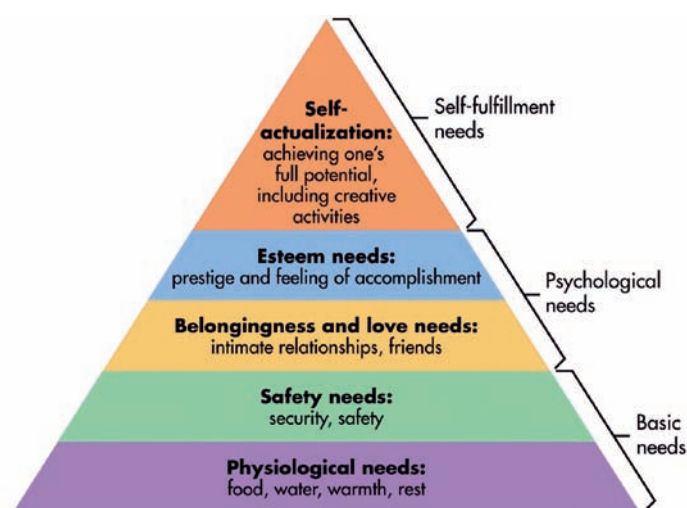


Counterinsurgency, Healthcare, and Human Nature: Tapping Into the Hierarchy of Needs

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We have all done it, making the decision to choose what you need over what you want. At its most basic level, this behavior ensures survival. In the developed world, it may be difficult to see the connection between seemingly unimportant day-to-day decisions and life expectancy or reproductive success but in unstable or underdeveloped parts of the world having what you need instead of what you want can mean the difference between life and death. This is one of the more human elements of counterinsurgency (COIN) operations and a reality which has the potential to positively influence the current fight, if only we could all get together on it.

One somewhat familiar way of categorizing what humans need to ensure survival was proposed by Abraham Maslow in 1943. Maslow's "hierarchy of needs" theory was developed as a means of describing the stages of psychological development in humans. There are many different representations of the hierarchy but the theory is most often depicted in a triangle shape divided into three categories and five levels.¹



In describing the hierarchy, Maslow surmised that "once an individual has moved past a level, those needs will no longer be prioritized. However, if a lower set of needs is continually unmet for an extended period of time, the individual will temporarily re-prioritize those needs – dropping down to that level until those lower needs are reasonably satisfied again."² Health typically falls into one of the two lowest levels or can be seen as a bridge between those levels depending on which diagram you refer to and what sort of culture you are considering. Although it is true that Maslow's theory is not without criticism and it may not be wholly applicable in all sit-

uations, when focusing on the two bottom levels (the basic needs) it is difficult to argue against the fact that those needs must be met before a person can undertake more demanding endeavors. Simply put, fulfilling these needs is a requirement for human survival.

In the current COIN strategy in Afghanistan the flawed perspective regarding unmet basic needs is demonstrated by the overwhelming belief that schools/education should be one of the top non-kinetic efforts in attempting to build stability and/or improve the perception of the government (local or otherwise). Clearly if a person is frequently sick or starving they cannot take advantage of educational opportunities and would likely forego or defer an education in order to work. In this case, work is related to survival while education and even literacy are not. Moreover, the person who is sick or starving is likely to resent a government which focuses on an educational infrastructure without first addressing more basic needs such as the provision of medical care, the availability of safe water or a level of security which allows access to either. In the developed world, citizens think education is important because the "basic needs" are readily met, but when it comes to establishing stability in a developing country, it is imperative to adjust one's perspective and consider how priorities would change if those basics were not met. There are very few countries currently facing more challenges to the establishment and success of a functioning public health infrastructure than Afghanistan.

It is commonly known that in Afghanistan access to healthcare is significantly limited across much of the country. Not unlike other municipal services, the reasons for this range from the isolating geography to the repressive efforts of the insurgents. While the Ministry of Public Health (MoPH) has developed a national strategy which outlines the various components of the healthcare system and a timeline of the associated goals, they are currently not able to function effectively as a nationally coordinating entity that ensures execution of the strategy at regional, provincial, district and village level. In some cases, the security situation prevents representatives of the Ministry from working where they are most needed. In other cases, the person/staff is there, but the austerity of the environment limits communication, hinders logistics, and otherwise stymies efforts to build a functioning healthcare system, even at its most basic level.

