

## CHAPTER 1

## OVERVIEW OF LOW INTENSITY CONFLICT

## Section I. INTRODUCTION

## 1-1. General

*a.* Planning for and executing medical missions across the LIC continuum requires flexibility and adaptability. This chapter provides a brief orientation to LIC, its operational categories, and the role of the command surgeon.

*b.* Under some circumstances, medical operations in low intensity conflict (MEDOLIC) may serve a somewhat different role from their traditional combat service support (CSS) role in conventional warfare. The provision of HSS and medical education may play a more direct role in countering the threat in LIC.

*c.* Medical operations and programs may be an integral element in some LIC psychological operations (PSYOP) and civil affairs (CA) efforts.

*d.* For additional information on LIC, refer to Field Manual (FM) 100-20.

## 1-2. Definition

*a.* Low intensity conflict is a political-military confrontation between contending states or groups below conventional war and above the routine, peaceful competition among states. It frequently involves protracted struggles of competing principles and ideologies. Low intensity conflict ranges from subversion to the use of armed force. It is waged by a combination of means employing political, economic, informational, and military instruments. Low intensity conflicts are often localized, generally in the Third World, but contain regional and global security implications.

*b.* United States LIC policy recognizes that indirect, rather than direct, applications of US military power are often the most appropriate and cost-effective ways to achieve national goals. The principal US military instrument in LIC is security assistance. Security assistance may take the form of training, equipment, combat support (CS), and

CSS. Where friends and allies are involved in LIC, the object of US security assistance is to ensure that military institutions are able to provide security for both the citizens and the government. The US may also engage in combat operations when vital national interests cannot be adequately protected by other means. When a US response is called for (or when US assistance is requested by a host nation [HN]) and approved by the national command authority (NCA), the mission is developed in accordance with the principles of international and domestic law. These principles affirm the inherent right of states to use force in individual or collective self-defense against an armed attack.

*c.* Medical operations in LIC can be defined as encompassing all military medical actions taken or programs established to further US national goals, objectives, and missions in a LIC environment. These actions and programs, while basically involving the provision of quality health care, may differ to some degree from the traditional CSS role of the Army Medical Department (AMEDD) in both war and peace. These medical operations can play a significant and proactive role in enhancing HN stability by—

- Assisting with the refinement or development of the military medical infrastructure.
- Providing and maintaining the basic necessities of life for the general population through HN civilian medical programs.
- Providing assistance to repair, improve, or establish basic services once hostilities have ceased.

## 1-3. Low Intensity Conflict Imperatives

The LIC imperatives apply in all operational categories and are—

- Political dominance.
- Unity of effort.

- Adaptability.
- Legitimacy.
- Perseverance.

*a. Political Dominance.* In LIC operations, as in all military operations, political objectives drive decisions at the strategic level. While the individual operator need not be driven by political motives, it is important for the leadership at the tactical level to recognize the importance of political objectives in planning and executing the tactical mission.

*b. Unity of Effort.* Military leaders in LIC must integrate their efforts with other governmental agencies so that all gain mutual advantage. Planning must address the military contribution to initiatives that are political, economic, and psychological as well as military in nature.

*c. Adaptability.* The skill and willingness to change or modify structures or methods to make them applicable to the situation characterize adaptability.

*d. Legitimacy.* This is the willing acceptance of the right of a government to govern, or for a group or agency to make and enforce decisions. It is the perception that authority is genuine and effective and that it uses proper agencies for reasonable purposes.

*e. Perseverance.* Low intensity conflicts rarely have clear beginnings or ends marked by decisive actions culminating in victory. They are, by nature, protracted struggles. Even those short, sharp contingency encounters which do occur are better assessed in the context of their contribution to long-term objectives. Perseverance is the patient, resolute, persistent pursuit of national goals and objectives for as long as necessary to achieve them.

#### 1-4. Historical Perspective

*a.* The LIC environment is not a new phenomenon; however, in the past 30 years there has been a dramatic surge in its occurrence. In his address to the 1962 graduating class at the United

States Military Academy, West Point, New York, President John F. Kennedy remarked—

“This is another type of war, new in its intensity, ancient in its origins. War by guerrillas, subversives, insurgents, assassins; war by ambush instead of combat, by infiltration instead of by aggression...seeking victory by eroding and exhausting the enemy instead of engaging him. It requires...a whole new kind of strategy, a wholly different kind of force...”

