Addressing Maternal Healthcare Needs in the Counterinsurgency Environment

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ABSTRACT

All pregnant women are at risk of obstetric complications, most of which occur during labor and delivery among women with no previously identified risk factors. More than 95 percent of these deaths occur in developing countries. In sub-Saharan Africa, a region of the world currently experiencing significant humanitarian crises, the lifetime risk of maternal death is one in 30 whereas the lifetime risk in developed countries is one in 2,800.[1] The majority of maternal deaths from obstetric complications are due to hemorrhage, eclampsia, sepsis, or obstructed labor, each of which is treatable. Emergency obstetric care is critical to reducing maternal death and disability. SOF medical personnel supporting counterinsurgency (COIN) operations may find themselves in situations where no legitimate agencies are available to provide maternal healthcare. Similarly, SOF medical personnel should be prepared to assist in rebuilding infrastructure and basic services to include the provision for maternal health. This article provides an overview of maternal health in underdeveloped countries; the importance of addressing the unique healthcare needs of women during COIN operations; and how the employment of Female Treatment Teams (FTT) can assist in meeting these needs. A subsequent article will review the basics of prenatal care and life-saving emergency obstetric care, and discusses the essential information and skills that should be taught in a MEDSEM covering maternal healthcare.

Background

Across the globe, a woman dies every 90 seconds from complications associated with pregnancy and childbirth. More than half a million women die from medical conditions associated with pregnancy and childbirth each year.[1,2] Unfortunately, this number has not declined substantially in over two decades. Based on 2005 data, the average lifetime risk of a woman from an underdeveloped country dying from pregnancy related complications is 300 times greater than for a woman living in an industrialized country.[1] No other mortality rate is so unequal. Due to this disparity, having a child remains among the most serious health risks for women in developing countries. Yet for every woman who dies, another 20 more will have survived an obstetric related injury, but will suffer from severe, often lifelong disability as a result. The number is astonishing: Every year an estimated 10 million women who survive their pregnancies experience adverse outcomes such as vesicovaginal fistula, rectovaginal fistula, or uterine prolapse.[3]

Around 15 percent of all pregnant women will develop a potentially life-threatening complication that requires skilled medical intervention.[4] Most maternal deaths are related to complications that arise during childbirth including postpartum hemorrhage, infection, hypertensive disorders, and prolonged or obstructed labor. Many of the causes of maternal mortality can be prevented or readily treated with basic healthcare in the presence of a skilled birth attendant and through appropriate access to medical providers familiar with emergency obstetric care.[4] A recently published index of 164 countries ranked Afghanistan the worst place in the world to be a mother.[2] Another eight of the lowest ranking ten countries are located in sub-Saharan Africa where less than half of all births have a skilled attendant present, and on average one in 30 women will die from pregnancy related causes.[1,2] According to a global report on midwifery, 58 countries located primarily in Africa and South Asia account for more than 90 percent of the global burden of maternal mortality, and 80 percent of both stillbirths and neonatal mortality.[5] Less than 17 percent of the world's skilled birth attendants are available to care for the pregnant women in these 58 countries.[5]

Like maternal deaths, the overwhelming majority of neonatal deaths occur in developing countries. Neonatal mortality is the death of a newborn between birth and the first 28 days of life. The health of mothers and newborns is intricately related, and obstetric complications can lead to stillbirth or early neonatal death, which combined are referred to as perinatal deaths. The World Health Organization reported 5.9 million perinatal

deaths in 2004.[1] More than 80 percent of neonatal deaths can be attributed to infection, asphyxia, or preterm birth.[1] As with pregnant mothers, adequate prenatal care, clean delivery practices, and improved obstetric care provided by a skilled attendant can prevent or alleviate many of the causes of neonatal mortality.

Complex Emergencies

Populations affected by armed conflict typically experience severe public health consequences from the breakdown of social structure caused by the disorganized movement of internally displaced persons, food shortages, and the collapse of public health infrastructure. The subsequent crisis that results from the collapse of authority may require an international response and is known as a complex humanitarian emergency. The traditional focus of relief efforts during complex emergencies has been the provision of adequate food, water, shelter, and basic healthcare. Like women anywhere, pregnant mothers caught up in complex emergencies can encounter medical complications associated with pregnancy and childbirth. The available data on maternal and infant health during complex emergencies suggest that poor outcomes are common in many war-affected populations.[6] A number of factors can increase the risk of maternal morality in refugee settings. During the initial phase of a complex emergency, pregnant women may become malnourished and anemic and are therefore at higher risk of infectious diseases. They may be exposed to physical and psychological violence. They are often alone and may have to give birth under hazardous conditions. As a result, humanitarian assistance for refugees and internally displaced populations requires particular attention to the common causes of morbidity and mortality in women and infants.

