Chapter 37

OPERATION IRAQI FREEDOM 05-07 MEDICAL CIVIL–MILITARY OPERATIONS: LESSONS LEARNED IN HUMANITARIAN ASSISTANCE

JEFFREY S. YARVIS, PHD*

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**Lieutenant Colonel, Medical Service Corps, US Army; Chief, Behavioral Health, Department of Psychiatry, Borden Pavilion, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307; formerly, Director of Social Work, Uniformed Services University of the Health Sciences, Bethesda, Maryland*

INTRODUCTION

The primary mandate of Task Force 30th Medical Brigade (TF 30) is force health protection. During Operation Iraqi Freedom (OIF) 05-07, TF 30 saved the lives of an unprecedented 96% of the wounded soldiers entering its facilities. Also historic was the way in which the task force commander employed behavioral health assets and their unique skills for the brigade's civil-military operations.

Medical brigades, with their organic clinical operations section and civil-military operations staff, represent a robust public health team capability unsurpassed by even the public health teams organic to a civil affairs brigade. Nearly half of the casualties seen in coalition hospitals were Iraqi; to transition these medical cases back to the Iraqis, Iraqi military and civilian medical capabilities must be enhanced.[1] TF 30 Medical Civil-Military Operations (CMO) joined together with the Department of State, Multi-National Force–Iraq (MNF–I), nongovernmental organizations (NGOs), private companies, and the Focused Stabilization Task Force of the Multi-National Corps–Iraq (MNC–I) to accomplish this goal. TF 30 also facilitated humanitarian assistance to vulnerable populations in Iraq.

In fiscal years 2005 and 2006, TF 30 assisted in securing more than $70 million to support humanitarian needs, including establishing emergency health services; enhancing water treatment and sewage plants, clinics, hospitals, and schools; and facilitating agricultural projects through effects-based planning with local and regional host-nation government officials. These efforts bolstered the legitimacy of the local medical officials, opened lines of communication between local individuals and local leaders with the Iraqi national government, created access to care, and promoted livelihoods. Due to the highly fluid nature of the internally displaced person (IDP) population in Iraq, TF 30 also supported ongoing preventive medicine operations for humanitarian assistance for IDPs. This chapter will discuss the medical civil-military lessons learned by TF 30 during OIF 05-07.

BACKGROUND

The US military routinely executes medical humanitarian missions. These missions encompass everything from medical support, to civic action, to capacity development or enhancement projects, to major theater wartime operations. The public affairs benefit of military medical forces providing support to another nation in conflict seems apparent. Assisting the injured, sick, and wounded, and providing access to care to displaced peoples seems beneficial. However, as Ritchie and Mott[2] point out, many pitfalls are associated with providing assistance. Past literature on the pitfalls of military humanitarian assistance was largely concerned with the ethical issues of providing care that cannot be sustained by the host nation, resulting in "doing more harm than good." This harm is often associated with the medical rules of engagement that are tied to the amount of resources the US military brings to support troops in a theater of operations. However, often overlooked are how the medical humanitarian assistance missions are tied to the strategic end state of an operation and how these missions may contribute to or detract from a mission.[3]

To frame military humanitarian assistance missions, it is necessary to go back to the purpose of all operations: to create a secure environment in which political and economic development can proceed. Therefore in Iraq, the end state of all missions, to include medical civil-military missions, is to create legitimate local and provincial Iraqi governments capable of continuing political and economic development. Furthermore, to stabilize the Iraqi government, the effect of the insurgency must be minimized. Insurgency is both a political and a military phenomenon. Insurgents will be frustrated if the government has a competent and capable administration that dispenses services and effectively coordinates a multitude of political, economic, and security policies. In Iraq, access to and delivery of medical care represents a tangible reminder that the government is functioning. These functions are also exploited by the insurgency. If the insurgency or those sponsoring it control service-oriented ministries, then the Iraqis will believe that it is the insurgency that is providing this care to them. In other words, healthcare is something that can be utilized by both the US military and the insurgency. The perceived Iraqi government response to the medical needs of its people is thus a key variable in achieving US political-military objectives.

