Guidelines for Implementing Medical Operations in the Counterinsurgency (COIN) Fight: A Framework for Engagement

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Abstract

Several articles have been published over the last decade that describe the current role of medical operations (variously known as MEDCAPS- Medical Civic Action Programs, CMEs- Co-Operative Medical Engagements, etc.) in COIN and stability operations.[1-3] Many of these articles focus on the experiences of healthcare and support personnel and their observations of inappropriately used U.S. Military healthcare resources. These medical assets were often used to provide fragmented and direct patient care to local populations. These operations were conducted in a non-sustainable fashion.[2] Most importantly, poorly organized efforts damage COIN efforts and alienate local populations.[3-5]

Effective medical operations must be nested within the larger realm of overall COIN actions. In this paper, a fundamental framework is presented to align medical operations within COIN missions.

Introduction

A simple definition of medical operations are those engagements conducted by U.S. military medical personnel (including training, mentoring, delivery of supplies etc.) that are designed to impact non-U.S. civilian or military forces. Evidence shows that appropriate use of medical operations can be a powerful tool to assist commanders in furthering COIN and strengthening local infrastructure.[6] The goal of our medical operations efforts is to support the validity of local and national governments in concert with other COIN efforts. Medical engagements must be designed to support this function. This must be paramount to, and precludes rendering direct patient care to civilian populations. There must be a cogent reason to provide medical operations. Although provision of care to decrease suffering is noble, that objective is best left to private voluntary and non-governmental organizations. If we are not mindful of this we will damage the strategic value of overall COIN actions.

The framework presented here defines two avenues of engagement. These paths help to synergize medical operations with overall COIN goals and simplify planning. Although this framework cannot be all encompassing, it does provide a way to rapidly organize and focus efforts within an environment where time and resources are often limited.

Misguided efforts at providing direct and transient medical care, as well as poorly planned engagements with local populations (ordinary citizens and medical professionals), have the potential to cause outright harm and significantly degrade COIN operations. [7]

Medical Operations Should be Designed to Support COIN Goals

The main objective of COIN operations is to foster development of effective governance by a legitimate government.[8] There must be a compelling value proposition for people to support the government over supporting an insurgency. Most of the civilian population exists in an uncommitted and un-affiliated state. [9,10] However, it often seems that hospital-based practitioners are the ones most often engaged in medical operations. These individuals are most likely already pro-government, and may not be the key demographic that needs to be influenced. From a marketing perspective, the population to be influenced can be thought of as any potential customer. The targeted civilian population must be understood, engaged, and then repeatedly nurtured with the COIN message and product. As with any effective strategy, this needs to be a unified and simple message.[9]

It is key to realize that the goal of medical operations in COIN is **not to provide longitudinal or episodic medical care** to the civilian population. The goal is also not to raise the standard of local medical care to that present in the United States. The objective is to support a nation's government and allow its own institutions to build capability and then sustain it.[8,10] It is imperative that citizens gain confidence in their own governance so that an increase in the standard of care can be supportedby the local government.

Medical operations are another opportunity for the commander to influence COIN operations – just as direct military action is. To maintain focus in structuring medical operations, a framework is proposed that addresses the goals of medical operations within COIN.

Use Two Lines of Effort in Medical Operations to Rapidly Support COIN

Two lines of engagement are described and the framework for each has been kept simple to support rapid and focused implementation. It is understood that there are always many other tasks occurring during these engagements. For instance, while supporting training to local civilian populations, there are opportunities to evaluate the general health and nutritional status of the community. There may be discernible signs of infectious disease such as widespread rashes or febrile illness. In fact, the amount of participation in medical events, and which tribe or clan is represented, can provide important clues on the security situation. This information will contribute to the total COIN effort.

In light of this, a simple framework for medical operations should be focused on two lines of engagement:1) Population Centric
2) Military centric.

1) Population Centric

COIN practitioners understand that control over the population is the ultimate goal of both government and insurgents.[10] Two elements are important in working with a population. First, the population at risk must be defined. In the COIN arena, "at risk" means the population demographic that is most likely to be the target of insurgent influence. There are several factors that will make the risks of civil strife and insurgency more likely within a particular nation, but the key factor is a financially, organizationally, and politically weak central government.[11]

Populations that may be vulnerable to insurgent influences can be identified in concert with local national and US military commanders. Features of this targeted demographic may be: 1) a population that is ignored and/or beyond the reach of a geographically distant central government; 2) communities that have been marginalized in the past; 3) communities that have a history of decreased economic capacity compared to other areas. These are populations in which taking the COIN initiative early can prevent later destabilization.