The national-level documents which set the parameters for healthcare in Afghanistan are the Basic Package of Healthcare Services³ and the Essential Package of Hospital Services.⁴ These two documents are both nested in the Afghanistan National Development Strategy⁵ and set reasonable expectations for the establishment of a healthcare/public health system. They

also take into consideration many of the challenges Afghanistan presents and acknowledge the fact that the country must embrace programs which others might consider simplistic unless the perspective is adjusted. Two such programs beginning to make headway in Afghanistan are midwifery and community health worker (CHW) training. The training addresses common health issues and provides feasible solutions which may actually have some success in lessening maternal and infant mortality, two of the most significant healthcare problems facing Afghanistan.

The CHW program is designed to reach the most remote areas through the training of local residents. This builds somewhat on the “health post” concept which already exists in parts of Afghanistan but it provides a more formally trained individual. Critical to the impact of this program is public health training in basic sanitation and hygiene, the single most effective way to lessen the spread of the infectious and communicable diseases that still plague much of the developing world. Another benefit is that both of these programs empower the Afghan people with the basic knowledge necessary to become healthier and get past the first levels of the needs hierarchy; this in turn reflects positively on the government. When these programs (or even the ideas that drive them) reach the parts of Afghanistan where healthcare is either restricted or provided by the insurgents, they can help to build communities that are more likely to deny the assistance of the insurgents as opposed to tolerating or supporting them out of necessity. Effective community health workers can even positively influence situations involving internally displaced persons who often go without assistance of any sort because they are not entitled to protection under international law, but remain the responsibility of their own government.⁶

For those who have not been to Afghanistan it may be difficult to imagine why, if reasonable guidance exists from the MoPH, the development of a healthcare system is not further along. Why does one of every four Afghan children die before the age of five?⁵ Why are diseases like polio, malaria, typhoid, and cholera still commonplace?⁵ Why are there still Afghans either relying on the insurgents for medical care or having their care restricted by them? Can anything actually be done about it anyway? Yes, there may be something that can be done and it is not difficult to grasp, it is in part just a matter of all of us sending out the same message from strategic planning down to tactical execution; one that echoes what the MoPH is trying to accomplish. This effort starts with very simple steps to improve the health of the population. In developed countries we may not frequently think about the fact that our population is quite healthy because we learn the value of hand-washing at an early age but if we did not teach one another to wash our hands after using the toilet or before eating a meal it would not be part of our culture and the good health we take for granted would not be the norm. Teaching one Afghan mother about the importance of hand washing has the potential to impact many people because verbal communication is central to the development of human society. Unfortunately, getting all of the entities in Afghanistan to send out a similar message, even when the

MoPH⁵ and ISAF⁷ have already put it in writing, is much easier said than done.

In 2010 the International Security Assistance Force (ISAF) finally published guidance on the “acceptable” application of medically related missions as part of COIN operations in Afghanistan.⁷ Unfortunately this document set some unrealistic requirements in the approved execution of medical engagements, medical outreach programs and the dreaded “MEDCAPs” (medical civic action programs). Just as unfortunate, it seems the leadership in Afghanistan and in fact many key players in the development of COIN strategy consider the term “MEDCAP” to be synonymous with short term, band-aid types of medical engagements with little potential for long term impact⁷. This simply does not have to be the case in the execution of medically based endeavors, even those which are executed for purposes other than development. Freedom of movement and passive information gathering are just as easily gained through education as they are through handing out pills. It takes no longer to impart basic public health knowledge and methods of sanitation on the host nation than it does to pack and hand out a bag of pills and the impact is just as rapid and much greater over the long term. It is time to make it clear from the tactical level that a MEDCAP is not necessarily bad, it is not necessarily short-sighted and it can support the strategic plan⁵ while echoing the MoPH guidance. It can fit well into the execution of a comprehensive COIN strategy. If we are expected to leave Afghanistan in the fairly near future, the basic medical knowledge which could be imparted on the Afghan populace either formally or informally would undoubtedly help to build healthier communities over the long term and it should not matter what one entitles the effort.