President George W Bush recognized the importance of healthcare in achieving US political-military objectives when he said,

> America is now threatened less by conquering states than we are by failing ones.…The United States should invest time and resources into building international relationships and institutions that can help

> manage local crises when they emerge.…We will use our economic engagement with other countries to underscore the benefits of policies that generate higher productivity and sustained economic growth, including…investments in health and education that improve the well-being and skills of the labor force and population as a whole.[4]

Tommy G Thompson, the former US Secretary of Health and Human Services, noted that military missions must include medical strategies. He stated that the "[m]ost effective arsenal against terrorists [contains]: education, compassion, and medicine."[5] He also said that the "[b]est chance to defeat the terrorists [is] by enhancing our medical and humanitarian assistance."[5] History demonstrates the effectiveness of such strategies. During World War II, the US employed military humanitarian assistance in the Philippines. It has continued to do so in places such as Haiti and Bosnia because of a moral mandate in support and sustainment operations.[2]

The military operations other than war and peacetime engagement projects that represented the bulk of military humanitarian missions in the 1990s were inherently different than the missions occurring today in Iraq and Afghanistan. In Iraq, for example, the war began with kinetic fighting—attacking the enemy with weapons and destroying infrastructure along the way. As the United States approached the transition phase of operations during OIF 05-07, efforts were refocused on building projects. The various projects were undertaken to restore basic health services and address public health concerns to mitigate the health effects that were the result of the kinetic fight.

Now as the shift continues to the nonkinetic fight, the aim is to preserve existing structures, develop capacities, and target key structures critical to transitioning the health "battlespace." After three to four rotations in Iraq, medical civil-military operations were incorporated into all transition operations from the start and in all levels of planning—strategic, operational, and tactical. Waiting until the kinetic fight is over to plan and execute civil-military projects is not a workable concept.[6] Simultaneous integration of civil-military operations represents a shift in the operational effort following combat operations to a nonkinetic main effort. As the transition phase proceeded, the civil dimension became a part of the main effort. Following security gains, constructive engagement to repair damage and build on security success must begin in earnest. This is where longer-term success and true transition to civil control will become possible. The civil dimensions noted in Ritchie and Mott[2]—rule of law; facility/critical infrastructure assessment and repair; critical needs assessment (health, safety, and so forth); and local governance/leadership—all had to be focused. In addition, the TF 30 medical civil-military operations included nontraditional actors in the planning and execution process, such as NGOs and international organizations.

As mentioned earlier, medical civic action programs (MEDCAPs) and other medical military humanitarian assistance projects have apparent benefits such as "winning the hearts and minds." However, the contrary was true in Iraq; the apparent benefits of "tailgate" medicine were not realized because these missions were not tied to lines of operation and the strategic political-military objectives. Furthermore, the value to US medical personnel was not apparent. The need to transition patients back to an independent and capable host nation medical system was burdened by MEDCAPs. The medical civil-military end state defined by the XVIII Airborne Corps during OIF 04-06 was defined as: "To conduct coordinated cooperative medical engagements at the provincial level to strengthen governance and transition lines of operation in support of campaign plan and overall US objectives in Iraq."[7] No clear end state was identified in this mission statement. Past operational civil-military operations and plans did not effectively develop governance capacity in provinces. Furthermore, no standing organizations existed for coordination and support to medical civil-military operations at the national level. By OIF 05-07, it was clear that what was needed were fundamental changes in behavior, structure, and organization to address gaps in medical civil-military staffing and skill sets at the operational and strategic level. Inattention to these gaps led to inconsistent and "stovepiped" MEDCAPs that offered little long-term benefit and could not be quantified in terms of measures of effectiveness.

To implement the national strategy at the transition phase of operations in Iraq to achieve the political-military objectives set forth by the commander of the MNF–I, the following seven assumptions were made by the US medical civil-military operations team:

1. Increased governance capacity building and assistance is necessary to develop sustained capability of provincial governments.
2. Existing organic civil affairs public health teams will maintain current capability in provinces until their efforts are tied to the operational main effort, which when established will represent fully coordinated, joint

medical civil-military teams.
3. A need exists to develop a formalized mechanism for coordinating provincial activities and support at the Department of State and MNF–I.
4. Capability to provide enhanced health support to provincial governments must persist beyond elections.
5. The Iraqi national government will need to support increased medical outreach at the provincial and district levels.
6. Coalition resources necessary to support any new medical civil-military operations efforts will be available.
7. Medical civil-military efforts can be tailored to meet the needs and security situation existing in each province. Substantial capability of provincial governments will be developed in 2 years, allowing transition to more traditional US Agency for International Development (USAID), international organization, governmental organization, and NGO assistance delivery mechanisms to provincial and local governments for an additional 2 years.

