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Ministry  
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Joint Doctrine Note 3/14

# The Military Medical Contribution to Security and Stabilisation



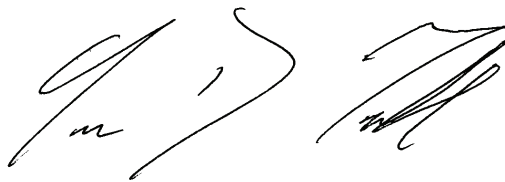
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## Joint Doctrine Note 3/14

### The Military Medical Contribution to Security and Stabilisation

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is promulgated  
as directed by the Chiefs of Staff



Head of Doctrine, Air and Space

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## Preface

‘The resolution of complex contemporary crises may involve a hybrid of conventional warfighting and irregular activity combined, as well as concurrent stabilisation activity, all in the same theatre.’

British Defence Doctrine<sup>1</sup>

## Context

1. There are many examples of UK military medical services being used to alleviate suffering amongst non-combatant populations in the aftermath of conflict. UK field hospitals operating in Iraq saw Iraqi combat casualties, civilians and children at the accident and emergency department and provided surgery in an emergency. Similarly, the UK field hospital in Camp Bastion in Afghanistan cared for detainees, indigenous civilian security force and civilian casualties, as well as NATO casualties. Our military medical services helped to develop indigenous security forces medical services in Brunei, Oman, Iraq and Afghanistan. We are likely to need to remain competent in engaging with, and supporting, indigenous health sectors, as part of our military medical capability.

## Purpose

2. Joint Doctrine Note (JDN) 3/14, *The Military Medical Contribution to Security and Stabilisation*, provides guidance on the role of military medical assets in humanitarian assistance, security sector reform and developing the civilian health sector. It recognises the relationship between health and security and the characteristics of a failing health system. It also highlights the potential requirements to build capacity in the indigenous security forces medical services and develop the civilian health care system. This guidance is underpinned by a set of enduring principles and highlights the necessity to measure success and adequately prepare military medical personnel to deliver their role.

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<sup>1</sup> Joint Doctrine Publication (JDP) 0-01, [British Defence Doctrine](#) (BDD), 4<sup>th</sup> edition.

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## Audience

3. JDN 3/14, *The Military Medical Contribution to Security and Stabilisation*, should be used by commanders and staff at the operational level involved in employing military medical assets on contemporary operations.

## Structure

4. JDN 3/14, *The Military Medical Contribution to Security and Stabilisation*, is divided into four chapters.

- Chapter 1 – a typical health sector in crisis;
- Chapter 2 – providing emergency care;
- Chapter 3 – supporting the indigenous security forces; and
- Chapter 4 – developing health care within the indigenous civilian population.

## Linkages

5. Although JDN 3/14, *The Military Medical Contribution to Security and Stabilisation*, is currently a standalone publication, in time it will be incorporated into a hybrid Allied Joint Publication (AJP). It is intended to be read alongside Joint Doctrine Publication (JDP) 4-03, *Joint Medical Doctrine*, (3rd edition) and AJP 4-10, *Allied Joint Medical Support Doctrine*. It should also be read with JDP 3-40, *Security and Stabilisation: The Military Contribution* and AJP 3.4(A), *Allied Joint Doctrine for Non-Article 5 Crisis Response Operations*, including its subordinate publications. These publications collectively offer guidance on employing military capability on security and stabilisation operations.

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A typical health sector in crisis

## Chapter 1 – A typical health sector in crisis

### Section 1 – Background

1.1. The absence of security in a country does not just affect national military defence. Article 25 of the United Nations Charter of Human Rights asserts that being healthy and having access to health care are essential elements of human security.<sup>2</sup> This underpins the UN 'Responsibility to Protect' agenda<sup>3</sup> that emphasises preventive and developmental interventions, as well as using military force to support populations within countries in crisis.<sup>4</sup> Three of the eight millennium development goals of the UN Millennium Project are directly related to health. They are:

- Goal 4 – reduce child mortality rates;
- Goal 5 – improve maternal health; and
- Goal 6 – combat HIV/AIDS, malaria and other diseases.

1.2. Conflict has a direct impact on population health as individuals become injured because of the fighting. It also has a significant indirect impact through population displacement, damage to health institutions and the collapse of economic activities needed to fund health programmes.<sup>5</sup>

1.3. A study linking health indicators and conflict status across countries in Africa emphasises both the consistent need to support basic health and public health services in countries affected by conflict.<sup>6</sup> The study also highlights that conflict is a much more common cause of large-scale epidemics than natural disasters.<sup>7</sup> Furthermore, analysis of building state

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<sup>2</sup> 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 6 February 2014).

<sup>3</sup> The UN Responsibility to Protect only deals with situations of genocide, war crimes, crimes against humanity and ethnic cleansing.

<sup>4</sup> 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/en/peacebuilding/pdf/historical/hlp\\_more\\_secure\\_world.pdf](http://www.un.org/en/peacebuilding/pdf/historical/hlp_more_secure_world.pdf) (accessed 6 February 2014).

<sup>5</sup> C J L Murray, G King, A D Lopez, N Tomijima and E G Krug. *Armed Conflict as a Public Health Problem*. *British Medical Journal* 324 (2002), pages 346-349.

<sup>6</sup> 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 Centre for International Development and Technology Transfer, Tulane University, April 2000.

<sup>7</sup> 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.



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institutions on operations since 1945 highlights that the health sector has an impact on the security, economic stabilisation and political development of a state.<sup>8</sup> Overall, it is clear that threats to health and health services are significant aspects of security for populations in crisis. Access to health services is an essential component in restoring stable governance.

## Section 2 – International humanitarian principles

1.4. This section is based on UN and NATO guidance covering the military medical services involvement with humanitarian assistance and support to governance, reconstruction and development.<sup>9</sup> Medical support to military operations is tailored to the military population at risk and guided by the assessed risks to deployed UK troops. However, it will always be necessary to provide support to captured persons and often to friendly indigenous military forces. Supporting our military force must remain paramount, together with providing emergency care to all casualties when urgently needed (in accordance with international humanitarian principles).

1.5. We must adhere to the following principles (based on UN guidelines) when our military is involved in the medical aspects of governance, reconstruction and development.<sup>10</sup>

- a. **Do no harm.** The most important principle when assisting in health sector development is to 'do no harm'. There is a real risk that the work of other agencies and their security (including those they treat), might be compromised by involving our military medical services in providing direct health care to the indigenous population.
- b. **Clinically appropriate.** Any intervention must be clinically appropriate, considering the capabilities of the health care sector and the host-nation governmental institutions' policies and direction. This

<sup>8</sup> Seth G. Jones, Lee H Hilborne, C. Ross Anthony, Lois M Davies, Fedrico Giroso, 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](http://www.rand.org/pubs/monographs/2006/RAND_MG321.pdf) (accessed 6 February 2014).