From a medical operations standpoint, the second key factor is to understand the drivers of disease burden in the targeted population. It is tempting for medical providers to think of the health needs of the population in terms of hospital-based needs. This is a Western and ethno-centric based approach. A majority of the population in remote areas cannot travel to or afford hospital care. Focusing on hospital-based training and assessment may not be meaningful in COIN. Medical staff and other contacts at hospitals can provide effective opportunities for understanding regional disease burdens. However, the training they desire is often at a level not beneficial to developing healthcare systems that influence COIN effectively. For instance, receiving requests to provide training on in-vitro fertilization or a complex surgical procedure from hospital staff is not likely to change the high rate of infant and maternal mortality. Additionally, the hospital staff may already be supporters of the central government and have their own varying agendas. They are generally not the target population.

In a scenario where time is crucial, it is important to quickly reach the correct population on the ground at the district and village level and assess the health issues they have. For instance, if diarrheal diseases are affecting a village population, this may be an opportunity to empower the local leadership on managing water resources. The demographic of the apparently uncommitted local villager is most at risk for insurgent influence. Providing training and support that immediately empowers them to make changes for their children and families can rapidly accrue benefits to local and national governments. Additionally, such training can be completed with limited resources and be disseminated by members of the community or its immediate leadership. Many medical issues will be improved by non-medical COIN operations. Maintaining clean water supplies in villages is a prime example.

Training should be structured with awareness of the cultural factors relevant to the area. Many of the most pressing health issues affect women's and children's health. Additionally, in traditional societies, women are key in forming the social networks that insurgents use for support.[9] Winning the support of neutral or friendly women, through targeted social programs can be a significant factor in curtailing insurgents. Women who are local opinion leaders and influencers within the female community are good sources to work with.

The best medical operations would therefore be ones that keep people out of the local hospital by empowering local knowledge. This involves training that is simple and reproducible, modular, and can be targeted to various populations. For instance, the benefits of basic instruction on hand washing and use of safe water sources may yield better results than CPR instruction (which we consider relatively easy to teach in the United States).

Constructing a flexible resource of 8-10 interchangeable training modules (which may be anywhere from 10-30 minutes in length per module), gives many opportunities for engaging and evaluating populations across a spectrum of different venues. These training modules should require minimal equipment, be socially relevant, and taught by the local population to each other. These modules can also be adapted for the following military centric arm described below.

To be clear, initial training is best conducted in concert with competent linguistic and culturally aware trainers, and to a cohort of local influencers. Medical COIN operators serve to initially develop or refine training, find future trainers, and then mentor them. They then serve in an over-watch position to assess the effects of these medical operations, and tailor them for maximum results. This requires repetitive engagement and relationship building, but on a more focused scale than the large MEDCAPS of the recent past.

2) Military Centric

(Although this arm is termed "Military Centric", it should be understood that this means working with a spectrum of host- nation security forces including paramilitary and police elements.) There is quite a bit of overlap in this element with the population centric arm, and indeed local troops and militia may have relatives in nearby communities that are affected by population centric efforts. Isolated units in a conscripted military are also possible targets for insurgent propaganda, as well as being the targets of potential violence. Stressing the professionalism of the national military and national control is vital. Military forces in areas prone to insurgency will usually have little basic medical support. Even large armies may not have effective tracking systems for disease and non-battle injuries. A significant percentage of local troops may also have poor health. In this case, teaching advanced lifesaving skills may be less relevant than getting healthy soldiers out in the field. Providing hygiene, nutrition and sanitation skills first will be more valuable. Work with the local commander to understand the reasons soldiers are not fit for duty. In this way, you can get them on the job and battling insurgents.

The focus of U.S. medical training is often on providing higher-level combat lifesaving skills. Although this may seem basic from our perspective, it can be very advanced to native soldiers with limited education. For instance, estimates are that only 11% of the enlisted personnel in the Afghan military can read and write.[12] This does not mean they do not have combat smarts, but that modern and basic health concepts are unknown to them.

Training should be adjusted to allow local troops to gain knowledge which allows them to immediately take charge of their own health. This can entail guidance on such topics as food handling, hygiene and other sanitation practices. Conscripted troops

will often have minimal knowledge of hygiene and field sanitation issues. They will also likely suffer from the same diseases that are present in the local civilian population. Just as in the population centric arm, the concept here is on self-development and confidence building. A simple method of doing this is to allow the supported local military element design its own training. This training could be based on what has previously been taught. Potential future and local leaders can then be mentored and observed in this way.