Given these assumptions, the following mission statement for medical civil-military operations was developed:

- To assist Iraq's provincial director generals of health with developing a transparent and sustained capability to promote public health and provide provincial administration necessary to meet the basic health needs of the population.
- To provide timely and relevant assessments of health infrastructure and political developments in the Ministry of Health at the local level, and to promote Coalition governance and capacity development goals.

To implement the mission statement, the following eight tasks were identified:

1. Facilitate achievement of Coalition goals in Iraq by enhancing the capabilities of the Iraqi health sector from the district level within the Ministry of Health and the battalion level within the Ministry of Defense.
2. Promote health reform at the provincial level.
3. Assist local ministry representatives and Iraqi Army surgeons with developing a comprehensive strategy that results in a capable and accountable local government.
4. Assist provincial governments with identifying and prioritizing the needs of their citizens and with addressing those needs via the Iraqi government, Coalition, donor, and NGO resources.
5. Assess health capabilities of provincial governments and develop a joint plan of action to increase these capabilities, with emphasis on sustainability.
6. Assist provincial governments in developing short- and long-term goals for public health programs, and assist with their implementation.
7. Coordinate with other major subordinate commands to synchronize medical governance efforts with stability operations.
8. Coordinate with civil affairs assets to assess health sector developments at the local level, and to advocate Coalition goals and objectives.

These tasks were augmented with some of the peacetime concepts for civil-military operations noted in Ritchie and Mott[2]—train, coach, and mentor local government medical entities to develop their capacity to:

- develop core competencies and standards of care;
- establish effective linkages with ministries and central government;
- help Iraqi health officials plan and prioritize direction and activities;
- prepare critical needs lists, identify funding needs, and identify resources; and
- determine facility staffing requirements and assist medical officials to address these with their next higher minister or officer.

The G-5 (civil-military operations officer) of TF 30 also addressed systemic gaps through resource development activities for the MNC–I. Specifically, TF 30: (*a*) coordinated support by donors and NGOs; (*b*) communicated with stakeholders via effective public affairs and information operations activities; (*c*) provided and enhanced the delivery of provincial and municipal health services to include emergency medical services; (*d*) developed subordinate medical civil-military operations working groups; and (*e*) involved host-nation medical contacts in medi-

cal reconstruction activities to ensure the cultural relevance of all TF 30 projects. All of these efforts had to be observable in some meaningful way, therefore qualitative and quantitative measurements of success against established benchmarks were provided.

The involvement of Iraqi healthcare officials in TF 30's medical civil-military operations planning seems obvious, however, it had been routinely ignored by previous rotations. Upon implementation of the TF 30 medical civil-military engagement strategy, Iraqis were part of meetings at all levels of planning. This involvement was key to the paradigm shift from MEDCAP as the main thrust of medical humanitarian assistance to a more comprehensive process called "cooperative medical engagements." Cooperative medical engagements are specific humanitarian assistance opportunities led by Iraqi civilian or military medical personal for which US involvement is incidental to the overall engagement. Each cooperative medical engagement must focus on assisting the Iraqi medical system and the Iraqi Security Forces to provide for its civilian population. The projects must advance operational security goals; improve access (to regions and to the people); reinforce security and stability; and generate good will to enhance the US ability to shape the operating environment. Projects must be humanitarian in nature and must compliment the strategic goals and objectives of the Ministry of Health. Addressing the medical rules of engagement and misuse of MEDCAP, cooperative medical engagements do not allow for direct care to the Iraqi people unless it is a life, limb, or eyesight issue. The corps surgeon is the coordinating and approving authority for all cooperative medical engagements.

