Saving Lifes – A COIN Effect

Slide 1 – Saving Lives – A Coin Effect?

Sirs, Ladies and Gentlemen. I am Colonel Martin Bricknell, I am currently coming to the end of my one year tour as the Medical Director in Region Command (South) This is my second tour in Afghanistan, having done a similar job in HQ ISAF in 2006/7.

My presentation will argue that saving lives, be they ISAF, Afghan security forces or Afghan civilian is a COIN effect. What I hope to show is some ideas of activities at the tactical level that deliver this effect.

Slide 2 What is a COIN effect.

Whilst intuitively we might all agree that saving lives is a COIN effect, we do need to understand why. Firstly it is an essential element of maintaining domestic support for the international mission. As we have seen in the US over issues with the Walter Reed hospital, national media has intense interest in the quality of care for injured soldiers. The second effect is on the moral component of fighting power for the ANSF in the same way as it impacts on ISAF forces. The third effects is in the demonstration of the effectiveness of the government of Afghanistan in meeting the essential needs of its population.

Slide 3 Whose life?

So whose life should be saved? Clearly prevention is better than cure.

Slide 4 Afghanistan health indicators

We are probably all aware that Afghanistan has some of the worst health indicators of any country in the world across all forms of measurement. However the underlying cause of this inauspicious fact is insecurity – consequently the most important effect of the security operation on health would be to increase access to civilian health services by the Afghan rural population. This does not require the intervention of ISAF or ANSF medical services.

Slide 5 Casualties of conflict

Maybe we should refine our COIN effect to casualties of conflict?

Slide 6 Whose life?

Statistics available from the internet show that Afghan civilian deaths are about 5 times higher than Afghan security force deaths, which in turn are about equal to ISAF deaths. The figures for Afghan casualties from conflict may not be exactly accurate but, they do emphasise the point that Afghan civilians are taking the brunt of the conflict.

Slide 7 COIN Lesson 1

This draws out my first COIN Lesson - COIN health effects should support care to all three populations, ISAF, ANSF and Afghan civilian.

Slide 8 Indigenous health sectors

At the macro level, there are multiple actors in the Afghan Health Sector. The Ministry of Finance is responsible for the allocation of funds from both national and donor sources to each Ministry which provides health services. In addition, 3 major donors – the World Bank, United States Agency for International Development (USAID) and the European Union directly manage funds for the provision of health services. In turn, the Basic Package of Health Services is actually delivered by NGOs to the MoPH policy framework. The Ministry of Public Health is responsible for the procurement of curative care, public health, and preventive medicine services for the whole population. The Ministry of Higher Education has responsibility for Health Education and Training. This ministry both runs medical facilities to be able to place students into health-service delivery environments and to maintain the clinical practice that clinical teachers need. The Ministry of Public Health is the lead ministry for Emergency Preparedness and Response but both the Ministry of Interior and the Ministry of Defence own command and control centres and ambulances that respond to security incidents. The Ministry of Defence is responsible for the provision of health services to the armed forces. The Ministry of Interior is responsible for medical support to the Police and also the provision of medical care to detainees/prisoner.

Slide 9 COIN Lesson 2

My second COIN Lesson is that indigenous health sectors are complex and do not necessarily match Western models.

Slide 10 Health sector relationships in Kandahar province.

This slide illustrates health sector inter-relationships at the local level in Kandahar. Dr Pukla is the Director of Public Health, Colonel Hakim is the Command Surgeon for 205 Corps, Colonel Baseer is the Commanding Officer of the ANA Kandahar Regional Military Hospital, KRMH. Col Sefat Shah is the Command Surgeon for the ANP 404th Maiwand Police Zone and I am the Medical Director for Regional Command (South).

Slide 11 Missions and tasks

This same inter-relationship is covered in the mission and tasks for medical forces in Regional Command (South). I am responsible for the co-ordination of medical support to ISAF entitled casualties of conflict, for the ISAF assistance to the development of medical support to the ANA and ANP, and for ISAF medical engagement with the civilian health sector.

Slide 12 COIN Lesson 3

COIN Lesson 3 is that ISAF medical forces have 3 tasks – caring for casualties of conflict, supporting development of ANSF medical services, and appropriate engagement with the Afghan civilian health sector.