SUPPORTING CONCEPTS

Training formats and venues should be closely coordinated with local commanders and medical personnel

One important aspect of training for the Military Centric effort is to provide the basic skills, mindset and tools so that local forces can conduct their own population-centric medical operations. For example, soldiers who have been instructed in basic hygiene and field sanitation can then convey personal experiences to the local community. This can have a very powerful duality of increasing military capability in terms of unit fitness and confidence, as well as building confidence in the civilian population. By interacting with, and empowering themselves and the supported population, a sense of trust can begin to develop. This tactic is used to undermine the insurgent goal of destabilization. By considering a marketing perspective, COIN's goal is to build a compelling value proposition for the population to support the national government. The population will subconsciously analyze the risks and benefits of the COIN product offering, and compare it with the insurgents' offering. If U.S. military personnel provide direct training or medical care on a routine basis, it merely undermines the tenuous authority of national governments. Large training events to the civilian population should be conducted by **local forces** with the support of U.S. personnel. This means that we serve in the role of assistants and even subordinates to the local individuals we have trained. The focus should be on analysis, evaluation, planning engagements, and developing champions within the local community and military. These are the people that will lead and shape opinions over the long term.

Synergy of Thought and Synergy of Action / Do not Work Alone

Medical operations in COIN must not be isolated. They can be effectively linked to economic, political and broad educational efforts that cover the spectrum of confidence building. For instance, if there is an opportunity to distribute therapeutic foods to a remote community, what are the opportunities to collaborate with Civil Affairs (CA) teams? They may be aware of opportunities that involve local private businesses and increase economic support. These resources could be used to provide transportation and distribution. In addition, there are often opportunities for local media to be involved, or other ways to increase the visibility of the local government, or local medical practitioners. Coordination with CA or psychological operations teams can be valuable in this effort.

Always consider opportunities to drive synergy with other COIN resources, and design medical operations within a total COIN environment.

Measures of Effectiveness (MOE)

Evaluating the success of COIN efforts can take years. In an environment that is constantly in flux, the parameters of success can constantly shift. Effectiveness should be tied to obtaining a focused end-state, or creation of an effect. In the recent past, events such as MEDCAPS- a term that has persisted since the Vietnam conflict- were geared to providing numerical returns. In the Vietnam experience, each new unit would strive to see as many "patients" as possible, only to be outdone by the next arriving unit. The success of these efforts was based only on the amount of money expended, and the number of people seen. The latter number was often inflated as each new unit sought to outdo the preceding one.[7]

It can be difficult to generate appropriate MOE. However, their design can be based upon the suggestions given in FM 3-24 Counterinsurgency.[8] This Field Manual acknowledges the difficulty of using numerical figures in measuring social environments. Additionally, the short duration that U.S. military forces are engaged before rotating means that the MOEs are continually reworked and not always carried forward as new units and commanders arrive.

Considerations and other Issues to Address

Using the two-pronged medical operations engagement framework allows rapid introduction of COIN effects while maintaining the ultimate goal of confidence building and support for governance. Some considerations for implementation are listed below.

Population Centric

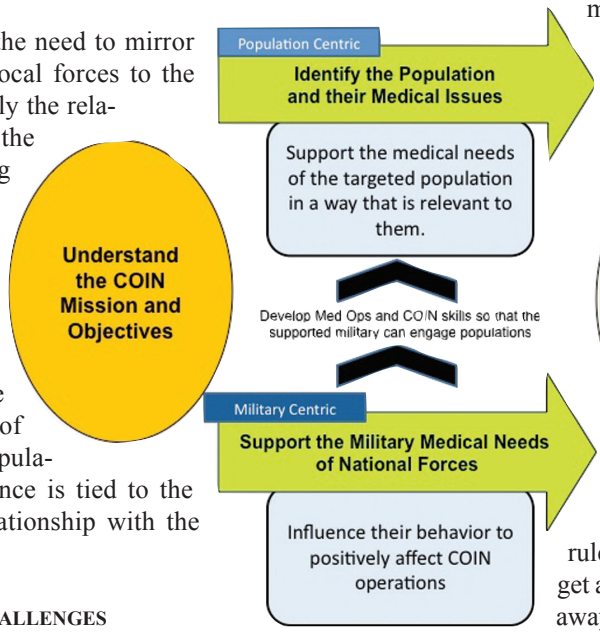
Influence the most at-risk populations rapidly and keep them engaged with projects that are important to them. At-risk populations are those at most risk to be co-opted by anti-government forces.

