ISAF HEADQUARTERS

Kabul, Afghanistan

ISAF OVERVIEW BRIEF

MHS Conference

January 2011

Report Documentation Page

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Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std Z39-18

OUTLINE

I. Theater and Organizational Constructs

II. ISAF Campaign Plan and Theater Health Strategy

III. CJMED Lines of Operation
- A. Care for the Coalition
- B. Enable ANSF Health System Development
- C. Support Health Sector Development

IV. ISAF Health Sector Engagement Focus, 2011

V. Questions / Discussion

ISAF CAMPAIGN DESIGN

Understand the Operational Environment

Strategic Communications

Protect the Population

Population safeguarded from violence, coercion, intimidation, and predatory groups

Support Development of ANSF

ANSF leading in population security, and law enforcement serving the Afghan people

Neutralize Insurgent Networks

Insurgents neutralized to a level with which ANSF can deal; insurgent ranks substantially reduced by reintegration and reconciliation; cross-border movement of insurgents / explosives reduced significantly; extremist safe havens in Afghanistan denied

Neutralize Criminal Patronage Networks

CPN threats to GIRoA capacity, Afghan rule of law, and the ISAF/IC mission reduced to a manageable level

Support Development of Legitimate Governance

Governance sufficiently inclusive, accountable, and acceptable to the people

Support Sustainable Socio-Economic Development

Licit economy expanding; IC economic support channeled through GIRoA ministries

JOINT CAMPAIGN PLAN DESIGN

COMPREHENSIVE CIVIL-MILITARY APPROACH

Security

Governance

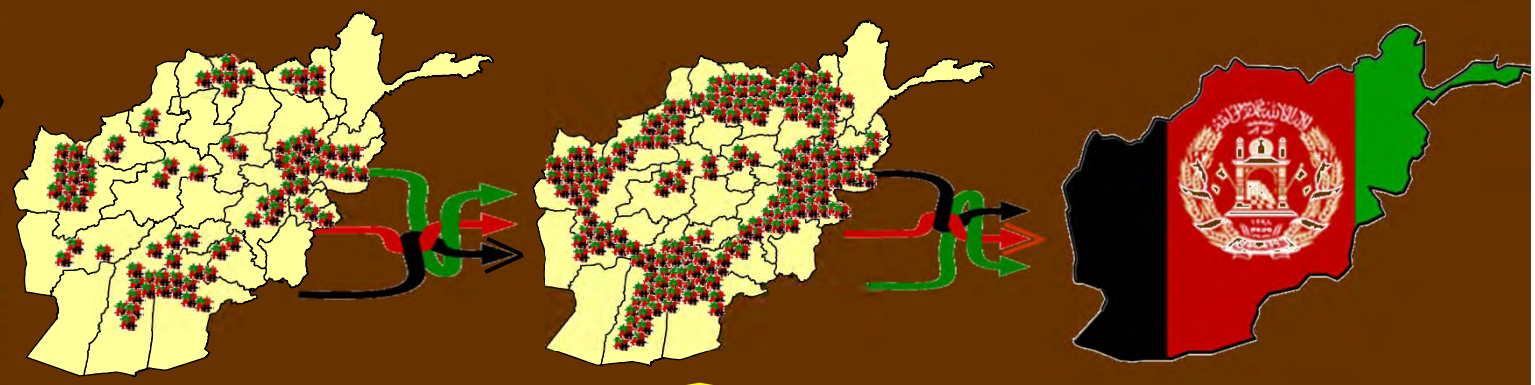
Development

Partner → Support → Enable

Conditions Based Transitions

Conditions Based Transitions

NEAR TERM — **INTERMEDIATE TERM** — **LONG TERM**



Supporting Activities

Reintegration/Reconciliation
Transition
Rule of Law
Borders & Customs
Strategic Communications
Reduction of corruption that undermines security and governance

NATO / ISAF UNCLASSIFIED

BUILDING TO MEDICAL TRANSISTION
(ISAF MEDICAL LINES OF OPERATION)

ISAF

کمک او همکاری

TRANSITION

GIRoA Capable of Assuming and Sustaining Execution of Medical Operations

CARE FOR THE COALITION

- Sustain Theater Public Health Services
- Provide Medical Care (Including Evacuation)

ASSESSMENT:

Force Health Protection

ENABLE ANSF HEALTH SYSTEM DEVELOPMENT

- Develop Afghan Vision for ANSF
- Provide Effective Advisors and Partners Across ANP / ANA

ASSESSMENT:

An Effective and Sustainable ANSF

SUPPORT CIVIL HEALTH SECTOR DEVELOPMENT

- Improve Coalition Effectiveness and Coordination of Resources
- Provide Clear Guidance to Coalition
- Increase Overall Resources Applied to Determinants of Health (CERP,Donors)

ASSESSMENT:

Improved Public Health

BUILDING THE MEDICAL "HOUSE"

OVERALL ASSESSMENT:

Theater Medical Campaign

FOUNDATIONAL PRINCIPLES

(Success depends on a solid foundational "Mix")

- Governance
- Development
- Nutrition
- Clean Water
- Security
- Education / Literacy
- Sanitation

OPERATIONAL BATTLE SPACE

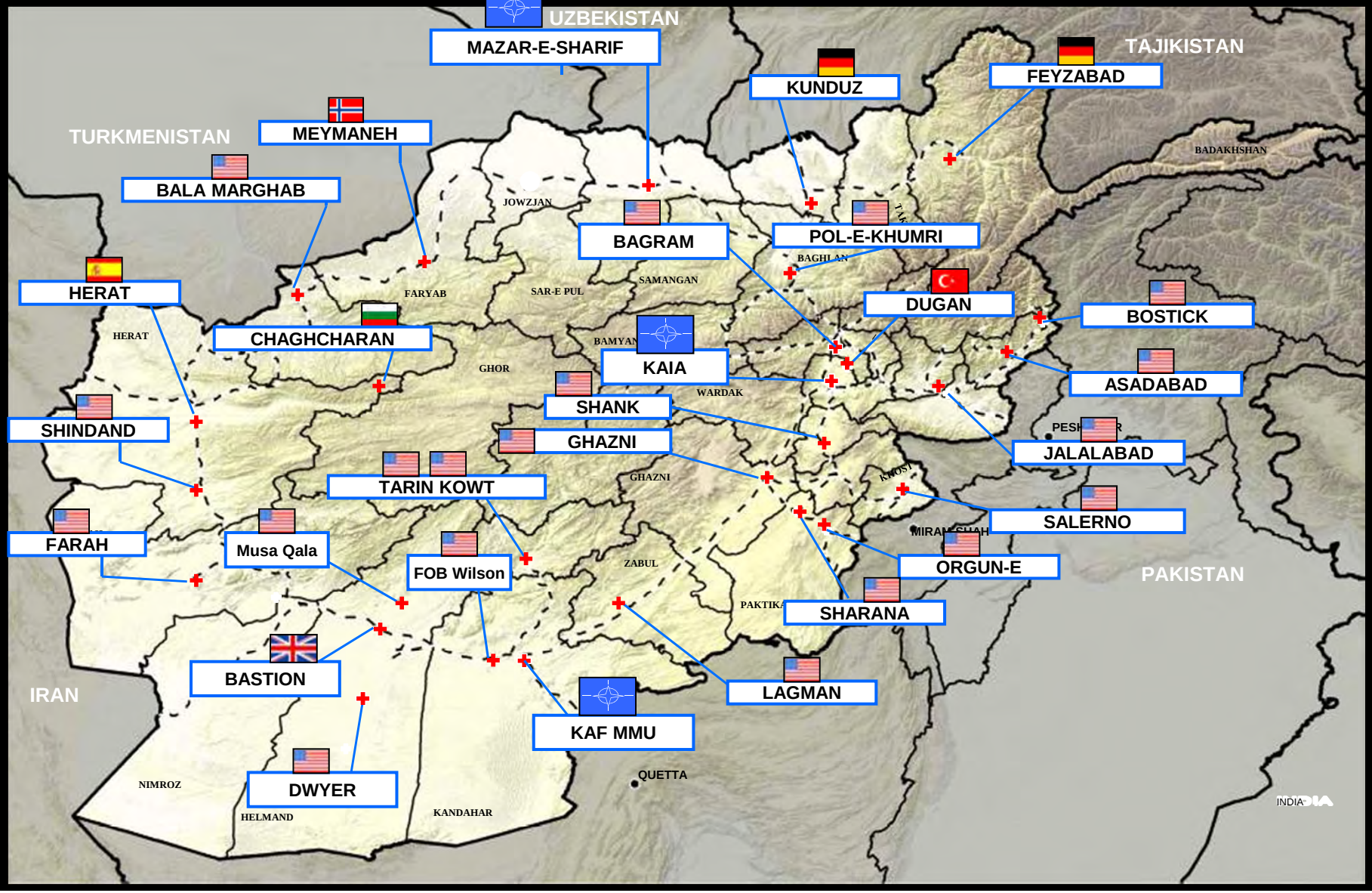
LINE OF OPERATION #1

Care for the Coalition

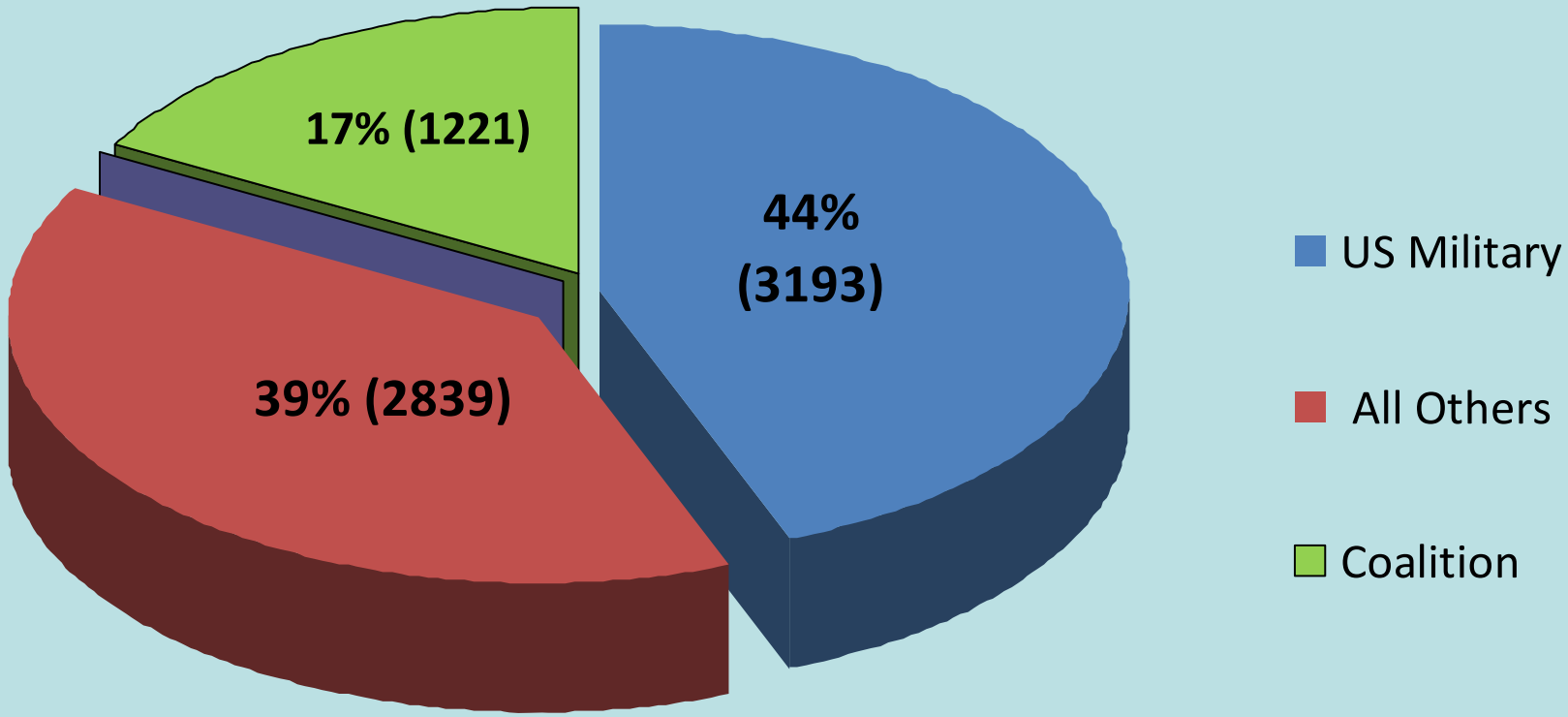
- Capability
- Advances in Care
  - JTTR Data
  - TCCC
  - JTTS - 32 CPGs
  - Worldwide Grand Rounds
- MEDEVAC
- STRATEVAC
- mTBI: Concussion protocol and recovery centers

