

JALLC Report – Not Bi-SC Endorsed



**A Report by NATO's  
Joint Analysis and Lessons Learned Centre**



JALLC/CG/10/152

16 July 2010

The logo for Allied Command Transformation (ACT). It is a circular emblem with a purple outer ring containing the text "ALLIED COMMAND TRANSFORMATION" in white. Inside the ring is a globe with a white compass rose overlaid on it. The text "Medical Civil-Military Interaction" is written in large, bold, black letters across the center of the globe.

**Medical Civil-Military  
Interaction**



## Medical Civil-Military Interaction

16 July 2010

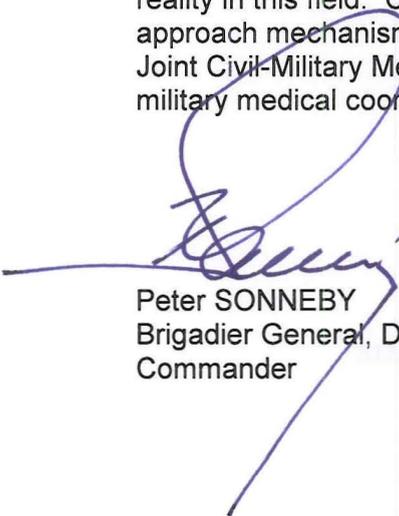
### **FOREWORD FROM THE COMMANDER**

I am pleased to forward this report to a wide target audience among the military medical community and our civilian counterparts, as well as to those working on civil-military interaction and the comprehensive approach.

In the recent past, the military has played an increasingly significant role in relief operations such as the Indian Ocean Tsunami (2004), Hurricane Katrina (2005), the Pakistan Earthquake (2005), and the Haiti Earthquake (2010). There is a clear trend for increasing the use of military capabilities in the humanitarian domain. However, the legitimacy and effectiveness of using the military for humanitarian purposes is not always clear.

On the one hand, the generally successful outcome of the military engagement in the above-mentioned disasters triggered a positive response from the population and many civilian aid organizations, which has encouraged humanitarian organizations to consider the military as a valuable supporter of humanitarian needs. However, on the other hand, when humanitarian distress occurs in an insecure or violent environment, civilians and militaries have the tendency to fall back into their traditional roles: Civilian aid organizations provide aid to anybody in need regardless of the security situation and the military works to establish security, sometimes by using force, other times through means similar to those used by the humanitarian organizations. The fundamental difference in roles becomes blurred and civilian aid providers question whether military engagement in humanitarian assistance and reconstruction & development is actually more damaging than helpful.

This report proposes that now is the right time to open a new chapter in civil-military medical interaction whereby civilian and military actors are seen as complementary in achieving long-lasting peace and stability and the comprehensive approach becomes a reality in this field. Central to achieving this is the creation of medical comprehensive approach mechanisms between NATO and other organizations. Specifically, a new Joint Civil-Military Medical Coordination Board should be established to support civil-military medical coordination at the strategic level.



Peter SONNEBY  
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Commander

## **Medical Civil-Military Interaction**

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From July 2009 to April 2010 at JALLC Monsanto, Lisbon, Portugal and includes data collected from September to November 2008 in Afghanistan, and the United Nations (UN Headquarters, UN Assistance Mission in Afghanistan offices, UN Office for the Coordination of Humanitarian Affairs), the International Committee of the Red Cross delegates to Allied Command Transformation and the World Health Organization.

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The recommendations included in this report require endorsement by the Strategic Commands and/or its principal customer. To know which recommendations have been endorsed, please contact SHAPE FOR RER FSL Lessons Learned or HQ SACT CAPDEV PPM LLI or check the NATO Lessons Learned Database.

## Executive Summary

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### **MISSION**

The Joint Analysis and Lessons Learned Centre (JALLC) was tasked by Supreme Allied Commander Transformation (SACT) to prepare an analysis report on Medical Civil-Military Interaction. The agreed analysis requirement and objectives were:

**Analysis Requirement:** Analyze NATO's multinational medical capability to assist in Humanitarian Assistance (HA) operations and Reconstruction and Development (R&D) activities. Focus on how this capability could support the establishment/re-establishment of a host nation military health care system and more broadly on the development of the civilian health sector with special consideration of medical civil-military interaction.

**AO-1.** Provide recommendations to enhance the role of NATO's multinational medical capability in support of establishment/re-establishment of a host nation health care system and the civil-military medical interface. With respect to this role:

**Sub AO-1.1.** Identify constraints that impact on the use of NATO multinational medical capability.

**Sub AO-1.2.** Identify best practices/ lessons from medical civil-military interaction that could inform changes to policy/ doctrine/ procedures.

### **BACKGROUND**

The past two decades have seen civilian organizations and the military experience an increasing number of civil-military interactions, and have seen the creation of primary international mechanisms for inter-agency coordination of humanitarian assistance (the Inter Agency Standing Committee (IASC) and UN Office for the Coordination of Humanitarian Affairs (OCHA)). The increasing number of military involvements in providing health care support to the local population and restoring/developing a national and military health care system has raised a particular question: how are civilian organizations and the military harmonizing their objectives and activities?

This JALLC report is designed to provide feedback and recommendations for NATO's strategic military medical stakeholders for their further development of policy, doctrine, and procedures.

### **METHODOLOGY**

This study has collected data mainly from Afghanistan but also considers data collected elsewhere and literature reflecting civil and military studies and lessons. Besides visiting the International Security Assistance Force, in-theatre data collection visits were made to Combined Security and Transition Command – Afghanistan, United Nations Assistance Mission in Afghanistan offices, Agency Coordinating Body for Afghan Relief, the European Commission, United States Agency for International Development and the Kabul Health Cluster. Outside Afghanistan, interviews were held at the international HQs of UN Medical Service Support, UN OCHA, World Health Organization (WHO) and the International Committee of the Red Cross (ICRC) military delegation, with several NGOs. Team members consolidated their understanding of the issues through information exchange courses and syndicate work at NATO Medical Conferences, the 94th UN Civil-Military Coordination Course and the pilot joint civil-military course of Military Medical Support in the Humanitarian Arena.

In order to validate the findings, draft versions of this report were sent to all stakeholders, NATO HQ, the Joint Medical Committee (JMC), HQ SACT, the Joint

Warfare Centre, all ACO HQs, and to some civilian representatives of international organizations and NGOs that had provided information to this study. Their comments were incorporated in this final version.

## **MAJOR CONCLUSIONS**

There is a role for the military as a complementary contributor to HA operations and R&D activities. However, this role requires a profound understanding of the consequences of intentions and actions on the part of the military when becoming involved in a complex socio-cultural situation. This report identifies problems that arise when the military is engaged in HA operations and R&D activities. Most problems occur from underestimating the negative impact of well intended support to civilians. Therefore, NATO has to recognize its limitations in what it can realistically achieve and the potential negative secondary effects that can arise when the military is involved in providing direct medical support to the civilian population and, most importantly, the erosion of security of civil agencies when the distinction of civil and military health providers is unclear. On the other hand, NATO also has to retain its option to act if no other help is provided.

The military possesses vital capabilities to support HA and R&D. Nevertheless the decision to make use of military capabilities for humanitarian purposes will demand a tailored approach which has to be continuously adjusted to the current situation. This approach requires not just an open dialogue with civilian humanitarian stakeholders but, much more, a concept designed by civilians and military in conjunction, constituting a medical contribution to the Comprehensive Approach. The approach must also recognize the separation needed between the *humanitarian space* and the *military space*, to avoid blurring the fundamental distinction between these two types of aid providers, and allow for coordinated action when the prevailing situation dictates that civilian organizations and the military must work jointly in what JALLC terms the *joint civil-military space*.

The critical capability that NATO is missing in order to contribute to the medical part of the Comprehensive Approach is a joint medical civil-military coordination mechanism that can monitor and manage NATO's military contribution to medical HA and R&D and deliver guidance, expertise, and continuity to the military conducting medical HA and R&D activities.

Military medical support in R&D also requires that military medical personnel are trained to understand their role in complex humanitarian challenges, their interaction with international civilian aid organizations and the host nation health care sector. A key shortfall is the availability of personnel within NATO with the necessary expertise in international R&D and who can be deployed for the length of time needed to truly build up a national health care system.

Currently, the international community (military and civilian) is missing an accepted and supported lessons learned sharing platform for humanitarian and R&D matters.

Finally, NATO needs to be aware of the importance and impact of the quality of public health in relation to peace and social stability. Specific attention is required when military medical support is used for winning hearts and minds. There is the risk of misusing medical care to achieve military objectives. In such cases, the consequence is that military health care loses its impartiality and potentially strays from fundamental humanitarian values which are bound to the Geneva Conventions and Protocols. Nevertheless, since the military is likely to be engaged at the forefront of humanitarian distress, there is a moral obligation to provide appropriate support in the humanitarian arena if aid is not provided by somebody else.

## **KEY RECOMMENDATIONS**

NATO (JMC and SHAPE Medical Directorate) should create, in conjunction with IASC, UN OCHA and WHO, a Joint Civil-Military Medical Coordination Board with extended monitoring and management authority for coordinating NATO's military medical contribution to HA and R&D.

The JMC and SHAPE should develop prearrangements/preplanning with UN OCHA and WHO (Health Action in Crisis) which would support ad hoc disaster relief activities. NATO has to consider providing liaison to UN OCHA and WHO at global, national and local levels.

NATO should develop a HA and R&D concept to inform detailed military doctrine and policy papers. This concept should:

- a. Be developed in conjunction with the main stakeholders in HA and R&D (UN OCHA, WHO, IASC, ICRC, partners of the Global Health Cluster);
- b. Be consistent with the UN developed and internationally agreed frameworks for humanitarian assistance and R&D, notably the Health Cluster Guide;
- c. Define NATO's role to:
  - Support indirect assistance capabilities such as reconstruction of destroyed medical facilities and public health care infrastructure.
  - Provide exceptional (last resort) interim referral medical expertise (extended and critical care).

NATO should encourage nations to invest in advanced training programs to generate military medical development and reconstruction expertise in humanitarian disasters and complex emergencies.

NATO should trigger a fundamental discussion on a specific ethos of military medical personnel, their moral obligation as legitimate carriers of the Red Cross symbol, and their impact on doctrine, planning and operational campaigns. The Medical Advisor should be empowered to act as a professional advocate and guardian, alongside the legal advisor, of the Geneva Conventions to (and for) the military commander in the field.

NATO should support and contribute to the creation of a universal HA and R&D lessons learned sharing tool, preferably under the lead of a UN agency, that allows promoting best practice and avoiding repetition of mistakes.

## Distribution

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**BACKGROUND**

1. NATO, in a number of its operations over the last decade, has used its military capabilities, particularly those related to the medical field, to support Humanitarian Assistance (HA) operations and Reconstruction & Development (R&D) activities. Some observers, both military and civilian, would prefer to rule out such involvement in HA and R&D for NATO, and militaries more generally, because they believe such efforts are more appropriately handled by civilian organizations. Others argue that because civilian organizations are often not able to operate in a combat zone, military organizations may need to undertake preliminary reconstruction efforts until they can be transferred to other organizations.

2. On one hand, civilian organizations have questioned the mandate, the skills, and the appropriateness of such military involvement in the civilian sectors/functions and governance<sup>1</sup>. On the other hand, activity in this area is already being formalized into some NATO Nations' operating concepts<sup>2</sup> and as said by one senior NATO officer, "*it [military involvement in HA and R&D] is just happening*". It is a reality all sides need to recognize.

3. Within NATO, SHAPE and HQ Supreme Allied Commander Transformation (SACT) are in the process of codifying NATO's approach to the use of its military medical capability. SHAPE has recently developed a strategy for military medical engagement in humanitarian assistance, stabilization and health care development (Reference C). Simultaneously, HQ SACT and US Joint Force Command (JFCOM) are drafting new allied joint doctrine for support to civilian authorities (AJP 3.4.3) and, more specific to medical, for a joint civil-military medical interface (AJMedP-6)<sup>3</sup> to provide the doctrinal framework for the civil-military medical interface. An understanding of the constraints that impact NATO's use of military medical capability and of the lessons and best practices arising from the employment of military medical capability for HA and R&D is essential to support the drafting of these documents. In order to provide input on this topic, SACT tasked the Joint Analysis and Lessons Learned Centre (JALLC) in its 2009 Programme of Work (Reference D) to conduct a study on NATO's medical civil-military interaction.

**ANALYSIS REQUIREMENT AND OBJECTIVES**

4. The Analysis Requirement and associated Analysis Objectives (AO) were developed out of initial requirement identified from the 2009 Programme of Work and refined in cooperation with the principal customer, HQ SACT's Joint Development and Sustainment – Medical Branch.

**Analysis Requirement:** Analyze NATO's multinational medical capability to assist in HA operations and R&D activities. Focus on how this capability could support the

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<sup>1</sup> As one example of reference: United Nations Assistance Mission to Afghanistan's (UNAMA), Human Rights Unit Annual Report on Protection of Civilians in Armed Conflict (Reference A)

<sup>2</sup> For example, the US Military, in its Capstone Concept for Joint Operations (Reference B), recognizes "relief and reconstruction" as one of the four basic activities US forces will engage in during joint operations.

<sup>3</sup> As these two Allied Publications are still in Study form, they will not be cited but their status can be checked at the NATO Standardization Agency's publication catalogue.

establishment/re-establishment of a host nation military health care system and more broadly on the development of the civilian health sector with special consideration of medical civil-military interaction.

