

## ORIGINAL PAPERS

# ROLES FOR INTERNATIONAL MILITARY MEDICAL SERVICES IN STABILITY OPERATIONS (SECURITY SECTOR REFORM)

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## Abstract

**This is the second in a series of three papers that examine the role of international military medical services in stability operations in unstable countries. The paper discusses security sector reform in general terms and highlights the interdependency of the armed forces, police, judiciary and penal systems in creating a 'secure environment'. The paper then looks at components of a local military medical system for a counter-insurgency campaign operating on interior lines and the contribution and challenges faced by the international military medical community in supporting the development of this system. Finally the paper highlights the importance of planning the medical support of the international military personnel who will be supporting wider aspects of security sector reform. The paper is based on background research and my personal experience as Medical Director in the Headquarters of the NATO International Stability Assistance Force in Afghanistan in 2006.**

## Introduction

This paper is part of a series of three papers that examine the role of international military medical services in stability operations in unstable countries. Recent military operations in Iraq and Afghanistan have widened the role of military forces to include 'stability operations'. The US Department of Defense defines 'stability operations' as '*military and civilian activities conducted across the spectrum from peace to conflict to establish or maintain order in States and regions*' (1). This operational task includes helping to develop or rebuild indigenous institutions including various types of security forces, correctional facilities, and judicial systems necessary to secure and stabilize the environment – so called 'security sector reform'. The international community provides this help through a combination of governmental or international organizations and military forces. The paper will examine the contribution and challenges involved in supporting security sector reform, both in terms of supporting the local security services in the development of their own healthcare system and also in terms of providing medical support for the personnel of international military forces who may be involved in supporting the wider development of the local security services.

## The context of Security Sector Reform

The need to restore and develop a robust security sector to support emerging governments in a post conflict environment is not new. The OECD defines the overall objective of security system reform (SSR) as '*to create a secure environment that is conducive to development, poverty reduction and democracy*' (2). This secure environment rests upon two essential pillars: the ability of the state, through its development policy and

programmes, to generate conditions that mitigate the vulnerabilities to which its people are exposed; and the ability of the state to use the range of policy instruments at its disposal to prevent or address security threats that affect society's well-being. A functional security system will enable the government to execute its responsibility for the security for its people and will enable the withdrawal of international military forces. The United Kingdom emphasises the need for 'joined-up' partnering between the departments of foreign affairs, interior and defence when providing external support to SSR (3). Ideally the activities of these agencies in an overseas country should be synchronised and mutually supporting. This function in Stability Operations is not new and formed a significant element of the military plan in other counter-insurgency campaigns in places such as Malaya, Oman and Northern Ireland. In military terms, the local army (and supporting arms) will be employed in a counter-insurgency (COIN) role, operating on 'internal lines' with easy access to base facilities. This is different to the employment of international military forces that will be conducting expeditionary operations some substantial distance from their home base. The common model SSR is based on 'embedded training teams' (ETTs) from international military forces who provide training and mentoring to the local security forces. This is complemented by the attachment of mentors and liaison officers to support the chain of command in the local security forces and by the provision of training support in the central training centres (particularly the recruit training centre and the officer training school). Finally the international community may offer out-of-country training to individuals or groups from the supported country.

These factors influence the development of the medical services supporting security sector reform. Each agency (e.g. Army, Navy, Air Force, Police) may recognise the needs for access to medical support of its personnel and may establish its own medical system. There is little need for a large, deployable military health system because the security forces are operating

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within their own country and thus the balance of investment should be towards fixed facilities supporting garrisons, regional organisations and the central requirements of the sponsoring ministries. The field medical system should be focussed on pre-hospital care (including Role 1) and medical evacuation to fixed facilities.