<sup>9</sup> Allied Command Operations Directive 83-2 *Allied Command Operations Guidance for military medical services involvement with humanitarian assistance and support to governance, reconstruction and development*, dated 8 March 2010.

<sup>10</sup> *Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief*, Oslo Guidelines (Revision 1.1 dated 1 November 2007). [http://www.auswaertiges-amt.de/cae/servlet/contentblob/648034/publicationFile/181195/Oslo\\_guidelines2.pdf](http://www.auswaertiges-amt.de/cae/servlet/contentblob/648034/publicationFile/181195/Oslo_guidelines2.pdf) (Accessed 6 February 2014).

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may include us providing short-term support as a part of a development programme. For example, in sub-Saharan Africa, providing cataract surgery allows many people to return to productive lives and thereby improving their health and wellbeing. Therefore, development activity should aim to support and mentor indigenous ophthalmic surgeons in the necessary techniques.

- c. **Culturally sensitive.** Any health sector intervention we provide must be culturally appropriate and socially acceptable to the indigenous cultural, social and religious values, while noting the specific issues of gender, and gender specific roles, in health care in many nations.
- d. **Coherent.** Our intervention should not be focused on just one aspect of governance, reconstruction and development, such as buildings or equipment. These projects are often unsustainable if they are not considered with other aspects of development, for example, availability of trained staff and mechanisms for meeting recurring costs.
- e. **Sustainable.** Any intervention should seek to make sure that once military forces withdraw, the intervention can be sustained by national medical services or non-governmental organisations. Any equipment that has been donated must be able to be maintained in the long term by the local population, using local resources.
- f. **Civilian primacy.** Involving our military in developing civilian health care must only be undertaken if there is no civilian alternative. It should always be the last option 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 with the government, non-governmental organisations and other agencies will be essential.

1.6. Although the military is not considered a humanitarian agency, there may be occasions during combat or other military operations where we are required to deliver humanitarian assistance.

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## Deploying medical forces on Operation GABRIEL – Rwanda, 1994

The British contingent to the UN Force in Rwanda (UNAMIR) in 1994 included a medical battalion (23 Parachute Field Ambulance). The expected main task was to provide humanitarian relief. The medical regiment initially deployed to the north-west to reduce the flow of Rwandan refugees into camps in Goma, Zaire.

As the acute crisis settled, a similar emergency was developing in south-west Rwanda. The French Army had deployed to this area 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 people who may be fearful of arbitrary reprisals or being caught up in further conflict. Only a small number of international organisations and non-governmental organisations were operating in the area, with little or no medical activity taking place. There were, therefore, real and perceived threats to human security from disease and violence.

The concern was that the internally displaced persons 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 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.

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Following a reconnaissance and health needs assessment, 23 Parachute Field Ambulance established health posts in both villages and camps of internally displaced persons and mobile clinics to travel across the area. Stabilising the population was achieved and the responsibility for medical support to the camps was subsequently successfully handed over to incoming non-governmental organisations.

While at first sight it was 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 Joint Doctrine Publication 3-40, *Security and Stabilisation: The Military Contribution*, stating that the military should only lead on providing civilian health care 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 at a tactical level as a humanitarian relief operation, and at the operational level a stabilisation operation.<sup>11</sup>



British military contingent arrives at Kigali airport, Rwanda, August 1994<sup>12</sup>

<sup>11</sup> Hawley A, *Rwanda 1994: a study of medical support in military humanitarian operations*, Journal Royal Army Medical Corps, 143, (1997), pages 75-82.

<sup>12</sup> Picture supplied by the Imperial War Museum.

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1.7. The vignette is an example of how military medical capability was used to both respond to a humanitarian crisis and support a stabilisation operation. In such cases NATO states that the following principles must be respected.<sup>13</sup>

- a. **Humanity.** The dignity and rights of all those sick and injured must be respected and protected. Indigenous cultural requirements must also be respected.
- b. **Impartiality.** Medical assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relieving 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.

1.8. Well-intentioned but uncoordinated military medical activities (particularly those undertaken for ostensibly humanitarian reasons) risk undermining efforts made by the host nation government to rebuild its own health system with the help of key donors and humanitarian agencies. The likely goal for the host nation government is a trained, equipped, and sustainable health system (equivalent to those existing in neighbouring peaceful countries) which contributes to overall national political and economic stability. Military medical activity undertaken for perceived short-term gains may undermine the military mission in the medium to longer term, particularly in counter-insurgency operations, by reducing the indigenous population's confidence in their government's ability to provide these essential services.

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<sup>13</sup> United Nations Office for the Coordination of Humanitarian Affairs *Guidelines on the Use of Military and Civil Defence Assets to Support United Nations Humanitarian Activities in Complex Emergencies* (Revision 1- dated January 2006). <https://docs.unocha.org/sites/dms/Documents/ENGLISH%20VERSION%20Guidelines%20for%20Complex%20Emergencies.pdf> (Accessed 6 February 2014).

