A New Plan for the 800-Pound Guerrilla: Perinatal mortality

A 21st Century Medical Counterinsurgency Model for Afghanistan

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Abstract

Afghanistan has the highest perinatal mortality rate in the entire world. One Afghani woman dies every 30 minutes from perinatal-related event. One of eight Afghani women will die from perinatal events. Maternal mortality is (use percentage, not fractions) 1600/100,000 vs 13 /100,000 in the United States. Afghanistan is one of the only countries in the world in which the average woman's life expectancy is shorter than a males- despite the active, nationwide combat fought primarily by Afghani males. Meaning, women in Afghanistan are not routinely involved in combat, yet are more likely to die than a man of the same age.

This article presents an alternative model Medical Seminar (MEDSEM) for a successful Special Forces (SF) medical counterinsurgency (COIN) plan that can obtain real results by addressing the mission of the Afghan Ministry of Health versus clinging to old notions. This model forms around the medical capabilities of the SF Operational Detachment (ODA)- Alpha (A) and preventinmaternal-infant complications.

My perspective on this issue is from a former A-team Special Forces Medic (18D) and then as a Special Forces battalion surgeon. I now practice as an obstetrician and gynecologist (obgyn). I deliberately avoid older texts, which address COIN, such as ***Revolt in the Desert*** by TE Lawrence,[1] ***The Centurions*** by Jean Larteguy,[2] and even FM3-24, which may still circulate among teams. Instead, I defer to the author David Kilcullen and his distillation of the most modern 21st century thought regarding COIN, expressed in his most recent work ***Counterinsurgency***.[3] I hope to be as concise as possible, and not lean toward an academic doctoral thesis or war college treatise on medical COIN warfare. My purpose is that the ideas presented will give detachment leaders in Afghanistan a medical COIN model to incorporate into master COIN plans. This model further supports and coordinates the directives to non-government organizations (NGOs) administered by the Afghanistan Ministry of Health (MoH).

The time has come to quit fighting the eight-hundred-pound COIN gorilla with an M-5 medical bag. A "ground level up" (boots-on-the-ground) practical model for the SF (A) detachment commander is presented for employing a medical COIN program- one that fits tactically into the strategic, long-term mission for Afghanistan. The recent success of insurgents in Afghanistan is well summarized by Masood Farivar's timely quote in the text ***Confessions of a Mullah Warrior***: "… an obsession on the part of U.S. policymakers with short-term tactical victories at the expense of long-term strategic vision ... Little thought goes into what actions today will mean in the future" (p. 314).[4] The medical COIN model I present introduces a way to positively affect a profound, widespread problem in Afghanistan: perinatal (mother/newborn) mortality, the number one priority of the Afghanistan ministry of health.

"Counterinsurgency is armed social work; an attempt to redress basic social and political problems while being shot at. This makes civil affairs a central counterinsurgency activity, not an afterthought" (p. 43).[3] Civic action programs' long history plays a key COIN role in the SF unconventional warfare arena. The U.S. Army has intuitively understood the importance of civilian medical assistance as part of a successful COIN campaign for over 100 years. "Over the past six decades, MEDCAP operations have grown to be the leading medical engagement employed by commanders." (p. 17).[5] For the last 40 years, this assistance has taken on names such as MEDRETE (Medical Readiness Training Exercise) and MEDCAP (Medical Civic Action Program), but both have had similar negligible COIN results.

For example, the classic 1965 movie *The Green Berets* depicts Sergeant First Class (SFC) "Doc" McGee running a Montagnard MEDCAP outside the wire perimeter of an A-team camp in Viet Nam. McGee orders candy for children with earaches and diagnoses an infected "pungi stake" wound in another child. The SF psyche needs to retire Doc Mcgee and give the 18D team medic a 21st century civic action COIN program that will have real impact on the local Afghan population. The understanding of U.S. Army COIN medical care has not evolved along with the standard of care in medicine since 1965. Kilcullen also supports the evolution in COIN thinking: "…stop your people from fraternizing with local children… children are sharper-eyed, lacking in empathy, and willing to commit atrocities their elders would shrink from". (p. 40)[3] Notes Kicullen further: "…counterinsurgency practitioners, Soldiers and intelligence operators must rebuild their mental model of this conflict, redesign their classical counterinsurgency methods to meet the challenge of the new conditions, and continually develop innovative and culturally effective approaches. (p.227)[3]