Whilst it is important for the medical services of the local security forces to meet the specific needs of each agency, it is clearly inefficient for each to establish its own healthcare infrastructure in competition with public health services as each will be competing in the same pool for healthcare professionals produced by the education system. It is interesting to note that this overlap does exist in many international health economies, and is often sustained by the variation in investment in medical services achievable because of the substantial difference in political power between the defence and interior ministries compared to the ministry of health. This imbalance is perpetuated by extending entitlements to the military healthcare system to political dignitaries and dependants of military personnel and thus providing a multi-tier health system. There is international evidence to suggest that these arrangements become unsustainable when the cost of meeting the demand from the dependant population (particularly when this includes retirees and elderly relatives) starts to distort the allocation of funds for operational health services. Eventually the ministry of defence is forced to transfer the responsibility for non-uniformed beneficiaries to the civilian sector such as the ministry of public health or private providers.

The most important element of the military medical task in supporting security sector reform is to establish the 'right' central structure and relationships within ministries and between ministries. Investment and development needs to achieve the right balance between the infrastructure health system, the operational health system and individual clinical services whilst ensuring medical procurement, training and education, preventive medicine (including selection and screening of recruits) and research are also enabled. It is vital that the most appropriate relationship between the medical function, the personnel function and the logistic function in support of security sector forces is established from the outset. There are a variety of models including establishing the medical command as an entity in its own right or subordinating it to personnel or logistics; each has its own benefits. It is vital, during live operations, that medical staffs are empowered to engage with operational planning in the timeframe for good clinical care and not in logistic timeframes. Senior commanders involved in the transformation process must understand and support the role of health services in order to ensure that it is resourced to provide the patient treatment, evacuation, preventive medicine and medical logistic services required to care for security force casualties from the point of injury to definitive care.

## International military medical tasks in security sector reform

### Field medical system

The first, and most immediate, task for international military forces is to facilitate 'in extremis' medical support for security sector forces. It is highly unlikely that the medical system for indigenous security forces will be functioning effectively in the immediate aftermath of conflict or instability and thus the international military medical system may be the only source of casualty care. The provision of visible and effective combat casualty care is as much an important moral and morale component of motivation for local security forces as it is for the

international military forces. Troop contributing nations may be concerned that providing access to international military medical facilities has the potential to conflict with the capabilities and capacity available for international forces. However, as local security forces become more involved in security operations, international military casualties should reduce. The key challenge is the 'hand-off' of local security force casualties once they have received their immediate clinical care. It is vital that the clinical care provided to casualties is appropriate to the technology and clinical care available locally and is not just a replication of 'western' trauma surgery. The local infrastructure health system may not be able provide the necessary clinical care or the security situation may make these patients vulnerable to attack if treated outside the security cordon. This can be ameliorated if the international military medical forces assist the security forces hospital system to provide access to nursing and rehabilitation services.

#### Example 1 – Teaching Nursing Care of External Fixators

*In Afghanistan, the US Combat Support Hospital in Bagram wanted to manage local security force casualties who had had fractures treated by external fixation as out-patients in order to reduce in-patient bed occupancy. The 'rate-limiting' factor was the provision of local wound care for external fixators. This was addressed by teaching patients and their immediate carers how to provide simple wound care for the external fixator wound sites and by providing a stock of dressings. This enabled the patients to be discharged from in-patient care and to be followed as outpatients.*

The development of the security sector will require an expansion in recruiting and the basic training system. Furthermore the limited opportunity for other employment might make the security sector the most attractive source of work. The recruiting process should include a simple system for the medical screening of recruits, particularly as there is likely to be a high prevalence of chronic disease in the country. This medical screening should also form the start point for a basic medical record system for security personnel. This might be based on a patient held record in view of the limited central control and communications within the medical system. The basic training system should include training in the maintenance of health and hygiene in communal conditions and elementary first aid. Finally there should be medical oversight of the physical training environment for recruits to ensure that the need for demanding a realistic training is balanced with the risk of injury.