On August 18, 2005, then Secretary of Defense Winkenwerder stated that, "[t]he primary goal of the US Government in matters of world health is to build capability and capacity so that societies may address their healthcare needs." Cooperative medical engagements promote this concept. Initial reconstruction efforts had been designed to create entire healthcare systems for, and not with, the Iraqis. According to the Department of State,[7] $786 million from international and US sources was provided for health-sector development. However, few substantial gains were made in terms of transitioning healthcare back to the Iraqis or increasing access to care. TF 30's goals were more modest: building on existing platforms, identifying medical systems that could assist with the transition to the host nation through partnerships with the Iraqi Security Force and TF 30 facilities, or assisting medical systems key to stabilizing Iraq. Department of Defense Directive 3000.5 states, "Integrated civilian and military efforts are key to successful stability operations."[8] Executing this directive meant implementation at the local and regional levels, and allowing lower-level officials to communicate needs in a culturally acceptable way with the National Ministry of Health. Such open lines of communication and systemic cooperation across the country enhanced the legitimacy of all the health officials involved. Involving Iraqis through cooperative medical engagements addressed issues created by MEDCAPs. Ritchie and Mott[2] describe pitfalls of peacetime engagement projects. Some of the pitfalls that they identified—short-term focus, inadequate planning, disruption of local healthcare, and raising expectations for care—were all real problems that undermined long-term political-military objectives in Iraq. For instance, many medical civil affairs public health teams conducted "a MEDCAP a week," without any apparent reason. In addition to the problems discussed by Ritchie and Mott,[2] MEDCAPs also created parallel systems, vacuums of care when medical assets were moved around the battlefield, and resentment among Iraqi officials who often did not have an opportunity to vet these projects, determine if there was need for US interventions, or simply have the means to sustain US efforts once care was withdrawn. TF 30 and the corps surgeon's office were determined to achieve small, sustainable, and observable efforts.

Small sustainable humanitarian assistance projects created tangible results, increasing the legitimacy of Iraqi medical care and governance with potential for growth of Iraqi systems in a culturally relevant way. Using Natsios' "Nine Principles of Reconstruction and Development"[9] and considering the dimensions of nation building, TF 30 had highly successful cooperative humanitarian assistance operations, engaging Iraqis at the tactical, operational, and strategic levels (Exhibit 37-1).

These nine principles should guide medical planners in the targeting and execution of medical CMO and humanitarian assistance missions. Such planning is consistent with the effects-based planning conducted by military planners representing the full spectrum of battlefield operating systems and is not limited to medical planners. When employing these principles, the objectives of all CMO efforts should be to gain targeted effects that support the mission of the higher command, the commander's stated lines of operation, and the national strategy for the intervention for Iraq. It is also important, however, to understand that these concepts represent a departure from civil-military doctrine.[10]

EXHIBIT 37-1

NINE PRINCIPLES OF RECONSTRUCTION AND DEVELOPMENT

In 2005, Natsios[1] delineated nine principles that guide the US foreign assistance community, which includes the US military, in the provision of aid to a variety of war-torn countries:

> In a time of increasing collaboration between the two organizations [military and USAID], it is important that the military gain a better understanding of how USAID [US Agency for International Development] and development agencies generally approach their work, and how the two communities can beneficially build on this cooperation. . . .When a foreign assistance agency adheres to the Nine Principles, this greatly enhances the likelihood of success. Conversely, failure to take the Nine Principles into account when designing and managing a program increases the risk of program failure. . . . Just as a particularly skilled battlefield commander can violate one or two of the principles of war and still prevail, a development officer may violate one or two of the development principles and still succeed. But generally development agencies ignore these principles at great risk, particularly in countries like Iraq, Afghanistan, and Sudan, where major reconstruction efforts are under way.[1(p5)]

This table presents the nine principles for successful collaboration between the US military and other agencies, and the US military experience in Iraq with the utilization of the principles. The first two columns are from the Natsios article; the third column delineates how TF 30 interpreted and employed the "Nine Principles" in Iraq.