Counterinsurgency and Stability Operations

In the current operational environment, military forces can expect to be utilized to preserve security and stability in order to facilitate the re-establishment of civil order and a functional public infrastructure. Counterinsurgency (COIN) doctrine can be summarized as "Shape—Clear—Hold—Build" and may encompass the various military missions and activities conducted in order to maintain or reestablish a safe and secure environment and to provide essential government services, emergency infrastructure reconstruction, and humanitarian relief. Department of Defense Instruction 6006.16, dated 17 May 2010, requires that the military health system, "be prepared to establish, reconstitute and maintain health sector capacity and capability for the indigenous population when indigenous, foreign or U.S. civilian professionals cannot do so."

It has been said that counterinsurgency is armed social work. Nation-building efforts cannot be successful without adequate attention to the health of the host nation population. In the non-permissive to semi-permissive environment, military forces are often the only personnel interacting with the local populace with little to no support from other International Agencies (IAs) or Non-Government Organizations (NGOs). As a result, military medical personnel may find themselves required to engage in all levels of medical stability operations from providing direct patient care to the reconstruction or development of host nation healthcare capabilities. In these environments, it is essential to address the needs of the entire population and not to overlook the needs of women.

Women, Counterinsurgency, and Health

A successful COIN strategy relies on the popular support of a community and should include the female half of the population. Women play key roles as peacemakers and peacekeepers, and this is perhaps related to the disproportionate amount of harm that both women and children experience in war. In contrast to World War II where civilian casualties were just over half, civilians are now being specifically targeted so that approximately 80 percent of casualties are civilian; of these, nearly 90 percent are women and girls.[7] Women and children are increasingly targeted in order to destabilize populations and to destroy the bonds within a society, and it is estimated that they comprise 80 percent of the world's refugees and displaced persons.[8] The essence of COIN is to focus on the entire population, not just the male half. Therefore, it is imperative to recognize the importance of women in rebuilding a society and to integrate their concerns into military lines of operation.

Given the opportunity, women will actively participate in conflict prevention and resolution, and their empowerment is inextricably linked to the achievement of COIN objectives. Their collaboration skills, their ability to work across ethnic, political and religious lines for the common good, and their willingness to use available resources for social stabilization and reconstruction make indigenous women essential allies in the counterinsurgency effort. Although most insurgent fighters are men, women are extremely influential in forming the networks that insurgents use for support. Likewise, they are the foundation of social and economic networks that eventually undermine an insurgency. Additionally, women are able to guide the behavior of adolescents who are prone to recruitment by insurgent forces, but efforts to communicate with and understand the needs of the female population are required to leverage their influence over the male population.

A recently published essay by COL (Ret) John Agoglia, former Director of the Counterinsurgency Training Center in Afghanistan, describes that in some villages the women's greatest fears are death in pregnancy or loss of children for lack of simple things like midwifery care and basic medical interventions.[2] According to a Rand Corporation study of operations following major conflicts, nation-building efforts cannot be successful without adequate attention to healthcare.[9] The assessment concluded that health has an independent impact on political, economic, and security objectives during nation-building operations. As U.S. COIN strategy seeks to mesh development and security objectives through activities that enhance the legitimacy of the host nation government, the military must be prepared to meet civilian health requirements during the conduct of stability operations. Some of these activities are designed to improve health infrastructure and others are designed to provide care to civilians in remote or insecure areas. A successful counterinsurgency campaign must promise as well as deliver on guarantees for the security and basic needs of the indigenous population, to include those of women.

Direct Care by Military Medical Personnel

The U.S. military has limited experience in the application of non-kinetic actions specifically directed at indigenous women. FM 3-24, Counterinsurgency, addresses the engagement of women only briefly. While commenting that the support of women and families is, "a big step toward mobilizing the populace against the insurgency," the manual does not go into depth regarding the, "targeted social and economic programs [that] build networks of enlightened self-interest that eventually undermine insurgents."[10] The key non-kinetic effect the military should be seeking in engaging women is to positively influence this half of the population so that they will then be advocates for U.S. efforts and activities. Within the health sector, the potential exists for the provision of military medical support to non-military personnel during stability operations as a way to "target" vulnerable populations such as women and children.