#### Example 2 – Teaching in Basic Hygiene to Iraqi Army Recruits

*NATO has a small military training team supporting the training of recruits to the Iraqi Army. It was found that there was a high incidence of gastroenteritis amongst recruits in the training camp. The local NATO medical officer developed a teaching package in basic field hygiene that was culturally appropriate but emphasised the importance of personal hygiene. This was taught to the local Iraqi instructors who then taught this package to their recruits.*

The development of the operational medical system should be designed around a holistic package of training, equipment and manpower. A 'field medic' training programme might be considered to be the 'pump-primer'. The paucity of professional medical staff means that this programme is best mechanism to provide good quality casualty care. The 'field medic' can also provide limited primary care, maintain health and hygiene standards in the field. The literacy, culture and religious experience of young people in the local country will require the syllabus and methods of delivery for all medical subjects to be

adjusted from that taught to standard 'western' military forces. This should be very simple, practical and deliverable with the minimum of training aids. The assessment process should also be culturally appropriate as, in some countries, failure is associated with significant stigmatisation. The 'field medic' syllabus and teaching materials should be standardised and shared between international military medical ETTs so as to minimise the likelihood of discrepancy due to variation between national 'field medic' training. A good syllabus is the First Aid in Armed Conflict and other Situations of Violence published by the International Committee of the Red Cross (4). The employment of the graduates of the 'field medic' training should be carefully monitored as the intellectual ability of these students might make them attractive as candidates for other employment in the expanding security sector.

*Example 3 The Introduction of the Combat Lifesaver Course to the Afghan National Military Medical Training Centre*

*The US Combat Lifesaver Course was introduced into the Afghan Military Medical Training Centre as part of the US support to the Afghan National Army. This course was translated into Pashtun. This included both the course handbook and the Powerpoint® slides. The US instructional staff rehearsed the delivery of the course with translators and then taught it to a cohort of potential instructors. This then formed the basis of the medical training given to selected soldiers in the Afghan National Army. This same training package was then shared with all other NATO medical staff so that continuation training could be run for Afghan Combat Lifesavers by all of the NATO military medical community.*

### Infrastructure Health System

The development of infrastructure health services for the security sector should be aligned to the development of public health services. Whilst there may be very good reasons for a separation between these health sectors, if this occurs, it must be a positive choice and not the result of lack of awareness of the issues. The international community will be supporting the country in order to establish a stable, governable society. This effort may be undermined if the disparity in support (not only medical) between the security sector and the general population causes discontent.

*Example 4 Development of Afghan National Military Hospital and regional medical system.*

*In Afghanistan the US has invested considerable sums in the development of the Afghan National Army medical infrastructure. This is based on a central, National Military Hospital located in Kabul with regional medical centres located in the regional military headquarters for each region. The investment provides for the infrastructure. It has been much more challenging to recruit medical staff, both doctors and paramedical staff, to man these facilities as many health professionals are employed by the international community as interpreters and this pays much better wages than the local health economy.*

As stated earlier, the infrastructure health system for the security sector will be based on fixed medical facilities in garrisons, regions and at a national level. The capability of these facilities should reflect the prevalence of disease in the country and also the need to provide trauma care to injured security forces personnel. It is likely that the distribution of these facilities will align to the distribution of international military medical units and so there is scope for partnership between the two medical communities. In addition to general medical topics, education programmes for security force medical staff should cover subjects such as advanced trauma care, incident management, military medical ethics, and war surgery. The

international military medical services will be keen to reduce the level of 'in-extremis' support provided to the local security forces and therefore the post-operative care and rehabilitation of war injured is a particularly important subject to share, especially the role of non-medical staff. Training for this clinical capability might include basic wound care, care of external fixators, elementary physiotherapy, and follow-up care of the amputated limb (and simple prosthetic management). This might merit the development of training course at a national level that can be cascaded down to all security force medical facilities.