- Define the population to be targeted for maximum COIN benefit
  - Define a population that is likely to be co-opted by insurgents (e.g., a demographic that has been marginalized by the national or local government.)
  - Work with military and COIN commanders to complement other operations
- What are the major health issues that affect the population right now?
  - Gather this information from the population through direct contact and relationships with medical, COIN or military personnel.
- What are the health plans and goals of the national / regional government? Seek alignment with these to prevent duplication of effort or undermining national healthcare projects.
  - What other organizations, such as NGOs, are working in these areas and what are they doing? (For example, there is a 2009 World Bank grant to combat schistosomiasis in Yemen, and the Yemeni Government is a proponent of this.) Target these initiatives before starting your own. What projects can be designed to facilitate government support for these efforts and accrue further positive effects to the government? Coordination with the government health authorities is a must.
  - Are insurgents also developing heathcare / charity / social structures in your area of responsibility? They may have already identified a valid target population.

Military Centric

- Identify the types of military units you will support:
  - What is the core mission and make-up of their personnel? For example, will you be supporting border security troops or a local militia that lives nearby? Do the forces have a particular tribal or religious orientation? What types of equipment and transportation do they use?
  - What are their challenges and goals?
  - How do they align with U.S. objectives?
  - Seek synergies to pull together.
- What medical needs do common soldiers and government militias have?
  - What are the issues that units face with disease and non-battle injuries?
  - Conduct training that keeps more soldiers in the field while also doing the typical combat lifesaver training. An example of this is to teach personal hygiene, water and food sanitation. Reducing sickness and getting soldiers better nutrition will get more government troops to the fight.
- How have local forces engaged with the civil population?
  - What is the relationship of local military and paramilitary forces to the population?
  - Have there been past efforts to assist the local population in healthcare?

Keep in mind, the need to mirror the relationship of the local forces to the population, not necessarily the relationship of the U.S. to the population. Supporting local relationships first is the conduit to building support for national governments. For example, in Yemen people just 100 miles from the capital may not be aware they are even in the nation of Yemen.[13] For these populations, their entire existence is tied to the local tribe and their relationship with the sheikh.



Key Learnings and Challenges

- Seek to eliminate self-reference criteria. That is, the tendency of individuals, often unconsciously, to use the standards of one's own culture to evaluate others. Instill the belief that a member of the community is the lead member of the team and you exist in a advisory and partnership role. Use opportunities to show your deference to this team leader.
- We often use the term "train the trainer". However, this is a concept that is not prevalent in many developing and post conflict nations. In hierarchical societies, information and knowledge hoarding is often practiced. Ensure those with knowledge of the local culture and language deliver training right from the outset. Reinforce the need for continual training. Assess and monitor, but keep people self-sufficient.
- Do not work alone. Coordinate and plan with civil affairs units and psychological operations teams. Is local media operating in your area? How about Non-Governmental organizations?
- Resist the temptation to believe that just being nice to people and providing limited and isolated medical training will make them somehow feel grateful. Allow the local population to maintain dignity, honor and respect. Merely doing medical care, or providing training does not always mean you are supporting COIN. Efforts must be part of the larger plan to support the national government, as well as coordinated with other COIN events.
- Mirror the capabilities of the local forces and build incrementally on these. In other words, do not use a U.S. centric healthcare approach (often equipment and education intensive) that will not survive when we leave.
- Use care not to undermine the honor and prestige of civilian healthcare resources.[14]
- It is easier for U.S. military medical providers to engage local physicians at the hospital level and provide training to them there. Assess if this training is influencing the population most at risk for insurgency. Although interacting with hospital-based specialists can be helpful in assessing the needs of the broader community, this is often not the case. Providing hospital-based training is not the way to influence those most at risk for insurgent influence. Look for ways to keep the population out of the hospital and drive a population centric approach.
- Do not undermine local and national healthcare systems, despite the appearance they are not succeeding. Instead, support them by managing expectations (yours and theirs) and create an environment of emotional understanding to bring the healthcare system to the level appropriate to the region and not to the capabilities of the U.S.
- Finally, from the author's experience, a good rule of thumb is that if a medical provider is starting to get a feeling of doing good, or a warm glow from giving away a teddy bear or being thanked by local people, that medical provider must immediately **stop** and ask themself how that positive feeling can be transferred to a member of the local government or security forces.[15]

Summary

Medical operations in support of COIN are another part of the total COIN effort. They should fully support the COIN objective in the same way as other COIN actions – which are to develop effective governance by the local authorities. These efforts are hindered by providing direct and transient patient care or U.S. lead medical training. This includes short-term training on U.S. military compounds. The true COIN fight is at the level of the uncommitted masses and these are the groups that must be given

the confidence and capability to effect lasting change.

Following the guidelines above will align medical operations to support the COIN fight.

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