**AO-1.** Provide recommendations to enhance the role of NATO's multinational medical capability in support of establishment/re-establishment of a host nation health care system and the civil-military medical interface. With respect to this role:

**Sub AO-1.1.** Identify constraints that impact on the use of NATO multinational medical capability.

**Sub AO-1.2.** Identify best practises/ lessons from medical civil-military interaction that could inform changes to policy/ doctrine/ procedures.

5. The analysis requirement with which JALLC was tasked groups together two activities that in reality are very distinct, *humanitarian assistance* and *reconstruction & development*. This report will, as much as possible, consider these two activities separately in the analysis.

### ***PURPOSE AND SCOPE OF THE REPORT***

6. The purpose of this report is to provide feedback to policy and doctrine makers at HQ SACT, SHAPE, NATO HQ, the Committee of the Chiefs of Military Medical Services in NATO (COMEDS) and the Joint Medical Committee (JMC) on current medical HA and R&D activities and to provide recommendations to NATO and Nations, specifically to the representatives of COMEDS, on the way ahead for NATO's use of military medical capability for HA and R&D.

7. Additionally, this report should also inform interested civilian organizations about NATO's ongoing military medical developments and intentions to support HA and R&D activities and to allow them to consider the possible advantages of greater cooperation with NATO.

8. During the course of this study, it was impossible to consider civil-military *medical* issues in HA and R&D without considering more generic civil-military issues in these fields. Thus, in some parts of the report, the medical focus had to be broadened to consider the more general HA and R&D framework.

9. The scope of this study was limited to the relationship among strategic and operational levels and therefore the mechanisms for Civil Emergency Planning (CEP)<sup>4</sup>—including its coordinating committee, the Euro-Atlantic Disaster Rescue Coordination Centre (EADRCC), and the JMC—although important entities with respect to civil-military medical interaction, were not considered apart from their potential contribution to the military strategic and operational levels. Similarly, the report does not examine NATO funding policies in detail or consider the limitations established by current funding policies on NATO's potential capability to contribute to HA and R&D.<sup>5</sup>

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<sup>4</sup> JALLC recognizes that on 11 June 2010 new structures and nomenclature were established for the Civil Emergencies Groups.

<sup>5</sup> For example, ACO Directive (AD) 83-2 (Reference C) states that, in order to comply with the NATO Funding Policy For Non-Article 5 NATO-Led Operations (Reference E) only essential emergency treatment may be provided for host nation casualties, as required under international humanitarian principles, and that NATO common funding will not be used for nation-building purposes.

## **A Wealth of Literature**

10. In recent years, a great deal of literature has been published regarding civil-military issues in HA and R&D. These reports provide a wealth of in-depth knowledge on specific aspects of the topic of medical military-civilian interaction, focusing on military contribution to disaster relief, but with some excellent work on military contribution to ongoing HA and R&D. The JALLC will not in this report achieve the level of in-depth analysis and conclusions presented in those documents and will not attempt here to merely repeat their findings. The JALLC highly recommends many of them. For those wishing to understand this topic better and to gain a deeper appreciation of external, mainly civilian, perspectives, a list of Recommended Further Reading is provided at the end of the References section.

## **METHODOLOGY**

11. The analysis was conducted in accordance with the Joint Analysis Handbook (Reference F). The experience and data gained from previous projects (three medical-related projects—the reports are References G through I—and seven projects overall for the Project Manager) were used to support the study design and data collection planning. The first part of the study was a preparation for in-theatre active data collection. It consisted of developing an understanding of the issues involved through passive data collection, literature review, analysis preparation, and preliminary data collection. In addition, during this phase team members attended:

- The Allied Command Operations (ACO) Medical Advisor Conferences (October 2008, May 2009);
- The Battlefield (June 2008) and Defence (November 2009) Health Care Conferences;
- Quarterly Medical Lessons Learned Video Teleconferences.

12. Passive data collection began by studying the findings from Exercises STEADFAST JAW 07, STEADFAST JUNCTURE 08 and STEADFAST JOINER 08 and relevant documents from the Kosovo Force (KFOR) operations. This phase also included a review of civilian literature, which was chosen based on the team members' awareness of its existence, on internet searches from unclassified sources, and on recommendations from those interviewed. Unfortunately, because of the small team size versus the vast array of available literature on the topic as noted above, it was not possible to conduct a systematic literature review that guarantees that literature selection bias was avoided. Nonetheless, the JALLC is confident that the literature reviewed represents a broad and inclusive range of ideas from a wide variety of perspectives. All literature reviewed is listed in the References section at the end of the main body of this report.

13. An open questionnaire was developed with the intention of understanding opinions and concerns regarding NATO's current civilian-military interaction across civilian agencies. This questionnaire was sent to a broad range of military and civilian organizations and posted on the JALLC internet web page. The JALLC received 23 responses, which served to highlight key issues for further study and provided initial points of contact for later interviews, as well as focusing the content of those interviews.

14. The main focus for active data collection was the International Security Assistance Force's (ISAF) medical operations in Afghanistan. During deployment to the ISAF theatre, key leaders in HQ ISAF and the Regional Commands (RC) such as chiefs of staff, and J3 Operations, CJMED and J9 Civil-Military Cooperation (CIMIC)

branch heads and staff officers were interviewed in a semi-structured<sup>6</sup> way. The data collected in theatre were principally qualitative and collection techniques were designed to avoid any evaluation of interviewees. Data collection in Afghanistan also took place at the Combined Security Transition Command – Afghanistan (CSTC-A), and in meetings at the United Nations Assistance Mission in Afghanistan's (UNAMA) offices in Kabul and Mazar-e Sharif, at the Health Cluster Office Kabul coordinated by the World Health Organization (WHO), with major NGOs represented by the Agency Coordinating Body for Afghan Relief (ACBAR) and with donor representatives from the European Commission (EC) and US Agency for International Development (USAID). While every effort was made to interview each of the key leaders involved in civil-military interaction in Afghanistan, some personnel were not available during the deployment timeframe. Every effort has been made to capture input from these individuals through remote communication.

15. Outside Afghanistan, the team conducted interviews at the international HQs of the UN Medical Service Support, UN Office for the Coordination of Humanitarian Affairs (OCHA), WHO, and the International Committee of the Red Cross (ICRC) military delegation. Further interviews took place with NGOs at their HQs and information exchange occurred during conferences, courses, and syndicate work that team members attended. The project manager attended the 94th UN Civil-Military Coordination Course and the pilot joint civil-military course of Military Medical Support in the Humanitarian Arena in May 2009.

16. Data was analyzed by primarily qualitative means, which led to development of the principle findings that were to answer the analysis objectives. These findings were refined by additional passive research and written up into an initial Executive Summary for Discussion Paper, which was circulated for comment to the customer, stakeholders and many of those who had been interviewed, both within and outside of NATO. Much valuable feedback to this discussion paper was received from a variety of sources and proved valuable in drafting the main report. Once initial report writing was concluded, the draft was likewise sent, this time to a mainly NATO audience, for another round of external review and comment. To this draft, useful feedback was received only from SHAPE CIMIC Directorate and ISAF RC South. Nonetheless, both these commentators provided a valuable chance to refine and clarify many of the main ideas in this, the final report.

### ***FACTORS AFFECTING THE ANALYSIS***

17. The strategic and operational level data collected for this study was heavily ISAF/Afghanistan orientated. Unfortunately however, limitations imposed on in-theatre travel made it impossible to visit Provincial Reconstruction Teams (PRT) during the data collection for this report. This made it difficult to validate data from PRTs collected passively and actively from previous visits to PRTs by the project manager when working on other projects.

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<sup>6</sup> As defined in the Joint Analysis Handbook, p 56.

## Framework for the Analysis

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### **INTRODUCTION**

18. In order for the reader, especially those less familiar with HA and R&D topics, to put the findings of this report in context, it is necessary to have a basic understanding of the framework for analysis of the use of NATO's military medical capabilities for HA and R&D upon which the findings are based. The framework is given by a brief discussion of the definitions of the terms *humanitarian assistance*, *reconstruction & development* and of the humanitarian principles, a brief review of the principal actors involved in medical HA and R&D, a review of the agreements and protocols that are, or should be, binding for NATO and Nations contributing to HA and R&D, and the current status of developments in policy, both within NATO and among external organizations. The chapter concludes with a brief discussion of the legitimacy of NATO's military medical assets' acting in the realm of HA and R&D and a summary of recent and ongoing work in NATO on this topic.

### **DEFINITIONS OF TERMS**

19. The analysis requirement for this project, to analyse NATO's military medical capabilities to conduct HA and R&D, groups together two activities that in reality are very distinct, *humanitarian assistance* and *reconstruction & development*. This distinction is recognized in ISAF<sup>7</sup>. Possessing the capability to contribute to one does not necessarily mean that the same capability is appropriate to the other. This report will, as much as possible, consider these two activities separately in the discussions presented in each of the subsequent chapters. First it is necessary to provide an agreed definition for these and related terms.

#### **Humanitarian Assistance**

20. HA is defined by the international community in the Oslo Guidelines (Reference K) as:

*Aid to an affected population that seeks, as its primary purpose, to save lives and alleviate suffering of a crisis-affected population. Humanitarian assistance must be provided in accordance with the basic humanitarian principles of humanity, impartiality and neutrality.*

21. NATO has its own definition, as given in AAP-6 (Reference L):

*As part of an operation, the use of available military resources to assist or complement the efforts of responsible civil actors in the operational area or specialized civil humanitarian organizations in fulfilling their primary responsibility to alleviate human suffering.*

22. For the purposes of this report, JALLC considers NATO to be involved in two distinct types of HA: disaster relief operations, and ongoing HA efforts such as those that take place in the course of a drawn-out conflict like the one in Afghanistan. Each type places different demands on the HA provider and, when being provided by military forces as in the NATO definition, is seen by civilian organizations to have different levels of effectiveness and legitimacy. Thus this report will address each type of HA separately in subsequent discussion.

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<sup>7</sup> ISAF OPLAN (Reference J) Annex XX

## Reconstruction & Development

23. There is no agreed international or NATO definition for R&D. However, international humanitarian organizations generally consider their activity to take place in three phases: relief, recovery and rehabilitation. In this context, HA would fall under relief, while R&D would be largely synonymous with the latter two. In other words, R&D is concerned with building the capacity of the affected population to meet its own needs, while HA is providing support for needs which cannot be met by the affected population.

24. For much of this report, ongoing HA and R&D will be discussed together, and separately from disaster relief. This is because these two activities take place concurrently within the same types of operation—e.g. ISAF—using the same capabilities, often within the same individual activities. Therefore the line between them is not at all clear. For example, if during a veterinary outreach visit, military veterinarians engage with locals to vaccinate a herd of goats, is that HA (support was provided directly by the military where no local capability to provide a similar service exists) or is it R&D (a herd of goats is now more healthy, leading to increased prosperity for the owner and thus long-term economic development, while local veterinarians who participated improved their capability to provide the service in the future), especially when the stated goal of such a programme is to "help foster a positive relationship between coalition forces, government leaders and the people"?<sup>8</sup>

## The Humanitarian Principles

25. The definitions of the Core Humanitarian Principles are described in UN General Assembly Resolution 46/182 (Reference N) and in the Oslo Guidelines (Reference K) and are widely used as the reference. The humanitarian principles have also been defined in the other documents described in the next section. While there are some differences among them on specific wording, they generally align.

### Humanity

*"Human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women and the elderly. The dignity and rights of all victims must be respected and protected".*

### Impartiality

*"Humanitarian assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relief of the suffering must be guided solely by needs and priority must be given to the most urgent cases of distress."*

### Neutrality

*"Humanitarian assistance must be provided without engaging in hostilities or taking sides in controversies of political, religious or ideological nature".*

26. Generally, the principle of Humanity can and should be upheld by all actors, military included. In fact, it is generally analogous to the principles of *military necessity* and *proportionality* defined in the Law of Armed Conflict applicable to all military actors<sup>9</sup>. Military forces can also be an impartial assistance provider, such as during

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<sup>8</sup> CTFJ-82 Press Release – ADT [Agri-Business Development Team] holds record VETCAP [Veterinary Civic Action Program] in Asadabad (Reference M)

<sup>9</sup> It must however be noted that the principles of military necessity and proportionality defined in the Law of Armed Conflict have the aim of avoiding causing unnecessary suffering rather than alleviating existing suffering, which is the aim of the Humanitarian Principle of Humanity.

support of disaster relief operations, as long as assistance is provided based solely on need. Those military specialties with a non-combatant status, such as military medical personnel or military chaplains, have not only additional legal obligations under the Geneva Conventions but also additional *moral* ones based on higher expectations for standards of conduct for these personnel with respect to the principles of Humanity and Impartiality.

27. However, for many organizations involved in relief work, and especially for military forces, there is a difficulty in upholding the principle of Neutrality. By their very nature, many such organizations are not able to remain neutral in the sense defined in international law or in the core principles. For example, because the UN decision-making bodies—the Security Council and the General Assembly—are charged with passing judgement in favour of one side or the other on an issue, any act as a result of these decisions cannot be considered neutral. Therefore, the activities, including humanitarian ones, of any political or military mission resulting from a decision by the UN cannot be truly neutral.

28. Other government agencies and many NGOs also face difficulty in maintaining their neutral status, especially those that in addition to their relief activities are also proponents of certain political or cultural causes—human rights, environmental protection, or gender equality—that put them in opposition to the politics of the sovereign state in which they conduct relief. As one example, the fact that human rights were a core value of many humanitarian organizations involved in the Pakistan Earthquake response caused a negative impact on the NGOs' perceived neutrality by many Pakistanis, who consider the issue of human rights to be a tool to promote western political and cultural agendas<sup>10</sup>.

