Medical Operations in Counterinsurgency

Joining the Fight

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COUNTERINSURGENCY (COIN) CAMPAIGNS generally emphasize nonlethal means more than conventional engagements, but medical units at the battalion and brigade level are deployed in COIN theaters according to conventional doctrine dictating a focus on caring for combat casualties. U.S. military forces have no medical doctrine specific to COIN, and expeditionary health support operations are not mentioned in conventional COIN doctrine. When combat units have primarily engaged primarily in COIN operations in Iraq and Afghanistan, the disconnect between conventional medical support doctrine and operational conditions has resulted in significant underuse of medical assets, particularly at forward surgical teams assigned at the brigade level.[1]

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Insurgents are drawn to rural communities that are underserved by the host-nation health sector.[2] Because COIN is primarily a civil-military endeavor, properly leveraged expeditionary medical assets can be force multipliers in the effort to improve governance and marginalize the activities of insurgents.

This article examines the theory and practice of COIN operations conducted by a forward-deployed special operations surgical element in Uruzgan Province, Afghanistan, in 2012. The Tarin Kowt Forward Surgical Element (TK FSE) was uniquely integrated into the regional special operations task force (SOTF) COIN mission and contributed to the expansion of medical care in Uruzgan and beyond. The experience of TK FSE in Uruzgan should serve as a model for future special operations and conventional military medical unit participation in COIN missions.

General Principles

The goal in COIN is to promote the legitimate host-nation government as a source of stability and order in the lives of the indigenous population.[3] To this end, medical operations should focus on increasing the capacity of the host-nation health sector and promoting the host-nation government's role in the people's health. Military medical programs that provide direct care to local nationals can be useful in the initial stages of a COIN engagement to gain the trust of the populace and accustom them to foreign military involvement in their health care. However, direct medical care should be avoided in the long term because it eventually leads to undesirable reliance on foreign medical care and marginalization of the country's health sector.[4]

In contrast to direct care, capacity building can be achieved in two ways: first, through the focused delivery of sustainable direct health and reconstruction aid, and second, by leveraging medical skills and knowledge through training programs and partnerships with the country's health system. Both of these require intensive engagement and relationship building with key health sector leaders. These relationships should form the basis of all COIN health engagements. Specifically, military and host-nation leaders should jointly conduct real-world needs assessments to develop reasonable goals for COIN health programs. Local leaders should maximize the use of host-nation personnel, facilities, and materials in any planned health sector interventions.

Assessments of needs and health sector progress should be performed continually during any health operations in COIN. Engagements and programs should be flexibly designed and executed to allow for responses to fluctuations in local sociopolitical circumstances and changes in the security situation. Measurement of outcomes should be planned for from the beginning of any health program in a COIN mission. The *output* of foreign military activities in the indigenous health sector is easy to measure, in terms of the volume of patients seen and treated. The *outcome* of a COIN health program is reflected in the ability of the host nation's health sector to care for the population; the key data to capture and use to plan further engagements will measure this outcome.

TK FSE and Uruzgan Provincial Healthcare

Uruzgan Province, located in southeastern Afghanistan, has just over 300,000 inhabitants and is one of the poorest, most rural areas in the country. The province has one hospital, located in the capital of Tarin Kowt (TK Hospital). This facility provides referral-level care for the residents of Uruzgan and parts of the adjacent provinces of Day Kundi and Zabul. TK FSE was a small U.S. special operations medical facility, established in 2010 and located on a base just outside the city of Tarin Kowt. The FSE's primary mission was to provide combat casualty and acute primary care for coalition special operators and Afghan partner forces from southeastern Afghanistan. The FSE was adopted an additional mission to leverage its assets in support of the broader SOTF COIN mission. The goal of the engagements arising from this leverage was to increase Afghan regional healthcare capacity and decrease reliance on coalition medical assets, especially for trauma and acute surgical care. The expected strategic outcome of this mission was further legitimacy for the Afghan government, reinforcing it as a provider of health resources for its people.

Afghan Medical Training Partnership and Validation

TK FSE initiated the Afghan Medical Training Partnership and Validation (AMTPV) program in 2010, which was TK FSE's primary COIN medical engagement. The program was a response to an assessment by SOTF medical personnel—through

engagements with district and provincial Afghan health officials—that found unmet health needs in Uruzgan.

The assessment's principal finding was a significant knowledge and skills deficit in the individuals providing trauma services at TK Hospital. Therefore, most injured patients were cared for in U.S. and coalition facilities in the area. To address the deficit and expand local capabilities for the future, a three-year training program for TK Hospital staff was designed, approved, and implemented. An essential criterion for entry into the program was a commitment on the part of the participants to remain in practice at TK Hospital and serve the population of Uruzgan following their graduation. The complement of participants included four groups of three local Afghan providers, each including a physician, a nurse, and an anesthetist. The participants lived and worked at TK FSE alongside U.S. personnel for three months of the year and worked and trained others at TK Hospital the remaining nine months. The trainees participated in all aspects of care performed at the FSE, including the resuscitation of trauma and acute surgical patients, assisting in operations, and caring for patients in the small hospital ward. U.S. military trauma and orthopedic surgeons supervised all aspects of the Afghan trainees' work and validated their progress.