Slide 13 RC(S) Casualty Flow

Within RC(S) we consider 5 dependant populations – Afghan civilians, ANA, ANP, ISAF, and Detainees. Each flow into one of 3 hospitals in Kandahar, the civilian regional hospital Mir Weis, the ANA KRMH and the ISAF Kandahar Role 3. The flow out also depends on their final destination – ranging from home for Afghan civilians to strategic aeromedical evacuation to native country for ISAF casualties. We need to collectively manage the medical system so as to ensure this system is in balance – the essence of medical planning.

Slide 14 COIN Lesson 4

This is COIN Lesson 4 – the capacity of the hospital system for casualties of conflict needs to ensure balance between inflow, capacity and outflow.

Slide 15 Situation in RC(S)

The reality in most of Afghanistan is that there is no publicly funded, ventilated ICU bed in a civilian hospital. Hospital care is variable and reflects limited nursing capability, supplementation of publicly funded care with out-of-pocket costs and limited increase in patient care by moving between public hospitals. It will take considerable time to substantially increase hospital care but the 3 components of the hospital capability, civilian, ANA and ISAF can collaborate to ensure the best possible care for casualties.

Slide 16 SCHB – T2?

This leads us into medical planning to support COIN operations. You are probably familiar with the ISAF doctrine of Shape, Clear, Hold, Build. I would like to add transition/transfer after build to represent the need to shift from development to sustainable provision of services by the indigenous government. A key COIN lesson is to plan from Back – the endstate – to Front. The slide shows some examples of activities in the health sector for each phase leading to provision of health services by the ministry of public health. This starts with health sector co-ordination during the Shape, being prepared to provide emergency care during the Clear, renovating health infrastructure and facilitating access to Afghan civilian mobile clinics in the Hold, and planned capital investment to support implementing partners during the Build phase.

Slide 17 SCHB T2 – Rainbow

An alternative model is to consider this as a spectrum of healthcare solutions dependant on threat. In the most insecure environments, the provision of security and healthcare might have to be provided in an emergency by ISAF – the so called MEDCAP. But this should be the exception as Afghan security and health provision should always be considered first.

Slide 18 COIN Lesson 5

The COIN lesson is that an ISAF delivered MEDCAP should only be done'in-extremis', and as agreed with Afghan officials during the SHAPE phase.

Slide 19 Combined Team – Shaping

What I would like to do now is illustrate the theory by considering some evidence of this in practice as demonstrated during the HAMKARI operations in RC(S). On the left of this slide is Dr Pukla, the Kandahar Director Public Health briefing his provincial health development plan at the Governor's Palace. On the right is the Kandahar city major incident medical response planning meeting that involved Dr Pukla, the ANA, ANP and ISAF.

Slide 20 MEDEVAC for Casualties of Conflict

In areas of conflict, ISAF and the ANA may be the only source of emergency medical care. This slide shows the RC South concept of operation for caring for casualties of conflict and their flow through the medical system to the appropriate medical facility. ISAF helicopter MEDEVAC is a key contribution to this system.

Slide 21. Gate keeping demand

ISAF clearly cannot underwrite all of the deficiencies in the Afghan health system. Indeed, it is vital that Afghans are cared for by Afghans whenever possible so there is a system of 'gate-keeping' that ensures appropriate transfer of Afghans from the ISAF medical system balancing clinical, cultural and social needs. If we start with the premise that ISAF will not evacuate Afghans from Afghanistan – the right hand side – the system imposes greater and greater 'filtration' on Afghans as they flow through the system.

Slide 22 COIN Lesson 6

The COIN lesson is that ISAF medical facilities must establish mechanisms to transfer Afghan patients back into the Afghan medical system.

Slide 23 Eligibility for MEDEVAC

The key to managing demand is the Medical Rules of Eligibility shown here. Essentially ISAF will provide life, limb or sight saving care for an Afghan if there is no suitable

alternative Afghan medical facility. This is adjusted depending on the workload in ISAF medical facilities in accordance with the colour-coded thresholds shown on the slide.

Slide 24 COIN Lesson 7

The COIN lesson is that medical rules of eligibility have to be established in order to ensure provision of medical care by international forces is both ethical and does not distort the market for indigenous health care.

Slide 25 Developing Afghan Health Sector Capability/Capacity

I would now like to discuss how ISAF medical forces can contribute to the development of Afghan Health Sector Capability/Capacity – activities that should be continuous through Shape, Clear, Hold, Build, Transition and Transfer.

Slide 26 COIN Lesson 8

My first point COIN lesson in this section, is that ISAF should concentrate on development of ANSF medical capabilities rather than the civilian sector as there are many other agencies that engage with the civilian sector.

