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A PERSPECTIVE ON MILITARY MEDICAL SERVICE ROLE IN
STABILIZATION OPERATIONS:

EXPANSION OF AIR FORCE MEDICAL SERVICE CAPABILITIES IN
MEDICAL DIPLOMACY

by

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Biography

Lieutenant Colonel (Dr.) Brian G. Min is a United States Air Force Dental Officer. Currently, he is a resident student at the Air War College, Maxwell Air Force Base, Alabama. Dr. Min is a Diplomate of American Board of Endodontics. He served in the Air Force Medical Service as a clinician, instructor, and chief of dental services.



Abstract

This research paper advocates that the US military health workers will be more effective in medical diplomacy than their NGO counterparts in building capacity and winning hearts and minds in non-permissive (uncertain and hostile) environments. Due to the non-permissive environments, civilian aid workers are restricted in conducting their missions creating a critical “gap” in rebuilding health care infrastructure in Afghanistan. Conflict resolution is a long process. It is primarily a civil problem that require military support where the military can set the conditions for successful conflict resolution by filling the critical “gaps.” The US military medical capability can be utilized in a broader capacity than traditional Humanitarian Relief Operations, with the aim to better support the Joint Task Force (JTF) commander in bringing stabilization to unstable regions such as Afghanistan. With the escalating number of conflicts in the world, the US will be expected and asked in nearly every incident to assist in stabilizing the area. The military health workers through medical diplomacy with early intervention during the transition phase can assist the JTF commander with a more effective option in bringing stabilization to an unstable region such as Afghanistan. The Air Force International Health Specialist Program has a sound doctrine and organization with adequate training and education, but seem to lack capacity. Unfortunately, the current capacity and with more violent conflicts expected in the future, the US may not be able to afford such tasking. But on the other hand, it would be in the best interest to begin expansion and broadening the current scope and operations to meet such demand in the future.

Introduction

The United States Military Health System (MHS) continues to play a significant role in supporting our warfighting capabilities by providing preventive, routine, palliative, and emergent health care to our Soldiers, Sailors, Airmen, and Marines by equipping our nation with combat ready forces. The traditional effort of MHS has been focused on caring for our fighting men and women in pre-, intra-, and post- deployment phases of operation, as well as to provide aero-medical evacuation capabilities. Over the years, the scope of MHS has broadened to include “humanitarian assistance activities to support geographic combatant commanders (GCC) security cooperation” through “steady state program activities and limited contingency operations in support of another United States Government department or agency,” often in response to a disaster, also known as Humanitarian Relief Operations (HUMRO).¹ In the traditional sense, military medical components of the HUMRO missions assisted in stabilization operations by providing humanitarian assistance through limited direct patient care for the indigenous population in the affected regions for a brief and specified duration of time. The Army’s 2006 *Counterinsurgency* manual implicitly expands the DOD function by challenging the military medical system (MHS) to assist in what traditionally has been the role of the US State Department and various civilian agencies. The Foreword of the COIN doctrine clearly states:

“Soldiers and Marines are expected to be nation builders as well as warriors. They must be prepared to help re-establish institutions and local security forces and assist in **rebuilding infrastructure and basic services**. They must be able to facilitate establishing local governance and the rule of law. The list of such tasks is long; performing them involves extensive coordination and cooperation with many intergovernmental, host-nation, and international agencies.”²

¹ Joint Publication 3-29, *Foreign Humanitarian Assistance*, January 2014, 10.

² Field Manual 3-24, *Counterinsurgency*, December 2006.

While the intent of this paper is not to advocate the exclusive use of MHS for foreign nation building, this research wishes to explore broadly how military health workers can assist the JTF in providing stability in Afghanistan and any other region that will be affected in the future by assisting the US Department of State in their mission for nation building in Afghanistan. The concept of medical diplomacy isn't new. Yet, as the Air Force Chief of Staff has mentioned, let us explore the medical capability of the US military, specifically the US Air Force, to be utilized in a broader capacity than traditional HUMRO, with the aim to better support the Joint Task Force (JTF) commander in bringing stabilization to unstable regions such as Afghanistan.

In the past, the USAID, in collaboration with various civilian agencies, international organizations (IO), and non-governmental organizations (NGO), provided humanitarian assistance to bring social stability to affected regions. In Afghanistan, the case has proven to be different due to the persistent violence that exists still to this day. The civilian agencies and organizations have been severely restricted in conducting their mission due to the increase of non-permissive environment.³ The result of continued violence and vast territory of unsecured regions has increased the amount of civilian aid workers are being killed, kidnapped or injured.⁴ Despite the civilian aid workers' desire to maintain impartial and neutral stance, this desire is often disregarded and violated by insurgents as they indiscriminately carry out violence to meet their objectives to spoil any progress toward stability. This research paper advocates that the US military health workers will be more effective in medical diplomacy than their NGO counterparts in building capacity and winning hearts and minds in non-permissive (uncertain and hostile)

³ Eliot A. Cohen, *Supreme Command in Irregular Warfare, Counterinsurgency Leadership in Afghanistan, Iraq and Beyond* (Marine Corps University Press, 2011).

⁴ George Bragg, "Civil-Military Relations in Afghanistan: How has increasing interaction between NGOs and the military affected humanitarian operations in complex emergencies?" e-ir.info (September 2011). <http://www.e-ir.info/2011/09/11/civil-military-relations-in-afghanistan/>.

environments. With better coordinated force protection to allow more freedom of movement to engage key local leaders and to have more leverage for negotiation and partnership during the transition phase from phases 3 to phase 4 in the operational campaign.⁵ This paper does not propose or encourage military health workers to provide medical diplomacy through direct patient care, but to focus on the greater objective with assistance in initiating relationship with leaders of the indigenous population for reconstruction of health care infrastructure and system to enable provision of basic services in Afghanistan and future regions alike to assist in bringing local stability to the overall efforts of the JTF commander in stabilization operations. Hence, this paper supports the expansion the AFMS spectrum of capabilities for medical stabilization operations to more effectively support the JTF commander in bringing stability to the region. This research paper will also evaluate the current capability of the AFMS International Health Specialist (IHS) program for its potential role in assisting in building health care infrastructure in Afghanistan using the doctrine, organization, training, education, exercises, materiel, leader, personnel, and facilities (DOTMLPF) analysis. This research paper is organized to describe the 1) concept of stabilization operations, 2) medical stabilization operations and recent development, 3) Air Force International Health Specialist Program, 4) stabilization triad and the Afghan case, and 5) current DOTMLPF analysis of IHS Program, and 6) rationale for medical diplomacy through military health workers.

Stabilization Operations

In order to understand the concept of Medical Stabilization Operations, the concept of Stabilization Operations should be discussed. Moreover, one will need to become familiar and

⁵ Joint Publication 3-07, *Stability*, August 2016.

comprehend its purpose, goals of the mission and the over-arching principle of the strategy. There are national level policies and strategies that shape and drive the conduct of stability operations: the National Security Strategy, National Defense Strategy, and National Military Strategy, National Security Presidential Directive 44, and Department of Defense Directive 3000.05.⁶ These strategies and national policy not only reflect American posture of internationalism, but provide the direction that is “necessary to conduct operations to support national interests.”⁷ The American strategy and policy clearly states our desire for a safer and more peaceful world. The concept and goal of stabilization operations are shaped by the aforementioned strategies. See Appendix A.