Military personnel should only attempt to provide direct medical support where there is no comparable civilian alternative and only when the use of military assets can meet a critical humanitarian need. Even then, medical services should be tailored to local cultural and religious customs and rules. Any care provided should take into account the capabilities and resources of the local community. This often necessitates that it would be inappropriate to initiate medical care for conditions that are expected to require continuing medical supervision and treatment.

Following a complex emergency the primary concerns of the population are food and water, security, and medical care. By virtue of their unique missions, SOF medical personnel are often the only outside sources of interaction with segments of the host nation populace because of security constraints that prohibit other nation-building partners from working in non-permissive, semi-permissive, or remote areas. SOF medical providers may thus find themselves in the unique position of being called upon to provide emergency medical care for isolated groups of an indigenous population. Depending on cultural norms this might be expected to include women. While many medical conditions coexist in men and women and can be treated similarly in either gender, the medical conditions encountered during pregnancy are uniquely female. Often pregnancy related medical problems can be properly treated with basic interventions; however, it is strongly encouraged that only those medical providers who have received adequate training and are proficient in obstetrical life support measures consider providing direct care to a pregnant woman. At no time should any provider practice outside his or her level of competency. For those situations in which it is anticipated that host nation females will require assistance from military medical assets, the SOF Female Treatment Team (FTT) can be an invaluable resource. The FTT concept will be discussed in greater detail later in this article.

Facilitating Host Nation Medical Development

The end-state for stability, reconstruction, and development of the health sector as part of a COIN operation is for the host nation to provide culturally and clinically appropriate healthcare to its indigenous populace. While military personnel in an unstable setting may provide essential healthcare services, the provision of direct medical care should be turned over to NGOs or host nation government entities as soon as conditions permit. However, recent experience has demonstrated that the traditional model of separation between the military and the civilian humanitarian relief community is no longer absolute. The Rand study previously mentioned identified poor planning and coordination within and between U.S. government military and civilian agencies, and a lack of an overall health sector reconstruction plan as obstacles leading to failed efforts in Afghanistan.[9] Therefore, it is not only appropriate but also necessary for the military to function as an integral partner in the reconstruction of the health sector during all phases of the COIN campaign.

The initial focus on health sector reconstruction should directly support the counterinsurgency effort and should incorporate specific programs that address women's health issues including maternal morbidity and mortality.

Medical stability operations should be directed at culturally acceptable, sustainable interventions that build host nation capabilities including medical staffing, training and education, logistics, and public health programs. Developing programs based on western medical models, while admirable, may not be the most suitable approach. For example, an obstetrics mobile training team conducted a comprehensive assessment at a women's hospital in Kabul following the death of a patient during an emergency cesarean section and found a lack of basic knowledge and decision-making capabilities.[11] Efforts to correct the deficiencies had to be redirected after the team initially attempted to provide advanced level training. Subsequent hands-on instruction with basic equipment and fundamental instruction regarding the management of obstetric emergencies proved to be more successful. Recognizing the expectations and limitations of host nation health sector capabilities is essential to sustainability of training and mentoring programs.

Engagement of host nation women in the development of the health sector can lead to more effective programs that may promote a more sustainable peace. Women should be involved in the assessment and project design processes so that their medical concerns and needs will be considered when developing health sector reconstruction plans. Often this will require the presence of female counterinsurgents in order to gain the confidence of the local female population. Recent experience has shown that local women will discuss their gender-specific medical problems with female medics.[12] These interactions have led to the development of programs that work with the host nation government to create a sustainable infrastructure for women to provide healthcare to other women. The importance of engaging the female half of the population with regard to security, healthcare, and education has been recognized by ISAF, which directed that all BCTs would have trained Female Engagement Teams (FET) assigned to the unit prior to deployment as of August 2011.

Female Treatment Teams

Understanding that a successful COIN strategy relies upon the popular support of women as well as men, the SOF medical community has developed the Female Treatment Team (FTT) to promote health sector development programs available to the female half of an indigenous population. The concept of the FTT dates back to 2009, with the first team deployed in 2010. The FTT model was designed to encourage the education of women and midwives, and it has thus far been limited to operations in Afghanistan. The idea for the FTT evolved out of the SOF Cultural Support Team (CST). Initially, each CST was to include a medic as a member of the four-person team; however, shortages of available, trained personnel required modifications to the team structure. Ultimately, the FTT was developed to meet the gap in medical capability that was not provided by the CST.

The mission of the FTT is to build health capacity at the village level in order to improve women's healthcare over the long-term. This is accomplished primarily through teaching local women who would otherwise have no access to medical education. In addition to teaching basic skills to female volunteers, the FTTs provide emergency obstetrical training and other continuing medical education courses to village midwives. They emphasize the importance of recognizing the conditions that require the referral of mothers and newborns from the home to the hospital for additional medical support.

