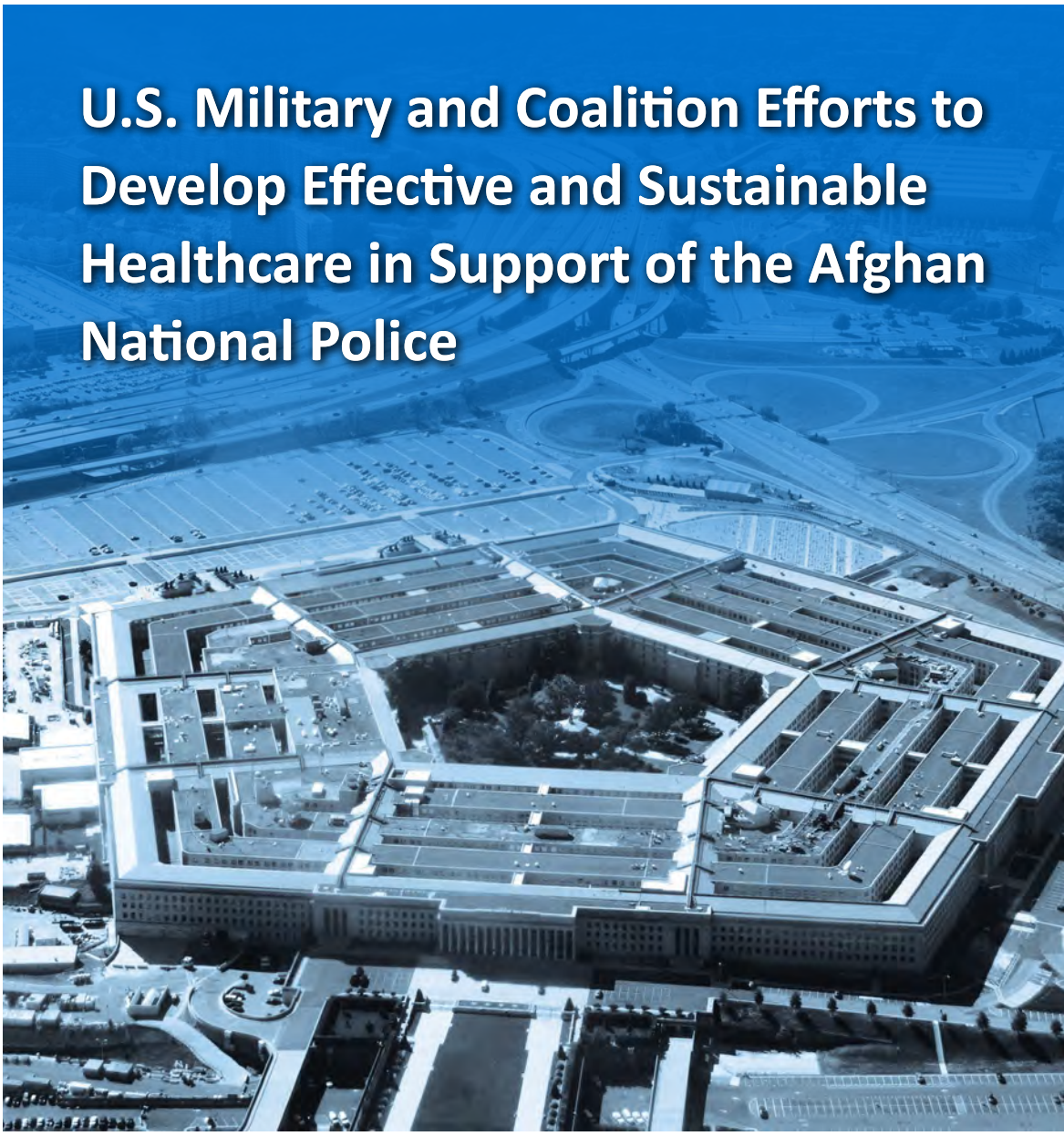
Report No. DODIG-2014-072

INSPECTOR GENERAL

U.S. Department of Defense

MAY 19, 2014

U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police



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Results in Brief

U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police

May 19, 2014

Objective

The overall purpose of this project was to assess the progress of U.S. and Coalition efforts to develop effective and sustainable healthcare in support of the Afghan National Police (ANP). Specifically, we assessed whether the plans to develop effective and sustainable healthcare services for the ANP were comprehensive and implemented to meet the transition timeline. Additionally, we determined whether advisory resources were sufficient and appropriate to support the medical needs of the ANP. Finally, we assessed whether developmental efforts were on schedule and effective in ensuring there was adequate medical capability, including logistics, to provide proper medical support to ANP personnel from the point of injury to the next required level of care.

Observations

The Afghan Air Force is developing the casualty evacuation capabilities utilizing fixed and rotary wing aircraft, C-208 and Mi-17s respectively. We found that significant progress was made by the Afghan Air Force in conducting casualty evacuation this past year with an increased number of casualty evacuations and improved response times.

We found examples of improved cooperation among Government of the Islamic Republic of Afghanistan organizations which have

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Observations (cont'd)

had a positive effect on the development of the Afghan National Security Forces healthcare system and direct medical support to the ANP. Examples include the General Officer Steering Council and cooperation among the ministries regarding the medical care provided to ANP casualties.

However, we found that U.S. and Coalition plans and advisory efforts were not consistently focused on developing the ANP medical capability to provide effective point-of-injury and en route care for combat casualties. Additionally, we found that medical advisory resources were not sufficient or, in some cases, not skilled and trained to aid in the development of ANP medical capability.

We also found that the ANP did not have sufficient medics, nor the necessary medical equipment and supplies, to properly care for injured police personnel. Furthermore, ANP ambulances were not stocked with necessary equipment and supplies and not properly utilized to transport casualties to the next level of care. Additionally, the ANP had not been providing sufficient basic medic training and did not have training programs to develop first-aid training to adequately prepare non-medical police personnel to render effective first aid.

Additional development assistance was needed by the ANP Office of the Surgeon General to provide effective oversight and management of medical activities within the Ministry of Interior. Priority focus on the shortages of medical personnel at the ANP Hospital was needed to support the increasing number of ANP casualties and to ensure there were sufficient pharmacists to provide effective pharmacy operations. Additionally, we found that the ANP medical logistics system was marginally effective and required significant improvement to ensure that medical supplies, including pharmaceuticals, were available as needed for patient care.

Results in Brief

U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police

Recommendations

International Security Assistance Force Joint Command (IJC), North Atlantic Treaty Organization Training Mission–Afghanistan (NTM-A), and Combined Security Transition Command–Afghanistan (CSTC-A) advise and assist the MoI to:

- ensure there are sufficient medics available to provide effective medical support to ANP personnel;
- ensure that ANP have adequate equipment and medical supplies, including first-aid kits, medic first-aid bags, and equipped ambulances, to properly care for the combat injured;
- develop effective and sustainable training programs to produce ANP medics and provide additional first-aid training, including combat lifesaver skills, to non-medical police personnel;
- ensure there are sufficient medical personnel, including pharmacists, at the ANP Hospital to provide effective medical support and well-managed pharmacy operations;
- understand the healthcare limitations at the ANP Hospital and develop patient protocols to identify and transfer those patients whose healthcare needs may require a higher level of care;
- evaluate and improve the medical logistics process for the receipt and distribution of medical supplies; and
- update the Office of the Surgeon General Organization and Functions Manual.

Recommendations (cont'd)

NTM-A/CSTC-A, in coordination with IJC, conduct key leader engagements with Ministry of Interior to ensure that the Surgeon General is provided authority to discharge his responsibilities for the oversight of healthcare services provided to the ANP and for the manning, equipping, and training of ANP medical personnel.

International Security Assistance Force, in coordination with IJC and NTM-A:

- update and distribute medical development plans, and ensure the development of ANP point-of-injury care and patient evacuation remains a top priority; and
- continue to conduct key leader engagements with Ministry of Interior, Ministry of Defense, and Ministry of Public Health to encourage improved relationships and sharing of healthcare resources.

U.S. Central Command (USCENTCOM), in coordination with NTM-A, ensure that medical logistics advisor positions are filled with qualified personnel with the requisite medical logistics experience.

Management Comments and Our Response

USCENTCOM, IJC, and NTM-A provided comments to this report. Management concurred with all but one recommendation; however, their responses did not include what actions they have taken or plan to take to accomplish the recommendations. We request that these commands provide additional comments to the final report specifying any progress made with the recommendations.

Results in Brief

U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police

Comments (cont'd)

USCENTCOM provided a response to Recommendation 8.a explaining that it was critical that the sourcing service and those monitoring personnel assignments pay close attention to the special remarks and job descriptions listed in the Joint Manning or the Request for Forces documents to ensure that Individual Augmentees/service members tasked to these billets have the appropriate skillset to provide guidance to their mentees. Furthermore, USCENTCOM explained that using just the Military Occupational Specialty/Air Force Specialty Code/Naval Officer Billet Classification does not always guarantee that the tasked officer has the required skillset. This recommendation was revised to address USCENTCOM's comments and now includes coordination with the sourcing service to ensure that the ANP medical logistics advisor position is filled with qualified personnel with medical logistics experience.

We did not receive a written response from International Security Assistance Force prior to the publication of the final report and request that they provide their response to Recommendations 6.a and 7.a for the final report. All responses to the final report should be provided by June 20, 2014.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
U.S. Central Command	8.a	
International Security Assistance Force	6.a; 7.a	
International Security Assistance Force Joint Command	1.a, 1.b, 1.c, 1.d; 2.a, 2.b, 2.c; 4.a, 4.b, 4.c, 4.d, 4.e, 4.f; 7.b(1), 7.b(2); 8.c	
NATO Training Mission–Afghanistan (NTM-A)	3.a; 5.a, 5.b, 5.c; 6.b(1), 6.b(2); 8.b; 9.a, 9.b, 9.c, 9.d	3.b

Total Recommendations in this report: 31

Please provide comments by June 20, 2014.

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

May 19, 2014

MEMORANDUM FOR SECRETARY OF DEFENSE
DEPUTY SECRETARY OF DEFENSE
COMMANDER, U.S. CENTRAL COMMAND
COMMANDER, INTERNATIONAL SECURITY ASSISTANCE FORCE/UNITED STATES FORCES-AFGHANISTAN
COMMANDER, INTERNATIONAL SECURITY ASSISTANCE FORCE JOINT COMMAND
COMMANDER, NORTH ATLANTIC TREATY ORGANIZATION TRAINING MISSION-AFGHANISTAN

SUBJECT: U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police (Report No. DODIG-2014-072)

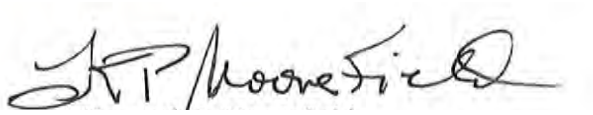
The Deputy Inspector General for Special Plans and Operations is providing this report for your review and use. This report is the fifth in a series of reports that focus on the development of a sustainable medical logistics and healthcare capability in support of the Afghan National Security Forces. We considered management comments to a draft of this report when preparing the final report.

Comments from the U.S. Central Command (USCENTCOM), International Security Assistance Force Joint Command (IJC), and NATO Training Mission-Afghanistan (NTM-A) were partially responsive, as they concurred with our recommendations without describing what actions they had taken or planned to take to accomplish the recommendations. We request that as a follow-up to the final report, USCENTCOM, IJC and NTM-A describe what actions they have taken or plan to take to accomplish their respective recommendations.

The International Security Assistance Force (ISAF) did not provide comments on the recommendations for which they were the Office of Primary Responsibility. We therefore request that ISAF provide comments to those recommendations in response to the final report. The comments should state whether you agree or disagree with the observation(s) and recommendation(s). If you agree with a recommendation, clearly state that you "concur" or "concur with comment" and describe what actions you have taken or plan to take to accomplish the recommendation and include the completion dates of your actions. Send copies of documentation supporting the actions you may have already taken. If you disagree with the recommendations or any part of them, please clearly state that you "non-concur" and give specific reasons why you disagree and propose alternative action if that is appropriate.

Please provide comments that conform to the requirements of DoD Directive 7650.3. If possible, send your comments in electronic format (Adobe Acrobat file only) to SPO@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. We should receive your comments by June 20, 2014.

We appreciate the courtesies extended to the staff. Please direct questions to Mrs. Patricia Goodin at (703) 604-9485 (DSN (312) 664-9485)/ patricia.goodin@dodig.mil, or Mr. David Corn at (703) 604-9474 (DSN (312) 664-9474)/david.corn@dodig.mil. We will provide a formal briefing on the results, if management requests.



Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations

Contents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Introduction

The purpose of this project was to assess the progress of U.S. and Coalition efforts to develop effective and sustainable healthcare in support of the Afghan National Police (ANP). This report provides data and analysis and makes recommendations intended to improve the effectiveness of ANP medical capability to the North Atlantic Treaty Organization (NATO) International Security Assistance Force (ISAF), ISAF Joint Command (IJC), and the NATO Training Mission–Afghanistan/Combined Security Transition Command–Afghanistan (NTM-A/CSTC-A). The report contributes to the ongoing DoD Office of Inspector General (OIG) efforts to assess DoD plans and activities leading to the development of an independent Afghan National Security Forces (ANSF) and the transition of security responsibility for Afghanistan to Afghan lead.

Objective

On April 26, 2013, the DoD OIG announced the assessment of the "U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police," (Project No. D2013-D00SPO-0154-000). The specific objectives were to determine whether:

- plans to develop effective and sustainable healthcare services to the ANP are sufficiently comprehensive, coordinated with the Government of the Islamic Republic of Afghanistan (GIRoA), and being implemented so as to meet the transition timeline;
- advisory resources are sufficient and appropriate in order to develop the healthcare services necessary to support the medical needs of the ANP; and
- developmental efforts are on schedule and effective in ensuring there is adequate medical capability, including logistics, to provide proper medical support to ANP personnel from the point of injury to the next required level of care.

Background

After the overthrow of the Taliban in 2001, U.S. and Coalition forces developed a plan for creating a national security force, to include a military healthcare system. According to NTM-A, the ANSF healthcare system was developed to be an interdependent regional/zone healthcare system focused on the provision of comprehensive medical services to soldiers and policemen. This included basic rehabilitative and neuropsychiatric services designed to return these individuals to duty or assist them with the transition into productive civilian life.

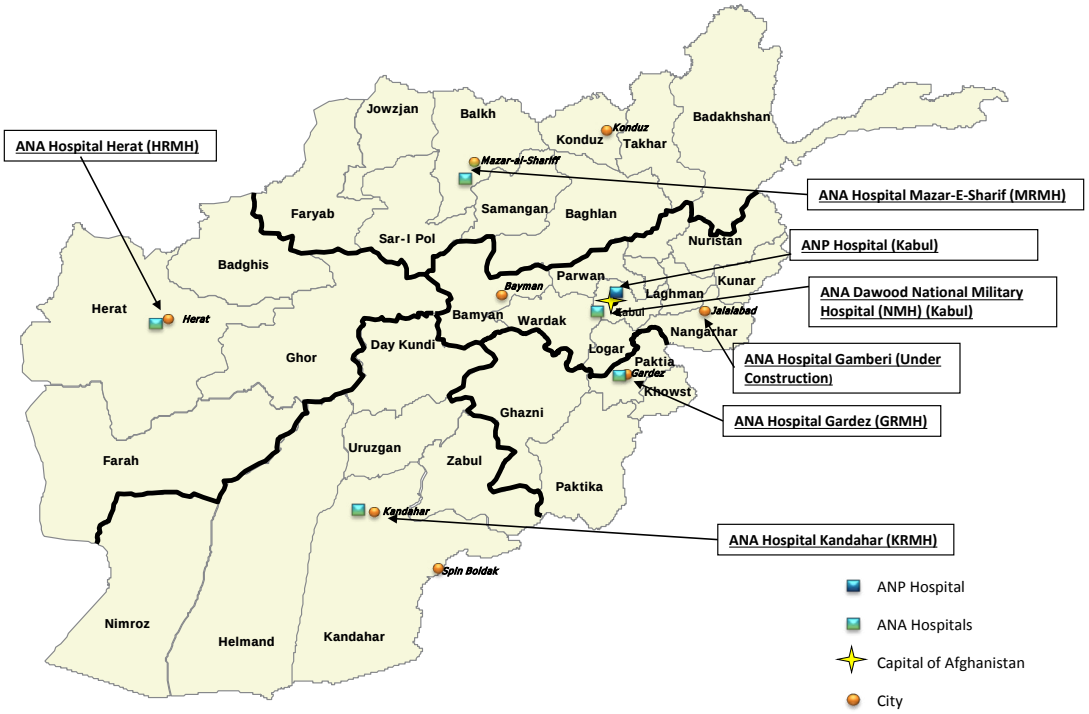
Afghan National Security Forces Casualties

The ANSF are now leading security operations in Afghanistan, which has resulted in a significant increase in casualties, particularly in the ANP. Some reports estimate that the ANP have five times as many casualties as their Afghan National Army (ANA) counterparts. Reducing ANSF casualties and fatality rates is therefore a priority for both IJC and the Ministry of Interior (MoI).

Afghan National Security Forces Healthcare in Afghanistan

Today, there are six Afghan hospitals that support the ANSF. The ANP maintains a single Afghan National Police Hospital (ANPH), a 161-bed facility (recently expanded from a 74-bed facility) in Kabul, the capital of Afghanistan. The ANA has 5 military hospitals: the 410-bed Dawood National Military Hospital in Kabul and 100-bed regional hospitals in Kandahar, Gardez, Herat, and Mazar-e-Sharif. There is a sixth ANA regional hospital under construction in Gamberi, Laghman Province. In addition, by agreement with the Ministry of Public Health (MoPH), ANSF personnel are able to receive initial casualty care at local provincial and district hospitals. These patients, once stabilized, are transferred to either the ANPH or army hospitals for further medical treatment as needed.

Figure 1. Afghanistan National Security Forces Hospitals (Army and Police)



Source: NTM-A

Healthcare Facilities in Support of Ministry of Interior

To support the healthcare requirements of the MoI's police force, there is the ANPH and a 65-bed drug rehabilitation hospital located in Kabul augmented by a system of over 130 clinics located throughout the country. The MoI has 4,825 medical positions on its Tashkil or manpower document, including 387 physicians, 2 physician assistants, 257 nurses, and 1,649 medics. The remaining 2,530 Tashkil positions include medical technicians specialized in laboratory or radiology, for example, and other non-medical support personnel such as clerks and housekeepers.

ANP Hospital

The ANPH is responsible for the medical care needs of up to 157,000 ANP personnel and their families. There are eight wards (General Surgery; Orthopedic; Neurosurgery; Internal Medicine; Recovery; Ladies; Very Important Persons; and Ear, Nose, and Throat) in the hospital, as well as an emergency room with five beds, and one operating suite with two surgical tables. On average, they conduct five surgeries per day.

The following services are provided at the hospital:

- Surgical Services including General Surgery; Orthopedics; Neuro Surgery; Urology; and Ear, Nose, and Throat
- Medical Services including Internal Medicine and Ophthalmology
- Pediatrics
- Dental
- Emergency Care
- Anesthesia
- Physical Therapy
- Laboratory and Blood Bank
- Radiology

The Surgeon General plans to establish an Intensive Care Unit in the expanded hospital to help care for severely wounded combat casualties who require a higher level of care than what the hospital currently has available. In preparation for the opening of the Intensive Care Unit, medical personnel are undergoing training at the Dawood National Military Hospital to give them experience in providing medical care to critically ill patients.

Figure 2. ANP Hospital in Kabul, Afghanistan
Source: NTM-A

ANP Clinics

There are over 130 medical clinics throughout Afghanistan offering medical support to ANP personnel. These clinics are usually co-located or near police headquarters in the provinces and at the ANP training centers. The medical clinics range in size from a single room to facilities with multiple exam rooms. Several of the larger clinics have beds where patients can remain overnight if their medical condition warrants continued observation. Medical personnel assigned to the clinics range from a single medic running a clinic to multiple physicians, including dental and surgical specialists, for the larger clinics.

Medical Advisory Resources

NTM-A was responsible for advising at the ministerial level. At the time of our visit, in June 2013, there were five medical advisors assigned to the Office of the Surgeon General (OTSG). They primarily mentored the OTSG in the following areas: budget and finance, facilities, medical readiness, personnel, plans, and medical logistics. Advising at the ministerial level was expected to remain in place through 2014.

Medical Training Advisory Group

The NTM-A Medical Training Advisory Group (MTAG) was established in November 2009, to provide medical advisors to every regional command and associated ANSF hospital. These U.S. and Coalition military and civilian advisors,

consisting of doctors, nurses, administrators, logisticians, and clinical services support and technical personnel advise and train Afghan healthcare personnel providing care to Afghan sick or wounded on the battlefield, in the operating room, the intensive care unit, on the hospital wards, and at the supply depots. MTAG advisors operate in close partnership with their Afghan counterparts during the performance of their duties.

At the time of our visit, there were eight medical advisors assigned to the MTAG in support of mentoring at the ANPH. As part of the drawdown of U.S. and Coalition forces leading to transition in 2014, the number of advisors at the ANPH decreased to six in October 2013, then three in December 2013. In December 2013, the hospital transitioned to Afghan-lead. As of February 2014, four medical advisors continued to mentor at the OTSG level. Additionally, NTM-A formed a Multi-Function Advisory Team (MFAT) to provide advisory support to the hospital, if required. This team has seven members who are medical subject matter experts and deploy to any ANSF medical facility to address targeted deficiencies.

Medical Advising at the Police Unit Level

IJC was responsible for medical advising at the regional level. Regional Commanders used Security Force Assistance Advisory Teams (SFAAT) to cover advisory duties within specific police units. Although not their primary job, the medic or other medical personnel assigned to the SFAAT were responsible for assisting in the development of ANP clinics in their geographic area of responsibility.

Afghan National Police Forces

The ANP conducts operations in 34 provinces of which 12 are considered high threat areas where daily combat is occurring against terrorist forces. According to NTM-A, the ANP is conducting more "military-like" operations than a traditional police force, without the advantage of having the equipment and training provided to the ANA. According to the Afghan National Police Strategy, "terrorist tactics focus predominately on the police rather than the international military and ANA." Consequently, the ANP continue to suffer significantly higher number of casualties than the ANA and have limited medical capability and casualty evacuation capacity to support operations in remote locations. Additionally, with the drawdown of U.S. and Coalition forces and their subsequent reduction in air casualty evacuation, police casualties are being transported by the Afghans using ground transportation, such as pickup trucks and in some cases ambulances, with either no, or limited medical care provided at the point of injury or en route to a hospital.

The end-strength objective for the ANP is 157,000 personnel, of which 150,588 positions had been fielded as of January 2014. The police force is responsible for maintaining civil order and law enforcement. Specifically, their responsibilities include:

- combatting crime and disorder (including terrorism and illegal armed activity);
- preventing the cultivation, production, and smuggling of narcotics;
- fighting corruption; and
- ensuring the sovereignty of the state and protecting its borders.