The concept of stabilization operations dates back to the American 18th century with small-scale military interventions throughout the world that reflects both successful and failure cases. Post World War II stabilization operations in Germany and Japan serve as models as the American military retrained its forces for a peacetime role of reconstruction and development of war-torn nations.⁸ On the other hand, the war in Vietnam taught the US an invaluable lesson in understanding the “complexity of conducting operations among the people.”⁹ Stabilization operations has become one of the core missions of the DOD and defined as “various military missions, tasks, activities conducted outside the US in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential government services, emergency infrastructure reconstruction, and humanitarian relief.”¹⁰ It is

⁶ Field Manual 3-07, *Stabilization Operations*, October 2008.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Joint Publication 3-0, *Joint Operation*, September 2006.

important to realize that stability operations is present throughout all phases of operational campaign and serve as the bedrock in balance to offensive and defensive operations. See Appendix B.

In the recent years, reconstruction has become an integral part of US operations. It is important to note the clear distinction between *Stabilization* and *Reconstruction* and their respective jurisdictions. According to FM 3-07, *reconstruction* is defined as “the process of rebuilding degraded, damaged, or destroyed political, socioeconomic, and physical infrastructure of a country or territory to create the foundation for long-term development.”¹¹ On the other hand, *stabilization* is defined as “the process by which underlying tensions that might lead to a resurgence in violence and breakdown in law and order are managed and reduced, while efforts are made to support preconditions for successful long-term development.”¹² Any effort through various operations will inherently influence both, but in general, *reconstruction* falls under the jurisdiction of the State Department and *stabilization* falls under the Defense Department. Stabilization efforts seek to reshape the relationships within the indigenous populations and institutions.¹³ Hence stabilization operations are designed, ultimately, to serve as the precursor to reconstruction and as the bridge for long term development. Furthermore, the tasks and activities that make up stability operations fall into three broad categories:

Initial response, transformation, and fostering sustainability. The **initial response** stage generally reflects actions executed to stabilize an operating environment in a crisis state. During this stage, military forces perform stability actions, in concert with other agencies, during or directly after a conflict or disaster when ongoing violence poses a threat. The **transformation** stage represents the broad range of post-conflict reconstruction, stabilization, and capacity building tasks. Military forces perform these tasks in a relatively secure environment, free from most wide-scale violence, often to support broader civilian efforts. The **fostering sustainability** stage encompasses long-

¹¹ Field Manual 3-07, *Stabilization Operations*, October 2008.

¹² Ibid.

¹³ Joint Publication 3-07, *Stability*, August 2016.

term efforts that capitalize on capacity-building and reconstruction activities to establish conditions that enable sustainable development.¹⁴

Medical Stabilization Operations and Recent Development

The United States MHS's main focus is to assist in sustaining the performance, health and fitness of every in-garrison service members and deployed members within the Continental United States (CONUS) or overseas (OCONUS), respectively, in support of global operations. Then, where does medical stabilization operations fall within the stability operations? In 1967, an article titled *Medical Role in Military Stabilization Operation* was published by Col Spurgeon Neel in the *Military Medicine Journal*. Colonel Neel predicated that "stabilization operations have become the third principal mission of the United States Army."¹⁵ Furthermore, he stated that, while "preventing insurgency" is not typically viewed as the duty of the military, the United States military is "uniquely suited to sponsor and conduct stabilization operations."¹⁶ Over the years, the Air Force has been increasingly called upon to deliver medical capabilities throughout the range of military operations to include diverse medical missions consisting of civil-military operations, global health engagement, or humanitarian assistance/disaster relief as part of joint or multinational operations.¹⁷ Since then, the US military has focused on developing military health programs such as the Medical Civic Action Program (MEDCAP) in the 1960's and International Health Specialist program in 2000 to support Department of State and the USAID in their missions.

¹⁴ Ibid.

¹⁵ COL Spurgeon Neel, "Medical Role in Military Stabilization Operation," *Military Medicine*, August 1967, 605.

¹⁶ Ibid.

¹⁷ Air Force Doctrine Document Annex 4-02, *Medical Operations*, September 2015.

In 2008, “The Reconstruction and Stabilization Civilian Management Act” (RSCMA) was passed. This Act authorized the Department of State’s Office of the Coordinator for Reconstruction and Stabilization with “integrating all relevant US resources and assets in conducting reconstruction and stabilization operations.”¹⁸ Following the RSCMA, in September 2009, Department of Defense Instruction (DODI) 3000.05, *Stability Operations*, was published. Then in May 2010, DODI 6000.16, *Military Health Support for Stabilization Operations*, soon followed. The DODI 3000.05 laid the framework in anticipation of the drawdown and rebuilding of Afghanistan. The Pentagon’s Directive 3000.05 drove to create a Deputy Secretary of Defense for Stability Operations, and a Defense Reconstruction Support Office to oversee its nation-building program. According to Directive 3000.05, **the military was mandated to fill gaps in capacity on the civilian side.**¹⁹ Also, in August of 2014, DODD 3000.07, was reissued to establish the following directives regarding Irregular Warfare (IW). It stated that appropriate DoD IW-related activities will be integrated with the efforts of other US Government (USG) agencies, foreign security partners, and selected international organizations by supporting:

- 1) combined policies, plans, and procedures, including collaborative training, education, and exercises that promote interoperability, 2) integrated civilian-military teams, 3) information strategies and operations to neutralize adversary propaganda and promote US strategic interests, 4) efforts to enhance information sharing, as appropriate, to synchronize planning, execution, and transition of IW activities and maintain the shared understanding of the operational environment required to counter irregular challenges or threats, 5) integration of collective requirements and capabilities into unified planning efforts to optimize development and employment of capabilities, 6) provision of essential

¹⁸ Angel Rabasa, John Gordon IV, Peter Chalk, Christopher S. Chivvis, Audra K. Grant, K. Scott MaMahon, Laurel E. Miller, Marco Overhaus, Stephanie Pezard, *From Insurgency to Stability: Key Capabilities and Practices*, (Santa Monica, CA, RAND), 2011, 13.

