U.S. Army (Zackary Root)

Soldiers load patient onto UH-60 Black Hawk at Forward Operating Base Shank, Afghanistan

FORWARD-DEPLOYED MEDICAL ASSETS AND THE COIN OFFENSIVE

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Deployed U.S. military medical assets are primarily structured to support combat operations on the conventional battlefield, but they are increasingly deployed in support of expeditionary counterinsurgency (COIN) operations. The development of doctrine to guide medical support in a COIN environment has not kept up with the brisk pace of operations, resulting in significant gaps in the capabilities necessary to meet needs. With the publication of Field Manual 3-24, *Counterinsurgency*, in 2006, the U.S. Army and Marine Corps jointly developed a strategic framework to guide COIN operational planning, but medical and health support activities are not mentioned.

Historically, deployed medical units have employed mission profiles reflecting the U.S. Army Medical Department motto, "to conserve the fighting strength." While a necessary primary mission, caring only for friendly force casualties, injuries, and illness vastly underutilizes deployed medical resources.[1] This situation is especially true at the forward-deployed levels of care, where battalion-level medical companies and brigade-level forward surgical teams (FSTs) are scattered over the battlefield and generally care for a young, fit force operating on the relatively nonkinetic COIN battlefield.[2] Larger deployed medical units such as combat support hospitals are more fully utilized; they act as clearinghouses in the evacuation chain for friendly force sick and wounded from many smaller units. Given the civil-military emphasis of COIN operations, integrating the activities of small, forward-deployed medical assets into the broader COIN "offensive" is a clear step toward achieving mastery of

the comprehensive set of capabilities that modern COIN warfare embodies.[3]

U.S. special operations forces (SOF) medical units have consistently demonstrated the feasibility of targeted medical operations in COIN. The medical seminar and medical mentorship approaches have achieved tangible goals in SOF COIN engagements. These techniques should be transitioned to conventional medical assets in COIN theaters of operations. Our hypothesis is that conventional, forward-deployed military medical assets can and should be used in expeditionary COIN operations as low-cost, high-value force multipliers. We address this by first answering the question, "Why should conventional medical assets play a role in the COIN offensive?" After presenting the rationale for the involvement of deployed medical assets in COIN operations, we answer the question, "How do we do this?"

operations to legitimize the indigenous health sector would be most effective in underserved rural areas

Why Do This?

In expeditionary COIN, the territory contested is the support of the populace for the legitimate host nation government. Rather than the typical approach of "winning hearts and minds," the goal of COIN has been recast as providing the population with "a sense of order and predictability to their lives."[4] Expeditionary COIN operations strive to assist the host nation government in achieving legitimacy as a source of stability for the governed. For a government to achieve legitimacy, it must demonstrate a capacity to provide four essential types of security: physical, economic, ideological, and—the subject of this article, health. A government must be able to answer the question, "Who will care for me and my family when we are sick or injured?" Increasing the capacity of the indigenous health sector is the most effective use of deployed medical assets in COIN.[5]

Expeditionary medical units in a COIN environment should develop operations to stake an underserved host nation population's need for health care to the legitimate host nation government's ability to provide it. Operations to legitimize the indigenous health sector would be most effective in underserved rural areas where the need for basic health care is most acute. Such areas are primarily served by smaller, forward-deployed military medical units, such as medical companies and FSTs. Not coincidentally, these areas tend to be havens for insurgents because the government has limited presence. The relationship between insurgency and underserved populations multiplies the positive effect of health engagements in the broader context of the COIN campaign, resulting in medical operations that are inherently high in value. This is evident in the unique perspective and information gained through the conduct of medical operations in Afghanistan and Iraq.[6]

In addition to being high-value, forward-deployed medical assets can participate in direct COIN engagements with ready availability and low cost. Conventional medical companies and FSTs will always be deployed to support combat forces in forward areas. These units deploy with supplies, facilities, and expertise that can be leveraged at low cost to accomplish specific COIN missions. Leveraging assets can be accomplished with minimal impact on the primary mission of caring for friendly battle casualties because COIN operations tend to be relatively nonkinetic, resulting in far fewer serious casualties than conventional operations. Once established, most of the costs of running these facilities are fixed—remaining the same regardless of the volume of care occurring at the facility and whether the patients are friendly forces or local nationals.

