DOCTRINE NOTE 11/22 **Authority**
DGAMS

MILITARY MEDICAL CONTRIBUTION TO HEALTH SECTOR DEVELOPMENT WITHIN SECURITY AND STABILISATION OPERATIONS

References:

A. Joint Doctrine Publication 3-40 Security and Stabilisation: The Military Contribution.
B. Joint Doctrine Publication 4-03 3rd Edition Joint Medical Doctrine.
C. ACO Directive 83-2 Allied Command Operations Guidance for Military Medical Services Involvement with Humanitarian Assistance and Support to Governance, Reconstruction and Development dated 8 Mar 2010.

INTRODUCTION

1. References A and B provide a list of the potential roles for UK military medical services within the doctrine for the UK military contribution to security and stabilisation operations. Reference C provides NATO guidance in this field. This Army Doctrine Note (DN) builds upon these references and provides a fuller description of the factors to consider and medical capabilities required to achieve the maximum effect for any military medical contribution to indigenous health sector support. It starts by examining the impact of insecurity on health and common issues affecting health sectors in crisis. The main focus is the role of international military medical forces in supporting the development of health services support for indigenous security forces within wider Security Sector Reform (SSR). The closing section considers how international military medical services can support the wider international community in the development of the indigenous civilian health sector. This DN is focussed on the Land Environment but the principles apply to the use of Joint military medical capabilities employed in this role.

2. There are multiple examples of UK military medical services being used to alleviate suffering amongst non-combatant populations in the aftermath of conflict. These include the restoration of hospital services for Turkish prisoners in Damascus in 1918, the inclusion of medical staff in the Allied Government of Occupied Territories in World War Two, the restoration of public services in Suez after the invasion in 1956, the humanitarian relief operation in Northern Iraq in 1991, the stabilisation operation in Rwanda in 1994 and as part of military 'Quick Impact Project' (QIP) activities in Bosnia and Kosovo in the late 1990s. UK Field Hospitals operating in Iraq saw Iraqi combat casualties, Iraqi civilians and Iraqi children at the accident and emergency department and provided surgery in emergencies. Similar to Iraq, the UK hospital in Camp Bastion in Helmand province in Afghanistan has cared for detainees, indigenous civilian security force and civilian casualties as well as NATO casualties. The UK military medical services have contributed to the development of indigenous security forces medical services in Brunei, Oman, Saudi Arabia, South Africa, Iraq and Afghanistan. Annex A is a short narrative describing Op GABRIEL to Rwanda in 1994. This is a case study of how military medical capability was used to both respond to a humanitarian crisis and support a stabilisation operation. The UK is likely to require an enduring competence to engage and support indigenous health sectors as part of military medical capability.

THE IMPACT OF INSECURITY ON HEALTH

3. The absence of security does not just concern national military defence. Article 25 of the United Nations Charter of Human Rights asserts that being healthy and having access to healthcare are an essential element of human security[1]. This underpins the UN 'Responsibility to Protect' agenda that emphasises preventive and developmental interventions in addition to military force for supporting populations within countries in crisis[2]. Three of the eight Millennium Development Goals of the UN Millennium Project are directly related to health[3]. Conflict has a direct impact on population health through injury to individuals caught up in the fighting. It also has a significant indirect impact through population displacement, damage to health institutions and the collapse of economic activities required to fund health programmes[4]. A study linking health indicators and conflict status across countries in Africa emphasises the consistent need to support basic health and public health services in countries affected by conflict[5], and that conflict is a much more common cause of large-scale epidemics rather than natural disasters[6]. A RAND analysis of nation-building operations after 1945 argues that the health sector has an impact independent of other reconstruction and development sectors (security, economic stabilisation and political development) and that the other sectors have an impact on the health sector[7]. Overall it is clear that threats to health and health services are significant aspects of security for populations in crisis. Supporting access to health services is an essential component of the restoration of essential services in support of the establishment of governance.

HEALTH SECTORS IN CRISIS

4. It is essential to understand the relationships that influence indigenous health sectors as a holistic concept at a national level. This section is an illustrative narrative of these relationships and is summarised in Figure 1. The precise balance of power will vary and will almost certainly be different to Western, socialised health systems. The Ministry of Finance is likely to be responsible for the allocation of funds from both national and donor sources to each Ministry that provides health services. A Ministry of Public Health (MoPH) is usually responsible for the procurement of curative care, public health, and preventive

---

[1] United Nations. 'The Universal Declaration of Human Rights'. General Assembly resolution 217 A (III) of 10 December 1948. http://www.un.org/Overview/rights.html (accessed 18 Nov 2008).

[2] United Nations. 'A more secure world: Our shared responsibility.' Report of the Secretary General's High-level Panel on Threats, Challenges and Change. 2004. http://www.un.org/secureworld/report.pdf (accessed 18 Nov 2008).

[3] Goal 1 – Eradicate extreme poverty and hunger; Goal 2 – Achieve universal primary education; Goal 3 - Promote gender equality and empower women; Goal 4 – Reduce child mortality rates; Goal 5 – Improve maternal health; Goal 6 – Combat HIV/AIDS, malaria and other diseases; Goal 7 – Ensure environmental sustainability; Goal 8 - Develop a global partnership for development. UN Millennium Development Project. 'Millennium Development Goals.' http://www.unmillenniumproject.org/goals/index.htm (accessed 19 Nov 2008).

[4] CJL Murray, G King, AD Lopez, N Tomijima and EG Krug. 'Armed Conflict as a Public Health Problem'. *British Medical Journal* 324 (2002): 346–349.

[5] Nancy Mock. 'A Comparison of Health, Population and Nutrition Profiles in Countries According to Conflict Status: Findings from the Demographic and Health Surveys.' CERTI Project. New Orleans, Payson Center for International Development and Technology Transfer, Tulane University, April 2000.

[6] Paul B Spiegel, Phuoc Le, Mija-Tesse Ververs and Peter Salama. 'Occurrence and overlap of natural disasters, complex emergencies and epidemics during the past decade (1995–2004).' *Conflict and Health* 1, (2007):2.