*b.* Almost since its inception, the US Army has been involved in some form of LIC. From the French and Indian Wars, the settling of the West, through the Philippine insurrection, and up through modern involvement in the Caribbean, Central America, and the Middle East, Americans have fought in a LIC environment.

*c.* Because of the uniqueness of LIC, the threat environment may take many forms. The actual scenario is based on—

- Country or countries involved.
- Social, economic, and political factors at play in the area.
- Level of organization and financial status (or backing) of the threat forces.

*d.* The range of potential activities that fall within the broad spectrum of LIC are numerous. The AMEDD, moving from its traditional CSS role, has the responsibility of responding to the LIC continuum. This is accomplished by developing plans and procedures to maximize the effectiveness of military medicine and to support the objectives of the unified or combined commands.

*e.* For some nations facing internal or external threats to their national security and independence, the US may provide economic and military assistance to help prevent or defeat the threat. (A detailed discussion of security assistance programs is contained in FM 100-20.) The Department of State has responsibility for all aspects of foreign assistance. The United States Agency for

International Development (USAID) administers developmental assistance programs. There are five major security assistance programs—all of which fall under the control of the Department of State. The Department of Defense (DOD) administers two programs: International Military Education and Training (IMET) and Foreign Military Financing (FMF), both cash and credit. The Department of State and USAID administer the remaining three programs: Economic Support Fund, peacekeeping operations, and commercial export sales.

### 1-5. Low Intensity Conflict Operational Categories

Low intensity conflict is divided into four broad operational categories; they are—

*a. Support for Insurgency and Counterinsurgency.* The security interests of the US may lie with either an incumbent government or with the insurgents. What primarily distinguishes insurgency from counterinsurgency and from the other categories is the principle objective they are supposed to achieve. The primary objective in insurgency is to overthrow the government. The primary purpose of counterinsurgency is to prevent the overthrow of the government. Both insurgency and counterinsurgency rely on political motivation. Operational techniques in insurgency and counterinsurgency require a multidimensional approach. It is important to be included early on in the mission planning. Early planning will maximize the effectiveness of HSS resources. In counterinsurgency, health service support can alleviate a major cause of discontent (health and quality of life issues); prevent mobilization based on those issues; and help mobilize the population. For information concerning the HSS aspects to support for insurgency and counterinsurgency, refer to Chapter 2.

*b. Combatting Terrorism.* The aim of combatting terrorism is to protect installations, units, and individuals from the threat of terrorism. Combatting terrorism is an umbrella term covering antiterrorism (defensive actions for force protection) and counterterrorism (offensive measures against terrorists) actions taken to oppose terrorism throughout the operational continuum. In combatting terrorism, programs are designed which provide coordinated action before, during, and after

terrorist incidents. From an operational perspective, combatting terrorism is a campaign directed toward a strategic goal of removing the threat. For information on the HSS aspects of combatting terrorism, refer to Chapter 3.

*c. Peacekeeping Operations.* Peacekeeping operations are military operations which maintain peace already obtained through diplomatic efforts. A peacekeeping force supervises and implements a negotiated truce. The force operates strictly within the parameters of its terms of reference, doing neither more nor less than its mandate prescribes. A distinguishing feature of these operations is that the force is normally forbidden to use violence to accomplish its mission. In most cases, it can use force only for self-defense. For information concerning the HSS aspects of peacekeeping operations, refer to Chapter 4.

*d. Peacetime Contingency Operations.* Peacetime contingency operations often take place away from customary support facilities. These operations often require deep penetration and temporary establishment of long lines of communication (LOC). These operations may be conducted in a medically demanding or potentially hostile environment. They form a large operational category that includes many diverse actions (ranging from humanitarian assistance to land, sea, or air strikes against centers of hostility). Peacetime contingency operations may require the concentration of violent action or the exercise of restraint and the selective use of force. For information concerning the HSS aspects of peacetime contingency operations, refer to Chapter 5.

### 1-6. Medical Threat Assessment

A critical element of the medical assessment, for any mission, is a thorough appraisal of the medical threat to deploying forces and to the residents of a HN. This is particularly true in LIC scenarios as the incidence and exposure to endemic disease is greater in developing nations. The medical threat is derived from a variety of informational sources outside of the military, as well as through formal intelligence channels. The medical planner should consider the following points:

a. The ability to obtain, interpret, and use intelligence is critical to the success of a medical mission. This is essential in the LIC arena due to the more direct role played by medical forces and the greater vulnerability of these forces to the medical threat.

