U.S. Special Forces Medics in Afghanistan Look to Partner with NGOs on Rural Health

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U.S. Special Forces (SF) medics operating in small groups in remote areas of Afghanistan can make significant health impacts by assimilating themselves into the local culture, and working side-by-side with Afghan medical providers.

They often grow beards and don the local attire to fit in, in contrast to larger conventional forces that mostly operate in the country's urban centers. In a recent discussion convened by the International Health Division within the Department of Defense (DoD) Force Health Protection and Readiness (FHP&R) offices in Falls Church, VA, some SOF medics who had just redeployed from Afghanistan, and several DoD, U.S. government interagency, and international health policy leaders, broached the idea of having a development or nongovernmental organization (NGO) specialist accompany the medics on some of their medical outreach missions. Since the SF medics often blend in with the culture, the missions could hold appeal for civilian aid agencies, contractors, or NGOs to partner and help make more sustainable inroads on rural health in Afghanistan.

"SF guys are going in, but no one takes over after each one leaves," said CPT Dan Winschel, PA-C and former SF medic (18D), who has done two tours in Iraq ('03, '05) and one in Afghanistan last year. "We need to tie in with international organizations (IOs) and NGOs to survey the ground situation and security in remote areas and have a bigger impact."

Dr. Warner Anderson, Director of FHP&R's International Health Division (IHD), raised the possibility of DoD contracting NGO expert liaisons to assist military medical personnel in connecting with their civilian counterparts in places like Afghanistan. He said it worked very well following the 12 Jan earthquake in Haiti. IHD member Dr. Lynn Lawry had extensive NGO experience and expertise and was funded by the NGO International Medical Corps to travel to the disaster site. Once there Dr Lawry assisted with interagency medical relief coordination (please see resulting paper at (http://content.nejm.org/cgi/content/full/NEJMp1001555).

"I also think we need to do a better job working with our Army Civil Affairs guys" added CPT Winschel. "As the military, we need liaisons to reach out to NGOs. There needs to be someone to bridge the gap because there is a huge gap of what we could be getting out of it. Maybe a broker from the Department of State to say we're going to be here a long time (would be helpful)."

John Dunlop, a U.S. Agency for International Development (USAID) officer for military affairs, said SF medics and NGOs working together could be very positive and allow for more flexibility and less bureaucracy than the regular Army might. "You can have that flexibility between SF and NGOs to interact with the UN, IOs, and NGOs," he said.

Dr. Anderson referenced an iconic black and white photograph of U.S. Special Forces riding on horseback with Northern Alliance members in Afghanistan in 2002 as a testament to SF Soldiers' efforts to learn about and work from within other cultures. "All SF Soldiers are trained in local languages and given extensive cultural awareness classes," CPT Winschel said. "Wearing of local garb is just what feels right when interacting with the locals. They feel you are more relaxed and it opens to cultural interaction. We would often join the locals in celebrating

their holidays, family birthdays, and even weddings when the opportunities allowed. This is a general way of making inroads and developing trust. The growing of beards is another way of being respected in their culture (a beard is also a sign of masculinity there)."

The U.S. Special Operations Command does a good job of training SF Soldiers on all aspects of the particular culture they will be working in, including language training, said CPT Winschel. "The numerous rotations have required other SF groups, which normally would not operate in the Middle East, to rotate over to operations in Iraq or Afghanistan," "These Soldiers rely on their interpreters to communicate with the local forces and civilians. For example, I did not get any Dari language training for my rotation in Afghanistan; however, the cultural courses do teach you some salutations and common phrases."

CPT Winschel said the Special Forces are trained to be diplomats. "In Iraq, (NGOs) had their own security, but we would interchange assessments and develop courses of action that would help coordinate civil-military operations. This time, in Bagram (Airbase-Afghanistan), NGOs and IOs were either on the base or would travel from one major city to another; however, they never made it to the remote areas like they did in Iraq. The Afghan National Army (ANA) could accompany them and facilitate such assessments, and (they could help) develop more sustainable projects and programs if we could get the security improved."