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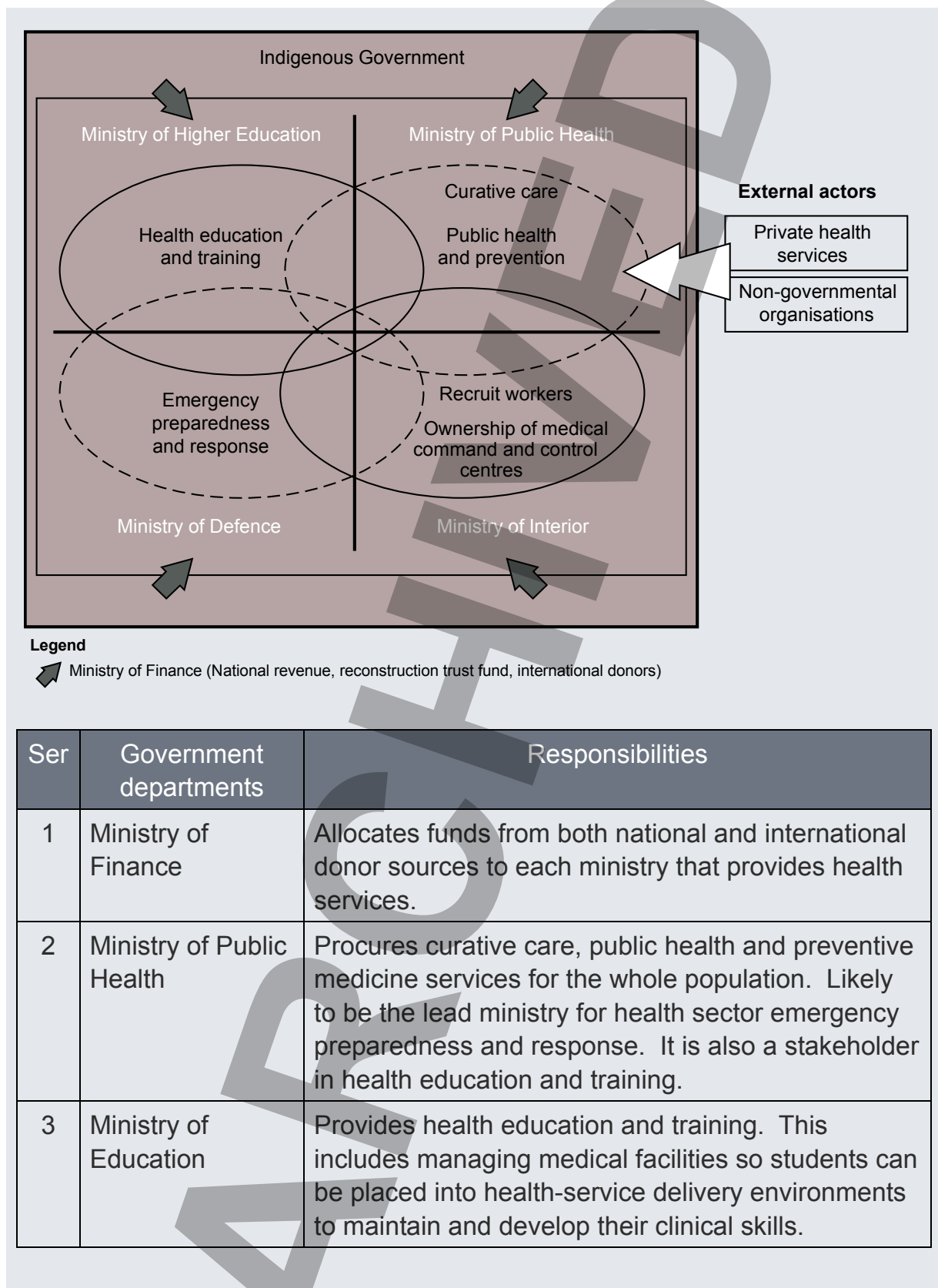
Military medical activity can adversely affect indigenous medical capabilities unless carefully planned and coordinated

### Section 3 – Indigenous health sector relationships

1.9. It is essential that we develop an understanding of the responsibilities and relationships that influence indigenous health sectors as a holistic concept at a national level. This section illustrates these relationships. The precise balance of power will vary and will almost certainly be different to Western, socialised health systems. Figure 1 is a model illustrating the relationships between indigenous health sectors within a theatre of operations.

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Ser	Government departments	Responsibilities
4	Ministry of Interior	Recruits members of the health sector workforce. Owns command and control centres and ambulances that can respond to mass-casualty incidents. <sup>14</sup> Medical support to the police and, routinely, provides medical care to detainees/prisoners.
5	Ministry of Defence	Provides health services to the armed forces. The Ministry of Defence also has the ability to deploy command and control centres and ambulances that can respond to mass-casualty incidents. <sup>15</sup>
6	Private Health Services	Provide privately funded health care, including curative care.
7	Non-governmental organisations	Impartial and independent support to the indigenous health sector in providing curative care, public health and prevention.

Figure 1 – Indigenous health sector relationships

1.10. It is vital to consider the private, insurance or informal health care market where many health care 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. There may also be a challenge to dissuade health care workers from taking employment as interpreters or migrating from the country due to the financial benefits. The ideal solution would be for the indigenous education system to train sufficient health care workers to staff all national health requirements, including the military medical services. This should cover all health care professions, not only doctors and nurses, but also, for example, radiographers and

<sup>14</sup> The Ministry of Interior may have limited medical services and will need to use the Ministry of Public Health and/or Ministry of Defence medical facilities to treat members of the police and detainees/prisoners.

<sup>15</sup> The Ministry of Defence and Ministry of Interior 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 Ministry of Public Health facilities.



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ambulance, laboratory, and medical equipment technicians. Overall, international military medical activities should complement wider programmes for developing capacity in the indigenous health sector.

## Section 4 – Assessing indigenous health needs

1.11. Providing health care is often an emotive subject because of the impact disease and illness can have on society's wellbeing. It can, therefore, become a destabilising influence if access is reduced or controlled in favour of certain groups of society. Helping the host nation government provide health care may, therefore, be an important stabilising function.<sup>16</sup> State delivered health care, is a governance function and is an indicator to the government's commitment to protect its population and its view on human rights.<sup>17</sup>

1.12. Joint Doctrine Publication (JDP) 4-03, *Joint Medical Doctrine*, and JDP 3-40, *Security and Stabilisation: The Military Contribution*, highlight the importance of assessing the indigenous health needs (as part of the estimate) to identify and consider the likely military medical services' tasks – in theatre. This should cover:

- the context of the health sector;
- statistics on the health of the population;<sup>18</sup>
- information on current health services; and
- a description of the stakeholders in the health sector.

1.13. A comprehensive health-needs assessment (at anything above village or district level) is a time-consuming, technical task that dedicated specialist staff may need to undertake. Ideally this should be conducted by indigenous health professionals with technical assistance from civilian agencies (where appropriate). However, if the military medical services are asked to assist, we should be prepared to help.

<sup>16</sup> Evans G, *The Responsibility to Protect*, (Canada, International Research Centre, 2001), pages 319 – 324.

<sup>17</sup> Declaration of Alma-Ata; International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978; [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf) (Accessed 6 February 2012).

<sup>18</sup> This could include indigenous, UK or international (for example, UN, WHO) health statistics.

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Providing emergency care

## Chapter 2 – Providing emergency care

2.1. Casualties from conflicts must be treated in priority, solely based on clinical need. The military medical plan will define the patient groups who are eligible for access to the international military medical system. The plan may include cross-government coordination (for example, the Foreign and Commonwealth Office and Department of Health), and bi- or multinational agreements. The international military system comprises of:

- initial medical evacuation;
- entry to an allied military hospital; and
- in-theatre transfer to an allied or indigenous hospital and strategic medical evacuation.

2.2. The population at risk 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 forces will be eligible to access all aspects of an allied medical system, which may include strategic aeromedical evacuation. In stabilisation or counter-insurgency operations, eligibility may be extended to indigenous security forces and the civilian population.