¹⁹ Conor Keane, Glenn Diesen, "Divided We Stand: The US Foreign Policy Bureaucracy and Nation-Building in Afghanistan," *International Peacekeeping*, Volume 22, Issue 3, 2015, 212. Author interview with Michael Miklaucic, Department of State Deputy for War Crimes Issues 2002–03 and USAID representative on the Civilian Response Corps Inter-Agency Task Force 2003–08, Washington, DC, 23 Apr. 2012.

governmental services, emergency infrastructure restoration, and humanitarian relief, if directed.²⁰

The DODI 3000.05, defined stabilization operation as an overarching term encompassing various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief.²¹ This specified the goals for DODI 6000.16, which stated that

1) Medical Stabilization Operations (MSOs) are a core US military mission that the DoD Military Health System (MHS) shall be prepared to conduct throughout **all phases** (See Appendix B) of conflict and across the range of military operations, including in combat and non-combat environments. MSOs shall be given priority comparable to combat operations and be explicitly addressed and integrated across all MHS activities including **doctrine, organization, training, education, exercises, materiel, leadership, personnel, facilities, and planning** in accordance with DODI 3000.05, Stability Operations, 2) the MHS shall be prepared to perform any tasks assigned to establish, **reconstitute, and maintain health sector capacity and capability for the indigenous population when indigenous, foreign, or US civilian professionals cannot do so**, 3) the MHS shall be prepared to work closely with relevant US Government departments and agencies, foreign governments and security forces, global and regional international organizations (IOs), US and foreign nongovernmental organizations (NGOs), and private-sector individuals and for-profit companies.²²

The DODI 6000.17 clearly laid the direction on how MHS will prepare for and conduct MSO. While the DODI 6000.17, does not specify the MSO to re-establish infrastructure, DODD 3000.07 does instruct to restore emergency infrastructure which can serve to re-establish infrastructure. What then can the MHS offer through MSO to assist the government of Afghanistan and civilian organization in reconstructing and re-establishing health sector infrastructure and capacity?

²⁰ DOD Directive (DODD) 3000.07, *Irregular Warfare*, August, 2014.

²¹ DOD Instruction (DODI) 3000.05, *Stabilization Operation*, September, 2009.

²² DOD Instruction (DODI) 6000.16, *Military Health Support for Stabilization Operation*, May, 2009.

Air Force International Health Specialist Program

Over the past five decades, the US military health system has broadened its scope of care from the main traditional role of just taking care of soldiers, airmen, sailors, marines, and their families to providing humanitarian assistance through various missions in delivering medical aid, supplies, and care around the globe. All branches of US military service have provided multiple levels of services ranging from the US Army's mission in response to Ebola outbreak in Africa to US Navy's USS Comfort's support to Haitian migrants providing humanitarian services among many. In 2000, the United States Air Force established the International Health Specialist (IHS) Program designed "to support Combatant Command (COCOM) theater campaign and security cooperation, create health sector partnerships within their regions, facilitate culturally appropriate military-military and military-civilian interactions and collaboration, and support the health aspects of operational planning."²³ The IHS program was designed to provide an "expeditionary capability that traverses health career fields and can deploy to force packages and serve as key global health engagement capabilities across all phases of an operation" to be "tailored for the health engagement within peace operations, major combat operations, transition to and from hostilities, humanitarian assistance (HA), disaster relief (DR), and security cooperation projects and exercises designed to build relationships, stability, and capacity in partner nations."²⁴ Until recently, the IHS program's focus remained in the phase 0 of the operational campaign.

²³ Air Combat Command Global Health Branch, *Operational Use of International Health Specialist Program*.

²⁴ Ibid.

The Stabilization Triad and the Afghan Case

There are three components to bringing stability. The probability of successful stabilization is a function of the host nation's potential and willingness of the people to **build up local capacity**, the availability of **international economic assistance**, and **level of hostility** in the region.²⁵ See Appendix C. The transitional strategies must decrease the level of hostility first to increase local capacity.²⁶ Both will require international economic and military assistance for providing security and reconstruction. The International Security Assistance Force (ISAF) has focused efforts to train and build up the Afghan National Police force to provide long-term security for the region. Capacity building is the other key component to the peacebuilding process and helps the host nation's government to gain legitimacy to continue their governance. Since legitimacy is the irreplaceable keystone for stability and peace, the primary aim of stabilization operations is to help establish the legitimacy of the host government. Provision of basic health care by government programs and institutions will win the hearts and minds of the people by building local capacity to ultimately, contributing to the legitimacy of the government, especially in an area where tribalism has dominated throughout its history.

Reconstruction is the responsibility of the host nation and it must be an "indigenous process."²⁷ However, most often the host nation cannot do it alone, in Afghanistan or any other nations. There is a need for external intervention to provide the initial impetus for reconstruction

²⁵ Michael Doyle and Nicholas Sambanis, *Making War and Building Peace: United Nations Peace Operations*, (Princeton, NJ, Princeton University Press), 2006, 69.

²⁶ Ibid.

²⁷ David A. Lake, *Statebuilder's Dilemma: On the Limits of Foreign Intervention*, (Ithaca, NY: Cornell University Press, 2016).

with financial assistance and economic development, but more importantly, to establish the legitimacy of the government and local security.

Building capacity and capability to respond and take care of its citizens starting with assessments then moving on to community outreach through dental, medical, veterinary care, water, school, and construction of roads, bridges, piers, and airstrips to meet their basic needs.²⁸

Hence, security, building local capacity, and international assistance are requirements for success in bringing legitimacy to the government. Reconstruction and stabilization help fill the Peacebuilding Triangle and bring legitimacy as depicted in the diagram where the ideal situation will be where hostility (H), local capacity (LC), and international capacities (IC) will reach the maximum value of 1. See Appendix C.

The stabilization considerations of COIN are rooted in the political nature of the conflict and the primary focus should be on the population, rather than just the insurgents. Stabilization efforts are typically required to reinforce the legitimacy of the affected government while reducing insurgent influence.²⁹ After the conflict in conventional warfare, civilian may have more freedom to conduct their operations. Yet in asymmetric warfare, civilian health workers will be restricted and therefore require more constant military presence in the area of operations. Although reconstruction is the job of civilian aid agencies and NGOs, in Afghanistan, during the transitional period and stabilization phase, the US military health workers had been involved as part of the Provisional Reconstruction Team missions. Provincial Reconstruction Teams (PRTs) was first deployed in 2002 and by the end of 2008, 12 teams were in operation. The PRTs implemented quick-impact projects in areas of business, agriculture, public health, and

²⁸ Air Force Doctrine Document Annex 3-2, *Irregular Warfare*, July 2016.

²⁹ Joint Publication 3-07, *Stability*, August 2016.

infrastructure, in hopes of facilitating inter-agency cooperation and common positions for US nation-building in the field.³⁰ Although the PRTs have been identified as an authentic fusion of agency expertise, they were dominated by the military.³¹ In 2009, there were 1,021 military personnel in PRTs.³² On average, only two civilian representatives were ensconced in a PRT at any time. Their composition reflects that they were essentially military units that reflected military preferences in the non-permissive environments. Unfortunately, PRTs no longer operate in Afghanistan.

On the other hand, military health workers will have more secure access to areas and are able to help build clinics for provision of care. Hence, military health providers working in partnership with local leaders can improve the security of the region working with both the US military or coalition forces and the host country to help win the hearts and minds of the local populace. This would provide a more viable option for the JTF commander in stabilizing the region through building health care infrastructure for the local population.

It is essential to note that in COIN operations, the “clean break” between phases is rare, which makes the environment questionable where civilian aid workers can operate under. Angel Rabasa *et al* defined, the “transitional phase” as when the level of violence has been declining in the contested region for at least 12 months along with security being assumed by the local police

³⁰ Conor Keane, Glenn Diesen, "Divided We Stand: The US Foreign Policy Bureaucracy and Nation-Building in Afghanistan," *International Peacekeeping*, Volume 22, Issue 3, 2015, 213.