(1) Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or areas of operations (AO), and is significant to military planning. Until medical information is appropriately processed (ordinarily on a national level by the Armed Forces Medical Intelligence Center [AFMIC]), it is not considered to be medical intelligence.

- Medical epidemiologic information is available from international sources such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO).

- Direct contact with health authorities by health professionals may yield useful information. Caution must be used when collecting medical information from local sources. The reliability of local information is dependent upon—

- Resources available to collect the information, to include the experience and training of individual collector.

- Political considerations impacting on reporting the information.

(2) Full use of the special training of the preventive medicine (PVNTMED) officers and personnel (to provide a clear assessment of the threat and to make recommendations for types of activities and their prioritization) is essential to ensure the wise use of limited resources. Prevention and control of diseases or conditions which impede

HN personnel from achieving their own success have a high priority for action. Preventive medicine personnel are specifically trained and equipped to collect, analyze, and interpret health information. Preventive medicine personnel should have free access to all types of specialists within the medical force and HN to consult with during the threat assessment.

(3) Medical planners must acquaint themselves with the various intelligence products which currently exist for their use. The medical planners must be familiar with national level intelligence products such as the Medical Capabilities Studies (MEDCAPs) and Disease Occurrence Worldwide (DOWW). These reports are specific produced to support US military medical operations. These reports can be obtained through operational and medical intelligence channels. Refer to FM 8-10-8 and Appendix A for specific information on requesting intelligence products.

(4) As medical plans and operations progress, the requirements for additional intelligence will occur. All such requirements should be requested through intelligence channels as soon as they are validated.

(5) Medical planners must make themselves aware of enemy weapons capabilities. For example, nuclear, biological, and chemical (NBC) munitions (Appendix B), or potential employment options such as terrorist acts or artillery fires. Planning for HSS operations and force survivability necessitate that units remain abreast of the complete intelligence picture.

b. Should HSS personnel gain information of potential medical intelligence value while in the performance of their duties, they are required to report it (FM 8-10-8) to their supporting intelligence element (Intelligence Officer [US Army] [S2]/ Assistant Chief of Staff [Intelligence] [G2]).

## Section II. MEDICAL INVOLVEMENT IN LOW INTENSITY CONFLICT

### 1-7. General

United States involvement in the LIC arena is expanding some of the traditional roles of CS and

CSS elements. Of particular note are the varied roles that HSS (Appendixes C through G) and other CSS units will accomplish through medical operations and programs in LIC. These newly defined roles

require that the HSS planner be proactive in developing HSS plans. These operation plans (OPLANs) must meet the commander's guidance and intent and support US national goals and objectives. These plans are based on the missions, tasks, and the forces supported in the AO. The command surgeon plays a pivotal role in the development of plans and the implementation of programs within the commander's geographic AO. Refer to paragraph 1-9 for a discussion of the command surgeon's duties and responsibilities.

## 1-8. Foundations for Medical Programs Conducted in Low Intensity Conflict

*a.* The cornerstones of MEDOLIC include—

- Planning for and providing direct health care services to US and allied military forces.
- Furtherance of US national goals and objectives.
- Enhancement of medical readiness by real-time, hands-on training. This training is conducted in an unfamiliar venue, involving diseases not normally widespread in the US, and in varying public health conditions.
- Promotion and enhancement of the growth potential of a HN medical infrastructure.
- Planning for and developing programs which provide direct patient care for both HN military and civilian populations.
- Planning for and providing medical education and training for HN or US-backed military or paramilitary forces.

*b.* Flexibility and initiative are required to enhance the potential for success in this environment.

*c.* Many of the medical missions conducted in the LIC environment will be in support for insurgency and counterinsurgency operations. These new missions will shape and define what role the US military medical programs will play in overall LIC operations.

- Combined HN and US HSS to the indigenous population is essential to reduce a medically-related threat. Health service support has proven to be one of the most effective resources to gain support of a population. Medical assistance is constructive in nature and is generally welcomed rather than feared and rejected. A high premium is placed on available US health service resources because of—

- The extensive health hazards prevalent in most developing nations.

- The general shortage of HN medical personnel and facilities.