Unfortunately, traditional MEDCAP efforts have brought more harm than benefit. In the mid-1980s, my own experiences with MEDRETE (medical readiness training exercise) missions in rural Honduras were during the "contra" years, while fighting the Nicaraguan insurgency. As a young captain and physician- fresh out of a rotating internship- I was given the mission by the 7th SFG(A) Commander to "win hearts and minds" by taking groups of 18dDs to the most rural parts of Honduras, while working with the local Hoduran Army. I followed the traditional "Doc McGee" tactic by taking a dentist, veterinarian, and physician with six to eight 18Ds to rural villages for a "sick call". The vet took a couple

of medics and ran an animal sick call; the dentist took a couple of medics and extracted a few hundred teeth; and I supervised a mass "de-worming" program and outpatient "sick call" clinic. After administering a few of these feel-good "hero" clinics, it became apparent that this concept was a waste of resources. It also created an expectation to the local populace that the U.S. Army could not meet in either the short- or long-term. However, the commander did get his numbers for a glowing after action report (AAR): many teeth were pulled, animals vaccinated and de-wormed, and bodies were passed through the sick call curtain.

After a year of repeated six-week deployments to various team areas of operation (AO), with our "dog and pony show," I developed a gnawing feeling that what we intended to do (COIN) and what we were actually doing (placing our own emotional Band-Aids) were not even close to the same desired outcome. Even the NGO U.S. Peace Corp volunteers in Honduras at that time had nothing but disdain for our efforts when we crossed paths. The Peace Corp volunteers knew back then that what we did in the Army was futile and even misleading to the local populace. In SF, we have been too slow to acknowledge these errors.

Until recently, the futility of these efforts was not even recognized in the literature, despite the best intentions. Matt Rice and Omar Jones' 2010 article "Medical Operations in Counterinsurgency Warfare: Desired Effects and Unintended Consequences" highlights this observation.[6] Battalion commanders and medical officers- often inexperienced in third-world medicine- have often felt obliged to "do something" when faced with medical conditions that are diametrically opposite to those in the U.S. This amounts to a form of moral panic. This moral medical panic to "do something" has even evolved into shipping pallets full of medications to be given away in mass "Band-aid" civic action clinics by conventional units. Rice and Jones even describe the potential harm that has been done by this archaic conventional Army policy.[6]

Many highly motivated 18D senior medics realize the limitations of these clinics, but fail to understand the strategic COIN Afghanistan strategy. To quote the Army's Special Forces Command Surgeon's Senior Enlisted Advisor at the time, Master Sergeant Oscar Ware in his editorial "In the last Special Operation Combat Medic Training Task Survey, medics indicated "training needs to start being emphasized in routine sick-call problems." (p. 66).[7] Doc McGee's ghost still haunts the halls of the Joint Special Operations Medical Training Center (JSOMTC). We just do not understand the value of the evolution of the medical COIN. The medical COIN role as an 18D is better served on a bigger local scale. SOF medics are best utilized as teachers. We must expand 18Ds' knowledge base in order to realize a more diverse set of problems associated with a "sick call." As suggested by MSG Ware's editorial, "sick call" is not the 21st century answer to a better COIN program and better medics.[7]

"Doc Mcgee's sick call efforts" run parallel to the indigenous medical system in Afghanistan, and have inadvertently undermined the strategic mission of nation-building. These free clinics are rarely coordinated with the indigenous health system structure, despite the Afghanistan Ministry of Public Health's (MoPH) instructions to do otherwise. NGOs are a fact of life in Afghanistan, to a greater or lesser degree, depending on whom is in power over the last 60 years. Many times, these efforts have been misdirected and uncoordinated.

The 2005 Afghanistan Ministry of Health report, "A Basic Package of Health Services (BPHS) for Afghanistan 2005" states: "The MoPH expects all NGOs and others delivering health services in Afghanistan to base the implementation of their health programs upon this document.[8] Hence those delivering health services to Afghans must first provide the BPHS before adding any other services" This 67-page document describes how health-care services are to be administered: from health posts, basic health centers, comprehensive health centers and district hospitals. It also specifies the staff, equipment, diagnostic services and medications required to provide those services. Furthermore, the BPHS document "is the basis for the primary health care system of our country and establishes its standards." Traditional BN Medcaps (out of ignorance) have disregarded the guidance of this document.