³¹ Conor Keane, Glenn Diesen, "Divided We Stand: The US Foreign Policy Bureaucracy and Nation-Building in Afghanistan," *International Peacekeeping*, Volume 22, Issue 3, 2015, 213. Michael McNerney, 'Stabilization and Reconstruction in Afghanistan: Are PRTs a Model or a Muddle?', *Parameters*, Vol.35, No.4, 2005–06, pp.32–46; Craig Cobane, 'Provincial Reconstruction Teams and Security Assistance: Comments on an Evolving Concept', *Journal of International Security Assistance Management*, Vol.27, No.4, 2005, pp.91–8.

³² Conor Keane, Glenn Diesen, "Divided We Stand: The US Foreign Policy Bureaucracy and Nation-Building in Afghanistan," *International Peacekeeping*, Volume 22, Issue 3, 2015, 213. USAID, *Provincial Reconstruction Teams in Afghanistan: An Interagency Assessment*, Washington, DC: USAID, 2006, p.5.

rather than the military.³³ Appendix D. The transitional phase in Afghanistan has been protracted, therefore, restrictions on civilian operations caused loss of valuable time and delayed reconstruction. In Afghanistan, a significant amount of violence has persisted even during the transition phase. A diagram from Donald Crane depicts that the realistic vision of transition will vary greatly from the idealistic vision. Appendix E. The protracted transitional phase will delay the hand off point from military to civilian organization to later than expected. This will result in a significant “**gap**” between military to civilian transition. The readiness of the medical forces to seize the “golden moment” after the hostilities end to deliver immediately and prepare the foundation for longer term infrastructure is key.³⁴ Strategic planning to capture this “window of opportunity” will be critical to a successful transfer to the civilian agencies. It is important to take into consideration that transitions between operational phases will require distinct shifts in focus by the joint force, which is usually event-driven, not time-driven.³⁵ This challenge will require “an agile shift in joint force skill sets, actions, organizational behaviors, and mental outlooks; and coordination and collaboration with a wider range of other organizations—USG departments and agencies, multinational partners, IGOs, and NGOs—to provide those capabilities necessary to address the mission-specific factors.”³⁶ Therefore, the military must step up its role to provide the necessary services that civilian organizations would typically render during this critical transition period where it is still not safe for the civilians to do so.

³³ Angel Rabasa, John Gordon IV, Peter Chalk, Christopher S. Chivvis, Audra K. Grant, K. Scott MaMahon, Laurel E. Miller, Marco Overhaus, Stephanie Pezard, *From Insurgency to Stability: Key Capabilities and Practices*, (Santa Monica, CA, RAND), 2011, xvi.

³⁴ *Ibid.*, 38.

³⁵ “Overview” and “Organization and Interagency Coordination”, Joint Publication 3-29, *Foreign Humanitarian Assistance* (3 January 2014).

³⁶ *Ibid.*

It is commonly construed that many developing nations “share the fundamental problem of significant medical deprivation” which in turn inhibits the modernization process of such nation.³⁷ The Afghanistan case has not been any different. Afghanistan has been at war since 1978. Among other political, economic, military, and social infrastructures, their health care infrastructures have suffered tremendously over the past 40 years. Since 2001, health care in Afghanistan has been provided mainly provided by NGOs which has become more challenging over time. As long as the conflict and violence persist in Afghanistan, its people will continue to fall victims to poor health care system. In Afghanistan, as of 2008, there were only 6,000 physicians and 14,000 nurses to serve a population of 28 million.³⁸ For comparison, according to the 2014 census, in the US, there are approximately 920,000 licensed physicians for a population 330 million. That is approximately one physician for every 4600 people in Afghanistan compared to one physician for every 360 people in the US. Since medicine is a universal language, it has the potential for providing “immediate high-impact communication with any culture, anywhere in the world,” and improving health care system can have a profound impact on the indigenous population with a potential to “rise above the level of political turbulence and distrust of their host government.”³⁹ Therefore, medical intervention stabilization operations have the potential in Afghanistan and elsewhere to succeed where other civic action efforts may fail, potentially contributing to the overall success of the stabilization operations.⁴⁰ In many

³⁷ Ibid.

³⁸ John R. Acerra, Kara Iskyan, Zubair A. Qureshi, and Rahul K. Sharma, “Rebuilding the health care system in Afghanistan: an overview of primary care and emergency services,” *Int J Emerg Med* 2(2) (June 2009): 77-82., <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2700223>.

³⁹ COL Spurgeon Neel, “Medical Role in Military Stabilization Operation,” *Military Medicine*, August 1967, 605-608.

⁴⁰ Ibid.

countries, the military medical organization plays a significant role in providing health services to the civilian populace because the military is often the best organized, equipped, most stable, and most logistically competent compared to other organizations.⁴¹ Recently, on September 12, 2016, the Italian Military deployed 200 soldiers and 100 doctors and nurses to Libya at the request of the United Nations for humanitarian assistance.⁴² The same could be true in Afghanistan even on a larger scale to help build local capacity.

Assessment of Doctrine, Organization, Training, Materiel, Leadership & Education, Personnel, and Facilities (DOTMLPF)

Doctrine

The United States Military Health System has clearly adopted instructions and directives such as the DoDI 3000.05 (Stabilization Operations), DoDD 3000.07 (Irregular Warfare), and DoDI 6000.17 (Medical Stabilization Operations) in accordance with the guidance issued by the Headquarters Department of the Army Field Manual 3-07, Stability Operations. The capabilities are outlined for International Health Specialist Program. See Appendix F.

Organization

The United States Air Force has an active International Health Specialist Program which provides the organizational structure needed to meet the currently outlined mission required for stabilization operation. The program has greatly focused its efforts to meet the geographical

⁴¹ Ibid.

⁴² Reuters, "Italian Medical Intervention in Libya," Thomson Reuters Foundation News, 12 September 2016, <http://news.trust.org/item/20160912111653-7mziv/>.

medical challenges as well as cultural communication challenges. While the organizational structure has been established the current scope of mission and the operations focused on phase zero of operational campaign. Individual IHS and IHS teams are embedded within COCOM as well as throughout active, reserve, and guard components of the Air Force. The organization is clearly outlined in Air Force Instruction 44-162 (International Health Specialist Program). See Appendix I.

Training

The full-time International Health Specialist typically have Masters in Public Health degree and receive additional training for Theater Security Cooperation for one week, Embassy Immersion for five weeks and DoD Regional Security for 1-2 weeks before taking the position. Further study is required to explore to see how these members are trained to meet the demands of the medical stabilization operation which is more specific to a particular region. One of the major challenge is cultural and language deficiency. Upon recognition of this grave challenge the Air Force Culture and Language Center was established to meet the language and culture training requirement through various immersion and online training program to fill this gap through a robust language sustainment program known as the Language Enabled Airmen Program (LEAP). The IHS members are identified by their IHS Special Experience Identifier (SEI) and Defense Language Proficiency level of competency. As of 2014, there are 2067 active duty personnel, 247 reservists, and 92 guardsmen with foreign language skills.⁴³ Currently, it is unknown as to how many military medical personnel have foreign language skills specific to the Middle East region.