Principle	Description	Experience in Iraq
Principle 1: Ownership—*Build on the leadership, participation, and commitment of a country and its people.*	The first principle of development and perhaps the most important is ownership. It holds that a country must drive its own development needs and priorities.	Leadership, participation, commitment of host nation. Activities should enhance legitimacy of host nation.
Principle 2: Capacity Building—*Strengthen local institutions, transfer technical skills, and promote appropriate policies*.	Capacity building involves the transfer of technical knowledge and skills to individuals and institutions so that they acquire the long-term ability to establish effective policies and deliver competent public services.	Activities that enhance legitimacy of local professionals through accredited training models and certification programs. Activities that allow self-sustaining operational capability such as training in use of budgets and logistical systems. Activities that promote personal accountability and ownership of product and process.
Principle 3: Sustainability—*Design programs to ensure their impact endures.*	The core of the sustainability principle is that development agencies should design programs so that their impact endures beyond the end of the project.	Impact must endure, for example: TF 30 created the first self-sustaining Iraqi medical association in Iraq. Risk if ignored: alienation of local population.
Principle 4: Selectivity—*Allocate resources based on need, local commitment, and foreign policy interests.*	The selectivity principle directs US bilateral assistance organizations to invest scarce aid resources based on three notions: humanitarian need, the foreign policy interests of the United States, and the commitment of a country and its leadership to reform.	Needs assessment plus political-military objectives need not be expensive or time consuming.[2] Example: disease nonbattle injuries (DNBIs) at Iraq Security Force camps increased during the Ramadan holiday. Targeted Iraqi camps (nodes) were given handwashing campaign posters and water-testing strips for under $50/camp. In 2 months, DNBI from food- and water-borne sources went from approximately 300 Iraqi soldiers per month to zero. Lesson learned: did not have to create an entire preventive medicine program to address some immediate short- and potentially long-term problems.[3]

(**Exhibit 37-1** *continues*)

Exhibit 37-1 *continued*

Principle 5: Assessment—*Conduct careful research, adapt best practices, and design for local conditions.*	One of the most important tasks a development agency must undertake before designing and implementing a program is to conduct a comprehensive assessment of local conditions.	Research best practices, design for local conditions. Nongovernment orgnizations (NGOs) may already have this information. Example: International Medical Corps has been doing medical humanitarian assistance for nearly 30 years in Iraq.
Principle 6: Results—*Direct resources to achieve clearly defined, measurable, and strategically focused objectives.*	The principle of results is an outgrowth of the assessment principle. It means that before a donor agency even enters a particular country, it first determines its strategic objectives.	Results measured by standards, indicators, and effectiveness. Measures of standards; qualitative or quantitative. Example of qualitative standards: increased use of host-nation ambulances to clear battlefield and increased transportation of Iraqi casualties directly to host-nation facilities. Performance (process) indicators: decreased length of stay by Iraqi patients at targeted US facilities (nodes) by as much as 70% in one year's time. Impact indicators: increased host-nation care for burn patients through capacity enhancement projects with Iraqi hospitals. Measures of effectiveness: combination of key indicators, interdependent and multisectoral; more useful in longer missions; useful to determine transition criteria; need to partner with civilian agencies to do these right.
Principle 7: Partnership—*Collaborate closely with governments, communities, donors, nonprofit organizations, the private sector, international organizations, and universities.*	The partnership principle is a central element of USAID's business model and holds that donors should collaborate closely at all levels with partner entities, from local businesses and private voluntary organizations to government ministries.	Collaborate not only with the health attaché and host-nation minister of health, but also NGOs and international organizations.
Principle 8: Flexibility—*Adjust to changing conditions, take advantage of opportunities, and maximize efficiency*.	Development assistance is fraught with uncertainties and changing circumstances that require an agency to continuously assess current conditions and adjust its response appropriately.	Adjust to changing circumstances. Be aware of cultural, political environment.
Principle 9: Accountability—*Design accountability and transparency into systems and build effective checks and balances to guard against corruption.*	There are two important aspects to the accountability principle: donors should work to fight corruption in the countries where they operate, and donors must also ensure that the actual programs they implement are transparent and accountable.	Transparency (within security restrictions). Avoid corruption. Perception is everything.

(1) Natsios A. Nine principles of reconstruction and development. *Parameters*. 2005:5–20. (2) Bonventre G. Capacity-building in the health sector. Presentation to the Combatant Command Surgeons Conference. December 2005. Washington, DC. (3) Yarvis JS. Social workers as civil affairs officers: medical civil affairs in Iraq. In: Actionable strategies for caring for our warriors, veterans and our country. Presented at the 112th Annual Meeting of Association of Military Surgeons of the United States (AMSUS). San Antonio, Tex. November 2006.