### **The Humanitarian, Military, and Joint Spaces**

29. The spaces of action—the *humanitarian space*, the *military space*, and the *joint civil-military space*—play an important role in the findings presented in this report. It is thus necessary to provide a brief description of these spaces here. It is important to note that these spaces are conceptual areas of activity, not geographic, and that it is possible for each to exist simultaneously within a given geographic area or operation. Determining which space one is operating in is largely a factor of the prevailing security situation and the specific type of activity each actor is conducting.

30. Oxfam<sup>11</sup> defines *humanitarian space* (Reference P) to be an operating environment in which the right of populations to receive protection and assistance is upheld, and where aid agencies can carry out effective humanitarian action by responding to their needs in an impartial and independent way. Humanitarian space allows humanitarian agencies to work independently and impartially to assist populations in need, without fear of attack or obstruction by political or physical barriers to their work. For this to be the case, humanitarian agencies need to be free to make their own choices, based solely on the criteria of need.

31. JALLC was unable to find an internationally agreed definition for the terms military or joint civil-military space and thus established the following working definitions for this report. The military space is an operating environment in which, because of the security situation, the legal mandate of the military forces, and the mission objectives, the military is placed in the lead role for upholding the right of the population to receive

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<sup>10</sup> Feinstein International Center at Tufts University's ongoing study: "Winning Hearts and Minds?" Understanding the Relationship between Aid and Security (Reference O)

<sup>11</sup> Oxfam is "an international confederation of 14 like-minded humanitarian organizations working together with partners and allies around the world to bring about lasting change." Quoted from Oxfam's home web site *About Us*: <http://www.oxfam.org>

protection and assistance and where civilian actors are dependent on the military for their own security and for access to the population in need. Generally this is limited to pure combat situations. The joint civil-military space is that area in between, where the security situation is unstable or fluctuating, where the mandate does not explicitly cover which activities are under the lead of which actor, and where coordination between all actors is necessary to accomplish their work and meet the needs of the population.

32. Figure 1 depicts the three spaces and describes the principal tasks that the military should be doing within each space at the different levels of command. The different spaces are intimately related to the type of mission being conducted and the security situation of the environment. Pure HA missions, such as disaster relief, fall clearly in the humanitarian space, and combat situations result in R&D taking place purely in the military space in support of military objectives.

|   | Operational R&D in the military space  | HA / R&D in military and humanitarian joint space  | Complementary military HA in the humanitarian space  |
|---|--|--|--|
| <b>Strategic level</b><br>•Policy and Concepts at civilian and military HQs   | <ul style="list-style-type: none"> <li>Communicate at international and host nation level the mandate and legitimacy to provide HA and R&amp;D</li> </ul>  | <ul style="list-style-type: none"> <li>Developing HA and R&amp;D joint concepts</li> <li>Define common end state for military and civilians</li> </ul>   | <ul style="list-style-type: none"> <li>Developing concepts which are supporting civilian or domestic military leadership</li> </ul>  |
| <b>Operational level</b><br>•Defining of R&D objectives and end-state<br>•Monitoring of goals & MOEs<br>•Providing continuity in or outside the country                   | <ul style="list-style-type: none"> <li>Defining military space</li> <li>Defining humanitarian corridors</li> <li>Defining the link where military and civilian can deconflict their activities</li> <li>Proactive information sharing</li> </ul>   | <ul style="list-style-type: none"> <li>Defining military, humanitarian and joint spaces.</li> <li>Defining the role of the military within the joint and humanitarian space</li> <li>Coordinate military operations with Civilian</li> </ul>   | <ul style="list-style-type: none"> <li>Defining the organization (leadership) which the military will support.</li> <li>Defining the role of the military within the joint and humanitarian space</li> </ul>         |
| <b>Tactical and country level</b><br>•Defining capability modules to support common HA and R&D goals<br>•Defining assessment requirements<br>•Sharing medical information | <ul style="list-style-type: none"> <li>R&amp;D as a tool to achieve military objectives</li> <li>After combat: rapid initiation of R&amp;D projects to ensure security</li> <li>Military option if CA or civil agencies are not responsive enough</li> <li>Identify indirect assistance and indirect ways to establish contact and information exchange to ensure security of civil aid workers</li> </ul> | <ul style="list-style-type: none"> <li>R&amp;D activities are coordinated and match the overall concept</li> <li>R&amp;D assessment of Fact Findings Teams</li> <li>Military option if CA or civil agencies are not responsive enough</li> <li>Coordinate and share information on host nation health resources and capability.</li> </ul> | <ul style="list-style-type: none"> <li>Employing medical military HA assets under local civilian leadership.</li> <li>Conduct common Public Health-, R&amp;D- and need-assessments of Fact Findings Teams</li> </ul> |

Figure 1: Role of the Military in the Three Engagement Spaces<sup>12</sup>

### **INTERNATIONAL HUMANITARIAN ACTORS AND AGREEMENTS**

33. Over the past two decades, primary mechanisms for interagency coordination of humanitarian assistance—the Inter-Agency Standing Committee (IASC) and UN OCHA (formed out of the Department of Humanitarian Affairs – DHA)—were created. Over this time, civilian organizations and the military have experienced an increasing number of civil-military interactions. In response, these two bodies have taken the lead on developing civil-military guidelines, such as the Oslo Guidelines and the Guidelines for Complex Emergencies (Reference Q and R). The IASC, in conjunction with the WHO and other civilian organizations, also recently developed the Global Health Cluster Guide (Reference S) to reduce avoidable mortality, morbidity and disability and to restore the delivery of health care as quickly as possible. All of these documents should have an impact on NATO’s development of policy and procedures.

<sup>12</sup> MOE: Measure of Effectiveness; CA: Comprehensive Approach.

### **International Humanitarian Actors**

34. International relief work is largely conducted by an assortment of international organizations and bodies in conjunction with a variety of NGOs represented at international level by a number of umbrella organizations. The most relevant of these bodies to the topic of NATO military medical contributions to HA and R&D are:

- United Nations Office for the Coordination of Humanitarian Affairs – For the purposes of HA and R&D, the legally mandated international governing body is the UN OCHA, formerly the DHA.
- Inter-Agency Standing Committee – The IASC was created to strengthen coordination and effectiveness of humanitarian assistance, called for by UN General Assembly resolution 46/182 of 1991. Through resolution 48/57, the UN General Assembly affirmed the IASC's role as the primary mechanism for inter-agency humanitarian coordination. It is a key vehicle to formulate common policy and guidelines among a broad range of humanitarian actors. The IASC is made up of nine full members, all UN agencies, and numerous standing invitees, ranging from the ICRC and International Federation of Red Cross and Red Crescent Societies (IFRC) to the International Council of Volunteer Agencies.
- World Health Organization – WHO is the directing and coordinating authority for health within the UN system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends.
- The Global Health Cluster – After a UN Humanitarian Response Review in 2005, the IASC designated eleven sectors of humanitarian activities, each one to be coordinated by a "cluster". For the global health sector, the Global Health Cluster, under the leadership of the WHO and with 36 partners, is responsible for improving the effectiveness, predictability and accountability of humanitarian health actors at global, regional and country levels.
- International Red Cross and Red Crescent Movement – The International federation of Red Cross and Red Crescent Societies (IFRC) and their national societies together with the ICRC make up the International Red Cross and Red Crescent Movement. While the IFRC carries out relief operations to assist victims of disasters, the ICRC is mandated to be the guardian and promoter of international humanitarian law in conflicts. Whereas the previously mentioned organizations are subject to the Humanitarian Principles of humanity, impartiality, neutrality and independence, for both Red Cross organizations upholding the Humanitarian Principles are their *raison d'être*.

### **International Humanitarian Agreements: Law, Protocols, and Guidelines**

35. The comprehensive set of protocols and guidelines for humanitarian efforts and for military involvement in them, which are relevant for planning civil-military medical interaction are:

- The Geneva Conventions and their Additional Protocols.
- UN General Assembly Resolution 46/182 on Strengthening of the Coordination of Humanitarian Emergency Assistance of the United Nations (Reference N).
- The Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, known as the *RC/NGO Code*.
- Guidelines for the Use of Foreign Military and Civil Defence Assets in Disaster Relief, known as *The Oslo Guidelines* (Reference K).

- Guidelines on the Use of Military and Civil Defence Assets (MCDA) to United Nations Humanitarian Activities in Complex Emergencies, known as the *MCDA Guidelines* (Reference Q).
- Civil-Military Guidelines & Reference for Complex Emergencies (Reference R).
- The Health Cluster Guide recently developed by the IASC and the WHO in conjunction with other civilian organizations (Reference S).
- The IASC endorsed Operational Guidance on Responsibilities of Cluster/Sector Leads & OCHA in Information Management.
- Country specific guidelines such as the guidelines for Afghanistan<sup>13</sup>.

36. Figure 2 represents graphically the guidelines or international laws that apply, and the different roles of the military, across the spectrum of the security situation. The Oslo Guidelines, developed under the lead of the IASC, enclose the Principles of Humanitarian Aid and, as an addendum, a Code of Behaviour for Military and Civil Defence Personnel in International Disaster Relief Assistance which was prepared by the IFRC<sup>14</sup>. The MCDA Guidelines for Complex Emergencies, also developed by the IASC, address the interaction of civilian and military actors in situations that fall between war and peace. The Geneva Conventions and International Humanitarian Law direct that support to non-combatant civilian populations must be provided by the military when that military organization is either the intervening force or has effective control over a territory or when humanitarian aid organizations are unable or reluctant to operate.

37. It is essential that NATO military commanders and staffs are familiar with and apply these guidelines. The Oslo and MCDA Guidelines especially, in whose development NATO was actively involved, are vital for use in disaster relief and the principles therein can be applied to other military involvement in humanitarian assistance activities.

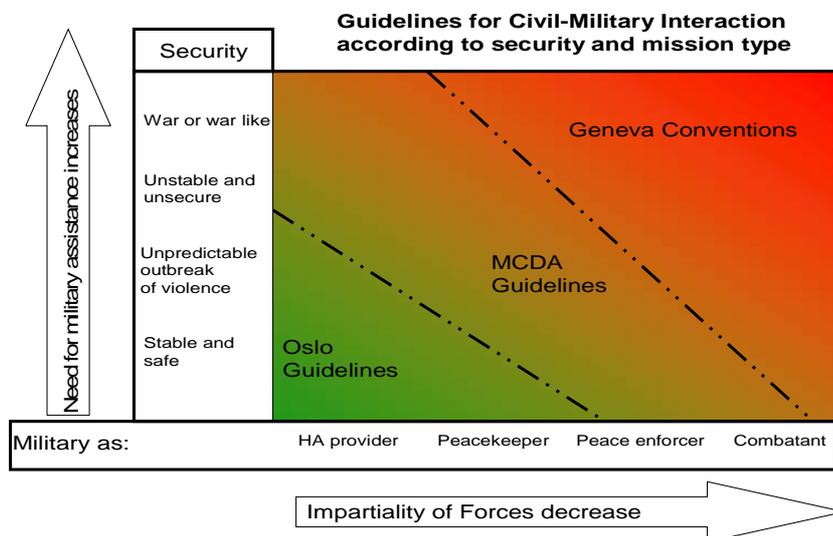


Figure 2: International Agreements that Apply to Military Activity in Different Security Environments

<sup>13</sup> Guidelines for the Interaction and Coordination of Humanitarian Actors and Military Actors in Afghanistan (Reference T)

<sup>14</sup> Addendum available at (last accessed 14 May 2010):

[http://www.reliefweb.int/ocha\\_ol/programs/response/mcdunet/0guidad.html](http://www.reliefweb.int/ocha_ol/programs/response/mcdunet/0guidad.html)

### **THE NEED TO ACT – IS IT LEGITIMATE?**

38. A final element of the framework for this analysis is to examine the question of when there is a legitimate need for NATO military medical assets to act in the realm of HA and R&D. In determining if there is such a need, it must first be determined if there is a legal mandate for action.

39. In disaster relief, NATO Policy<sup>15</sup> is clear—NATO will only become involved in disaster relief at the request of the stricken country or a relevant international organization and declares the UN to have the primary coordinating role. AMedP-15 (Reference V) adds that any NATO provision of medical relief will normally be under the auspices of UN OCHA and goes on to list the Conventions, Principles and Legal Aspects for such provision. Thus the NATO legal basis for involvement in disaster relief is well-defined. The same cannot be said for NATO military involvement in ongoing HA or in R&D, for which there is neither NATO policy nor agreed doctrine that define under what circumstances NATO will engage in these activities.

40. When NATO's military forces are involved in an out-of-area operation that is covered by either a UN Security Council resolution or mandate (e.g. ISAF) or an invitation from the host nation (e.g. Pakistan Earthquake), the legality and legitimacy of NATO's presence is assured. It then becomes a question of whether the specific activities are legitimate.

41. From the point of view of civilian organizations, the legitimacy of the military being involved in HA or R&D of the host nation's infrastructure is not clear. Specifically military involvement in the area of ongoing HA is questioned by some civilian organizations—*what is your mandate, what are you doing there?* The civilian concern is that the military is not a humanitarian actor or a humanitarian partner since the military can't ensure adherence to all humanitarian principles at all times. The mantra of most civilian agencies remains the same: the military should not be providing humanitarian aid, specifically in the humanitarian space. The main civil-military guidelines by UN agencies and IASC state that military forces should be strongly discouraged from playing a role as humanitarian aid providers.