Improving Medical Support to Stability Operations

One of the primary objectives of IHD is to develop policy for Military Health System (MHS) support to international stability operations. The division wrote a health instruction (DoDI 6000.16) for such missions that was approved in May and outlines military responsibilities in planning for and conducting medical stability operations. It directs the MHS to be prepared to establish, reconstitute and maintain the health sector capacity and capability for other populations when local, international or U.S. civilian professionals cannot do so. IHD is also developing a MHS capabilities needs assessment and medical stability operations training plan for DoD personnel that promotes interoperability with other relevant agencies. "If you think strategically, you see health as a matter of development," Dr. Anderson said. "In DoD, health assets are those of the line commander; historically, to care for the troops, but also host nations. There is a history of the U.S. military providing direct care services to other countries that is partly humanitarian, but also a matter of stabilization. I maintain it is the medical officer's responsibility to take a health neutral thing like a MEDCAP (short-term medical civic action project) and turn it into a positive thing, and it is our job to show them how."

The new health instruction builds off a policy (DoDI 3000.05) that was issued last September and stemmed from a 2005 department directive that establishes stability operations as a core U.S. military mission. DoD must be prepared to carry them out with a proficiency that is on par with combat operations. The policy requires DoD to support, jointly plan, and conduct stability operations led by other U.S. government agencies and to collaborate with allied governments, their security forces, international and regional government organizations, NGOs and the private sector. DoD must further be prepared to lead stability operations whenever necessary, heed national and international laws, establish security, restore essential services, repair critical infrastructure, and provide humanitarian assistance. Global MHS interactions involving host country health infrastructure and care to civilians can take place across the range of peacetime, disaster, conflict, and post-trauma environments.

Special Forces is just one military element that can contribute to building local health capacity and stability, and their adaptive, unconventional nature carries the potential to make significant impacts in counterinsurgency development efforts. "The U.S. Army Special Forces were created to provide direct contact with foreign nationals by living among them and by organizing guerrilla groups in those countries," Dr. Anderson said. "They are supposed to be interlocutors, interact with cultures, train, and equip them."

Since these missions are dangerous, SF medics are also trained to provide situational awareness and security. "My job was to be a clinical facilitator," CPT Winschel said. "You have to be aware of your surroundings. The SF Soldiers are really the only ones going into the most remote areas and it is required that they go with their partnered host country unit (in Afghanistan, they would go with the ANA, Afghan National Police, or SF Commandos)."

Since conventional Army units are not getting out to these remote areas due to their mission requirements, CPT Winschel would recruit physicians, dentists, and veterinarians from those units to support the SF medics' mission requests to host a Village Medical Outreach Project (VMOP), which provides care to a local village for one to two weeks. "I had to get approval from the conventional Army unit or hospital commander," he advised. "All the commanders were very supportive and believed in opportunities to help the Afghan war effort. I would brief the recruits on what was needed. Once I got the hand-picked team of (Army medical) specialists flown into the rural SF firebase, I would have them briefed by the SF Operational Detachment Alpha (ODA) team leader and sergeant."

At the same time, CPT Winschel would get the local ANA or ANP unit medics and doctors involved with the VMOP. "The partnerships with the U.S. specialists enhanced their overall medical capabilities," he said. "The face of the operations were the local (Afghan) units. The SF Soldiers would advise and train them. The SF team medics ran the operation and I would be the clinical facilitator."

When providing direct care to local civilians, Dr. Anderson stressed that it is crucial the U.S. medics do not provide treatment that cannot be sustained locally and, at a minimum, causes no harm to patients. "The SF officer-in-charge tells his battalion surgeon to do a MEDCAP and then it's up to the surgeon to do no harm," he advised.

CPT Winschel credits LTC Gilliam, the Commander of the 2nd Battalion, 19th Special Forces Group-Airborne, for his leadership in this area. "He was the one who delegated that I become the VMOP commander and help his ODAs run their VMOPs."