Organizationally, the GIRoA police forces reside under the MoI Deputy Minister of Security. These forces are composed of various types of activities in support of policing responsibilities, referred to as "Police Pillars." Appendix D contains a listing and description of each of the police pillars.

This assessment focused on the healthcare capability for three of the ANP pillars; specifically, Afghan Uniformed Police (AUP), Afghan Border Police (ABP), and Afghan National Civil Order Police (ANCOP). Their respective roles and missions are as follows:

- **Afghan Uniform Police:** Maintain rule of law, adapting an intelligence-based policing model. Consists of the ANP Regional Zones, the Traffic Police, and the Fire and Rescue Department.
- **Afghan Border Police:** Secure and safeguard national borders and maintain security in the Border Security Zone that extends 50 kilometers into the territory of Afghanistan.
- **Afghan National Civil Order Police:** Maintain the rule of law and order utilizing proportionate armed capability. The lead police organization in counter insurgency operations.

Part I

Notable Progress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Working Towards Transition

A priority goal of ISAF is to successfully transition security responsibility to the GIRoA by the end of 2014. The continued development of an effective ANSF healthcare system, among other enabler[1] functions, is critical to achieving a successful transition by 2014, and sustaining independent ANSF operations after 2014. Through the efforts and leadership of ISAF, IJC, and NTM-A/CSTC-A working at all levels of the Ministry of Defense (MoD), MoI, and MoPH, progress has been made in laying the foundation for building an effective ANSF healthcare system including at the ANPH.

Afghan National Security Forces Hospital Healthcare Standards and NTM-A Healthcare Validation Team

In 2010, NTM-A/CSTC-A awarded a contract to *CURE International*, a non-governmental organization, to develop healthcare standards for specific GIRoA hospitals. These standards, referred to as the "ANSF Healthcare Standards," were finalized in 2012 and were based on a "tiered" approach, where successive tiers represented a graduated measurement of capabilities, based on defined standards and criteria. Specifically, Tier 1 standards demonstrated functions of a basic, self-sustaining healthcare system; Tier 2, a self-sustaining healthcare system with limited advanced capabilities; and Tier 3 standards represented advanced capabilities and included criteria for credentialing and advanced certifications. ANSF medical leaders refer to these healthcare standards to focus their efforts as they work to improve their hospitals and the medical care provided to the ANSF.

In December 2011, NTM-A developed a survey tool, hereafter referred to as the "Validation Tool," to measure a hospital's performance and compliance with Tier 1 of the established ANSF Healthcare Standards. Beginning in December 2011, the NTM-A Healthcare Validation Team conducted periodic visits to ANSF hospitals, including the ANPH, and used the Validation Tool to assess the level of compliance by individual hospital departments. Coalition advisors use the ANSF Healthcare Standards and the results of the Healthcare Validation Team's inspections to guide and prioritize their mentoring and advising efforts within ANSF hospitals.

[1] "Enablers" are focused on providing ANSF with capabilities to enable them to operate autonomously, including operation and sustainment of a combined arms force. Examples of enablers are command and control, aviation, intelligence, signal, special operations forces, medical support, explosive ordinance disposal/counter improvised explosive disposal, and logistics. See "Planning for the Effective Development and Transition of Critical ANSF Enablers to Post-2014 Capabilities Part I - Afghan National Army Enabler Description," (Report No. DODIG-2013-129), September 20, 2013, for additional detail on enablers.

Capability Milestone Ratings and Readiness to Transition

The scores derived from the NTM-A Validation Tool are compiled into a metric that is used to determine a capability milestone (CM) rating for each area assessed, as well as an overall CM rating for the hospital. The CM ratings range from CM-1A to CM-4 and are based on the level of current capabilities. The CM ratings serve as a forecast as to when the hospital will most likely be ready to transition to Afghan-lead. Specifically, a rating of CM-1B is the required transition decision point and indicates that a hospital is capable of executing functions with Coalition oversight only. The end-state goal for the hospital is to achieve a CM-1A rating, indicating that the hospital is "capable of autonomous operations."

Table 1 lists the transition status for all ANSF hospitals and includes the dates identified for visits by the NTM-A Healthcare Validation Team.

Table 1. Status of Transition for ANSF Hospitals

Transition of ANSF Hospitals		
Afghan National Security Forces' Hospital	**Transition Date**	**Healthcare Validation Team Post-Transition Visit**
ANA Regional Military Hospital—Mazar-e-Sharif	30-Jun-13	August 2013
ANA Regional Military Hospital—Gardez	30-Jun-13	September 2013
ANA Regional Military Hospital—Herat	30-Jun-13	September/October 2013
ANA Regional Military Hospital—Kandahar	30-Sep-13	November/December 2013
ANA National Military Hospital—Kabul	30-Sep-13	December 2013
ANP Hospital—Kabul	31-Dec-13	March 2014

Source: NTM-A

Progress Noted in Capability Milestone Ratings at Afghan National Police Hospital

NTM-A conducted its first inspection of the ANPH using the Validation Tool in December 2011 and rated the hospital as CM-3, which indicated that the hospital required significant Coalition assistance to accomplish its mission. Subsequent inspections were conducted in May 2012, February 2013, and May 2013 resulting in progression to a CM-1B rating "capable of executing functions with Coalition oversight only."

In September 2013, the NTM-A Healthcare Validation Team conducted a pre-survey focusing on departments that did not achieve a CM-1A rating in May 2013. The overall rating achieved in September 2013 was CM-1B. Although progress was noted in various areas, additional effort was required in developing standard operating procedures, improving staff training and continuing education, and better written documentation for the provision of medical care to include current and thorough patient progress notes written by physicians and nurses. See Table 2 for a comparison of the CM ratings for the various departments within the ANPH.

The hospital successfully transitioned to Afghan-lead in December 2013. NTM-A stated that they would continue to assist ANPH and ANA hospitals post-transition using a MFAT. This team would consist of a group of subject matter experts (Coalition and Afghan) who will conduct follow-up visits 60 to 90 days post-transition. This team will also be used to deploy to a healthcare facility to address targeted deficiencies or problematic processes.

Table 2. ANPH Departmental Capability Milestone (CM) Ratings for 2011-2013

ANP Hospital	Dec-11	May-12	Feb-13	May-13	Sep-13
Anesthesia	CM-2B	CM-1B	CM-2A	CM-2A	CM-1A
Biomedical Repair	CM-4	CM-2B	CM-1A	CM-1A	NA
Blood Bank	CM-2A	CM-1B	CM-1B	CM-1B	CM-1B
CSSD	CM-3	CM-2A	CM-1B	CM-1A	NA
Dental	CM-4	CM-1B	CM-1A	CM-1A	NA
Emergency	CM-3	CM-2A	CM-2A	CM-1B	CM-1A
Facilities Management	CM-3	CM-2B	CM-1B	CM-1B	CM-1B
Human Resources	CM-2B	CM-2A	CM-1A	CM-1A	NA
Infection Prevention	CM-3	CM-1B	CM-2B	CM-2A	CM-1B
Internal Medicine	CM-2B	CM-1A	CM-1B	CM-1A	CM-1A
Laboratory	CM-1B	CM-1B	CM-1A	CM-1A	NA
Leadership Council	CM-2B	CM-1A	CM-1A	CM-1A	NA
MEDLOG	CM-2B	CM-1B	CM-1B	CM-1B	CM-2A
Nursing	CM-2B	CM-1B	CM-2A	CM-2A	CM-2A
Operating Theater	CM-3	CM-2A	CM-1B	CM-1B	CM-1A
Outpatient	CM-2B	CM-1A	CM-1B	CM-1B	CM-1B
Patient Administration	CM-2A	CM-1A	CM-1B	CM-1A	NA
Pharmacy	CM-3	CM-2A	CM-1B	CM-1A	NA
Physical Therapy	NA	CM-2A	CM-1B	CM-2A	CM-1B
Preventative Medicine	CM-2B	CM-1B	CM-2A	CM-1A	NA
Radiology	CM-3	CM-1B	CM-2A	CM-1B	CM-1B
Surgery	CM-2B	CM-1B	CM-1B	CM-1A	NA
Ultrasound	NA	NA	CM-1A	CM-1A	NA
OVERALL RATING	**CM-3**	**CM-2A**	**CM-1B**	**CM-1B**	**CM-1B**

Color-Coding is based on the level of Capability Milestone Rating with red as the lowest level of CM-4; Orange as CM-3; Yellow as CM-2B; and variations of green for CM-2A, CM-1B, and CM-1A. White are areas not evaluated by the Healthcare Validation Team. CM-1B is the transition decision point.

CM-4 indicates the institution cannot accomplish its mission.

CM-3 indicates the institution cannot accomplish its mission without significant Coalition assistance.

CM-2B indicates the institution can accomplish its mission but requires some Coalition assistance.

CM-2A indicates the institution is capable of executing functions with minimal Coalition assistance.

CM-1B indicates the institution is capable of executing functions with Coalition oversight only.

CM-1A indicates the institution is capable of autonomous operations.

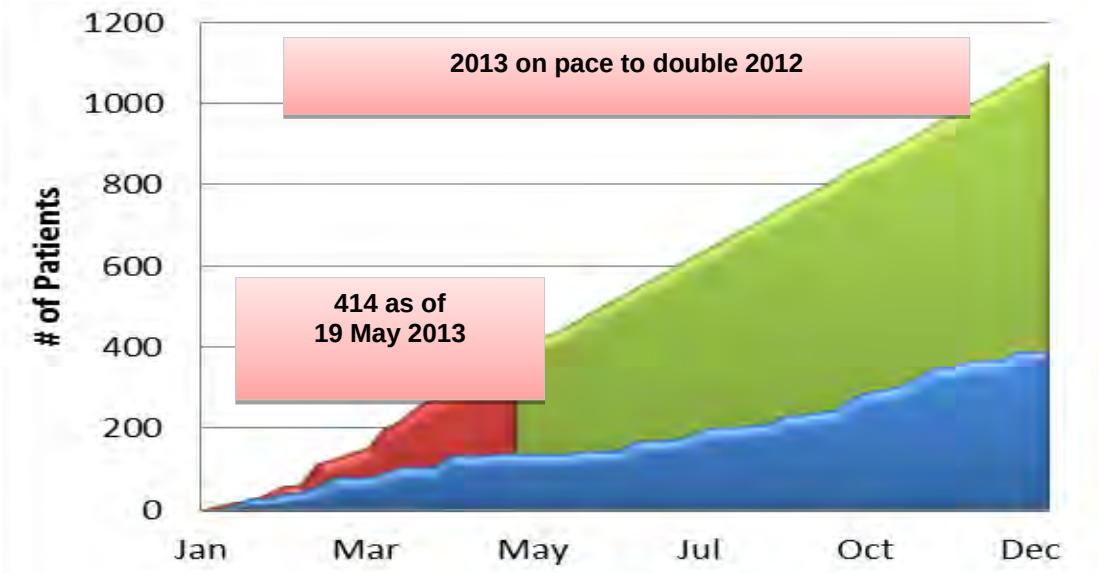
Source: NTM-A

Afghan Air Force Casualty Evacuation

The ability to quickly transport combat casualties from the point of injury to more definitive medical care is critical for the effective treatment and survival of the injured. With the drawdown of U.S. and Coalition forces, there is a commensurate reduction in the ability to evacuate casualties by air. In response, NATO Air Training Command–Afghanistan (NATC-A) was working with the Afghan Air Force (AAF) to develop the capability to transport casualties using C-208 and Mi-17 aircraft.

We found that significant progress was made by the AAF in conducting casualty evacuation (CASEVAC) this past year. Specifically, the AAF increased air CASEVAC missions by 139 percent from 192 missions during the first quarter of 2013 to 460 in the second quarter. Additionally, the AAF improved their response time from 72 hours to less than 3 hours.

Figure 3. AAF Casualty Evacuation Movements



Source: NATO Air Training Command–Afghanistan
Green: Projected CASEVAC mission at current OPTEMPO from 19 May 2013 - 31 Dec 2013.
Blue: 329 total CASEVAC flight in 2012.
Red: 414 CASEVAC from 1 Jan - May 19, 2013.

This critical capability was not specific to one location, but occurred throughout the country as various AAF units received the necessary equipment and training to conduct CASEVAC missions. At the time of this assessment, CASEVAC missions were being conducted by the AAF at Kabul, Shindand, Kandahar, Herat, Jalalabad, and Mazar-e-Sharif.

Additionally, the AAF, with assistance from NATC-A, developed an AAF flight medic course to prepare AAF medics to conduct CASEVAC missions. This course is 2-weeks long with the first week spent in the classroom learning flight physiology and the second week practicing clinical skills on the flight line.

Figure 4. Mi-17 Casualty Evacuation Mission
Source: NTM-A

The first flight medic course was conducted in April 2013, at the 438 Air Expeditionary Wing in Kabul. It graduated 17 AAF personnel to serve as flight medics and assist in the care of ANSF casualties.

The AAF Surgeon General cited the importance of the development of an effective air CASEVAC capability: "Before, we relied on ISAF for CASEVAC support. But now, with the steps that the Afghan Air Force has taken, we've been able to continuously improve our own CASEVAC procedures," and "we are beginning to be able to rely on ourselves more and more." As the Afghans assume the lead for security operations in Afghanistan, the efforts by the AAF to develop an effective air CASEVAC capability will help to save lives and be key to maintaining ANP effectiveness.

Cooperation Among GIRoA Organizations

U.S. and Coalition advisory efforts have led to improved cooperation among the various Afghan ministries. This increased cooperation among GIRoA organizations had a positive effect on the development of the ANSF healthcare system and direct medical support to the ANP. One such example was the General Officer Steering Council (GOSC), a forum where medical leaders from MoD, MoI, and MoPH meet to discuss common problems and issues related to the healthcare capabilities and medical services available for the ANSF. Previously, the topics of discussion for these meetings were coordinated by ISAF medical personnel. However, now the Afghans have taken the lead, developed the agenda, and coordinated the various presentations.

Figure 5. Afghan-led General Officer Steering Council, May 29, 2013—Camp Eggers, Kabul
Source: NTM-A

We observed the first Afghan-led GOSC in May 2013. Both the ANA and the ANP Surgeons General attended the meeting, as well as a senior representative from the MoPH. The major topic for discussion was medical logistics, which we found was a significant challenge for these organizations. The meeting was well-organized, informative, and clearly run by the Afghans. At the end of the meeting, there was a strong sense of professional satisfaction among the various Afghan attendees. Planning for future topics included discussion and support for the development of an Inter-Ministerial Council which would focus on national and international cooperative efforts to reduce the casualty rate for security forces and civilians.

Figure 6. ABP Medical Officer with ANA Hospital Commander at Paktiya Regional Military Hospital
Source: DoD IG-SPO

Increased cooperation among the ministries was also evident regarding the medical care provided to ANP casualties. The MoPH made its medical facilities available to treat casualties, and we did not hear any complaints that ANP patients had been turned away. Additionally, we were informed by ANA medical leaders at the Army's regional hospitals that policemen received care at their facilities and there was no difference in the medical care that was provided to soldiers and policemen. Furthermore, we spoke with ANP patients, several of whom were undergoing treatment at an ANA hospital, and they indicated that they were generally satisfied with the medical care that they received.

Part II

Challenges


INSPECTOR GENERAL
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Observation 1

Point-of-Injury Care

ANP personnel were unable to render effective point-of-injury care (self-aid and buddy-aid).

This occurred because the majority of police personnel did not have individual first-aid kits available when conducting security operations. Neither did they have access to tourniquets and pressure dressings necessary to stop blood loss from injuries incurred on the battlefield.

Additionally, although 10 hours of first-aid training was included in the ANP Basic Patrolman Course, not all policemen had attended this training and therefore lacked basic life saving measures.

Furthermore, there was little evidence of a training program to improve or sustain the effectiveness of individual first-aid skills.

As a result, ANP policemen were unable to provide effective care for injured personnel, which may result in increased mortality and have a demoralizing effect on ANP personnel.

Applicable Criteria

(See Appendix C, number 13, 14, and 17, and for additional details.)

Afghan National Police Training General Command, Afghan National Police Initial Police Training Course Overview, v2.0, dated July 2012.

Afghan National Police Training General Command, Non-Commissioned Officer Eight Week Police Course Overview, dated February 2010.

Afghan National Police Training General Command, Operations Training for the Fielded Force, v1.2, dated April 2012.

Discussion

The ANP were unable to conduct effective point-of-injury care (self-aid and buddy-aid) due to the lack of appropriate medical supplies and training. Individual Afghan

First-Aid Kits (AFAKs) were lacking, and first-aid refresher training and combat life saver training was inadequate or not provided at all. At the ministerial level, it was believed that the ANP personnel had the required equipment and training. Nevertheless, approximately 20,000 police personnel had not attended the initial police training course (IPTC), and therefore they had no first-aid training. Furthermore, we found an insufficient number of ANP medics on the battlefield (see Observation 2 for the discussion of ANP medics), thus the reliance on point-of-injury care consisted mainly of self-aid and buddy-aid.

Afghan First-Aid Kits

According to NTM-A, the AFAK is an organizational clothing and individual equipment[2] item intended to be issued to the ANP once they completed their initial training. However, during our visit, we could not find evidence of the AFAK being issued to ANP upon completion of their training. Inside the AFAK pouch, there are three items: a nasopharyngeal airway tube,[3] tactical tourniquet, and trauma wound dressing (pressure bandage). In visits to the ANP Regional Training Command in Kandahar and a Provincial Headquarters Clinic in Mazar-e-Sharif, the police were able to produce AFAKs in storage which contained the three items. However, we were unable to locate AFAKs at the remaining 10 clinics we visited in Kabul, Paktiya, Nangahar, Kandahar, and Balkh Provinces.

During our assessment, we interviewed ANP casualties from various police pillars[4] who, when injured, did not receive self-aid because neither they nor their unit had AFAKs. During our interviews, injured policemen reported that they often did not receive any initial first-aid treatment but, instead, were put into the first vehicle that was available and transported to the nearest medical facility.

The lack of AFAKs may be due to the lack of sufficient attendance in the IPTC or refresher (sustainment) training. Although several MoI and ANP leaders we interviewed believed that saving lives was important and that the police force had adequate medical equipment and training, this was not substantiated by our observations in the field.

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[2] Standardizing ANSF organizational clothing and individual equipment approval documents include the ANP Basis of Issue Plan, dated October 21, 2007. The plan includes seasonal clothing, winter clothing, physical training clothing, individual equipment (inclusive of the AFAK), unit specific items, and unit controlled items.

[3] Nasopharyngeal airway tubes are designed to be inserted into the nasal passageway to secure an open airway; this is seen typically with a semiconscious patient not tolerating an oral airway.

[4] The Ministry of Interior's Afghan National Police is comprised of various types of police organizations referred to as pillars including the Afghan Uniform Police (AUP), Afghan National Civil Order Police (ANCOP), and Afghan Border Police (ABP). See Appendix D.

Figure 7. Contents of an Afghan First-Aid Kit at the Provincial Headquarters AUP Clinic, Mazar-e-Sharif
Source: DoD IG-SPO

In Kabul, MoI leaders asserted that every policeman had one AFAK and each medic had three AFAKs, while ANCOP and ABP leaders in the provinces reported that not all their police had AFAKs. An ABP Zone Commander justified his policemen not having first-aid kits by reasoning that his medics had those items available to them when they conducted operations, indicating a poor understanding of the basic field requirement for point-of-injury care. A senior medical subject matter expert in Kandahar responsible for the oversight of ANP medical development had seen firsthand only about 30 AFAKs. Realizing that there were not enough AFAKs for each patrolman, the U.S. and Coalition advisors worked with the ANP to order them. Additionally, subsequent to our visit, IJC and NTM-A began to track the number of AFAKs for all police pillars and was working with MoI to improve the availability of AFAKs to the ANP.

Police Training

There were a significant number of policemen who had not attended the IPTC (see Table 3.) In accordance with the description of the IPTC course, new police recruits received 10 hours of basic first-aid training and other first responder topics such as "Handling a Dispute," "Post Blast Scene Management," and "Traffic Collision." After the IPTC, the new patrolman should be able to administer first-aid to injured policemen with life threatening injuries.

Table 3. Patrolmen Numbers Untrained (non-commissioned officers not included)

Untrained Afghan National Police as of August 2013			
ANP Pillar	**Patrolmen (PM) Untrained**	**Patrolmen Tashkil**	**Percent Untrained**
AUP	15,058	59,318	25%
ABP	2,592	14,565	18%
ANCOP *	4	10	40%
Total PM	**17,654**	**73,893**	**24%**

*ANCOP personnel are primarily non-commissioned officers (NCOs) and attend a specific NCO course for their entry-level police training. This chart only includes the number of basic patrolmen under the level of NCO.

Source: NTM-A

However, one in four patrolmen had not received their initial police training, and thus many were untrained in basic life-saving measures. At the time of our visit, NTM-A and IJC asserted they were working with MoI to reduce the number of "untrained" police personnel. Ensuring that personnel receive initial police training, to include 10 hours of basic first-aid training, would help improve the ANP's ability to provide first aid at the point of injury.

The Commandant at the ANP Training General Command (TGC) asserted that the first-aid training the police received in the basic or non-commissioned officers (NCO) courses was not enough; they also needed additional refresher or sustainment training. Additionally, he stated that unit-level commanders were responsible for conducting sustainment or refresher training. Each Provincial Chief of Police had a training unit to assist his commanders with this critical task and a training director to focus on various specialty and refresher training requirements for units in the province. There were 34 ANP training units, one in each of the 34 provinces. The training units had copies of the programs of instruction and required training material, including first-aid refresher. However, the Commandant was informed by policemen in the field that the refresher training was not being conducted. In response, the NTM-A was working with the ANP TGC Commandant and the Provincial Chiefs of Police and various police commanders to ensure that a viable refresher training program, to include first-aid skills, was implemented.

Additional Medical Training Available to the Police

There were a limited number of police medics available at the point of injury. Providing additional medical training to non-medical police personnel would increase their ability to provide first aid at the point of injury. During our assessment, we observed limited evidence of this type of training being offered to the various police units. Courses on combat life-saver skills were provided by some police

units usually through the efforts of the IJC advisory teams. The courses were taught by Coalition forces, contractors, non-governmental organizations, and the police pillars of the ANSF. However, these individual courses were not standardized nor approved by the MoI.

Listed below are some of the first-aid courses that were conducted and offered at varied police units:

- "Combat Lifesaver Skills (CLS) Training" (Coalition forces/2 days) AUP basic combat lifesaving procedures;
- "Combat Life Support Course," (Contractor/3 days), the course is made available to the AUP, ANCOP, ABP, and any other MoI ANP unit;
- ABP "CLS Class" (4 days); and
- International Committee of the Red Cross (ICRC) "First-Aid Training" (NGO/3 days), AUP, and ALP training.