PARTNERING WITH NONGOVERNMENTAL ORGANIZATIONS AND GOVERNMENTAL ORGANIZATIONS

TF 30 could not achieve optimal results without coordinating and synchronizing efforts with NGOs such as the International Medical Corps and Assisting Marsh Arabs and Refugees, and US governmental organizations such as USAID. These organizations are experienced in managing the second-order effects of combat and have substantive relationships in Iraq that often began well before OIF. Lacking a Commander's Emergency Response Program of its own, TF 30 relied on the resources of the MNC–I as well as the NGOs. In turn, the NGOs relied on the technical expertise, security capability, and networking ability of the military to effectively develop partnerships between the Iraqi military medical community, Iraqi civilian medical community, and the Coalition medical community to accomplish humanitarian assistance missions. For example, TF 30 facilitated the identification and movement of over $60 million in humanitarian assistance medical supplies for Iraqi hospitals and primary healthcare centers from Humanitarian Assistance-Kuwait and US donors (via the Denton Amendment[11]). TF 30 was the lead on medical issues for the MNC–I Humanitarian Assistance Working Group, working to match the needs of the Iraqi medical systems with available medical supplies and to focus the medical efforts being conducted by agencies working in the health sector. This coordination by the TF 30 CMO staff gave visibility to the "ground truth" from the tactical level of the health sector, thereby giving actionable intelligence to the health attaché for the US Department of State as it coordinated with the Iraqi National Ministry of Health.

The partnerships were not just focused on the delivery of tangible medical goods. Tangible goods, although extremely important in terms of demonstrating that Iraq can provide for its own people, are but one of many issues. Partnering with NGOs also involved sharing technical expertise and systems that enhance health promotion and delivery of services. Some of the enduring projects were the creation of three burn centers and a national trauma-training center, with an approximate cost of $2 million. These programs would allow Coalition hospitals to train and share expertise with their Iraqi counterparts while simultaneously developing the capacities of key Iraqi facilities. This will enable the Iraqis to gradually take over healthcare for critical neighborhoods and thus allow Coalition forces to transition out of caring for seriously ill and wounded Iraqi citizens and soldiers. An example of success in the area of Iraqi capacity was evidenced in their ability to "clear" or evacuate their own casualties from operational and civilian areas independent of Coalition evacuation assets. For example, during rotation 05-07, Iraqi medical facilities took over the health "battlespace," increasing the clearing rate from 41% to 81% and caring for casualties directly without the help of the Coalition medical assets, meaning the Iraqis were now clearing 81% of their casualties themselves. Another example of success was the decrease in the "length of stay" of Iraqi military and civilians in US medical facilities. Length of stay was defined as the number of days occupying a bed. In 7 months of capacity building, the length of stay in US beds decreased by an average of 6 days. This significant decrease occurred because Iraqi hospitals could now accept an increased number of patient transfers due to better Iraqi facilities, evacuation assets, and trained providers. Such capacity-building indicators were now being used by the MNC–I surgeon as measures of effect toward operational and strategic goals.

NGOs were well established in all 18 Iraqi provinces and therefore had relationships and credibility with the host nation. Because NGOs are neutral they can reach less approachable members of the health sector in the Iraqi Ministry of Health. NGOs must maintain the appearance of neutrality to be effective; military partnerships with them are less formal and not used as part of a military public affairs campaign. While humanitarian assistance activities make for good photo opportunities, the best public affairs stories come from programs that actually succeed. The worst example of health sector failures are structures that were built by the United States for Iraq, but sit empty or are used for other purposes by the enemy. Such failures can undermine US information operations. Typical focused humanitarian assistance partnership programs in the health sector are successful because the projects involve local contractors and workers, train local officials to staff programs and facilities, and are typically resourced at a degree that the community can maintain with its current level of financial, natural, and human resources. Furthermore, US medical CMO projects were linked to other civil-affairs projects to make them more comprehensive. TF 30's preventive and veterinary assets were heavily involved in sewer, water, electricity, and trash (SWET) projects. When SWET projects augment humanitarian efforts, the insurgency was diminished in those "Beladiyahs," or Iraqi districts. The key lesson learned from the NGO partners is that it takes much more than money and infrastructure development to be successful.

SUMMARY

TF 30 had highly successful civil-military operations and successfully transitioned its operations to the 3rd Medical Command for OIF 06-08. Recognizing the importance of CMO and humanitarian assistance in stability, security, transition, and reconstruction operations, the 3rd Medical Command deployed a more robust CMO capability to capitalize on the successes of TF 30. However, to date very few Army medics are trained in humanitarian assistance, and there is no proponent in the Army Medical Department for medical CMO or humanitarian assistance. The civil dimensions of war must be planned for. To facilitate medical planners' cognizance of the importance of CMO, doctrine and courses must be developed to meet needs of the operational commanders on today's battlefields.

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