Making an Impact in Remote Areas

CPT Winschel said simple things can often help local populations in significant ways, such as civic action projects that he developed and managed with NGOs and IOs in Iraq. As a 443rd Civil Affairs Officer, for instance, he was asked by local doctors if he could get them medical textbooks. The doctors wanted to teach their own students so they could take care of their own people. CPT Winschel put out the word through his Special Forces Chapter 54 in Boston and that organization got the word out to former SF Soldiers who in turn donated books. The books came in by the planeload and before long, they delivered countless medical textbooks to local providers and formed 16 new medical libraries throughout northern Iraq in the process.
Another project involved handing out shoes donated from U.S. citizens to Afghan village children and adults, and bringing in flour, sugar, blankets, and tools. "We try to help these people help themselves," CPT Winschel said. "We work with village elders and religious leaders to distribute medical care out of a tailgate of a truck (at times)."

At one of the Afghanistan forward operating base clinics he worked in, CPT Winschel removed a bullet from a local man who was shot 30 years ago. This was one of many opportunities he and his SF medics and Marine Special Operations Team Corpsmen had to train Afghan medics on basic surgical capabilities in the field, he said. "We got Afghan medics to run sick call on their men and treat combat wounds," he said. "We were able to greatly enhance the overall medical capabilities of these Afghan medics."

It is actions such as these, even in rural areas, that can help garner the support of the population overall. Furthermore, with over 50 SF medical clinics in Afghanistan that serve as the primary medical provider in remote areas and can stabilize patients for 24 hours or more, a widespread impact can be made. Special Operations Medical Association (SOMA) President LTC Bob Harrington, spoke to the group at the FHP&R offices about his recent experiences as a

dentist at a rural Special Forces medical clinic in Afghanistan. He said the SF firebase clinics treat thousands of people a year, performing surgeries and lifesaving procedures. They are manned by 15 to 18 U.S. personnel and approximately 50 Afghans who provide security for the clinic. Two medics are responsible for providing U.S. and allied force health protection, as well as running clinics a few times a week for the local Afghan population since there is no public health ministry presence in the area.

LTC Harrington said there is a huge need for medical training in these areas since there is a high preponderance of violence, trauma, domestic abuse, and accidents. He cited an example of how training has benefitted one particular Afghan medic, who is now able to perform a variety of medical and dental procedures after receiving five years of mentoring by U.S. Special Operations Forces medics. "Mentoring is the only thing that will work for medical personnel in Afghanistan," LTC Harrington advised. "Many Afghan (medical) personnel are good and have been trained by SOF medics for several years, so there is the potential to hand off to them when security stabilizes."

Training Afghan medics will help DoD work its way out of a job in the country. CPT Winschel said "Special Forces commandos and the ANA are providing security in order to do VMOPs to make (Afghan) military units and medical providers better."

LTC Harrington said MEDCAPs are best done in war zones and can work well if kept simple and one is well-informed about the operational environment. Many of the people in these rural areas have never been seen by their government medical providers.

Since just two SF medics are oftentimes involved in each medical outreach mission, additional civilian support could help achieve a more lasting impact. "We need to provide collaborative care," CPT Winschel advised. "It can't be just two SF medics, who are on the ground for six to nine months. A USAID coordinator would be able to manage and assist each SF team that works his/her region to maintain continuity of development along the Afghan government's guidelines."

A large percentage of Afghan patients in rural areas are children, and there is a strong need for pediatric and maternal healthcare. LTC Harrington said USAID or an NGO could send physicians out to one of the rural SF clinics for a week or so at a time and have the opportunity to see many patients.

Charles Craft, DDS, USPHS, who was involved with dental projects in recent deployments to Afghanistan, said it is important to set up projects that invite NGO participation, and hand off programs to local management for long-term sustainment. Having Afghans run the projects is vital.

"Don't try to force our U.S. programs into rural Afghanistan," Craft advised. "Research what they have. Don't go in and put in a whole new system. We need basic level providers who have Third World experience. Go in with realistic projects and ones that the people want, not what we want, and not weaken the community because they are too big or too much for them to sustain. Don't measure success because of the amount of money we spend. Measure it by what's working."

By working with local NGOs in Afghanistan, Craft trained a dental team that in turn brought in Afghans from other provinces and trained them. He suggested the best way to succeed and gain knowledge over the long-term is to work with local NGOs and support them. Locally sustainable projects work best, while a new hospital, for example, may not be the best solution.

