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Health Initiatives and Counter-insurgency Strategy in Afghanistan

Summary

- An initiative by the Ministry of Public Health in Afghanistan to expand health services throughout the country, including rural communities, and supported by donors including USAID, has vastly expanded access to primary health care services, significantly reduced child mortality, and increased the capacity of the Afghan government to provide an essential service to its people. The program is based on principles of equity, national ownership, community engagement, and women's equality, and it warrants continued development. Many challenges remain, not least expanding services in insecure areas, and a more stable environment could better enable the Ministry of Public Health to achieve its goals.
- The U.S. military has supported health services development for the Afghan army and also offers significant emergency care services to civilians in insecure regions, training for health workers, construction of health facilities and other health -related programs. The military's civilian health initiatives, largely disconnected from the Ministry of Public Health, are short term, ad hoc, and unsustainable, and to date have lacked a consistent rationale or strategy, and have not been subject to evaluation.
- U.S. counterinsurgency strategy seeks to mesh development and security objectives through activities that enhance the legitimacy of the Afghan government in the eyes of its people. In the field of health, there are considerable tensions between counterinsurgency and development strategies, which must be addressed to increase the capacity of the government and meet health needs of the people.

"Despite its emphasis on capacity-building and promotion of government legitimacy, there is sufficient tension between counterinsurgency strategies and effective health development that USAID and Department of Health and Human Services programs should not be driven by counterinsurgency policy."

Introduction

In a speech about development in January 2010, Secretary of State Hillary Rodham Clinton said: "We are working to elevate development and integrate it more closely with defense and diplomacy in the field. Development must become an equal pillar of our foreign policy, alongside defense and diplomacy, led by a robust and reinvigorated AID."

She continued:

"Now, I know that the word integration sets off alarm bells in some people's heads. There is a concern that integrating development means diluting it or politicizing it—giving up our long-term development goals to achieve short-term objectives or handing over more of the work of development to our diplomats or defense experts. That is not what we mean, nor what we will do. What we will do is leverage the expertise of our diplomats and our military on behalf of development, and vice versa. The three Ds must be mutually reinforcing."

Though Secretary Clinton was seeking to reassure, her remarks raised additional questions about what 'mutual reinforcement' means and how the leverage between military and development activities works.

Nowhere are these questions posed more acutely than in health programs in Afghanistan, where civilian and military agencies have pursued distinct and disconnected activities. USAID has announced a commitment by the United States to bring development activities within the counterinsurgency strategy, such that "the proposed activity will contribute to U.S. counterinsurgency goals."

To discuss the relationship between health initiatives, support for the Afghan state and counterinsurgency, on January 8, 2010, USIP's Health and Peacebuilding Working Group convened a panel of experts in the field including Dr. William Newbrander, senior technical adviser with Management Sciences for Health and senior adviser to the Afghanistan Minister of Public Health; Dr Warner Anderson, director of the Division of International Health in the Office of the assistant secretary of defense for Health Affairs, Dr. E. Anne Peterson, research professor, Center for Global Health at George Washington University who leads a study of U.S. sponsored health programs in Afghanistan; and Sepideh Keyvanshad, senior development adviser to the special representative for Afghanistan and Pakistan. Leonard Rubenstein, coordinator of the working group, moderated. The views expressed in this Peace Brief are exclusively those of the author.

The Afghan Ministry of Public Health Expands Services

Decades of war have taken a horrific toll on the health and well-being of the Afghan people. Rates of infant, under-five and maternal mortality are among the highest in the world and life expectancy is 47 years. The health sector is characterized by severe shortages of trained health workers, equipped facilities, and medicines, as well as inadequate planning, management and financial resources. In 2002, the World Bank, USAID and the European Commission began to support the Afghan Ministry of Public Health in developing and managing a system of primary care service. This effort focused on increasing ministry capacity in six key functions: health services delivery, human resources, health information, access to quality pharmaceuticals, health financing systems, and leadership and governance. Among other goals, the program seeks to assure that health services are equitable, responsive to communities' needs and meet the urgent reproductive health needs of women.

The ministry's plan focuses on a basic package of health services. Since the ministry lacks the human resources to offer services directly, it contracts with local and international nongovernmental organizations (NGOs) to provide them. Donors, including USAID, provided extensive technical assistance to the ministry. The Department of Health and Human Services supplements the initiative through support for health development activities such as medical residency training in delivery care.

Afghanistan's strategic approach to health has been subject to rigorous external assessments through facility surveys, patient provider observations, exit interviews, health worker surveys, household surveys and focus group discussions. Despite the ongoing conflict, the ministry has made progress on all six core functions. Between 2002 and 2007, annual clinic visits rose from just over 100,000 to more than 700,000; deliveries in clinics increased more than five-fold to 5,000 a month, and the percentage of clinics with female health workers went from 21 percent to 83 percent. A health information system is in place, pharmaceuticals are widely available, financing systems, though still weak, are sufficient to manage donor funds directly, and the ministry has demonstrated leadership. Perhaps the best indicator is the decline in infant and under-five mortality by 22 percent and 26 percent respectively.

Still, major challenges remain, including extending services to insecure areas, improving quality and supervision of staff, assuring the use of information available to the ministry, establishing a strong pharmaceutical management system, improving financial management, providing mental health services, engaging communities, and implementing a plan for expanded hospital services.