Figure 8. A Security Forces Assistance Team Medic Providing CLS Training to AUP Personnel at Provincial Headquarters
Source: IJC

Subsequent to our visit, IJC assisted MoI and MoD to develop a standardized combat lifesaver course curriculum, which was piloted in late fall of 2013. As of February 2014, the ANSF intend to provide courses at 11 Afghan Regional Training Centers. On the battlefield, trained ANP medical personnel had only limited ability to provide immediate medical care at the point of injury. Within the United States Army, the combat lifesaver course was developed as a bridge between the self-aid/ buddy-aid (first-aid) training given to all soldiers during basic training and the medical training given to the combat medic. The combat lifesaver is a nonmedical soldier who can provide lifesaving measures as a secondary mission as his/her primary (combat) mission allows.

Figure 9. Security Forces Assistance Team Providing Train-the-Trainer Combat Lifesaver Course at AUP Reserve Kandak in Qalat, Zabul Province (April 1-3, 2013)
Source: IJC

Adequate first-aid training and combat life-saver skills are crucial to the ANP, given the increasing number of casualties sustained and the limited number of medical personnel on the battlefield.

Conclusion

The AUP, ANCOP, and ABP's lack of basic first-aid kits and basic first-aid training resulted in an inability to render effective point-of-injury care to their fellow policemen and to themselves. Commanders need to train their personnel so they are proficient with basic life-saving skills. This will not only save lives, but improve morale by showing ANP personnel that, if injured, there will be trained individuals available to provide effective first aid. With ground evacuation as the primary means of patient transport and the long distances required to get the injured to a medical treatment facility, implementing effective basic first aid at the point of injury is critical to saving lives.

Recommendation, Management Comments, and Our Response

Recommendation 1

International Security Assistance Force Joint Command, in coordination with the North Atlantic Treaty Organization Training Mission–Afghanistan and Combined Security Transition Command–Afghanistan, advise and assist the Afghan Ministry of Interior and Afghan National Police to:

a. Develop a policy for the issuance and use of Afghan First-Aid Kits that includes provisions for the procurement, distribution, issuance, and replenishment of the first-aid kits.

b. Provide oversight to ensure that Afghan National Police personnel have the appropriate medical supplies, including an Afghan First-Aid Kit, to effectively render first aid during police operations.

c. Identify the population of untrained police and ensure these individuals are afforded first-aid training to include the use of an Afghan First-Aid Kit.

d. Develop additional trauma training which is beyond the 10-hour basic first-aid course offered to non-medic personnel in basic training, such as Combat Lifesaver Skills.

International Security Assistance Force Joint Command

IJC concurred with recommendations 1.a, 1.b, 1.c, and 1.d without any additional comments.

Our Response

The response from IJC was partially responsive. While concurring with each recommendation, IJC did not specify what actions it had already taken or planned to take for implementing the recommendations. We request that IJC provide an update within 60 days after the issuance of the final report describing what actions it has already taken or plans to take for implementing each recommendation.


INSPECTOR GENERAL
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Observation 2

Afghan National Police Medics

The ANP did not have sufficient medics deployed to provide medical care to injured policemen at the point of injury. Additionally, these medics did not have the proper equipment to conduct effective life-saving measures.

This occurred, in part, because the ANP Tashkil authorization for medics was inadequate given the increase in ANP casualties, and MoI and ANP leaders did not understand or accept that medical care being provided was inadequate.

Furthermore, some medics, once trained in the 8-week medic course, were being reassigned to other positions and were not available to support ANP field operations.

Further complicating matters, trained medics had not been issued medical bags with the required equipment and medical supplies to provide effective first aid to ANP casualties.

The lack of medics and insufficient medical equipment has resulted in situations where injured policemen did not receive the necessary treatment in a timely manner, leading to increased suffering and mortality.

Applicable Criteria

(See Appendix C, number 9, 10, and 11, for additional details.)

Solar Year 1391 Tashkil. Provides Ministry of Interior-authorized personnel information for Solar Year 1391 (equivalent to mid-2011 through mid-2012). Includes an authorized listing of personnel positions identified by job-type and sorted into specific police units.

Solar Year 1392 Tashkil. Provides Ministry of Interior-authorized personnel information for Solar Year 1392 (equivalent to mid-2012 through mid-2013).

Tashkil Order of the Ministry of Interior of GIRoA – Number 51, Dissemination and Implementation of MoI 1392 Tashkil, received April 13, 2013.

Discussion

ANP medics are police personnel who have successfully completed an 8-week Trauma Assistance Personnel (TAP) course. These individuals play a vital role in providing medical support to ANP casualties from the point of injury to patient transport to the next level of medical care. Since the ANSF assumed the lead for security operations in the summer 2013, the casualty rate for the ANSF has increased dramatically, especially for the police units patrolling the streets and protecting the borders. Consequently, it is imperative to have an adequate number of trained medical personnel with the appropriate medical equipment to properly care for these casualties.

In June 2013, we visited several AUP, ABP, and ANCOP headquarters and their associated medical clinics, in northern, eastern, and southern Afghanistan. During these visits, we spoke with senior police leaders, ANP medical personnel, and Coalition advisors to determine the extent to which the ANP were capable of providing effective medical care at the point of injury. Our sources confirmed that in most cases the ANP did not have sufficient numbers of trained medics available with the necessary medical equipment to treat casualties and were therefore generally unable to provide the medical care needed.

Tashkil (ANP Personnel Positions)

The Tashkil is an official GIRoA document that is updated annually and includes an authorized listing of the required number of personnel by position and rank. It is similar to what the United States Army refers to as a table of organization and equipment, and is delineated by unit type. It also provides the required quantity of equipment by unit and type. In accordance with ISAF plans to support the development of the MoI and transition to Afghan-lead, the Solar Year (SY) 1392 Tashkil and Tashkil database were produced by MoI with NTM-A support. This was the first time MoI took the lead in developing the Tashkil, and their further development of that plan will be an ongoing responsibility.

Table 4 lists the number of authorized medics by police pillar and ratio of medics per policemen. For SY 1392, the ratio of medic-related positions to total number of policemen per police pillar was: AUP 1:297, ABP 1:25, and ANCOP 1:55. In comparison, the ratio for ANA was 1 medic for 16 soldiers. The ANA intends to increase the number of medics per company to 15, which will result in a ratio of ANA medics to soldiers of 1:8. There are no established standards to determine the appropriate number of medics to support police operations. However, given the higher

ANP casualty rate, which is reportedly five times higher than the ANA's, the ANP appeared to be deficient in the number of medics to ANP personnel.

Table 4. List of Medics by Pillar and Ratio of Medics per Policemen

Type of Medics	Solar Year 1391 Tashkil - Authorized				Solar Year 1392 Tashkil - Authorized			
	AUP	ABP	ANCOP	SUM	AUP	ABP	ANCOP	SUM
Ambulance Driver / Medical Technician	2	87	97	186	-	93	92	185
Deputy Squad Leader / Medic	10	90	-	100	10	-	-	10
Driver / Medical Technician	1	-	-	1	1	-	-	1
Evacuation Sergeant	67	-	-	67	2	-	-	2
Medic	-	-	54	54	27	7	14	48
Medic / Driver	296	134	-	430	250	-	-	250
Medical Clinic NCOIC	1	-	-	1	1	-	-	1
Medical Clinic Sergeant	1	-	-	1	1	-	-	1
Medical Sergeant	-	134	12	146	2	-	63	65
Medical Technician	6	-	-	6	-	-	-	-
Platoon Sergeant / Medic	-	-	309	309	-	-	9	9
Special Weapons Police Officer / Medic	-	-	1,181	1,181	-	-	89	89
Squad Commanders / Medic	-	804	-	804	-	834	-	834
Police Medic, Pillar Total	384	1,249	1,653	3,286	294	934	267	1,495
Tashkil Auth., Pillar Total	85,367	23,090	14,541	122,998	87,401	23,435	14,588	125,424
Medic : Police	1 : 222	1 : 18	1 : 9	1 : 37	1 : 297	1 : 25	1 : 55	1 : 84
	SY1391 Tashkil - Authorized				SY1392 Tashkil - Authorized			

Source: NTM-A

As noted in Table 4, SY 1392 reflected a significant reduction in the number of ANP authorized medics from SY 1391. An NTM-A senior medical advisor asserted one reason for this decrease was the redistribution of police personnel after the disestablishment of the AUP police zones.[5] The total number of police personnel did not decrease with the re-organization of the police zones; however, the number of medic positions for the AUP, ABP, and ANCOP police pillars decreased by more than half to a total of 1495 in SY 1392. NTM-A could not explain why the number of

[5] The disestablishment of the police zones occurred at the beginning of Solar Year 1392 (March 21, 2013). The Tashkil of the six regional zones were dissolved and reorganized into the Tashkil of the six Type A Provincial Headquarters (Herat, Kandahar, Helmand, Nangahar, Paktiya, and Balkh).

police medic positions decreased from SY 1391 to SY 1392; however, they were working with MoI to conduct an accounting of these positions.

Subsequent to our visit, the ANP Surgeon General, with the assistance of NTM-A, prepared his SY 1393 Tashkil request. The Surgeon General calculated the number of medics required based on the type and size of the police headquarters and associated medical clinics. He concluded that an additional 370 ANP medic positions were required for SY 1393. NTM-A was working with the ANP Surgeon General to prepare his defense to MoI for the additional medic positions. Additionally, NTM-A planned to assist the Surgeon General to determine and prioritize the work locations for the additional medics once the Tashkil was approved.

Trained ANP Medics Removed From Medic Positions

Coalition forces have advised senior ANP leadership to assign policemen who completed the 8-week TAP training program into the appropriate medic slots on the Tashkil. However, we were informed of several situations where TAP-trained individuals were re-assigned to conduct non-medical duties, such as the police commander's driver. One medical officer from a combined AUP/ANCOP medical clinic reported that 50 percent of his assigned medics were not working in his clinic and were posted elsewhere by the police unit commander. This practice contributed to the shortage of ANP medics and negatively impacted the medical support available for treating ANP casualties. IJC police and medical advisors explained that police commanders believed that police personnel who completed the TAP training course were literate and more desirable to fill administrative positions supporting the police commander than working in a clinic. The advisors continued to work with police leadership to ensure that TAP-trained personnel were placed in medic Tashkil positions and remained working in police medical clinics.

The ANP Surgeon General was aware of this problem. He previously sent out a cipher[6] to police units explaining the importance of a medic in units and directing that medics should be retained in their authorized positions. However, he did not have the authority to direct police commanders to comply. NTM-A was working with the Surgeon General and MoI to improve the utilization of trained medics.

[6] A cipher is an Afghan written order.

Medical Equipment for Trained ANP Medics

Previously, NTM-A provided first-aid bags to medics who completed the TAP training program. The ANP Office of the Surgeon General has now assumed this responsibility but was having difficulty supplying medic bags to TAP graduates. Specifically, a large order for TAP medic bags was placed by MoI early in 2013; however, the vendor who supplied the bags did not have the proper license to sell medical supplies, and Afghan customs officials prevented the release of the items once they arrived in country. As a result, ANP medics who graduated from TAP after October 2012 were not issued appropriate medic bags. NTM-A is currently coordinating with the OTSG and MoI to get the bags released from customs. Additionally, NTM-A is assisting OTSG to develop a sustainable MoI process for future procurement and issuance of these medic bags.

The medical readiness officer from the OTSG asserted that all policemen had the AFAK, and each medic had a TAP medic bag. During our fieldwork we rarely found this to be true. A Coalition forces official in Kandahar explained that he had not seen a TAP medic bag on any of his ANP visits during his 10-month assignment. We were able to locate medical supplies in the AUP clinic in Mazar-e-Sharif that included the TAP medic bags, but the perishable contents inside had expired. Additionally, ANP medics showed us their medic bags at an ABP clinic in Paktiya province.

Figure 10. TAP Medic Bags at 2nd Zone ABP Clinic, Paktiya
Source: DoD IG-SPO

Conclusion

The ANP did not have an adequate number of trained medics or the proper medical equipment to effectively care for police casualties. Action is necessary to:

- validate and adjust the number of ANP medics on the Tashkil;
- ensure TAP-trained policemen were assigned to, and remained in, medic positions; and
- develop and implement reliable procedures for the issuance and replenishment of ANP medic first-aid bags.

These actions will serve to significantly increase the quality of battlefield casualty care and survivability.

Recommendations, Management Comments, and Our Response

Recommendation 2

International Security Assistance Force Joint Command, in coordination with the North Atlantic Treaty Organization Training Mission–Afghanistan and Combined Security Transition Command–Afghanistan, advise and assist Ministry of Interior and the Afghan National Police to:

a. Determine the appropriate number of Afghan National Police medic positions required to provide effective medical support to various police units and update Tashkils accordingly.

b. Ensure that Afghan National Police medic Tashkil positions are filled with appropriately trained police personnel.

c. Ensure that trained medics currently serving in medic positions receive the proper equipment, to include an appropriate medic first-aid kit, in order to conduct effective point-of-injury care.

International Security Assistance Force Joint Command

IJC concurred with recommendations 2.a, 2.b, and 2.c without additional comment.

Our Response

The response from IJC was partially responsive. While concurring with each recommendation, IJC did not specify what actions it had already taken or planned to take for implementing the recommendations. We request that IJC provide an update within 60 days after the issuance of the final report describing what actions it has already taken or plans to take for implementing each recommendations.


INSPECTOR GENERAL
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Observation 3

Trauma Assistance Personnel Training Program

The ANP medic training program was ineffective and may not be sustainable.

This occurred because the contractor responsible for the Trauma Assistance Personnel (TAP) training program was unable to produce the required number of medics because MoI and police commanders did not identify and send sufficient numbers of students to fill the TAP courses.

Additionally, several ANP training centers transitioned to Afghan control resulting in fewer locations for the contractor to conduct this training due to security concerns.

As a result, the lack of a sustainable ANP medic training program inhibited ability to produce the required number of qualified medics, thereby jeopardizing the effectiveness of the ANP healthcare system at a time of increasing casualties.

Applicable Criteria

(See Appendix C, number 4 and 19, for additional details.)

Afghan National Police Training General Command Training Catalogue, "Afghan National Security Forces Trauma Assistance Personnel," Course Overview.

North Atlantic Training Mission–Afghanistan/Combined Security Transition Command–Afghanistan MoI Mentoring and Training Statement of Work (W91CRB-11-C-0053), Section 9.6, "Trauma Assistance Personnel Course," March 31, 2012.

Discussion

The contractor-provided ANP medic training program, also referred to as the TAP course, did not produce the required number of trained medics. As of July 2013, the contractor had trained 1,211 ANP medics of the 2,000 required. Since the TAP course was not officially approved and endorsed by the MoI, the contractor was largely unable to gain MoI and ANP support to recruit sufficient ANP medic course participants. Additionally, the number of training locations where the contractor could securely provide TAP training decreased due to the transition of ANP training centers to Afghan control.

The Trauma Assistance Personnel Program

In 2008, the Afghanistan Civilian Advisor Support program[7] initiated the TAP training program to develop ANP medics to address the high percentages of preventable trauma-related mortalities among the ANP. As of the summer 2012, 540 medics were trained.

In 2012, NTM-A/CSTC-A modified the "MoI Training and Mentoring" statement of work to require a contractor to manage the TAP training program and to train 2,000 ANP medics at selected sites by November 10, 2013. The contractor was additionally required to train no fewer than 150 train-the-trainers in order to increase ANP effectiveness in pre-hospital medical care and to provide for ANP TAP training self-sustainment.

The TAP training program is equivalent to the ANA combat medic training. It is an 8-week, hands-on training course educating ANP personnel on life-saving skills to include the following major topics (see Appendix E for the complete listing of course topics):

- basic first aid and hygiene,
- extrication,
- immobilization,
- use of tourniquets,
- medication and fluid administration,
- trauma assessment and emergency management skills,
- combat life saver skills, and
- trauma combat casualty care.

[7] Under the Afghanistan Civilian Advisor Support program, a contractor provided at least 580 civilian police advisors to advise, train, and mentor the ANP and MoI. These police advisors assisted the U.S. State Department and the CSTC-A to meet the U.S. goals of increasing Afghanistan's overall capability to provide police presence, improve public security, and support the rule of law.

Figure 11. Contractor Instructor Assists TAP Students to Practice Evacuating a Patient from a Vehicle
Source: NTM-A

Challenges in Producing the Required Number of ANP Medics

While the baseline target for contractor-provided TAP training was 2,000 TAP Medics and 150 qualified train-the-trainers by November 2013, as of October 2013 when the Afghans assumed control of the training program, the contractor had trained 1,288 TAP basic students and 146 train-the-trainers.

Various factors contributed to the challenges which the contractor experienced in delivering the TAP training program and producing the required number of medics. The TAP training program was not approved by MoI, and the ANP TGC had not listed the contractor-provided TAP training program as an official course. As a result, the contractor reported it had received limited support from the ANP in recruiting students for the training, resulting in low student participation and graduation, as well as instances where the course had to be canceled for lack of sufficient participation.

Initially, most ANP training sites were supported by Coalition forces, which made it easier for the contractor to manage the logistics required to train at those locations. Also, Coalition forces provided the necessary security and force protection for the TAP training program to be conducted at these Afghan locations. In 2012, however, ANP training centers began transitioning to Afghan-lead. Once a training center transitioned to Afghan control, Coalition forces reduced their presence, and this reduced the force protection for the contracted instructors teaching the TAP training.

Consequently, the contractor stopped teaching at these transitioned ANP training centers and tried to find other locations to conduct their training but was unable to do so. As of July 2013, the contractor was only using the Helmand Lashkar Gah Training Center to provide TAP training. Although the Regional Training Center in Kandahar was not transitioned to Afghan-lead, the contractor no longer used this location to teach TAP due to increased security concerns related to insurgents fighting in the area and pending transition of that location. Table 5 identifies the locations where the contractor had offered the TAP training program and their transition dates.

Table 5. Transition of ANP Training Centers

Schedule for Transition of ANP Training Centers Coalition to Afghan Control		
Training Center - District	**Projected Date**	**Status**
Regional Training Center - Nangahar	March 30, 2012	Complete
Regional Training Center - Gardez	December 1, 2012	Complete
Central Training Center - Kabul	June 29, 2013	Complete
Regional Training Center - Herat	June 30, 2013	Complete
Regional Training Center - Kunduz	August 24, 2013	Complete
Lashkar Gah Training Center - Helmand	December 2013	Complete
Regional Training Center - Kandahar	Date is pending	Pending

Source: NTM-A

Progress in Transitioning TAP Training Program to Afghans

In the Spring 2013, NTM-A advisors worked with the contractor and MoI and ANP TGC to effect an orderly transition of TAP training to Afghan-lead planned for November 2013. The TAP training program was reviewed and approved by the ANP TGC Professional Development Board on August 28, 2013, and is now listed as an official MoI course. In September 2013, ANP medical trainers successfully took the lead on teaching the TAP course with oversight provided by the contractor. In February 2014, the ANP graduated 12 TAP students from an Afghan-led program in Kabul. Their plans are to provide TAP training at a total of eight training centers.

To help ANP train additional medics, ANA has offered to train police personnel in the army's combat medic course when they have seats available. NTM-A is working with the ANP Surgeon General to ensure that MoI accepts the army's course as a suitable substitute for TAP training.

Figure 12. ANP TAP Students Practice Transporting a Patient
Source: NTM-A

Conclusion

The contractor was not able to graduate the required number of ANP medics because they had an insufficient number of trainees. This significantly delayed the availability for assignment of badly needed medics and jeopardized the ability of the ANP to properly care for their combat-injured personnel, thus putting their lives at risk.

Recommendations, Management Comments, and Our Response

Recommendation 3.a

North Atlantic Treaty Organization Training Mission–Afghanistan, in coordination with Combined Security Transition Command–Afghanistan, advise and assist Ministry of Interior to ensure that the Trauma Assistance Personnel training program is properly institutionalized and supported by Ministry of Interior and the Afghan National Police to produce the required medics to fill the Tashkil.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 3.a without any additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request NTM-A provide an update within 60 days after the issuance of the final report on the TAP training program to include the number of ANP personnel trained after the MoI assumed responsibility for the course. In addition, describe MoI's plan for future iterations of the TAP training program.

> ***Recommendation 3.b***
>
> North Atlantic Treaty Organization Training Mission–Afghanistan, in coordination with Ministry of Interior and Ministry of Defense, explore the option of using the Afghan National Army Combat Medic Course as a substitute for Trauma Assistance Personnel training, if needed, and implement a plan to use this course as an additional program to train Afghan National Police medics.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A nonconcurred with recommendation 3.b and explained that there was a lack of commitment by the ANP to send police personnel to the MoI-sponsored TAP course. Since the ANA combat medic course and the ANP TAP course were both 8-week programs and had similar curriculums, NTM-A inferred that the ANP were not likely to send police personnel to the ANA's combat medic course. Additionally, NTM-A explained that there was little confidence that changing the TAP course would improve ANP attendance. NTM-A suggested that it would be better to focus efforts on getting ANP leaders to commit to send their personnel to the TAP course and then keep them, once trained, to serve as ANP medics.

Our Response

We note NTM-A's nonconcurrence but believe NTM-A misunderstood our recommendation. We did not recommend and do not advocate changing the ANA combat medic or ANP TAP curriculum. We suggested that the ANA combat medic course be considered a viable substitute for ANP medic training until the

MoI TAP training program was fully implemented and running effectively. We agree with NTM-A that they should continue to work with MoI and ANP leaders to commit to send their personnel to the MoI-sponsored TAP course. The priority should be for the ANP to fill the available seats in their TAP course before utilizing the ANA combat medic course. We will request NTM-A provide an update within 60 days after the issuance of the final report on this clarified recommendation.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Observation 4

Medical Transport of Afghan National Police Casualties

The ANP's ability to provide en route care during the movement of casualties from the point of injury to the next higher level of care was limited.

This occurred because ANP medics were not trained to provide en route care during patient transport. Additionally, the ANP did not use their ambulances properly for patient transport, nor were they adequately outfitted with the required medical equipment and supplies.

Furthermore, although the MoD published an order allowing for the medical treatment of ANP patients at ANA medical facilities, ANP casualties were at times delayed by security personnel at ANA installation entry control points, impeding their transfer to the next level of care.

As a result, ANP casualties often did not receive timely required medical care which is likely to lead to the worsening of the casualty's medical condition and possibly unnecessary loss of life.

Applicable Criteria

(See Appendix C, number 8, 16 and 20, for additional details.)

Ministry of Defense Beneficiary's Treatment Policy at the Afghan National Army Medical Facilities, approved, dated May 23, 2012, with Attachment 3: Memorandum of Agreement between Minister of Defense, Minister of Interior, Minister of Public Health and Combined Security Transition Command–Afghanistan.

Ministry of Interior Order to the Support and Admin Deputy Office, OTSG, Medical Readiness Department for the Afghan National Police Emergency Ambulance Vehicle Operation Standard Operating Procedures, dated March 24, 2010.

Memorandum of Agreement (MOA) Between Minister of Defense (MoD) and Minister of Interior to Work Together for the Health Care Needs of the Afghan National Security Forces, dated June 5, 2009.