The Afghan participants were paid for their participation in the AMTPV program by Commander's Emergency Relief Program funds from the SOTF, with a total annual cost of $76,000. The FSE could help provide care for local national and noncoalition military patients who would not otherwise receive coalition medical care because of their ongoing training of Afghan providers and also the SOTF command's support of medical COIN engagements. The additional workload at the FSE increased resource utilization and provided training experience for AMTPV participants, expanding the capacity of the Afghan health sector to care for its own people. The success of the program was striking: at the program's midpoint, TK Hospital experienced a 100 percent increase in admissions, and we saw a corresponding decrease in the local population's use of coalition health resources.

TK Hospital—TK FSE Partnership

With the successful implementation of the AMTPV program, a strong and durable partnership between TK Hospital and TK FSE evolved. This

Afghan physicians and nurses making patient rounds at Tarin Kowt Provincial Hospital. This practice emerged as a result of education programs instituted by the Tarin Kowt Forward Surgical Element. (Maj. David S. Kauvar)

partnership was reinforced by ongoing needs and capabilities assessments performed by FSE staff at TK Hospital and through frequent key leader engagements with district and provincial health sector officials. The knowledge gleaned from these engagements allowed the FSE to tailor AMTPV program training to the specific capabilities and challenges the participants faced when they worked at the hospital. Specific knowledge of the situation "on the ground" at TK Hospital also permitted the FSE to guide medical reconstruction and humanitarian assistance efforts toward providing the aid and services that would be most sustainable and beneficial.

A patient transfer agreement between the medical director of TK Hospital and the medical staff of the FSE was developed to enhance the education of AMTPV participants and to facilitate complex trauma and initial surgical care for Afghan patients at the FSE. TK Hospital's director communicated via telephone with one of TK FSE's two embedded interpreters, facilitating the transfer of patients with needs exceeding TK Hospital's capabilities to the FSE for care by the AMTPV residents under the supervision of FSE staff. Such transfers were typically sought because of the lack of surgical resources at TK Hospital, compared to those at the FSE. The patient would be transferred back to TK Hospital for ongoing care after being stabilized, usually after initial operative care. Local Afghan surgeons from outside the residency program occasionally accompanied their patients to TK FSE to participate in operations with FSE surgeons, increasing their skills to perform more complex procedures at their home facility.

Patients from Uruzgan and the adjacent provinces of Day Kundi and Zabul gained access to TK Hospital and FSE resources by first seeking care at smaller, local Afghan facilities or SOTF Village Stability Program sites. Then they could be referred to TK Hospital, and then to the FSE if needed. Patients were also evacuated by coalition medical assets from the Village Stability Program sites for more urgent care at the FSE followed by transfer to TK Hospital.

The FSE also hosted a clinic dedicated to caring for local nationals, seeing primarily follow-up patients from TK Hospital and the surrounding area. AMTPV program participants were used in this clinic, learning aspects of long-term care in an austere environment. To preserve base security and control access, the FSE used a *parcha* (paper) system, requiring outpatients seeking care at the FSE to have a referral or follow-up note signed by one of the U.S. physicians stating their need for FSE care on a certain day. This also ensured that in almost all circumstances, patients would be seen at TK Hospital before being seen at the FSE.

Afghan physician examining x-rays of a transferred Afghan patient with his U.S. counterpart at the Tarin Kowt Forward Surgical Element. (Maj. David S. Kauvar)

Partner Force Care and Training

Supporting the ability of indigenous forces to conduct the campaign is a central principle of COIN military operations. To this end, TK FSE and medical elements of their local partner forces, the 8th *Kandak* (camp) Afghan National Army (ANA) commandos and the 4th Kandak ANA conventional forces, developed a partnership for the training and supervised care of ANA soldiers. The ANA medics had basic field medical training, including the use of direct pressure and tourniquets to control bleeding and the use of intravenous fluids for initial resuscitation. In consultation with senior ANA medics and

Personnel from the Tarin Kowt Forward Surgical Element delivering donated medical supplies to Tarin Kowt Provincial Hospital. (Maj. Tucker A. Drury)

physicians through embedded interpreters, FSE staff members taught specific advanced field and hospital medical skills to the ANA elements in response to their specific needs. Such training reduced the ANA's reliance on coalition medical resources in the field and decreased the need for coalition combat casualty care. The ANA medics were highly motivated and quick learners, and their skill set and comfort level with treating complex battle trauma expanded greatly because of the combined training program.

In addition to medical training, TK FSE provided supervised medical care to the 8th Kandak Commandos. A weekly primary care clinic for commandos was held at the FSE. The senior commando medic attended these clinics, learning from FSE primary care providers and AMTPV program participants how to manage commonly encountered problems. The FSE also provided acute and dental care for commandos in a similar fashion. Over time, the number of commandos treated at the FSE declined as the commandos' medical assets assumed much of their routine care.