Nongovernmental organizations (NGOs) such as the International Committee of the Red Cross and nonmilitary governmental agencies such as the U.S. Agency for International Development are already involved in health support and reconstruction operations in many areas beset with insurgencies. Despite their expertise in development, civilian agencies should not be the only "key enablers of a successful COIN strategy."[7] The level of civilian participation in these operations is directly related to the security situation. Only as security is established can civilian participation safely increase to the point that real improvements are possible in the indigenous health sector. Even in reconstruction-focused operations such as medical projects, the inability to maintain security in the inherently unpredictable COIN security environment can easily impede progress.[8] To maintain the support of the indigenous population, civil health reconstruction must begin simultaneously with security operations, establishing a "feedback relationship" between access to health services and freedom of movement of the populace.[9] Military medical assets are designed to support combat operations in an unstable security environment and are well suited to direct participation in COIN engagements, especially during initial stages when the security situation is particularly volatile.

Provincial Reconstruction Teams (PRTs) are hybrid military-civilian units developed to support COIN operations in Iraq and Afghanistan. They are charged with facilitating reconstruction efforts and focus primarily on infrastructure development. PRTs have historically been lacking in medical assets and have no inherent medical care capacity. This limits their usefulness in direct medical actions as part of a broader COIN offensive. Coordination between expeditionary military medical assets and NGOs, PRTs, and other governmental agencies is vital to the strategic success of medical COIN operations. Synchronization between all groups involved in medical civic actions is necessary to avoid duplication of effort, present a united position of support for the legitimate government, and prepare for transition to nonmilitary agencies when military assets leave the COIN theater.

Civil-military operations performed by small, forward-deployed conventional medical units at the battalion and brigade levels should be an integral part of COIN tactical planning and execution. Engagements should be focused on increasing indigenous health-sector capacity in the name of the legitimate government. Employed in this way, medical units can move from the sidelines to the frontlines of a COIN campaign and contribute to its success.

How Do We Do This?

Insurgencies embody unique characteristics of the societies they arise from. Strategies and tactics to counter them must be tailored to exploit the specific avenues

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Combat medic dresses wounded hand of Afghan National Army soldier after IED attack

to increase legitimacy presented by each situation.[10] While it is impossible to fully characterize the particular tactics that will be successful in a medical COIN operation, the general principles for medical engagements can be elucidated. These principles create a framework that should be used for planning and executing such operations.

Medical operations in COIN must always strive to increase the capacity of the indigenous healthcare sector to care for the host nation's population. Simply having expeditionary medical assets provide care to local civilians in the manner of the traditional medical civic action program (MEDCAP) does not meet this goal and is not advisable for several reasons. The inherently transient nature of MEDCAP engagements risks alienation of the population when military assets are no longer present and disaffection when frequently encountered complex medical needs cannot be met during a short humanitarian mission. Additionally, when foreign military medical assets provide direct care to host nation civilians, a reliance on these assets is established. The reliance on foreign care marginalizes the local health sector in the eyes of the population, directly countering the strategic objective of increasing indigenous legitimacy.[11] Limited MEDCAP-type operations may be valuable during the initial phases of an expeditionary COIN operation in order to accustom the population to working with military medical personnel, but these should be performed in concert with indigenous healthcare providers and rapidly transitioned to more sustainable practices.

Medical COIN efforts should be focused where the need for health sector improvement is most acute. Healthcare sophistication spans a continuum from no available care (0) to the best care available in the developed world (10). The people of an area such as Uruzgan Province, Afghanistan, for instance—where we have planned and participated in such activities—have limited access to fairly primitive care. If this area rates 0.1 on the aforementioned continuum, a reasonable goal would be a tenfold increase in sophistication, bringing the score to 1. This can be done relatively cheaply and is certainly within the capabilities of a deployed military medical company or FST. A further tenfold increase would require bringing healthcare sophistication to the level of a modern Western hospital, which would cost millions of dollars and is completely unfeasible.