Discussion

The primary means for ANP casualties to be moved to the next higher level of care was by ground evacuation, also known as casualty evacuation. [8]However, we found there was limited ANP capability to effectively evacuate casualties by ground means and to provide appropriate en route care.[9] Training of ANP personnel to provide en route care was inadequate, and the ambulances were not adequately equipped or properly utilized for patient transport.

En Route Care

NTM-A is working with MoD and MoI to develop patient treatment and evacuation capabilities. However, with the exception of the AAF's flight medic course, we did not find any evidence of ANP training or advisory focus to prepare ANP medics to provide en route care during patient transport. ANP casualties were often transported in non-medical vehicles, as opposed to ambulances, and therefore did not have trained personnel or the medical supplies needed to provide effective en route care.

During the assessment, we received reports of several incidents in which wounded police did not receive any en route care from the battlefield to the medical facilities. A senior AUP official in Kandahar relayed a story regarding one of his policemen injured from an improvised explosive device. The policeman sustained eye trauma and a wounded shoulder from the blast. This individual did not receive medical care until he arrived at the hospital to which he was transported by a Ford Ranger pick-up truck.

Some factors affecting necessary en route care during ground transport were:

- improper patient classification when requesting transport,
- negligible planning/coordination for use of ambulances,
- ambulance drivers not trained as medics who could not help stabilize and treat patients prior to transport, and
- insufficient or no medical equipment on board the ambulance.

The AUP in Gamberi stated they did not use ambulances for police operations and often transported their own wounded in the back of the Ranger pick-up trucks. We

[8] Casualty Evacuation (CASEVAC) is a term used to refer to the movement of casualties aboard non-medical ground vehicles or aircraft.

[9] En route care is medical treatment provided to a casualty while in transport to the next level of care.

did not hear any complaints from the ANP that ambulances were not available, or they needed more because they did not have enough.

NTM-A, IJC, and subordinate units were developing patient evacuation plans. These plans focused on ground medical evacuation and forward casualty care. Specifically, the plans addressed the following:

- improving ANSF ability to conduct en route medical care and stabilization of patients during ground evacuation;
- enhancing the communications capabilities and procedures for submitting CASEVAC and medical evacuation requests; and
- improving the decision-making process for determining what medical facility (MoPH, MoD, or MoI) would receive the patient.

Utilization of Ambulances

We found that the ambulances at the ANP clinics we visited did not have adequate equipment or inventory checklists as defined in the MoI "Emergency Ambulance Vehicle Operations Standard Operating Procedures", dated March 24, 2010. Nor were they properly stocked with the appropriate medical supplies to operate effectively while providing continued treatment on the ANP casualty. We visited 10 clinics and found that the majority of the ambulances were un-equipped, with the exception of one ambulance in Paktiya Province. This ambulance was equipped with a litter, stretcher, and limited supplies of gauze and bandages (Figure 13). There were other ambulances in Kandahar Province that were not available for patient transport because they were used to transport and store clinic supplies due to the relocation of the clinic (Figure 14).

Figure 13. Donated Korean Ambulance at 2nd Zone ABP Clinic, Paktiya
Source: DoD IG-SPO

Figure 14. Korean Ambulance Used to Transport and Store Medical Supplies at AUP Clinic, Kandahar
Source: DoD IG-SPO

Ministry of Interior Ambulance Oversight

The MoI OTSG was responsible for oversight of ANP ambulance operations. According to the OTSG Medical Readiness (Patient Transport) Director, in June 2013, there were 629 ambulances supporting ANP operations. Ambulance types included Ranger, Korean ambulances, High Mobility Multipurpose Wheeled Vehicle (HMMWV), and patient transit vehicles. The specific numbers of ambulance types are listed in Table 6 and pictures are included in Figures 15-17.

Table 6. Afghan National Police Ambulances

		Ambulances as of June 2013				
		Ranger	Korean	HMMVV	Transit	Total
1	ANP Hospital	7	8	2	0	**17**
2	Drug Rehab Unit	1	2	1	0	**4**
3	MoI Clinic	0	1	0	0	**1**
4	Central Units (Afghan Uniform Police)	9	14	10	0	**33**
5	Training Centers	6	12	11	0	**29**
6	Afghan National Civil Order Police	88	10	95	56	**249**
7	Afghan Border Police	20	12	52	0	**84**
8	Zones (Afghan Uniform Police)	88	44	80	0	**212**
		219	**103**	**251**	**56**	**629**

Source: ANP, OTSG

Figure 15. Two Different Ford Ranger Ambulance/Ford Transit (side-by-side) at 3rd Brigade ANCOP Clinic, Mazar-e-Sharif
Source: DoD IG-SPO

As discussed previously, we found the majority of ambulances did not have the required medical supplies to render effective en route care. The OTSG Medical Readiness Director explained the HMMWVs did not arrive with medical kits; however, there were ambulance kits provided by NTM-A and available to stock these ambulances. The Republic of Korea donated 103 ambulances which had some initial outfitting of medical supplies and equipment. The OTSG Medical Readiness Director explained that the OTSG desired to improve the outfitting and utilization of ambulances. Accordingly, in the fall 2013, the OTSG, working with NTM-A, developed a plan to generate a medical kit and contract for the kits to equip all ambulances. In October 2013, OTSG conducted a complete inventory of ambulances, associated medical supplies, and equipment and was working with NTM-A to determine the necessary actions to fully equip the ambulances.

Figure 16. HMMVV 1152 Ambulance at Provincial Headquarters AUP Clinic, Kandahar
Source: DoD IG-SPO

Figure 17. Ford Ranger Ambulance and Donated Korean Ambulance at Provincial Headquarters Afghan Uniform Police (AUP) Clinic, Kandahar (June 23, 2013)
Source: DoD IG-SPO

MoI Policy for Emergency Ambulance Vehicle Operations

A MoI order signed March 24, 2010, directs the establishment of a proper system of ambulance performance and requires all units related to medical readiness to follow the standard operation procedures (SOP) for emergency ambulance vehicle operations. Some descriptive parts of the SOP include:

- Clinical officers responsibility to:
    - supervise the maintenance and inventory of the ambulance vehicles, and
    - maintain all ambulance checklists.
- Driver/medic responsibility to:
    - monitor the medical equipment,
    - verify the equipment on the checklist and that it is operational, and
    - reorder supplies if they become expired or consumed.
- Equipment required for operations, include:
    - two fully stocked equipment bags,
    - one oxygen tank with regulators,
    - one Automated External Defibrillator (AED),
    - one backboard,

- cervical collars,
- head blocks,
- one pediatric trauma kit,
- one vehicle safety kit, and
- one operator's manual.

The SOP has significant procedures for vehicle safety, driver's training, and vehicle operation. Furthermore, there were procedures for the driver to follow, if he is a crew member (first responder), to assist in patient care.

Although we found this SOP to be fairly complete, it did not identify the responsibilities for the medic or medical provider in providing care at the point of injury or for care en route during patient transport. An SOP that fully covers medical support duties and responsibilities and which has been verified as having been implemented could significantly enable the capability of the ANP to properly care for injured personnel.

Patient Treatment Agreements

There are several versions of memorandums of agreement between the MoD, MoI, MoPH, and Coalition forces intended to coordinate support for the healthcare needs of the ANSF. Yet none of these joint ministerial agreements were signed and, evidently, none have been implemented.

However, the MoD had a policy pertaining to the treatment of individuals at ANA medical facilities. This policy, dated May 2012, included an attached "Memorandum of Agreement between Minister of Defense, Minister of Interior, Minister of Public Health, and Combined Security Transition Command–Afghanistan." The goal of this treatment policy is to create a clear, accurate and high quality ANA healthcare system for receiving and treating patients that are included in the approved beneficiary's list at the ANA medical facilities. Included in the beneficiaries list were ANP personnel. However, this treatment policy called for the injured policemen to bring official documents from the OTSG in order to establish eligibility for care at the ANA medical facility, an action which has proven to be highly impractical in a medical emergency situation.

Although the MoD's approved treatment policy included the eligibility for ANP patients to receive care at ANA medical facilities, procedures were not in place at the

ANA installation entry-control points to allow easy access to its medical facilities. We received complaints in the field concerning delays in patient treatment due to the time it took for ANP patients to get clearance to proceed through ANA checkpoints to gain access to ANA hospitals. One senior advisor said that this denial of entry to ANP personnel occurred every day.

ANP senior leaders disagreed over whether prompt access and care was being provided to injured police by the ANA. One senior MoI leader stated, "We have had reasonably good luck. We have never had a patient turned back from an ANA facility." However, a senior hospital official at the ANPH was "not satisfied with the delay in treatment of injured police" at ANA medical facilities.

Prevention of ANP casualty care also occurred at Coalition facilities. The commander at the NATO Role 3 Multinational Medical Unit[10] in Kandahar said he had problems with ANSF patients arriving at Kandahar Air Field entry control points and gaining subsequent clearance for them to enter. The problems included direct refusal to allow entry and communication challenges due to language barriers. Reportedly, there were procedures in place for Kandahar security forces guarding the gates to address this issue; however, successful implementation relied on the Role 3 facility receiving prior notification that ANP patients were on their way. The commander for the Role 3 facility informed us that they were coordinating with MoI, MoD and base security to address these challenges and to improve the process for patients to enter the Kandahar base.

Conclusion

The ANP's ability to provide en route care during the ground movement of casualties from the point of injury to the next higher level of care was impaired due to improper use of and inadequately equipped/supplied ambulances. In addition, the lack of effective coordination regarding ANP patients gaining access to ANA installations and medical facilities delayed timely medical treatment for ANP casualties. There were also coordination problems between ANA and the Coalition regarding gaining access to the hospital on Kandahar base. If unaddressed, these access issues could result in the worsening of the casualty's medical condition and possibly result in unnecessary loss of life.

[10] NATO Role 3 Multinational Medical Unit is a world-class combat trauma hospital that serves a unique population of U.S. and Coalition forces, as well as Afghan National Army, National Police, and civilians wounded in the Southern Afghanistan region.

Recommendations, Management Comments, and Our Response

Recommendation 4

International Security Assistance Force Joint Command, in coordination with North Atlantic Treaty Organization Training Mission–Afghanistan and Combined Security Transition Command–Afghanistan:

a. Advise, assist, and monitor Ministry of Interior in the development of an effective Afghan National Police en route care capability, including proper use of ambulances and associated equipment.

b. Advise and assist Ministry of Interior to ensure that Ministry of Interior standard operating procedures for ambulance operations are updated to include responsibilities for the medic and medical provider during point-of-injury care and en route care.

c. Advise and assist Ministry of Interior and Afghan National Police to develop a sustainable en route care training program.

d. Advise and assist Ministry of Interior to ensure all ambulances are properly equipped and that there is a sustainable system for procurement and replenishment of medical supplies.

e. Conduct key leader engagements with Ministry of Interior and Afghan National Police leadership to increase utilization of ambulances and encourage the use of tactical ambulances where appropriate.

f. Advise and assist Ministry of Interior and Ministry of Defense to determine if there are unnecessary delays at ANA installation entry control points when ANP casualties are transported to ANA medical facilities and to take appropriate action to minimize these delays.

International Security Assistance Force Joint Command

IJC concurred with recommendations 4.a, 4.b, 4.c, 4.d, 4.e, and 4.f without any additional comments.

Our Response

The response from IJC was partially responsive. While concurring with each recommendation, IJC did not specify what actions it had already taken or planned to take for implementing the recommendations. We request that IJC provide an update within 60 days after the issuance of the final report describing what actions it has already taken or plans to take for implementing each recommendation.

Observation 5

Pharmacy Operations

The ANP Hospital did not have sufficient numbers of pharmacists or proper inventory control procedures in place to effectively manage its pharmacy and properly dispense medications.

This was due, in part, to insufficient number of authorized pharmacist positions at the ANPH in the 1391 Tashkil and was made more apparent when compared to authorized pharmacist positions at ANA regional hospitals.

The shortage of pharmacists has been aggravated by the September 2013 expansion of the inpatient-bed capacity from 74 to 161 beds, with no subsequent increase in the number of pharmacy personnel to handle the increased number of patients.

Additionally, ANPH did not effectively manage the inventory and control of pharmaceuticals,[11] including controlled substances.[12]

As a result, the shortage of pharmacists and lack of accountability and control regarding medication management limited the ability of ANPH to safely and effectively dispense medications and manage its pharmacy operations. Specifically, the lack of pharmacists impacted their ability to implement proper quality control measures necessary to prevent mismanagement, theft, and waste of pharmaceuticals.

[11] Pharmaceuticals pertain to items in a pharmacy and medicinal drugs.

[12] A controlled substance is any medication that has the potential for abuse or addiction and must be kept in a separate locked area to prevent unauthorized removal from the pharmacy department.

Applicable Criteria

(See Appendix C, number 1 and 12, for additional details.)

International Security Assistance Force Afghan National Security Forces Healthcare System Development Support Plan to COMISAF OPLAN 38302, November 28, 2011.

Policies and Procedures of the Pharmacy Department Afghanistan National Police Hospital Kabul, Afghanistan, January 31, 2013.

Discussion

The director of the pharmacy (an ANP colonel) was responsible for the main hospital pharmacy and the polyclinic (outpatient) pharmacy. Additionally, he provided oversight of medical logistics for the hospital which included the ordering, receipt, and distribution of consumable medical supplies, such as bandages, needles, and syringes, as well as medical equipment.

The pharmacy for the hospital was located on the first floor and was comprised of one large room which was divided into two sections—the dispensing area and the bulk-storage area. The dispensing area had a large self-contained glass cabinet with shelves that held various medications used for patients in the hospital. The bulk storage area also contained a similar glass cabinet used to store a 30-day supply of hospital medications. The pharmacy staff used the medications from the bulk storage area to refill the storage shelves on the dispensary side, once they were depleted.

According to the pharmacy director, the hospital filled 50 to 60 outpatient prescriptions daily, processed physician's prescriptions for hospital inpatients, and distributed these medications to the patient wards.

Figure 18. Medication Storage Cabinet in ANPH Dispensary
Source: DoD IG-SPO

Pharmacy Personnel

The 1931 Tashkil authorized the ANPH pharmacy to have two pharmacies and one technician However, the pharmacy director indicated he needed additional pharmacy personnel to properly run the pharmacy. He suggested six additional pharmacy personnel would be needed to maintain effective operations—two pharmacy quartermasters (responsible for the ordering and receipt of medical supplies), two pharmacy technicians, and two pharmacists.

Although the pharmacy director believed he needed six more employees, the NTM-A pharmacy advisor recommended that one additional pharmacist would be adequate. This person would serve as a clinical pharmacist and visit the wards more frequently, review medication profiles (listing of medications that a patient is prescribed), and check the medication carts and medication supplies on the wards.

The hospital averaged 70 to 114 inpatients during 2012 and 2013. In September 2013, the hospital opened an expansion facility which increased bed capacity to 161. Although the hospital expanded its inpatient-bed capacity, there were no plans to increase the number of pharmacy personnel to manage medications for the potential increased number of patients.

Previously, DoD IG reported on pharmacy personnel shortages at the ANA Dawood National Military Hospital.[13] We determined that the ANA had three pharmacists assigned to regional hospitals, each of which operated between 50 to 100 beds. ANPH pharmacist capability appeared to be disproportionate, especially given that ANP casualties were a significant multiple of those incurred by the ANA.

Our team observed that ANPH did not have sufficient pharmacists to regularly make rounds of the patient wards. In addition, during our visit to the hospital, we found large quantities of expired medications on the wards. Moreover, the nurses on the ward were unaware of the procedures to handle expired medications and returned them to the hospital general medical supply storage room, instead of to the pharmacy for proper disposal. Additional pharmacists would enable training to hospital personnel on proper medication handling, including monitoring safe medication practices on the patient wards.

[13] "Oversight of the U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable ANSF Medical Logistics at the Dawood National Military Hospital," (Report No. DoDIG-2013-053), March 13, 2013.

Inventory Control Measures

The pharmacy did not employ automated inventory accountability and control methods to manage their medication stock. Instead, pharmacy personnel annotated their accounting for medication quantities by using manual methods and transcribing this information onto ledgers. The pharmacist reviewed the process used to reconcile the quantities of medications in the pharmacy to verify what was ordered and what was dispensed. He said he performed this review monthly; however, he did not conduct the reconciliation daily. According to the NTM-A pharmacy advisor, both daily and monthly reconciliations were required.

The pharmacy standard operating procedures required the pharmacist to maintain accurate and up-to-date stock cards for each medication maintained in the pharmacy. The stock card was required to identify the name and quantity of medication available on the storage shelves. When we visited the pharmacy we found the storage shelves were labeled with the name of the medication, but the quantities were not updated to account for medications dispensed.


استاک کارت ادویه stok ca

تاریخ انقضا Exp Date	مقدار	ملی کرام	نوعیت	اسم ادویه
3/2015		100	vial	Hydrocortisone
12/2014		50	inhaler	Bekson
2/2017		1.1000	spray	Xynosine
6/2014		20	Drops	Bactimide
6/2013		15	ointment	Betamethasone
11/2014		15	ointment	Gentamicin
12/2014		30	cream	Ketoconazole
9/2014		15	ointment	Triamcicort-n-n
8/2014		25	Gel	Xylogel
10/2014		30	cream	Burnol

Figure 19. Example of Stock Card in ANPH Pharmacy, Kabul
Source: DoD IG-SPO

Storage of Controlled Substances

Although the ANPH pharmacy had adequate written procedures for the security and storage of controlled substances, we noted that the storage cabinet and desk used to store these medications were not properly secured. We found narcotics and other controlled substances stored in a locked desk drawer.

The pharmacy SOP required that these medications be kept in a locked cabinet, secured to a permanent structure. The locked desk drawer could be easily opened or broken into. The desk was not secured or bolted to the floor and could be carried out of the pharmacy.

The pharmacy director informed the team he previously requested a safe using the MoI Form 14 process. The request was denied by hospital leadership. The pharmacy director was not given a reason for the disapproval. Subsequent to our visit, NTM-A and hospital leadership initiated a new request for two safes to store controlled substances. The contract was scheduled for approval by September 30, 2013, and the safes were expected to be delivered within 60 to 90 days after the awarding of the contract.

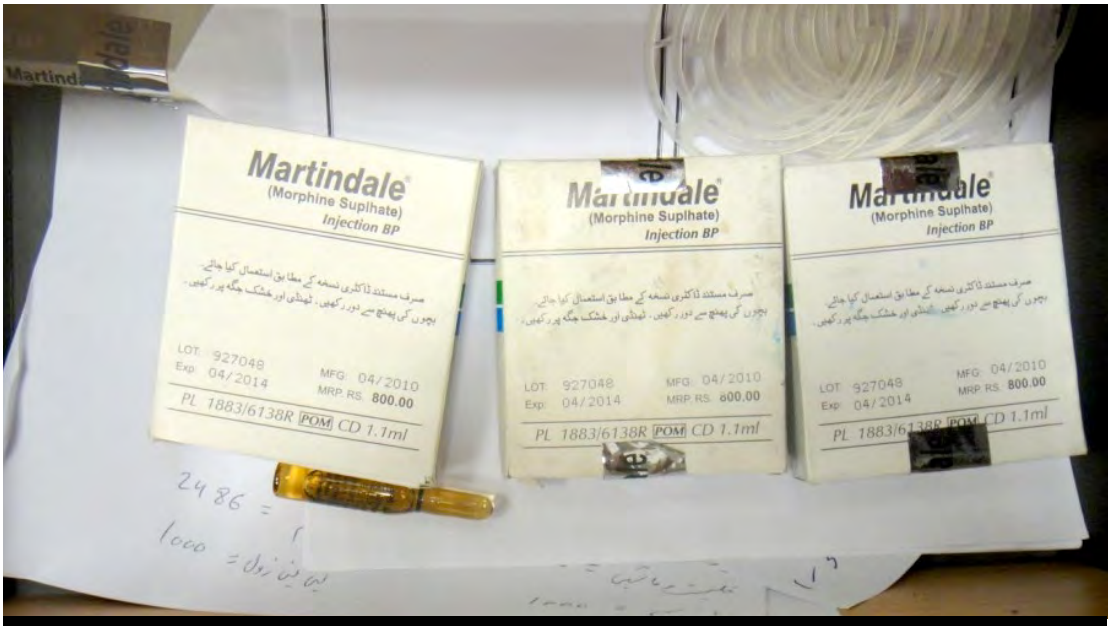


Figure 20. Morphine (Controlled Substance) Stored in Desk Drawer in Pharmacy at ANPH, Kabul
Source: DoD IG-SPO

Authorized Stockage List for the Pharmacy

There were 270 pharmaceutical items authorized on the Authorized Stockage List (ASL). However, the ASL was not maintained by the ANP supply system. The ANPH pharmacy only had 70 of these items on their shelves when we visited. The pharmacy director stated he regularly received only 50 percent of the items he requested from MoI's National Medical Warehouse without any explanation for the shortages. He specifically identified that the pharmacy was consistently short of the following high demand items:

- antibiotics, such as Amoxicillin and Doxycycline,
- anti-emetic/anti-vomiting drugs, and
- bandages for wound dressing changes.

In addition to the ANPH pharmacy, several ANP clinics complained of shortages in anti-emetics and antibiotics, particularly Doxycycline, which was used and needed as an anti-malarial drug.

Conclusion

We found that additional efforts and staff were required to improve the operations of the ANP Hospital pharmacy. Given the increased patient load at the hospital, without a commensurate increase in pharmacy staffing, the hospital was at risk for poor patient medication support and health care outcomes. More pharmacists are needed to responsibly and safely dispense medications to patients, to provide effective oversight of medication practices within the hospital, to support the increased patient load, and to ensure sustainable effective medication management.

Recommendations, Management Comments, and Our Response

Recommendation 5.a

North Atlantic Treaty Organization Training Mission–Afghanistan advise and assist the Afghan National Police Hospital to re-assess and validate the number of pharmacists and pharmacy personnel needed to support effective and efficient operation of the Afghan National Police Hospital pharmacy. Identify and implement interim measures to ensure that qualified personnel are available to meet the current workload demands in the Afghan National Police Hospital pharmacy.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 5.a without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide an update on the pharmacist staffing at the ANPH and describe any measures that have been taken to ensure that the ANPH has qualified personnel available to meet the workload demands in the ANPH pharmacy.

Recommendation 5.b

North Atlantic Treaty Organization Training Mission–Afghanistan advise and assist the Afghan National Police Hospital to ensure that the Afghan National Police Hospital pharmacy is conducting operations in accordance with their existing standard operating procedures to include both daily and monthly reconciliation of medications and that controlled substances are secured properly to prevent mismanagement, theft, and waste of pharmaceuticals.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 5.b without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide an update on whether the ANPH pharmacy is conducting daily and monthly reconciliation of medications and that controlled substances are secured properly in accordance with their SOP.

Recommendation 5.c

North Atlantic Treaty Organization Training Mission–Afghanistan advise and assist the Afghan National Police Hospital to ensure that medication requisition requests are accurately filled by the Ministry of Interior National Medical Warehouse.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 5.c without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide an update on whether the MoI National Medical Warehouse accurately fills medication requisitions submitted by the ANPH.