The Afghan Ministry of Public Health (AMOPH) has also put new guidelines in place for the construction of health facilities to ensure that they can be properly staffed afterwards. Therefore, it is important to work with them. "We need to offer them consults when there is a vested interest in building a healthcare clinic, but they need to build their own facilities," CPT Winschel stressed. "Have the AMOPH approve and build it themselves instead of outside contractors so it is something that empowers local medical providers and local leaders. Newly built clinics need to be owned and operated by the Afghan government. NGOs and IOs have

supported such projects around the world and would be very helpful if they could get out to the remote areas to access and consult the AMOPH on how to develop a quality healthcare system throughout Afghanistan. By putting an Afghan face on such efforts to improve the local military units and medical personnel, we hope to legitimize the government. In the interim, there have been great inroads with the VMOPs where we got the local elders and villagers involved. It gave them credibility."

Making it Local

CPT Winschel cautioned against making too many promises, so that subsequent deployers are not walking into unrealistic demands. "There needs to be expectation management," he said. "Furthermore, don't promise treatment until you talk to the local docs to see what the capability is, or what the transportation capability is to Kabul or the nearest large city with a hospital. Long-term care should be avoided in remote areas since sustainability is impossible. You have to be honest and credible if specialty care is not available."

Dr. Shakir Jawad, an IHD member who was a brigadier general in the Iraqi army and an orthopedic surgeon who cared for several American POWs in OIF, later helped the U.S. begin to rebuild the new Iraqi healthcare system and now provides Middle East health policy expertise for the division. He often speaks of host nations as the "forgotten stakeholders" in stability operations. Working with host country personnel from the beginning to identify what they need and manage expectations is crucial, he said, particularly since their perceptions of U.S. projects are often different than how the U.S. perceives them. Dr. Jawad said stability operations require more developed U.S. government interagency planning, and U.S. transparency and genuineness in its actions. Having clear objectives and assurances of enough funding and that it will be used for its intended purpose are also crucial. He also said it is important to carefully plan projects out before pouring money in, and to think of what the needs and sustainable capabilities are from the local perspective. "Sometimes the host nation doesn't know how to prioritize what they want," he said. "We can help, (But) we need to change the way we think."

A long-term strategy is vital to avoid going in and carrying out medical missions with no follow-up, which can then be viewed by the local population as empty promises. "The U.S. military is just now learning the value of NGOs," Craft said. "My advice is to get NGOs in from the beginning (in the planning stage on) and work with them. When there is mutual support and respect (between DoD, NGOs and the local population), the end result is much better."

International elements can also help, as was the case when CPT Winschel and an Italian doctor from a nearby International Security Assistance Force-Afghanistan NATO unit worked with a SF Commando doctor, an ANA doctor, a local doctor, an X-ray tech, a pharmaceutical tech and two local female Russian nurses (who had married Afghans and stayed when the Russian army left) in a local facility for several months in remote western Afghanistan. CPT Winschel also flew in an all-female treatment team from Bagram to help. This special team of healthcare providers was utilized by him and the SF medics in other parts of Afghanistan, as well. It put a female face on culturally appropriate care to Afghan women, and provided health education about hygiene and dental care. "A female interpreter helping kids or a female provider respects the culture. We're not trying to make it like the U.S., but help (through adapting to) their culture," CPT Winschel said. Likewise, other U.S. Army specialists can work with the local community and ministry of agriculture on projects that contribute to economic development, such as watering plants or teaching in dining facilities. One veterinary specialist said he did that in Iraq while working on provincial reconstruction teams, conducting weekly classes and treatment missions with local veterinarians that had an impact. "There are great agricultural needs and opportunities to teach them how to do for themselves," CPT Winschel said. "Educational programs are the best bang for the buck. Literacy programs, teaching them how to better brush their teeth, and Veterinary Civic Action Projects (VETCAPS) that protect Afghan livestock, help greatly. We had local veterinarians out there and worked with them. In one particular VETCAP

we treated over 1,100 animals while training the Afghan veterinarian how to do it. A good vet can make a big impact in the countryside."