[7] Seth G. Jones, Lee H Hilborne, C. Ross Anthony, Lois M Davies, Fedrico Girosi, Cheryl Benard, Rachel M Swanger, Anita Datar Garten, Anga Timilsina. 'Securing Health. Lessons from Nation-Building Missions'. Centre for Domestic and International Health Security. RAND. http://www.rand.org/pubs/monographs/2006/RAND_MG321.pdf (accessed 18 Nov 2008).

medicine services for the whole population. While the MoPH is a stakeholder in health education and training, this may be the responsibility of the Ministry of Education (MoE). This ministry may also run medical facilities in order to place students into health-service delivery environments and to maintain the clinical practice that clinical teachers require to maintain their skills. The MoPH is likely to be the lead ministry for health sector emergency preparedness and response but both the Ministry of Defence (MoD) and the Ministry of Interior (MoI) may own command and control centres and ambulances that can respond to mass-casualty incidents. The MoD is responsible for the provision of health services to the armed forces. The MoI is responsible for medical support to the Police and often for the provision of medical care to detainees/prisoners. However, the MoI may have limited medical services and so have to use MoPH and/or MOD medical facilities. While both the MoD and MOI need to recruit members of the health sector workforce, profession-specific training should normally be delivered under the oversight and licensing arrangements of the MoE. The MoD and MoI may have negotiated special access and funding arrangements to cover circumstances where curative medical care for military personnel and their dependants is best delivered through MoPH facilities. Finally, it is essential to consider the private, insurance or informal healthcare market where many healthcare workers may earn the majority of their salary. The size of this market will be affected by the comparative value of government salary levels to the costs of living and the role of 'graft' in personal economic influences. There may also be a challenge to dissuade healthcare workers from taking employment as interpreters or migrating from the country. The long-term solution is for the indigenous education system to provide sufficient healthcare workers for the national health economy, including the military medical services. This needs to cover all professions in healthcare, not only doctors and nurses but also, for example, ambulance technicians, laboratory technicians, radiographers and medical equipment technicians. Overall international military medical activities should complement wider programmes for the development of human and institutional capacity in the indigenous health sector.

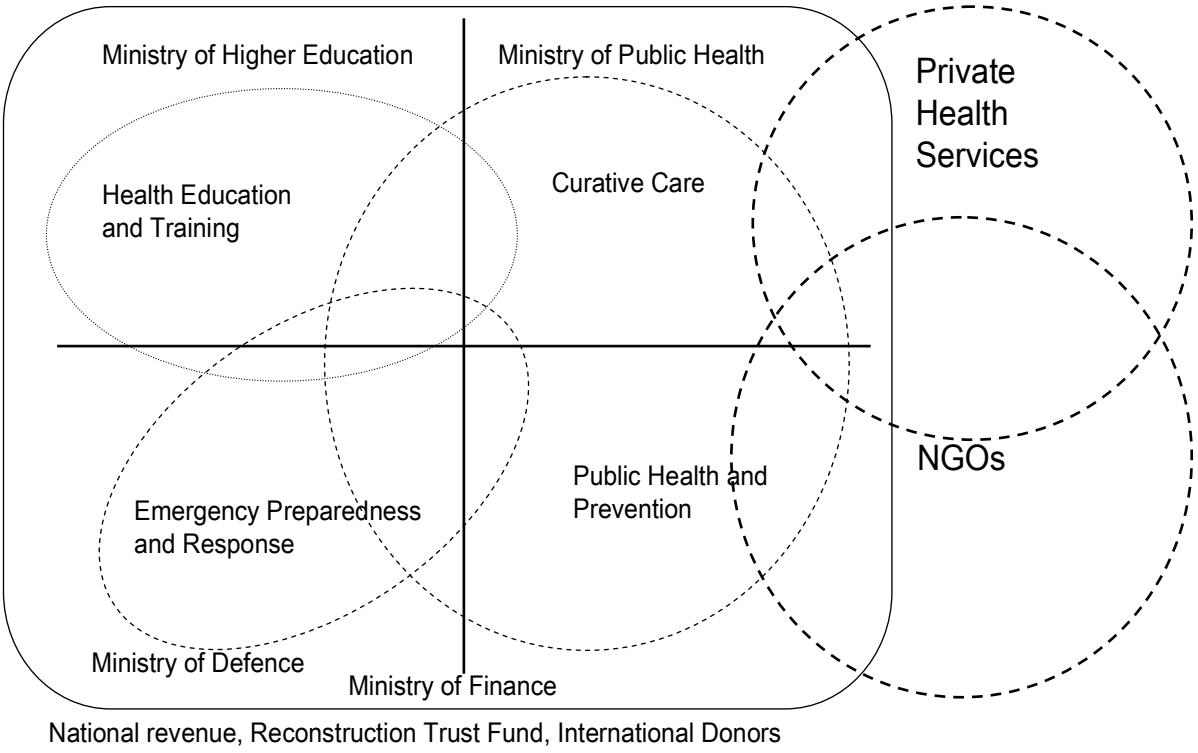

Figure 1 – Indigenous Health Sector Relationships

5. Health provision is often an emotive subject and if access is reduced or controlled in favour of different groups may become a destabilising influence. Supporting indigenous health provision may therefore be an important stabilising function[8]. Health and the delivery of healthcare by a state is a function of governance and a proxy indicator of the government's intention to protect its population and its view on human rights[9]. As stated in References A and B, it is essential that an indigenous health needs assessment is undertaken as part of the strategic estimate for the likely tasks for military medical services in a military campaign. This will need to cover the context of the health sector, the state of indicators of the health of the population, information on health services and a description of the stakeholders in the health sector. A comprehensive health needs assessment at anything above village or district level is a time consuming, technical task that may require dedicated specialist staff to undertake. Ideally this should be conducted by indigenous health professionals with technical assistance from civilian agencies, but the military medical services should be prepared to assist if requested.

PRINCIPLES

6. This section is based upon Reference C. Medical support to military operations is tailored to the military Population at Risk (PAR) and the assessed risks to deployed UK troops, although it will often be necessary to provide support to indigenous military forces (and Captured Personnel (CPers)). Support to the military force must remain paramount, together with the provision of emergency care to all casualties where this is urgently needed (in accordance with international humanitarian principles). Well intentioned but uncoordinated military medical activities, particularly those undertaken for ostensibly humanitarian reasons, risk undermining efforts made by the indigenous government to re-build its own health system in conjunction with key donors and humanitarian agencies[10]. The likely goal for the indigenous government is a trained, equipped, and sustainable health system equivalent to those existing in neighbouring peaceful countries, contributing to overall national political and economical stability. Military medical activity undertaken for perceived short-term gains may undermine the military mission in the medium to longer term, particularly in Counterinsurgency (COIN) operations, by reducing confidence among the indigenous population in their government's ability to provide these essential services.

7. The following principles, based on the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) guidelines on the use of Military and Civil Defence Assets (MCDA) to support UN humanitarian activities in complex emergencies[11] and the UN 'Oslo Guidelines'[12], must be adhered to when the military is involved in medical aspects of Governance, Reconstruction and Development (G,R&D):

---

[8] Evans G et al; The Responsibility to Protect; Report of the International Commission on Intervention and State Sovereignty; International Development Research Centre; 2001; http://www.iciss.ca/pdf/Commission-Report.pdf

[9] Declaration of Alma-Ata; International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978; http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

[10] As an example, although the NATO mission in Kosovo had been running for almost ten years, Kosovo Serbs were still being treated in the NATO field hospital in northern Kosovo in 2009 for non emergency medical care; a result of continued anxiety among minority groups within Kosovo over their care by the Kosovo Albanian majority. The withdrawal of military hospital facilities in this area following the announcement of Deterrent Presence required that an alternative solution be found.