NATO / ISAF UNCLASSIFIED

COALITION HEALTHCARE FACILITIES

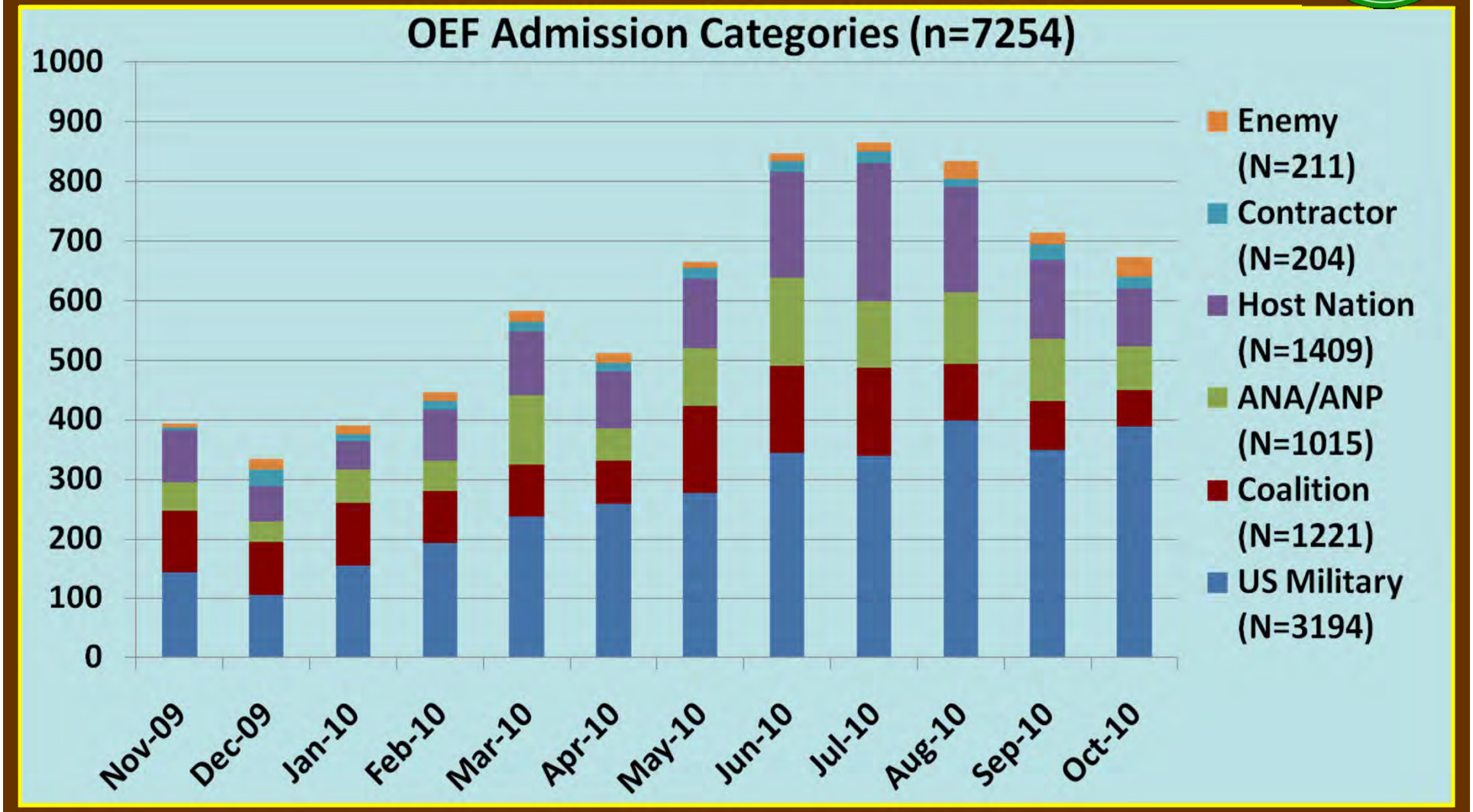


OEF ADMISSIONS

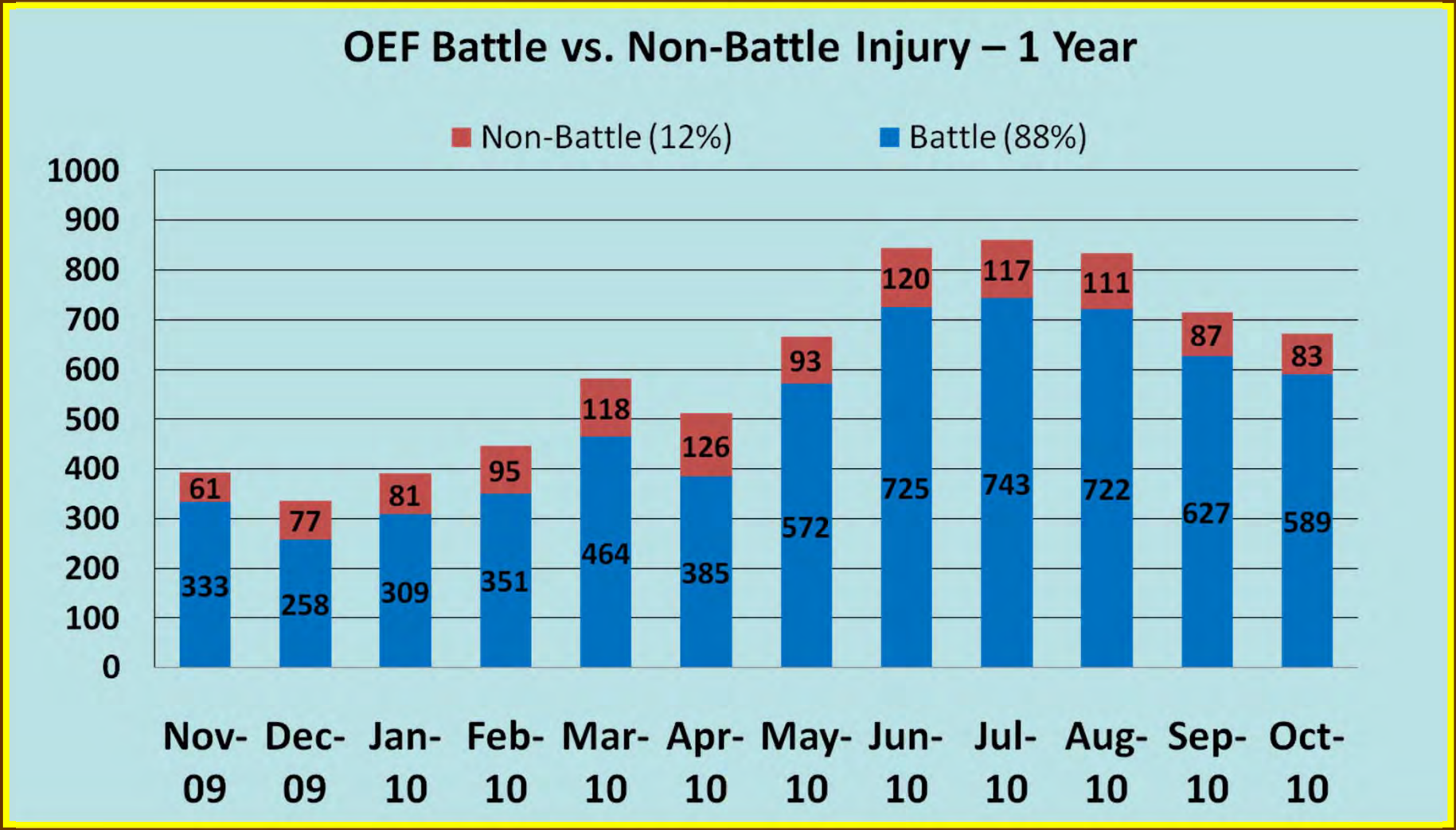


Rolling 12 months: Nov 09 – Oct 10

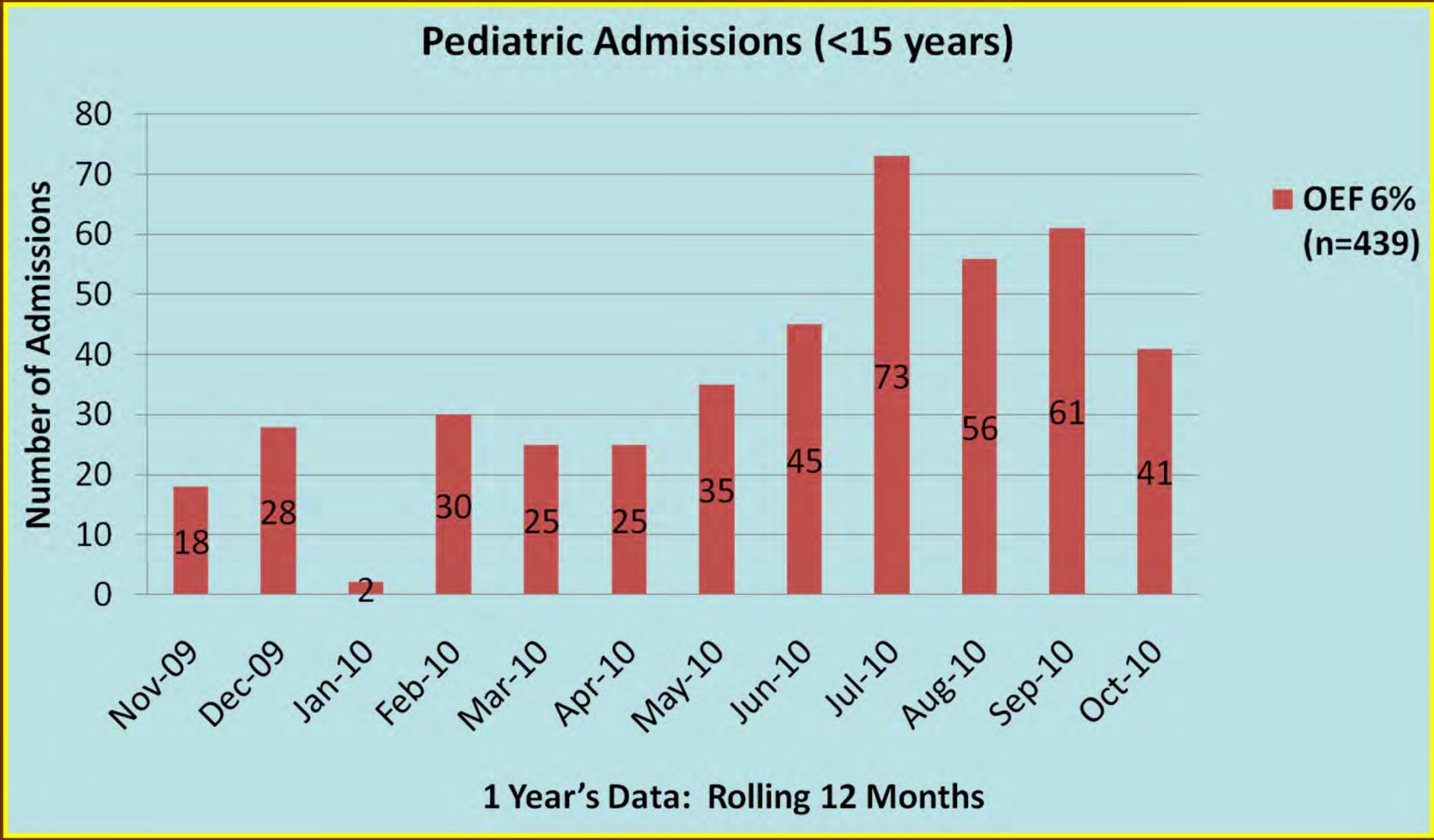
OEF ADMISSIONS
(By Category)