Patient groups will be identified by an allied medical plan



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Providing emergency care

## Section 1 – ‘Gate-keeping’ access

2.3. Armed conflict – causing indigenous casualties – may occur 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 access to, and delivering, indigenous health care services. These barriers may include insecurity, poor public health measures and governance difficulties. There may be substantial differences between the capabilities of the international military medical system and the indigenous health system, but, it is unlikely that the international military medical system can cover all of these deficiencies. This may cause moral and ethical challenges for allied military medical personnel that need to be addressed during pre-deployment training and by in-theatre policy direction.

2.4. Indigenous patients should receive care from indigenous health care workers unless there are overriding reasons why the international military medical system should provide this care. There may be exceptional circumstances when indigenous patients are evacuated from their country for treatment and this may be under the care of international, humanitarian or non-governmental organisations. Casualties amongst local civilians and security forces may, however, be given access to medical evacuation and medical care in the international military force system, but this will be increasingly constrained the further they progress along the evacuation chain.

2.5. Our military medical system includes a management process that controls entry and can be adjusted according to capacity – this is known as ‘medical rules of eligibility’. Generally, all personal care for patients in indigenous civilian hospitals is likely to be 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 health care escalates in direct relation to the distance the patient moves from their locality. Once inside the military medical system, controlling medical evacuation is influenced by the need to provide increasing levels of care and the complexity for the family for supporting the patient. This issue is summarised as ‘gate-keeping’ access shown in Figure 2.

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Providing emergency care

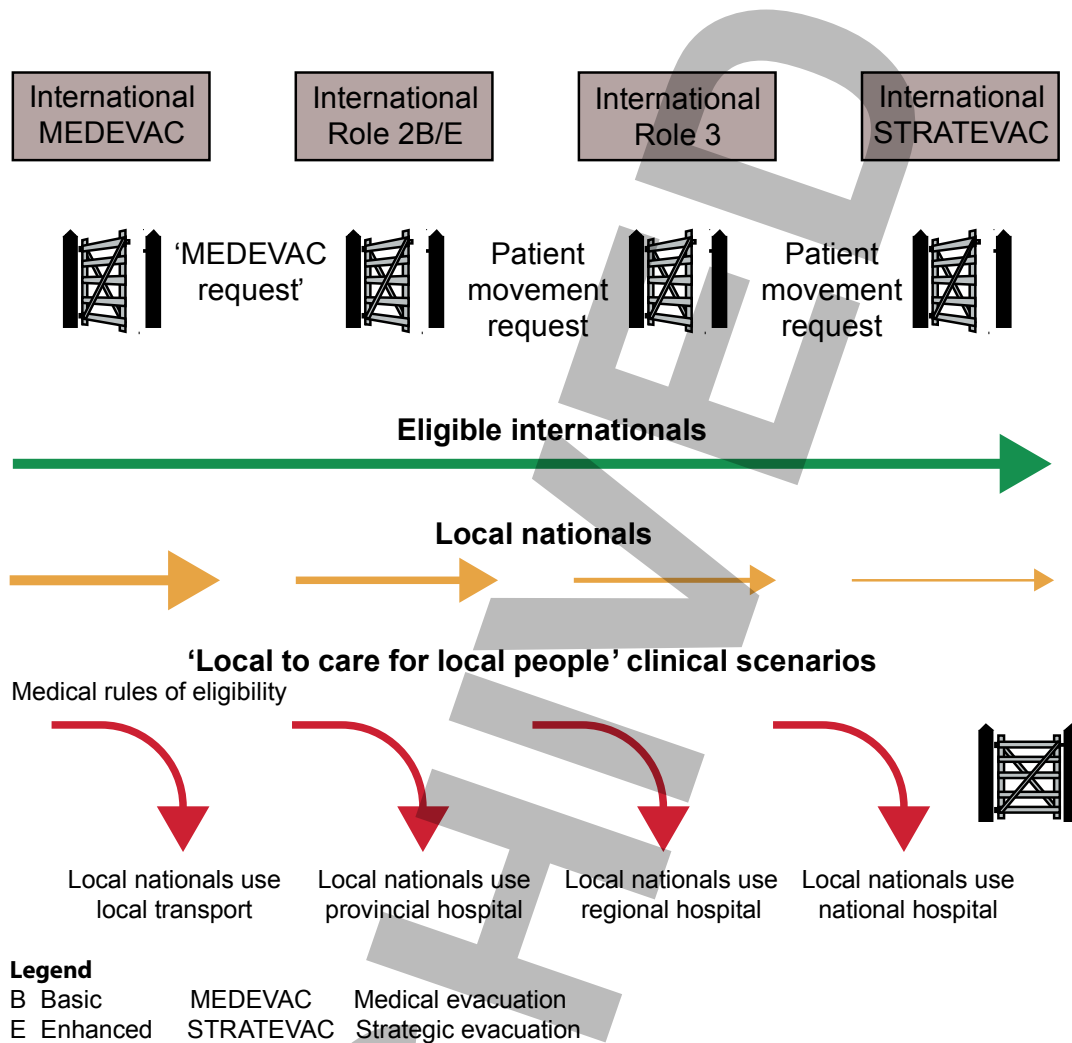


Figure 2 – 'Gate-keeping' access

## Section 2 – Medical rules of eligibility

2.6. The medical rules of eligibility 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 (life, limb or eyesight saving care) to achieve the same effect on the moral component of their fighting power as the medical system achieves for international forces. Care for indigenous civilians may follow the same principles but could be further limited to injury from conflict reducing access for normal medical and surgical emergencies. Describing and applying these rules have to be carefully balanced to make sure the international military medical system

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follows the principles highlighted earlier and supports consent building without undermining the development of the indigenous health economy.