42. The Oslo Guidelines define the six principles to be used to guide the use of military forces in disaster relief. While the guidelines are laid out specifically for disaster relief, these principles are suitable to be applied when determining whether to employ military assets in support of ongoing HA or R&D. Particularly the principle of Last Resort—i.e. only in the absence of any other civilian alternative available to support urgent humanitarian needs in the time required—should be the guiding principle for determining if there is a need for military forces to act in a given situation.

43. The military is often confronted with humanitarian challenges which are not being addressed by other organizations and finds itself filling the void. For instance, after a severe bomb explosion at the UN compound in Baghdad 2003, many international organizations (IO) and NGOs closed their offices in the country, resulting in a gap in providing humanitarian assistance. Similarly in Afghanistan, ISAF has had to deliver medical supplies to NGO-run clinics because humanitarian agencies did not have access to the area for security reasons. In these situations the military has the obligation to do something but does not know how to other than by providing the help themselves. There is a moral need to act (if means and capabilities are available) to initiate relief activities and the action can be considered legitimate if it meets the principle of Last Resort, as would be any action resulting from a direct request by the mandate giver (i.e. the UN or the host nation).

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<sup>15</sup> NATO Policy On Cooperation for Disaster Assistance In Peacetime (Reference U)

44. There are signs that the international community is beginning to recognize that the military will be involved in humanitarian activities. At the most recent NATO Medical Conference, a senior representative of the WHO addressing the audience stated, *“There is no monopoly in humanity for humanitarian agencies ... WHO has adapted a pragmatic approach in interacting with the military by respecting the humanitarian principles”*.<sup>16</sup>

### **CURRENT DEVELOPMENTS IN NATO POLICY**

45. At the political and strategic level, NATO is addressing the need for closer cooperation with other bodies. Besides the ongoing work on NATO's part of a military contribution to a Comprehensive Approach, new doctrine and policy are in the works. Below is a summary of current relevant projects that describe different approaches to the use of military medical capability. Because most of these, with the exception of AD 83-2, are in an early study or drafting phase JALLC chose not to incorporate their contents into this report:

- SHAPE has developed ACO Directive (AD) 83-2 – ACO Guidance for Military Medical Services Involvement with Humanitarian Assistance and Support to Governance, Reconstruction and Development (Reference C).
- HQ SACT is drafting AJMedP-6, an allied joint medical publication for Military/Civilian Medical Interface, and US JFCOM is the custodian for developing AJP 3.4.3, Allied Joint Doctrine for Support to Civil Authorities.
- The Military Committee (MC) has given priority to developing a framework to better support NATO's Comprehensive Political Guidance (Reference W) by introducing respective doctrine and strategy<sup>17</sup>.
- MC 0326/2 NATO Principles and Policies of Operational Medical Support (Reference Y) will be reviewed to update the civil-military interaction guidance.
- Currently, Allied Command Transformation (ACT) is conducting a gap analysis in civil-military interaction to inform the International Military Staff (IMS).

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<sup>16</sup> Second NATO Medical Conference in Estoril, Portugal, October 2009

<sup>17</sup> MC 0572, NATO Military Medical Vision and Objectives 2007-2016, (Reference X)

## 3

## NATO's Capability to Support Medical HA and R&D

*The medical needs of a displaced population may be both huge in scale and complex in detail with considerable challenges to both logistics and actual medical care. As a result, it is depressingly easy to be confused and even paralyzed by the task. Hastily mounted expeditions to alleviate obvious human distress and devastation may themselves become part of the problem. Inadequate preparation, poor equipment, ill-focused priorities, and sheer logistical non-sustainability may lead to the helpers needing help themselves and so detract from the main effort. In the maelstrom of an immediate response to a crisis, philanthropy is a poor substitute for professionalism—ideally you need both. – A. Hawley (Reference Z)*

46. In 1994, SHAPE published a report (Reference AA) examining NATO's capability to assist in international disaster relief operations. That report found, among other things, that it was not suitable for NATO military headquarters "at any level" to be involved in disaster relief because it would merely "create another layer of bureaucracy". Similarly the report concluded that it would not be feasible for NATO to contribute or attempt to coordinate assets, leaving that to individual member nations to do bilaterally. Little could the authors of that report have imagined that just over ten years later NATO would be directly engaged at joint HQ level in a disaster relief operation as far away as Pakistan. Much has changed since the SHAPE report was written.

47. There is often a need for military forces to act, especially when such action meets the Oslo Guidelines' principle of Last Resort. This study finds that NATO is lacking some capabilities to act effectively in the area of medical HA and R&D (and in HA and R&D more generally). The critical capability that NATO as a whole lacks is that which allows NATO to work together with other organizations and bodies. Most of the specific capabilities discussed below are in fact provided by national militaries which may or may not act under NATO operational or tactical control. NATO's capability to support medical HA and R&D does not just concern whether a given deployed unit possesses the right mix of skills, tools, and awareness to contribute successfully to HA or R&D, but also, and more importantly, concerns NATO's organizational capacity for successful coordination and cooperation with other humanitarian actors. This in fact was also a finding of the SHAPE report from 1994, where it recommended that NATO engage with the UN DHA (now UN OCHA) to develop multinational standard operating procedures (SOP) and encourage Nations to adopt them. 16 years later such coordination and cooperation mechanisms are needed more than ever.

### **NATO'S ABILITY TO CONTRIBUTE TO DISASTER RELIEF**

48. For disaster situations, military forces possess certain specific capabilities that are either not available or not available in the required quantity among civilian relief organizations. Some examples are logistics capability including large numbers of transport aircraft, especially helicopters, command and control (C2), and communication capabilities. Particularly the provision of military C2 is something HA organizations have frequently commented positively on. The military, with its predefined C2 structures and deployable communication equipment, can more quickly

establish order out of chaos and build the coordination and communication links necessary for cooperation with all involved organizations.<sup>18</sup>

49. Some capabilities that would normally be provided by civilian agencies or organizations are, when needed rapidly and in large quantities, only available through the military, as was made apparent during the recent earthquake in Haiti—for instance, drinking water production and air traffic control. Only the military had the capabilities to provide these in the timeframe and quantity needed in Haiti, with naval ships producing the water and air force controllers bringing the deployable personnel and equipment to allow an airport that had had only a few regular flights per day to handle the more than one hundred relief flights per day that flooded the country (Reference AC).

50. With respect to medical capabilities applicable in the immediate aftermath of a major disaster, there is generally an immediate need for trauma care to treat the injured and wounded. Within a few weeks however, the need for primary care and disease prevention becomes more important. Military medical personnel have strong skills in trauma care as well as in disease prevention. However, it is generally considered that most civilian medical relief organizations have stronger skills in primary care than the military.<sup>19</sup> Nonetheless, when military medical core competencies are combined with their inherent rapid deployability, self-sufficiency, and strong C2 structures, military medical resources can be an extremely valuable asset in the first chaotic days of a major disaster.<sup>20</sup>

#### **NATO'S ABILITY TO CONTRIBUTE TO ONGOING HA AND R&D**

51. Some of the capabilities that can contribute to disaster relief discussed above can also play a role in ongoing HA and R&D in operations such as ISAF. However, the principal capabilities that should be provided by the military are those that improve security and provide access to the population in need. These capabilities thus directly serve to enable the civilian aid agencies to accomplish their work, rather than having the military perform direct medical HA or R&D. In fact, most military medical staff do not have the necessary education, professional background, and expertise for ongoing medical HA or R&D<sup>21</sup>. The most significant shortcoming is the fact that there is a lack of understanding on the part of the military of the complex relationship with and among humanitarian agencies in complex emergencies. The lack of cultural awareness and lack of sensitivity to feedback concerning the people's perception also have an impact on providing coherent and long-term medical R&D advice and strategy.

52. The military does have capabilities that are useful in providing coherent and long-term medical R&D advice and strategy. One such strength is expertise in medical and

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<sup>18</sup> A Tufts University report on the Pakistan Earthquake response noted: "the most important factors ... for the Pakistan Army's effective leadership of the relief phase were its strengths in logistics, decision-making, coordination, and listening and learning", which the report believes explain "the positive perception of the role of the Pakistan Army in the relief phase of the Earthquake [which] is particularly noteworthy given the anti-military sentiments of many humanitarian aid workers, and the antagonistic relationship that often exists between aid agencies and military forces." The report concludes that, "the central role of the Pakistan Army in leading the very successful relief effort illustrates the potential benefits of a coherent and closely integrated civil-military response in a natural disaster context." (Reference AB)

<sup>19</sup> The Stockholm International Peace Research Institute's report on *The Effectiveness of Foreign Military Assets in Natural Disaster Response*, Page 94 (Reference AD).

<sup>20</sup> For an example, see the case of France's and Singapore's medical contribution contrasted with that of the Mexican Field Hospital during the Tsunami relief effort. *Ibid.* pages 33–36

<sup>21</sup> As reported in the Joint Center for Operational Analysis Journal's article: *Military Medical Support for Humanitarian Assistance and Disaster Relief: Lessons Learned from the Pakistan Earthquake Relief Effort* (Reference AE).

health programme management and administration. This expertise can be used as the basis for establishing indigenous medical capacity, especially at health ministry and, for military forces, defence ministry level and in mentoring health administrators.

53. Such activity is also to some extent negated by the lack of another capability. Very few NATO Nations have personnel who can be deployed for the period of time necessary to build up their own understanding of civil-military interaction or to see complex projects like establishment of a national health care system through to completion. Instead, military medical staff are limited to relatively short rotations, in ISAF of generally six to nine months. The short rotation does not allow for acquiring the necessary expertise, and experience gained leaves the country before it can be capitalized upon. Likewise, building relationships to crucial actors—such as the Ministry of Public Health (MoPH), IOs, and NGOs—is hampered by the short presence in theatre. As said by the US Assistant Secretary of Defense for Health Affairs, Dr Ward Casscells:

*“We have learned also that we must send people over who have some cultural and linguistic fluency. They need to speak Arabic. They need to speak state department. They need to speak WHO. There are some languages that we are teaching people to speak. It is not easy, particularly for career military to make that switch and start speaking NGO-speak. It’s just not the way we work but we are learning. And we hope that this will induce NGOs to work more with us.”<sup>22</sup>*

54. In an effort to partially address this shortcoming, the US military has developed, over the last decade, programmes to create a cadre of international health development experts (References AG and AH). NATO could encourage other NATO Nations to develop similar programmes and develop a coordinating concept in order to ensure this capability is available for future NATO-led operations.

### **CONSTRAINTS ON MILITARY ENGAGEMENT IN HA AND R&D**

55. Analysis objective 1.1 tasked JALLC to identify constraints on the use of multinational military medical capability. The Guidelines for Operational Planning (Reference AI) define constraints as obligations which must be met<sup>23</sup>. However, in the context of this report it is also important to consider restraints, those things that must not be done. In fact, restraints play a more important role. The situations where military medical assets must be employed are far fewer than those where such employment can have negative consequences. Defining limitations—constraints and restraints—then becomes a question of determining when it is appropriate for military medical capabilities to be used in various types of HA and R&D.

56. In all NATO missions there is a certain population at risk (PAR) for which the military assumes the responsibility of providing the right medical care. This PAR is defined in all mission statements and operation plans. In Afghanistan, the PAR is defined as ISAF personnel, Afghan National Security Forces (ANSF) conducting ISAF operations, and event-related civilian casualties, all of whom are thus eligible for treatment at ISAF treatment facilities. It is most certainly appropriate to provide medical care to those injured directly through military action, whereas there is not as strong a case for providing it in other situations.

57. In evaluating those other situations, the desired end state must be considered in terms of the long-term effect on both the local population and civilian relief agencies. Generally the desired end state is a self-sufficient and functional indigenous medical

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<sup>22</sup> Speech by Dr. Casscells (Reference AF)

<sup>23</sup> In the February 2010 Trail Version of Allied Command Operations' Comprehensive Operations Planning Directive, constraints are defined as, “a requirement placed on a commander that dictates an action”.

system that can meet the needs of the population. But their needs must also be met in the interim. A balance must therefore exist between providing ongoing HA to meet these immediate needs, and building up local capability, the R&D portion. Often provision of the former can actually hinder effectiveness of the latter, whereby provision of HA creates dependency and expectation on the part of the populace and slows development of indigenous capability.

58. The Oslo Guidelines' principle of Last Resort<sup>24</sup> can again provide the guidance necessary for resolving the issue of where and when the military should provide ongoing HA, where and when it should conduct medical R&D, and when it should do nothing and allow civilian relief organizations or the indigenous medical system to perform the tasks. Based on these considerations, the military would be justified in providing ongoing HA in situations such as:

- When the security situation is so bad that no other organization can operate in the area to alleviate suffering.
- When the medical situation poses a direct danger to the military force (epidemic disease outbreak or suffering caused by or that benefits the enemy).
- When civilian agencies are not responsive enough.

59. The military would be justified in providing R&D:

- When the lack of medical infrastructure directly impacts meeting the operation's goals—much as military engineers will rebuild a destroyed bridge so troops can use it but, as an ancillary benefit, the bridge also provides passage to the local population.
- In assisting host nation government agencies in building up a medical system for their own military forces.
- When requested by competent civilian authority (e.g. Government of the Islamic Republic of Afghanistan (GIROA) or UNAMA for ISAF) and where no civilian organization has the required capability.