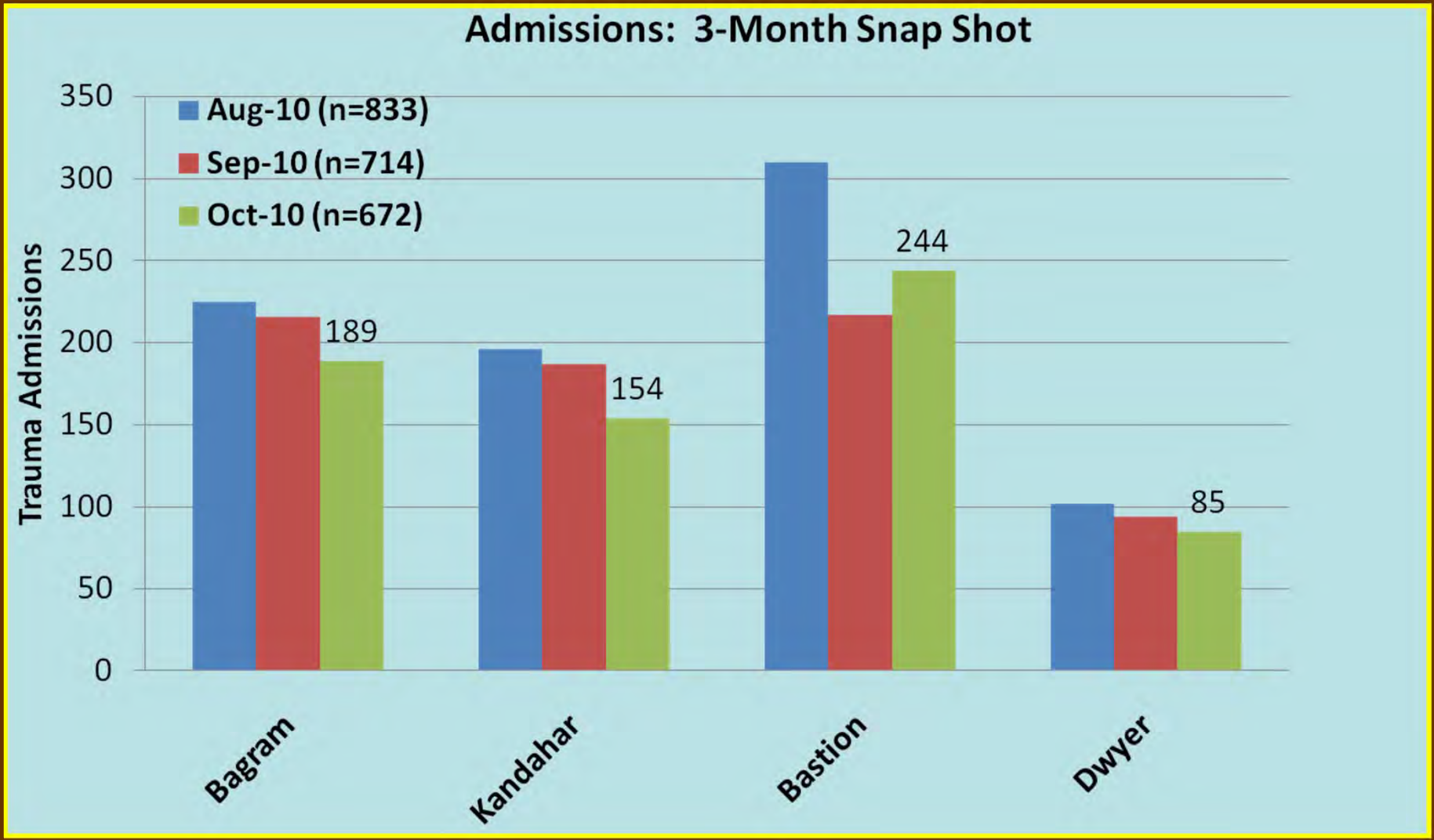
OEF BATTLE V. NON-BATTLE INJURY (1-Year)



PEDIATRIC ADMISSIONS
(<15 Years)

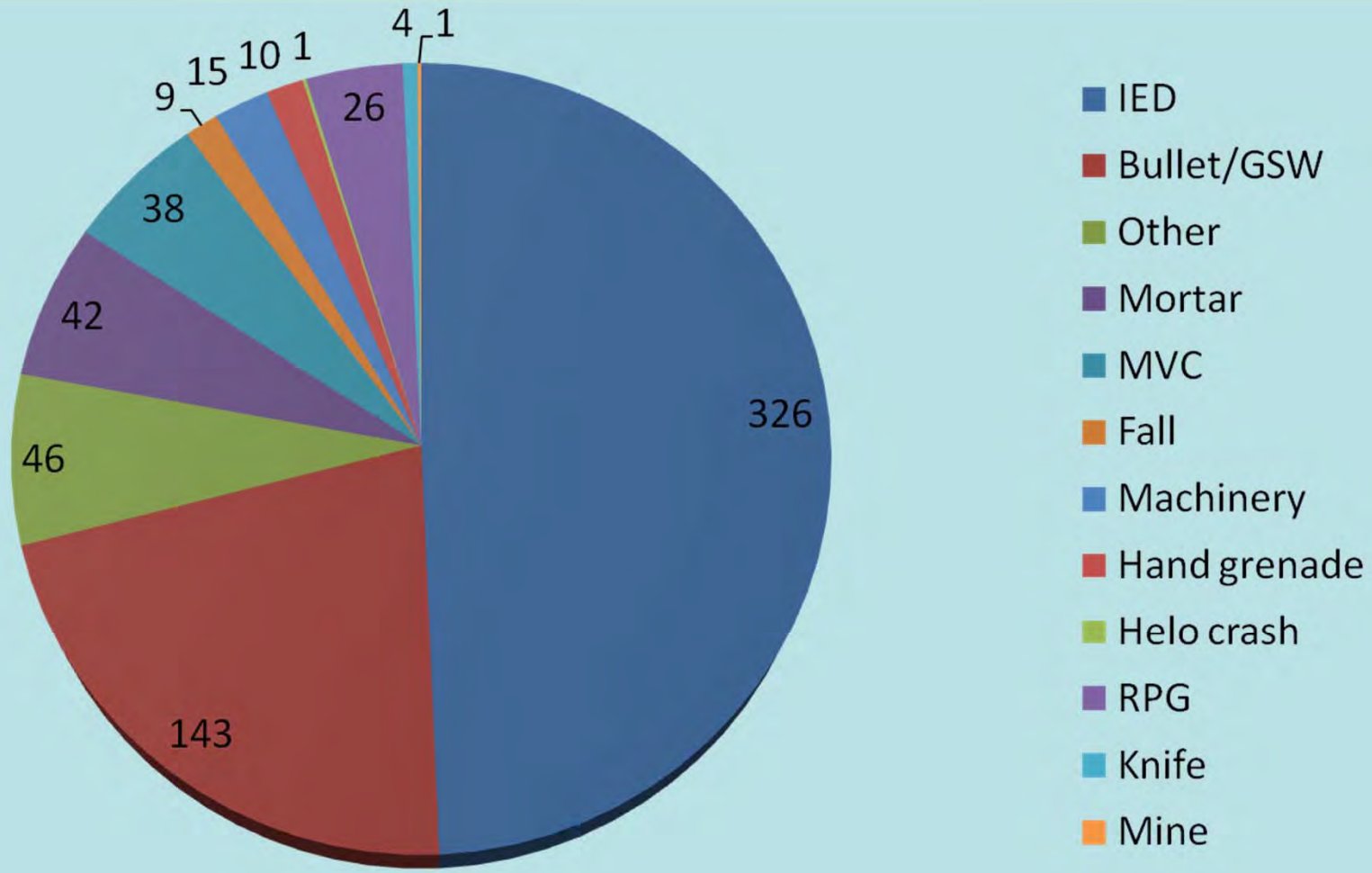


MONTHLY TRAUMA ADMISSIONS
(By Facility)



CAUSE OF INJURY
(October 2010)

N= 715



**Includes both battle and non-battle injury*

TACTICAL COMBAT CASUALTY CARE (TC3)

- Battlefied trauma care is different than civilian trauma care
- TC3 focuses on preventable causes of death

  Bleeding **Pneumothorax** **Airway Obstruction**
- CLS Training is being incorporated into all initial entry training

Care under fire: Combat Lifesaver, Corpsmen or Medic

Protect self & casualty

Stop major bleeding

Move casualty to cover

Tactical Field Care

Rapid trauma assessment

Treat preventable causes of death

Stabilize and prepare for evacuation

Combat Casualty Evacuation Care

Stabilization and treatment (dependant on evacuation mode)

Goals of TC3:

Treat the casualty.

Prevent additional casualties.

Complete the mission.

JOINT THEATER TRAUMA SYSTEM

- Institute of Surgical Research Clinical Practice Guidelines
- Weekly World-Wide Grand Rounds

Joint Theater Trauma System Clinical Practice Guideline

Management of Pain, Anxiety and Delirium in Injured Warfighters

Original Release/Approval	23 Nov 2010	Note: This CPG requires an annual review.	
Reviewed:	Oct 2010	Approved:	22 Nov 2010
Supersedes:	This is a new CPG and must be reviewed in its entirety.		
☐ Minor Changes *(or)*	☐ *Changes are substantial and require a thorough reading of this CPG* *(or)*		
☐ Significant Changes			

1. **Goal.** To provide an evidenced based framework for the management of pain, anxiety and delirium in injured combat casualties. To provide state of the art pain services to combat casualties and to reduce the incidence of chronic pain syndromes, PTSD and chronic narcotic dependency.
2. **Background.**
   a. Pain is universally present in combat casualties. Adequate early pain control has been

Joint Theater Trauma System Clinical Practice Guideline

AMPUTATION

Original Release/Approval:	1 Mar 2010	Note: This CPG requires an annual review	
Reviewed:	Feb 2010	Approved:	1 Mar 2010
Supersedes:	This is a new CPG and must be reviewed in its entirety		
☐ Minor Changes *(or)*	☐ Changes are substantial and require a thorough reading of this CPG *(or)*		
☐ Significant Changes			

1. **Goal.** To provide standardization of care for the performance of wound management and life saving amputations that will provide maximum limb length preservation, promote healing of viable tissues, and facilitate optimal rehabilitative function.
2. **Background**. The notion of the "zone of injury" is dependent upon the mechanism of injury i.e. blast, gunshot and crush injuries, as well as co-morbidities and physiologic status of the

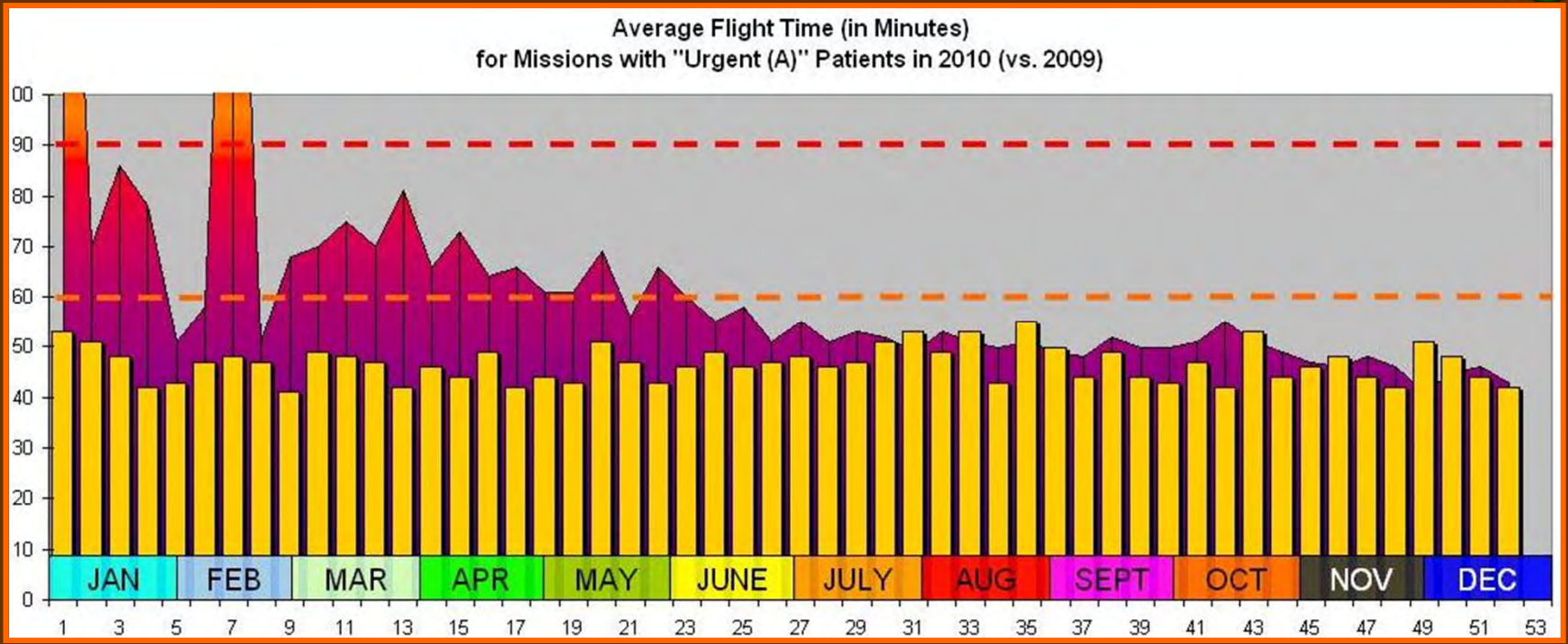
Joint Theater Trauma System Clinical Practice Guideline

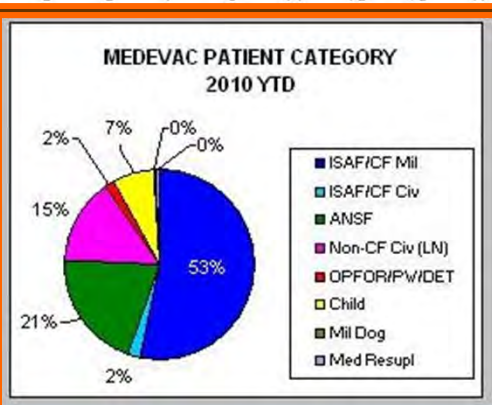
MANAGEMENT OF PATIENTS WITH CATASTROPHIC, NON-SURVIVABLE HEAD INJURY

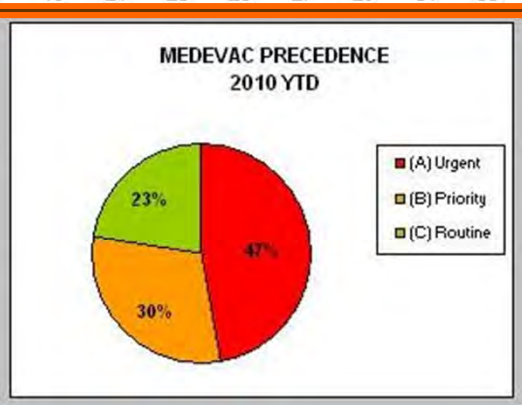
Original Release/Approval:	1 Mar 2010	Note: This CPG requires an annual review	
Reviewed:	Feb 10	Approved:	1 Mar 2010
Supersedes:	This is a new CPG and must be reviewed in its entirety		
☐ Minor Changes *(or)*	☐ Changes are substantial and require a thorough reading of this CPG *(or)*		
☐ Significant Changes			