The Ministry of Public Health (MoPH) has determined that priorities and content of their health programs must contain five "pillars":

1. Impact major health problem
2. Intervention effectiveness
3. Potential for scaling up program to a national level
4. Sustainability and
5. Equity and access to all

(p.4).[8]

The MEDCAP concept does not address these five pillars. I suspect the Special Operations Forces (SOF) community hasn't heeded the MoPH direction's contained in this document, and innocently undermine the government's community health efforts. Additionally, page 10 of this document details the Seven Elements of the BPHS and that their components also must be recognized.

The seven elements of BPHS in no way, shape, or form contain the elements of a traditional MEDCAP format, with the exception of vitamins and vaccinations. There exist no references to dental care, or even veterinary care, on which traditional Medcaps have historically focused. The NUMBER ONE MoPH directive is **maternal and newborn health**. Any medical program devised by the SOF community for the local populace COIN model must contain strong elements of maternal-newborn health if it is to support the Afghan government's directive. This is based on Afghanistan's atrocious rate of infant and maternal mortality; it is number one, with Sierra Leon a close second.

Numerous studies confirm the maternal-infant problem, and some NGOs attempt to get involved but do not have the security arm to administer such maternal health programs in the remote parts of Afghanistan, in which 80% of the population is rural. Indigenous factors which contribute to the maternal/infant problem- in addition to SECURITY- are as follows: no understanding of prenatal care, poor nutrition, lack of training to local birth attendants (not just midwives), lack of clean facilities, and 85% of births are at home. Cultural mores (explain the mores) about delivering at a government facility, misunderstanding the importance of C-sections, males in medicine, transportation problems, and clinical issues such as tetanus status, malnutrition, tuberculosis, malaria, and HIV also contribute to the mortality rate.

The MoPH report "National Guidelines for Safer Home Birth 2005" attempts to address some of these factors for the very rural population.[9] States patients: "I live six hours from the hospital. There is no midwife in my community. I have to have my baby at home. But I don't know what to make it safer" (p. ii). The audience for this document includes developers and managers of community based programs. This document is the core guide for implementing a simple and local training plan to decrease maternal/newborn mortality. Kilcullen also recognizes the importance of women in an effective COIN program: "…in traditional societies, women are hugely influential in forming the social networks that insurgents use for support.[3] Co-opting neutral or friendly women, through targeted social and economic programs, builds networks of enlightened self-interest that eventually undermine the insurgents…win the women, and you own the family unit. Own the family, and you take a big step forward in mobilizing the population. " (p.40)[3]

Now that I've brought to light two important invitations for synergistic opportunity for an effective medical COIN program in rural Afghanistan:

1) The Afghan MoPH's direction to prioritizing women's healthcare to medical NGOs

2) If the core of latest doctrine in COIN supports women.

It is simple. As COIN practitioners, we can take this "rocket science" and apply it in a simple program. The old saw "Give a man a fish and he will eat for a day. Teach a man to fish and he will eat for a lifetime" applies to 21st century COIN.

Improving the woman/infant mortality statistics could easily be the core of a COIN MEDSEM (Medical Seminar) model as described by Aldermen et al**, which introduces** the MEDSEM concept, successfully deployed in in the Medical Operation Enduring Freedom-Philippines COIN program, supplanting the MEDCAP concept.[5] The MEDSEM concept runs parallel to what the Peace Corp has administered for the last 50 years.

> The Peace Corp Act (1961) declares the program's purpose as follows: Make available to interested countries and areas' men … of the United States qualified for service abroad and willing to serve, under conditions of hardship if necessary, to help the peoples of such countries and areas in meeting their needs for trained manpower.

It is not a coincidence that both the SOF community and the Peace Corp are involved in nation-building, and that both organizations were the concomitant brainchild of the same president- John F. Kennedy. He recognized the importance of SOF Unconventional Warfare (UW). "The first steps in improving public health and starting on the road to self-sufficiency are the identification of needs and collaborative pooling of information and assets….

