**ISAF Overview Brief**

<table>
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<th>1. REPORT DATE</th>
<th>2. REPORT TYPE</th>
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<tr>
<td>JAN 2011</td>
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<td>00-00-2011 to 00-00-2011</td>
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<td>ISAF Overview Brief</td>
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<th>7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)</th>
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<tbody>
<tr>
<td>International Security Assistance Force (ISAF) Headquarters, MEDAD Office, Kabul, Afghanistan,</td>
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**DISTRIBUTION/AVAILABILITY STATEMENT**

Approved for public release; distribution unlimited

**SUPPLEMENTARY NOTES**

presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland

**ABSTRACT**

**SUBJECT TERMS**

**SECURITY CLASSIFICATION OF:**

<table>
<thead>
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<th>a. REPORT</th>
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**LIMITATION OF ABSTRACT**

Same as Report (SAR)

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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**
  - Protect the Population
  - Support Development of ANSF
  - Neutralize Insurgent Networks
  - Neutralize Criminal Patronage Networks
  - Support Development of Legitimate Governance
  - Support Sustainable Socio-Economic Development

- **Support Development of ANSF**
  - ANSF leading in population security, and law enforcement serving the Afghan people
  - 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
  - CPN threats to GIRoA capacity, Afghan rule of law, and the ISAF/IC mission reduced to a manageable level

- **Neutralize Insurgent Networks**
  - Governance sufficiently inclusive, accountable, and acceptable to the people

- **Neutralize Criminal Patronage Networks**
  - Licit economy expanding; IC economic support channeled through GIRoA ministries

Population safeguarded from violence, coercion, intimidation, and predatory groups
Joint Campaign Plan Design

**Partner**
- Comprehensives Civil-Military Approach
  - Conditions Based Transitions
  - Governance
  - Development

**Support**
- ISAF
  - Conditions Based Transitions

**Enable**
- ISAF
  - Conditions Based Transitions

**Near Term**
- Reintegration/Reconciliation
- Transition
- Rule of Law
- Borders & Customs
- Strategic Communications
- Reduction of corruption that undermines security and governance
BUILDING TO MEDICAL TRANSITION
(ISAF MEDICAL LINES OF OPERATION)

TRANSITION
GIRoA Capable of Assisting 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

FOUNDATIONAL PRINCIPLES
 görüş depends on a solid foundational “Mix”)

Governance
Nutrition
Clean Water
Security
Education / Literacy
Development
Sanitation

OPERATIONAL BATTLE SPACE

BUILDING THE MEDICAL “HOUSE”
OVERALL ASSESSMENT:
Theater Medical Campaign
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
Total Admissions (n=7254)

- 44% (3193) US Military
- 39% (2839) All Others
- 17% (1221) Coalition

Rolling 12 months: Nov 09 – Oct 10
OEF ADMISSIONS
(By Category)

OEF Admission Categories (n=7254)

- Enemy (N=211)
- Contractor (N=204)
- Host Nation (N=1409)
- ANA/ANP (N=1015)
- Coalition (N=1221)
- US Military (N=3194)
PEDIATRIC ADMISSIONS
(<15 Years)

Pediatric Admissions (<15 years)

Number of Admissions

1 Year’s Data: Rolling 12 Months

- Nov-09: 18
- Dec-09: 28
- Jan-10: 2
- Feb-10: 30
- Mar-10: 25
- Apr-10: 25
- May-10: 35
- Jun-10: 45
- Jul-10: 73
- Aug-10: 56
- Sep-10: 61
- Oct-10: 41

OEFF 6%
(n=439)
MONTHLY TRAUMA ADMISSIONS
(By Facility)

Admissions: 3-Month Snap Shot

- Aug-10 (n=833)
- Sep-10 (n=714)
- Oct-10 (n=672)

Trauma Admissions

- Bagram: 189
- Kandahar: 154
- Bastion: 244
- Dwyer: 85
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

Tactical Field Care

- Protect self & casualty
- Stop major bleeding
- Move casualty to cover

Combat Casualty Evacuation Care

- Rapid trauma assessment
- Treat preventable causes of death
- Stabilize and prepare for evacuation

Goals of TC3:

*Treat the casualty.*
*Prevent additional casualties.*
*Complete the mission.*
• Institute of Surgical Research Clinical Practice Guidelines

• Weekly World-Wide Grand Rounds
MEDEVAC PERFORMANCE

Average Flight Time (in Minutes) for Missions with "Urgent (A)" Patients in 2010 (vs. 2009)

MEDEVAC PATIENT CATEGORY 2010 YTD

- ISAF/CF Mil: 53%
- ISAF/CF Civ: 21%
- ANSF: 15%
- Non-CF Civ (LN): 2%
- OPFOR/RPVIDET: 7%
- Child: 2%
- Mil Dog: 2%
- Med Resupl: 2%

MEDEVAC PRECEDENCE 2010 YTD

- (A) Urgent: 47%
- (B) Priority: 30%
- (C) Routine: 23%

MEDEVAC FLT TIME 2010 YTD

- <=60': 95%
- >60' <90': 2%
- >90': 5%
<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
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<tbody>
<tr>
<td>US Mil</td>
<td>857</td>
</tr>
<tr>
<td>Coalition</td>
<td>209</td>
</tr>
<tr>
<td>ANA/ANP</td>
<td>257</td>
</tr>
<tr>
<td>Afghan LN</td>
<td>497</td>
</tr>
<tr>
<td>Detainee</td>
<td>72</td>
</tr>
<tr>
<td>Contractor</td>
<td>65</td>
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</tbody>
</table>
STRATEVAC
"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
- 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

US
- Lived: 95.7% (3056)
- Died: 4.3% (137)

