to* Natsios(6)	
A. Humanity, Neutrality and Impartiality	1.	Ownership
B. Humanitarian Access to Vulnerable Populations	2.	Capacity building
C. Perception of Humanitarian Action	3.	Sustainability
D. Needs-Based Assistance Free of Discrimination	4.	Selectivity
E. Civil-Military Distinction in Humanitarian Action	5.	Assessment
F. Operational Independence of Humanitarian Action	6.	Results
G. Security of Humanitarian Personnel	7.	Partnership
H. Do No Harm	8.	Flexibility
I. Respect for International Legal Instruments	9.	Accountability
J. Respect for Culture and Custom		
K. Consent of Parties to the Conflict		
L. Option of Last Resort		
M. Avoid Reliance on the Military		

Table 1: Principles for Civil-Military Relationships in a Complex Emergency and Reconstruction and Development

Principles for the Wider Employment of Military Medical Forces

The military element of the international community is unique in that it deploys as a fully integrated package including medical support. Military medical services may be the only medical capability in remote areas and in areas with poor security, and thus military medical services may be the only source of medical care for other IAs and NGOs operating in this environment. This same principle may apply to local security forces, especially if they do not have a well-developed medical service and they are operating alongside international military forces. The Geneva Convention and other international law mandates minimum standards in the health care of detained individuals, even if they are not classed as prisoners of war. Therefore detainees may also become a defined dependant population. Finally there is the local community; in the event of life or limb threatening emergencies this group has access to military medical care under humanitarian grounds. However any extension of military medical support for the local population beyond this definition requires very careful consideration for the principles described above and the detail described below. Non-military populations potentially eligible for military medical support during stability operations are summarised in Table 2.

International Agencies/Non-governmental Organisations
Local security forces
Detainees
The local community

Table 2: Potential Military Medical Support to Non-military populations in stability operations.

When considering the employment of military medical forces beyond the provision of medical support to 'own' forces, a clear

understanding of the philosophy behind such assistance is required in order that the affected civilian population may be best served, both in the short and longer term. Wilensky has recently reviewed the effectiveness of the military medical programmes in support of civilian populations during the Vietnam War (7). He identifies 7 principles for these activities that are shown in Table 3.

1. The value must be based on training the indigenous population to care for themselves.

2. Civilian care programmes are always a secondary mission to providing medical care for military forces.

3. Medical intelligence of disease prevalence obtained from caring for the local population is useful.

4. Supporting the development of the indigenous healthcare infrastructure must be determined by what the local population needs and is prepared and resourced to support.

5. Military medical care programmes for local civilians can be effective in advancing campaign objectives.

6. The objective must be to engender support for the local government, not foreign forces.

7. Military support to civilian aid programmes can only be effective if the civilian population has a need and such activities fit wider campaign objectives.

Table 3: Principles for Military Medical Engagement in Civilian Health Care Programmes

In principle the affected population should be encouraged to help themselves and military medical assistance should only be provided on a subsidiary basis when IAs or NGOs are unable to meet the overall requirement. This should be carefully defined to avoid competition and also to avoid either duplication of effort or gaps in the overall care provided. Military medical services are structured to provide the best possible care for military forces and may exceed the technology available within the host nation. Any clinical care provided to the indigenous population should take into account aspects such as the availability of medical follow-up capabilities, military means and resources and the need to have sufficient capabilities and capacities left for support of the military force. Even if there is a clear health need, the military response should be designed to enable sustainment by the local community with the final outcome being the establishment of the local civil medical infrastructure under local political control. Alongside these clinical sensitivities, it is vital that medical services are tailored to local socio-cultural and religious customs and rules. This particularly applies to the role of women within health professions and in the care of local women. Finally, military medical services must be employed in a manner consistent with their non-combatant status under the Geneva Convention. Although under military command, tasks given to military medical services must be in accordance with clinical need and should not be dependant on engagement with military operations such as intelligence collection – though it is legitimate to conduct this in parallel but using separate organisations.