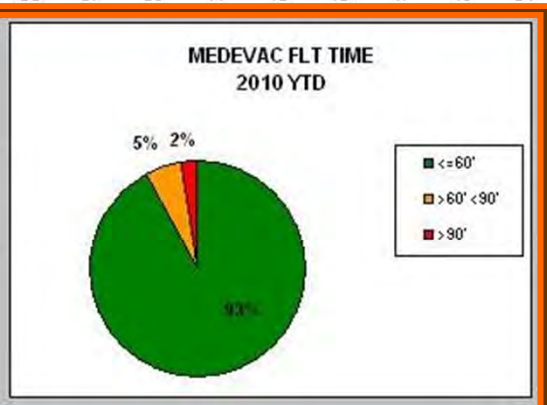
1. **Goal.** Provide useful guidelines for the management of casualties with catastrophic, non-survivable head injury at Level II and Level III facilities.
2. **Background.**
   a. Catastrophic head injury, for the purpose of this guideline, is defined as any head injury that is expected after imaging evaluation and /or clinical exam to result in the permanent loss of all brain function above the brain stem level. **NOTE: For patients with potentially survivable but severe Traumatic Brain Injury, refer to CENTCOM JTTS CPG, *Management of Patients with Severe Head Trauma*).**
      i. The intent of this guideline is to provide clinically useful recommendations that will allow providers at all echelons who encounter these injuries to optimize the opportunity for these patients to be transported safely and appropriately to the next echelon of care.
      ii. It is not the purpose of this guideline to address the complexities of brain death

MEDEVAC PERFORMANCE









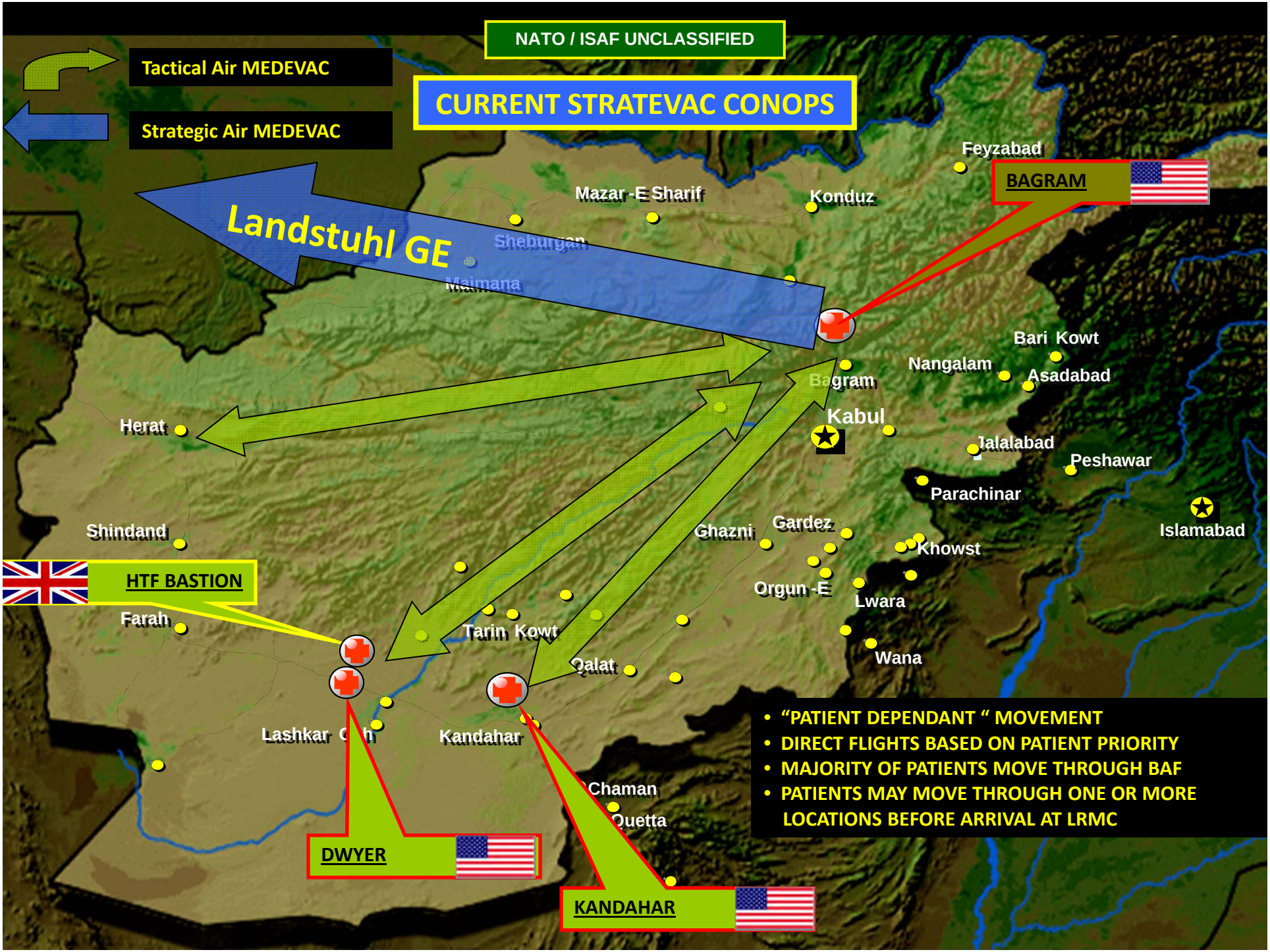
Trauma Bay

2010	
US Mil	857
Coalition	209
ANA/ANP	257
Afghan LN	497
Detainee	72
Contractor	65

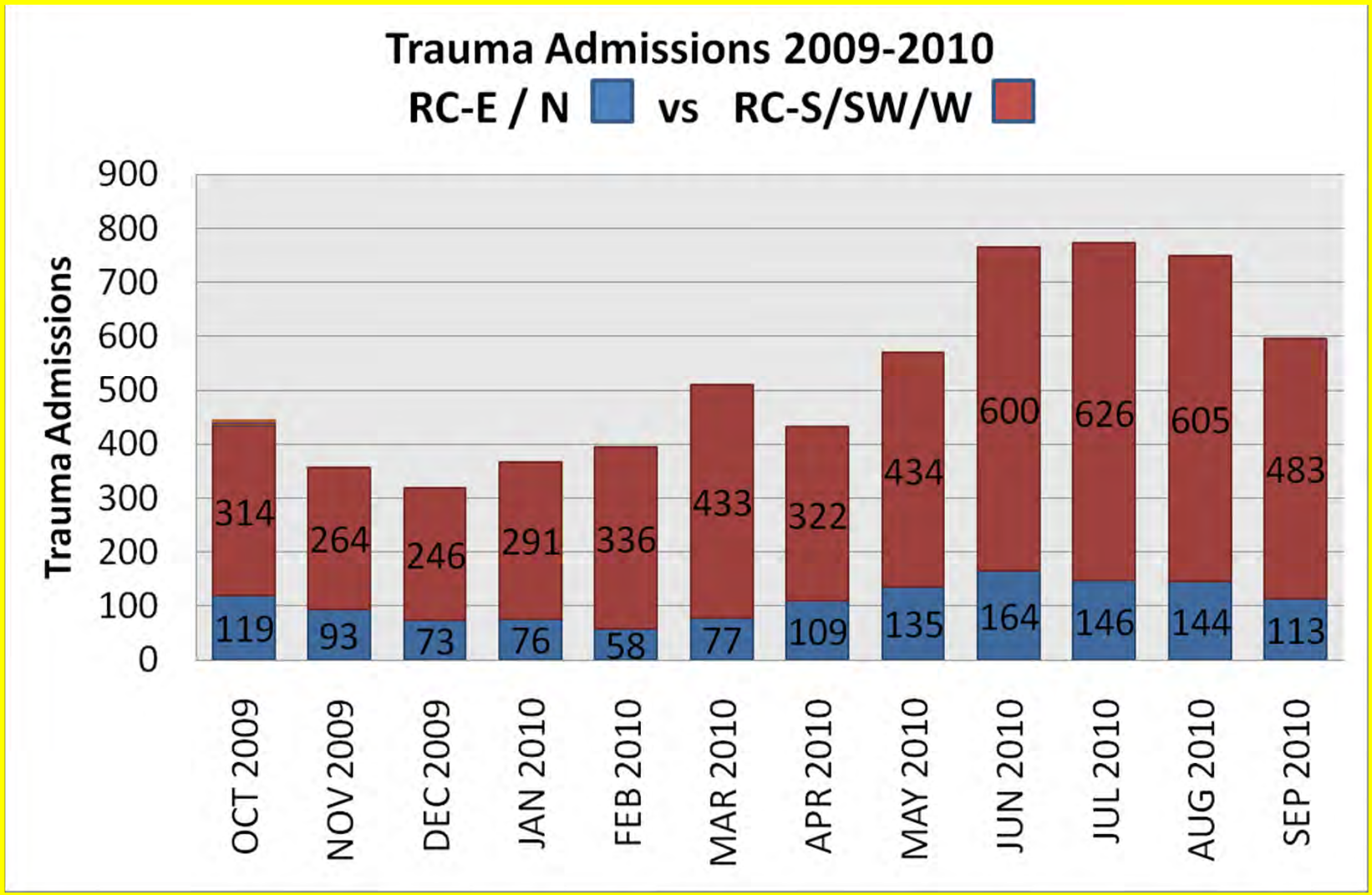
2
E11-12
17-18
TRAUMA SHOCK
TREATMENT ROOMS

