

International Military Medical Engagement with the Indigenous Civilian Health Sector

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Abstract

This paper examines the engagement of international military medical services with the indigenous health sector. It focuses on the relationship between security forces, both international and indigenous, with the indigenous civilian health sector based on experiences and observations at the operational and tactical level from engagement with the Afghan civilian health sector in 2009/10. The paper provides a practical description of medical engagement within the 'Shape-Clear-Hold-Build-Transfer' construct for counter insurgency operations.

Introduction

This paper looks at the engagement of international military medical services with the indigenous health sector and examines the relationship between security forces, both international and indigenous, with the indigenous civilian health sector. It focuses on experiences and observations at the operational and tactical level from engagement with the Afghan civilian health sector in 2009 - 10 and introduces the practicalities of medical engagement within the 'Shape-Clear-Hold-Build-Transfer' construct for Counter Insurgency (COIN) operations.

Background

The engagement of the international military medical force with the indigenous civilian health sector on expeditionary operations is inevitable and their role [1,2] will be dependant on their 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. This operational experience has emphasised the primacy of civilian health services providers, either indigenous or international, 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 organisational structure of the public sector of the health care system in Afghanistan is well described [4,5]. There is a pyramidal system of public medical facilities starting from basic health posts and health clinics through to district, regional and national referral hospitals. The majority of effort by the Afghan Ministry of Public Health has been to increase access to healthcare through the Basic Package of Health Services (BPHS). It is important to remember 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 bases, which may include communication links to insurgents. The director of the contractor providing the BPHS and the director of the provincial hospital are also important. These three individuals control the flow of money allocated by the Ministry of Public Health from a national to a district level. Nationally, financial management is weak with substantial uncertainty over budget allocations and actual flow of funds that 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 (ICRC), not all of whom are permanently resident in the South of Afghanistan. The United States Agency for International Development, the World Bank and the European Union are the biggest donors to the health sector and the main source of funding for the operating costs of the BPHS, though each has their own mechanism for allocation of funds and managing contracts. Other national development agencies such as the Canadian International Development Agency (CIDA), also support the health sector through local projects managed by their Provincial Reconstruction Teams (PRTs). There may be smaller aid organisations operating locally as well.

The Afghan security force medical services are also likely to be influential as they often care for local civilians, and, dependant

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on the security situation, may also undertake private practice. The international military are also important local stakeholders funding development projects – usually on a capital basis by the ‘for-profit’ private sector as the final element of the health economy. 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. Many 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 monopolising 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 (MoPH) has recommended that all donations should be as public as possible and made within the oversight of MoPH representatives.

Military Engagement

At the strategic level, the surge in military forces in Afghanistan that occurred from mid-2009 was accompanied by a surge in development resources – both originating mainly 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 both the number of Afghan-educated technocrats who are competent to manage development projects and the number of interpreters who can facilitate international civilian engagement with the Afghan community and the partnership between international military forces and their Afghan military counterparts. This, compounded by the insurgents’ threats to those who work with government institutions, has created a challenging market for employing local Afghan technocrats. Expanding the pool of Afghans capable of leading their public services will only be delivered by extending access to education and will take many years to have a significant impact. The developmental challenge in Afghanistan has been to convert this surge in development assistance 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’ (MRE) and lie

within the provision of the Geneva conventions to care for the sick or injured on the basis of clinical need alone.

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 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, followed by lack of employment, access to health services and education. The issues of personal security differ markedly between a civilian healthcare worker from a different tribe to the local population living in a rented apartment travelling to work in private taxis compared to an international soldier with personal and vehicle armour, living in a protected camp. 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 recognising that the civilian health providers may be negotiating with all 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 immunisation co-ordinators have negotiated with as many parties to conflict as possible (including the Taleban) to recognize the impartiality of the vaccinators and to give them unimpeded access to the civilian community.

Activities

US military doctrine for COIN is summarized in the phrase Shape-Clear-Hold-Build (to which some commentators have added ‘Transition’)[6]. The UK uses a similar framework of Shape-Secure-Hold-Develop [7]. This paper will use the US version as this was used in Regional Command (South) during the period of reference for this paper. 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 including the (re)establishment of local governance. ‘Build’ is the phase of reconstruction and development in order to demonstrate to the population the benefits of supporting the instruments of government and 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 Regional Command (South) (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'[8]. The implication of these issues on health services at a local level is often complex (Box 1).

At first glance military units may believe that the solution is direct military medical aid to local communities 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 description of on-off, non-emergency primary healthcare clinics provided by International Security Assistance Force (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 [9]. 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-Transition (SCHBT)' construct (Figure 1) and 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. There may be occasions where there is no alternative to ISAF providing both medical services and security, but 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.

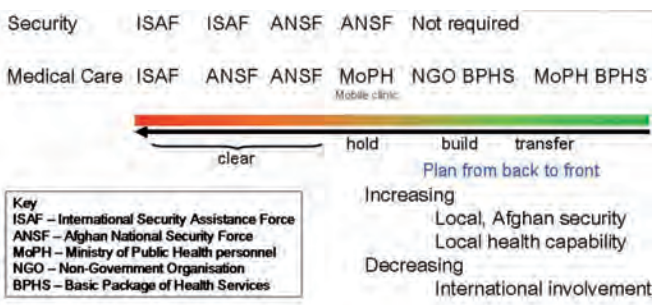


Figure 1. A schematic showing how ISAF can support development towards the long-term goal of 'an Afghan caring for an Afghan'

Shape

Military medical representatives should actively engage 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

"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 kilometres 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 gastroenteritis, 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 Improvised Explosive Device within 500 metres of the gate. She was driven by family members though 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 'jobbing 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."

Box 1. A narrative by a Medical Officer at an International Security Assistance Force (ISAF) Forward Operating Base (FOB).

include agreement on hand-off arrangements back into the civilian health sector.

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 February 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 Figure 1. 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 Transition

Ideally there would be no international military medical engagement during the Build and Transition 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 shown that the international military medical forces will almost inevitably have to engage with the indigenous civilian health sector in the country of operations. It has described the range of activities of the ISAF military medical services working with the civilian health services in the South of Afghanistan during the stages of Shape, Clear, Hold, Build and Transition for military operations in 2010.

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