[11] UN OCHA Guidelines on the Use of Military and Civil Defence Assets to Support United Nations Humanitarian Activities in Complex Emergencies (Rev 1, dated Jan 06).

[12] Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief 'Oslo Guidelines' (Revision 1, dated 1 Nov 07).

a. **Do No Harm**. The most important principle in providing assistance to health sector development is 'to do no harm'. There is a real risk that the work of other agencies might be undermined by the involvement of military medical services in direct healthcare provision to the indigenous population, and that their security, and that of those treated, might be compromised.

b. **Clinically Appropriate**. Any intervention must be clinically appropriate, taking into consideration the capabilities of the healthcare sector and the indigenous governmental institutions' policies and direction. This might include providing short-term support as a component of a development programme. In sub-Saharan Africa, for example, the provision of cataract surgery returns many people to productive lives and thereby improves their health; development activity would aim to support and mentor indigenous ophthalmic surgeons in the necessary techniques.

c. **Culturally Sensitive**. The provision of any health sector intervention must be culturally appropriate and socially acceptable to the indigenous cultural, social and religious values, noting the specific issues of gender, and gender specific roles in healthcare in many nations.

d. **Coherent**. The intervention should not be focused on just one aspect of G,R&D, such as buildings or equipment, as these are often unsustainable without attention to other aspects of development, for example availability of trained staff and mechanisms for meeting recurring costs.

e. **Sustainable**. Any intervention should seek to ensure that once the military forces withdraw, the intervention can be sustained by indigenous medical services or NGOs. Any equipment donated must be able to be maintained in the long term using local resources.

f. **Civilian primacy**. Military involvement in civilian healthcare development must be undertaken only where there is **no civilian alternative**. It should always be the option of last resort and explicitly limited in time and scale.

g. **Coordination**. Medical engagement must only take place where there is **agreement** with the indigenous Government or other appropriate authority; effective liaison and coordination will be essential with the Government, NGOs and other agencies.

8. Although the military cannot be considered a humanitarian agency, there may be occasions during combat or other military operations where there is a requirement to support the delivery of humanitarian assistance. In such cases the following principles must be respected[13]:

a. **Humanity**. The dignity and rights of all those sick and injured must be respected and protected; indigenous cultural requirements must be respected.

[13] UN General Assembly Resolution 46/182 on Humanitarian Assistance as developed by UN Office for Coordination of Humanitarian Affairs.

b. **Impartiality**. Medical assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relief of suffering must be guided solely by clinical needs, and priority must be given to the most urgent cases. Casualties who are members of opposing forces must be treated in line with this principle; medical personnel have a responsibility to report violations of this principle to an appropriate authority.

c. Neutrality. Military medical services are not neutral (as they are part of the deployed military force) but must treat cases under the impartiality principles above.

THE PROVISION OF EMERGENCY CARE

9. Annex A to Chapter 1 of JDP 4-03 Joint Medical Doctrine summarises the obligation to treat casualties from conflict in a priority solely based on clinical need. The UK military medical plan will define the patient groups who are eligible for access to the international military medical system. This may include cross government coordination (eg FCO and DoH), and bi or multinational agreements defined by MOUs. The system comprises initial medical evacuation, entry to first UK military hospital, in-theatre transfer to either UK hospitals or indigenous hospitals and strategic medical evacuation. The PAR is likely to include all international forces, international civilians supporting military forces, and opposing forces detained by the international force. It is likely that international, coalition forces are eligible for access to all aspects of the UK medical system which may include Strategic Evacuation (STRATEVAC). In a stabilisation or COIN operation, eligibility may be extended to indigenous security forces and the civilian population. Armed conflict may well result in indigenous casualties at a time when indigenous medical facilities (military and civilian) are underdeveloped and under pressure. In such complex emergencies there may be significant barriers preventing the access, development and delivery of the indigenous healthcare services. These may include insecurity, poor public health measures and governance difficulties. There may be a substantial disparity between the capabilities of the international military medical system and the indigenous health system; however it is unlikely that the international military medical system can underwrite all of these deficiencies. This may cause moral and ethical challenges for UK military medical personnel that need to be addressed during pre-deployment training and by in-theatre policy direction.

10. As a matter of principle, indigenous patients are not evacuated from their country except in specific circumstances, perhaps under the care of an international, humanitarian NGO. Furthermore, indigenous patients should receive care from indigenous healthcare workers unless there are over-riding reasons why the international military medical system should provide this care. Casualties amongst local civilians and security forces may be given access to medical evacuation and medical care in the international military force system but this will be increasingly constrained the further along the evacuation chain that they progress. The military medical system requires a management process that controls entry and can be adjusted according to capacity – this is known as ‘Medical Rules of Eligibility’ (MRoE). Once inside the military medical system, control of medical evacuation through the UK system is balanced between increasing levels of care and the complexity for the family for supporting the patient. The reality is likely to be that all personal care for patients in indigenous civilian hospitals is provided by family members and much of the in-patient medical care has to be paid for even in the ‘free’ public hospital system. Therefore the social costs of healthcare escalate in direct relation to the distance the patient moves from their locality. This issue is summarised as ‘gate-keeping access’ shown, as illustrated in Figure 2.