Observation 6

Caring for Combat Casualties at the Afghan National Police Hospital

Increasing numbers of ANP casualties have strained the medical support capability of the ANPH which is not capable of providing effective care to all its patients. The ANPH, formerly a 74-bed inpatient care hospital, had increased to a capacity of 161 beds in September 2013, without any increase in medical personnel.

The increased patient load has exacerbated the limited ANP medical capability. MoI and ANP leaders and the OTSG have not responded to the hospital's need for additional medical personnel to address the patient load caused by the ANP's increased casualty rate and subsequent increased patient care requirements at ANPH.

Furthermore, no protocols were identified that provided guidance when severely injured ANP casualties exceeded the available level of care and needed to be transferred to ANA or MoPH hospitals.

Consequently, ANPH was not capable of providing appropriate and necessary care to the number of casualties it was receiving, which led to sub-optimal medical care and potential increased mortality.

Applicable Criteria

(See Appendix C, number 1 and 3, for additional details.)

International Security Assistance Force Afghan National Security Forces Healthcare System Development Support Plan to COMISAF OPLAN 38302, November 28, 2011.

North Atlantic Treaty Organization Training Mission–Afghanistan ANSF Health System Development Plan, May 2013.

Discussion

ANSF are now leading security operations in Afghanistan, and this has resulted in a significant increase in casualties, particularly in the ANP. According to NTM-A, the ANP incur five times as many casualties as their ANA counterparts and the numbers of ANP casualties are rising over previous years. This increasing number of ANP casualties has strained the bed capacity and medical capability of the ANPH.

Current Capabilities at ANP Hospital

Previously described in the Background section, the ANPH is a 161-bed inpatient care facility. The staffing for medical personnel at the hospital is included in Table 7. The number of authorized medical staff positions was based on the previously authorized 74-bed capacity for the ANPH. The fill-rate percentages in Table 7 are based on the 1392 Tashkil and compare the fill-rate against authorized positions.

Table 7. ANP Hospital Medical Personnel Percentages

Afghan National Police Hospital – Medical Personnel as of September 2013			
Position	**Positions Filled**	**Positions Authorized**	**Fill-Rate**
Physicians*	70	82	85%
Nurses	37	42	88%
Medics	13	18	72%
*There are an additional 15 Physicians that are involved in clinical training at ANPH			

Source: NTM-A

In 2006, there were no specialty-trained physicians in the ANP. Today, there are 50 physicians awarded specialty diplomas working throughout the ANP. Additionally, there are 53 physicians currently attending specialty training, either at ANPH or MoPH hospitals. These physicians, once they complete their specialty training, will be assigned to the staff of the ANPH or one of the outlying ANP clinics to fill a vacant position based on the priorities determined by the Surgeon General at that time.

DoD OIG Assessment Team Visit to ANPH

In June 2013, the DoD IG assessment team visited the ANPH and spoke with 13 ANP patients and 1 family member. At that time, the hospital had a patient census of 82 and additional beds were set up in the patient waiting rooms and in the hallways to accommodate the high number of patients. The majority of patients we visited were combat casualties, several of whom had significant injuries, including amputations, head trauma from blast exposure, open fractures, and extensive wounds from improvised explosive devices.

In general, the patients we spoke with responded positively to questions about their medical treatment at the ANPH. The patients we interviewed had clean bed linens and pajamas, their bandages and dressings were clean and properly applied, and the patient rooms, although congested due to overcrowding, were tidy and generally clean.

Figure 21. ANP Patients Overflowed Into the Hallways and Visitor Lounges, Kabul
Source: DoD IG-SPO

Although we did not see or interview ANPH patients who needed a higher level of care, we received reports of previous situations in which a patient's medical condition worsened to the point that their care was beyond the capability of the ANPH. According to NTM-A medical advisors, the ANPH did not have a protocol to transfer such patients to other hospitals with a higher degree of medical capability. Such a protocol would need to define the medical criteria for identifying patients requiring medical care not offered at the ANPH and also establish procedures to affect their transfer to the ANA Dawood National Military Hospital (NMH), where a higher level of care was available. NTM-A medical advisors at ANPH indicated they were working with the ANPH and NMH to develop such a policy.

Office of the Surgeon General Priorities

Because of the increasing number of ANP casualties, the ANP Surgeon General focused on expanding the number of ANPH inpatient beds and adding additional regional hospitals to provide for the care of these casualties. However, this focus did not include increasing the medical personnel required for the expanded number of ANPH beds.

The ANPH expansion initially involved adding 40 beds to the original 74-bed facility. Our assessment team discussed, with the ANP Surgeon General, the need we had identified for more medical personnel and equipment to accommodate the additional bed space. He acknowledged that he already had the staff available at the ANPH to accommodate the additional patients once the expanded bed capacity opened. Furthermore, he explained that NTM-A was assisting with the procurement of medical equipment to support the expanded bed capacity.

However, in early September 2013, due to the increasing number of ANP casualties, the Surgeon General was concerned that even with the 114-bed expansion facility open he would not have enough bed space to care for all ANP casualties. As such, the Surgeon General reconfigured the hospital's administrative spaces, which opened up additional rooms in the hospital for patient beds. As a result, the expansion project, which opened in September 2013, resulted in a total of 161 inpatient beds versus 114 beds as originally planned. During our follow-on discussions with the Surgeon General in October 2013, he acknowledged that he needed additional medical personnel to accommodate 161 beds and was working with NTM-A to propose an increase in the hospital's Tashkil.

Figure 22. Walkway from the ANP Hospital to the Expansion Facility, Kabul
Source: DoD IG-SPO

Another priority for the ANP Surgeon General was the renovation of the former "Red Hospital" to a 200-bed ANP Hospital. The "Red Hospital" is located within close proximity of the ANPH and was previously a hospital constructed by the Soviets.

The building was severely damaged during the Afghan Civil War and subsequently renovated to be used as a hospital again. However, the MoI decided to convert the building into administrative spaces for the ANP Training General Command, responsible for the training of the expanding ANP force. The ANP Surgeon General indicated that he had always viewed this building as belonging to the OTSG and lobbied MoI to have it converted back into a hospital. NTM-A did not support the Surgeon General's plan to reclaim this former hospital given the ongoing expansion plans for the current ANPH. However, the Surgeon General pursued his plan without the assistance of NTM-A and lobbied MoI to accept his proposal to renovate the "Red Hospital.

In June 2013, MoI endorsed the plan for the renovation of the "Red Hospital" and initially approved a 328-person Tashkil of medical personnel for the planned 200-bed facility. However, in September 2013, new leadership within the MoI cancelled the approval of the Tashkil, and renovation plans for the "Red Hospital" were halted. The Surgeon General planned to re-engage with MoI leadership to regain approval for the 200-bed hospital.

The ANP Surgeon General was also pursuing construction of several 50-bed hospitals in the outlying provinces with $10 million donated by the Republic of Korea. There were no ANP hospitals operating in the provinces. Medical care for ANP casualties in outlying provinces was provided by MoPH facilities and ANA regional military hospitals. MoI was identifying the land, upon which to construct these hospitals, however, the MoI did not expect to complete the project for several years. As of November 2013, this was a MoI-led initiative without assistance from NTM-A.

While these separate expansion efforts ultimately may be necessary, the concern we identified was that the ANPH was in need of additional medical personnel to address the increased hospital bed capacity as ANP casualties were increasing. The various expansion initiatives significantly detracted attention of the ANP Surgeon General from the pressing need for additional medical assistance now at the ANPH. NTM-A agreed with our position and was coordinating with the Surgeon General to prioritize his effort to focus on developing a proposal for additional medical personnel at the ANPH. Furthermore, NTM-A believed that the medical equipment procured for the ANPH expansion, and scheduled to arrive in late fall 2013, would be adequate to meet the needs of the additional patients at the ANPH. However, the Surgeon General was working with MoI, to procure additional equipment,

such as a CAT Scan and MRI machines, which would expand the capability of the hospital. This additional equipment was being procured through MoI channels without the assistance of NTM-A.

Concerns for the Current and Future ANP Healthcare Capability

Senior NTM-A officials acknowledged that ANP medical capability was limited and agreed that the ANP needed more beds for patients at the ANPH. NTM-A also concurred that the current ANP medical priority should be given to improving existing facilities and providing necessary medical personnel and equipment at the ANPH. To this end, NTM-A medical advisors were working with the ANP Surgeon General and ANPH medical personnel to emphasize the importance of this objective.

In support of ISAF's plan for developing the ANSF healthcare system, NTM-A senior officials and medical advisors sought to develop healthy working relationships between the ANP and the ANA, especially at the Surgeon General and ministerial levels. Although these efforts were ongoing; we found significant professional and personal differences and a lack of trust between ANA and ANP senior medical leaders in the Kabul area. The ANP Surgeon General seemed intent on seeking medical care for ANP casualties at the ANPH and was reluctant to willingly ask for medical help for ANP personnel from the NMH when a patient required a higher level of care. We identified that these barriers did not exist in the provinces as ANP casualties were often treated at ANA regional hospitals.

Conclusion

Increasing numbers of ANP casualties have strained the limited staffing and medical capability of the ANPH. ANP medical leadership was focused on expanding their bed capacity and building additional facilities to care for these combat casualties. MoI/OTSG emphasis on new expansion elsewhere detracted from first ensuring that the ANPH was capable of providing effective medical care to the increasing of number casualties it was receiving.

Recommendations, Management Comments, and Our Response

Recommendation 6.a

International Security Assistance Force Command, in coordination with International Security Assistance Force Joint Command, Combined Security Transition Command–Afghanistan and North Atlantic Treaty Organization Training Mission–Afghanistan, conduct key leader engagements with Ministry of Interior and Ministry of Defense to continue to build formal, cooperative relationships between Ministry of Interior and Ministry of Defense medical leaders so that the Afghan National Police who require medical care that is beyond the capability of the Afghan National Police Hospital are able to take better advantage of more robust healthcare resources that are available at the Afghan National Army National Military Hospital.

International Security Assistance Force Command

ISAF did not respond to the draft report prior to publication.

Our Response

We request that ISAF provide an update within 60 days after the issuance of the final report on progress made in building formal, cooperative relationships between MoD and MoI medical leadership to ensure that ANP casualties who may require medical care beyond the capability of the ANPH are willingly transferred from the ANPH and able to receive medical treatment at the ANA NMH.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with the recommendation and explained that, in addition to using the ANA NMH, MoPH medical facilities could also be used to care for ANP casualties who required medical care that was beyond what was available at the ANPH. Additionally, NTM-A commented that NMH and MoPH medical facilities were currently being used to treat ANP personnel.

Our Response

The response from NTM-A was responsive. We request an update in 6 months describing any progress made in ensuring that ANP casualties receive adequate medical care.

> ***Recommendation 6.b(1)***
>
> North Atlantic Treaty Organization Training Mission–Afghanistan continue to advise and assist the Ministry of Interior and the Surgeon General to determine the number of medical personnel that are needed to provide safe and effective medical care at the Afghan National Police Hospital, based on the current and projected increase in patient load.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 6.b(1) without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide an update within 60 days after the issuance of the final report describing coordination efforts with the MoI and OTSG on the medical personnel staffing requirements for the ANPH.

> ***Recommendation 6.b(2)***
>
> North Atlantic Treaty Organization Training Mission–Afghanistan continue to advise and assist the Office of the Surgeon General to develop a plan to identify patients whose medical condition exceeds the capabilities offered by the Afghan National Police Hospital. This plan should include the development of a protocol that also provides for the timely transfer of these patients to a higher level of care medical facility.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 6.b(2) without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide an update within 60 days after the issuance of the final report on whether procedures are in place to identify patients whose medical conditions exceed the capabilities offered at the ANPH and require transfer to another hospital.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Observation 7

Developmental Plans and Advisory Resources

ISAF planning efforts and advisory resources were not sufficient to develop the ANP capability to provide effective point-of-injury care.

This occurred because of the following:

- Prior medical advisory efforts were primarily focused on ANA development.
- ANSF medical leaders did not fully embrace the overarching ISAF medical development plan because they found it hard to understand and not relevant to what they believed was important.
- ISAF medical planning for the ANP had not been sufficiently implemented at the regional level.
- Because of conflicting duties, some advisors had limited time available to mentor ANP medical personnel.
- Medical advisory resources were projected to decrease as part of the drawdown of Coalition forces jeopardizing future development of improved ANP medical capability.

As a result, the limited development of ANP's ability to effectively treat casualties on a sustainable basis cannot be expected to significantly improve in the foreseeable future and thus the survivability of many injured policemen will be put at risk.

Applicable Criteria

(See Appendix C, number 1, 2, 3, 5, and 6, for additional details.)

International Security Assistance Force Afghan National Security Forces Healthcare System Development Support Plan to COMISAF OPLAN 38302, November 28, 2011.

International Security Assistance Force Joint Command Standard Operating Procedures 1147 ANSF Healthcare Development-Corps and Below, January 15, 2011.

North Atlantic Treaty Organization Training Mission–Afghanistan ANSF Health System Development Plan, May 2013.

North Atlantic Treaty Organization Training Mission–Afghanistan/Combined Security Transition Command–Afghanistan Base Order 2012-2014, Command Surgeon, January 9, 2012.

Government of the Islamic Republic of Afghanistan, Ministry of Interior Affairs, Deputy Ministry of Policy and Strategy, "Afghan National Police Strategy; 1392–1397," March 2013.

Discussion

The ANSF have taken the lead in fighting the insurgency and as a result are suffering more casualties than in previous years. ANP forces are particularly targeted because they patrol in small groups, using more predictable patrol patterns, and do not have the same capacity as the ANA to defend themselves against attack or respond with a sufficient quick reaction force. As a result, ANP personnel are suffering a significantly higher casualty rate than the ANA. This can impact ANP personnel morale and retention and, therefore, its sustainable effectiveness.

The MoI identified reduction of ANP casualties as one of its top 10 priorities in the recently published National Police Strategy. However, on reviewing Coalition plans, we found that most plans and field-level initiatives were primarily focused on ANA medical development. The limited guidance that existed for ANP medical development was not sufficient to properly guide ANP advisors in the areas of point-of-injury care, patient evacuation, and en route care.

ISAF ANSF Healthcare Development Plan

ISAF released their plan, "Afghan National Security Forces Healthcare System Development Support Plan to COMISAF OPLAN 38302," in November 2011. Senior Coalition medical leaders asserted that this plan was overly complex and hard to understand by both Coalition medical advisors and ANSF medical leaders. Additionally, a senior ISAF medical representative explained that both the ANA and ANP Surgeons General had no ownership of the plan and contended that the content within the plan was not what they wanted to focus on.

During an interview with a senior ISAF medical leader, we discussed the possibility of revising the medical development plan and, while the interviewee appeared receptive to the idea, he noted that future modifications and revisions to this plan would be completed based on direction provided in the NATO Operation Resolute Support mission for 2015 and beyond. This guidance and work was expected to begin in the fall of 2013 and into 2014.

NTM-A ANSF Medical Development Plans

In support of the November 2011 ISAF ANSF Healthcare System Development Plan, NTM-A published their initial plan, "NTM-A/CSTC-A BASEORD 2012-2014 for Command Surgeon," in January 2012. Coalition medical advisors asserted that this plan was easier to understand and implement than the ISAF plan. The NTM-A plan focused medical advisory efforts at both the ministerial level and hospital level to help achieve transition of the hospitals to Afghan lead by the end of 2013. This plan was updated in May 2013 and addressed the development of the ANSF to conduct point-of-injury care, patient evacuation, and en route care, among other things.

IJC ANSF Medical Development Plan

NTM-A and IJC shared the responsibility for the development of medical capability within the ANSF. NTM-A assumed responsibility for development of the "above Corps/Zone"[14] ANSF medical organizations in the ANP, including the Office of the Surgeon General, ANP Hospital, National Medical Warehouse, and the ANP Regional Training Centers. The responsibility for the medical development of the "Corps/Zone and below" medical assets fell to IJC. Specifically for the ANP, IJC mentored the development of medical capabilities for the police headquarters at the provincial levels, including ANP clinics supporting the various headquarters elements.

Figure 23. NTM-A Medical Advisor and Medical Personnel from Provincial Headquarters AUP Clinic, Kandaharl
Source: DoD IG-SPO

[14] "Above Corps/Zone" refers to ANSF medical organizations and institutions above the ANA Corps and ANP Region/Zone level. Whereas "Corps/Zone and below" refer to ANSF medical elements at ANA Corps and ANP Region/Zone level and below which includes the provinces and districts.

IJC did not have a specific written plan for ANSF medical development. However, they did provide guidance in "ISAF Joint Command Standard Operation Procedures 1147 ANSF Healthcare Development-Corps and below" in January 2011. The IJC SOP identified several end-states for ANP medical capability including "providing specialized first aid, triage, and evacuation of casualty from point of injury to an appropriate medical treatment facility." However, the SOP had not been updated since 2011 and it did not prioritize the efforts for IJC's Regional Commands (RCs), which were responsible for advising and developing ANP medical capability in the provinces.

Although IJC was responsible for the planning effort of ANSF medical development at "Corps/Zone and below," we found varying degrees of execution at the RC level. An exception was the RC-East Command Surgeon's office that had reviewed all relevant ANSF medical development plans and available doctrine and developed a robust plan for ANSF medical development. This plan included the assessment of point-of-injury care, patient evacuation, en route care, medical training, and medical logistics, among others, for both the ANA and ANP.

In contrast, the RC-Southwest Medical Advisor focused their developmental efforts on improving the medical capability of the ANA and encouraged the use of civilian healthcare facilities. In effect, RC-Southwest did not specifically advise on ANP medical support. RC-Southwest determined the best course of action was to develop and improve the medical capability of ANA, which in turn would provide medical support to injured ANP personnel.

SFAAT[15] assumed responsibility for medical advising in the RCs conducted, in most cases, at the provincial level. Some RCs provided limited guidance regarding ANP medical development to the SFAAT medical advisors. This approach may have developed because ISAF and the MoI had not agreed on an ANP medical development plan. Regardless, several of the U.S. military medical advisors we interviewed in the police zones could not demonstrate a working knowledge of any specific medical system development plan upon which to base their mentoring activities. The SFAAT advisors generally agreed that they needed to operate under one comprehensive and integrated ISAF planning strategy, fully coordinated with the MoI and ANP, with sufficient guidance provided them to be able to implement the strategy.

[15] Security Forces Assistance–Advisory teams are small mission-specific teams designed to provide support and assist in the development of the ANSF.

Despite the lack of a centralized development plan or strategy for the development of ANP medical capability within the provinces, we found isolated efforts by the SFAAT to provide medical advising and first-aid training to police units to help improve their ability to properly care for ANP casualties. Examples of this include the provision of combat lifesaver skills courses previously discussed in Observation 1.

Advisory Efforts Focused More on the ANA than the ANP

NTM-A had initiated medical advising for the ANA Medical Command and for the development of the ANA hospitals in 2004, whereas medical advising at the ANPH did not begin until 2009. As a result, the ANA medical system was further developed than the ANP medical system. We were informed that this occurred because NTM-A lacked sufficient resources to adequately advise both the ANA and ANP hospital development and ANA development was given priority. Additionally, Coalition advisors asserted they had no experience in developing a medical care system for police forces. As a result of these factors, the Coalition gave priority emphasis to use the MoPH state-run public health organization to provide medical support to the ANP and to make ANA hospitals available for use by the police forces.

Several senior Coalition leaders agreed that development of the ANA had been the higher priority. One senior ISAF official asserted that, "It is clear, the priority was the ANA, not MoI and the ANP." Another leader described the ANP as "the stepchild" and explained that the Coalition had in the past concentrated its advisory efforts on the ANA. We were informed and found that, currently, additional emphasis was being placed on ANP development.

Feedback from Medical Advisors

We surveyed and interviewed numerous medical advisors working in the field and found that little effort was expended by their in-country commands to establish a baseline of knowledge for medical advisors to understand and be able to perform their duties in developing ANP healthcare capability. We were informed that one reason that this occurred was due to the haste to deploy medical personnel down range. It also had to do with the fact that orientation to advisory job duties received less priority than unit relief-in-place operations. No one we interviewed ever mentioned having received brigade- or division-level orientations. Advisors consistently reported lack of preparatory knowledge and direction as to what

to emphasize in their jobs once they had assumed their duties. One advisor, after 2 months into an 8-month tour, was told to just "figure it out."

In preparation for our fieldwork, we used a questionnaire to solicit feedback on the experiences of medical advisors who were currently deployed and worked with either the ANA Corps Surgeon or with the ANP police units within the provinces. Of the 14 responses received, 10 were from medical personnel assigned to SFAAT who advised the ANP. Three responses were provided by medical advisors to the ANA Corps Surgeon and one response was received from an NTM-A medical advisor who served as a liaison officer with one of the ANA hospitals. Common themes in the responses included:

- There was a lack of clarity regarding what higher headquarters expected with respect to ANP medical development.
- There was limited knowledge of the ISAF Campaign Plan and Unified Implementation Plan. Several advisors were aware these plans existed but were not familiar with the content. Higher headquarters strategic and operational plan orientations took the form of "threat" briefings.
- With respect to guidance and medical development documentation, responses indicated very little knowledge concerning identifying specific doctrinal manuals and in-country resources. Some advisors characterized their orientations as "surfing command websites."
- Regarding mission and end-state, most responses conveyed a subjective answer to this question, not a precisely understood attainment goal. Respondents provided what they believed they could accomplish during their rotation based on their individual assessments. General comments such as: "having Afghan sustainable systems . . . or achieving the best available medical support they were capable of achieving" were common, but not specific.

Limitations in Medical Advising for the ANP

We found that the majority of advising for point-of-injury care at the provincial-level was conducted by the medical members of SFAAT. However, several of the SFAAT medical personnel expressed that they did not have adequate time to spend on their advisory duties, due to other competing priorities within the SFAAT. As an example, several medical advisors explained that the primary role of the SFAAT medic was to provide for the medical needs of the team and any advisory efforts were a secondary role.

Figure 24. Hungarian SFAAT, Mazar-e-Sharif
Source: DoD IG-SPO

One of the complaints was that the SFAAT had limited resources and was not supported by higher command elements in handling administrative duties, such as completing performance evaluations, award nominations, or other military-specific duties. Additionally, much medical personnel time was spent researching and collecting information for requests for information and feeding this information to higher headquarters. All of these additional duties took time away from face-to-face advising with police units and their medical personnel.

The planned reduction of Coalition forces in support of ISAF's withdrawal of combat forces by December 2014 will reduce, progressively, the number of dedicated medical-advisor assets across the area of operations.

Conclusion

ISAF planning efforts and advisory resources were insufficient for developing the ANP capability to provide effective point-of-injury care.

Although some advisors had individually embarked on efforts to improve the medical training and assistance provided to ANP forces, these efforts were made without the guidance of an ISAF development plan and could have been more focused with a better understanding of the Coalition's specific goals and objectives to establish a sustainable medical program for the care of ANP casualties.