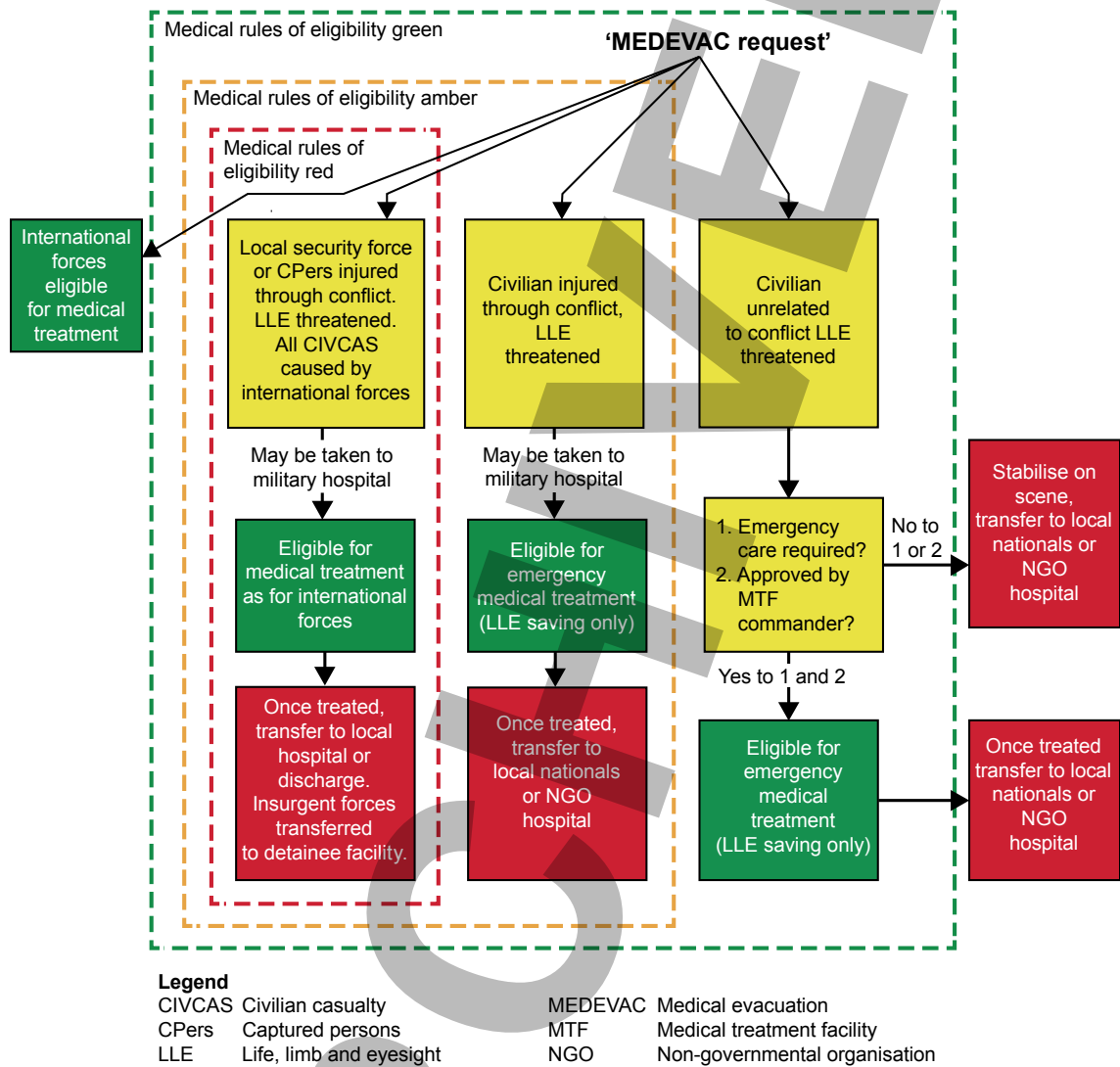


Figure 3 – An example of medical rules of eligibility

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Providing emergency care

2.7. Figure 3 provides a medical rules of eligibility example for a medical evacuation during a military operation. It is colour-coded so the eligibility rules can be adjusted for access by indigenous patients' dependant on the unoccupied capacity in the medical system.

- a. Medical rules of eligibility – 'Green' describes the normal situation in which indigenous civilians may be admitted for emergency medical care to receive life, limb and eyesight saving treatment.
- b. Medical rules of eligibility – 'Amber' excludes those indigenous civilians with life, limb and eyesight conditions that are not conflict-related, unless by prior agreement with the formation medical director and the hospital commander.
- c. Medical rules of eligibility – 'Red' is imposed when our 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 captured persons would still be eligible for emergency care.

2.8. The medical rules of eligibility may be further refined with medical policy for specific clinical scenarios, such as severe burns, closed head injuries with low 'Glasgow coma' scales and neonatal emergencies. If the medical rules of eligibility is insufficient to control access and the deployed medical system is full, we may need to consider curtailing security operations to reduce the risk to security forces and the potential demand for medical care. This is only ever a short-term, emergency response. It 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.

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Notes:

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Supporting the indigenous security forces

## Chapter 3 – Supporting the indigenous security forces

3.1. Joint Doctrine Publication 3-40, *Security and Stabilisation: The Military Contribution*, emphasises security as the bedrock to stability. From the outset, our military forces should consider helping to develop indigenous security forces within the medium-term plan to achieve stability. Health services support is a key moral and physical component of fighting power and is one of the essential capabilities that enables the indigenous security forces to become self-sufficient. Our operational experience in Sierra Leone, Iraq and Afghanistan demonstrate that international military medical services may need to provide field medical support to casualties from indigenous forces. This support will normally be provided 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 3A provides a list of tasks that may be considered as activities for our military medical forces to undertake alongside with indigenous security forces.



Medical education, training and mentoring of the indigenous security forces plays an important role in security sector reform



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Supporting the indigenous security forces

## Section 1 – Strategic-level issues

3.2. The strategic level of operations that facilitates military medical engagement in security sector reform has two dimensions: out-of-country and in-country.

a. The 'out-of-country' dimension concerns integrating national 'integrated approaches' across the international community to achieve coherence in the theatre of operations. The out-of-country effort for the military medical services will require us to consider how security sector reform should be integrated into the wider in-country international military medical mission. It also requires us to think how the medical function integrates security sector reform activities with wider governance, reconstruction and development.

b. The 'in-country' dimension includes employing international resources to complement and support indigenous plans for security sector reform. It is essential that there is an out-of-country strategic plan to develop the indigenous military medical services to make sure there is continuity of the security sector reform programme between rotating in-country post holders.

3.3. Any international military medical services need 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, may also be used as a catalyst for a shift in civilian medical services, from hospital-based care to primary care, to support wider development goals.

3.4. From the outset, it is important to determine eligibility for access to the indigenous military medical system for the different elements of the local 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. The military medical system may also provide care for dependants of military personnel

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Supporting the indigenous security forces

and veterans. This has substantial implications for them to provide specialist clinical services, such as paediatrics, obstetrics and gynaecology, and they may also be required to provide 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.

3.5. The two main factors limiting the overall indigenous military medical services development are human resources (numbers and competency) and lack of money. The former may see the indigenous military medical services in competition with the civilian health sector to recruit health care personnel and the latter is a competition for resources within the security sector.

a. **Competition for health care personnel.** There may be a national shortage of health care personnel, which could be mitigated by employing expatriate health care workers as either indigenous contractors or loan service personnel. An intermediate solution could be to maximise education opportunities for indigenous military and civilian health care workers by sharing educational opportunities across all sources, including those from non-governmental organisations and international military forces. The indigenous government could also provide funding to sponsor students to study overseas until the indigenous tertiary level education system has been developed sufficiently.

b. **Competition for funding.** The funding for medical support for security forces is likely to be found from the Ministry of Defence or Ministry of Interior. It is highly unlikely that international agencies or non-governmental organisations will provide assistance to military medical services because they want to be perceived as being impartial. Furthermore, the medical services compete for funding with other security capabilities, such as ground manoeuvre or firepower. The financial support provided will depend on organisational and political factors, but is heavily dependent on the lobbying capability of senior members of the military medical services.