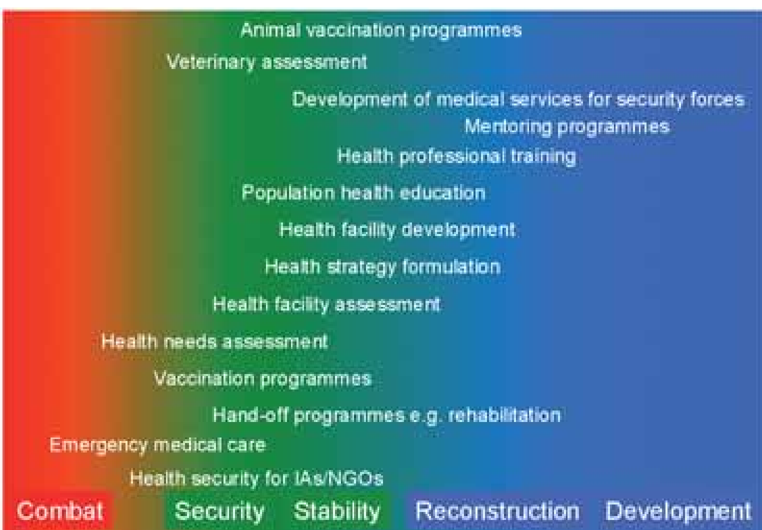

Figure 1 Examples Of Military Medical Activities In Support Of Civil Populations

Military medical forces have the potential for involvement in a wide range of activities in support of non-military populations within stability operations (Figure 1).

Figure 1 also highlights areas beyond pure medical treatment where military medical services may have an effect. This includes technical assessment and planning, public health interventions such as vaccination and health education through to training and mentoring local health providers. These capabilities extend beyond just doctors to include nurses, paramedics, laboratory technicians, physiotherapists, environmental health specialists, dentists, optometrists and veterinary surgeons. Many military medical services are able to access particular specialist advice through the deployment of reserve forces.

Provision of Direct Clinical Care by Military Medical Services

As stated earlier, military medical services have an ethical duty on humanitarian grounds to provide emergency medical care to any patient, particularly those from a vulnerable group. This does not mean automatic access to the full national military medical evacuation chain but should be limited to treatment within the country of origin, care appropriate to local capability for further management, and early hand-off to local medical providers or health-related IAs/NGOs. The definition of emergency may be difficult and there may be pressure from external agencies to facilitate access to military medical services as a source of influence. Furthermore there have been occasions where opposition groups have used simulated patients as an attempt to bypass security systems. Thus the management of access to military medical treatment facilities by the local population requires a form of access control. This should usually include a security check (balancing cultural norms with security imperatives) and a preliminary medical assessment to determine need. This preliminary medical assessment should also determine whether the military medical facility has the resources to influence the patient's clinical outcome. As local medical services develop, this assessment process should be based on a formal referral from a local medical practitioner – but the military medical services should ensure that this arrangement is not exploited for personal gain. Joint clinical casework can be a further refinement of referral, where military medical personnel visit local medical facilities as part of a mentoring programme and agree to jointly manage cases with local practitioners. Joint clinical casework has the potential to increase knowledge and understanding between medical personnel from both settings and can also be used as a mechanism to role model more 'Western' styles of clinical care involving multi-disciplinary teams including nurses, physiotherapists and other practitioners in holistic care of patients. All clinical care should be in accordance with local capabilities and cultural norms. This includes ensuring that all medication is prescribed in accordance with local formularies and ensuring that hand-off or discharge arrangements reflect the realities of providing continuing care in the local community. It would normally be inappropriate to initiate medical care for chronic, long-term conditions that require continuing medical supervision and treatment unless this has been very carefully co-

ordinated with local medical providers, possibly including NGOs, and included such issues as care at home and financial support.

Example 1 – US Military Medical Programmes in Vietnam

During the Vietnam War US military medical services ran a number of programmes in support of the civilian community through such efforts as PHAP (Provincial Health Assistance Program), MILPHAP (Military Provincial Health Assistance Program), MEDCAP (Medical Civic Action Program), and CWCP (Civilian War Casualty Program). Apart from the humanitarian aspects of the various civilian medical assistance programs, this involvement provided US, medical personnel gainful and rewarding activity during lulls between peak military medical support requirements. This, in turn, contributed to the high morale of committed U.S. "medics."(8)

The provision of direct clinical care can be very rewarding to military medical practitioners but introduces a number of practical and ethical challenges that are not normally present in 'western' clinical practice. As the military operation evolves from the immediate post-conflict phase, it is vital that any clinical support is fully co-ordinated and integrated with the prevailing local health economy. There should be no suggestion that the presence of a military medical treatment facility is distorting or undermining the regeneration and development of long-term medical services for the local community. This includes being sensitive to the way in which local medical care is financed (i.e. to not provide free treatment if local providers have to raise charges) and ensuring that all costs are covered by the military medical services. It is vital that military medical staff are aware of these issues before deployment and recognise that their primary duty remains to provide care for the military community.