Placing indigenous personnel and assets in the lead is essential to the success of any COIN operation. Personnel from forward-deployed medical units must frequently engage leaders of the indigenous healthcare sector and build durable relationships. These interactions and relationships will become the core of medical programs and maximize sustainability. Local stakeholders should be required to provide a realistic and truthful view of their specific needs in consultation with expeditionary forces prior to planning any health operation. This assessment process should continue for the duration of intervention, and

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Medic reviews lesson plan for combat lifesaver refresher class in Farah Province, Afghanistan

programs should be flexible enough to adapt to changing needs over time. Setting realistic goals is another key aspect of program planning. It must be feasible to meet the goals of a program within operational constraints including resource availability and security. The expectations of local stakeholders should be reasonable as well. In COIN, it is often worse to break a promise than not to make one at all.[12]

COIN medical programs should be designed to meet the goal of decreasing reliance on expeditionary military medical assets. Indigenous resources should be used to the maximum possible extent in any medical COIN engagement. Local stakeholders have insight as to what resources are available locally and should provide the labor, expertise, and materiel for programs in which expeditionary forces participate. Health-sector leaders should be heavily involved in programs directing the distribution of humanitarian aid such as medical supplies, durable equipment, and medical devices coming from foreign sources.

Forward-deployed medical assets employ highly trained but frequently underutilized medical personnel. Leveraging their knowledge and skills to train members of the indigenous health sector costs nothing and represents the most powerful and sustainable type of medical COIN operation. Training programs should follow a "train-the-trainer" regimen in which individuals trained by the deployed military unit are utilized as trainers for other indigenous healthcare personnel. Use of this technique exponentially increases the capacity-building impact of COIN medical programs. In underserved areas, training by expeditionary forces should be accompanied by a commitment on the part of the trained providers to remain in the underserved areas following the completion of training. Programs should be tailored to impart the skills and knowledge most relevant to indigenous needs and capabilities. Teaching rural medical providers to read diagnostic X-rays does not improve their ability to serve in a clinic with no X-ray machine.

Programs in Tarin Kowt

An example of a successful COIN medical training program is the Afghan Medical Training Partnership and Validation (AMTPV) program, which we have participated in at the Special Operations Forward Surgical Element (FSE) in Tarin Kowt, Afghanistan. Tarin Kowt is the capital of Uruzgan Province, one of the most rural and poor in Afghanistan. An assessment by district health officials and special operations physicians in 2010 revealed that the Tarin Kowt Provincial Hospital had essentially no personnel trained to care for victims of significant injury, and almost all injured local nationals were being cared for at U.S. facilities. The medical capabilities available at the hospital (that is, basic operative, laboratory, X-ray, and ultrasound) were similar to those of the forward-deployed U.S. FSE, but a significant deficit was noted in the knowledge and skills of the hospital providers. Building trauma care capacity at the hospital would greatly improve the care provided to Afghans in the ongoing insurgency.

A 3-year training program was initiated with 12 participants from the provincial hospital. Four groups, each consisting of a physician, anesthetist, and nurse, spend one 3-month period per year living and working alongside FSE personnel at the U.S. facility. These individuals participate in all aspects of care under the supervision of U.S. military providers. The remainder of the year is spent working at the hospital and training other providers. The trainees are modestly paid through the local U.S. commander's discretionary funds and, in exchange for their participation, have committed to practice at the hospital following completion of the program. The AMTPV program costs little, is entirely sustainable, and has resulted in dramatic improvements in the care of injured patients at the hospital and a reduction in reliance on U.S. and coalition care in Uruzgan and surrounding provinces.

To fully engage the indigenous health sector, expeditionary medical units should pursue integration with host nation healthcare facilities. The resources available at even smaller deployed military units may exceed those routinely available at indigenous facilities, so patient transfer agreements can facilitate the best available care for local patients. When local providers training at military facilities participate in the care of host nation patients, capacity-building still occurs even though care is being provided at military facilities. The medical director of Tarin Kowt Provincial Hospital has the authority to request the transfer of patients with complex injuries to U.S. FSE for surgical care currently unavailable at his facility. At the earliest opportunity following surgery, patients are transferred back to the care of providers at the provincial hospital. Because AMTPV participants care for these patients at the FSE, at no point is a patient's care solely being provided by U.S. personnel. Command support of the medical COIN mission is vital due to the security implications for local patient and provider movement on and off forward-deployed military installations.