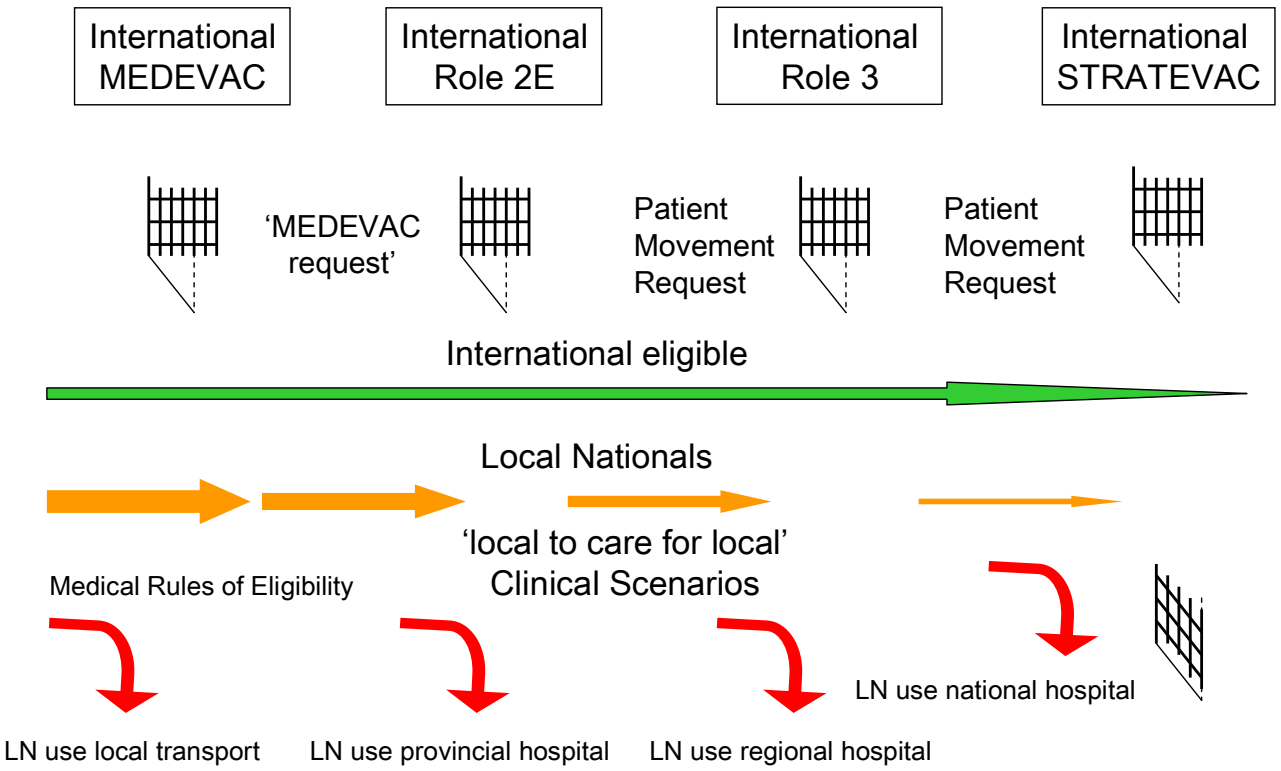

Figure 2 – 'Gate-keeping' Access

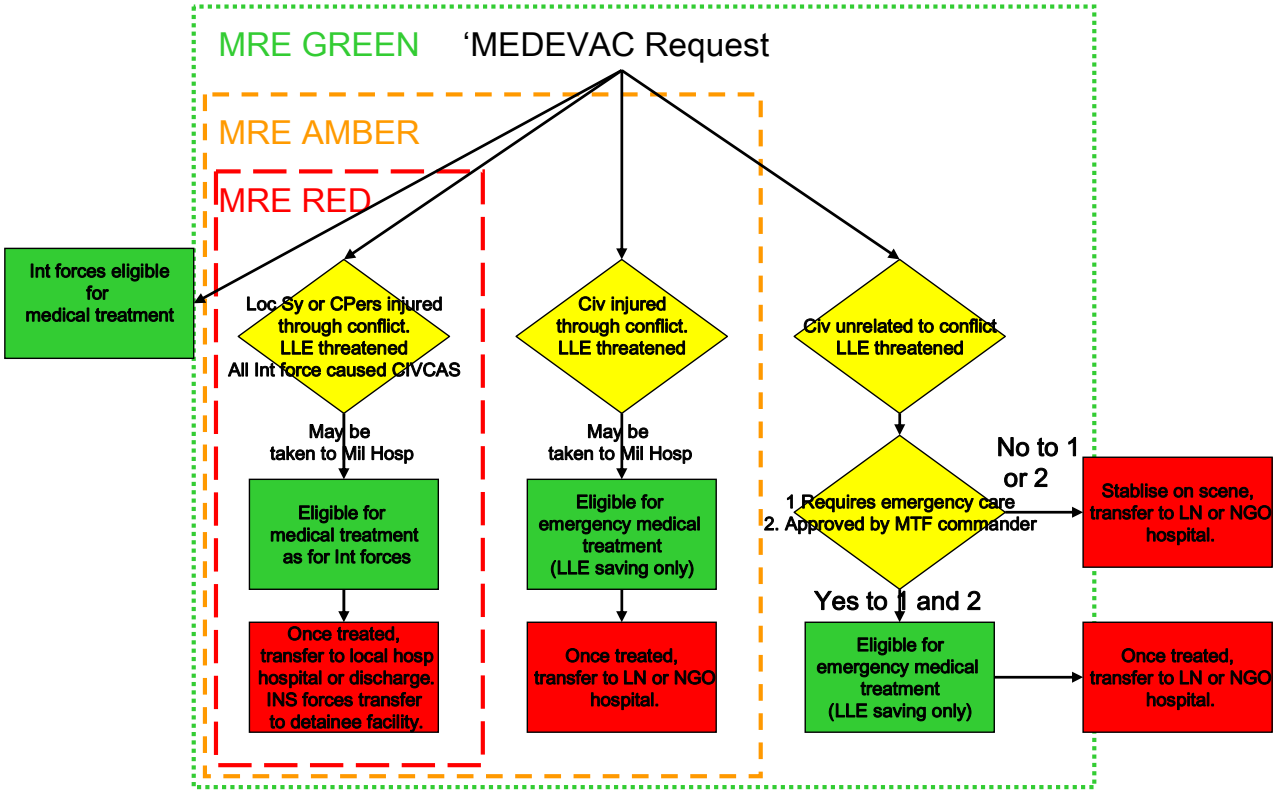

Figure 3 – Example of Medical Rules of Eligibility

11. The MRoE process defines patient groups by their level of access to the international military medical system. International forces usually have right of access to the whole system. Indigenous security forces may have right of access for emergency medical care (LLE – Life, Limb or Eyesight saving care) in order to achieve the same effect on the moral component of their fighting power as the medical system achieves for international forces. It is unlikely the international medical system will provide routine medical care for indigenous forces. Care for indigenous civilians may follow the same principles but could be further limited to injury from conflict in order to reduce access for normal medical and surgical emergencies. The description and application of these rules have to be carefully balanced to ensure the international military medical system follows the principles in paragraph 7 and supports consent building without undermining the development of the indigenous health economy. An example of the MRoE for MEDEVAC for a military operation is shown in Figure 3.

12. Figure 3 is colour-coded to allow an adjustment to the MRoE for access by indigenous patients dependant on the unoccupied capacity in the medical system. MRoE GREEN describes the normal situation in which indigenous civilians may be admitted for emergency medical care to receive LLE saving treatment. MRoE AMBER excludes those indigenous civilians with LLE conditions that are not conflict related unless by prior agreement with the formation Medical Director and the hospital commander. MRoE RED is imposed when the UK hospital system is full and therefore no indigenous civilians can be accepted unless injured as a direct result of international military actions. Local security force casualties and CPers would still be eligible for emergency care. The MRoE may be further refined with medical policy for specific clinical scenarios such as severe burns, closed head injuries with low Glasgow coma scales[14] and neonatal emergencies. If the MRoE is insufficient to control access and the deployed medical system is full, it may be necessary to consider whether to curtail security operations in order to reduce the risk to security forces and the potential demand for medical care. This is only ever a short-term, emergency response and should be accompanied by demand for rapid medical evacuation to clear the medical system and a review to determine whether medical capacity should be increased.