- Health service support operations conducted in a HN must not exceed the capabilities of the HN or its health professionals. When US assistance is withdrawn, the HN must be capable of continuing these programs. If the HN or its health professionals cannot continue the programs, the HN's legitimacy may be undermined. For example, prevention and education are two low technology options which are more easily sustained than high technology treatment or rehabilitative support.

- Refer to Chapter 2 for a detailed discussion of the HSS aspects in support for insurgency and counterinsurgency.

## 1-9. Command Surgeon

*a.* The command surgeon is instrumental in planning, developing, and implementing military medical programs and support in the LIC environment.

*b.* The number of personnel in LIC operations may be restricted and a full contingent of medical personnel may not be deployed on a specific mission. The senior medical officer assigned to the operational force will serve as the command surgeon. Additionally, a formal chain of command is established within the task-organized force as the command surgeon does not act unilaterally, but rather acts within the context of the task force.

*c.* The duties and responsibilities of a command surgeon include, but are not limited to, the following:

- Advising on the health services of the command and of the geographical territory within the commander's AO.

Advising on the medical effects of the environment and of NBC weapons on personnel,

Determining requirements for the requisition, procurement, storage, maintenance, distribution management, and documentation of medical, dental, veterinary, and optical equipment

Determining the requirements for

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- Health status of the HN's military and civilian communities.

- Potential medical threat under various operational scenarios.

- Available medical resources and assets from within the US military, other US government agencies, civilian and religious organizations, and the HN.

(2) An axiom of US assistance is that outside aid should only be provided when all resources of the geopolitical unit in need have been fully and efficiently used.

(3) Current and timely medical intelligence (paragraph 1-6 and Appendix A) is an important aspect in preparing a comprehensive medical assessment.

(4) Updated assessments should be maintained on each specific geopolitical area within the commander's AO.

*b. Problem Solving.* Due to the uniqueness of the LIC environment, planning for operations in the potential scenarios requires initiative and possible improvisation to successfully complete established missions. As medical planners, command surgeons must not become inflexible in their thinking, or rely solely on the traditional methods of health care delivery to accomplish their missions. In LIC, the AMEDD is being assigned new roles and missions. Health service support planners must explore all potential alternative courses of action to fulfill these roles. They must also be prepared to deal with unanticipated complications. As medical resources will be scarce and the care provided will normally be austere, the planner needs to be flexible enough to maximize the use of these resources.

*c. Planning.*

(1) It is important that HSS planning be proactive. It should be initiated at the earliest possible phase in the plan's development. Early planning can help to ensure that—

- Adequate HSS assets are available.

- Requirements which cannot be completed by medical elements are identified and appropriate action taken.

- An accurate assessment of the medical threat is included in the plan.

(2) The medical plan (Appendix I) is formulated to support the many aspects of an operation. The plan furthers the accomplishment of US national goals and objectives. If medical programs are developed independently and without integration into the plan, they may in fact hinder, rather than further, US national goals and objectives for the region.

(3) If a command surgeon is not designated on a specific operation, the senior medical officer assigned assumes this role. Thorough planning in the early stages of the mission development must still be accomplished and coordinated.

*d. Coordination.*

(1) The planning and execution of operations requires thorough coordination prior to implementation. This coordination ensures that—

- Duplication of services and/or missions does not occur.

- The mission is executed properly.

- Interoperability exists between the services in such areas as communications.

- Adequate CSS resources are allocated for the mission. This includes all classes of supply and the means to resupply the operation.

- Scarce resources are used effectively and efficiently.

- Operational security requirements are met.

(2) In LIC, coordination is not limited only to the military forces operating within the geographical area, but extends to other US agencies, civil and religious organizations, and the HN.

(3) Thorough coordination during the planning process ensures that the final plan—

- Attains US national goals and objectives.
- Satisfies the requirements of the HN.
- Can be accomplished with the resources available.
- Provides a favorable climate for the acceptance of the government program by the populace.

- Does not bypass or discourage the full application of all appropriate HN resources to the problem.

(4) The importance of HCA programs in both counterinsurgency and peacetime contingency operations will increase with our commitments in LIC. The command surgeon plays an integral role in developing courses of action which enhance programs being developed or implemented within the region.

(5) A sample standing operating procedure (SOP) for a medical element deployed in LIC is provided in Appendix J.