⁴³ International Health Specialist Program Office. AFMS Language and SEI roster as of 1 March 2014.

Materiel

Unknown at this time.

Leadership & Education

Currently, there is no US military medical representative/liaison officer in the United Nations to coordinate medical stabilization operation issues. The only military medical officers assigned are from the Troop Contributing Countries to support their own deployed troops. There is a US Army medical liaison officer in USAID in Washington, D.C. There are Major Command Surgeon General and 8 IHS staff specifically assigned to CENTCOM.

Personnel

IHS program data show that there are 65 full-time position billets over the world. The entire program has over 300 part time International Health Specialists with foreign language skills, cross-cultural competency, geopolitical insights, diplomacy, regional health expertise, interagency coordination, security cooperation expertise capabilities. They are identified with a Special Experience Identifier (SEI).

Facilities

No known facilities related constraints.

Recommendation

The similarity between humanitarian aid assistance and disaster relief missions and stability missions within medical operations is that both types of missions serve as the pre-cursor

operations for the long term reconstruction and rehabilitation of the existing health care infrastructure. Also, timely response is the key to a better long term outcome. As the preeminent global power, the US will be asked in nearly every incident to assist the world community in managing these crises effectively.⁴⁴ If medical stabilization operations become successful, the Afghanistan case can serve as the beacon to the future operations in the region, but unfortunately the war in Afghanistan has been overshadowed by the war against ISIS. In Afghanistan, the insurgents have the option of simply waiting out until the US loses political will. Without reconstruction, the time is on the side of the insurgents, but with rebuilding approach focusing on the winning the hearts and minds of the people, the time is on the side of the coalition.

The Afghans lost 40 years of growth due to persistent wars. As the war in Iraq and Syria is heating up, the Afghans are losing even more precious time. Unfortunately, due to the non-permissive environment, the civilian agencies have not been too successful in reconstructing health care infrastructure at the local level.⁴⁵ The US military health workers have the potential capability to provide the needed services in non-permissive environment better than NGOs can. With the anticipated protracted hostile environment the military can fill the civilian gap and lay the necessary groundwork for the NGOs and various civilian aid workers to help the indigenous population to build their own nation. In Afghanistan, the legitimacy of the government has not been firmly established due to corruption and its inability to effectively extend their authority to provide security or basic services. Thus far, the top-down approach has not been very effective. A bottom-up approach, including the reconstruction of health care infrastructure at the local level must be conducted simultaneously. Providing security in the region is of the utmost importance

⁴⁴ *Joint Military Operations Historical Collection*, 15 July 1997, Chapter VI, "Operations in Somalia."

⁴⁵ Eliot A. Cohen, *Supreme Command in Irregular Warfare, Counterinsurgency Leadership in Afghanistan, Iraq and Beyond* (Marine Corps University Press, 2011).

in priority, but also in a protracted transitional environment, waiting for an absolute safe environment can further deteriorate the situation by significant delaying the progress. Demonstration of progress in the social realm will, in fact, contribute to local stability and security. Hence, this paper advocates that during the transition phase the military health workers along with the force protection provided should engage in medical diplomacy by initiating key relationship to shape the environment conducive for the civilian workers to operation their mission without losing valuable time. This concept of military stability operations can be evinced in the doctrine of Italian Army Doctrine. See Appendix G. While the “gap” is filled by the military the gradual transition or hand-off to the civilian will occur as the environment permits. See Appendix H.

To many military members and leaders alike, the term nation building may be an aversive term for many DOD personnel since that is not the job of warfighters, but our MHS does possess the capability and can provide national assistance in preparation for nation building as is evident in our doctrine as well as in our coalition forces. There is a shared understanding and approach to stabilization through medical diplomacy because the focus on health can provide opportunities to overcome insurgency by strengthening the young Afghan government and set the conditions for long-term economic growth.⁴⁶ Medical diplomacy and interventions can provide “an important component of a diplomatic strategy to regain moral authority for US actions, regain the trust of moderate Muslims, and deny terrorists and religious extremists unencumbered access to safe harbor in ungoverned spaces.”⁴⁷ Closely coordinated and combined with offensive military operations, defensive security actions, and other reconstruction activities can lead to a long-term

⁴⁶ Donald F. Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan,” *Defense Horizons*, no 63, May 2008.

⁴⁷ *Ibid.*

desired outcome. Hence, comprehensive and holistic approach through unified action and unity of effort is the keystone to a successful outcome. Joint Doctrine is explicit about the importance of collaborative effort to “achieve and maintain unity of effort within the joint force and between the joint force and US Government, international, and other partners.”⁴⁸ Commanders should press for building exercises with as many agencies as possible before deployment.⁴⁹ In military operation, the use of overwhelming force is necessary to accomplish the mission. Every violent conflict must be followed by reconstruction. Without it, the end result is suffering for the civilians. When the reconstruction plans and efforts are vague or severely under sourced, the consequence should be of no surprise. Spoilers will always be present to bring back chaos which ultimately hinders progress and inciting new violence leading to poor security, which is the key stone to rebuilding local capacity. Hence, medical stability operations, while not the focus of the many operations, may be a critical element to success. This will assist the host nation in their own efforts in reconstruction and nation building. This paper does not propose that the US military build westernized hospitals for the nation which they cannot sustain for themselves, but to assist them in planning their own infrastructure that fits their culture and their level of need by not only advising with limited financing, but to get their respective local authority to plan and execute with their own hands. Nation building is not the responsibility of the DOD nor the US military. The host nation and its people must build their own clinics, hospitals, and other infrastructures. They must build it themselves with their own plans, labor, and hands to meet their needs. They must be able to take pride in their own accomplishments. If they build with their own hands, insurgents and spoilers will be less likely to destroy them. We need to

⁴⁸ Joint Publication 3-0, *Joint Operations*. January 2017

⁴⁹ William Flavin, “Planning for Conflict Termination and Post-Conflict Success,” *Parameters*, Autumn, 2003.

incentivize current professionals to build more medical schools and nursing schools. But the US military and health workers can provide the necessary means and environment to initiate the process without delaying the initial steps. And of course, cooperation between military and civilian organization from the outset of planning to the transfer of authority is of the utmost importance as well as collaborative training which can enhance civil-military working relationship toward the common objective. This will then help to achieve the national objectives to provide stable Afghanistan to secure the region and contribute to global security.