BUILDING THE CAPACITY OF HEALTH SERVICES SUPPORT TO THE INDIGENOUS SECURITY FORCES

13. JDP 3-40 emphasises security as the bedrock to stability. From the outset, UK military forces should consider supporting the development of indigenous security forces within the medium-term plan to achieve stability. Indigenous security forces will view health service support in a similar way as international forces; it is a key moral and physical component of fighting power. Health services support is one of the essential capabilities that enable the indigenous security forces to become self-sufficient. Case studies from Oman, Sierra Leone, Iraq and Afghanistan demonstrate that international military medical services may need to provide field medical support to casualties from indigenous forces until the indigenous security forces medical services are capable of providing this capability themselves. Helicopter medical evacuation and initial surgical care are the most sophisticated medical capabilities that international military forces possess and the most difficult to transfer to the indigenous forces. Annex B provides a list of tasks that may be considered as activities for UK military medical forces to undertake with indigenous security forces.

[14] The Glasgow Coma Scale (GCS) comprises three tests: eye, verbal and motor responses. The three values separately as well as their sum are considered. The lowest possible GCS (the sum) is 3 (deep coma or death), while the highest is 15 (fully awake person). Teasdale G, Jennett B (1974). 'Assessment of coma and impaired consciousness. A practical scale.'. *Lancet* **2** (7872) pp. 81–84.

STRATEGIC ISSUES

14. For military medical engagement, there are considered to be two dimensions to the strategic level of operations in the context of SSR. The 'out-of-country' strategic level concerns the integration of national 'comprehensive approaches' across the international community in order to achieve coherence in the international stability operation as presented to the recipient country. The 'in-country' strategic level is that of the employment of international resources to complement and support indigenous plans for SSR. The international out-of-country effort for military medical services will need to consider how the SSR function should be integrated into the wider in-country international military medical mission and how the medical function integrates SSR activities with wider G,R&D. It is essential that there is an out-of-country strategic campaign plan for the development of the indigenous military medical services in order to ensure continuity of the SSR programme between rotating in-country post-holders.

15. The contribution of international military medical services needs to be coordinated with the in-country strategic plan for the indigenous health sector (which includes the security force medical services). This should be balanced against meeting the primary task of providing medical support to international forces. The organisational structure of military medical services, with its emphasis on pre-hospital and primary care, might also be used as a catalyst for a shift in civilian medical services from hospital-based care to primary care in support of wider development goals.

16. At the outset it is important to determine eligibility for access to the indigenous military medical system for the different elements of the security forces and their beneficiaries as this has considerable implications on the demand for health services. It is also important to establish whether the medical support arrangements for the security forces are organised as a coherent whole or whether each component has its own system[15]. The military medical systems may also provide care for dependants of military personnel and veterans. This has substantial implications for the provision of specialist clinical services, such as paediatrics, obstetrics and gynaecology, and may also require the provision of musculoskeletal and psychological rehabilitation services for injured veterans. This issue of eligibility must be interwoven with wider personnel policies for the security forces to ensure coherence with funding allocations from parent ministries and international donors.

17. The two main factors limiting the overall development of the indigenous military medical services are human resources (numbers and competency) and money. The former is a competition for healthcare personnel with the civilian health sector and the latter is a competition for resources within the security sector. There may be a national shortage of healthcare personnel which could be mitigated by the employment of expatriate healthcare workers as either indigenous contractors or Loan Service personnel. An intermediate solution could be to maximise education opportunities for indigenous military and civilian healthcare workers by sharing educational opportunities across all sources including those from NGOs and international military forces. The indigenous government could also be supported to sponsor students to study overseas pending the development of sufficient critical mass to establish an indigenous tertiary level education

[15] As an example, in Oman the Sultan of Oman's Special Force had separate medical arrangements from that of the Land Forces. In South Africa, the medical arrangements for the Army, Navy and Air Force were the responsibility of the South African Medical Service (SAMS) of the National Defence Force and organised as a fourth Service. The SAMS also provided medical support to the South African Police Service when conducting combined operations.

system to train students. The funding for medical support for security forces is likely to be found from the MoD or MoI. It is highly unlikely that international agencies or NGOs will provide assistance to military medical services. Furthermore the medical services compete with other security capabilities such as ground manoeuvre or firepower. The financial support provided will depend on organisational and political factors, but is heavily dependant on the lobbying capability of senior members of the military medical services. This illustrates the need to mentor senior indigenous military medical personnel in military politics and staff procedures in order that they can compete effectively for resources in this environment.

18. HIV/AIDs are likely to be a significant issue, especially in stability operations in Africa. The UN AIDS programme recognises the potential impact of AIDS on the experience, skills, and training capacity within the uniformed services which can seriously affect military readiness. Diminished readiness in the security sector, and particularly in defence forces, as a result of HIV/AIDS related disease can thus be considered a threat to international peace[16]. The indigenous security forces employ a large number of young men who are a potential source of disease transmission. They should be an explicit target audience for HIV/AIDs awareness, testing and treatment programmes. Whether these are funded by the MoPH or NGOs, it is important to ensure that the military population has access to the same HIV prevention and management programmes as the rest of the national population. This is a good example of the impact of wider national health issues upon the capability of the security sector.

OPERATIONAL ISSUES

19. The development of the field medical system is the most important operational level issue. This comprises pre-hospital care (emergency trauma care and primary care) for the troops in the field, supported by a medical evacuation system that transports casualties to initial hospital care. It may also be necessary to have a medical transfer system to move casualties from the initial hospital to specialist referral hospitals. Counterinsurgency campaigns are primarily fought within national borders. Thus casualties can be taken to fixed medical facilities and so there may be a limited requirement for mobile, deployable field medical facilities. These might be required at a later stage of development, if indigenous military forces are to have an expeditionary capability as part of a wider, regional security construct. The network of fixed hospitals required to support security forces could also support the indigenous civilian population and, again, this might require coordination between military and civilian health agencies[17]. Overall the concept for the use of security forces medical services must be aligned to the operational employment of the security forces. This requires the senior indigenous military medical staff to understand the practical issues surrounding planning and managing medical arrangements to support military operations.

[16] UN AIDS. *Security and Humanitarian Response to AIDs.* http://www.unaids.org/en/PolicyAndPractice/SecurityHumanitarianResponse/default.asp (accessed 19 Mar 2009).

[17] As an example, in Oman the field surgical team (FST) in Salalah provided surgical care for both military and civilian patients until the Ministry of Health was able to open a new hospital. The FST then withdrew from the town to the military airbase and restricted itself to caring for military personnel. In Iraq, the initial plan was for the civil medical system to provide hospital care for security forces but as the security situation deteriorated it became necessary to establish protected medical facilities for the security forces.

TACTICAL ISSUES

20. The most common tactical activity for international military medical assistance is supporting development of pre-hospital care and medical evacuation through the provision of first aid training and military ambulance vehicles (ideally including helicopters for medical evacuation). This training should to be designed to reflect the educational ability of the indigenous personnel and the medical equipment available aligned to indigenous cultural attitudes. This may require a different training programme from that delivered within the medical training schools of the international forces. In a multi-national environment there needs to be coordination to ensure the syllabus is the same across different national training contingents.