Slide 27 Advising/Partnering Triangle

As we have moved from a train and equip mission to one of enabling the fielded force – our focus should be to use mentoring as an enabling activity to make partnering work. As an example – the best person to partner with an ANA Commanding Officer of hospital is the commander of an ISAF hospital – not a junior officer who have never done this job.

Slide 28 Advising/Partnering – enabling Afghans

My next point is that we need to shift our use of interpreters – particularly in the medical field – from that of enabling ISAF medical staff to care for Afghans to that of supporting Afghan medical staff to improve there care for Afghans. Given the market value of interpreters compared to government employees, we may need to look at some form of 'job share' so that Afghans employed to support international workers to communicate with Afghans might also be expected to perform some of the duties of the Afghan being communicated with.

Slide 29 COIN Lesson 9

The COIN lesson is that we need to ensure that our use of interpreters is not removing the very Afghan human capacity needed to reconstruct the country.

Slide 30 Embedded partnering Medical

I am not expecting you to read the detail of this slide, suffice to say that there are range of ways in which ISAF medical elements can work with and alongside Afghan medical elements. The exact activity will depend on the ISAF medical task, the security situation, the capability development need etc. I firmly believe that every ISAF medical unit should be required to nominate and activity partner with an ANSF medical element.

Slide 31 MEDEVAC

So some further examples. This shows an ISAF MEDEVAC aircraft landing at Kandahar Airfield – left side – with an ISAF ambulance collection, and on the right, an ISAF MEDEVAC aircraft landing at KRMH with an ANA ambulance collection.

Slide 32 KRMH – KAF R3. This slide shows different facets of partnering the KRMH. On the left a KAF R3 surgeon mentoring ANA surgeon operating on ANA casualty, supported by MTAG KRMH ETT, on the right a KRMH surgeon operating on ANA casualty mentored by MTAG KRMH ETT.

Slide 33 KRMH Admissions.

This slide is the evidence that investment, mentoring and partnering achieves results. The slide shows the monthly number of admissions at KRMH, illustrating the significant increase in clinical work over the past year. We are at the stage in RC South that all MEDEVACs for Afghans are taken directly to KRMH and only transferred to KAF Role 3 if KRMH needs clinical assistance.

Slide 34 AAF TACEVAC-451 EAES

A further positive example is the development of ANA tactical aeromedical evacuation from KMRH to Kabul. Through partnering with the USAF aeromedical evacuation squadron at KAF supported by USAF mentors the Afghan Air Force has been doing regular medical escorted flights since September.

Slide 35 COIN Lesson 10

The COIN Lesson from this is that partnering by ISAF medical units can substantially increase the pace of ANSF health services development beyond mentoring alone.

Slide 36 CERP macro capital investment

Although I have concentrated on ISAF support to the development of the ANSF health services, the Provincial Reconstruction Teams can play a vital role in the civilian health sector alongside the Ministry of Public Health, international agencies and NGOs. The critical game changer is the use of US Commander's Emergency Relief Programme, CERP, money as a capital investment. This slide shows how a 2.7 million dollar CERP project to build a new location for the Kandahar Nursing and Midwifery School can lead to improved capacity in the public medical system in Kandahar in both the short and

medium term. This is the largest investment in the health sector in the South of Afghanistan since the 1970s and is a good COIN example of CERP investment to improve the provision of basic services for the Afghan population.

Slide 37 CERP micro capital investment

The same principle can be applied at the micro level. This slide provides an example of how an initial investment in building comprehensive health centres was not fully linked in to the BPHS provider. However, as a result of the co-ordination during the shaping phase of HAMKARI, it was agreed that security, staff, drugs and operating budget were in place to properly open this medical centre through a CERP funded refurbishment programme.

Slide 38 COIN Lesson 11

The COIN Lesson is that CERP can be used as a game-changing capital investment in the development of Afghan civilian health services but must be full co-ordinated with all stakeholders.

Slide 39 legality, legitimacy, intent

In closing, I would highlight that not all activities by ISAF forces in the civilian health sector have been positive – but we have learned from our mistakes. COMISAF has issued direction to ISAF forces not to enter Afghan medical facilities except when specifically invited and with the appropriate force protection posture. HQ ISAF has issued policy guidance direction ISAF to avoid the direct provision of medical care to Afghan civilians, MEDCAPS, except for the specific circumstances I described earlier under the Shape, Clear, Hold, Build, Transition, Transfer construct.

Slide 40 Questions

I would be delighted to take any questions you might have.