Conclusion

In Afghanistan, or in any other war stricken nation, stabilization operations will heavily influence the outcome. Medical Stabilization Operations can assist significantly in stabilizing a degraded nation by contributing to the basic needs of the people in the end, “alleviate the suffering through achieving economic development and legitimacy of the government.”⁵⁰ Conflict resolution is a long process. It is primarily a civil problem that require military support where the military can set the conditions for successful conflict resolution by filling the critical “gaps.”⁵¹ The US military and coalition forces must utilize medical diplomacy to win hearts and minds of the local populace. Air Force IHS individuals can forge relationships with Afghans and help stabilize the region. The Air Force International Health Specialist program has a sound doctrine and organization with adequate training and education, but seem to lack capacity. Medical Stabilization Operations can make a difference, but the current DOTMLPF assessment

⁵⁰ Mary V. Krueger, “Medical Diplomacy In The United States Army: A Concept Whose Time Has Come,” (Army Command and General Staff College, Fort Leavenworth, KS), June 2008.

⁵¹ William Flavin, “Planning for Conflict Termination and Post-Conflict Success,” *Parameters*, Autumn, 2003.

demonstrates limited capacity within the Air Force IHS program. The Military Health System will need a more robust build up stabilization operations capability by addressing additional education and training expansion of the IHS program to increase capacity. The more important question is: Even though the MHS has the initial capability, can we increase the effectiveness and sustain our capabilities? Does the US government possess the political will and commitment to invest in nation building of Afghanistan? Unfortunately, with more violent extremism spreading, the US may not be able to afford such tasking. But on the other hand, it would be in the best interest to begin expansion and broadening the current scope and operations to meet such demand in the future. Lastly, the continuing effort for the development of framework for better interoperability between civilian agencies and other organizations to build partnership and collaboration will be paramount. Hence, military health workers through medical diplomacy with early intervention during the transition phase, which is considered to be a non-permissive environment, can assist the JTF commander with a more effective option in bringing stabilization to an unstable region such as Afghanistan. It would be in the United States vast interest to help Afghanistan succeed, for the benefit of our security, the region and the world.⁵²

⁵² Secretary of Defense Ash Carter, "2017 Defense Posture Statement," (February 2016).

Appendix A

- A. “Some conflicts pose such a grave threat to our broader interests and values that conflict intervention may be needed to restore peace and stability.”

-National Security Strategy of the United States

- B. “The inability of many states to police themselves effectively or to work with their neighbors to ensure regional security represents a challenge to the international system.”

-National Defense Strategy of the United States

- C. “Winning decisively will require synchronizing and integrating major combat operations, stability operations and significant post-conflict interagency operations to establish conditions of stability and security favorable to the United States.”

-National Military Strategy of the United States

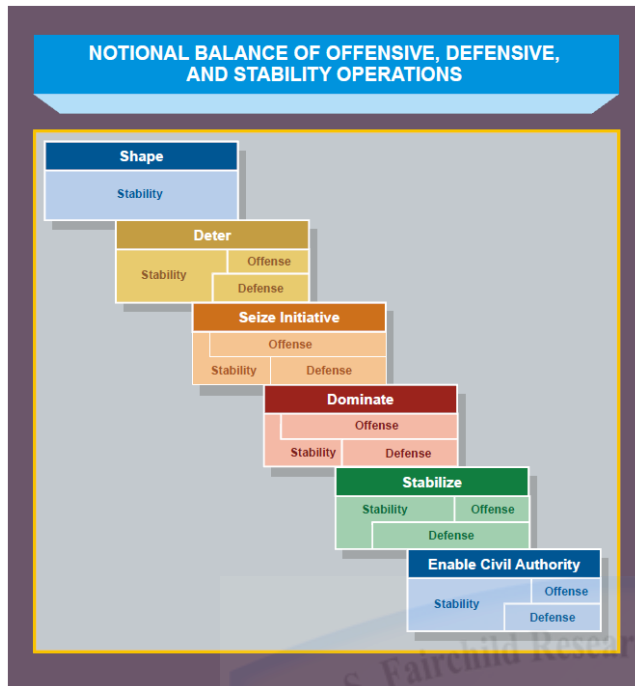
- D. “The United States should work with other countries and organizations to anticipate state failure, avoid it whenever possible, and respond quickly and effectively when necessary.”

-National Security Presidential Directive 44

- E. “Stability operations are a core US military mission that the Department of Defense shall be prepared to conduct and support. They shall be given priority comparable to combat operations and be explicitly addressed and integrated across all DOD activities.”

-Department of Defense Directive 3000.05

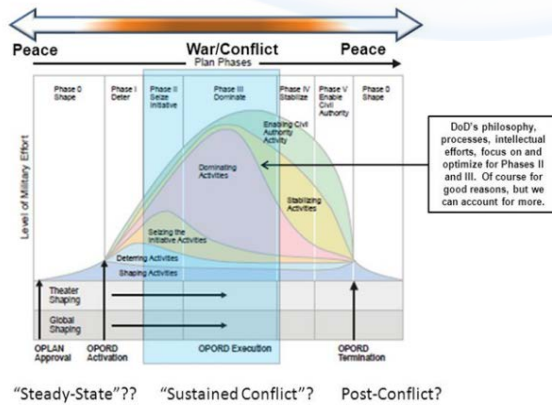
Appendix B



53



Where do we focus our institutional attention?



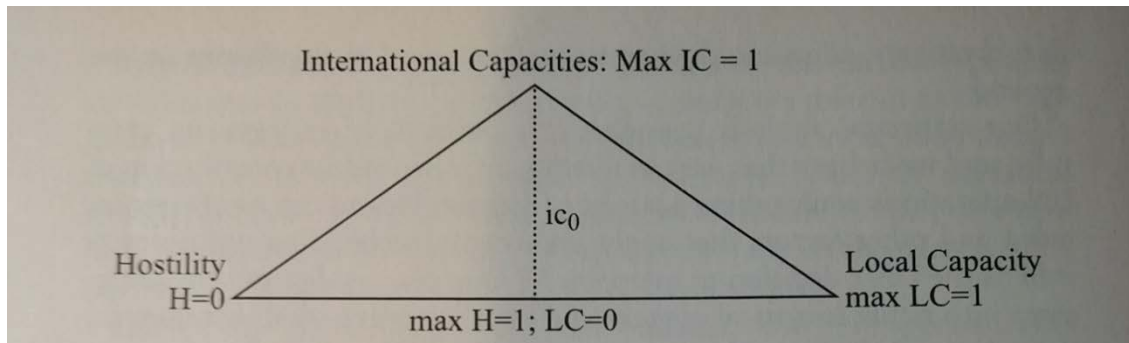
JP 5-0, Joint Operational Planning

54

⁵³ Stability Operation, (lecture, Air War College, Maxwell Air Force Base, AL, 15 Feb 2017).