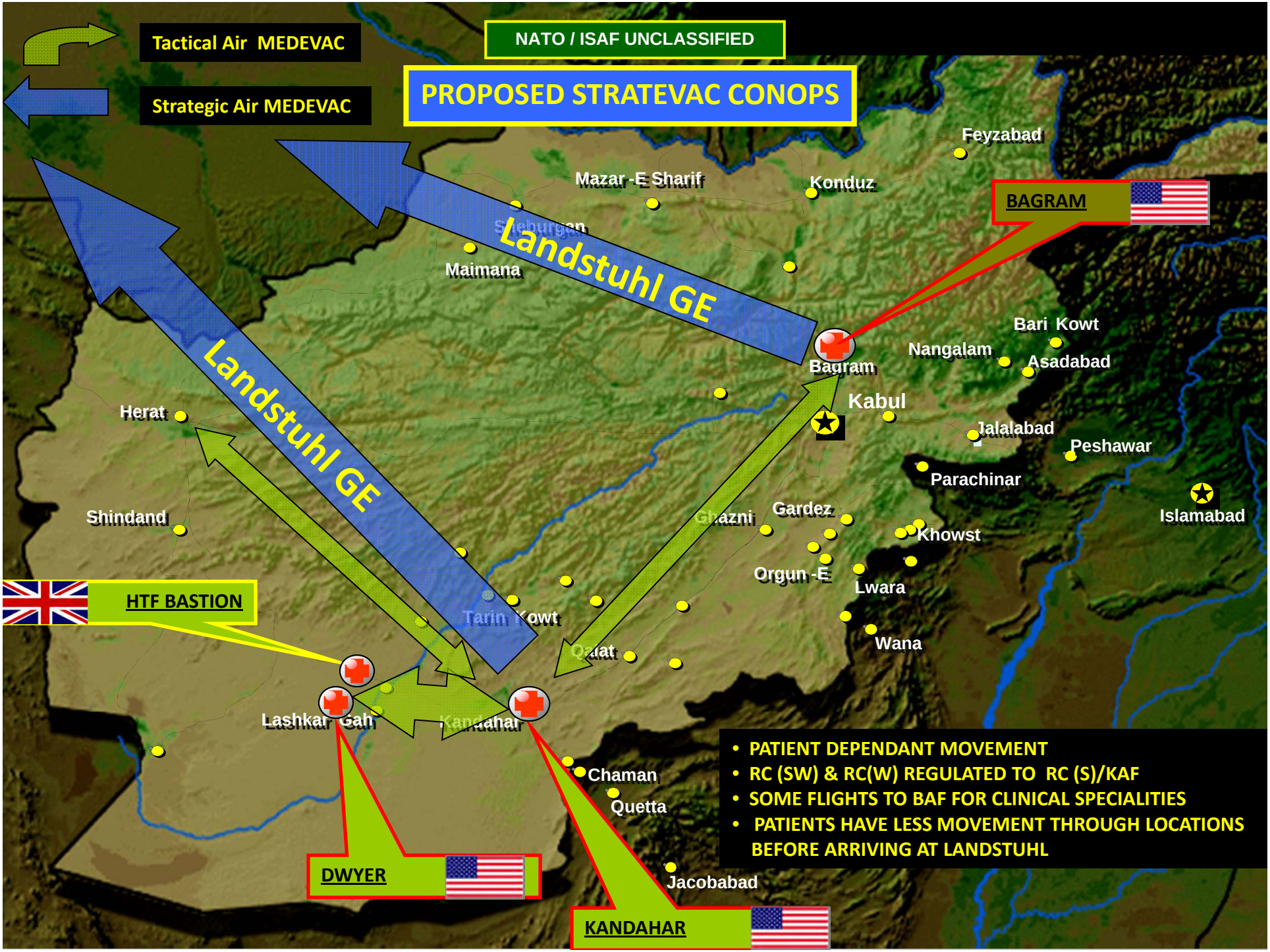
STRATEVAC

NATO / ISAF UNCLASSIFIED

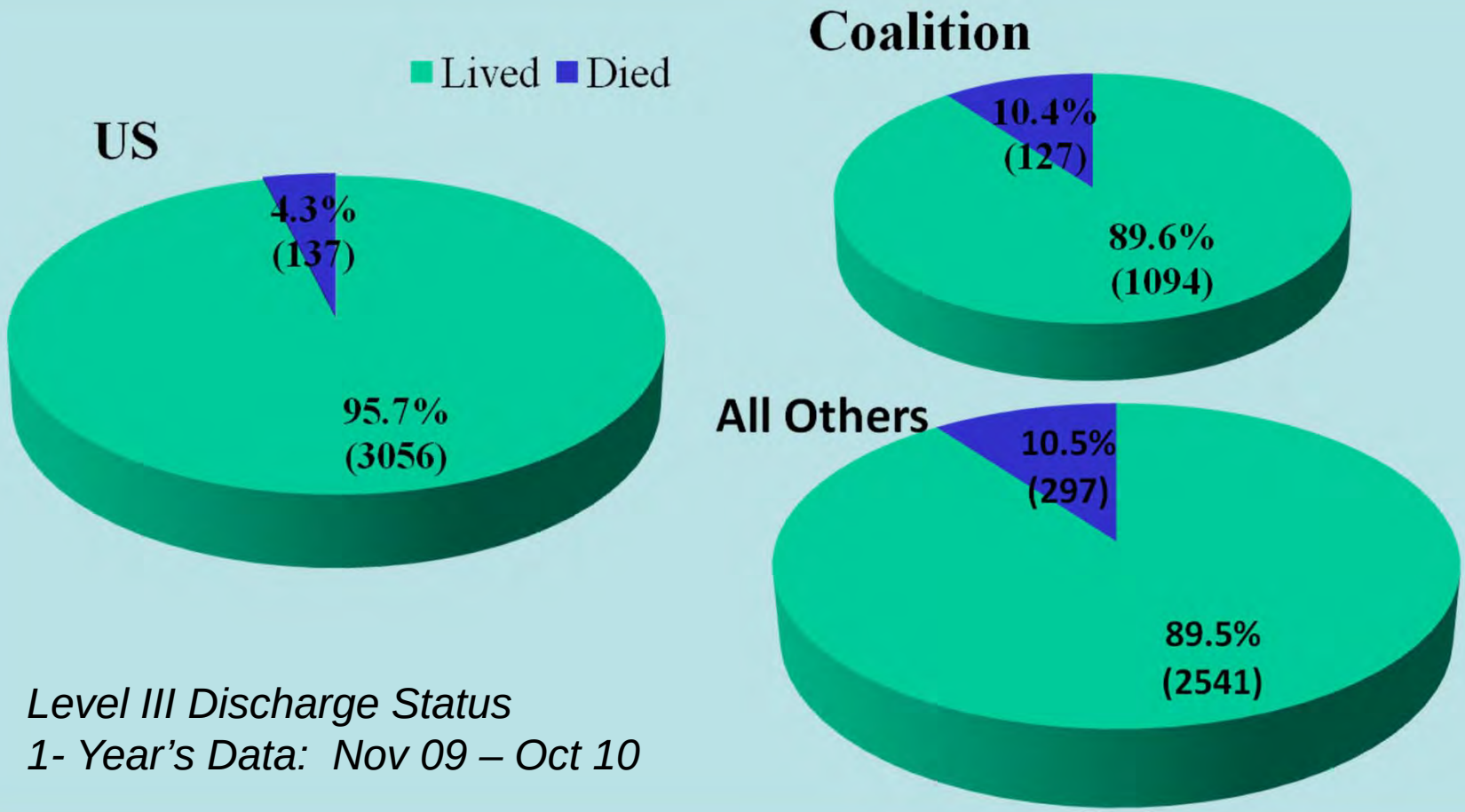

NATO / ISAF UNCLASSIFIED
CURRENT STRATEVAC CONOPS
Tactical Air MEDEVAC
Strategic Air MEDEVAC
Landstuhl GE
Feyzabad
BAGRAM
Mazar -E Sharif
Konduz
Sheburgan
Maimana
Bari Kowt
Nangalam
Asadabad
Bagram
Kabul
Herat
Jalalabad
Peshawar
Parachinar
Islamabad
Shindand
Ghazni
Gardez
Khowst
HTF BASTION
Orgun -E
Lwara
Farah
Tarin Kowt
Wana
Qalat
Lashkar Gah
Kandahar
Chaman
Quetta
DWYER
KANDAHAR
• "PATIENT DEPENDANT " MOVEMENT
• DIRECT FLIGHTS BASED ON PATIENT PRIORITY
• MAJORITY OF PATIENTS MOVE THROUGH BAF
• PATIENTS MAY MOVE THROUGH ONE OR MORE LOCATIONS BEFORE ARRIVAL AT LRMC

TRAUMA ADMISSIONS
(2009-2010)




Tactical Air MEDEVAC
Strategic Air MEDEVAC
NATO / ISAF UNCLASSIFIED
PROPOSED STRATEVAC CONOPS
Landstuhl GE
Landstuhl GE
BAGRAM
HTF BASTION
DWYER
KANDAHAR
Feyzabad
Mazar -E Sharif
Konduz
Maimana
Bagram
Bari Kowt
Nangalam
Asadabad
Kabul
Jalalabad
Peshawar
Parachinar
Islamabad
Herat
Shindand
Gardez
Khowst
Orgun -E
Lwara
Wana
Tarin Kowt
Lashkar Gah
Kandahar
Chaman
Quetta
Jacobabad
• PATIENT DEPENDANT MOVEMENT
• RC (SW) & RC(W) REGULATED TO RC (S)/KAF
• SOME FLIGHTS TO BAF FOR CLINICAL SPECIALITIES
• PATIENTS HAVE LESS MOVEMENT THROUGH LOCATIONS BEFORE ARRIVING AT LANDSTUHL

OEF IN-THEATER SURVIVAL



Level III Discharge Status
1- Year's Data: Nov 09 – Oct 10

CONCUSSION CARE
(mTBI Initiative)

Pre-Role I / Role I

FACILITIES	• 5 increasing to 8 rest centers (RC-E, RC-S, RC-SW) • Core staffing: OT, OT Tech • Supported by unit PA / provider
MISSION	• Facilitate rest in a controlled environment • Early ID of Red Flags • Appropriate symptomatic management • Appropriate referrals to higher level care
CHALLENGES	• Ensure appropriate medical oversight of soldiers/sailors at rest centers • Continuity of medical care • Timely assessment / feedback regarding care
BEST PRACTICES	• Active Surgeon involvement • ADOBE Connect sessions between Role I and Role II providers • Open lines of communication with neurologist

CONCUSSION CARE
(mTBI Initiative)

Role III

	BAF (RC-E)	KAF (RC-S)	LNK / Bastion (RC-SW)
FACILITIES (RC-E)	• Recurrent concussion evaluation and management • Tertiary neurology care		• Concussion Restoration Care Center (CRCC)
MISSION	• Neurologist • Neuropsychologist • PT • NCO • Post concussion quarters	• Neurologist • Neuropsychologist • OT / OT tech • PT / PT tech • Family medicine • LNO for quarters	• Sports medicine • Psychiatrist (inpatient LNO) • Family medicine • Psychologist • Nurse • OT / PT • 0.5 FTE FM (data entry) • 5 x corpsmen • Rely on CASF / step-down unit
BEST PRACTICES	• Near daily multi-disciplinary rounds • SNCO involvement	• OT military specific functional assessment (warrior tasks)	• Inpatient liaison • Data capture • Corpsmen on team

LINE OF OPERATION #2

Enable ANSF Health System Development

- Afghanistan National Army (ANA)
- Afghanistan National Police (ANP)

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MTAG FUNCTIONS AND KEY INITIATIVES

- Leader Development – Advise the ANSF Surgeons General on matters of leadership and policy development.
- Clinical Advising – Develop Critical Warfighter Medical Capabilities: Preventive Medicine, Trauma Surgery, Emergency Medicine, Intensive Care, Physical Therapy/Rehabilitation.
- Standard of Care Development - Elevate Standards of Care through daily advising to healthcare workers and the healthcare leadership.
  - Formalize Standard of Care policies and procedures.
- Military Medical Training:
  - Combat Medics/Trauma Assistance Personnel
  - Nurses
  - Doctors
  - Allied Health and Technicians (Lab, Radiology, BioMed)
- Key Initiatives:
  - -- Preventive Medicine Tech
  - -- Physician Assistants (PA)

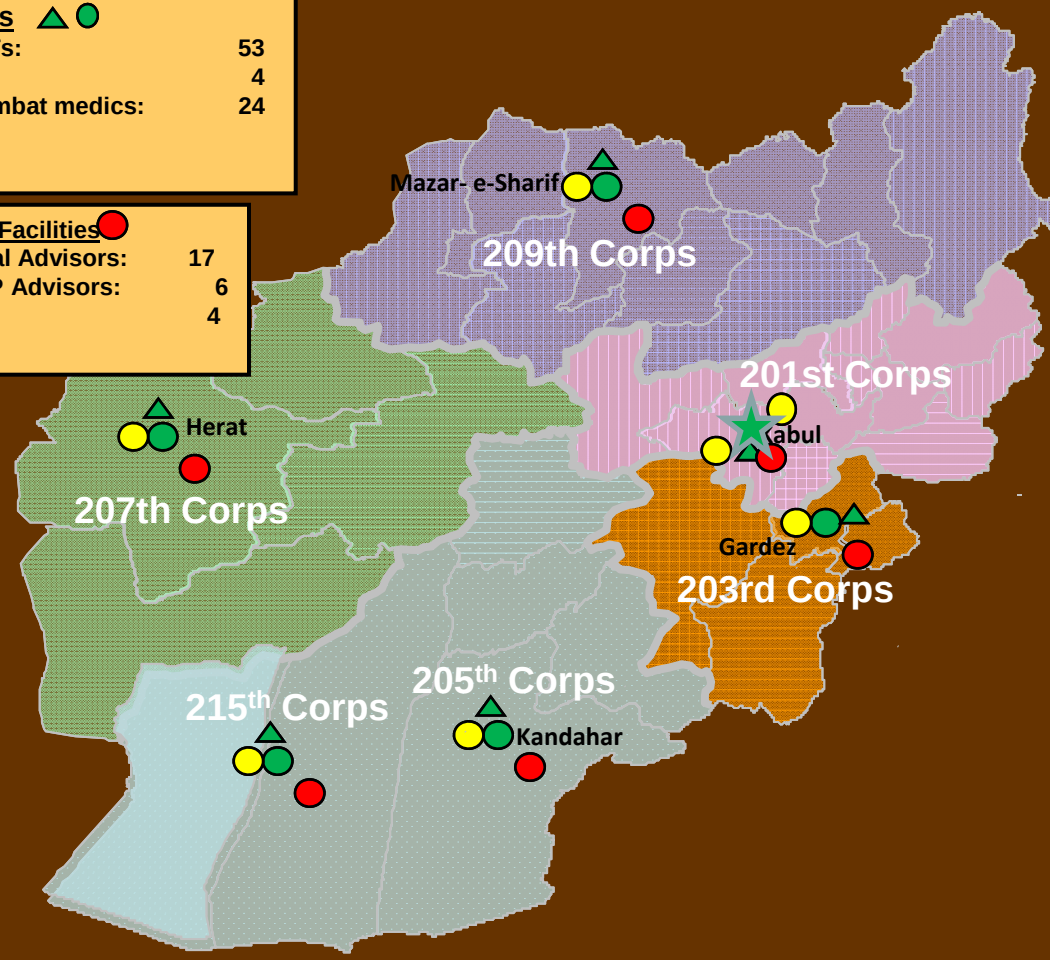
MTAG SUPPORTED KEY INSTITUTIONS

Regional ANA Hospitals and Depots

Hospital ETTs:	53
DynCorp:	4
Regional combat medics:	24

ANP Medical Facilities

MTAG Medical Advisors:	17
Regional ANP Advisors:	6
MPRI:	4



Kabul

National Military Hospital:	25
AHPI:	4
MTAG Staff & Advisors:	22
MEDCOM Warehouse:	2
DynCorp:	8
CJSOR (French)	10