Critical Enablers and Difficulties

Several critical factors influenced TK FSE's ability to contribute to the SOTF's broader mission by performing medical COIN engagements. The most important of these were consistent command support. TK FSE was fortunate to have SOTF commanders who supported its participation in COIN activities and who understood the low-cost benefit that embedded medical participation in COIN operations provides. These commanders provided the Commander's Emergency Relief Program funds necessary for projects such as the AMTPV program and authorized leeway in the medical rules of engagement to allow the FSE to assist in the care of local national patients. The SOTF commanders were crucial to ensuring security for FSE personnel during "outside the wire" missions to TK Hospital.

Security was a critical enabler of TK FSE's COIN activities. Civil-military operations in COIN can only be effective in an environment where security has been established, both to provide a stable environment for civil operations and to secure and thus gain the trust of the populace so they will accept such operations.[5] TK FSE's COIN mission was facilitated by the willingness of the SOTF command to provide security for medical engagements on and off the base. The FSE's acceptance of Afghan medical providers and care of local national patients on our installation required force protection measures beyond those usually in effect. Local national patients had to be searched upon arrival, and the

residents who worked and lived with FSE personnel had to be thoroughly vetted before gaining entry.

The final critical enabler for TK FSE's COIN operations was highly motivated, strongly dedicated personnel who were committed to the mission. Without such personnel, the FSE could not have participated in complex, often demanding medical COIN operations. Basic understanding and acceptance of the cultural differences between FSE personnel and their local national patients were vital as well. Included in the personnel essential to accomplish this mission were the embedded interpreters who lived and worked with the FSE every day. These team members, in addition to interpreting, also provided links with local health authorities and valuable cultural insights. The value of embedded interpreters was multiplied as they worked in the medical environment—learning and practicing basic medical skills, narrowing the cultural gap between host nation patients and coalition medical providers, and becoming true medical interpreters.

The expansion of TK FSE's mission into COIN operations revealed some notable difficulties as well. When operating in the midst of an active insurgency, security was always an issue. FSE operations had to remain flexible within a variable security environment. Planning missions with inherent adaptability helped to mitigate some security difficulties. Another complication in the FSE's COIN operations was the broad cultural gap between FSE providers and Afghan residents, community stakeholders, and patients. Continually fostering a clinical environment in which such differences were acknowledged and accepted, as well as encouraging cultural education by the embedded interpreters, was vital in enhancing cultural understanding among FSE personnel.

The easy part of the FSE's mission was providing medical care to the sick and injured—this is what all medical personnel have trained for. The hardest and most important TK FSE COIN mission was to decrease local reliance on coalition medical assets so Afghans eventually could provide medical care independently. The intricacies encountered in focusing on training our local partners to better prepare them for caring for their own populace proved vexing. We strived to incrementally increase our partners' capacity to care for their own people. Continual reinforcement of and adherence to the fundamental COIN principle of enhancing indigenous capacity and maintaining a mission profile consistent with this principle helped mitigate some of these difficulties.

Conclusion

Integrating a forward-deployed U.S. surgical unit into the indigenous host-nation health sector in the midst of a COIN operation was a new approach to medical operations in COIN. TK FSE joined the SOTF COIN offensive to an unprecedented degree, its missions garnering measurable positive outcomes in the health care capacity of Uruzgan Province and beyond. The education of local Afghan and partner force medical providers by U.S. military medical providers fulfilled the COIN principle of increasing indigenous health care capacity without unsustainable traditional direct health aid. The depth of TK FSE's involvement in the indigenous health sector allowed for long-term relationships with local Afghan entities that could continually adapt to a changing environment. These relationships resulted in partnerships that were the foundation for the success of the FSE's medical COIN operations in southern Afghanistan. The TK FSE experience was beyond the unsustainable humanitarian assistance efforts of most medical COIN operations. Operations were low cost and high value, and they resulted in dramatic and sustainable gains. TK FSE's resounding successes in increasing Afghan health sector capacity represent a framework for future COIN medical operations. ***MR***

NOTES

1. Richard W. Thomas, *Ensuring Good Medicine in Bad Places: Utilization of Forward Surgical Teams in the Battlefield* (academic research paper, U.S. Army War College, Carlisle Barracks, PA, 2006), 18.

2. Report prepared for the Office of the Secretary of Defense, *Counterinsurgency in Afghanistan,* Seth G. Jones, (Santa Monica, CA: RAND Corporation, 2008), 100.

3. Sebastian L.V. Gorka and David Kilcullen, "An Actor-centric Theory of War: Understanding the Difference Between COIN and Counterinsurgency," *Joint Force Quarterly* (1st Quarter 2011): 17.

4. Matthew S. Rice and Omar J. Jones, "Medical Operations in Counterinsurgency Warfare: Desired Effects and Unintended Consequences," *Military Review* (May-June 2010): 49.

5. Jones, 130-31.