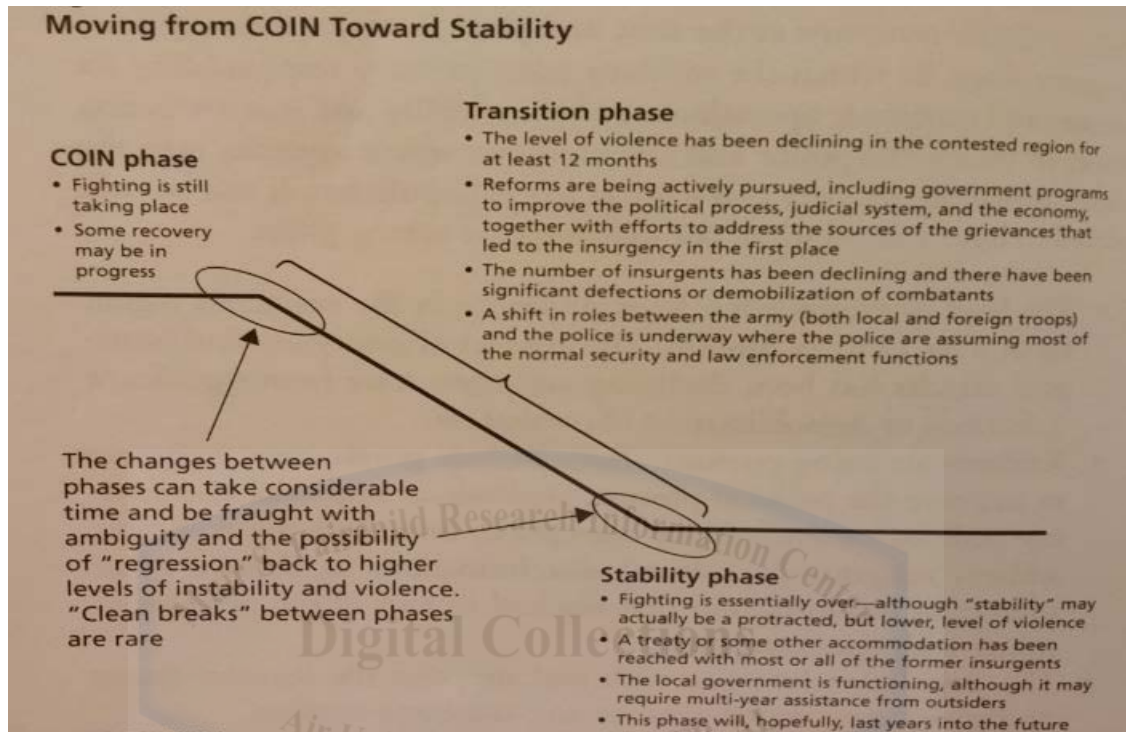
⁵⁴ Joint Publication 5-0, *Joint Operational Planning*, August 2011.

Appendix C



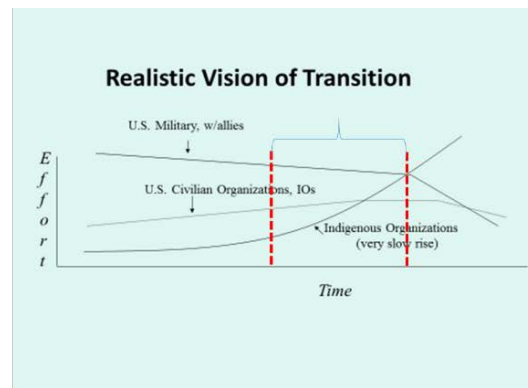
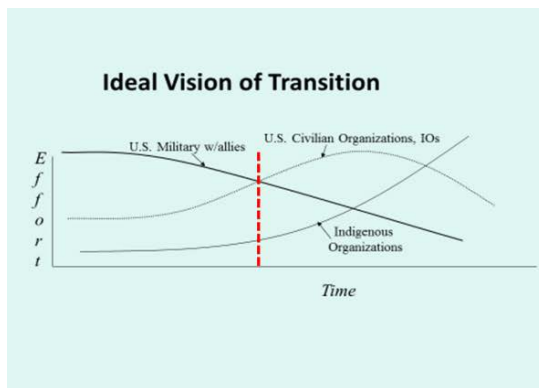
⁵⁵ Michael Doyle and Nicholas Sambanis, *Making War and Building Peace: United Nations Peace Operations*, (Princeton, NJ, Princeton University Press), 2006, 64.

Appendix D



⁵⁶ Ibid.

Appendix E



57



⁵⁷ Donald Crane, (lecture, Air War College, Maxwell Air Force Base, AL, 28 Oct 2016).

Appendix F

The following are the capabilities specified to be provided for the Combatant Commander through the IHS program outlined in the Air Force Instructions 44-162:

- 1) Security Cooperation, Stability Operations, and Counterinsurgency
- 2) Cultural Aptitude and Foreign Language proficiency
- 3) Force health protection, preventive medicine, public health, and health systems
- 4) Joint, combined, and interagency operational planning
- 5) Health engagement activities and their monitoring and evaluation
- 6) Direct clinical care and casualty management
- 7) Ground and aeromedical evacuation
- 8) Medical logistics and administration
- 9) Defense Support to Civil Authorities (DSCA) (domestic health engagement)
- 10) Foreign Humanitarian Assistance/Disaster Relief (HA/DR), to include public health for displaced populations.⁵⁸

In addition, the following deployment taskings have been outlined:

- 1) Task Force surgeon or surgeon's staff
- 2) Expeditionary Medical Support (EMEDS) augmentation
- 3) Air Advisor missions
- 4) Joint or any service strategic or operational planning cell
- 5) Humanitarian Assistance Survey Team (HAST) member
- 6) Health Liaison to Civil-Military Operations Center (CMOC) or Humanitarian Assistance Center (HAC)
- 7) Liaison to United Nations Health Cluster or Host Nation equivalent
- 8) Provincial Reconstruction Team (PRT) medical personnel
- 9) Medical Embedded Training Teams (mETT)
- 10) Military Training Team (MTT)
- 11) US Army, USMC, or USN Civil Affairs team augmentation
- 12) Liaison to US Embassy and/or USAID health mission
- 13) Joint/Multinational exercise controller/observer
- 14) Humanitarian and Civic Assistance (HCA) mission leader/planner/member (including Medical Civic Action Program (MEDCAP) or Medical Readiness Training Exercise (MEDRETE) missions)
- 15) International health systems and facilities design.⁵⁹

⁵⁸ Ibid.

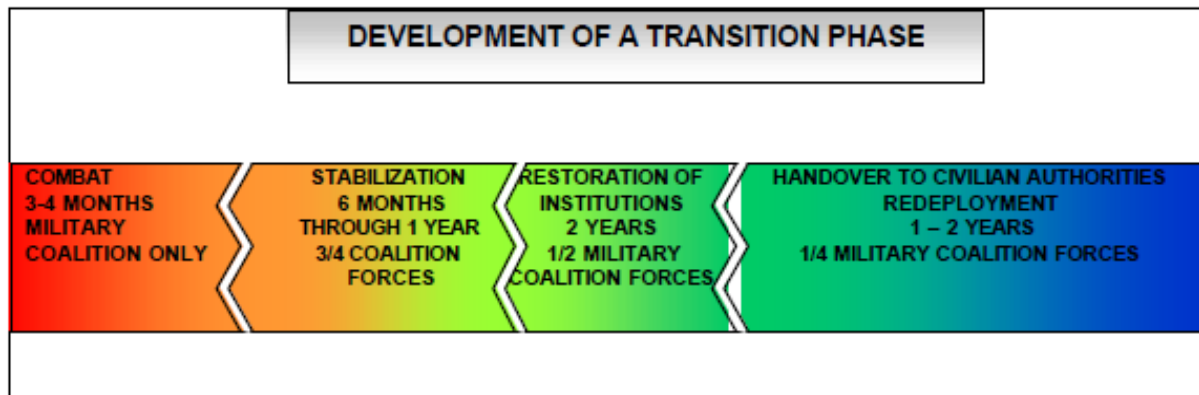
⁵⁹ Ibid.