The Role of the U.S. Military in Health Services for Civilians

The U.S. military seeks to strengthen the capacity of the Afghan military to meet the health needs of its troops and it also engages in many civilian health programs. The latter flows from a new doctrine on stability operations requiring that "[Defense Department] medical personnel and capabilities are prepared to meet military and civilian health requirements in stability operations." Civilian health support functions are offered through provincial reconstruction teams, the Commander's Emergency Response Program, Special Forces operations and other mechanisms. Some of these activities are designed to improve health infrastructure and others, particularly the many Special Forces medical outposts, are designed to provide care to civilians in insecure areas.

Military sponsored civilian programs are almost entirely disconnected from the multidonor initiative discussed above and there is little coordination between them. This gap stems in part from difficulties in communication and coordination between military and civilian agencies, but structural factors also inhibit a joint approach. Military health programs are generally oriented toward meeting immediate security goals and addressing acute health needs. While some activities like training can have development implications, these programs generally have short time frames and are more ad hoc than driven by a long-term plan or strategy. No process exists for sustaining military operated programs or for transitioning its emergency services to the Ministry of Public Health. Military programs have not been evaluated for effectiveness, measured either by improvement in the health of people served or by contributions to security, or evaluated for potential unintended harms such as setting unattainable expectations or placing civilian programs at risk of attack.

The lack of strategic direction is in some ways due to the lack of clarity about what Dr. Peterson refers to as the "lane" that the Defense Department occupies in the civilian sector. Its role in providing emergency care in insecure areas is clear. Yet in the development area, the default position is that because the Defense Department has so many more health personnel and financial resources at its disposal than civilian agencies, and the capacity to operate in dangerous areas, then it must play a significant role in health development activities. In certain respects, however, the resource gaps are more apparent than real, as civilian agencies can provide capacity-building support to the ministry, and the military lacks expertise in health systems development. An alternative approach for development activities is for the Defense Department to respond to requests from the ministry to engage in activities that are within its capacity, such as construction, equipment maintenance, or for the DoD to propose and fund projects requested by provincial and central government officials that would be implemented by others. This approach would not preclude the military's provision of emergency care to civilians in dire need when no other entity could assist them, operating under principles of impartiality.

Health in Counterinsurgency Policy

In 2009, the U.S. government decided to link military and development goals in Afghanistan through a counterinsurgency strategy. The strategy seeks to contribute to sustained stability by connecting military actions with the political goal of improving the capacity of Afghan government institutions to provide services to and engage with the Afghan people, all toward persuading the Afghan people to have confidence and trust in their government and thus decrease their allegiance

About This Brief

Multidonor civilian health initiatives in Afghanistan have brought remarkable improvements in access to health care, government capacity to organize services and survival rates among children. The U.S. military is engaged in a variety of civilian health activities, including emergency services in insecure areas. U.S. policy now seeks to tie USAID health development activities to a larger counterinsurgency strategy. This Peace Brief suggests that health development in Afghanistan should be driven by longer-term goals that include enhancing the capacity of the Afghan government to deliver health services.

to the Taliban. The counterinsurgency strategy also assumes that development programs such as health can contribute to security, though to date evidence is lacking.

As Secretary Clinton's speech indicates, development and counterinsurgency approaches are often seen as congruent in that they emphasize building the legitimacy and capacity of the host government. There are, however, key differences, indeed tensions, between development and counterinsurgency approaches to health. First, development stresses the deployment of resources in a manner that promotes equity across regions and ethnic and tribal groups, and focuses resources in areas of highest need. Counterinsurgency policy, by contrast, prioritizes activities in areas where insecurity is highest or where allegiance to the government is most at risk. Second, the timetables of the two approaches will likely vary. Activities designed to win support from populations to increase security in the short term may be quite different from those that would flow from the ministry's long-term strategy. Third, the merger of military and civilian approaches can increase the risk that civilian health providers come under attack as they become identified with a military strategy. Finally, and perhaps most important, a counterinsurgency approach raises questions whether the Ministry of Public Health itself will have sufficient authority to make decisions about program priorities.

Conclusion and Recommendations

1. The progress made to date in the ministry-led health initiatives in Afghanistan suggests its potential to meet critical health needs through primary care and hospital services and, at the same time, increase the legitimacy of the government. The principles that animate it, including geographical equity, access for the poor, women's equality, national ownership and decision-making, and community participation, should be preserved.
2. Despite its emphasis on capacity-building and promotion of government legitimacy, there is sufficient tension between counterinsurgency strategies and effective health development that USAID and Department of Health and Human Services programs should not be driven by counterinsurgency policy.
3. The U.S. military role in health services in Afghanistan needs to be set out clearly and can include a) supporting health programs for the Afghanistan military; b) establishing security so that health programs can operate; and c) offering temporary emergency services in highly insecure areas, operating under principles of impartiality; and d) contributing to funding development work under the leadership of the ministry and, when requested by the ministry, engaging on facility construction and equipment maintenance activities. Before engaging in civilian-related health activities it should assess whether its presence will place NGO-operated programs at risk.
4. Whether health programs can contribute to short-term security requires rigorous study.

Endnotes

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