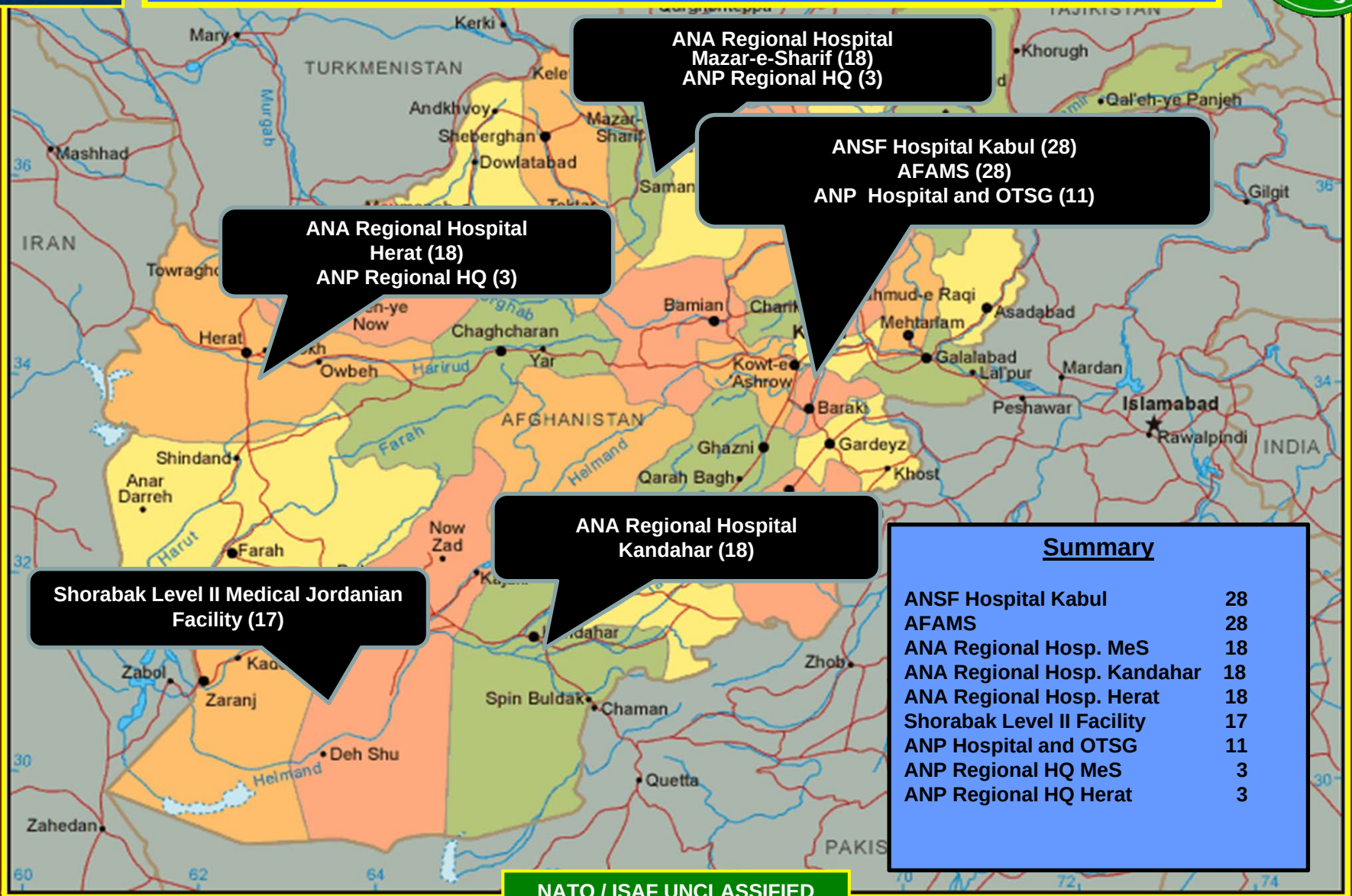
MTAG Training Courses

2 week courses
Combat Medic instructor *
Med Logistics *
8 week courses
Basic Officer Course *
Combat Medic *
NCO course *
52 week courses
Preventive Medicine
Biomedical Repair
Laboratory
Nursing
X-ray
PA start : 1 OCT

*Afghan Led As of 1 OCT

179 Advisors (68% fill) Throughout Afghanistan

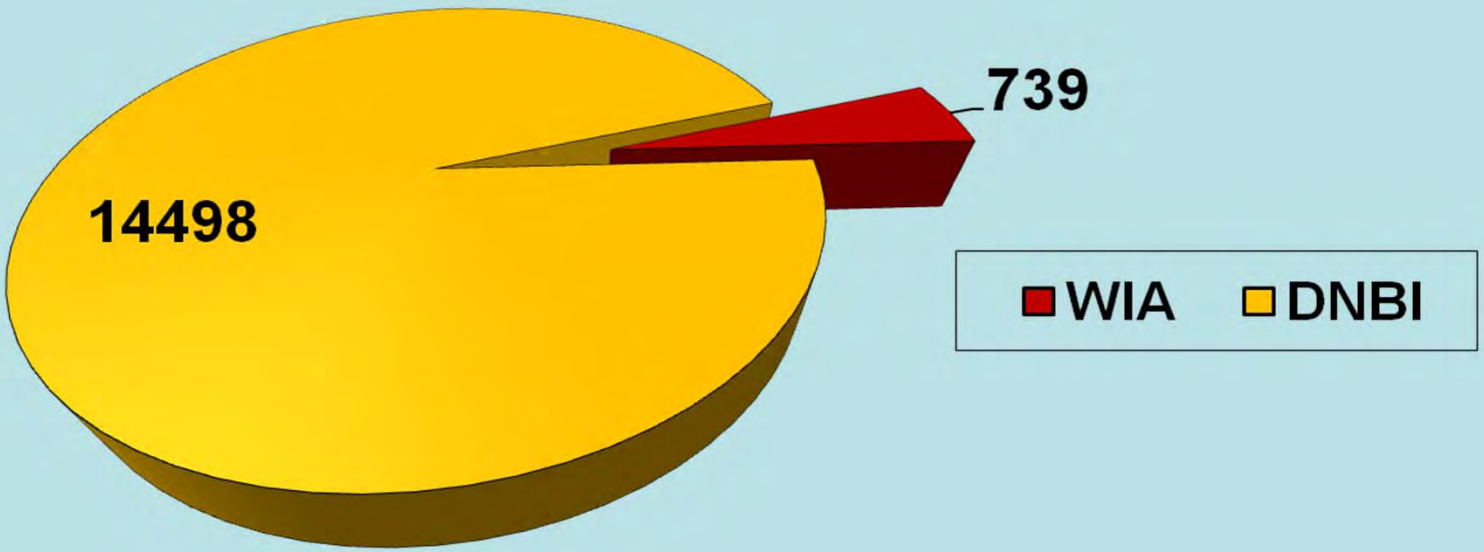
CJSOR: MTAG



Summary

ANSF Hospital Kabul	28
AFAMS	28
ANA Regional Hosp. MeS	18
ANA Regional Hosp. Kandahar	18
ANA Regional Hosp. Herat	18
Shorabak Level II Facility	17
ANP Hospital and OTSG	11
ANP Regional HQ MeS	3
ANP Regional HQ Herat	3

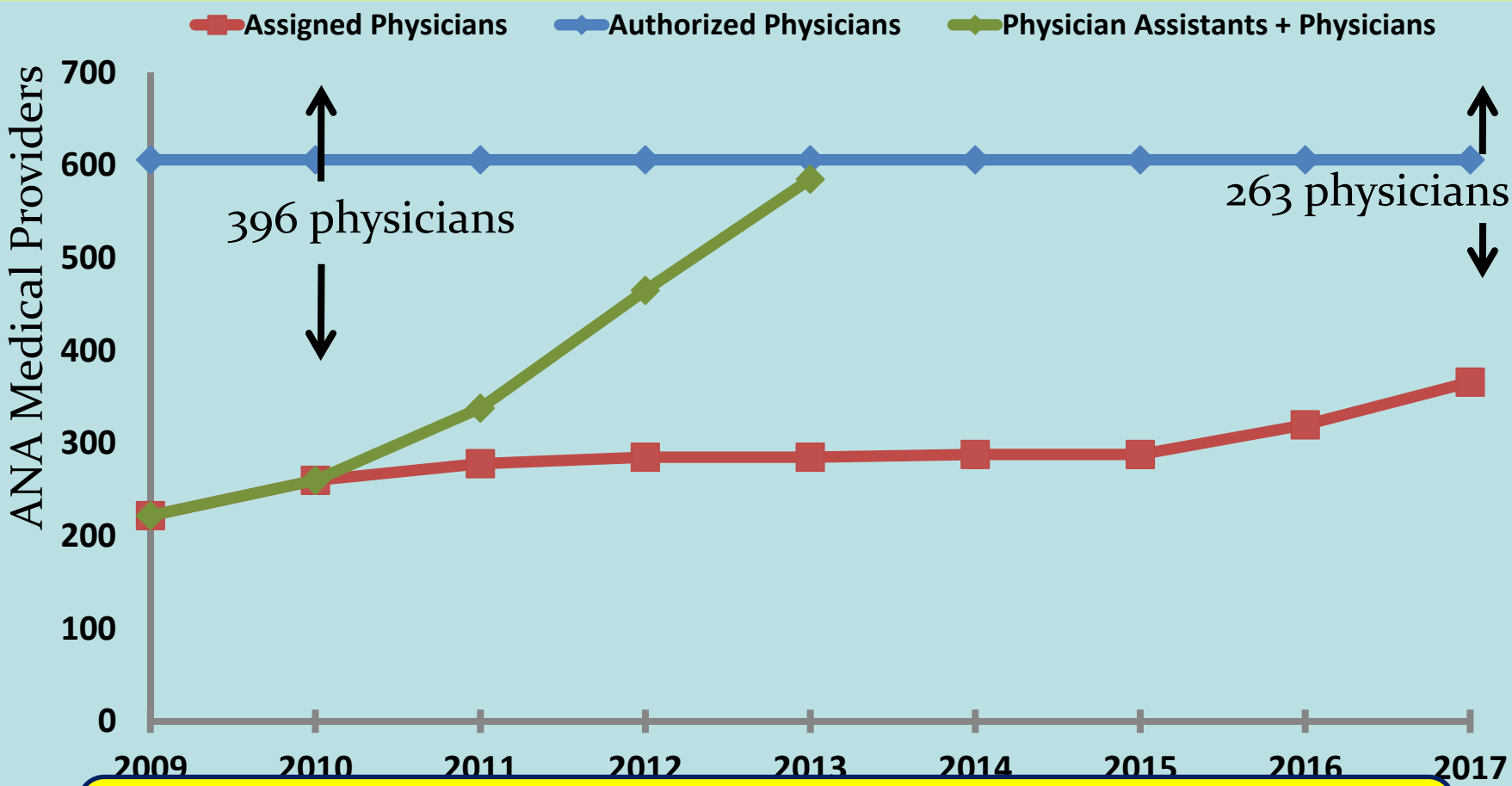
ANA CASUALTIES



~20 Disease, Non-Battle Injury (DNBI) casualties for every 1 combat casualty

Preventive Medicine = Force Protection
Conserve the Fighting Force

BRIDGING THE PROVIDER GAP



PA Initiative Will Resolve Physician Shortage 7 Years Sooner

NEW PA STUDENTS

Mentoring Eager Afghans

ANSF MEDICAL DEVELOPMENT

Challenges for Transition

- Attrition, Leader deficit, Literacy
- Shortage and distribution of physicians (56%) and nurses (25%) enterprise-wide
- Delegation of authority / accountability
- Medical logistics
- Need to define clear end-state
- Unfilled mentor requirements and problematic fit to fill process
- MoPH, MoHE, MOD, MOI coordination and sharing