A SOF FTT is typically attached at the team level to an ODA at a Village Stability Platform (VSP) site. At present, no published doctrine exists for the training or employment of an FTT; however, it is generally composed of two medically trained females with at least one being a physician, PA or NP provider and the other a 68W medic. Working together with the ODA, the FTT can gain access to host nation women in remote villages or semi-permissive environments where NGOs or governmental agencies are unable to administer their programs. The FTTs have the ability to meet face-to-face with women inside their homes in order to determine their level of medical knowledge and their health concerns. The majority of women in Afghanistan have extremely limited access to medical care, and their cultural norms place stringent restrictions upon their interaction with any man outside their family. Through their presence with the ODA, the FTT along with the 18D can serve as the eyes on the ground where USAID or Ministry of Public Health officials are unable to obtain access for security or other reasons.

An important role of the FTT is to teach, advise, and assist local providers whenever possible. In the absence of trained village women, the FTT can teach basic hygiene and healthcare to the local populace. The FTT can also promote medical engagements specifically targeting women's healthcare needs. In several cases the female provider on the FTT has been able to assist with the delivery of a baby, and in one particular situation the FTT provider proved to be instrumental in saving the lives of both mother and baby when she determined that it was necessary for the mother to be evacuated to a facility capable of performing a cesarean section.[13] Even though the program is in its infancy, the FTTs have made significant strides and played critical roles in bridging the gender gap through identifying and meeting the healthcare needs of indigenous women. The interactions with female counterinsurgents has even had a positive influence on the male half of the population as illustrated by a

local elder who commented that, "Your men come to fight, but we know the women are here to help."[14]

Maternal Health in Afghanistan

The reconstruction of the Afghan health sector provides useful lessons for other countries confronting poverty and insurgency. Afghanistan ranks amongst the countries with the highest maternal and infant mortality rates in the world where about one out of every eight women dies from causes related to pregnancy and childbirth every year and about one in six children dies before the age of five.[1,2] As of 2005, only 30 percent of primary care clinics offered basic maternal services, and only 10 percent of hospitals could perform cesarean sections.[9] It is not surprising that the Afghan Ministry of Public Health (MoPH) is seeking to assure that health services are equitable and able to meet the urgent reproductive needs of women. Unfortunately, the MoPH lacks the human resources necessary to offer such services. The paucity of trained medical personnel, especially female ones, is a reflection both of the culture and the many years of Taliban control when girls and women were barred from education and employment. Educated women, including midwives, were specifically targeted by the Taliban, who killed and intimidated any who dared to continue their work.

A report published in 2011 indicated that skilled attendants were present at less than 15 percent of births in Afghanistan with only 2 midwives available for every 1,000 live births.[5] While the training of birth attendants and midwives has increased, their poor distribution has left much of the country underserved with continued record high maternal mortality rates. The risk of maternal mortality is increased with greater remoteness. Numbers of deaths from maternal complications exceeded those from all other causes among women in rural areas where hemorrhage and obstructed labor were the most common causes of mortality.[15] Three fourths of infants born alive to mothers who died also died.[15]

Faced with the poor performance of uncoordinated health sector activities of both civilian and military agencies, the Afghan MoPH defined a package of priority primary care interventions that included prenatal, obstetrical, and postpartum care. Despite ongoing conflict, progress has been made. Between 2002 and 2007, the number of in-clinic deliveries increased five-fold and the infant mortality rate decreased by 22 percent.[16] Unfortunately, the military programs typically lack a process for sustainment due to difficulties in transitioning the services to civilian agencies. Linking military COIN strategy to development goals offers the potential to contribute to sustained stability by connecting military actions with improvements in host nation health sector capabilities.

Conclusion

At its core, COIN is the struggle for the support of the populace. It is a fact that the welfare of the indigenous population is vital to the success of a COIN operation, and it can be expected that women will constitute roughly half of any nation's people. Women have greater incentives than men to peacemaking and peacekeeping; therefore, it is both reasonable and necessary to ensure that the medical assets of the counterinsurgent forces address the special healthcare needs of women. Safe motherhood benefits not only women but also their families, community and society and is an essential component of development. The engagement of international military medical forces with the indigenous health sector is inevitable. SOF medical personnel can expect to interact directly with the host nation populace in remote and semi-permissive environments often with few external resources, making it necessary that they are prepared to face challenges in many areas to include gender.

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