Recommendations, Management Comments, and Our Response

Recommendation 7.a

International Security Assistance Force Command, in coordination with International Security Assistance Force Joint Command, update development plans to ensure they include an emphasis on the development of Afghan National Police point-of-injury care, patient evacuation, and en route care.

International Security Assistance Force Command

ISAF did not respond to the draft report prior to publication.

Our Response

We request that ISAF provide an update within 60 days after the issuance of the final report on progress made in updating plans to ensure they include an emphasis on the development of ANP point-of-injury care, patient evacuation, and en route care.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with the recommendation and explained that an updated plan of action will demonstrate that they are currently working closely with the ANP to include the ANP Training General Command on the continued development of the ANP healthcare system, to include point-of-injury care. Additionally, NTM-A is working with the ANP OTSG to help them with en route care and patient evacuation, which will rely heavily on the collaborative relationships with the ANA and MoPH.

Our Response

The response from NTM-A was partially responsive. We request that within 60 days after the issuance of the final report NTM-A provide a copy of the updated plan of action which describes efforts addressing point-of-injury care, en route care, and patient evacuation.

Recommendation 7.b(1)

International Security Assistance Force Joint Command provide written guidance to Regional Commanders and advisor teams which, at a minimum, addresses goals, objectives, and metrics for the development of a sustainable program for the care of combat casualties.

International Security Assistance Force Joint Command

IJC concurred with recommendation 7.b(1) without additional comment.

Our Response

The response from IJC was partially responsive. While concurring with the recommendation, IJC did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that IJC provide an update within 60 days after the issuance of the final report on what guidance they have provided to the Regional Commanders and advisor teams to develop a sustainable program for the care of ANP combat casualties. Additionally, provide a copy of documents which describe the plan they have implemented to assist the ANP in building a viable program to care for their combat casualties.

Recommendation 7.b(2)

International Security Assistance Force Joint Command ensure that medical advisory assets, including those from the Security Force Assistance Advisory Teams, prioritize development of Afghan National Police point-of-injury care and patient evacuation capability. Specifically, ensure that Security Forces Assistance-Advisor Teams medical advisory personnel assist the development of an effective program to provide for the first aid, treatment, and transport of Afghan National Police casualties.

International Security Assistance Force Joint Command

IJC concurred with recommendation 7.b(2) without additional comment.

Our Response

The response from IJC was partially responsive. While concurring with the recommendation, IJC did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that IJC provide an update within 60 days after the issuance of the final report on the efforts of the SFAAT to develop an effective program to provide for the first aid, treatment, and transport of ANP casualties.

Observation 8

Medical Logistics

NTM-A and IJC efforts to establish an efficient and effective ANP medical logistics system were marginally effective and required additional development to improve the availability of Class VIII[16] medical supplies to the ANP Hospital and associated clinics.

This issue can be attributed to the following identified factors:

- Insufficient medical advisory resources were committed to the development of the ANP National Medical Warehouse (NMW) in Kabul which contributed to the warehouse being in disarray. Some supplies had been there for a prolonged period of time without having been distributed.
- The clinics often did not receive medical supplies requested by submitted MoI Form 14 documentation.
- The present distribution system for Class VIII supplies was so inefficient ANP personnel from clinics had to drive to the NMW to request and pick up their supplies, risking lengthy travel on dangerous roads.

Without an effective medical logistics system, the ANP cannot meet its supply needs for critical medications and essential medical supplies, which as a consequence, adversely impacts patient care.

[16] Class VIII supplies are medical supplies, including pharmaceuticals and repair parts for medical equipment.

Applicable Criteria

(See Appendix C, number 18, for additional details.)

Ministry of Interior Policy "Process for the Management of Logistics," January 2009.

Discussion

We found the ANP medical logistics system to be marginally effective in providing medical supplies and pharmaceuticals to ANP medical facilities. This was due, in part, to insufficient medical advisory resources focused on the development of the ANP medical logistics system, to include the NMW in Kabul.

Insufficient Medical Logistics Advisory Resources

There were two advisor positions authorized to mentor medical logistics development within the ANP OTSG. The advisor authorization included one contractor position and one military medical logistics subject matter expert. The contractor was responsible for mentoring the Deputy Director of the ANP Medical Logistics Warehouse/ Purchasing Agent, and the military advisor mentored the Director of the ANP Medical Logistics Warehouse.

We found that an assigned civilian contractor had been engaged in advising ANP medical logistics for nearly 3 years. This individual was highly knowledgeable about ANP medical logistics and the Coalition's previous developmental efforts to improve the system. However, he did not renew his term of employment and re-deployed in May 2013. Although the vendor immediately began recruiting efforts to replace this individual, his absence resulted in a 4-month gap in the contracted position. This resulted in a 50 percent reduction in advisory resources and left the military advisor, with much less experience, as the only resource to continue the necessary mentoring. This situation continued until September 2013 when a qualified contract medical logistics advisor was found to fill the vacant position.

A lack of continuity in filling the military advisor position further limited the medical logistics advisory effort. Initially, a U.S. Air Force officer filled the position. However, this individual was re-assigned within 1 month of her arrival to oversee the ANP medical finance and budget activities for NTM-A, based on her experience in finance.

In May 2013, another U.S. Air Force officer was assigned as the ANP medical logistics advisor after his arrival in Afghanistan. His military occupational specialty was financial management, and he had limited experience with medical logistics. This individual was initially selected to fill a financial manager position within NTM-A. Therefore he attended pre-deployment training that did not prepare him for his eventual advisory duties as the medical logistics advisor. He was not adequately prepared to assume this advisory role.

Another factor negatively impacting the development of the ANP medical logistics system was the limited hours available to the logistics advisor to directly mentor ANP medical logistics personnel due to insufficient transportation assets. The NTM-A Office of the Command Surgeon had several vehicles available to transport medical advisors. However, they were committed to other medical advisory missions and not made available for the medical logistics advisor. Although

the medical logistics advisor attempted to arrange other transportation with NTM-A movement assets, several of these missions were cancelled due to security reasons or higher priority movement requests.

As a result, the medical logistics advisor was only able to visit the medical warehouse five times in a 5-week period, whereas medical advisors at the ANPH were able to visit the hospital three to five times per week. Without significantly increasing the frequency of advisor visits, the medical warehouse will not receive the advisory attention it clearly needs and will not be able to provide effective medical logistics system support.

Additionally, written resource materials available for medical logistics advisors were very limited. The ISAF ANP Logistics Mentor Handbook, produced in 2011, contained general information regarding the organization and function of the ANP logistics systems. However, the handbook did not contain information specifically related to Class VIII supplies or the development of warehousing plans and operations.

ANP Medical Logistics and the National Medical Warehouse

In June 2009, the ANP Surgeon General assumed responsibility for the medical logistics process, with advisory support provided by NTM-A. The MoI/ANP medical logistics infrastructure consisted of the National Medical Warehouse (NMW), a 45,000 square feet medical depot in a leased facility in Kabul. The depot was responsible for distributing medical supplies and pharmaceuticals to the ANP Hospital, 21 ANP medical clinics within Kabul, and to over 100 ANP clinics throughout the remaining 33 Afghan provinces.

Figure 25. Interior of ANP National Medical Warehouse, Kabul
Source: DoD IG-SPO

NTM-A advisors reported the current supply depot to be inadequate due to structural issues and the lack of environmental controls. MoI, with the assistance of NTM-A, identified another warehouse facility and has planned to move the medical warehouse operations in the Spring 2014.

NTM-A and MoI were working to address the following required actions to support the move:

- obtaining additional pallets needed for the move,
- establishing a transportation contract to move items,
- clearing out the replacement facility,
- installing adequate shelving for the new operation,
- installing power receptacles for forklifts, and
- identifying requirements to facilitate the move, to include establishing Internet access and finalizing office accommodations.

In June 2013, when we visited the current warehouse and interviewed the staff, we observed that the facility was dirty, disorganized, and supplies were improperly stacked on the ground without proper pallets.

The military advisor explained that the Afghans did not have a written warehousing plan to organize the warehouse, but they could verbally articulate their plan for the new warehouse.

Additionally, there were significant amounts of medical supplies on hand, including antibiotics and intravenous solutions. These materials required the attention of warehouse personnel to ensure they were used prior to their stated expiration date. NMW had a policy to send items to the hospital and clinics so they could be used prior to expiring. Of the items we inspected, all were current and had at least several months left prior to expiring. However, the large quantities of these supplies on hand raised the question whether they would be used prior to their expiration date.

Figure 26. Excess Medical Gear in ANP National Medical Warehouse
Source: DoD IG-SPO

Distribution System for Class VIII Supplies

In general, we found that the ANP medical logistics system primarily operated as a "pull" system; the warehouse prepares to fill a request once a request for supplies is received from the ANPH and outlying medical clinics. In accordance with the MoI logistics policy, MoI Form 14s were used to request items, and Form 9s were used to acknowledge receipt when the items were delivered. Typically, the orders were requested on a quarterly basis. We also found that the warehouse "pushed" medications that were near expiration to the outlying clinics where they could be used prior to expiring. This process was outlined in their logistics policy and was intended to avoid the waste of expired medications.

The MoI had over 130 clinics in Afghanistan which were supplied from the NMW in Kabul. To obtain medical supplies and pharmaceuticals, an ANP medical quartermaster or other authorized medical officer had to drive to the NMW with the appropriate forms to obtain desired supplies. If the list of items requested was extensive, quartermasters were known to wait for several days while the order was filled to the extent possible. Medical personnel who performed this process informed us that they did not always receive all of the items that they requested. The warehouse did not have all items that they needed in stock and warehouse personnel did not tell them when, or if, they would receive those needed items.

Complaints included the following:

- A physician assistant from ABP Zone 2 medical clinic (Gardez) shared that he had to go to the local bazaar to purchase antibiotics because the clinic didn't have enough medications on hand to administer to patients. These outside purchases were not reimbursed by MoI. Additionally, he explained that he did not have any anti-malaria medicine, although it had been ordered several months before.
- The AUP Zone 202 (Nangahar) surgeon complained that he was not receiving all the items that he ordered. Specifically, he mentioned anti-malaria medicine as one medication that he needed but didn't have in stock. Additionally, a year ago he ordered 3,500 mosquito nets for police personnel in his zone, but only received 100 of them because that was all that was available in the warehouse.
- A physician from the 3rd Brigade ANCOP medical clinic (Balkh) stated that he requested 195 items, including medical consumable supplies and medications, but the clinic only received 40 to 50 of the requested items and were not told why they did not get the remainder.
- A physician from the Provincial Headquarters AUP clinic (Kandahar) claimed he requested 108 items, but only received 48 items. We offered to trace the MoI 14 request for this order. However, he didn't have a copy of the form that he could show us. Additionally, he claimed that he needed and was unable to receive from the NMW, antihistamines used to treat allergies.
- A medical advisor in RC-North (Mazar-e Sharif) reported that the ABP medical clinic had difficulty obtaining the necessary antibiotics to treat diarrhea conditions caused by drinking poor quality water.
- A medical officer in charge of the combined ABP (Zone 1)/ANCOP (5th Brigade) (Jalalabad) medical clinic told us that medical officers paid for items at the bazaar that they couldn't get from the NMW using money from their personal salary, without reimbursement. Additionally, patients purchased medications at the bazaar when they were not available at the clinic, again without reimbursement.

Additional concerns with the ANP medical supply distribution system pertained to the safety of the individuals who picked up medical supplies in Kabul and the

time medical professionals spent away from the clinic to obtain the supplies. Reports from several medical personnel working in the provinces indicated that they drove personal vehicles to Kabul for periods of up to 12 hours through treacherous, insecure areas to obtain medical supplies from the medical warehouse. Additionally, these individuals waited in Kabul for the request order to be filled before returning to their clinics, a process that at times took weeks to complete.

In an effort to reduce the waiting time in Kabul, the warehouse had recently started a process whereby supply requests could be submitted via e-mail. Additionally, NTM-A advisors informed that, on occasion, the warehouse utilized MoI Material Management Center (MMC) transport assets to carry medical supplies using existing supply convoys. However, there were no medical quartermasters within the MMC organization to oversee storage and distribution of medical supplies requiring special handling requirements.

The distribution process for the delivery of medical supplies appeared inefficient and, in numbers of cases, the medical clinics did not receive the supplies they required to properly care for patients. Additionally, medical personnel from the outlying clinics were at increased risk of harm given the primary method to obtain medical supplies was driving on dangerous roads to get to the Kabul warehouse.

ANP medical logistics personnel recommended that MoI establish four regional medical warehouses to improve supply distribution to the outlying clinics; however, this was not viewed as a priority by the ANP Surgeon General and therefore was not acted upon. Implementing a regional distribution system would alleviate the need for clinic personnel outside Kabul to drive to the NMW for medical supplies.

Conclusion

The ANP medical logistics system was marginally effective and required additional development to improve the availability of essential Class VIII supplies.

Developing an effective ANSF logistics system in Afghanistan has been a long-standing and challenging effort. As described in the "Report on Progress Toward Security and Stability in Afghanistan," published in July 2013, logistics is identified as one of the ANSF enablers that will need continued assistance through the end of December 2014 and beyond. As such, it is critical for the command to ensure there are sufficient qualified advisory resources to continue development of ANSF logistics in key areas.

Recommendations, Management Comments, and Our Response

Revised Recommendation 8.a

U.S. Central Command, in coordination with the North Atlantic Treaty Organization Training Mission–Afghanistan and the sourcing service, ensure that the medical logistics advisory position attached to the Afghan National Police Office of the Surgeon General is properly identified in the Joint Manning or Request for Forces document to ensure that the appropriate rank and requisite medical logistics skill experience is included and the position is filled appropriately by the sourcing service.

U.S. Central Command

U.S. Central Command concurred with recommendation 8.a and explained that the Medical Logistics mentor position should be filled with personnel that have the appropriate experience and training. Additionally, they added that it was critical that the sourcing service and those monitoring the assignment of personnel against these requirements pay close attention to the special remarks and job descriptions listed in the Joint Manning or Request for Forces documents. These details ensure that Individual Augmentees/service members tasked to these billets have the appropriate skillset to provide guidance to their mentees. Furthermore, USCENTCOM explained that using just the Military Occupational Specialty/Air Force Specialty Code/ Naval Officer Billet Classification does not always guarantee that the tasked officer has the required skillset.

Our Response

The response from USCENTCOM was partially responsive. While concurring with the recommendation, USCENTCOM did not specify what actions it had already taken or planned to take for implementing the recommendation. They did provide information which allowed us to revise the recommendation to address language needed in the Joint Manning or Request for Forces documents to ensure the medical logistics position is filled with a person of appropriate rank and skillset. We request that USCENTCOM coordinate with the sourcing service and NTM-A to provide an update within 60 days after the issuance of the final report on what actions were taken to ensure the appropriate language is included in the

Joint Manning or Request for Forces documents to properly identify the best personnel to fill the medical logistics advisor position. Additionally, provide an update on efforts to ensure that personnel filling the medical logistics advisor position in the future will have the appropriate rank and skillset.

Recommendation 8.b

North Atlantic Treaty Organization Training Mission–Afghanistan advise and assist the Office of the Surgeon General to improve the warehousing plan for the Afghan National Police National Medical Warehouse. Additionally, leverage available logistics experts to assist the Office of the Surgeon General in the design and implementation of this plan.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 8.b without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide an update on the warehousing plan for the ANP NMW within 60 days after the issuance of the final report. Additionally describe the current medical logistics advisory resources that are available to assist the OTSG in implementing an effective warehousing plan.

Recommendation 8.c

International Security Assistance Force Joint Command, in coordination with North Atlantic Treaty Organization Training Mission–Afghanistan and Ministry of Interior, assess the effectiveness of the current process for requesting, filling, issuing, and distributing Class VIII supplies. Specifically, evaluate the process and procedures used by the 130 Afghan National Police clinics when submitting Ministry of Interior Form-14s, the timely responsiveness of filling these requests by National Medical Warehouse, and the efficiencies of distributing these orders to the requesting clinics. Based on results, mentor the development of a plan to improve the effectiveness of the request and distribution process.

International Security Assistance Force Joint Command

IJC concurred with recommendation 8.c without additional comment.

Our Response

The response from IJC was partially responsive. While concurring with the recommendation, IJC did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that IJC provide an update within 60 days after the issuance of the final report on the effectiveness of the current process to request, fill, issue, and distribute Class VIII supplies for the ANP clinics outside the Kabul area. Additionally, provide information on what is being done to improve the effectiveness of the request and distribution process for the ANP clinics.

Observation 9

Oversight and Management of Afghan National Police Healthcare Capability

Although the OTSG had the responsibility for oversight and the management of all medical activities within the MoI, his lack of authority resulted in significantly varying degrees of medical support to the ANP.

This was due, in part, to the lack of clearly defined responsibilities and authority for the OTSG in reference to the oversight of the medical care and services provided to the ANP. Additionally, the placement of the OTSG within the MoI organizational structure was not optimal.

As such, the Surgeon General had limited influence to affect manning, equipping, and training of ANP medical personnel to improve healthcare operations. The lack of effective OTSG operations as well as MoI management and oversight of ANP healthcare services jeopardized the development of a uniformly effective and sustainable ANP medical system.

Applicable Criteria

(See Appendix C, number 1, 2, 3, 5, and 15, for additional details.)

International Security Assistance Force Afghan National Security Forces Healthcare System Development Support Plan to COMISAF OPLAN 38302, November 28, 2011.

International Security Assistance Force Joint Command Standard Operating Procedures 1147 ANSF Healthcare Development-Corps and Below, January 15, 2011.

North Atlantic Treaty Organization–Afghanistan/Combined Security Transition Command–Afghanistan Base Order 2012-2014, Command Surgeon, January 9, 2012.

North Atlantic Treaty Organization Training Mission–Afghanistan ANSF Health System Development Plan, May 2013.

Ministry of Interior "Surgeon General Organization and Functions Manual" (Draft), August 24, 2011.

Discussion

We found wide ranging degrees of medical support and capability across the ANP. This was due, in part, to organizational and operational complexities within the MoI which hindered the ANP Surgeon General from providing effective oversight to manage the medical developmental effort and his lack of authority to carry out essential support functions.

Healthcare Responsibilities and Span of Control

We found that the MoI had not published a document outlining the formal responsibilities of the ANP Surgeon General with respect to oversight and management of ANP medical activities. However, we were shown a draft "Surgeon General Organization and Functions Manual (OFM)," dated August 24, 2011, that outlined the Surgeon General's responsibilities as follows:

> The Surgeon General is responsible for the provision of all medical care and services to the ANP, reporting directly to the MoI Deputy Minister for Support. Additionally, the Surgeon General oversees the development of ANP medical policy and training development. The Surgeon General's direct span of command and control is limited. However, the Surgeon General exercises technical staff supervision over all other facilities and organizations of the ANP involved in the delivery of health services. The Surgeon General carries out much of his responsibilities by issuing medical-specific policy, directives, and decrees through the MoI and employing technical channels to coordinate with medical personnel assigned or attached to subordinate organizations within the MoI.

Oversight and Management of Medical Operations

A senior medical advisor within NTM-A explained that there was a "huge gap" in the oversight of medical operations between what occurred in Kabul and the medical activities throughout the provinces in the various AUP, ABP, and ANCOP clinics. There were communication challenges, as well as command and control issues between the MoI and ANP Surgeon General, and with the various police pillars (organizations). The senior advisor informed us that the ANP Surgeon General's authority outside of Kabul was negligible, and he believed this had a negative impact on the development of an effective ANP healthcare system.

Although the draft OFM designated the Surgeon General as responsible for the oversight of all medical activities within MoI, in reality the Surgeon General did not have the authority to perform this function. The individual police commanders and the police pillar leads, not the Surgeon General, had command and control over the management of medical personnel activities within the various police units in the provinces.

Observation 2 identified that ANP medics were not always assigned to work in medical positions. As a result, there were insufficient numbers of medics to properly care for ANP casualties in a number of ANP units and locations. The Surgeon General was aware of this problem, but he had no influence over the decisions made by police leaders to use medics in non-medical positions. A senior leader at IJC explained that, although MoI understood the priorities and level of effort to develop an adequate healthcare capability, provincial and district chiefs of police "really run things" and if they don't see medics and point-of-injury care as important, they will put their medics to work elsewhere. Recognizing this problem, IJC continues to advise and assist police leadership in the field to properly employ their medics to improve casualty response.

Complexity of the Police Operating Elements

The MoI organizational structure and command and control relationships were complex. The police forces were comprised of 4 main police organizations (also called "pillars") and 2 sub-pillars spread throughout Afghanistan's 34 provinces.[17] Although the various police pillars were contained within the MoI organizational structure, Provincial Chiefs of Police controlled the activities of the various police units within their respective provinces.

The Surgeon General reported directly to the Deputy Minister for Support; whereas the six police organizations (ABP, ANCOP, AUP, Afghan Anti-Crime Police (AACP), Afghan Local Police (ALP), and Judiciary Police) reported to the Deputy Minister for Security. This presented a significant challenge for the Surgeon General because the organizational structure made it difficult for him to directly assist or address medical issues for a particular pillar. One senior NTM-A official explained that MoI had significant institutional management challenges, to include the command and control structure for the various pillars of the ANP and that the various police units were scattered throughout the country. These challenges were more difficult

[17] The ANP are comprised of four main pillars (AUP, ANCOP, ABP, and AACP) and two sub-pillars (ALP and Judiciary Police). Refer to Appendix D for a description of each police pillar.

to overcome in the MoI than the MoD due to organization structure differences between the army and the police, thus making it more difficult for the Coalition to support MoI's ongoing developmental efforts. Appendix E presents a picture of the overall MoI organization and the placement of the Surgeon General and various police pillars.

Minimal Oversight for the Management of the ANP Healthcare System

We found several examples that reflected medical care inconsistencies and/or weak management that we believe contributed to the lack of a cohesive and comprehensive medical healthcare system for the ANP. Examples follow:

- Significant variance in ANP clinic capability and conditions. We found medical personnel were working in inadequate and unsafe conditions at the AUP Provincial Headquarters clinic in Kandahar. Patients were cared for in a sparsely furnished metal container with inadequate ventilation; medications were stored in ambulances due to the lack of adequate storage space. The clinic was located at the bottom of a hill and at times became flooded when it rained. Additionally, we saw puddles of brackish water at the top of the hill which drained towards the clinic during periods of rainfall. This raised a concern for the health of the individuals working in and visiting the clinic.

Figure 27. Provincial Headquarters AUP Clinic, Kandahar
Source: DoD IG-SPO

- Conversely, we found a combined ABP and ANCOP clinic in Paktiya Province that was in very good condition. The clinic was recently built, had a large triage room and several exam rooms, and eight beds to hold patients who required an overnight stay. Additionally, the clinic had a laboratory room and a fully equipped dental room. However, neither the laboratory nor dental room were listed on the clinic's Tashkil and therefore were not sustainable. ANP clinic personnel obtained the necessary equipment on their own in order to have a full service clinic. Clinic personnel were working with the Surgeon General to determine if they could add this medical equipment to the Tashkil in order to ensure proper maintenance of the equipment and receive the necessary supplies for sustainment.