SUPPORTING THE PROVISION OF HEALTH SUPPORT TO THE INDIGENOUS CIVILIAN POPULATION

21. The civilian health sector, indigenous or international, has primary responsibility for meeting the health needs for the indigenous population. The contribution of UK military medical services to supporting the indigenous civilian health sector is dependant on the wider context for the employment of UK military forces and should always be nested within a civilian plan. The relationship between international military forces and the indigenous civilian health sector will be dependant on the military mandate ranging from an exclusively civilian-military relationship in a humanitarian assistance mission to a *de minimis* relationship during war-fighting limited only to fulfilment of international obligations under the Geneva Convention. The end state for civilian health sector G,R&D is for an indigenous civilian healthcare worker to provide culturally and clinically appropriate healthcare for an indigenous civilian. Where possible, the international military role in the civilian health sector is to do nothing. There is likely to be a finite limit to the number of indigenous civilian educated technocrats who are competent to manage development projects. There is also a finite limit to the number of interpreters who can both facilitate international civilian engagement with the indigenous civilian community but also facilitate the partnership between international military forces and their indigenous civilian military counterparts. This, compounded with the threats by the insurgents to those who work with government institutions, may create a challenging market for indigenous civilian human capacity. The developmental challenge in indigenous countries will be to convert these resources into practical improvements in the quality of life at community level, especially in the vulnerable rural communities most exposed to the threats from insurgents.

22. At first glance military units may believe that the solution is short-term, direct provision of non-emergency primary care (often branded as 'MEDCAPS') 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 descriptions of on-off, non-emergency primary healthcare clinics provided by international military medical forces within an international military security envelope. There is very clear evidence of the ineffectiveness of mobile health clinics in anything other than the extreme short-term[18]. Alternatively the construction or refurbishment of health facilities or schools is often selected as a series of military development projects. However, buildings are not health capabilities and success depends on availability of healthcare workers and sustainable funding for medical supplies and equipment within the wider support of the local community. Overall the military role in improving access to health services should be

[18] Mobile Health Units. Methodological Approach. ICRC. May 2006. http://www.icrc.org/eng/assets/files/other/icrc_002_0886.pdf

considered within the wider 'SHAPE – SECURE – HOLD – DEVELOP (SSHD)' construct described in Reference A. The diagram at Figure 4 illustrates the spectrum of relationships between security forces and health providers according to the security environment. This illustrates the goal of 'local caring for a local' using local 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 of the slide. However, 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 of the slide.

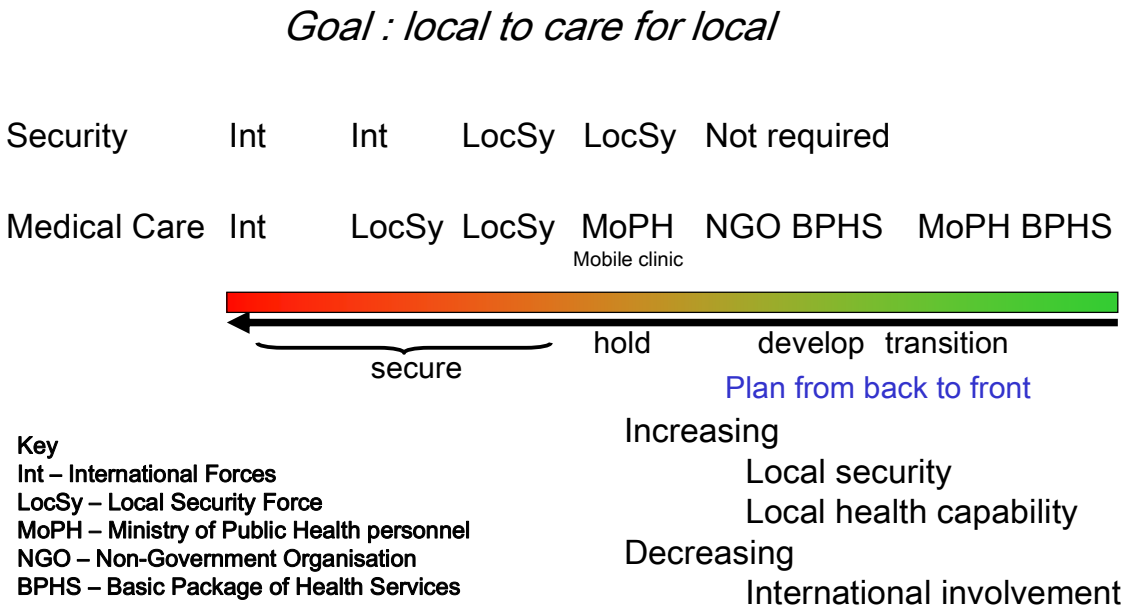

Figure 4 – Supporting Health Sector Development

23. Conceptually, security operations start by 'SHAPING' the environment to both build relationships with the indigenous population and also to define and then reduce the opposition. The 'SECURE' 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. This includes the (re)establishment of indigenous governance. 'DEVELOP' is the execution phase of reconstruction and development in order to demonstrate to the population the benefits of supporting the instruments of government and so gain their consent. This should include the transfer of governance and security from international security forces to indigenous political actors and 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. This may be consolidated into a Stabilisation Plan. Identification of the causes of civilian morbidity and mortality will point to those determinants of health (water, sanitation, nutrition, housing and education) that may need development assistance. Military activity in the first instance throughout SSHD should always be determinants of health driven before considering health infrastructure. An illustrative matrix of health sector tasks within the SSHD construct is at Annex C.

24. **Shape**. Military medical representatives should be actively engaged to both build relationships with the indigenous population and key health sector actors during the formulation of a Stabilisation Plan. At the indigenous 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 (eg helicopters) to assist indigenous civilian or international civilians to visit local communities in order to conduct 'community health meetings'. The most important outcome from the SHAPE phase 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 SECURE phase, continuously stressing civilian primacy. As a last resort, it may involve acceptance of civilian casualties into the military medical system, both indigenous civilian and international, but should always include agreement on the hand-off arrangements for these casualties back into the civilian health sector.

25. The information about civilian medical facilities can be compared with the indigenous 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, equipment and funds to cover operating costs once the buildings are ready for use. It may be appropriate to use military development money 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. There are ethical and legal constraints on what the military are permitted to gift or formally donate on behalf of HMG; for example it is not acceptable to gift time expired medications.

26. **Secure**. 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 including ensuring that entry of security forces to indigenous civilian medical facilities complies with indigenous and international law[19]. There will need to be close cooperation across the health sector to ensure that all casualties are transported to the most appropriate health facility for both immediate and long-term care. It may be necessary to provide military support to the provision of emergency medical supplies to the civilian sector, ideally by assisting with the transport of previously earmarked materiel or by emergency donation.