CPT Winschel stressed the application of innovation to solve problems in the field, such as using the radio to reach people and announce the arrival of medical teams or convince them to bring their goats and cows in for veterinary treatment, for instance. "If we can (also) teach kids how to read and they see there is more out there in the world, they will learn to value education," he said. "Take a step back and view the process. With a tailgate MEDCAP, we're trained to think outside of the box. Give the local doc a set of basic dental tools, not an $8,000 state-of-the-art chair that is not sustainable."

LTC Harrington said he utilized a unique, lightweight portable dental system that can do 90% of what a large expensive system can, and he flew by helicopter to Afghan villages to provide dental care with it. "There are no dentists at all in these places," he said.

Dr. Anderson said the ability of SF teams to integrate with villagers helps the mission. "I think just as a SF team might have tactical support, we need to think about having a USAID guy on the team, as well. He can be the development guy for the teams."

At the annual SOMA conference last December, COL Rocky Farr, who served in Vietnam as a Special Forces medic and recently as the U.S. Special Operations Command surgeon, spoke of a civil-military initiative in the early '60s in which U.S. Special Operations medics were sent to villages in Vietnam to perform MEDCAPs and work with USAID. "It was done with taking young men (from the village) to help with the war and (in return) we'll help you with your village," he said. "USAID was there and brought in rice crops, for example, so they didn't have to farm meanwhile. It also worked because it was a persistent presence. You become local."

However, although USAID is the international development lead for the U.S. and has participated in Iraq and Afghanistan civil-military provincial reconstruction teams, there is a shortage of agency personnel nowadays. Dunlop said the cadre of USAID's Foreign Service officers is a mere shadow of what it was during the Vietnam War. "We can contract personnel," he said. "This is something that's not going to be solved soon."

"Sometimes you have to win the hearts and minds of your colleagues, too," CPT Winschel said. "It's important to take a risk. My success in Iraq was I knew how to use my local NGOs and IOs. I was able to get the U.N. to help coordinate the cleaning of the streets and to develop a landfill, for example. We need to get more involved with big, international organizations that are involved or interested in Afghanistan to help long-term. The strategic humanitarian assistance effort in remote villages can have a great long-term impact, but we need more support from international organizations. There are vocational and agricultural needs and opportunities, as well as educational needs. An IO or NGO can help a lot with the development and sustainment of these opportunities."

Another issue CPT Winschel sometimes encountered was local bureaucracy and corruption being obstacles to obtain medicine and equipment for the medical outreach programs. The in-country policy is to have the purchases done locally, but he said it was reported that often the locals would get U.S. brands of medicines and sell them in the local market instead of taking the medications. Currently the purchases are done locally to stimulate the local economy, but this also stimulates Iran and Pakistan, where the medicines and medical supplies are produced. Furthermore, the SF teams utilize DoD CERP (Commander's Emergency Response Program) funding for the local purchases, but this tends to take several days to a week to obtain, if not longer. Having an IO come in to help develop a pharmaceutical company to hire locals and stimulate Afghanistan's economy would be a better long-term benefit, he advised. "There is a lot of opportunity for IOs and NGOs to come into Afghanistan, if the security increases, to provide such opportunities and to teach medical skills," he said. "Many Afghans could be trained to do basic healthcare if we get international help, an NGO or IO."

Fred Gerber, of the NGO Project HOPE, said it is important for DoD to think of the

consequences of MEDCAPs and dental or veterinary projects, have good measures of evaluation in place instead of just collecting numbers of patients treated, or medicines issued, and to use NGOs as force multipliers. "Anything you do ought to have health capacity built into it, (such as) training the local doctor at the institutional and organizational level in his hospital and network of clinics," he said. "(Raising local) health capacity is what will let you move out of the country."

Former Assistant Secretary of Defense for Health Affairs Dr. S. Ward Casscells attended the recent FHP&R meeting and praised the SF medics for their hard work, risk-taking, and innovation at the tactical and strategic level. "We've not taken enough advantage of IOs and NGOs," Dr. Casscells said. "We're talking about how the U.S. military can be an enabler, a builder, not a breaker."

For more information, please go to (www.fhpr.osd.mil/intlhealth).