- Substantial disparity in ANP medical clinic staffing, medical personnel qualifications, and availability of equipment. We found that there were no doctors assigned to the ABP clinic in Kandahar. In Mazar-e-Sharif, the ABP clinic director complained that they did not have enough medical personnel to cover nine provinces, which included eight ABP Kandaks and eight border patrol points. The medical personnel that he had assigned to support the 9 provinces were 5 physicians (including him) and 44 medics, of which only 30 were trained in the 8-week Trauma Assistance Personnel course.

Figure 28. Provincial Headquarters AUP Clinic, Mazar-e-Sharif
Source: DoD IG-SPO

- Additionally, the AUP clinic in Mazar-e-Sharif was just re-located to a larger compound due to the disestablishment of the AUP zone headquarters. The new location was a former eye clinic/hospital. It was fairly large, had multiple patient examination rooms and over 20 beds were set up to receive patients. However, the facility did not have adequate climate control (no air conditioning or heat), nor did it have the surgical staff or medical equipment listed on the Tashkil to properly care for police casualties. The medical director for the AUP clinic explained that the ANP in his location averaged 12 casualties per week, and he needed more surgical capability to properly care for the injured.

- Inconsistency in medical training and equipping for individual policemen and medics. As discussed in Observation 1, we found that, beyond basic first-aid training, there was no program for ongoing sustainment training for point-of-injury care and en route care. There was a basic lack of understanding among police leaders regarding the requirements and qualifications for medics. Lastly, we identified a severe shortage of individual first-aid kits and medic trauma bags, as well as a lack of understanding by advisors and ANP officials regarding how they were to be issued and maintained.

Conclusion

There was a fundamental lack of effective oversight and management of the ANP healthcare system. Although the Surgeon General had the responsibility for the management of MoI medical activities, as outlined in the draft OFM, he had no authority to influence conditions. The complexity of organizational structures within the MoI, coupled with the lack of sufficient delineation of responsibilities and authorities for medical development resulted in a disparate healthcare capability for which there existed no clear MoI or ANP plan to significantly improve conditions.

Recommendations, Management Comments, and Our Response

Recommendation 9.a

North Atlantic Treaty Organization Training Mission–Afghanistan advise and assist Ministry of Interior and the Office of the Surgeon General to review, update, and issue the Office of the Surgeon General Organization and Functions Manual that includes a description of the duties, responsibilities, and authority for the Afghan National Police Surgeon General.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 9.a without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide within 60 days after the issuance of the final report an update on the revision of the OTSG Organization and Functions Manual. If the manual has been updated, please provide a copy in your response.

Recommendation 9.b

North Atlantic Treaty Organization Training Mission–Afghanistan advise and assist Ministry of Interior and the Office of the Surgeon General to identify factors which exist to limit the Afghan National Police Surgeon General from providing effective oversight of the medical care and services for the police forces and propose solutions to make improvements.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 9.b without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide within 60 days after the issuance of the final report an update on improvements in the ANP Surgeon General's oversight of the medical care and services for the police forces.

> ### ***Recommendation 9.c***
>
> North Atlantic Treaty Organization Training Mission–Afghanistan advise and assist Ministry of Interior and the Office of the Surgeon General to identify the appropriate requirements for effective Afghan National Police clinic operations to include facilities, clinical services, manning, and equipment to provide quality medical care. Ensure Tashkils are updated accordingly.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 9.c without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide within 60 days after the issuance of the final report an update on the OTSG's efforts to identify the appropriate requirements for effective clinic operations to include facilities, clinical services, manning, and equipment needed for the provision of medical care. Additionally, provide an update on the Tashkils for these clinics.

Recommendation 9.d

North Atlantic Treaty Organization Training Mission–Afghanistan, in coordination with Combined Security Transition Command–Afghanistan, advise and assist the Office of the Surgeon General to conduct key leader engagements with Ministry of Interior to ensure the Afghan National Police Surgeon General is provided authority to discharge his responsibilities for oversight of healthcare services provided to the Afghan National Police and the manning, equipping, and training of Afghan National Police medical personnel.

North Atlantic Treaty Organization Training Mission-Afghanistan

NTM-A concurred with recommendation 9.d without additional comment.

Our Response

The response from NTM-A was partially responsive. While concurring with the recommendation, NTM-A did not specify what actions it had already taken or planned to take for implementing the recommendation. We request that NTM-A provide within 60 days after the issuance of the final report an update on any efforts or actions taken to improve the ANP Surgeon General's ability to provide effective oversight of healthcare services to the ANP. Include a description of improvements made in the manning, equipping, and training of ANP medical personnel.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Appendix A

Scope and Methodology

We conducted this assessment from April 2013 to September 2013, in accordance with the Quality Standards for Inspections. We planned and performed the assessment to obtain sufficient and appropriate evidence to provide a reasonable basis for our observations, conclusions, and recommendations, based on our objectives. Site visits to Afghanistan were conducted from June 7, 2013, to July 7, 2013.

We reviewed documents such as Federal laws and regulations, DoD directives, and instructions. We also reviewed appropriate U.S. Central Command, NATO/ISAF, U.S. Forces-Afghanistan, IJC, NTM-A/CSTC-A, and MoI guidance, to include published reports, operational plans, and previous inspection and/or assessment reports related to the ANSF healthcare system and ANSF medical logistics. Additionally, we reviewed activities that directly related to efforts to develop the healthcare capability for the Afghan National Police:

- U.S. and Coalition strategy, guidance, and plans;
- U.S. and Coalition orders, Fragmentary Orders, and policies;
- activities and opinions of U.S. and Coalition personnel;
- Afghan MoI strategy, guidance, and plans;
- GIRoA and MoI Decrees; and
- activities and opinions of Afghan officials and ANSF personnel.

The purpose of our assessment was to evaluate the progress of U.S. and Coalition efforts to develop an effective and sustainable healthcare capability in support of the Afghan National Police. As such, we wanted to determine whether U.S. and Coalition:

- plans to develop effective and sustainable healthcare services to the ANP are sufficiently comprehensive, coordinated with GIRoA, and being implemented so as to meet the timeline for transition goals;
- advisory resources are sufficient and appropriate in order to develop the healthcare services necessary to support the medical needs of the ANP; and

- developmental efforts are on schedule and effective in ensuring there is adequate medical capability, including logistics, to provide proper medical support to ANP personnel from the point of injury to the next required level of care.

We met with U.S. Military and Coalition members from the NTM-A/CSTC-A who mentor and advise at the MoI, MoD, MoPH, and ANPH. We also interviewed ANPH executive-level leaders and other Office of the Surgeon General personnel to determine matters pertinent to the overall care of the ANP, from treatment at the point of injury, transport to the next level of care, and treatment of the ANP at ANA and MoPH facilities. Additionally, we interviewed ISAF, ISAF Joint Command, and Regional Command (East, South, Southwest, and North) personnel responsible for ANSF development to determine the status of plans for the development of ANP healthcare capability to include point-of-injury care, en route care, patient evacuation, and medical logistics.

We visited ANP, ANA, and Coalition medical facilities in six provinces of Afghanistan: Kabul (Kabul), Paktiya (Gardez), Nangahar (Gamberi), Kandahar (Kandahar), Helmand (Shorabak), and Balkh (Mazar-e-Sharif). We interviewed medical leaders and conducted a walk-through of the medical facilities, focusing on the support that was provided to ANP casualties. Additionally, we interviewed 27 ANP patients to better understand the first aid that was given when they were injured and their impressions of the healthcare they received once they were transported to a higher level of care. During our site visit, we toured the following medical facilities:

- Coalition facilities: Kandahar & Bastion Hospitals;
- MoI facility: ANP Hospital–Kabul;
- MoD facilities: ANA Regional Medical Hospitals (Paktiya, Kandahar, and Mazar-e-Sharif);
- MoI facilities: ANP Regional and Provincial Clinics (Kabul, Gardez, Gamberi, Kandahar, and Mazar e-Sharif);
- MoD facilities: ANA Troop Medical Clinics (Gardez and Shorabak); and
- ANP National Medical Warehouse: Kabul.

Furthermore, we visited AUP, ABP, and ANCOP police headquarters at the MoI in Kabul, as well as associated AUP, ABP, and ANCOP police units in five provinces of

Afghanistan: Paktiya, Nangahar, Kandahar, Helmand, and Balkh. We interviewed police leaders to determine what challenges they had in caring for ANP personnel who were injured on the battlefield. Additionally, we spoke with U.S. and Coalition leaders and advisors who were associated with these ANP leaders. Specific ANP units we visited included:

- Kabul Province: ANCOP 1st Brigade Headquarters (HQ) and clinic;
- Paktiya Province: ABP 2nd Zone HQ and clinic;
- Nangahar Province: ABP 1st Zone HQ and Combined ABP 1st Zone and ANCOP 5th Brigade clinic;
- Kandahar Province: AUP Provincial Headquarters (PHQ) Kandahar and clinic, ABP 3rd Zone HQ and clinic, ANCOP 4th Brigade HQ clinic, Regional Police Training Center (RPTC)–Kandahar clinic; and
- Balkh Province: AUP PHQ Mazar-e-Sharif and clinic, ABP 5th Zone HQ and clinic, ANCOP 3rd Brigade HQ and clinic, RPTC Mazar-e-Sharif clinic.

Limitations

We limited our review to DoD-funded programs, NATO-funded programs, and international donation programs supporting the security forces of Afghanistan. We further limited our assessment to the AUP, ABP, and the ANCOP, equal to 80 percent of the total police force per Tashkil. Additionally, due to the increased threat, we were unable to visit ANP locations external to Camp Leatherneck and Camp Bastion, Helmand Province.

Use of Computer-Processed Data

We did not utilize any computer-processed data in this assessment.

Use of Technical Assistance

We did not use technical assistance to perform this assessment.

Appendix B

Prior Coverage

During the last four years, the Department of Defense (DoD), the Government Accountability Office (GAO), the Special Inspector General for Afghan Reconstruction (SIGAR), and the Department of Defense Office of Inspector General have issued a number of reports and testimony discussing the development, accountability, and control of logistics and supplies for the MoI and police component of the ANSF.

Unrestricted DoD reports can be accessed over be Internet at http://www.defense.gov/pubs.

Unrestricted GAO reports can be accessed over the Internet at http://www.gao.gov.

Unrestricted SIGAR reports can be accessed over the Internet at http://www.sigar.mil.

Unrestricted DoD IG reports can be accessed over the Internet http://www.dodig.mil/audit/reports.

Some of the prior coverage we used in preparing this report has included:

Department of Defense

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," July 2013.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," April and December 2012.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," April and December 2011.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," April and November 2010.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," June and October 2009.

GAO

GAO-13-381, "Security Force Assistance, More Detailed Planning and Improved Access to Information Needed to Guide Efforts of Advisor Teams in Afghanistan," April 2013.

GAO-12-951T, "Long-standing Challenges May Affect Progress and Sustainment of Afghan National Security Forces," July 24, 2012.

GAO-11-710, "Afghanistan: Actions Needed to Improve Accountability of U.S. Assistance to Afghanistan Government," July 2011.

GAO-10-842T, "Preliminary Observations on DOD's Progress and Challenges in Distributing Supplies and Equipment to Afghanistan," June 2010.

GAO-10-655R, "Strategic Framework for U.S. Efforts in Afghanistan," June 2010.

SIGAR

SIGAR Audit 13-17, Health Services in Afghanistan: USAID Continues Providing Millions of Dollars to the Ministry of Public Health despite the Risk of Misuse of Funds, September 5, 2013.

SIGAR Quarterly Report 2013-07-30, "Quarterly Report to the United States Congress," July 30, 2013.

SIGAR Audit 13-9, "Health Services in Afghanistan: Two New USAID-Funded Hospitals May Not Be Sustainable and Existing Hospitals Are Facing Shortages in Some Key Medical Positions," April 29, 2013.

SIGAR Audit 12-04, "DoD Improved Its Accountability for Vehicles Provided to the Afghan National Security Forces, but Should Follow Up on End-Use Monitoring Findings," January 12, 2012.

SIGAR Audit 11-10, "Despite Improvements in MoI's Personnel Systems, Additional Actions Are Needed to Completely Verify ANP Payroll Costs and Workforce Strength," April 25, 2011.

DoD IG

DoD IG Report No. 2012-035.5, "Assessment of Afghan National Security Forces Metrics, Ministry of Interior Police Forces, October 2013 – March 2013," June 28, 2013 (CLASSIFIED REPORT).

DoD IG Report No. 2013-081, "Assessment of U.S. Government and Coalition Efforts to Train, Equip, and Advise the Afghan Border Police," May 24, 2013.

DoD IG Report No. 2013-058, "Assessment of U.S. Efforts to Develop the ANSF Command, Control, and Coordination System," March 22, 2013.

DoD IG Report No. 2013-053, "Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable Afghan National Security Forces Medical Logistics at the Dawood National Military Hospital," March 13, 2013.

DoD IG Report No. 2012-109, "Assessment of U.S. Government and Coalition Efforts to Develop the Afghan Local Police," July 9, 2012.

DoD IG Report No. 2012-083, "Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution," May 7, 2012.

DoD IG Report No. SPO-2012-028, "Assessment of U.S. Government and Coalition Efforts to Develop the Logistics Sustainment Capability of Afghan National Army." December 9, 2011.

DoD IG Report No. D-2011-095, "Afghan National Police Training Program: Lessons Learned during the Transition of Contract Administration," August 15, 2011, a joint audit by the Inspectors General of the Department of State and Department of Defense (DOS Report No. AUD/CG-11-42).

DoD IG Report No. SPO-2011-007, "Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces," June 14, 2011.

DoD IG Report No. SPO-2011-003, "Assessment of U.S. Government Efforts to Train, Equip, and Mentor the Expanded Afghan National Police," March 3, 2011.

DoD IG Report No. SPO-2010-001, "Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces," March 31, 2010.

DoD IG Report No. SPO-2009-007, "Report on the Assessment of U.S. and Coalition Plans to Train, Equip, and Field the Afghan National Security Forces," September 30, 2009.

Appendix C

Criteria

International Security Assistance Force (ISAF)

1. **International Security Assistance Force (ISAF) Afghan National Security Forces (ANSF) Healthcare System Development Support Plan to COMISAF OPLAN 38302, dated November 28, 2011.** This transition plan was developed by ISAF to guide Coalition efforts in their assistance to the ANSF in the development of their healthcare system and to assist in preparing for transition at the end of 2014. The transition objective for the ANSF was focused on Warrior Care, providing health support to the ANSF members from recruitment through discharge in both outpatient and inpatient settings.

ISAF Joint Command (IJC)

2. **ISAF Joint Command SOP 1147 ANSF Healthcare Development-Corps and Below, dated January 15, 2011.** Establishes a program to guide ANSF Health Development at corps and below and assess progress towards the capability and end state. This plan defines roles and responsibilities; clarifies command and control relationships; establishes the objective measures and rating definition levels that integrate with the Commander's Update Assessment Tool (CUAT); established the mission essential task list; provides tactical level training guidance; establishes the methodology and timeline for reporting; and documents training resources for ANSF health development personnel.

North Atlantic Treaty Organization (NATO) Training Mission–Afghanistan (NTM-A)

3. **NATO Training Mission-Afghanistan (NTM-A) ANSF Health System Development Plan, dated May 2013.** This plan provides guidance and details of the NTM-A Command Surgeon's goals and objectives to be achieved in support of a transition to a sustainable and autonomous operation of the ANSF healthcare system. The plan identifies the lines of operation, lines of development, and measures of effectiveness guiding the advising mission in support of achieving a sustainable Afghan military healthcare system and is in support of the ISAF ANSF Healthcare System Development Support Plan. Line of Operation #1 is "Support to

Operations" and identifies Wounded Warrior as a line of development focused on ensuring all Wounded Warriors receive the highest possible care and services in support of their full recovery.

4. **NTM-A/CSTC-A MoI Mentoring and Training Statement of Work (W91CRB-11-C-0053), Section 9.6, "Trauma Assistance Personnel (TAP) Course," dated March 31, 2012.** Section 9.6 is specific to the TAP course and is in support of the ANP/MoI to provide oversight, continuity, and quality assurance and program management to train first-level healthcare providers and produce qualified and capable personnel to provide emergency and evacuation patient care in forward operating Afghan National Police operations in Afghanistan.

5. **NTM-A/CSTC-A BASEORD 2012-2014, Command Surgeon, dated January 9, 2012.** The NTM-A Command Surgeon's campaign plan is for the establishment of a functioning ANSF medical system by the end of 2014 in order to transition operations to an Afghan lead. The plan is in support of NTM-A BASEORD 2012-2014 and addresses the development of ministerial and institutional leadership, systems and processes, medical capability training, casualty care, hospitalization, patient's movement, and medical logistics.

Government of the Islamic Republic of Afghanistan (GIRoA)

6. **Government of Islamic Republic of Afghanistan, Ministry of Interior Affairs, Deputy Ministry of Policy and Strategy, "Afghan National Police Strategy; 1392 – 1397," dated March 2013.** The National Police Strategy provides strategic guidance for the continued development and operational capability of the Ministry of Interior to meet the current and future challenges of stabilization and security of Afghanistan. This strategy defines the objectives for continued development of the police, law enforcement activities, and associated systems.

7. **Government of Islamic Republic of Afghanistan, Ministry of Interior Affairs, Deputy Ministry of Policy and Strategy, "National Police Plan for Solar Years 1392 and 1393," dated March 2013.** The purpose of the National Police Plan is to provide planning guidance for the continued development of Ministry/Afghan National Police operational capabilities to meet current and future challenges of stabilization, civil order, law enforcement, and security faced by our Nation during Solar Year 1392 and 1393 (equivalent to 2013-2014). This plan was developed in accordance

with the Ministry Strategic Planning Directive and the Afghan National Police Strategy and assigns major tasks for each of the Deputy Ministers and independent departments to complete during the next 2 years according to the National Police Strategy.

8. **Memorandum of Agreement (MOA) Between Minister of Defense (MoD) and Minister of Interior (MoI) to Work Together for the Health Care Needs of the Afghan National Security Forces (ANSF), dated June 5, 2009 (unsigned).** This MOA and follow on activities will ultimately reduce died-of-wound rates, reduce prevalence of disease, improve quality of care, improve provider proficiency, and maximize utilization of existing services within the ANA and ANP or Afghanistan National Security Forces (ANSF).

GIRoA Ministry of Interior (MoI)

9. **Solar Year 1392 Tashkil 3 July 2013, retrieved July 28, 2013 and updated September 14, 2013.** Provides Ministry of Interior-authorized personnel information for Solar Year 1392 (equivalent to mid-2012 through mid-2013). Includes an authorized listing of personnel positions identified by job-type and sorted into specific police units.

10. **Solar Year 1391 Tashkil 3 July 2013, retrieved July 28, 2013.** Provides Ministry of Interior-authorized personnel information for Solar Year 1391 (equivalent to mid-2011 through mid-2012). Includes an authorized listing of personnel positions identified by job-type and sorted into specific police units.

11. **Tashkil Order of the Ministry of Interior of GIRoA – Number 51, Dissemination and Implementation of MoI 1392 Tashkil, received April 13, 2013.** Provides direction to re-organize the 1392 Tashkil for the Afghan Uniform Police into six Type A Provincial Headquarters (Herat, Kandahar, Helmand, Nangahar, Paktiya, and Balkh).

12. **Policies and Procedures of the Pharmacy Department Afghanistan National Police Hospital Kabul, Afghanistan, dated January 31, 2013.** These standard operating procedures defined the duties and responsibilities of pharmacy personnel. Additionally, the manual provided guidance on the following: dispensing of medications, handling of ward medication stock, controlled substances and expired medications, and procedures for management of medications in the pharmacy, among other things.

13. **Afghan National Police Training General Command, Operations Training for the Fielded Force, v1.2, dated April 2012.** The Operations Training program establishes training opportunities for the ANP fielded force in a manner that augments training received in the initial police training course (IPTC) Basic Eight and IPTC Reform Training courses. Operations' training is annual re-certification and re-qualification in those areas mandated by the ANP Training Command group. Operations' training supports the current training system with sustainment-type training to re-enforce skills learned in initial courses.

14. **Afghan National Police Training General Command, Afghan National Police (ANP) Initial Police Training Course Overview, v2.0, dated July 2012.** Program of instruction designed to provide ANP Police recruits with the necessary basic police knowledge and skills. This is a basic police course, designed to give an entry-level police recruit the necessary skills to be effective in the patrolman duties. This course is a building block for all additional ANP courses.

15. **Ministry of Interior "Surgeon General Organization and Functions Manual" (Draft), dated August 24, 2011.** This regulation defined and delineated the organization, functions, and responsibilities for Ministry of the Interior (MoI) Office of the Surgeon General (OTSG).

16. **Ministry of Interior Order to the Support and Admin Deputy Office, OTSG, Medical Readiness Department for the Afghan National Police Emergency Ambulance Vehicle Operation Standard Operating Procedures, dated March 24, 2010.** A Minister of Interior order directs the Support and Admin Deputy's Office to establish a proper system of performance, directing all units related to the medical readiness to follow the Standard Operation Procedures (SOP) for Emergency Ambulance Vehicle Operations.

17. **Afghan National Police Training General Command, NCO Eight Week Police Course Overview, dated February 2010.** Program of instruction designed to provide ANP advanced police skills, leadership, first-aid and first-responder responsibilities, firearms, and tactical training. This course is designed to focus democratic policing principals including ethics and human rights. Instill national pride and identity towards the Islamic Republic of Afghanistan and in the National Police organization. The course will introduce leadership skills and advanced police tactics.

18. **Ministry of Interior Policy "Process for the Management of Logistics," January 6, 2009.** This decree prescribed common procedures, formats, forms, and time standards for the logistics management processes of the MoI and movement of logistic information between supporting and supported organization/activities. Additionally, the decree identified the MoI Surgeon General as responsible for the day-to-day management of medical material and supplies. Specifically, the Surgeon General develops the policy, plans, and procedures for establishing and maintaining supply stockage levels and basic loads for all MoI hospitals and clinics.

19. **Afghan National Police Training General Command Training Catalogue, "Afghan National Security Forces (ANSF) Trauma Assistance Personnel (TAP)," Course Overview, v1.0, received August 11, 2013.** The TAP course provides a program of instruction designed to train first-level healthcare providers and produce qualified and capable personnel able to provide emergency and evacuation patient care.

GIRoA Ministry of Defense (MoD)

20. **Ministry of Defense Beneficiary's Treatment Policy at the Afghan National Army Medical Facilities, approved, dated May 23, 2012, with Attachment 3: Memorandum of Agreement between Minister of Defense, Minister of Interior, Minister of Public Health and Combined Security Transition Command–Afghanistan.** Aim of this policy is to create a clear, accurate, and high quality healthcare system for receiving patients that are in the approved beneficiary's list to be treated at the Afghan National Army's medical facilities.