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3.6. These areas of competition illustrate the need to mentor senior indigenous military medical personnel in military politics and staff procedures so that they can compete effectively for resources in this environment.

3.7. HIV/AIDS is likely to be a significant issue, especially in 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, therefore, be considered a threat to international peace.<sup>19</sup> 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 Ministry of Public Health or non-governmental organisations, it is important to make sure that the military population has access to the same HIV prevention and management programmes as the rest of the national population.

## Section 2 – Operational-level issues

3.8. Developing the indigenous field medical system is the most important operational-level issue. This comprises pre-hospital care (emergency trauma and primary care) for deployed personnel, 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. Counter-insurgencies are primarily fought within national borders. Thus, casualties can be taken to fixed medical facilities and, as a result, there may be a limited requirement for mobile, deployable field medical facilities. These may 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 military hospitals required to support security forces could also support the indigenous civilian population and, again, this may require coordination between military and civilian health agencies. Overall, the concept for using security forces' medical services must be aligned to the

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<sup>19</sup> UN AIDS. *Security and Humanitarian Response to AIDS*.  
<http://www.unaids.org/en/PolicyAndPractice/SecurityHumanitarianResponse/default.asp> (Accessed 19 March 2009).

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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.

### Section 3 – Tactical-level issues

3.9. The most common tactical-level activity for international military medical assistance is helping develop pre-hospital care and medical evacuation through providing first aid training and military ambulance vehicles (ideally including helicopters for medical evacuation). This training should be designed to reflect the educational level 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 international forces medical training schools. In a multinational environment, coordination is necessary to make sure the syllabus is the same across different national/international organisations and non-governmental organisation training contingents.

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### Annex 3A – Common activities in international assistance to indigenous security forces medical services

Ser	Possible military activity	Supporting military medical activity	Remarks
1	Professional military training at appropriate levels.	<p>Establish health training schools.</p> <p>Establish accreditation system for professional qualifications.</p>	<p>Military medical training and education programmes should be aligned with the whole health sector.</p> <p>Security force medical training should focus on trauma care and force health protection.</p> <p>Security force medical personnel should receive general military training.</p>
2	Education in the role of the security forces in a democratic society.	Education on universal medical ethics (for example, providing impartial emergency care, banning medical involvement during interrogation and overseeing medical research).	This is an important aspect of legitimacy for medical personnel employed in the security forces.
3	Conducting national defence reviews.	Conducting reviews of medical services supporting security forces.	Should be nested within the wider indigenous health sector.
4	Developing defence policies.	Developing policies for the security forces medical services, including organisational, administrative and clinical issues.	Policies need to be tailored to the local context and not solely an import of the system from a Western nation.

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Ser	Possible military activity (continued)	Supporting military medical activity (continued)	Remarks (continued)
5	Provide specific technical assistance.	Applies across the whole programme for developing 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 systems for procuring, accounting, distributing and sustaining medical equipment and pharmaceuticals.	Will need to link to the wider local health sector. Medical materiel that has high intrinsic value is therefore at risk of fraudulent management and use.
7	Strengthening military personnel management systems.	Establish medical staff support to recruit medical screening, administrative preventive medical interventions (for example, immunisations) and a system of medical categorisation and personnel management for those 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', civilian/military mix, professional salaries, private practice, professional development and so on.
8	Develop 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.

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## Chapter 4 – Developing health care within the indigenous civilian population

4.1. The end state for civilian health sector governance, reconstruction and development is for an indigenous civilian health care worker to provide culturally and clinically appropriate health care for an indigenous civilian. The civilian health sector, indigenous or international, has primary responsibility for meeting the health needs of the indigenous population. Whether our military medical services can support the indigenous civilian health sector is dependent on the wider context for employing allied military forces and should always be nested within an indigenous health plan. The relationship between international military forces and an indigenous civilian health sector will be dependent on the military mandate, ranging from an exclusively civilian-military relationship in a humanitarian assistance mission to a minimal relationship during war-fighting, limited only to fulfilling international obligations under the Geneva Convention.

### Section 1 – The role of the international military

4.2. Where possible, the international military role in the civilian health sector is to 'do nothing'. There is likely to be a limit to the number of indigenous civilian educated personnel 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 and also facilitate the partnership between international military forces and their indigenous military counterparts. This, compounded with the threats by the insurgents to those who work with government institutions, may also make it challenging to recruit sufficient numbers of workers from the indigenous population. The developmental challenge in an indigenous country may 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.



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Delivering mobile health clinics by military medical teams is ineffective in anything other than the short term

4.3. At first glance, military units may believe that the solution is short-term – directly providing 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 description of on/off, non-emergency primary health care 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 very short-term.<sup>20</sup> Alternatively, constructing or refurbishing health facilities or schools is often selected as a series of military development projects. However, health capability comprises more than buildings alone, and success depends on both the availability of health care workers and sustainable funding for medical supplies, and equipment within the wider support of the local community.

<sup>20</sup> Mobile Health Units. *Methodological Approach*. International Committee of the Red Cross. May 2006. [http://www.icrc.org/eng/assets/files/other/icrc\\_002\\_0886.pdf](http://www.icrc.org/eng/assets/files/other/icrc_002_0886.pdf) (Accessed 6 February 2014).

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## Section 2 – The military approach

4.4. The military role in improving access to health services should be considered within the wider ‘shape-secure-hold-develop’ approach described in Joint Doctrine Publication 3-40, *Security and Stabilisation: The Military Contribution*. Figure 4 illustrates the spectrum of relationships between security forces and health providers according to the security environment. This illustrates the goal of ‘local to care for local people’ using local civilian medical services. There may be occasions where a local solution cannot be achieved because of security or resource constraints and so the options may have to move to the left of Figure 4. However, this should always be considered to be the short-term solution to meeting an urgent health care need and there should be a plan to move the relationships to the right of the slide.