Example 2 - Managing obstetric emergencies and trauma – MOETs courses.

In Basra in Iraq, the military hospital has been used as a base to host a visiting team of non-military specialists in obstetrics and gynaecology to teach a short course in the management of obstetric and trauma emergencies to local Iraqi doctors. This provided a secure environment for the hosting of the course for both the visiting specialists and also the visiting local doctors. The course is an internationally recognised course, adds clinical credibility to the local doctors and also provides a tangible way to re-integrate Iraqi medical staff into the international medical community (9).

Medcaps or Village Medical Outreach Programmes

Engagement and consent of the local population is the key to success in counterinsurgency operations (10). In this respect, civil-military operations have been termed 'hearts and minds' operations. These have been characterised by images of military medics handing out pills and potions but, unfortunately, it is precisely these images that have led to criticism of the engagement of military medical services with 'hearts and minds' operation because of the transient and limited impact of such operations on the actual health of the local population.

The opening discussion on civil-military co-operation highlights military capabilities that can be vital in providing humanitarian support to a local population. Furthermore, it is vital that military forces are able to engage with the local community and provide tangible benefits to these communities of such an engagement. Military medical services are a legitimate instrument for such engagement, but, for the reasons described earlier, this must be done in conjunction with humanitarian and ethical frameworks. Whilst these programmes have been called MEDCAPs (Medical Civil Action Programmes), I prefer to use the phrase 'village medical outreach programmes' (VMOP).

VMOPs must be integrated within the overall military mission and must be planned and conducted to the same standard as any conventional military activity. This includes reconnaissance and assessment, pre-deployment rehearsals and preparation, and attention to security and logistics. It is useful to consider the appropriate composition of the team including medical, dental and veterinary staff. It has been found that female medical staff are particularly valuable because cultural taboos make it almost impossible for male medical staff to examine patients. Health activities within VMOPs should be consistent with the national health strategy and contribute towards the end-state of the national government meeting the needs of the local population within its own resources. These activities should combine assessments and surveys (such as disease detection, child health), public health interventions (immunisation, vitamin supplementation and health education) and direct medical treatments so as to achieve the maximum impact on the health of the village. Specific examples of such activities are shown in Table 4. VMOPs can be used as a means to assist local health officials and providers to access rural populations and ideally much of the actual health activities should be delivered by local staff. They can also be used as a means of education and mentoring local health staff.

Public Health Assessments:

General resources: Food, water, shelter, security and employment.
General health: mortality, burden of disease, specific disease surveillance
Child health: height, weight, body fat, immunisation uptake

Public Health Interventions:

Lower the high maternal mortality rate:
Review women of child bearing age
Provide assistance to midwife training programs
Provide multi-vitamin, iron, and folate therapy for women of child-bearing age
Provide health education on: the importance of pre- and post-natal care, breast feeding, nutrition, basic sanitation, maternal/child health, malaria, family planning

Lower the infant mortality and under-five child mortality rates
Assess height/weight/skin fold thickness
Provide assistance to ministry of health expanded program of immunizations (EPI)
Provide de-worming treatment for children
Promote use of oral rehydration therapy iodized salt, chlorine,
Promote use of insecticide-treated bed nets

Treatment Interventions:

Diagnosis and treatment of short-term conditions
Facilitated referral

Table 4: Examples of Health Activities undertaken within Village Medical Outreach Programmes

Over the period 18/19 April 2006, 500 people and 1500 animals were seen in a VMOP conducted in Khas Uruzgan by Afghan soldiers, Afghan doctors, US medical staff and veterinarians. At the invitation of the village doctor, Coalition and Afghan forces deployed to secure the village from any threat and established crowd control. Then US technical staff worked alongside the local doctor to provide clinical care, vaccinations and dental care to the local villagers and their animals (11).

Example 3 – US VMOP

Development of Medical Facilities

The renovation and construction of infrastructure medical facilities has been a natural extension of military 'hearts and minds' projects. Alongside examples of successful medical constructions projects are examples of decaying empty buildings that have no staff, have been ransacked of equipment and not provided any practical improvement in the health care available to the local population. Whilst the opening of medical facilities can be an important milestone in engaging the local population, it is vital that this investment is safeguarded for the long-term by ensuring the project lies within a wider health programme and is sustainable in terms of staff, equipment, consumables and local community commitment. There are very few indications for the use of military field hospitals for humanitarian aid and development (12).