Appendix D

Afghan Police and Security Organizations

Per the GIRoA Afghan National Police Strategy–Solar Year 1392-1397 (approximate to 2013-2018), the ANP are primarily responsible for maintaining civil order and law enforcement. The police forces work with the people to actively combat crime and disorder (including terrorism and illegal armed activity); prevent the cultivation, production, and smuggling of narcotics; and fight corruption.

Documents within the GIRoA, MoI, and NTM-A use the term "police pillars" to refer to the various police organizations that reside under the ANP. Specifically, there are four main police pillars (AUP, ANCOP, ABP, and AACP) and two sub-pillars (ALP and the General Directorate of Police Special Units (GDPSU) which contains the Judiciary Police)

Additionally, the MoI provides oversight of other security organizations, such as the Afghan Public Protection Force (APPF).

A description of the various police and security organizations under the MoI is included below:

1. **Afghan Uniform Police.** The AUP consists of the ANP Regional Zones, the Traffic Police, and the Fire and Rescue Department. Their specific roles, duties, and responsibilities are as follows:

    a. Focus on the core functions of policing and providing public services, training, and education, as well as equipping this force in order to prevent and detect crime, assure public safety, maintain civil order, protect property, and safely control traffic.

    b. Maintain the rule of law, adopting an intelligence-led policing model.

    c. Respond to emergencies and maintain public safety.

    d. With the support of the AACP, prevent, promptly detect, and investigate minor crime.

    e. Secure and preserve evidence, gather, and process criminal intelligence.

    f. Identify and protect witnesses and victims.

g. Arrest and detain suspects and perpetrators.

h. Build public confidence in the police and GIRoA.

i. Gather intelligence to support counter-insurgency operations.

j. Provide fire suppression, prevention, and rescue.

k. Ensure safety on the roads, prevent, and investigate traffic accidents.

l. Maintain orderly traffic flow, organize traffic affairs, and inspect vehicles for safety.

m. Provide public traffic courses to educate drivers on traffic control, traffic rules, and traffic signs, and issue driver's licenses and vehicle registrations.

n. Ensure enforcement of appropriate domestic violence legislation in order to promote familial and community stability in accordance with enlightened Islamic and Afghan family values.

o. Assure adequate security for candidates during elections. Perform according to Independent Election Commission standards and remain impartial during the election process.

p. Carry out other general policing duties.

2. **Afghan National Civil Order Police (ANCOP).** The ANCOP mission is to maintain the rule of law and order utilizing proportionate armed capability. It is organized geographically into regional brigades and battalions. The ANCOP will be the lead police organization in counter-insurgency operations and work in close cooperation with the ABP, AUP, and ANA.

Operations conducted by these units should be fully supported by military forces or conducted jointly with the military to support the 'clear' phase of counter-insurgency operations. The ANCOP will eventually be the primary police organization in the 'hold' phase of counter-insurgency operations and will support the AUP.

Their specific roles, duties, and responsibilities are:

a. Provide intelligence information and tactical support to the ANA during the 'shape' and 'clear' phases and be the lead police organization in the

'hold' phase of counter-insurgency operations, and work in partnership with the ANA and ABP during framework operations.

b. Replace and/or support the AUP in high-threat and unstable areas.

c. Maintain and restore civil order.

d. Conduct public order operations during sensitive or dangerous civil disturbances and riots.

e. Conduct operations that require a higher level of training and tactics or require a mobile quick reaction force for direct action such as hostage rescues and counter terrorism operations.

f. Support counter narcotics operations and assist in poppy eradication when required.

3. **Afghan Border Police (ABP).** The mission of the ABP is to secure and safeguard the national borders and maintain security in the Border Security Zone that extends 50 kilometers into the territory of Afghanistan.

Their specific roles, duties, and responsibilities are as follows:

a. Safeguard national boundaries.

b. Control the entry and exit of individuals and vehicles at borders and international airports. Ensure personnel have correct documentation.

c. Deter and counter insurgency and criminal activities within the Border Security Zone.

d. Take immediate action against incursions at the border in coordination with ANA.

e. Ensure the security of international airports and border crossing points.

f. Prevent all types of smuggling (weapons, ammunition, goods, drugs, historical artifacts, human trafficking, etc.)

g. Cooperate with neighboring countries' police in accordance with agreed treaties.

4. **Afghan Anti-Crime Police (AACP).** The AACP comprise the investigative and intelligence police capacities at all levels from the MOI to regional zones, provinces, and districts (with the exception of the functions of Inspector General and Internal Affairs).

They form one pillar of the ANP and consist of the following branches:

a. Counter-terrorism,

b. Police Intelligence,

c. Criminal Investigation,

d. Major Crimes Task Force, and

e. Police Special Operation Units.

The mission of the AACP is to provide police units with technical police skills not possessed by other members of the police. They will assist in investigations conducted by the offices of the Inspector General and Attorney General.

5. **Afghan Local Police (ALP).** In order to ensure the security of local communities and pave the way for reconstruction, development, and political stability, Decree Number 3196 of the Office of the President authorized establishment of the ALP.

   a. The current Tashkil for the ALP in 31 provinces and 138 districts is approved at 30,000 personnel.

   b. Approximately 20,560 personnel have been recruited in 97 districts and the process in ongoing to recruit the remainder.

   c. ALP is physically present in 92 districts and 5 provincial capitals which equal 97 sites.

   d. ALP have the direct support of ANP and ANA assigned in the area.

   e. A code of conduct, incentives, uniforms, responsibilities, and other issues relevant to the ALP have been organized in accordance with approved ALP procedures and based on Afghan law. The ALP program will last for between 2 and 5 years.

   f. The long term strategy for the ALP program is to provide sustained security and permanent stability, expand governance and increase development in the areas where the ALP will be established.

   g. The ALP does not have a police mandate to investigate crime or arrest suspects.

6. **General Directorate of Police Special Unit (GDPSU).** Provide specialist tactical capability to support counter-insurgent, counter-narcotics, and counter-organized crime activities. This includes the provision of a Crisis Response Unit, Intelligence and Surveillance capabilities, VIP security, and judicial security.

   a. **Prison Police (sometimes referred to as Judiciary Police.)** The prison police are considered a major part of the police force that executes its tasks and responsibilities for the effectiveness of the court system. They are focused to obey international convention regarding human rights, including the convicted and accused rights.

      This pillar of police is responsible for the following tasks:

      1) Ensure and maintain security of the prisons and prisoners.

      2) Ensure and maintain prisoners' rights in accordance with the laws of prisons and detention facilities and other enforced laws of the country.

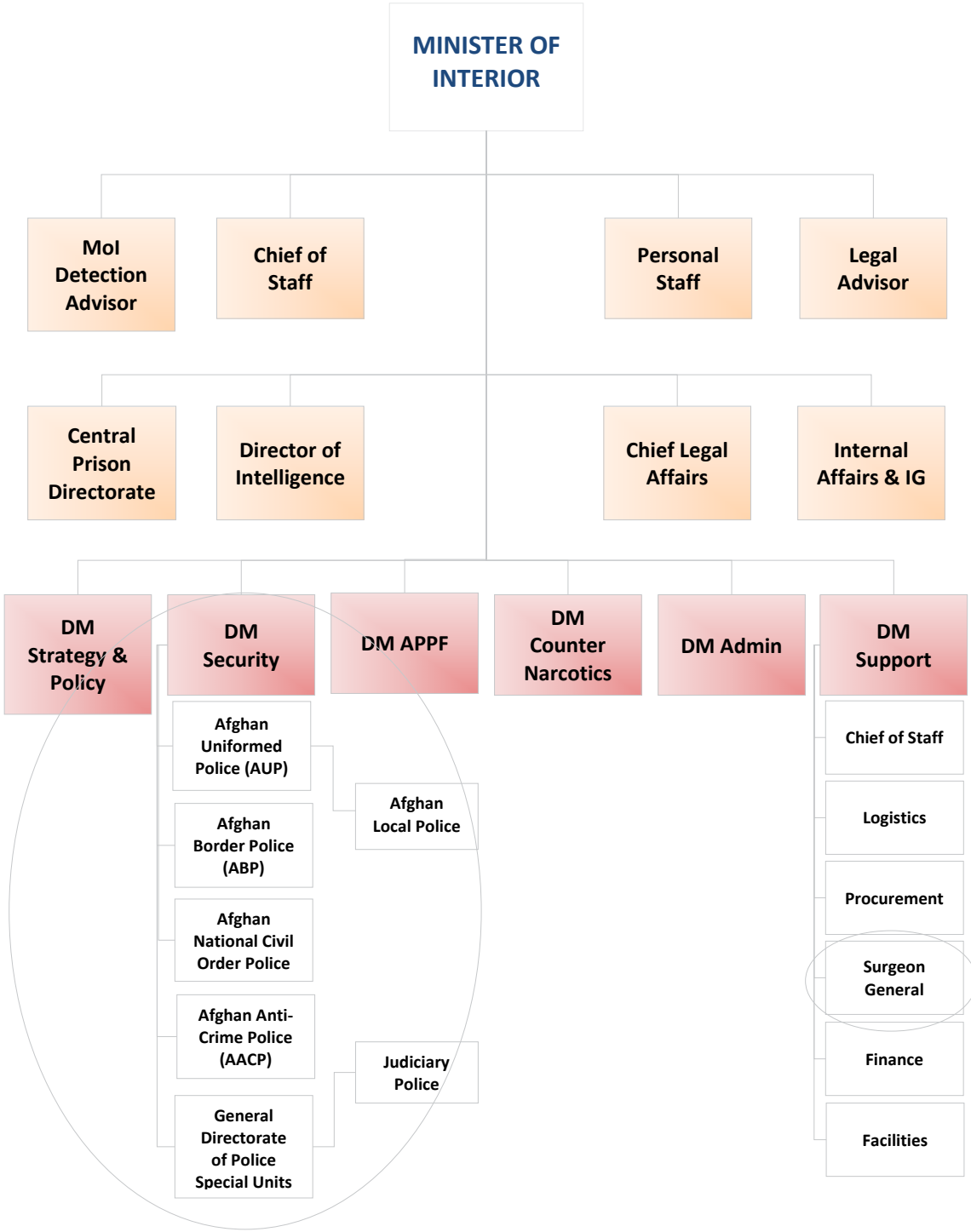
      3) Provide training and education opportunities for prisoners and retrain them to avoid criminal activity.

7. **Afghan Public Protection Force (APPF).** The APPF operates throughout the country to protect key infrastructure, facilities, construction projects, and personnel, with a special focus on protection from insurgency. It also provides protection for those facilities for which donors, international agencies, and private sector organizations previously contracted private security personnel. This removes the need to employ trained AUP officers in guard positions. The APPF permit more highly trained police resources to focus on providing effective law enforcement. In accordance with Decree Number 62 of the Office of the President regarding the disbandment of private security companies, the APPF will replace these companies.

   The APPF is a part of the ANSF under the direct command and control of MoI. The APPF is a regular state security force rather than militia, but does not have a police mandate to investigate crime or arrest suspects. The MoI has expanded its command and control capabilities to manage and exercise authority over the APPF. The APPF is funded by the MoI without the use or diversion of funding from the Law and Order Trust Fund Afghanistan.

Appendix E

Ministry of Interior Organizational Chart

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DEPARTMENT OF DEFENSE

Management Comments

U.S. Central Command Response

UNITED STATES CENTRAL COMMAND
OFFICE OF THE INSPECTOR GENERAL
7115 SOUTH BOUNDARY BOULEVARD
MACDILL AIR FORCE BASE, FLORIDA 33621-5101

13 Mar 2014

FOR: DEPARTMENT OF DEFENSE INSPECTOR GENERAL (DODIG)

SUBJECT: Review of DODIG D2013-D00SPO-0154.000 Draft Report "U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police"

1. USCENTCOM staff reviewed the subject draft report as requested. Our response to report recommendation 8a follows:

   a. Concur that MEDLOG mentor positions should be filled with personnel that have the appropriate experience and training. It is critical that the sourcing service and those monitoring the assignments of personnel against these requirements pay close attention to the special remarks and job descriptions listed in the Joint Manning or the Request for Forces documents. These details ensure that Individual Augmentees/service members are tasked to these billets have the appropriate skillset to provide guidance to their mentees.
   b. Using just the MOS/AFSC/NOBC code does not always guarantee that the tasked officer has the required skillset. MEDLOG mentor positions assigned to NTM-A CMD SURG are US O-4/NATO OF-3 officer billets.
   c. The US to NATO rank conversion often creates confusion that results in junior officers without the appropriate experience tasked to fill senior officer billets. Once again, it is a responsibility of those monitoring the assignments of these individuals to be aware of the ranks of those being sourced.

2. POC is Mr. Banks Edwards; ccigaudit@centcom.mil; (813) 529-0275.

DUANE T. RACKLEY
GS-15, DAF
Executive Director

International Security Assistance Force Joint Command Response

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INTERNATIONAL SECURITY ASSISTANCE FORCE (ISAF)
Joint Command (IJC)
Kabul, Afghanistan
APO, AE 09320

ISAF-IJC-MED

13 March 2014

MEMORANDUM THRU USFOR-A

FOR Department of Defense Inspector General, Quality Assurance and Follow-up Division

SUBJECT: Follow-up on OIG Report No. SPO-2011-003, "Assessment of U.S. Government Efforts to Train, Equip, and Mentor the Expanded Afghan National Police," March 3, 2011 (Project No. D2010-D00SPO-198.000)

1. Headquarters, International Security Forces-Afghanistan Joint Command has completed the review of DODIG project #D2013-D00SPO-0154.000 (U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police) with the Afghan National Police Medical Advisors and provides the following feedback.

2. ISAF JC MEDAD concurs with the following recommendations without comment:
   a. 1.a(1), 1.a(2), 1a(3), 1.a(4)
   b. 2.a(1), 2.a(2), 2.a(3)
   c. 4.a(1), 4.a(2), 4.a(3), 4.a(4), 4.a(5), 4.a(6)
   d. 7.b(1), 7.b(2)
   e. 8.c

3. Point of Contact (POC) for provided data is David E. Ristedt, COL, IJC/USFOR-A MEDAD, DSN 318-449-9266, david.e.ristedt.mil@mail.mil .

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IC.1082421536

DAVID E. RISTEDT
COL, MC
IJC/USFOR-A MEDAD

International Security Assistance Force Joint Command Response (cont'd)

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INTERNATIONAL SECURITY ASSISTANCE FORCE (ISAF)
Joint Command (IJC)
Kabul, Afghanistan
APO, AE 09320

ISAF-IJC-IG

11 March 2014

MEMORANDUM THRU USFOR-A

FOR Department of Defense Inspector General (DODIG)

SUBJECT: Follow-up to DODIG project #D2013-D00SPO-0154.000 (U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police)

1. IJC Inspector General has reviewed and concurs with Headquarters, North Atlantic Treaty Organization (NATO) Training Mission-Afghanistan's review and feedback as regards to the subject DODIG project (see enclosure).

2. Point of Contact (POC) for provided data is Steve Merkel, COL, Chief of Staff NTM-A, DSN 318-449-1241, steven.m.merkel@afghan.swa.army.mil.

3. POC for this response is IJC Deputy IG, Mr. Paul Archambault, DSN 318-449-9922, paul.b.archambault@afghan.swa.army.mil.

FRANCISCO ARCE Digitally signed by FRANCISCO ARCE DN: cn=FRANCISCO ARCE, o=Command Inspector General, ou=IJC, email=francisco.arce.mil@mail.mil, c=US Date: 2014.03.11 12:06:23 +04'30'

Encl

FRANCISCO ARCE
COL, IG
IJC Inspector General

North Atlantic Treaty Organization Training Mission - Afghanistan Response

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DEPARTMENT OF DEFENSE
NATO TRAINING MISSION-AFGHANISTAN
APO AE 09354-9998

NTM-A-COS 10 March 2014

MEMORANDUM FOR Department of Defense Inspector General (DODIG)

SUBJECT: Follow-up to DODIG project #D2013-D00SPO-0154.000 (U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police)

1. Headquarters, North Atlantic Treaty Organization (NATO) Training Mission-Afghanistan has completed the review of DODIG project #D2013-D00SPO-0154.000 (U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police) with the Afghan National Police Medical Advisors and provides the following feedback.

2. NTM-A concurs with the following recommendations without comment:
   a. 3.a(1) on page 40
   b. 5.a, 5.b, and 5.c on page 57
   c. 6.b(1) and 6.b(2) on page 65
   d. 8.b on page 84
   e. 9.a(1), 9.a(2), 9.a(3), and 9.a(4) on page 91

3. We do not concur with recommendation 3.a.2., " In coordination with Ministry of Interior and Ministry of Defense, explore the option of using the Afghan National Army Combat Medic Course as a substitute for Trauma Assistance personnel training, if needed, and implement a plan to use this course as an additional program to train Afghan National Police medics." We do not concur as both programs are eight (8) week programs and the curriculum is very similar. Additionally, there is a lack of ANP commitment for sending medics to the eight week TAP program already. There is little confidence that changing the course will improve ANP attendance. We suggest that the first priority is to get ANP leaders to commit to send their medics to TAP and then keep them as medics.

4. The point of contact for this memorandum is the undersigned at steven.m.merkel@afghan.swa.army.mil or DSN 449-1241.

// original signed //
STEVEN M. MERKEL
Colonel, U.S. Army
Chief of Staff
NATO Training Mission-Afghanistan

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North Atlantic Treaty Organization Training Mission - Afghanistan Response (cont'd)

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DEPARTMENT OF DEFENSE
NATO TRAINING MISSION-AFGHANISTAN
APO AE 09354-9998

NTM-A-COS

25 March 2014

MEMORANDUM FOR Department of Defense Inspector General (DODIG)

SUBJECT: Subsequent Follow-up to DODIG project #D2013-D00SPO-0154.000 (U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police)

1. Headquarters, North Atlantic Treaty Organization (NATO) Training Mission-Afghanistan has completed the subsequent review of DODIG project #D2013-D00SPO-0154.000 (U.S. Military and Coalition Efforts to Develop Effective and Sustainable Healthcare in Support of the Afghan National Police) with the Afghan National Police Medical Advisors and provides the following feedback.

2. NTM-A concurs with both recommendation 6.a and 7.a with the following comments:

a. Recommendation 6.a: "International Security Assistance Force Command, in coordination with International Security Assistance Force Joint Command, Combined Security Transition Command–Afghanistan and North Atlantic Treaty Organization Training Mission–Afghanistan, conduct key leader engagements with Ministry of Interior and Ministry of Defense to continue to build formal, cooperative relationships between Ministry of Interior and Ministry of Defense medical leaders so that the Afghan National Police who require medical care that is beyond the capability of the Afghan National Police Hospital are able to take better advantage of more robust health care resources that are available at the Afghan National Army National Military Hospital and Military of Public Health Medical Facilities."
Comment: Concur and recommend adding the underlined text above. Note that this is already happening at both the National level and Regional level.

b. Recommendation 7.a: "International Security Assistance Force Command, in coordination with International Security Assistance Force Joint Command, update development plans to ensure they include an emphasis on the development of Afghan National Police point of injury care, patient evacuation, and en route care."
Comment: Concur with recommendation. An updated plan of action will demonstrate that we are currently working closely with the ANP to include the ANP Training General Command (TGC) on their healthcare system to include POI. The remaining work will fall on The Office of the Surgeon General (OTSG) to help them with enroute route and patient evacuation, which will rely heavily on the collaborative relationships with ANA and MoPH.

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North Atlantic Treaty Organization Training Mission - Afghanistan Response (cont'd)

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NTM-A-COS
SUBJECT: Follow-up to DODIG on their 24 June 2013 report "Assessment of U.S. Government and Coalition Efforts to Develop Leaders in the Afghan National Army" (DODIG-2013-094)

3. The point of contact for this memorandum is the undersigned at steven.m.merkel@afghan.swa.army.mil or DSN 449-1241.

// original signed //
STEVEN M. MERKEL
Colonel, U.S. Army
Chief of Staff
NATO Training Mission-Afghanistan

2

Acronyms and Abbreviations

AACP	Afghan Anti-Crime Police
AAF	Afghan Air Force
ABP	Afghan Border Police
ACAS	Afghanistan Civilian Advisor Support
AED	Automated External Defibrillator
AFAK	Afghan First-Aid Kit
ALP	Afghan Local Police
ANA	Afghan National Army
ANCOP	Afghan National Civil Order Police
ANP	Afghan National Police
ANPH	ANP Hospital (Kabul)
ANP TAP	ANP Trauma Assistance Personnel
ANSF	Afghan National Security Forces
APPF	Afghan Public Protection Force
ASFF	Afghanistan Security Forces Fund (U.S.)
ASL	Authorized Stockage List
AUP	Afghan Uniform Police
BAS	Battalion Aid Station
BASEORD	Base Order
CASEVAC	Casualty Evacuation
CF	Coalition Forces
CJMED	Combined Joint Medical Branch
CJSURG	Combined Joint Surgeon
CLS	Combat Lifesaver Skills
CM	Capability Milestone (a readiness level)
CMD SURG	Command Surgeon
CNP	Counter Narcotics Police
CSTC-A	Combined Security Transition Command–Afghanistan
CTC	Central Training Center
CUAT	Commander's Update Assessment Tool
DCOM-P	Deputy Commander–Police
DoD	Department of Defense
DoDI	Department of Defense Instruction
DoD IG	Department of Defense Inspector General
GIRoA	Government of the Islamic Republic of Afghanistan
HMMWV	High Mobility Multipurpose Wheeled Vehicle

HQ Headquarters
ICU Intensive Care Unit
ICRC International Committee of the Red Cross
IJC ISAF Joint Command
IPTC Police Training Course
ISAF International Security Assistance Force
JCISFA Joint Center for International Security Force Assistance
JSU Judiciary Police (Prison Police)
LOE Lines of Effort
KLE Key Leader Engagement
MEDAD Medical Advisor
MEDCOM Medical Command
MEDEVAC Medical Evacuation
MEDLOG Medical Logistics
MFAT Multi-Function Advisory Team
MINDEF Minister of Defense
MMC Material Management Center (MoI)
MoD Ministry of Defense (Afghanistan)
MoI Ministry of Interior (Afghanistan)
MoPH Ministry of Public Health (Afghanistan)
MTAG Medical Training Advisory Group
NATO North Atlantic Treaty Organization
NCO Non-Commissioned Officer
NMH National Military Hospital
NMW National Medical Warehouse
NTM-A NATO Training Mission–Afghanistan
OCIE Organizational Clothing and Individual Equipment
OFM Organization and Functions Manual
OIG Office of Inspector General
OTSG Office of the Surgeon General
PHQ Provincial Headquarters
PRMH Paktiya Regional Military Hospital
RC Regional Command
RMH Regional Military Hospital
RTC Regional Training Center
SFAAT Security Force Assistance Advisor Teams
SG Surgeon General
SOP Standard Operating Procedure
SPO Special Plans and Operations

SY Solar Year
TAP Trauma Assistance Personnel
TGC Training General Command
TMC Troop Medical Clinic (ANA Garrison)
USC United States Code
USCENTCOM U.S. Central Command
USFOR-A U.S. Forces–Afghanistan


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