27. There should be a plan to medically support Internally Displaced Persons (IDP) stressing host nation primacy with the UN OCHA and Humanitarian Cluster. It may also be necessary to arrange for unfettered access for war wounded convoys under the protection of the International Committee of the Red Cross (ICRC). Both activities may require humanitarian corridors to be identified during the planning process and rehearsed with all actors in attendance. UN OCHA has provided guidance[20] in the response to IDP situations where the host nation's government has primacy, supported by UN OCHA and the humanitarian cluster that may well include other programmes such as the Global Polio Eradication Initiative[21]. Use of military medical elements to support IDPs is a last resort option that should only be undertaken at the specific request of the host nation and only then with close dialogue and advice from UN OCHA and Humanitarian Cluster.

---

[19] An example was the facilitation of safe passage of casualties across military lines brokered by the ICRC during OP MOSHTARAK in Feb 2010. This generated discussion over the authority of both international forces and indigenous civilian forces to screen these casualties to identify wounded insurgents. It was emphasised that all casualties have right of access to medical care independent of allegiance but the indigenous civilian security forces have the authority to detain them whilst in medical care for further investigation.

[20] UN OCHA; Guiding Principles on Internal Displacement; Sep 2004; http://ochanet.unocha.org/p/Documents/GuidingPrinciplesDispl.pdf

[21] WHO; Global Polio Eradication Initiative; http://www.polioeradication.org/

28. **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 Director of Public Health during the planning in the Shape phase. If there is an obvious unmet health 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. Ideally this should be done using indigenous military 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 Stabilisation Plan.

29. **Develop**. Ideally there would be no international military medical engagement during the DEVELOP phase because the implementation of the 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 coordination and cooperation. 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.

30. **Measuring Success**. It is important to establish performance metrics for health sector development. Ideally these will be the responsibility of civilian agencies though security forces may support the collection of data. This is likely to be based on a combination of Measures of Output and Measures of Outcome. This data is likely to be found from a range of sources including: Ministry of Public Health and World Health Organisation analysis, local civilian reporting, and military reporting. Table 1 shows examples of health sector development performance matrices.

Ser	Measures of Output	Ser	Measures of Outcome
(a)	(b)	(a)	(b)
1	No of Provinces with a Director of Public Health.	1	Number of hospital admissions due to conflict related trauma.
2	No of Provinces with a health sector development plan.	2	Maternal Mortality Rate.
3	No of Active Medical Treatment Facilities (MTF) – as a rate per 1000 Population at Risk (PAR).	3	Infant Mortality Rate.
4	No of Healthcare Staff by MTF. Sub-divide by groups (Doctors, Nurses, Midwives, Medics, Pharmacists).	4	<5 years Child Mortality Rate.
5	Vaccination Rates.	5	Incidence of Disease (Use epidemiological data as a proxy measure of total burden of disease – should decrease).
6	No of Villages participating in specific public health interventions – ie (Water, Sanitation, Nutrition, Housing).	6	Incidence of D&V. (Use Diarrheal Disease Infection Rates as a proxy measure of safe H_2O supply).
7	No of Students at University commencing basic medical professional trg (BPT).	7	Incidence of Acute Respiratory Infection (ARI). (Use ARI Rates as a proxy measure of improving housing conditions – indoor air pollution).
8	No of Students at University commencing higher medical professional trg (HPT).	8	Proportion of children showing evidence of malnutrition.
9	No of indigenous civilian MEDEVACs from PoW accepted direct to civilian MTFs.	9	Civilian Hospital Case Fatality Rates.
10	No and type of military medical healthcare engagements (should decrease).	10	Ranking of access to healthcare as an expressed ‘grievance’.

Table 1 – Examples of Health Sector Development Performance Matrices

PREPARATION OF INDIVIDUALS FOR ROLE

31. Generic military medical training and education should provide a robust underpinning framework for undertaking military medical activities in support of an indigenous health sector (eg first aid training, medical assistance clinics). Medical personnel should be trained and equipped to provide emergency medical care for the whole potential PAR (including paediatric, geriatric and general medical emergencies). However, it is essential that theatre specific issues are covered during pre-deployment training including medical rules of eligibility, indigenous arrangements for transfer of indigenous casualties, ethical dilemmas and the campaign plan for indigenous health sector engagement.

32. It will be necessary to have designated subject matter experts if engagement with the indigenous health sector (security sector or civilian sector) is a specified task at the operational or strategic level. The individuals will require significant postgraduate education in public health in conflict including knowledge of the roles of all stakeholders in health sectors in crisis with training in the World Health Organisation's Cluster Approach[22] and minimum standards to the delivery of health and humanitarian support[23]. Ideally these individuals will have prior practical experience before operational deployment. Understanding the culture and context of an indigenous health sector and building relationships with key stakeholders takes time. A 'one-off', 6-month tour is probably too short to achieve enduring impact. An alternative model of longer tours for a minimum of 9 months or continued longer-term engagement through reachback/forward is required for specialist personnel working in this field. It is important for these individuals to have sufficient maturity to understand complex issues such as the indigenous relationship between 'Western medicine' and traditional medicine, balancing tribal and cultural politics with performance and the pace of change, and to balance their own experience of the practice of medicine with culturally sensitive and clinically appropriate advice for the indigenous conditions.

Annexes:

A. The Deployment of Medical Forces on OP GABRIEL, Rwanda 1994.
B. Common Activities in International Assistance to Indigenous Security Forces Medical Services.
C. Illustrative Matrix of Health Sector Tasks in SSHD.

[22] United Nations; Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response; *Inter-Agency Standing Committee*; 24 November 2006; http://oneresponse.info/Coordination/ClusterApproach/publicdocuments/IASC Guidance Note on using the Cluster Approach to Strengthen Humanitarian Response (November 2006).pdf

[23] The Sphere Project; Humanitarian Charter and Minimum Standards in Humanitarian Response; 3rd Ed 2011; http://www.sphereproject.org/

ANNEX A TO
DOCTRINE NOTE 11/22

THE DEPLOYMENT OF MEDICAL FORCES ON OP GABRIEL, RWANDA 1994

The British contingent to the United Nations Force in Rwanda (UNAMIR) in 1994 included a medical battalion (23 Para Fd Amb). The main task was expected to be humanitarian relief to operations. The medical regiment initially deployed to the North-West to reduce the flow of Rwandan refugees into camps in Goma in Zaire.

As the acute crisis settled, a similar emergency was developing in the South-West. The French Army had deployed to this area of Rwanda on Operation Turquoise in June, and set up a Humanitarian Protection Zone to stabilise the area and prevent another mass exodus of refugees to Zaire. This had been achieved, and up to a million internally displaced persons were thought to be in informal camps there. The new Rwandan Government was opposed to the French presence in the country, being suspicious of French involvement in the conflict, and the French were due to withdraw. It was believed that many of those taking refuge in the Humanitarian Protection Zone were either implicated in the massacres and would not stay to face the vengeance of the victors, or innocent but fearful of arbitrary reprisals or of being caught up in further conflict. Only a small number of International Organisations and NGOs were operating in the area, with little or no medical activity taking place. There were thus real and perceived threats to human security from disease and violence.