The indigenous military will likely be fighting the insurgency long after the redeployment of expeditionary assets. Medical units contribute to the hastening of turnover of security operations by developing training and patient care relationships with partner force medical elements. Performing realistic combat casualty care training with indigenous military personnel facilitates their progress toward independence from expeditionary medical support. Additionally, wounded host nation military casualties cared for by deployed units should be transferred to host nation military medical facilities as soon as feasible. U.S. personnel from the FSE in Tarin Kowt engage in weekly trauma care education and simulation with the Afghan National Army (ANA) 8th Commando *Kandak* (Pashto for *camp*) and ANA 4th Brigade medics and physicians. When partner force casualties are treated at the FSE, their care is transitioned to ANA facilities as soon as possible. This relationship has resulted in meaningful advances in these ANA units' abilities to care for their own casualties.

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Other Considerations

The nature of the COIN environment is one of fluctuating security and civil considerations. Accordingly, medical COIN operations should be flexibly designed and executed. Giving host nation medical providers and patients access to a medical facility on a base in a combat environment is the prerogative of the local combatant commander. Establishing buy-in from this individual and his staff is crucial. Keeping local authority over the activities of forward-deployed medical units with the combatant commander (rather than with higher level medical commands in the theater) maximizes operational flexibility at the tactical level. This relationship allows operational flexibility for medical COIN activities and facilitates synchronization with other civil-military COIN activities in the battlespace. The local SOF task force commander oversees the Tarin Kowt FSE day-to-day operations while administrative authority rests with the theater-level special operations medical command. This structure allows the FSE to easily respond to the specific needs of Uruzgan Province's health sector while maintaining materiel and administrative support from higher levels of medical command.

Changes in the local security situation will affect the movement of patients and providers between indigenous and military facilities. It is unreasonable to expect 100 percent compliance with a rigid training schedule for local and partner force providers or zero missed appointments from scheduled clinics for local nationals. Medical programs should allow for increasing indigenous sector participation in care and should adapt as local capabilities expand over time. The successful "clear-hold-expand" framework in use for civil-military operations in COIN should be applied to medical engagements. The process begins with the clear phase, an initial needs assessment and program planning. Following this, program implementation represents the hold phase. As improvements are made or situations change, a continual needs assessment process results in modifications to existing programs or new engagements in the expand phase. Utilizing this framework results in dynamic programs responsive to the changing needs of the indigenous population and suits the variable COIN operational environment.

Assessing the effectiveness of medical engagements in COIN is crucial to ensuring ongoing success. Planning for such assessments should take place prior to the implementation of programs and the assessment process must be continual. Because the goal of engagement is to increase indigenous healthcare capacity, progress should be evaluated from the perspectives of host nation stakeholders rather than those of expeditionary forces. This ensures that what is being measured are the health-related outcomes of engagements and not just the outputs of provided care. An example is measuring changes in the monthly percentage of occupied beds at Tarin Kowt Provincial Hospital rather than the number of host nation civilians treated at the FSE. The former is an outcome of an intervention and the latter is the intervention's output. If the FSE is seeing more patients while the hospital's bed census is unchanged, no progress is being made in increasing its capacity, and any relevant initiatives should be reexamined.

Concluding Thoughts

There are three critical enablers of COIN medical engagements by forward-

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Army medics unload mock casualty from UH-60 Black Hawk during training exercise at Joint Readiness Training Center, Fort Polk

deployed medical units. The first is motivated expeditionary personnel who are willing to think beyond the doctrinal mission of conserving the fighting strength. These individuals will be culturally open-minded and willing to treat all patients equally. They will feel they have a stake in improving the indigenous healthcare sector. Not all personnel deployed with a unit will have these characteristics, but those who do should be sought out and challenged with this mission. Dedicated interpreters are crucial. Their expertise in language is obviously essential, but they also provide vital links with the local health authorities and valuable cultural insights on health and disease. Having interpreters embedded with units allows them to become medically savvy, and this understanding greatly facilitates integration with host nation facilities and personnel. Finally, the support of both medical and combatant commanders is absolutely essential to mission success. Medical commanders have to think outside of the doctrinal box to allow the leveraging of their assets to perform COIN missions. Combatant commanders must be willing to synchronize their civil-military COIN activities with medical engagements and to accept and mitigate the security risk that comes with such engagements.

Small, forward-deployed medical units are ideally suited to perform civil medical engagements in counterinsurgency. These units' capabilities can be leveraged at low cost and with high value, making them force multipliers. Though programs will differ depending on specific theater and local characteristics, increasing the capacity of the host nation indigenous healthcare sector is the desired endstate. Programs should be focused through collaborative needs assessments and designed to leverage skills and knowledge toward sustainable health goals. **JFQ**

NOTES

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