The renovation and construction of infrastructure health projects should be planned and co-ordinated with local and national health officials. Any infrastructure health project should start with a full needs assessment both in terms of the population and the requirements of the individual facility. The project should comply with local and national plans. Ideally the project should be used as a lever to develop local medical planning capacity and therefore should involve local health officials and any IAs/NGOs that may be legitimate stakeholders. The project plan should ensure the integration of all components: money, facilities, people, intellectual process, capital equipment, consumables. It is vital that all technology and equipment is appropriate to the local circumstances. Specific technological solutions, such as solar-powered refrigerators, may be better than conventional equipment. It should also include a post-completion plan to include follow-up engagement with key stakeholders, review of the use and maintenance of equipment, resolution of unforeseen problems and continued integration with local health plan. The whole process is summarised in Table 5.

- **Reconnaissance**
- **Project proposal:** analysis of demand, need, infrastructure, equipment, staff, training, consumables, funding, long-term support
- **Co-ordination (internal & external):** local representatives, MoPH military, IAs/NGOs etc
- **Project funding submission and award of funds**
- **Appointment of a local project officer**
- **Procurement of goods and supplies**
- **Local works**
- **Pre-handover training and familiarisation of equipment**
- **Formal handover**
- **Follow-up and post-project evaluation**

Table 5 Medical Infrastructure Project Process

A successful medical infrastructure project can be very rewarding for all involved as well as making a substantial difference to the local population served by the facility. However there are a number of pitfalls to avoid. Examples are listed at Table 6.

Table 6 Pitfalls to avoid in medical infrastructure projects

Providing field hospitals
Planning projects not programmes
Listening to only one opinion
Focussing on infrastructure rather than capability
Focussing on physical capital rather than human capital
Providing treatment solutions without considering prevention
Providing inappropriate technology
Providing 'one-off' donations of consumables
Concentrating on doctors without considering 'low-technology' health providers
Considering healthcare as only medical care (remember dental care, optometry, environmental health, veterinary programmes)

Conclusion

Military forces are a key component of 'Stability Operations' and can play a role within the 'reconstruction and development' agenda as well as the more military roles of imposition of security and Security Sector Reform. Whilst there are established guidelines for the role of military forces and military medical forces in the provision of humanitarian aid, the policy framework for longer-term engagement of these forces in reconstruction and development is less well defined. The paper has discussed three specific roles for military medical services: direct clinical care, Village Medical Outreach Programmes and the development of health facilities. All of these roles demand additional knowledge and skills beyond those required for medical support to a purely military population.

References

1. Department of Defense DIRECTIVE NUMBER 3000.05 November 28, 2005 Military Support for Stability, Security, Transition, and Reconstruction (SSTR) Operations
2. Allied Joint Publication 4-10(A) Allied Joint Medical Support Doctrine NATO
3. Guidelines on the Use of Military and Civil Defence Assets to Support United Nations Humanitarian Activities in Complex Emergencies (March 2003) http://ochaonline.un.org/DocView.asp?DocID=426 accessed Jul 2006
4. Civil-Military Relationship In Complex Emergencies - An IASC Reference Paper - Inter-Agency Standing Committee Working Group (IASCWG) as an IASC Reference Paper at its 57th Meeting of 16-17 June 2004. It complements the "Guidelines on the Use of Military and Civil Defence Assets to Support United Nations Humanitarian Activities in Complex Emergencies" of March 2003.
5. Relationships with Military Forces in Afghanistan – Guidelines for UNAMA Area Coordinators and other UN Personnel (2002) http://ochaonline.un.org/webpage.asp?Page=999 access Jul 2006
6. Natsios AS. Parameters, Autumn 2005 The Nine Principles of Reconstruction and Development.
7. Wilensky RJ. Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War. Texas Tech University Press. 2006.
8. Spurgeon Neel. Medical Support Of The U.S. Army In Vietnam 1965-1970 Department Of The Army Washington, D.C., 1991
9. Dr J Ryan. Personal Communication. Feb 2006.
10. Kitson F. Bunch of Five. London. Faber & Faber. 1977
11. Doctors Visit Khas Uruzgan. Coalition Forces Command – Afghanistan. Afghanistan Freedom. 8 May 2006 pp8-9.
12. WHO-PAHO Guidelines for the Use of Foreign Field Hospitals in the Aftermath of Sudden-Impact Disasters Area on Emergency Preparedness and Disaster Relief Pan American Health Organization Department of Emergency and Humanitarian Action World Health Organization International meeting Hospitals in Disasters—Handle with Care San Salvador, El Salvador, 8–10 July 2003 PAHO Washington DC 2003