Appendix G

According to Italian Army Doctrine, military forces ought to develop capabilities in the technical realm (civil engineers, transportation, health care, etc.) as well as in the fields of nation building (e.g. security and restoration of primary energy sources, businesses and industries) and culture (security and restoration of monuments/historical sites, and restoration of education institutions). Developing these capabilities does not mean that military forces can or must take the place of all the non-military agencies. ***These particular skills allow military forces to initiate post-conflict activities when the security conditions do not recommend the employment of civil components, or where the latter has not reached enough capabilities yet. This allows starting filling the afore-mentioned “gap” in order to ensure a secure and stable environment that is an essential requirement for a long lasting peace.*** In fact, to turn post-conflict management into a political and strategic success requires winning the consent and the support of civilians and helping them to restore adequate living conditions, primary infrastructures, health care systems, etc. As a result, it is crucial that Stabilization activities are to be started and continued throughout the entire operational cycle. Planning of combat and stabilization and reconstruction activities is to be developed together with a single and comprehensive operations plan, because historical and recent examples have demonstrated that a rapid and decisive military victory does not guarantee a peaceful post-conflict period.⁶⁰

⁶⁰ Gaetano Zauner, “Stabilization and Reconstruction operation. A Bridge between Conflict Termination and Nation Building. Roles, tasks and capabilities of the Italian Army.” US Army War College, Carlisle, PA, 2006.

Appendix H



61



⁶¹ Gaetano Zauner, "Stabilization and Reconstruction operation. A Bridge between Conflict Termination and Nation Building. Roles, tasks and capabilities of the Italian Army." US Army War College, Carlisle, PA, 2006.

Appendix I

Operational Use of International Health Specialists (IHS) and IHS UTCs

1. International Health Specialist (IHS) Unit Type Codes (UTCs)
2. What IHS brings for the Commander
3. IHS Deployment Roles

IHS UTC's and Capabilities

IHS teams and individual IHS special experience identifier (SEI) holders support Combatant Command (COCOM) theater campaign and security cooperation, create health sector partnerships within their regions, facilitate culturally appropriate military-military and military-civilian interactions and collaboration, and support the health aspects of operational planning. IHSers provide an expeditionary capability that traverses health career fields and can deploy either as individual augmenters or as two person force packages and serve as key global health engagement capabilities. The two unique UTCs are the Medical Regional Health Specialist Team (UTC: FFHSR) and the Medical Global Health Policy and Planning Specialist Team (UTC: FFHSG).

These force packages can be applied across the full spectrum of military operations and through all phases of an operation. They are tailored for the health engagement within peace operations, major combat operations, transition to and from hostilities, humanitarian assistance (HA), disaster relief (DR), and security cooperation projects and exercises designed to build relationships, stability, and capacity in partner nations. Neither UTC has stand-alone capability.

The *Medical Regional Health Specialist Team (FFHSR)* consists of two individuals, one officer and one enlisted member, each holding the IHS Regional SEIs, H8B and 452, respectively. It is a deployable force package applicable at the forward operational and tactical echelons with cultural, language and operational medicine capability to facilitate interoperability between the AFMS and other military or civilian health sector actors and organizations.

The team's role is to help deployed commanders evaluate the cultural context of the medical dimensions of the operational environment and the implications of health engagement on the overall mission. The team will enhance the AFMS ability to deploy in an expeditionary environment with foreign military, USG interagency, international, and host-nation presence and serve as a catalyst for successful, collaborative health activities.

The *Medical Global Health Policy and Planning Specialist Team (FFHSG)* consists of one officer and one enlisted each holding the IHS Global SEIs, H8C and 457, respectively. This

capability fills the need for senior medical personnel at strategic or higher operational levels with a comprehensive perspective on intergovernmental and interagency health initiatives leading to international cooperation and health capacity building.

The FFHSG provides higher headquarters or an embassy country team with insight and assistance in policy and strategy development, planning, and design of joint, civil-military, interagency, and international health engagement. The team shapes the expeditionary environment through adherence to USG health diplomacy policy and initiatives.

Both the FFHSR and FFHSG should be integrated with the deploying unit early in order to contribute to intelligence preparation and mission planning at their pertinent echelons. The goal is to design and execute health engagement with immediate and long-term effects that meet mission objectives and US national interests.

IHS Capabilities for the Commander

IHS personnel come from each medical corps and medical enlisted field, so the diverse knowledge of operational medicine inherent in IHS teams provides a broad range of expertise to commanders. These include, but are not limited to, knowledge of:

1. Security Cooperation, Stability Operations, and Counterinsurgency
2. Cultural Aptitude and Foreign Language proficiency
3. Force health protection, preventive medicine, public health, and health systems
4. Joint, combined, and interagency operational planning
5. Health engagement activities and their monitoring and evaluation
6. Direct clinical care and casualty management
7. Ground and aeromedical evacuation
8. Medical logistics and administration
9. Defense Support to Civil Authorities (DSCA) (domestic health engagement)
10. Foreign Humanitarian Assistance/Disaster Relief (HA/DR), to include public health for displaced populations

IHS UTC Appropriate Deployment Taskings (not all inclusive, capabilities-based)

1. Task Force surgeon or surgeon's staff
2. Expeditionary Medical Support (EMEDS) augmentation
3. Air Advisor missions
4. Joint or any service strategic or operational planning cell
5. Humanitarian Assistance Survey Team (HAST) member
6. Health Liaison to Civil-Military Operations Center (CMOC) or Humanitarian Assistance Center (HAC)
7. Liaison to United Nations Health Cluster or Host Nation equivalent
8. Provincial Reconstruction Team (PRT) medical personnel

9. Medical Embedded Training Teams (mETT)
10. Military Training Team (MTT)
11. US Army, USMC, or USN Civil Affairs team augmentation
12. Liaison to US Embassy and/or USAID health mission
13. Joint/Multinational exercise controller/observer
14. Humanitarian and Civic Assistance (HCA) mission leader/planner/member
 - a. Including Medical Civic Action Program (MEDCAP) or Medical Readiness Training Exercise (MEDRETE) missions
15. International health systems and facilities design

Operationally, the two IHS UTCs are rapidly deployable resources that enhance force capability for Service and Joint taskings. The teams can be tasked to supplement theater medical requirements as identified by theater planners, Air Force Forces (AFFOR), Joint Task Force (JTF), or combined Joint Task Force (CJTF). The IHS UTCs can be tailored to the specific mission; region or country, anticipated scope and level of international interaction, and the capabilities of expected partners.

The IHS UTCs are a viable Air Force and Joint asset that is applicable to current and future operations and can be requested through the appropriate force provider process.⁶²

⁶² Operational Use of International Health Specialist ACC/SGXI, Global Health Branch.

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