### Goal: Local to care for local people

Increasing: Local security, local health capability

Decreasing: International involvement

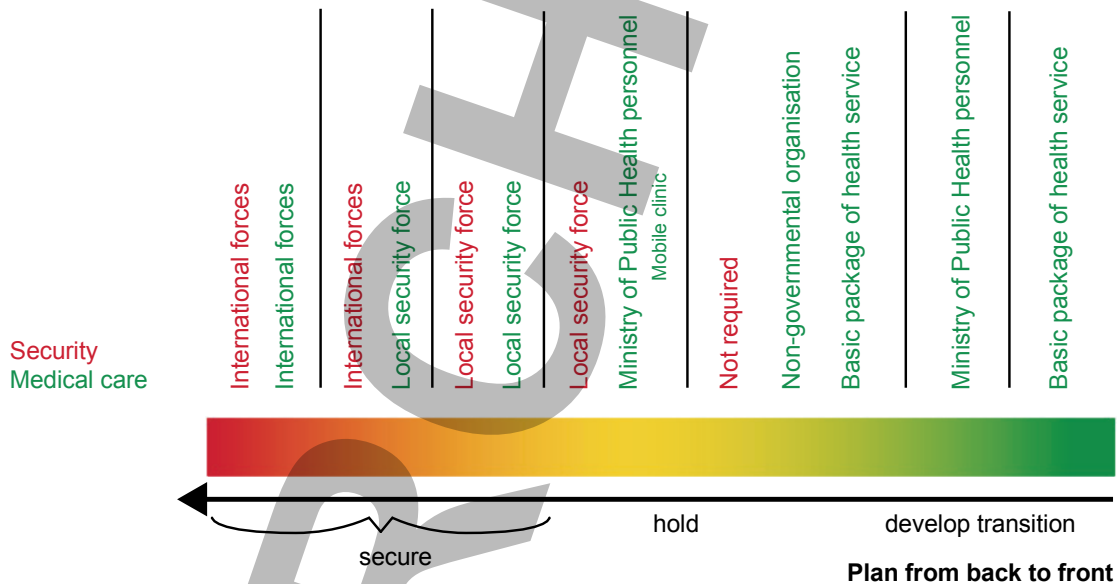


Figure 4 – Supporting health sector development

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4.5. Conceptually, security operations comprises of several phases.

- Shaping the environment to both build relationships with the indigenous population and also to define, and then, reduce opposition forces.
- 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 make sure the population is protected from the opposition forces. This includes (re)establishing indigenous governance.
- Develop is the execution phase of reconstruction and development to show the population the benefits of supporting the instruments of government and gain their consent. This should include transferring governance and security from international security forces to indigenous political actors and security forces.

4.6. This is not a linear process but requires a selection of these activities according to the context. Ideally, planning should be 'backwards' with agreement between stakeholders (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. Identifying the causes of civilian morbidity and mortality will point to those determinants of health (water, sanitation, nutrition, housing and education) that may need our help to develop. Military activity in the first instance throughout the 'shape-secure-hold-develop' process should always be driven by the determinants of health. Annex 4A provides an illustrative matrix of health sector tasks within the 'shape-secure-hold-develop' construct.

Shape

4.7. When forming a stabilisation plan, military medical representatives should be actively engaged to build relationships with both the indigenous population and key health-sector actors. This makes sure that the location, capability and capacity of the civilian health facilities are known and that this information can be compared with the community's reported requirements.

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To conduct health meetings, it may be appropriate to use military transport (for example, helicopters) to assist indigenous civilians or international civilians to visit local communities. The most important outcome from the shape phase for the security forces medical services is to agree the roles and responsibilities for managing 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 accepting civilian casualties into the military medical system, both indigenous civilian and international. But the agreement on the hand-off arrangements to get these casualties back into the civilian health sector should always be considered by our military.

4.8. The information about civilian medical facilities can be compared with the indigenous Director of Public Health's plan 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 refurbishing clinics and confirming 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 submitting funding applications into a military contracting process. There are ethical and legal constraints on what our military are permitted to gift or formally donate on behalf of Her Majesty's Government.

#### Secure

4.9. The secure phase's focus is the emergency care of casualties resulting from the conflict. Operational planners must be aware of their duties under the Geneva Convention,<sup>21</sup> particularly to avoid targeting known health care facilities, including making sure that security forces entering indigenous civilian medical facilities comply with indigenous and international law. There will need to be close cooperation across the health sector to make sure that all casualties are transported to the most appropriate health care facility for both immediate and long-term care. It may be necessary to provide military support by providing emergency medical supplies to the civilian sector, ideally

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<sup>21</sup> Article 36 of the 1949 Geneva Convention II.

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by assisting with transporting previously earmarked materiel or equipments provided by international emergency donation.

4.10. There may need to be a plan to medically support internally displaced persons stressing host nation primacy with the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) and humanitarian cluster. It may also be necessary to arrange for access to health care for convoys containing casualties under the protection of the International Commission of the Red Cross. Both activities may require humanitarian corridors to be identified during the planning process and rehearsed with all actors present. UN OCHA provides guidance<sup>22</sup> in the response to internally displaced persons situations where the host nation government has primacy, supported by UN OCHA and the humanitarian cluster that may include other programmes.<sup>23</sup> Using international military medical elements to support internally displaced persons 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.

Hold

4.11. During the hold phase, there may be a gap between imposing military control and the civilian sector's ability to establish routine medical services. During this period it may be necessary to provide access to health care using temporary, mobile services. This should be conducted 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 obviously 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. 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

<sup>22</sup> UN OCHA, *Guiding Principles on Internal Displacement*; September 2004, <https://ochanet.unocha.org/p/Documents/GuidingPrinciplesDispl.pdf> (Accessed 6 February 2014).

<sup>23</sup> World Health Organisation; *Global Polio Eradication Initiative*, <http://www.polioeradication.org/> (Accessed 6 February 2014).

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location of clinics to confirm the reconstruction and development requirements within the health sector element of the stabilisation plan.

Develop

4.12. Ideally there would be no international military medical engagement during the develop phase because implementing the stabilisation plan would have been handed back to international or host nation civilian leadership. In reality there should be continuing dialogue between all the health sector stakeholders to make sure there is 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.

### Section 3 – Measuring success

4.13. It is important to establish performance metrics for health sector development at the beginning of the process. These will routinely be the responsibility of civilian agencies though security forces may support data collection. This is likely to be based on a combination of measures of activity and measures of effect. This data is likely to be found from a range of sources including: the Ministry of Public Health; World Health Organisation analysis; local civilian reporting; and military reporting. Table 1 shows examples of health sector development performance indicators.

Ser	Measures of activity	Measures of effect
1	The number of provinces with a Director of Public Health.	The number of hospital admissions due to conflict related trauma.
2	The number of students at university commencing higher medical professional training.	Proportion of children showing evidence of malnutrition.
3	The number of active medical treatment facilities – as a rate of per 1000 population at risk.	Infant mortality rate.