LINE OF OPERATION #3

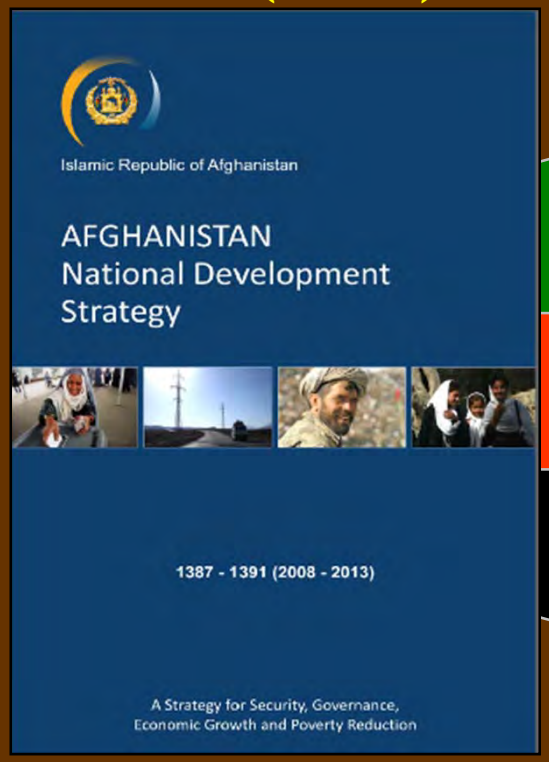
Support Civil Health Sector Development

- Afghan Development Strategy
- ISAF Guidance
- Focus for 2011 Engagement

NATO / ISAF UNCLASSIFIED

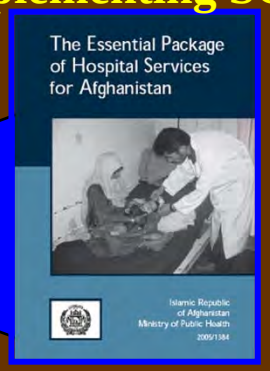
AFGHAN NATIONAL HEALTH POLICY

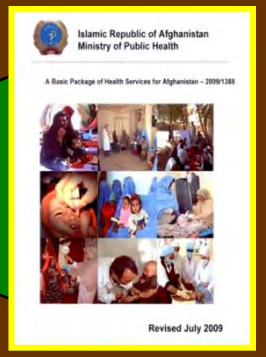
ANDS (MDGS)



HNSS

Implementing SOPs





BPHS and EPHS Comprise Afghanistan's Entire Referral System

AFGHAN HEALTH AND NUTRITION STRATEGY

Health & Nutrition Sector Strategy Vol. 2

- Desired results (Health Indicators)
- Vision
- Goals
- Objectives
- Programs

Essential Package for Hospital Services in AFG

- Capabilities
- Equipment
- Staffing
- Drugs

Basic Package for Health Services in AFG

- Capabilities
- Equipment
- Staffing
- Drugs

Few → Many

Most → Least Capability

Regional — 5

Provincial — 30

District Hospital (DH) — 67
100k-300k
XRAY, surgery, OB, physiotherapy, pediatrician, pharmacist, dentist.

Comprehensive Health Ctr (CHC) — 378
30k-60k
Limited inpatient care, lab, pharmacy. Severe childhood illness, malaria. **Complex mental health**. 2 doctors (male/fem), 2 nurses, 2 midwives.

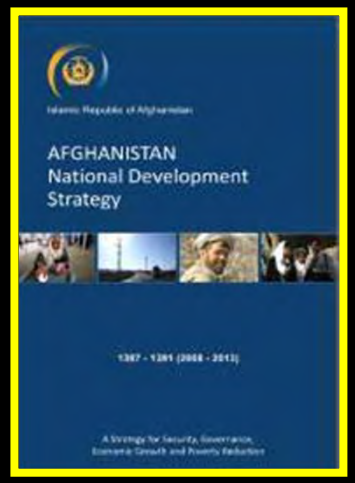
Basic Health Center (BHC) — 813
15k-30k
Complex outpatient care, **mental health**. Full OB care, **newborn** care, immunizations, childhood diseases. Treatment of malaria, TB. 1 doctor, 1 nurse, 1 midwife, 2 vaccinators. Supervise CHW.

Mobile Health Team — 99
10k-15k
An extension of the BHC. Visits remote villages every 2 months or as directed by PHCC. 1 male doctor or nurse, 1 female midwife or nurse, 1 vaccinator, and 1 driver.

Health Sub-Center — 447
3k-7k
Created to increase access **within 2 hours** walk. Routine **immunizations**, **prenatal** care, TB detection, 1 male **nurse** & 1 community **midwife**. Supervises HP.

Health Post — Data Unavailable
Covers 1,000-1,500 Afghans
Limited care: treatment of malaria, diarrhea, acute respiratory infections. **Education** on nutrition, birth control, STDs, prenatal warning signs. **Identification** of persons with disabilities and mental health illness. **2 CHWs** from their home.

Number of Facilities (HMIS, Sep 2010)



MoPH STRATEGY

- Focused on reducing maternal and child mortality as the key element
- Delivers a basic, not comprehensive, health package (BPHS)
- Secondary care, but minimal tertiary care (EPHS), e.g., no publicly funded ICU capability
- NGOs contracted to provide BPHS throughout the country
- MoPH's role is steward of the health system (far from perfect, but it works)

ISAF DIRECTION AND GUIDANCE

ISAF Standing Operating Procedures 01154:

ISAF Guidance on Military Medical Engagement in Health Sector Reconstruction and Development

NATO/ISAF UNCLASSIFIED RELEASABLE TO GIROA/UNAMA

Headquarters
International Security Assistance Force

STANDARD OPERATING PROCEDURES 01154
ISAF GUIDANCE ON MILITARY MEDICAL ENGAGEMENT
IN HEALTH SECTOR RECONSTRUCTION AND DEVELOPMENT

AUTHORIZED BY:	DCOS STAB
ISSUING AUTHORITY:	COS
DRAFTED BY:	ISAF HQ REES ALAN OF-5 IS
LAST UPDATE	28 July 2010

REFERENCES:

A. ACO Directive 83-2 dated 29 Mar 10 – Allied Command Operations (ACO) Guidance for Military Medical Services involvement with Humanitarian Assistance and Support to Governance, Reconstruction and Development.
B. Guidelines for the Interaction and Coordination of Humanitarian Actors and Military Actors in Afghanistan (Version 1) dated 20 May 2008.
C. US DOD Instruction 6000.16 dated 17 May 10 Military Health Support for Stability Operations.
D. COMISAF OPLAN 38302 Rev 4, dated 25 Sep 09.
E. SOP 1149 ISAF Medical Rules of Eligibility (1 Sep 09).
F. SOP 322 ISAF In Extremis Support to GIRoA and International Community (9 Jan 07).
G. Medical Mentor/Trainer/Advisor Manual – Healthcare Development of the Afghan National Security Forces (Rev Apr 10).
H. HQ ISAF MEDAD Guidance – ISAF Support to ANSF Medical Capability Development – 6 May 10.
J. COMISAF Directive on Medical Facilities (Entry and Use of Force) dated 30 Oct 09.
K. SOP 1145 Operational Medical Reporting (28 Apr 10).
L. HQ ISAF FRAGO 007-2009 Biometric Enrolment Campaign Planning.
M. HQ ISAF Strategic Partnering Directive (23 May 10) – Promulgated under cover of HQ ISAF/FRAGO/127-2010 (30 Jun 10).

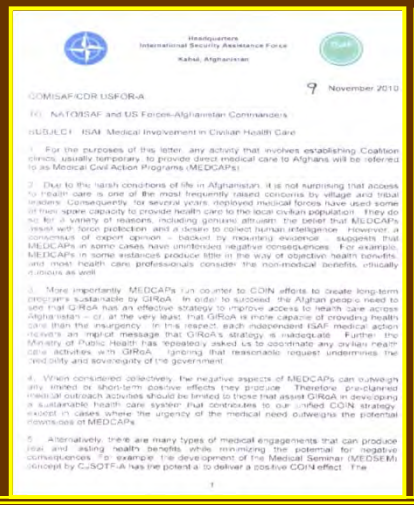
CONTENTS

PAGE	TITLE
3	Purpose
3	Background
4	Afghan Health System
8	Medical Involvement in Reconstruction and Development
10	Medical Engagements
16	Medical Civil Action Programmes (MEDCAP)

As of 28 July 2010 1 SOP 01154
NATO/ISAF UNCLASSIFIED RELEASABLE TO GIROA/UNAMA

COMISAF DIRECTIVE, 09 NOV 10:

ISAF Medical Involvement in Civilian Health Care



Headquarters
International Security Assistance Force
Kabul, Afghanistan

9 November 2010

COMISAF/CDR USFOR-A

TO: NATO/ISAF and US Forces-Afghanistan Commanders

SUBJECT: ISAF Medical Involvement in Civilian Health Care

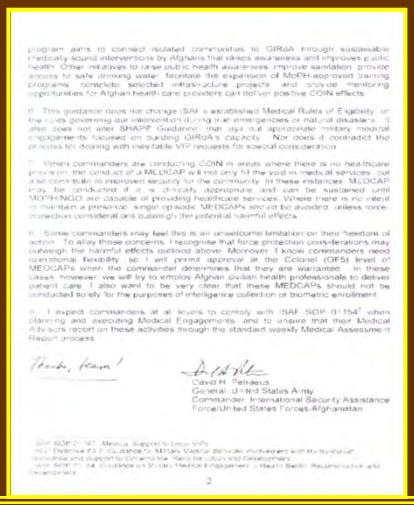
1. For the purposes of this letter, any activity that involves establishing Coalition clinics, usually temporary, to provide direct medical care to Afghans will be referred to as Medical Civil Action Programs (MEDCAPs).

2. Due to the harsh conditions of life in Afghanistan, it is not surprising that access to health care is one of the most frequently raised concerns by village and tribal leaders. Consequently, for several years, deployed medical forces have used some of their spare capacity to provide health care to the local civilian population. They do so for a variety of reasons, including genuine altruism, the belief that MEDCAPs reward with force protection and a desire to collect human intelligence. However, a consensus of expert opinion – backed by mounting evidence – suggests that MEDCAPs in some cases have unintended negative consequences. For example, MEDCAPs in some instances produce little in the way of objective health benefits, and most health care professionals consider the non-medical benefits ethically dubious as well.

3. More importantly, MEDCAPs run counter to COIN efforts to create long-term program sustainable by GIRoA. In order to succeed, the Afghan people need to see that GIRoA has an effective strategy to improve access to health care across Afghanistan – or, at the very least, that GIRoA is more capable of providing health care than the insurgency. In this respect, each independent ISAF medical action reinforces an implicit message that GIRoA's strategy is inadequate. Further, the Ministry of Public Health has repeatedly asked us to coordinate any civilian health care activities with GIRoA. Ignoring that reasonable request undermines the credibility and sovereignty of the government.

4. When considered collectively, the negative aspects of MEDCAPs can outweigh any limited or short-term positive effects they produce. Therefore, pre-planned medical outreach activities should be limited to those that assist GIRoA in developing a sustainable health care system that contributes to our unified COIN strategy, except in cases where the urgency of the medical need outweighs the potential downsides of MEDCAPs.

5. Alternatively, there are many types of medical engagements that can produce real and lasting health benefits while minimizing the potential for negative consequences. For example, the development of the Medical Seminar (MEDSEM) concept by CJSOTF-A has the potential to deliver a positive COIN effect. The



program aims to connect isolated communities to GIRoA through sustainable medically sound interventions by Afghans that raises awareness and improves public health. Other initiatives to raise public health awareness, improve sanitation, provide access to safe drinking water, facilitate the expansion of MoPH-approved training programs, complete selected infrastructure projects, and provide mentoring opportunities for Afghan health care providers can deliver positive COIN effects.

6. This guidance does not change ISAF's established Medical Rules of Eligibility, or the rules governing our involvement during true emergencies or natural disaster. It also does not alter SHAPE Guidance that lays out appropriate military medical engagements focused on building GIRoA's capacity. Nor does it contradict the process for dealing with inevitable VIP requests for special consideration.

7. When commanders are conducting COIN in areas where there is no healthcare provider, the conduct of a MEDCAP will not only fill the void in medical services, but also contribute to improved security for the community. In these instances, MEDCAP may be conducted if it is clinically appropriate and can be sustained until MoPH/NGO are capable of providing healthcare services. Where there is no need to maintain a presence, single episodic MEDCAPs should be avoided, unless force-protection considerations outweigh the potential harmful effects.