The concern therefore was that the internally displaced would leave the camps to become refugees in Zaire, repeating the Goma crisis and exacerbating international tensions, only this time without the resources to meet it: the aid agencies had already been stretched to breaking point and beyond, and there were scarcely any logistic resources left in the region to be mobilised.

The UN commander decided to move into the area to maintain stability as the French left, and the medical battalion was redeployed to provide medical support to the displaced population, to encourage them to remain in the area. The concept from the start was that the military medical presence would reassure the population, deter potential low level insurgent threats, and prevent large scale population movement. Following a recce and health needs assessment, 23 Para Fd Amb established health posts in both villages and camps of internally displaced persons, and mobile clinics to travel across the area. Stabilisation of the population was achieved, and the responsibility for medical support to the camps was subsequently successfully handed over to incoming NGOs.

While at first sight a purely humanitarian relief operation, the intended effect was to stabilise the region, through promoting human security, and supporting the state as it emerged from conflict. The operation was coherent with the current doctrine in JDP 3-40 that the military should only lead on civilian health provision for as short a time as possible, until the appropriate civilian authority can take over. It was thus both at one level a humanitarian relief operation, and at another, a stabilisation operation (in today's terms). Alternatively it can be thought of as at a tactical level a humanitarian relief operation, and at the operational level a stabilisation operation.

A fuller account can be found in:

Hawley A, 'Rwanda 1994: a study of medical support in military humanitarian operations', Journal Royal Army Medical Corps, 143, (1997): 75-82.

ANNEX B TO
DOCTRINE NOTE 11/22

COMMON ACTIVITIES IN INTERNATIONAL ASSISTANCE TO INDIGENOUS SECURITY FORCES MEDICAL SERVICES

Ser	Possible Military Activity	Supporting Military Medical Activity	Remarks
(a)	(b)	(c)	(d)
1	Professional military training as appropriate levels.	Establish health training schools Establish accreditation system for professional qualifications	Military medical training and education programmes should be aligned with whole health sector. Security force medical training should focus on the care of trauma, and force health protection. Security force medical personnel should also receive general military training.
2	Education in the role of the security forces in a democratic society.	Education on universal medical ethics eg impartiality in provision of emergency care, banning of medical involvement in interrogation, oversight of medical research.	This is an important aspect of legitimacy for medical personnel employed in the security forces.
3	The conduct of national defence reviews.	Conduct of reviews of medical services supporting security forces.	Should be nested within the wider indigenous health sector.
4	The development of defence policies.	The development of policies for the security forces medical services including organisational, administrative and clinical issues.	Need to the tailored to the local context and not solely an import of the system from a Western nation.
5	The provision of specific technical assistance.	Applies across the whole programme for the development of security forces medical services.	Likely to involve a combination of in-country personnel, short-term project teams, sponsored external visits and sponsored attendance at external training programmes.
6	Strengthening defence resource management and increasing accountability in defence procurement.	Establish system for procurement, accounting, distribution and sustainment for medical equipment and pharmaceuticals.	Will need to link to the wider local health sector. Medical materiel has high intrinsic value and thus at risk of fraudulent management and use.
7	Strengthening military personnel management systems.	Establish medical staff support to recruit medical screening, administration of preventive medical interventions (eg immunisations), a system of medical categorisation and management of personnel not fully fit including medical pension system.	Personnel management of security force medical staff has many unique aspects; recruiting and retention in a ‘seller’s market’, civ/mil mix, professional salaries, private practice, professional development etc.
8	The development of infrastructure and specialist facilities.	Establish and resource the fixed medical infrastructure for the security forces.	The size and location of these will depend on the entitled population, the capacity of the civilian health system and the resources available.

ANNEX C TO
DOCTRINE NOTE 11/22

ILLUSTRATIVE MATRIX OF HEALTH SECTOR TASKS IN SHAPE/SECURE/HOLD/DEVELOP[24]

Ser	Domain	DEVELOP	HOLD	SECURE	SHAPE
(a)	(b)	(c)	(d)	(e)	(f)
1	Health	Establish professional education programmes. Transfer NGO provision to local provision of services. Establish financial and equipment account systems for health sector.	Introduce Bed Nets (Malaria – MDG 6). Commence MoPH and epidemiological reporting/ stewardship. Refurbish Basic and Comprehensive Health Centres. Facilitate civilian access to healthcare.	Confirm HNA data. Ensure provision of emergency care Facilitate movement of district public health officer with district governor and his staff. Facilitate 'humanitarian corridors'.	Health Needs Assessment (HNA). Gov lead Public Health Messaging – how to stay healthy during clear, where to get healthcare from during secure phase, IDPs where to go to for assistance. Support recruitment of local public health officer and staff.
2	Water	Develop public water system.	Assess public water system.	Supply of potable water to LNs (well, stand pipe, truck, container, bottled). Health messaging on the importance of clean water, how to source and sterilise water.	Intelligence Preparation of the Battlefield (IPB) on potable and irrigation water supplies. Proxy indicators to include food production (irrigation), cholera outbreaks (potable water), malaria incidents (still water).
3	Sanitation	Develop public sanitation system.	Assess public sanitation system.	Identify grey water, sewage and waste disposal systems that have been affected during the clear and affecting the environment. Health messaging on where to defecate so as to not cause a health hazard.	IPB on sewage and waste disposal. Proxy indicators to include cholera outbreaks (potable water), Numbers of identified Ventilated Improved Pit Latrines, out houses, community refuse areas.

[24] The table reflects the plan backwards approach described at paragraph 23, 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.

Ser	Domain	DEVELOP	HOLD	SECURE	SHAPE
(a)	(b)	(c)	(d)	(e)	(f)
4	Housing/ Shelter	Support provision of fuel efficient stoves, smoke hoods and chimneys (↓ Acute Respiratory Infection (ARI) morbidity and mortality).	Ensure access to fuel. Ensure access to emergency shelter. Inform LN population on PERF.	↓ Collateral damage to properties. ↓ Collateral damage to infrastructure (irrigation, water, sanitation and health systems). Assess access to safe secure housing incl IDP locations. Assess access to secure and sustainable fuel sources. Monitor effectiveness of IDP response.	IPB on social infrastructure. Assess access to safe housing esp for women and children. Assess current access to secure and sustainable fuel supplies (for domestic cooking, lighting and heating) – is it wood, dung, agricultural by-product (ie poppy stems)? Support IDP response planning (Is a HN Gov responsibility with UN OCHA assistance – Coalition c/s in extremis sp only).
5	Food	Support agricultural development.	Solar Cookers. 'Strong food' interventions for malnutrition.	↓ Collateral damage to crops, food sources, livestock.	IPB on location of stores, access to markets, markets, locally produced product.
6	Engagement	Withdraw military engagement with civilian health sector.	Plan for withdrawal of military medical services from civilian engagement.	Support common medical operating picture across all medical services – international, security and civilian facilities.	Identify health sector stakeholders. Facilitate collaborative planning.