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Ser	Measures of activity (continued)	Measures of effect (continued)
4	The number of health care staff by medical treatment facility. Sub-divided by groups (doctors, nurses, midwives, medics and pharmacists).	Less than five years child mortality rate.
5	Vaccination rates.	Incidence of disease. (Use epidemiological data as a proxy measure of total burden of disease – it should decrease.)
6	The number of villages participating in specific public health interventions (for example, water, sanitation, nutrition and housing).	Incidence of diarrhoea and vomiting. (Use diarrheal disease infection rates as a proxy measure of safe water supply.)
7	The number of students at university commencing basic medical professional training.	Incidence of acute respiratory Infection. (Use acute respiratory infection rates as a proxy measure of improving housing conditions – indoor air pollution.)
8	The number of provinces with a health sector development plan.	Maternal mortality rate.
9	The number of indigenous civilian medical evacuations, from the point of wounding, being accepted directly into civilian medical treatment facilities.	Civilian hospital case fatality rates.
10	The number and type of military medical health care engagements. (This should decrease.)	Ranking of access to health care as an expressed 'grievance'.

Table 1 – Examples of health sector development performance indicators

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## Section 4 – Preparing personnel to support the indigenous population

4.14. Generic military medical training and education must provide a robust underpinning framework for undertaking military medical activities to support the indigenous health sector (for example, first aid training, medical assistance clinics and so on). Medical personnel must be trained and equipped to provide emergency medical care for the whole potential population at risk (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 transferring indigenous casualties, ethical dilemmas and the plan for indigenous health sector engagement.

4.15. It will be necessary to have designated subject matter experts if engaging with the indigenous health sector (security sector or civilian sector) is a specified task. These individuals will require postgraduate education in public health in conflict, including knowledge of the roles of all stakeholders in health sectors in crisis and training in the World Health Organisation's Cluster Approach.<sup>24</sup> An understanding of the minimum standards for delivering health and humanitarian support developed by non-governmental organisations, the Red Cross and Red Crescent is also required.<sup>25</sup> These individuals will ideally have prior practical experience before deploying.

4.16. Understanding the culture and context of an indigenous health sector and building relationships with key stakeholders takes time.<sup>26</sup> A 'one-off' six-month tour is probably too short to achieve enduring impact. An alternative model of longer tours for a minimum of nine months, or continued longer-term engagement through reach back/forward, is required for specialist personnel working in this field. It is important for these individuals to have sufficient maturity to understand complex issues. They will need to understand the indigenous relationship between 'Western medicine' and traditional medicine,

<sup>24</sup> United Nations; *Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response*; Inter-Agency Standing Committee; 24 November 2006; <http://www.refworld.org/pdfid/460a8ccc2.pdf> (Accessed 6 February 2014).

<sup>25</sup> The Sphere Project; *Humanitarian Charter and Minimum Standards in Humanitarian Response*; 3<sup>rd</sup> Ed 2011; <http://www.ifrc.org/PageFiles/95530/The-Sphere-Project-Handbook-20111.pdf> (Accessed 6 February 2014).

<sup>26</sup> Development Concepts & Doctrine Centre; JDP 04 *Understanding*; December 2010; [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/33701/JDP04Webfinal.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/33701/JDP04Webfinal.pdf) (Accessed 20 March 2014).



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balancing tribal and cultural politics with performance and the pace of change. They also need to balance their own experience of the practice of medicine with culturally sensitive and clinically appropriate advice for the indigenous conditions.

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### Annex 4A – Illustrative matrix of health sector tasks in shape/secure/hold/develop<sup>27</sup>

Ser	Domain	Develop	Hold	Secure	Shape
1	Health	<p>Establish professional education programmes.</p> <p>Transfer providing services from non-governmental organisation to local sources.</p> <p>Establish financial and equipment account systems for health sector.</p>	<p>Introduce bed nets.</p> <p>Commence Ministry of Public Health and epidemiological reporting/ stewardship.</p> <p>Refurbish basic and comprehensive health centres.</p> <p>Facilitate civilian access to health care.</p>	<p>Confirm health needs assessment data.</p> <p>Ensure emergency care is provided.</p> <p>Facilitate moving district public health officers with district governors and staff.</p> <p>Facilitate ‘humanitarian corridors’.</p>	<p>Assessing health needs.</p> <p>Government lead public health messaging – how to stay healthy, where to get health care from during the secure phase, where individually displaced persons to go to for assistance.</p> <p>Support recruiting local public health officer and staff.</p>

<sup>27</sup> The table reflects the ‘plan backwards’ approach described at paragraph 4.6, 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.

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Ser	Domain	Develop	Hold	Secure	Shape
2	Water	Develop public water system.	Assess public water system.	<p>Supplying potable water to local nationals (for example, well, stand pipe, truck, container, bottled).</p> <p>Health messaging on the importance of clean water, how to source and sterilise water.</p>	<p>Intelligence preparation of the battlefield on potable and irrigation water supplies.</p> <p>Proxy indicators to include food production (irrigation), cholera outbreaks (potable water) and malaria incidents (still water).</p>
3	Sanitation	Develop public sanitation system.	Assess public sanitation system.	<p>Identifying grey water, sewage and waste disposal systems that have been affected during the clear and affecting the environment.</p> <p>Health messaging on where to defecate so as to not cause a health hazard.</p>	<p>Intelligence preparation of the battlefield on sewage and waste disposal.</p> <p>Proxy indicators to include cholera outbreaks (potable water); numbers of identified ventilated improved pit latrines, out houses, community refuse areas.</p>

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Ser	Domain	Develop	Hold	Secure	Shape
4	Housing/ shelter	Support providing fuel efficient stoves, smoke hoods and chimneys (reduce acute respiratory infection morbidity and mortality).	<p>Ensure access to fuel.</p> <p>Ensure there is access to emergency shelters.</p>	<p>Reduce collateral damage to properties.</p> <p>Reduce collateral damage to infrastructure (irrigation, water, sanitation and health systems).</p> <p>Assess access to safe, secure housing including individual displaced personnel locations.</p> <p>Assess access to secure and sustainable fuel sources.</p> <p>Monitor effectiveness of individual displaced personnel response.</p>	<p>Intelligence preparation of the battlefield on social infrastructure. Assess access to safe housing especially for women and children.</p> <p>Assess current access to secure and sustainable fuel supplies (for domestic cooking, lighting and heating) – is it wood, dung, agricultural by-product (for example poppy stems)?</p> <p>Support individually displaced personnel response planning (is a host nation government responsibility with UN OCHA assistance – coalition assistance <i>in extremis</i> in a supporting role only).</p>

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Ser	Domain	Develop	Hold	Secure	Shape
5	Food	Support agricultural development.	Provide solar cookers.  'Strong food' interventions for malnutrition.	Reduce collateral damage to crops, food sources and livestock.	Intelligence preparation of the battlefield on stores locations, access to markets, markets, locally produced product.
6	Engagement	Withdraw military engagement with civilian health sector.	Plan for withdrawing 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.