From a public health perspective, coordinated planning, and continued progression are the most important aspects of improvement.[5] The two fundamentals for success in a COIN program are "local solutions and respect for the noncombatants." (p.3)[3] The MEDSEM concept directly supports these remarks. It is a "hand up" rather than a "hand out".

Traditionally, the SOF medical training community has not recognized the importance of women's healthcare. There have been various reasons for not recognizing the needs of 50% or more of the indigenous population. Our own cultural taboos may even come into play in discounting the need for this skill set. We must have the courage to go forward and modify our UW COIN medical paradigm to meet the needs of the Afghan Ministry of Public Health.

Ground upward MEDSEM medical operations start small, but could have a big impact. Alderman suggests an outline for building a MEDSEM program.[5] To avoid verbosity, I will not go into the evolution of the MEDSEM- Philippine program. The reader can explore that article for reference to building a similar plan in principle for his or her own AO.

The A-team leader with the initiative to institute the Afghanistan MEDSEP model should incorporate MoPH guidelines concerning maternal/infant health as part of his introduction to his AO. These are located on the Afghanistan MoPH Internet site.[8,9] Then he should coordinate with the government at the local and regional level. He should also use the "National Guidelines for Safer Home Birth" to develop a core indigenous curriculum to train local birth attendants in the most rural areas where SOF freely operates.[9] That training curriculum could be presented over a couple of days and recognize those graduating attendants with a particular government sanctioned certificate of completion. That training could be centralized in a safe area to include both birth attendant trainee and the family members. The team leader could also employ a midwife from a higher level of care in the MoPH system to do the actual teaching in order to minimize clashes in cultural morays.

These classes should run in conjunction with an immunization program so pregnant women can receive tetanus vaccinations. Each day at the end of the class, the 18D could administer an OJT (on the job training) prenatal clinic co-administered by the government-recognized midwife trainer, and newly graduated birth attendants. They could draw in pregnant mothers to receive immunizations and free perinatal visits. This OJT clinic would allow the newly certified birth attendants to practice skills associated with basic prenatal visits. (e.g., b/p, urine for protein and sugar, measure fundal height, and pregnancy tests) The 18D administrator could also supplement the OJT prenatal clinic with a simple handheld ultrasound clinic.

This complimentary sonogram "clinic" would only demonstrate fetal heartbeat and body position. Such a technology could have a huge psychological impact when a photo is printed and given to each pregnant mother. Field ultrasound is not a new concept to the 18D (p.59).[10] Fetal body position and heartbeat can be learned by the 18D in less than one 30 min block of instruction with a couple of pregnant models and a competent OB physician or ultrasound technician.

Husbands should be encouraged to attend the ultrasound clinic. This fetal ultrasound "clinic" could help overcome the cultural mores and would allow men to play a more active role in women's care. The MEDSEM at its outset must be associated with a clear understanding that the team and its members, (i.e., the 18D) will play absolutely no role in attending any deliveries. The 18Ds role is to create a safe teaching environment and not to administer OB care in any labor and delivery capacity.

Running a parallel class for men, teaching the basic importance of prenatal care should be taught by another man — the 18D. The program should discuss the importance of basic sanitation. It would also involve the husbands as a key part of a birth evacuation plan in the event of an obstetric emergency. The ministry of health actually has a preprinted guideline for a birthing plan. The program could also teach the lifesaving importance of C-Sections. PsyOps unit could develop and show an educational video in Pashto of C-section and happy results. Get the local press involved after obtaining the local mayor's and religious elders' "blessing" on these programs. Finally, remember the axiom: Primum non nocere: First, do no harm.

These arguments suggest that we should abandon the archaic Medical Civic Action Programs in favor of the 21st century Medical Seminar program. Afghanistan's abysmal perinatal maternal/infant mortality is a number one priority of the Afghanistan ministry of Public Health and creates a huge opportunity for an effective counterinsurgency program. The Special Forces detachment commander can implement a successful COIN program via a coordinated effort with the guidelines from the Ministry of Public Health Basic Package of Health Services directives and the MEDSEM model.[8] A COIN program such as one I've suggested addresses the mission requirements of the U.S Army and the nation-building of the Islamic Republic of Afghanistan.

"We also recognize that as we look forward, success increasingly depends upon the larger combination of defense, diplomacy and development activities." Admiral Eric T. Olson, Commander, USSOCOM 2010 posture statement.[11]

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