60. Yet it would seem that many military officers, including commanders and those directly involved in providing aid, are unaware of the principles and guidelines that they should abide by when involved in HA and R&D activities. For example, it was reported<sup>25</sup> that the NATO commander in the Pakistan Relief operation was not aware of the Oslo Guidelines until after the operation. Other personnel deployed to that mission stated that knowledge of them would have been helpful during the response. Likewise, at Exercise STEADFAST JOINER 09, a member of the "Grey Cell" reported his wonder that the military personnel in charge of dealing with civilian organizations were obviously not familiar with the concept of *humanitarian space* or *corridor*.

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<sup>24</sup> ISAF (Reference J, Annex XX) and SHAPE (Reference C) have adapted the concepts of the Oslo and MCDA Guidelines to define principles to be adhered to for military engagement in R&D. These are: do no harm; be clinically appropriate; be culturally sensitive; be coherent and sustainable; be agreed and coordinated with the host nation (or other recognized authority); and recognize civilian primacy.

<sup>25</sup> Dr. Andrew Wilder in *Perceptions of the Pakistan Earthquake Response* (Reference AB). Dr Wilder is the Research Director for Policy Process at Tufts University's Feinstein International Center and Primary Investigator for the ongoing research Project "*Winning Hearts and Minds?*" (Reference O).

## 4

## The Need for a Medical Comprehensive Approach

61. NATO finds itself increasingly involved in contributing its military medical capabilities to HA and R&D activities. While doubtless well intentioned, the results have so far been mixed—while much good has been done, especially in disaster relief operations, NATO has not yet managed to consistently coordinate its efforts with those of other medical actors and efforts at building host nation medical capacity have not progressed as hoped and have had unintended consequences.

62. During the Pakistan Earthquake relief effort, although NATO had success in coordinating in the short term with the host nation, international, and other organizations, the structures that allowed this were created on the fly by civilian, foreign and domestic military organizations<sup>26</sup>. For ongoing operations, such as ISAF, it has proven much more difficult to build up standing bodies that can coordinate and harmonize the activities of the various HA and R&D actors in theatre, and their parent organizations out of theatre, that would ensure progress toward common goals and prevent duplication of effort or working to cross purposes. ISAF has the potential to act as a powerful facilitator among stakeholders in the Afghan health sector and can be considered a relatively impartial contributor<sup>27</sup>, but the full benefits thereof cannot be realized until appropriate coordination structures are fully in place and empowered.

### **HARMONIZING MILITARY ENGAGEMENT IN HA AND R&D**

63. This study finds that NATO's ability as a whole to contribute to HA and R&D is hindered by NATO's not having the right structures that can engage with the other international and local actors to formalize coordination and deconfliction mechanisms. Not having such mechanisms results in a poor understanding of the respective areas of action, the so-called *humanitarian space*, the *military space* and the area in between where both can legitimately act depending on circumstances and which we will refer to as the *joint civil-military space*. It is this lack of understanding of the different spaces that explains the poor understanding of what effects action in each of these spaces have and how that action will be perceived. The resultant less-than-optimal coordination and deconfliction with other actors gives rise to much of the perception that the military is stepping into areas of activity for which it has no mandate.

64. It is the joint civil-military space, where HA and R&D both take place in a semi-permissive environment and are conducted by a combination of civilian and military actors, that presents the greatest challenge to NATO's capability to contribute to medical HA and R&D, because it is here that the roles overlap and the framework for interaction is least developed.

65. This can be explained in part by how NATO applies the classical three stages of war approach in its operations, which means: first combat, then hold and stabilize, and last reconstruct and leave when a secure and stable environment is attained. This approach worked as recently as in the Balkans. However, in Afghanistan all three stages are conducted simultaneously across the country, which has an impact on the channels and ways reconstruction and development can be delivered, either by civilian or military. This is the current situation in ISAF but it is not accepted NATO doctrine.

<sup>26</sup> From findings in the JALLC final report on NATO Disaster Relief in Pakistan (Reference AJ).

<sup>27</sup> According to Colonel M. Bricknell (former HQ ISAF Med. Director and current RC South Chief CJMED) in his article Reflections on Medical Aspects of ISAF IX in Afghanistan (Reference AK).

66. Military interventions for humanitarian purposes in the joint space have led to an erosion of the separation between the humanitarian and the military space, and may threaten to blur the fundamental distinction between these domains. Regardless of whether the humanitarian aid is provided by civilian or uniformed organizations or in conjunction, a common approach defined and monitored at strategic levels might be the best option to provide the most efficient (cost, resources, effects) support to a distressed community.

67. Figure 3 describes the question of military engagement in supporting HA and R&D in local health care. The Figure begins with the question *why*; that is, to what purpose is the military engaged in supporting HA and R&D in health care? The purposes are essentially three: to achieve military objectives; to support national and local capacity building; and to address humanitarian needs. Action in support of each purpose is accompanied by specific motives and objectives and results in generation of secondary effects and consequences, often unforeseen and counter-productive. The purposes, objectives and consequences shown in Figure 3 fall into the spectrum of engagement spaces, with the purely military space on the left, moving progressively through the joint space to the purely humanitarian space on the right.

68. The bottom portion of Figure 3 illustrates how, in theory, these purposes, objectives and secondary effects should be managed. Since the purposes span the military and humanitarian spaces, there must be an agreed desired end state. Reaching this end state requires implementing a joint Health Care Development Concept, which should be developed by an appropriate medical comprehensive approach mechanism, which JALLC shall name the Joint Civil-Military Medical Coordination Board and which can develop the Health Care Development Concept and address the question of who is responsible for it.

69. Currently, there is no medical civil-military comprehensive approach mechanism in place which is capable of providing overall, holistic guidance to restore and develop a national/local civil and military health care system, to follow and monitor projects, or to provide corrective direction if the projects are not providing the desired effect. Recognizing the increased number of military involvements in providing health care support to the local population and to restore/develop a national and military health care system, there is the question if civilian aid agencies and military are harmonizing their objectives and activities and who has to play which role?

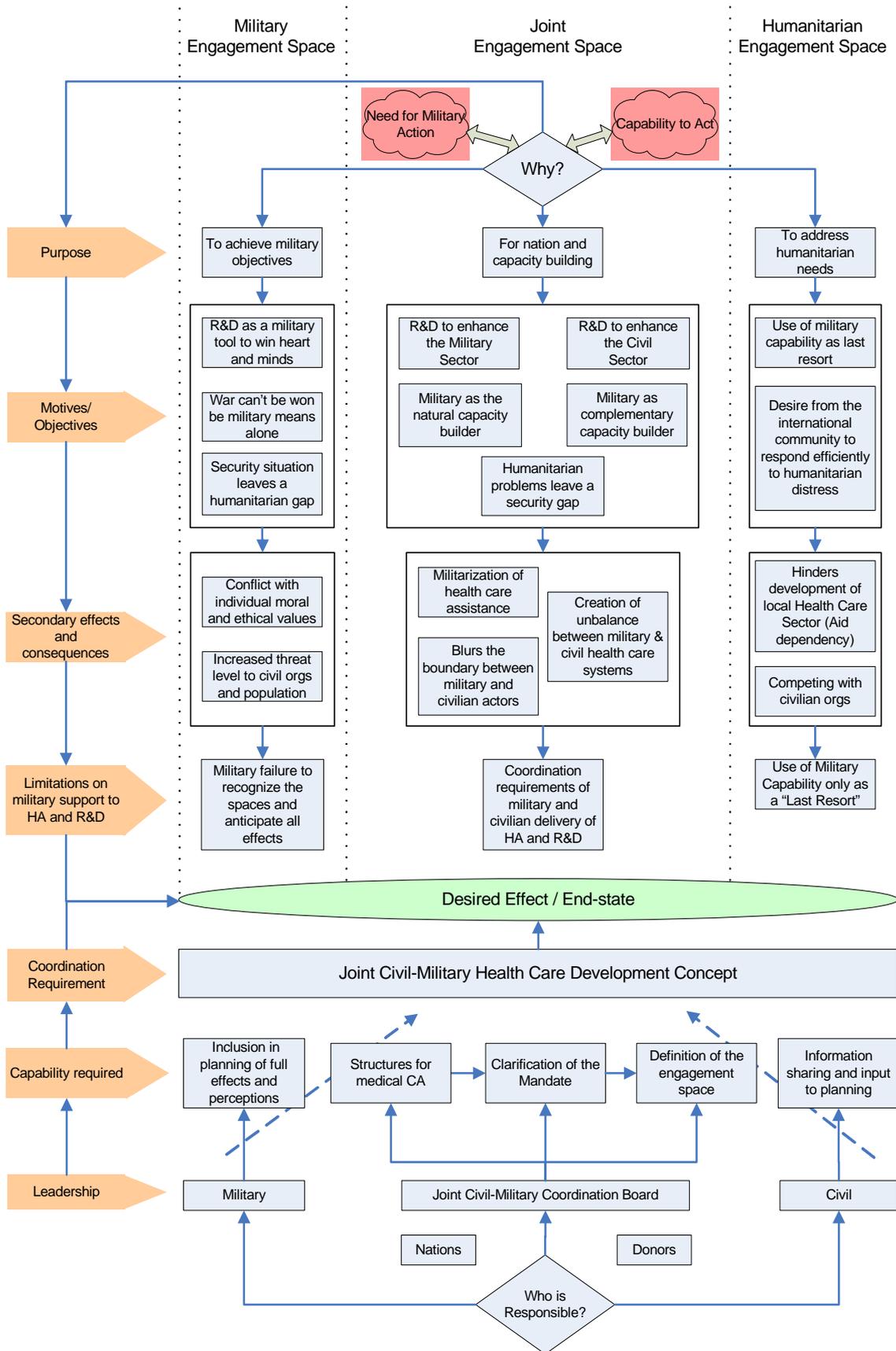


Figure 3: Military engagement in supporting, reconstructing and developing local health care

## **MEDICAL COMPREHENSIVE APPROACH MECHANISMS**

*“The military has to learn from the humanitarian actors to improve the military capability to support natural disasters.” – Lieutenant General Nadeem Ahmad, Pakistan Army, who, as Chief Military Coordinator of the Federal Relief Commission, was in charge of coordinating the foreign civil and military relief support in the aftermath of the 2005 earthquake.*

### **Relationships are established but are insufficient**

70. On a global level, NATO has established some structures, framework and relationships<sup>28</sup> with civilian organizations. However, as described in the preceding section, there is currently no visible medical comprehensive approach mechanism in place among civilian and military organizations. There seems to be no mechanism at the strategic level which can support coherent decision-making and defining common (civil and military) medical reconstruction and development objectives in conjunction with civilian organizations.

71. At the political level, NATO has bodies especially designed to interact with civilian organizations and with Euro-Atlantic Partnership Council (EAPC) nations. One such body is the EADRCC<sup>29</sup>, which plays a role in coordination and information capabilities in the response to disasters within the EAPC area. In the aftermath of the Pakistan Earthquake, the EADRCC was tasked by the North Atlantic Council to coordinate disaster response offers from NATO and Partner nations with NATO military commands, UN OCHA, the European Union and Pakistan authorities.

72. CEP embraces planning arrangements for the systematic and effective use of civil resources in support of Alliance strategy for Crisis Response Operations and Disaster Relief (Reference AL) as well as in cooperating with partners. There is a cadre of international civil experts accessible through NATO’s CEP Crisis Management Arrangements and the Crisis Element. Those experts may be used to provide advisory support at NATO Strategic and Operational Commands, as was the case at the early stage of the KFOR mission when Civil Aviation Planning Committee experts and military Movement and Transportation personnel were supporting the UN to schedule and deconflict flights in the operational area and manning an Air Cell in Geneva<sup>30</sup>.

73. The JALLC team noted during data collection that these political-level bodies exert very little coordination at the strategic level, leaving the medical functional areas of HQ SACT, SHAPE and mission HQs to work out their own coordination mechanisms. One of the principal lessons drawn by SHAPE Medical Branch from the Pakistan Earthquake Relief Operation was the lack of a relationship between NATO medical assets and civilian organizations and they proposed as a solution the development of closer cooperation between the strategic commands and both the Senior Civil Emergency Planning Committee and the EADRCC<sup>31</sup>.

74. Meanwhile, the international community continues to deepen its coordination measures. The newly established Global Health Cluster is a civilian approach to inter-

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<sup>28</sup> Relationships occur through regular JMC meetings and conferences at political and strategic level. However, at country level, the relationships are based on the individual personalities involved and are mostly limited due to high rotation frequency of the military and are thus lacking continuity.

<sup>29</sup> The EADRCC has two functional areas—Operations and Planning, and Exercises and Training—with eight staff positions in total.

<sup>30</sup> Presentation given by NATO International Staff, Civil Emergency Planning Operations Division.

<sup>31</sup> Presentation given by Deputy Medical Adviser SHAPE at the first Medical Lessons Learned Conference in Kaunas, Lithuania, September 2006.

agency coordination that was developed by IASC and WHO for implementation at country level but currently without military participation because there are as yet no formalized civil-military Health Cluster arrangements. By the military, including NATO, not being involved, there is a risk that both sides will develop independent approaches that turn out to be incompatible in practice. As part of developing its comprehensive approach, NATO needs to make the case for involvement in these external developments to ensure that its military contributions are in line with the desires of the international community. The military contribution to HA, and any R&D performed for reasons other than direct support of operational objectives, should be determined by the needs of the humanitarians. A Joint Civil-Military Medical Coordination Board could be the body to allow NATO to support UN OCHA and the Global Health Cluster by providing the interface between in-theatre coordinators and extra-theatre asset providers and align NATO's concepts, doctrine, policies and procedures for medical HA and R&D to be compatible with civilian approaches.