Finally we need to consider the mentoring and support required at ministry of defence level. It is likely that politically senior members of the local community will be holding appointments at this level, which may or may not align with their technical competence and experience. Organisations providing external financial assistance for security sector development may wish to have their own representatives inside the relevant ministries in order to ensure probity in the expenditure of their money. Thus there will almost certainly be a requirement for senior representatives of the international military medical community to act as mentors and conduits for external investment. These mentors can also facilitate the development of local medical policies and procedures by sharing information on these arrangements from their own nations. Finally senior mentorship can include sponsorship for out-of-country visits and attendance at conferences thus encouraging the senior local military medical leadership to become engaged with the international community. Whilst it is naturally assumed that Western military medical personnel have the competence to provide this advice, it may be more appropriate to invite nations from the international coalition with practical experience of developing military medical services during a period of economic and political transition to provide this mentorship function (e.g. former Soviet Union countries or Middle Eastern countries).

*Example 5 – OSC(A) / ISAF engagement at MOD level*

*In Afghanistan, both the US through the Organisation for Security Co-operation (Afghanistan) (OSC(A)) and ISAF through the Medical Branches have liaison with the Afghan Military Medical Services in the Ministry of Defence. The US also provides personal mentorship to the Afghan Army Surgeon General and a team of technical advisers for medical operations, medical logistics and preventive medicine. These teams provide technical advice, make submissions for financial support and examine options for direct support from US and other multinational forces.*

An important, intangible, aspect of the engagement of the international military medical community is the sharing and monitoring of ethical standards. Medical personnel play an important role in observing and reporting the behaviour of security forces towards the population they serve. Whilst local policing and judicial frameworks will reflect the local cultural and security situation, it is important that the security forces medical services align to internationally agreed standards of behaviour and do not become accessories in the maltreatment of detainees or members of the security forces.

### Not To Be Forgotten

This paper has focussed on the role of international military forces in assisting the development of the medical services of the local security sector. However it is important not to forget their role in the medical support of EETs providing mentoring and training support in other areas. EETs are likely to be living and working in close proximity to the local security forces and are

thus vulnerable to the same risks. They will require additional training in preventive medicine and advanced first aid as they will be more isolated than usual from conventional military medical care. It is also important to clarify the arrangements to enable them to access 'western standards' of military medical care.

### **Who And How To Do It?**

The final section of this paper will consider how these tasks should be delivered. It is unlikely that any single nation is able to provide the resources to meet the full range of tasks that I have outlined above. Thus the international military medical community will be working within a coalition or existing international framework. This framework may have challenging arrangements for the generation of military forces and financial support for security sector reform. Success requires shared and mutual understanding of the intent and mechanisms for delivery of the task. Whilst some assets such as mentors or ETTs will be dedicated to the tasks described, others assets such as pre-existing international military medical treatment facilities will have to balance their role in security sector reform with their main function of providing medical support to international military forces. There may be scope for other innovative methods of delivery such as the use of external civilian agencies or contractors in addition to using conventional military forces. This pluralistic model requires a significant investment in co-ordination and sharing of resources in order to achieve unity of effort even if the arrangements preclude unity of command. This includes pre-deployment orientation and training for ETTs, sharing of training resources and good practice, transparent funding arrangements for all parties and communication of plans and policies so as all parties understand the intent.

### **Conclusion**

This article describes the potential roles of international military medical forces within the context of security sector reform in stability operations. The paper highlight a number of challenges and practical examples where international military medical forces can make a significant contribution to the development of local national military medical services. The most immediate task is in the facilitation of 'in-extremis' medical care for local national casualties. However it is also important to take a longer-term view and to create the managerial structures and processes that will deliver a capable and effective infrastructure local medical system so as to reduce the potential dependency on international military medical facilities. At the tactical level this might include teaching basic field hygiene, running first aid training courses for instructors and mentoring the further education of local military medical staff. Overall, we need to establish a basic framework for these roles so that international military medical forces can be properly prepared for this task prior to deployment.

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