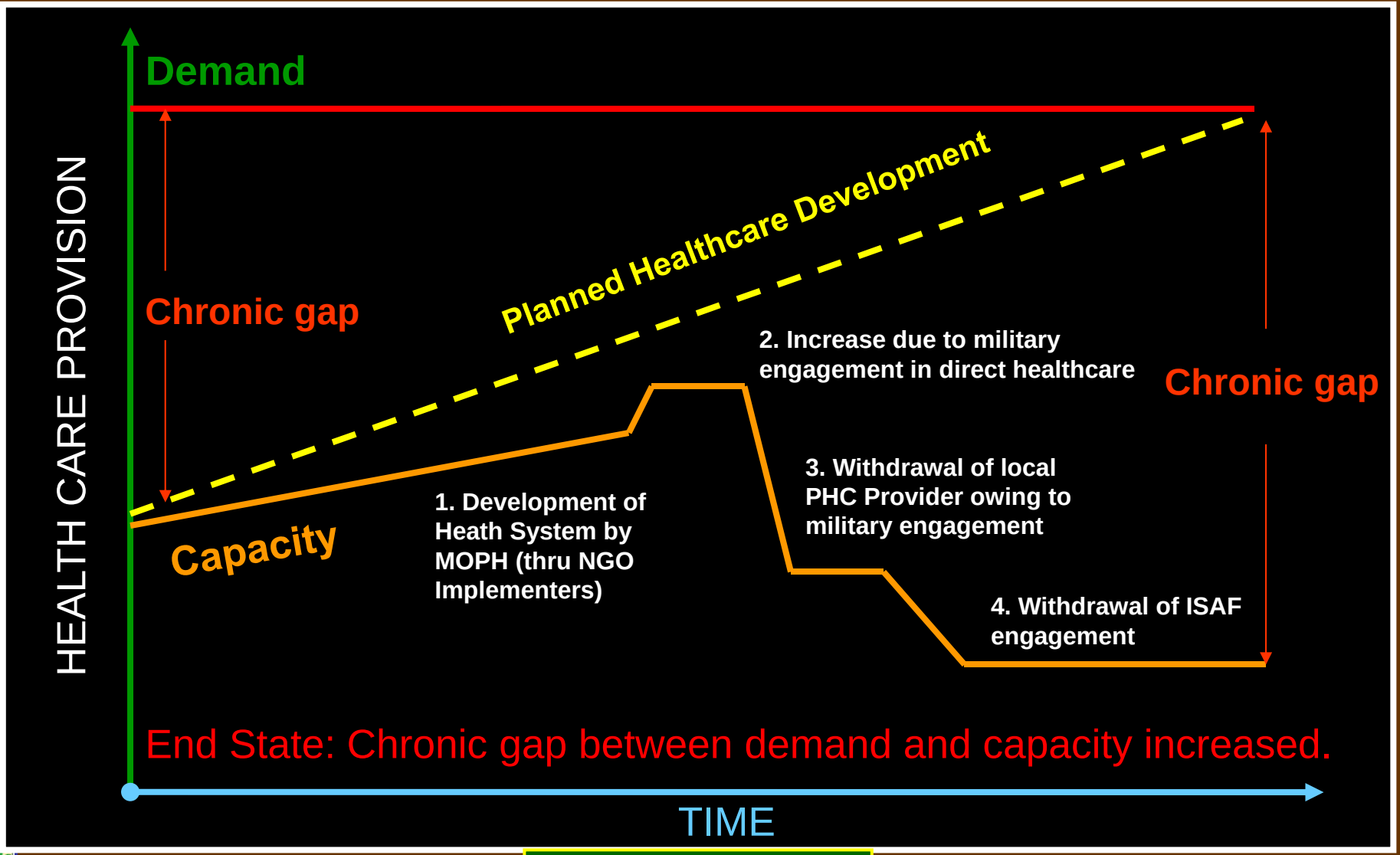
8. Some commanders may feel this is an unwelcome limitation on their freedom of action. To allay those concerns, I recognize that force protection considerations may outweigh the harmful effects outlined above. Moreover, I know commanders need operational flexibility, so I will permit approval at the Colonel (OF-5) level of MEDCAPs when the commander determines that they are warranted. In these cases, however, we will try to employ Afghan civilian health professionals to deliver patient care. I also want to be very clear that these MEDCAPs should not be conducted solely for the purposes of intelligence collection or biometric enrollment.

9. I expect commanders at all levels to comply with ISAF SOP 01154[2] when planning and executing Medical Engagements, and to ensure that their Medical Advisors report on these activities through the standard weekly Medical Assessment Report process.

Thanks, team!

David H. Petraeus
General, United States Army
Commander, International Security Assistance Force/United States Forces-Afghanistan

UNINTENDED CONSEQUENCES
THE PERFECT STORM SCENARIO



Focus for ISAF Engagement 2011

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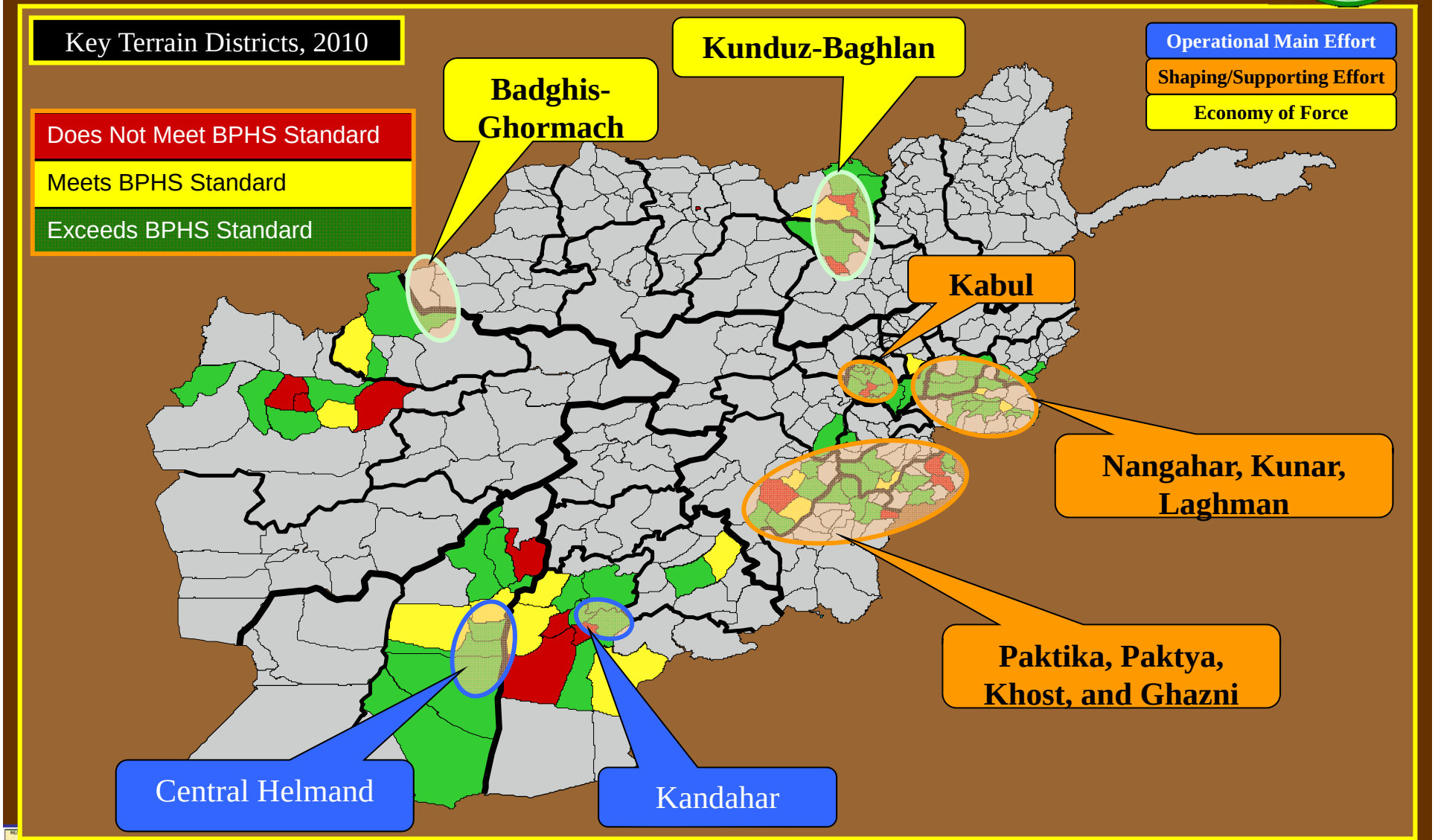
EXISTING HEALTH FACILITIES COMPARED TO BPHS BENCHMARKS



HUMAN CAPACITY BUILDING

Civil Sector Mentoring/Training

- Agreed with MOPH and BPHS/EPHS implementer
- Do not conduct if civilians able to provide training
- Use only MOPH approved standards and curricula
- Focus on training the Afghan trainer

ANSF Mentoring/Training

- Main effort for spare capacity
- Pivotal to security sector reform
- Competent and self-sustained medical service capable of supporting independent ANSF operations
- Significant challenges: shortage of mentors, weak leadership

WIDER DETERMINANTS OF HEALTH

- Average life expectancy is 42 ((regional average (RA) is 64))
- 1 in 5 children will die before the age of 5 (RA is 1/11)
- Improving the wider determinants of health (clean water, sanitation, nutrition, and vector control) will enhance public health
- Access to safe drinking water is assessed at 27% (low: 5%; high: 56%)
- Access to adequate sanitation facilities (urban: 21%; rural: 1%)

Source: National Risk and Vulnerability Report 2007/08

PASSIVE SUPPORT TO POLIO ERADICATION CAMPAIGN

- Promulgate the national and sub-national immunization days to all regional commands
- Further FRAGO issued prior to each NID and SNID in order to 'de-conflict' where possible
- Joint USAID / WHO Brief to COMISAF 11 January 11 (tentative)

Guidance Provided

- Do not offer direct support
- Do not intervene
- Do not prevent or direct vaccination
- Distance themselves from the program
- Appreciate importance of the program

FINAL THOUGHTS

"It is better to let them do it themselves imperfectly than to do it yourself perfectly. It is their country, their way, and our time is short."

- T E Lawrence

"When confronted with heartbreaking situations, we must choose the hard right rather than the easy wrong"'

LTCs Rice and Jones, US Army

ISAF
کمک او همکاری
Questions?
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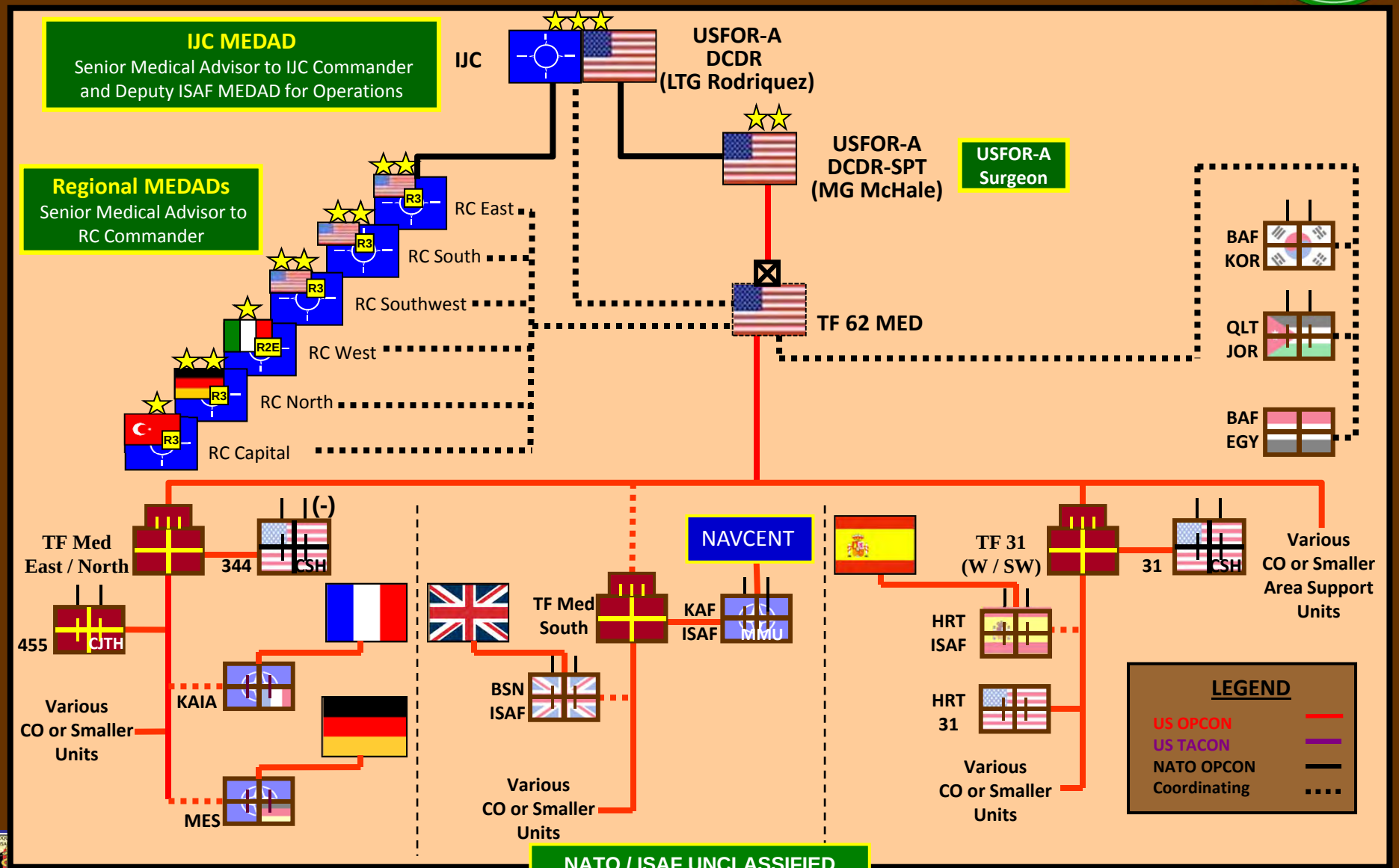
THEATER MEDICAL C2 OVERVIEW