### **Afghanistan – A Country Level Example**

*"I have to acknowledge that we do not, at this time, know what works in the building up of a healthcare program for Afghanistan. We absolutely know that Afghans are constituting about 80 percent of our hospital beds. It's difficult to support that. We need them to have their own system. Particularly the Afghan police have virtually no healthcare and because of that, their police have trouble recruiting new police. So they desperately need a better healthcare system"*

*– Dr Ward Casscells (Reference AF)*

75. In Afghanistan there are three separate government health care systems: first the civilian system developed by the MoPH; second the Afghan National Army (ANA) system; and third the Afghan National Police system. The three health care systems are supported by different donors and civilian or military organizations. The overarching question is whether Afghanistan's economy has the ability to sustain three separate systems after the departure of the supporting foreign troops, given that in many donor countries budget constraints impact spending on their own health care systems, military or civilian.

76. According to an article in *Defence Horizons* (Reference AM) there is an investment of hundreds of millions of dollars in the ANA health care system which may not be sustainable over the long term. It has been suggested that this investment would be better spent in local civilian health care institutions (such as medical/nursing schools, medical emergency systems, and health care for ANSF family members). On the other hand, the ANA military health care system has become more and more self-sufficient and is a big contributor to morale and prestige of ANA members. Sustainability will depend on the donors' long-term commitment.

77. Currently, support to the Afghan MoPH seems to be based on bilateral agreements with donors, civil aid agencies, countries, and the foreign forces rather than following a common approach. There have been programmes to achieve a better coordination of effort but the degree of civil-military interaction has mostly depended on personal initiatives by the HQ ISAF and RC Medical Advisors and of their civilian counterparts. In consequence there have been ups and downs in identifying coherent civil-military medical goals. In the absence of overarching civilian coordination bodies in the early days of ISAF (no OCHA/WHO in Kabul early 2002), the military started to implement its own HA and R&D projects according to their need assessments and military objectives. Involvement in these activities has persisted to this day.

78. The Joint Coordination and Monitoring Board in Afghanistan was implemented in 2005 to oversee the high-level benchmarks according to the Afghan Compact<sup>32</sup> and in part to address the coordination issue. However, despite some NATO involvement in this board, it appears that instead of following an overarching civil-military health care concept aimed at developing Afghanistan's overall health care system, ISAF's R&D priorities are decided by independent deployed forces and change with every commander and staff rotation and with the tactical situation, and are not forcibly following any long-term development plan.

79. Because of the interaction of civil and ANSF health care sectors, there is a requirement for a common civil-military approach in order to create a sustainable country-wide health care system, thereby investing in the preparedness of the indigenous public health care system so that it can remain operational when it is needed most. Future preparedness should focus on comprehensive health-risk management, including measures to reduce the vulnerability of the population<sup>33</sup>. As previously recommended by JALLC in its report on Multinational Medical Support (Reference I), ISAF/PRT nations could create a Military Medical Steering Group for specific areas, such as medical support and health care system development, similar to the steering group already in place for RC South nations. This would bring national donors, national troop contingents, and civilian stakeholders together in order to ensure the objectives are agreed and achieved.

80. Progress in the area of aligning ISAF units' action with agreed development plans is being made. In early 2008, the Afghanistan Civil Military Working Group with representation from the key actors in Afghanistan, including ISAF, Operation Enduring Freedom (OEF), UNAMA (and UN agencies), and the major NGOs represented by ACBAR, agreed the *Guidelines for The Interaction and Coordination of Humanitarian Actors and Military Actors in Afghanistan* (Reference T), whose purpose is to establish principles and practices for constructive civilian-military relations and support the development of a relationship between military and humanitarian actors in which differences are recognized and respected. Commander ISAF (COMISAF) and the PRT Executive Steering Committee directed, by Fragmentary Order (FRAGO) (Reference AP) all ISAF units and PRTs to implement and follow these Guidelines.

81. It appears, however, that implementation of these Guidelines has not been universal and some PRTs and units remain unaware of their existence, prompting COMISAF to direct (Reference AQ) all sub-units to meet with local humanitarian providers and respond to a survey to allow COMISAF to determine the extent to which the Guidelines are being implemented. The study is ongoing at the time drafting this report<sup>34</sup>. However, JALLC thinks that the results of this survey could be of great interest to NATO in understanding how to better implement coordinated working relationships with civilian actors on the ground.

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<sup>32</sup> The Afghan Compact is the outcome of the 2006 London Conference on Afghanistan, resulting from consultation of GIRoA with the UN and the international community. There is also the Afghanistan National Development Strategy, which is the foundation for the international community in providing a holistic support to Afghanistan; however JALLC data and other studies have demonstrated little efficiency in a coherent support—see the JALLC report on CIMIC and PRT Operations in ISAF (Reference AN).

<sup>33</sup> According to Claude de Ville de Goyet in his article *Health Lessons Learned from the Recent Earthquakes and Tsunami in Asia* (Reference AO).

<sup>34</sup> Surveys were due to COMISAF on 20 March 2010 and a query on initial findings by JALLC to HQ ISAF in early May has so far received no response.

### **Some Models that Work**

82. Many national Red Cross organizations and NGOs have already established special pre-arrangements with their domestic military in order to avoid time-consuming negotiations in ad hoc situations. NATO should seek analogous special relationships with international civilian organizations which would facilitate the response to large scale emergencies by developed pre-arrangements.

83. Some nations, such as the United States, have developed a national symbiotic and coherent relationship between their armed forces and governmental development agencies, which empowers the military to conduct projects on behalf of the civilian agency (e.g. USAID).

84. Good examples of civil-military interaction on a national level in natural disaster situations, such as Hurricane Katrina (United States) 2005, flooding of the Elbe (Germany) 2002, and also bi- and multinational military support such as was provided during the “2005 snow chaos” in north-west Germany, demonstrate areas where the military has provided effective support under lead of civilian governmental organizations.

### **THE NEED FOR PRE-PLANNING**

85. The models presented above largely reflect the benefits of pre-arrangements and pre-planning. Admittedly they are national arrangements that, at least in theory, are easier to arrange than at international level but, as Hurricane Katrina demonstrates, even at national level this is not easy. The reality is that military medical assets are in fact being used for HA and R&D and NATO needs to codify this use into its doctrine and strategy. The difficulty of national interagency coordination was one of the primary lessons from Katrina and pre-arrangements one of the proposed solutions. Currently, at international level, NATO, national militaries, and civilian actors, both governmental and non-governmental, are individually developing concepts that are not necessarily coordinated. Under the current structures, most civil and military interaction is based upon ad hoc reaction to disasters and needs created by conflicts<sup>35</sup>.

86. Lessons from KFOR recommend that military units and humanitarian organizations should participate in joint pre-mission planning and training to ensure greater cooperation in the field. Joint training and education can break down misunderstanding and mistrust so that CIMIC can be both a force multiplier for the military and an aid-delivery enhancer for the humanitarian community<sup>36</sup>. Establishment of liaison posts with key international partners, such as OCHA and WHO, would also provide an additional mechanism to streamline coordination during a crisis. Such liaison should take place at global, theatre, and local levels.

87. The IASC, in conjunction with WHO and other civilian organizations, recently developed the Global Health Cluster Guide (Reference S) to reduce avoidable mortality, morbidity and disability and to restore the delivery of health care as quickly as possible. The Global Health Cluster Guide is the most relevant recent documentation development for NATO’s strategic and operational levels and should serve as a key reference for NATO in considering how to further develop its role in R&D of a national health care sector. As one element of pre-planning, NATO should seek to actively contribute to sections of this Guide concerning civil-military interaction in R&D. At the same time, NATO needs to incorporate relevant content from the Guide into the doctrine currently in development to ensure alignment with civilian approaches.

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<sup>35</sup> As reported in a report by the Rand Corporation's Center for Domestic and International Health Security (Reference AR).

<sup>36</sup> As concluded by Dr. Thomas R. Mockaitis, Adjunct Professor at the US Naval Post Graduate School's Center for Civil-Military Relations (Reference AS).

88. However, some IOs and NGOs might remain reluctant to setting up an overall civil-military board with leadership function. For example, Oxfam stated in their policy (Reference P) that they “*will propose to oppose structural association between humanitarian and military entities in Multi-Dimensional Military Missions. Co-location, under a common leadership, of political, development, and military personnel, is seen as inappropriate and contrary to the fundamental humanitarian principles of independence and impartiality*”. Therefore, with some IOs/NGOs, the best that can be hoped for is improved information sharing, which is necessary between all actors involved in medical HA and R&D.

### **CIVIL-MILITARY MEDICAL HA AND R&D INFORMATION SHARING**

*The biggest challenge [in Pakistan] was the lack of a clear, common situational understanding of the humanitarian needs and outstanding requirements. “Assessment fatigue” was common among affected populations as many organizations were conducting assessments in parallel and there was no coordinated, systematic data collection/management system in place. This led to inefficient use of resources and an excess of aid resources arriving in more accessible areas while insufficient amounts reached areas that were less accessible or cut off.*<sup>37</sup>

89. Despite an improvement in sharing relevant NATO documents with civilian organizations, there is still insufficient information exchange among civilian actors and military at country level as well as at higher strategic level. Lessons from other nations, NATO, and civilian organizations are not shared and exploited. There is no comprehensive lessons learned approach in place yet. A major hindrance to establishing better information sharing is lack of transparency, both in the way the military attempts to share information and in civilian organizations understanding of how the military works.

90. There are promising initiatives which need to be explored more intensively to see if they could play a role in providing an accepted civil-military information sharing platform. Currently those initiatives are military or government dominated and require log-ins (such as the “Lessons without Borders” initiative of the US Department of Homeland Security<sup>38</sup>, and *Harmonieweb.org*<sup>39</sup>). The latest initiative is the creation of a medical portal within HQ SACT’s CIMIC Fusion Centre<sup>40</sup> website. However, civilian organizations have already indicated their reluctance to use those sites if they are not fully open. The impact of requiring a login has been documented with the NATO Lessons Learned Database (LLDb). When users were required to login and could no longer browse anonymously, the average number of user visits dropped by nearly 70%. Therefore, NATO should preferably support Lessons Learned and information sharing initiatives by interacting on well established open sites such the *reliefweb.int*<sup>41</sup>, *onerresponse.info*<sup>42</sup> or develop platforms in conjunction with civilian stakeholders.

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<sup>37</sup> The US Center of Excellence in Disaster Management & Humanitarian Assistance report on the Civil-Military Dimensions of the Pakistan Earthquake Response (Reference AT)

<sup>38</sup> <http://lessonsweborders.net>, “Lessons without Borders Initiative” administered by the US Department of Homeland Security

<sup>39</sup> [www.harmonieweb.org](http://www.harmonieweb.org), administered and sponsored by US Joint Forces Command

<sup>40</sup> [www.cimicweb.org](http://www.cimicweb.org), Civil-Military Overview, administered by the Civil-military Fusion Centre and sponsored by NATO

<sup>41</sup> [www.reliefweb.int](http://www.reliefweb.int); administered by UN OCHA

<sup>42</sup> <http://onerresponse.info/Pages/default.aspx> is the collaborative interagency website to enhance humanitarian coordination and which supports the Clusters' and OCHA's information management.

91. Many civilian organizations are not familiar with military hierarchy and responsibilities. The difference in mission between ISAF and OEF; and different structures within ISAF (HQ ISAF, ISAF Joint Command (IJC), RC, Task Forces), PRTs and NATO Training Mission – Afghanistan (NTM-A)/CSTC-A are not transparent for civilians, making it hard for them to find the right military counterpart with whom to share and coordinate. For example, lack of understanding of the military structure and system in Afghanistan led some civilian organizations to regard the PRTs as their main military counterpart in Afghanistan rather than anyone at HQ ISAF.

92. The area of disease surveillance and the reaction to epidemiological outbreaks have proven to be good examples of positive interaction/cooperation between civilian and military actors. The collection and sharing of epidemiological data (e.g. between NTM-A/CSTC-A and Afghan MoPH) and the joint civil-military Quick Reaction Team of the WHO are considered best practice. However, the development of NATO's new Disease Surveillance System could and should be expanded towards international civilian organizations such as WHO, centres for disease control (US/Europe), and national systems to share this information on the Internet.

93. Investment in information management and communication is a cross-cutting endeavour and should be integral to the work of disaster management experts and organizations. Information management and communication should be considered a culture more than a skill. The challenge is to show how communication and information management contribute to more effective and timely response, and therefore to saving lives, and how these activities can lessen the impact of disasters and emergencies and improve the quality of life of affected populations. Communication and information management must also be recognized as key elements in mobilizing resources, stimulating solidarity and support, increasing visibility, and strengthening the position of humanitarian stakeholders and of the health sector (Reference AU).

## Interaction with Local Populations, Institutions, and Civilian Aid Providers

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*Many humanitarian organizations assume that observing the principles of neutrality, impartiality, and independence will produce optimal results for aid beneficiaries. Conversely, policymakers and military actors tend to rush into humanitarian activity hoping it will achieve the desired security objectives. If the ultimate goals are a secure and stable environment that adequately meets civilians' humanitarian needs, military and humanitarian organizations must critically re-examine assumptions about the effects of their activities.*

*– Dr. Sarah Lischer, Professor of Political Science, Wake Forest University  
(Reference AV)*

94. As described in the previous chapters, support to non-combatant civilian populations must be provided by the military when that military organization is either the intervening force or has effective control over a territory or when humanitarian aid organizations are unable or reluctant to operate. However, when the military does become involved in medical HA and R&D, it can confuse the civil-military boundary and the expectations of the local population. The results range from a potential negative impact on local health care system development when external aid is delivered directly and for too long, to a counter-productive impact of delivering uncoordinated medical support to the population, and to, perhaps most importantly, the degeneration of security for civilian agencies and the local population when the distinction between civil and military health providers is blurred.