Related to that is the often overlooked feedback relationship between increased access to care and improved security. It may take a bit of effort to implement the security which is initially needed to increase access to care but the payback comes in greater freedom of movement for our forces, greater independence for the local population, decreased tolerance of the insurgents and increased credibility for the government.^{8,9} There are several recent examples from Afghanistan of discussions at key leader engagements which resulted in the LN leadership offering to provide improved security so that women and children could access care provided during Afghan-partnered village stability efforts. Though it may go without saying, healthier people are less likely to rely on external forces (either good or bad) for their survival.

One does not have to specifically agree with Maslow or the application of his theory to this particular situation to realize that access to healthcare and improved sanitation are paramount in the development of independent, self-sufficient communities whether they are outlined by tribal, geographic or political boundaries. As Hezbollah has clearly demonstrated in Lebanon, social services such as healthcare are an effective means of establishing power¹⁰ and while the situation in Afghanistan is in some ways very different from that in Lebanon, the need of an organization to

influence the population in order to affect the human terrain remains the same.

For nearly ten years of involvement in Afghanistan most of the key players have ignored the potential to influence and learn from approximately half of that human terrain. Thankfully, ISAF, and specifically CJSOTF-A are now leveraging female Soldiers “at the tip of the spear” in the implementation of Female Treatment Teams (FTT), Female Engagement Teams (FET), and Cultural Support Teams (CST).^{11,12} Through the application of the Medical Seminar concept (MEDSEM)¹³ and other longer term approaches¹⁴ these elements are already using Afghan-partnered community and individual public health education efforts to improve the peoples’ perception of the Government of the Islamic Republic of Afghanistan (GIROA) with great success. These same efforts are also empowering the Afghans and lessening the likelihood of them requiring or accepting the assistance of insurgent elements, even in the tumultuous south.

There are many critics who frequently express their opinion that the United States and its NATO partners will not leave Afghanistan with an “X” in the win column but their basic premise is flawed. Ultimately, it is the Afghans fight to win or lose; our role is to empower the Afghans while lessening the threat of external terrorism. One facet of this is arming the Afghans with the knowledge to take care of themselves and their government to take care of the population as a whole. The impact of this effort is two-fold; it can increase the human capital of the Afghan population while improving their perception of the government. The MoPH knows that the citizens of Afghanistan have one of the highest infant mortality rates in the world and they have a plan to mitigate it, but they need help getting the word out. Counterinsurgency is admittedly difficult but some of the endeavors which can positively influence it are not. Taking the time to become familiar with the Afghan healthcare strategy and being armed with that knowledge would be a worthwhile and low cost investment of our time. At the very least, it can facilitate interaction and program development at regional, provincial, district and village levels and increase freedom of movement in a given area.⁸ At most it can empower the host nation, strengthen the Afghan people and discredit the enemy when they restrict access to care. It may not be glamorous but it can be effective especially if we are all sending the same message.

A government’s ability to meet the needs of its people is fundamental in the development of sovereignty, but that ability must obviously cross the lines of operation. Focusing solely on security or governance or development instead of looking at them as an interlinked triad may allow minor movements of individuals up the “needs hierarchy,” but it will never allow for a situation in which a community can move permanently beyond the basic needs. Public health

and medical care, like many municipal endeavors, cross the lines of operation; they are linked to not only development, but also governance and security. The government cannot develop successful public health programs without community representation (governance) and they cannot gain credibility with programs the people cannot access (security). Evaluating COIN operations in the context of Maslow’s hierarchy or other studies of human nature is a means of applying basic human behavior to the interconnectedness of the lines of operation instead of viewing each individually. Of course this is true well beyond medical efforts, but few other examples so clearly demonstrate the relationship between human behavior and comprehensive application of COIN. After all, humans are biologically driven to ensure survival of the species; fundamentally people not only want but need to ensure the well-being of those they care for or at least those with which they have some form of relationship. Hence, without a more comprehensive consideration of human nature as a factor in COIN from strategic planning down to tactical execution it is likely that long-term success will be forever fleeting.

Author’s note: *Much of the discussion in this paper is based on my personal experience during multiple deployments to Afghanistan as opposed to referencing a document of someone else’s thoughts or experiences. I am very thankful to everyone I have worked with downrange in both CJTF-82 and CJSOTF-A. Without their interest in this subject and their requests for information I would not have delved so deeply into the topic through the reading of thousands of SITREPs and operational updates nor would I have been privy to so many of the medically related experiences (both good and bad) of the personnel in the thick of the fight.*

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