Coalition
- Lived: 89.6% (1094)
- Died: 10.4% (127)

All Others
- Lived: 89.5% (2541)
- Died: 10.5% (297)
# 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

<table>
<thead>
<tr>
<th>FACILITIES (RC-E)</th>
<th>BAF (RC-E)</th>
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<tbody>
<tr>
<td>• Recurrent concussion evaluation and management</td>
<td></td>
</tr>
<tr>
<td>• Tertiary neurology care</td>
<td></td>
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</tbody>
</table>

| MISSION |
|------------------|------------|
| • Neurologist |
| • Neuropsychologist |
| • PT |
| • NCO |
| • Post concussion quarters |

| BEST PRACTICES |
|------------------|------------|
| • Near daily multi-disciplinary rounds |
| • SNCO involvement |

<table>
<thead>
<tr>
<th>FACILITIES (RC-S)</th>
<th>KAF (RC-S)</th>
</tr>
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<tbody>
<tr>
<td>• Concussion Restoration Care Center (CRCC)</td>
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</table>

| MISSION |
|------------------|------------|
| • Neurologist |
| • Neuropsychologist |
| • OT / OT tech |
| • PT / PT tech |
| • Family medicine |
| • LNO for quarters |

| BEST PRACTICES |
|------------------|------------|
| • OT military specific functional assessment (warrior tasks) |

<table>
<thead>
<tr>
<th>FACILITIES (RC-SW)</th>
<th>LNK / Bastion (RC-SW)</th>
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<tbody>
<tr>
<td>• Sports medicine</td>
<td></td>
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<tr>
<td>• Psychiatrist (inpatient LNO)</td>
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<tr>
<td>• Family medicine</td>
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<tr>
<td>• Psychologist</td>
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<tr>
<td>• Nurse</td>
<td></td>
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<tr>
<td>• OT / PT</td>
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<tr>
<td>• 0.5 FTE FM (data entry)</td>
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<tr>
<td>• 5 x corpsmen</td>
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<tr>
<td>• Rely on CASF / step-down unit</td>
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| BEST PRACTICES |
|------------------|------------|
| • Inpatient liaison |
| • Data capture |
| • Corpsmen on team |
LINE OF OPERATION #2
Enable ANSF Health System Development

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

MTAG SUPPORTED KEY INSTITUTIONS

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

179 Advisors (68% fill) Throughout Afghanistan:
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
~20 Disease, Non-Battle Injury (DNBI) casualties for every 1 combat casualty
BRIDGING THE PROVIDER GAP

PA Initiative Will Resolve Physician Shortage 7 Years Sooner

Assigned Physicians
Authorized Physicians
Physician Assistants + Physicians

396 physicians
263 physicians

7 Years Sooner
NEW PA STUDENTS

Mentoring Eager Afghans
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
• Afghan Development Strategy
• ISAF Guidance
• Focus for 2011 Engagement
AFGHAN NATIONAL HEALTH POLICY

ANDS (MDGS)

BFHS and EPHS Comprise Afghanistan’s Entire Referral System

HNSS

Implementing SOPs

BPHS and EPHS Comprise Afghanistan’s Entire Referral System

ISAF Overview Brief, MHS Conference 2011
AFGHAN HEALTH AND NUTRITION STRATEGY

Regional

Provincial

District Hospital (DH)

100k-300k

XRAY, surgery, OB, physiotherapy, pediatrician, pharmacist, dentist.

Comprehensive Health Ctr (CHC)

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)

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

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

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

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)

- Regional: 5
- Provincial: 30
- District Hospital: 67
- Comprehensive Health Center: 378
- Basic Health Center: 813
- Mobile Health Team: 99
- Health Sub-Center: 447

Data Unavailable

Essential Package for Hospital Services in AFG

- Capabilities
- Equipment
- Staffing
- Drugs

Basic Package for Health Services in AFG

- Capabilities
- Equipment
- Staffing
- Drugs

Health & Nutrition Sector Strategy Vol. 2

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

The Essential Package of Hospital Services for Afghanistan

AFGHANISTAN National Development Strategy

A Strategy for Security, Governance, Economic Growth and Human Development

Institute for Security Studies

ISAF

کمک امنیتی
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 Standing Operating Procedures 01154: ISAF Guidance on Military Medical Engagement in Health Sector Reconstruction and Development

COMISAF DIRECTIVE, 09 NOV 10: ISAF Medical Involvement in Civilian Health Care
UNINTENDED CONSEQUENCES
THE PERFECT STORM SCENARIO

1. Development of Heath System by MOPH (thru NGO Implementers)
2. Increase due to military engagement in direct healthcare
3. Withdrawal of local PHC Provider owing to military engagement
4. Withdrawal of ISAF engagement

End State: Chronic gap between demand and capacity increased.
Focus for ISAF Engagement 2011
EXISTING HEALTH FACILITIES COMPARED TO BPHS BENCHMARKS

Key Terrain Districts, 2010

- Does Not Meet BPHS Standard
- Meets BPHS Standard
- Exceeds BPHS Standard

Operational Main Effort
Shaping/Supporting Effort
Economy of Force

- Badghis-Ghormach
- Kunduz-Baghlan
- Kabul
- Nangahar, Kunar, Laghman
- Paktika, Paktya, Khost, and Ghazni
- Central Helmand
- Kandahar

EXISTING HEALTH FACILITIES

- Badghis
- Ghormach
- Kunduz
- Baghlan
- Kabul
- Nangahar, Kunar, Laghman
- Paktika, Paktya, Khost, and Ghazni
- Central Helmand
- Kandahar
HUMAN CAPACITY BUILDING

**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

**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

*ISAF Overview Brief, MHS Conference 2011*
- 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
“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
Questions?