### **EFFECT ON LOCAL POPULATION AND INSTITUTIONS**

95. There are a number of issues surrounding the impact that the use of military medical for HA and R&D has on the local population and local institutions, both in the short and long term. The military needs to be aware of these issues in order to properly take into account the real effect of the use of military medical capability in mission planning.

### **Winning Heart and Minds**

*“There is a widely held assumption in military and foreign policy circles that reconstruction and development assistance is an important soft-power tool to promote stabilization and security. Counter-insurgency doctrine in particular emphasizes the importance of aid projects (often in the form of Quick Impact Projects...) to “win hearts and minds” and undermine support for insurgents and/or terrorist organizations. This assumption is having a major policy impact on how development assistance is apportioned and spent and provides an important rationale for the growing securitization of development assistance.”*

*– Dr. Andrew Wilder in Winning Hearts and Minds? (Reference O)*

96. Currently, more and more nations perceive medical care as a noncontroversial and cost-effective means to be used by the military to support national or global interests<sup>43</sup>. There appears to be an assumption of a causal relationship between increased aid and improved stabilization and security<sup>44</sup>. Some assert<sup>45</sup> that “In

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<sup>43</sup> As one example, US Joint Publication 3-57 Civil-Military Operations (Reference AW).

<sup>44</sup> *Winning Hearts and Minds?* (Reference O)

<sup>45</sup> For example, Dr. Joachim Gardemann from the Humanitarian Assistance Competence Center at the University of Applied Sciences, Münster, Germany (Reference AX)

*complex emergencies, public health activities have been shown to promote peace, prevent violence, and reconcile enemies.”*

97. However, some question whether the evidence for the efficacy of health in building peace is persuasive<sup>46</sup>. Given how widespread the assumption is, and given its major impact on aid and counter-insurgency policies, there is surprisingly little empirical evidence that supports the assumption of a causal relationship between increased aid and improved stabilization and security in counter-insurgency contexts.

98. Robert J. Wilensky, using data derived from extensive archival research as well as his personal experience in the Vietnam War, shows in his book (Reference AZ) how medical aid to Vietnamese civilians, at first based simply on good will, became policy:

*“Most important, there is no evidence that the good will built by U.S. doctors transferred to South Vietnamese forces. American programs may have emphasized the inability of the Republic of Vietnam to provide basic health care to its own people and may have demonstrated to Vietnamese civilians that foreign soldiers cared more for them than their own troops did. If that is the case, the programs actually did more harm than good in the attempt to win hearts and minds.”*

99. The Medical Civil Action Program (MEDCAP)<sup>47</sup> has been utilized in Afghanistan as medical support by military personnel to the local population. AD 83-2 (Reference C) defines MEDCAPs as a commander’s tool to win heart and minds. As such, MEDCAPs have been used for purposes beyond just serving purely local health needs. As an example, some military physicians complained about the misuse of the original humanitarian intent by combining MEDCAPs with an attempt to gather military intelligence. It was reported that in some areas this triggered a considerable enthusiasm for such activities among the non-medical military staff. The SHAPE Medical Advisor has recognized this as ethically unacceptable and contravening international humanitarian principles.

100. ISAF Regional Command South reviewed their MEDCAPs activities and concluded that MEDCAPs were neither providing lasting health care benefits to the local population nor supporting the MoPH in creating a sustainable health care system. They found that MEDCAPs have the potential to compete with the indigenous health care providers and disrupt rather than enhance the local health care capabilities. COMISAF (Reference J) has also recognized the shortcomings of MEDCAPs and the ethical dilemma posed to medical staff by their use for political purposes. In consequence, both ISAF and SHAPE Medical Branch now promote the concept of Medical Outreach which requires prior coordination with MoPH and other health-relevant agencies for medical engagements, in order to improve sustainability and continuity for further local health care development. Nevertheless, adopting new terminology does not automatically signify a change in mindset. Permanent careful oversight for ethical misuse of military medical care is required to ensure Medical Outreach does not become a tool to win hearts and minds, as MEDCAP had become.

### **Meeting Local Expectation**

101. All HA and R&D activities need to take account of the population’s needs and their expectations towards the international community. The perception of the support

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<sup>46</sup> For example, researchers from the Centre for Health and International Relations at the University of Aberystwyth (Reference AY).

<sup>47</sup> Note that many documents in ISAF define the acronym MEDCAP to mean, in contrast to AD 83-2 and the COMISAF OPLAN, Medical Civil Affairs Patrols, while ISAF SOP 1149 (Reference BA) calls it the Medical Civic Action Program. JALLC was unable to determine the reason for these discrepancies in terminology.

delivered is directly related to the perception of how fast and how long-lasting this support is provided. HA and R&D have two major points of opposition: the time needed to fulfil the promises made by the international community and the perception that projects are meeting the population's expectations. The population's perception that the international community and military are delivering on their promises and meeting their expectations is crucial for success. This perception will play a major role in the population's acceptance of the R&D objective as leading toward achievement of their goals.

102. One potential danger is that PAR patients' receiving the high quality care available at military treatment facilities can create the unrealistic expectation among local patients that these capabilities might be equally available for them. As mentioned by an ISAF medical officer providing medical support to Afghans, if expectations concerning what kind of treatment will be provided to them are not adequately addressed in advance, patients might leave disappointed at best but might also turn angry, resulting in the well-intentioned military support to the population having a more negative than positive impact.

103. NATO-led military operations need to manage expectations and be honest, recognizing that NATO does not have the capability to treat the wider population or provide long-term solutions. As stated in the WHO Outbreak Communication Guidelines (Reference BB), *“the overriding goal for outbreak communication is to communicate with the public in ways that builds, maintains, or restores the trust. This is true across cultures, political systems, and level of country development. ... The less people trust those who are supposed to protect them, the more afraid they will be and less likely to conform to [recommendations or guidelines].”*

#### **Effect on Developing Local Institutions**

104. The US military Newspaper *Stars and Stripes* has reported that mixing fighting and food distribution is a recipe for disaster. By using the example of Afghanistan and the PRTs, the article (Reference BC) contends that civilians and aid organizations are both negatively affected by concepts such as *“the US counter-insurgency strategy which places aid directly in the hands of the US military”*, which is more concerned with winning the favour of local elders than of helping those truly in need. At the same time, another negative consequence of direct military medical involvement is that aid projects are delivered, *“while bypassing and undermining the authority of traditional hierarchies and of local religious and political leaders.”*<sup>48</sup>

105. The lack of the Afghan government's reach to the local levels, combined with corruption, patronage, and the inequity in regional health care provision explains in part why direct military assistance is still being provided—it is intended to fill the void in what the Afghanistan government can provide. Yet the military contribution in this area appears to be having the opposite effect. As reported by a Medical CIMIC officer in ISAF, rather than filling this void: *“Treating local nationals in ISAF facilities has worsened an already fragmented healthcare system with poor referral mechanisms”* and affects ISAF's capacity to treat ISAF patients. This has led some to consider a new strategy that focuses on programmes to empower the national and provincial government as a direct health care provider.

106. In consequence, in some areas in ISAF referral guidelines were created to enable cross-referral between provincial hospitals and ISAF facilities<sup>49</sup>. For example, in order to deal with an increasing number of Afghan patients, some only nominally in

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<sup>48</sup> From Dr. Wilder's report *Perceptions of the Pakistan Earthquake Response* (Reference AB)

<sup>49</sup> Described in ISAF SOP 1149 (Reference BB).

the PAR, that were affecting RC South's capacity to treat ISAF patients, RC South initiated agreements to allow transferring these patients to local civilian hospitals.

107. Additionally, the access of Afghans to civilian health care facilities was supported by military transport. Road construction and the improvement of transport security have become a focus for improving access to local and regional health clinics. The military-to-military and military-to-civilian mentoring programme has proven to be a positive way to develop health care capabilities which allows respect for social and cultural aspects and minimizes the threat to health care professionals while improving the management of health care clinics and the capacity of qualified health professionals.<sup>50</sup>

108. Another issue is the impact of the military presence within or in the vicinity of local health care clinics. OCHA Afghanistan has reported (inter alia References BD and BE) that health facilities continue to be adversely affected by military presence. In September 2009, the Swedish Committee for Afghanistan reported that ISAF raided its hospital in Wardak province, looking for insurgents. This interfered with the hospital's operations and put the medical staff at risk of recrimination from insurgents. Similarly, health actors have asked ISAF not to assess the situation of the destruction of a clinic in Kandahar province in order to avoid complicating negotiations to re-establish the health care facility. The health cluster in Afghanistan continued to advocate against a military presence at civilian health facilities. ISAF has recognized the potential negative consequences of this kind of action and issued instructions to avoid them (Reference BF).

### **A Decision Making Tool – HISS-CAM**

109. Maintaining the public's trust throughout an emergency or disaster requires transparency (i.e. communication that is candid, easily understood, complete, and factually accurate). Transparency characterizes the relationship between the emergency managers and the public. It allows the public to view the processes of information gathering, risk assessment, and decision-making that are associated with controlling risks but transparency, by itself, cannot ensure trust. The public must see that competent decisions are made.

110. World Vision<sup>51</sup> has developed a decision-making tool based on their experience to help staff in making more transparent, accountable and considered choices for engagement with military and other armed actors called HISS-CAM (meaning **H**umanitarian imperative, **I**mpartiality and independence, **S**afety, **S**ustainability, **C**ompelling aim, **A**ppropriate, adapted, adequately informed, **M**inimal negative impact). It also offers a platform for collaborative decision-making that incorporates essential elements of humanitarian best practice and codes of conduct.

111. The tool's field applications have shown that the tactical choices laid out in UN OCHA's continuum of engagement can be substituted for a range of other operational questions, such as entry/exit to an area, engagement/non-engagement with a group or proceed/do not proceed with an operational choice. It provides a format for documenting the reasons for reaching a particular decision, which can then go towards future organizational learning and ultimately help to improve the quality of humanitarian work. The HISS-CAM tool assists in bringing local staff into discussions, building their capacity to think as humanitarians and communicate their ideas in a joint platform.

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<sup>50</sup> Presentation given by the RC South CJ9 Medical officer the NATO Operational Medical Conference, May 2009.

<sup>51</sup> World Vision is an international, evangelical relief and development organization founded in the United States. It is one of the world's largest NGOs.

112. JALLC thinks the HISS-CAM tool can provide an excellent model for a similar NATO tool to help guide decision making on military HA and R&D engagement.

### **EFFECT ON CIVILIAN AID PROVIDERS**

113. Currently military medical R&D is considered very controversial by civilian organizations. Specifically the provision of direct medical assistance to local populations by uniformed and probably armed health personnel is causing the main concern.

#### **Impact on civil organizations' funding**

114. Fundraising for civilian organizations is sometimes linked to the visibility of their activities. The military playing too predominant a role in the humanitarian space could have a negative impact on the generation of funds and the budget of the civil organizations, because donors<sup>52</sup> may believe there is no need to contribute when the military is seen to be doing the work. While this concern has been raised by some NGOs, it is more hypothetical than empirical, in that it expresses a fear that this could happen. In interviews with representatives of the main donors in Afghanistan (USAID and EC) there was no evidence that civilian organizations were in competition with the military for funds for humanitarian projects. Donors may also be reluctant to fund an IO/NGO that is seen to have a close relationship with the military.

#### **Impact on civilian organizations' way of doing business**

115. The military sometimes "intimidates" its potential civilian partners with its huge resources in manpower, availability of material, and mainly by its unity of command. This could lead to an unintentional assumption of leadership by the military, which might not be welcomed by the civilian partners. The bulk of many civilian organizations' personnel is generated by voluntary contributions of their members and supporters. This requires a specific "civilian" working philosophy which might be in contrast to the typical military mindset of *order and execution*. There is a concern that if the civilian organization cannot keep pace with the military tempo, there could be a negative impact on their image. In consequence, this concern could engender reluctance towards building a working relationship with the military, a concern which should encourage the military to develop greater understanding and sensitivity for civilian aid workers in order to improve relationships.

116. There are always cases of pushing and being pushed as the military develops its own timelines and perception of when the job has to be done. For example, in the aftermath of the 25 August 2009 bombing in Kandahar, ISAF pressured the humanitarian community to respond more quickly to the need assessment conducted by NGOs or else ISAF would distribute its own assistance (Reference BE).

117. Civilian organizations are keen to improve their efficiency. As one example of such efforts at improved efficiency, the Global Clusters have developed a "Proposed Responsibilities and Accountabilities Matrix" for the Health, Nutrition, and Water Sanitation Hygiene Clusters<sup>53</sup> which defines the responsibilities and accountabilities of these clusters during emergency response in areas of potential overlap. This Matrix has been developed through a broad consultative process, and should improve the

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<sup>52</sup> By donors is meant both individuals making charitable contributions to a private organization and governmental/international agencies (e.g. USAID or European Commission) in determining where to allocate budgetary assets.

<sup>53</sup> <http://onerresponse.info/GlobalClusters/Nutrition/publicdocuments/Forms?DispForm.aspx?ID=53>

coordination effort and efficiency in a way which is more familiar to the military work philosophy.

### **Increasing threat to civilian aid workers**

*"The days are gone when driving in a white jeep with a humanitarian logo was a guarantee of safety. Today aid has become a target." – Jonathan Mitchell, Emergency Response Director for CARE International<sup>54</sup>*

118. With the military providing HA and R&D in ongoing conflicts and being involved in offensive operations simultaneously, there has been an impact on the threat level and freedom of movement of HA actors, since they are perceived to be part of the whole (intruding) foreign military campaign. The increasing threat to civilian aid workers is reported in many papers and interviews as being the main constraint on combining military and civilian R&D efforts. It has been reported (Reference BC) that, "Aid and development workers say their fiercely protected neutrality is jeopardized when foreign militaries deliver aid intending to fulfil military, rather than purely humanitarian, objectives. Insurgents such as the Taliban then have even less incentive to distinguish between combatants and caregivers."

119. Al-Qaeda has called on the Taliban to kidnap more foreign civilians in Afghanistan for use in prisoner swaps. Abu Walid al Masri argued that the US had "changed the rules of the game" by not distinguishing between civilians and combatants and by torturing inmates. He said it was time for the fighters to "change the rules" and "accept the principle approved and implemented by the enemy—the abduction of civilians who have nothing to do with the battle" (Reference BH).

120. The example of vehicle colour from the quote above is just one of the concerns expressed by HA actors. In Afghanistan, ISAF has been made aware of these concerns. However, recently ISAF was resupplied with new vehicles that were again white. As another example, in response to the realization that ISAF medics and medical ambulances carrying the Red Cross symbol on their uniform and vehicles were deliberately targeted by insurgents, some nations in ISAF have camouflaged the Red Cross symbol on their ambulances and even installed weapons systems on them for self protection and in order to not be distinguishable from the rest of the convoy. This has further blurred the distinction among combatant, military medical, and civilian aid actors. Some civilian organizations understand these behaviours on the part of the military as disrespect or total ignorance of their concerns, which naturally has a negative effect on the civil-military relationship.

121. Not being distinguishable from the military is an important concern for civilians in insecure areas. A survey of Afghans<sup>55</sup> conducted on behalf of the ICRC reported that 27% of the interviewees said that health workers may sometimes be acceptable targets and 32% indicated that there are circumstances in which it is acceptable to target ambulances. When further questioned, those respondents indicated the acceptability of targeting health workers and ambulances was greater when, and even because, their neutrality was not clear.

122. On the one hand, neutrality is seen as promoting the safety of the NGO operatives. On the other hand, the reality is that, a) they must in some ways interact with the UN-mandated security force, and b) by their nature as foreigners, and often westerners, they are already associated with the military force in the eyes of many locals. Thus, while the military must uphold civilian aid workers' neutrality and avoid actions that jeopardize it, aid organizations should also adapt to the reality of these

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<sup>54</sup> Quoted in Reference BC.

<sup>55</sup> Our World: Views from Afghanistan, 2009 ICRC Opinion Survey (Reference BG)

factors affecting the perception of their neutrality if they plan to operate in close proximity to UN-mandated forces.<sup>56</sup>

### **Building trust with civilian aid organizations**

123. Beyond concerns for their personal safety and security, civilian aid workers have some reservations in trusting the military's intentions and activities. They fear that the military might have a hidden agenda which could then compromise the civilian organizations' impartiality and neutrality when associated with the military.

124. Although military medical support is not neutral and may not be impartial—the sending governments always have political objectives, regardless of whether the mission objective is of humanitarian or combatant nature—health professionals within the military and civilian organizations share common ethical values and principles which can ease civil-military interaction and understanding. These common values also lead to common responsibilities and obligations to monitor and document human rights abuses such as torture. As one medical officer in ISAF said, *“Yes, we are wearing uniforms but we are still human beings with a conscious, moral values and a medical oath. If we are confronted with suffering people, we have the moral obligation to help; we can't just look away and say, my country does not allow me to help even if we could.”*

125. There is much that NATO military forces could do to build upon the foundation created by these common values to create greater trust with their civilian counterparts. Military medical personnel, as carriers of the Red Cross symbol, have a legal and moral obligation to uphold human rights. There might be a special role for medical officers to act as the guardian of the Geneva Conventions within military campaigns. That is, medical officers should provide guidance and advice to commanders on the correctness of actions in HA and R&D and in ensuring that military activities do not conflict with or jeopardize those of civilian medical aid workers. If the military is seen to be actively involved in the CIMIC aspect of medical care and to respect the concerns of civilian organizations, those organizations would be more likely to trust, and thus cooperate with, the military.

126. A better awareness and understanding among military personnel of internationally accepted guidelines and the concepts therein would go a long way to building trust with civilian partners. As mentioned earlier in this report, even commanders are sometimes not aware of them. There is a strong need to ensure that all military personnel involved in HA and R&D are trained on the humanitarian principles and that NATO develop an ethos for how military personnel should apply them.

127. A final area where trust is needed is in information sharing. As discussed earlier in this report, civilian organizations expect, on the one hand, information sharing to be transparent. Yet on the other, if it is perceived that they are feeding intelligence to the military, they can jeopardize their own neutrality and consequently their freedom of action and safety. One option for building trust in this regard, as suggested in a US JFCOM white paper (Reference BI), would be to coordinate and exchange information with NGOs through national development organizations or IOs, which would add a buffer layer between the military and civilian aid organizations, in order to avoid direct contact.

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<sup>56</sup> As concluded by Dr Lischer (Reference AV).

## Conclusions and Recommendations

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### CONCLUSIONS

128. When NATO considers using its military capabilities for conducting HA and R&D, it must be aware of the potentially negative impact that may be had on the local population, local institutions, and civilian aid providers. The military is not necessarily the best equipped or trained organization to provide medical HA and R&D, but when its medical capability is considered alongside its C2 and self-sustainment capabilities, it can make important and valuable contributions.

129. While NATO has to consider its limitations in acting in the humanitarian space, it also must retain its option to act if no other help is provided. NATO needs to communicate to the civilian organizations that the military will not remain passive if humanitarian distress is not adequately addressed by civilian agencies. The military will not always wait until the military is branded as last resort. There is a need for military medical involvement in ongoing HA and R&D arising from lasting conflict where no other capabilities are present, or where the security situation prevents civilian organizations from operating, or where building up indigenous capability is essential to operational success. NATO military medical staff and commanders need greater awareness of the guidelines dictating the use of military medical capability for HA and R&D.

130. The use of military medical capabilities for HA and R&D is a reality of working in a semi-permissive environment—the joint humanitarian-military space. The use of military medical capabilities for HA and R&D requires that military has the capability to interact with the civilian agencies in everything from joint planning to informal information sharing. NATO military medical capability is currently not set up to facilitate this spectrum of necessary interaction at the strategic and operational levels.

131. There are many potential secondary effects and negative consequences that can arise when the military is involved in providing ongoing HA or R&D and that impact the local population, host nation institutions, and civilian aid agencies. Particularly the impact on the safety, security, and perceived neutrality of civilian aid workers and the retarding effect direct provision of aid can have on long-term development of indigenous, self-sufficient medical infrastructure are of grave concern. Military planners must be aware of these effects and consider the limitations on employment of military medical capability that they imply.

132. Seemingly based on a growing assumption that provision of public health care has a correlation with preventing violence and reconciling opponent parties, which some nations have already incorporated into their national diplomacy, using military medical capability to "win hearts and minds" has become commonplace in peacekeeping and counter-insurgency missions. Medical HA and R&D has also reportedly been used for intelligence gathering. The effectiveness of such activity is questionable and it puts the moral integrity of military medical personnel at risk.

133. NATO already has some mechanisms in place to work with civilian organizations regarding medical issues, but these mechanisms do not support the civil-military medical relationship at the strategic, operational, and country levels. This is evident in Afghanistan where NATO military medical actions are mostly conducted in isolation by individual troop contributing nations. On the other hand, there are also recent examples of when military and civilian actors have worked together effectively.

134. Lessons and best practice arising from the experience of civil and military medical actors working together suggest a need for a joint civil-military body with monitoring and management authority over the use of both military and civilian capability for HA and R&D. This standing body would support UN OCHA and the Global Health Cluster by providing the interface between in-theatre coordinators and extra-theatre asset providers. This body would also enable pre-planning of joint responses to certain types of incident as a force multiplier.

135. NATO needs to align its concepts, doctrine, policies and procedures for medical HA and R&D to be compatible with civilian approaches. The recently published Health Cluster Guide is one key reference for considering how to further develop NATO's role in assistance to R&D of a national health care sector.

136. NATO military personnel who are involved in medical HA and R&D must have a sound understanding of interacting with humanitarian organizations, be familiar with the humanitarian principles, and have professional skills in public health in developing countries in order to properly consider the effects and limitations of their actions. Carriers of the Red Cross/Red Crescent symbols are bound to the Geneva Conventions and Protocols, which implies ethical obligations that go beyond the obligations of regular troops.

137. In addition to formalized military civilian relationships and mechanisms for working together, there are a number of areas in which the civilian and military actors can routinely share information regarding medical HA and R&D. The medical HA and R&D efforts would benefit from military and civilians openly sharing lessons, information about what different parts of their organization are responsible for, points of contact, rationale behind their decision making, and disease surveillance and epidemiological data. Ideally, to overcome reluctance to and complexity of sharing information in each others sites, the civilian and military entities would collaborate to build a joint site that they can both use for information sharing.

### **A NEW PARADIGM FOR NATO**

138. This report highlights the need for a Medical Comprehensive Approach Mechanism to provide the structure for NATO to coordinate its contribution to medical HA and R&D and to define roles in the military, joint, and humanitarian spaces. The intervening chapter 4 described the issues that led to this conclusion in greater detail, which now allows presentation of a proposed new Paradigm and Roadmap for NATO's Medical Comprehensive Approach as well as recommendations for how, specifically, to implement this Approach.

139. The structure that JALLC proposes to fill the need for a Medical Comprehensive Approach Mechanism is a medical Civil-Military Coordination Board. The ultimate goal of this Civil-Military Coordination Board will be to work with IOs, NGOs, partners, and NATO Nations to create a Joint Civil-Military Health Care Development Concept and allow the sort of pre-planning that can facilitate, through better advance coordination and deconfliction, any future NATO contribution to HA and R&D efforts. Although the focus of this report has been on military *medical* contributions, JALLC sees such a structure as having a potential positive involvement in all aspects of HA and R&D coordination. To achieve this NATO will have to adopt a new paradigm for civil-military coordination in HA and R&D and agree a roadmap for implementing it in the medical sector.

#### **Paradigm**

- HA and R&D are primarily civilian spheres of activity.

- Military forces under the appropriate circumstances can legitimately act as a humanitarian actor in support of civilian efforts.
- All military activities in HA and R&D have to be done in accordance with the humanitarian principles.
- Military forces acting as combatants cannot simultaneously uphold the humanitarian principles and thus are not a legitimate humanitarian actor.
- In cases where the military cannot uphold all the humanitarian principles, the military (NATO) must still share and support fundamental humanitarian values.
- Military forces being employed to support HA and R&D activities need to be clearly distinguishable as performing a humanitarian function/role.
- Civilian humanitarian actors and the military, regardless of their roles as humanitarian actor or combatant, *can* complement each other in providing HA and R&D support to a country.

### Roadmap

- First: NATO should reach out to civilian organizations in order to create a joint civil-military board of medical, HA, and R&D subject matter experts to provide guidance and accountability in medical humanitarian assistance operations and reconstruction and development activities.
- Second: On the basis of jointly agreed medical civil-military concepts and principals, NATO should continue its effort to develop doctrinal and strategic framework documents for the use of military medical capabilities in HA and R&D environment.
- Third: In conjunction with civilian HA actors, NATO should identify areas where complementary military medical capabilities are required.
- Fourth: As a consequence of the identified complementary capability gaps, NATO, along with donors and NATO Nations can continue to develop their military medical capabilities to assist with HA and R&D.
- Fifth: NATO personnel involved in HA and R&D should be trained on the humanitarian principles as taught by IASC, UN OCHA, and NGOs such as Oxfam.
- Sixth: The doctrines and policies developed for the use of NATO military medical capabilities should inform the definition of minimum training and professional skill requirements for military medical personnel employed in HA and R&D and their commanders. Nations could use these definitions to inform development of their own short- and long-term HA and R&D military medical training programmes.

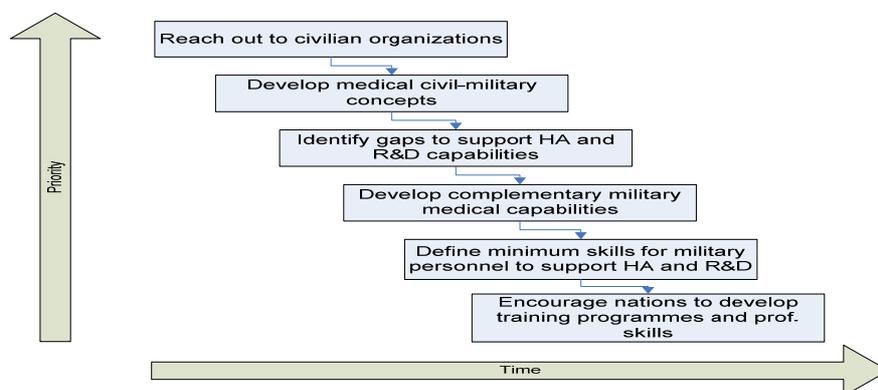


Figure 4: Proposed Roadmap to Enhance Medical Civil-Military Interaction

## **RECOMMENDATIONS – IMPLEMENTATION OF A MEDICAL COMPREHENSIVE APPROACH**

### **Concept and Doctrine**

140. NATO should develop a medical HA and R&D concept to inform detailed military doctrine and policy papers. This concept should:

- a. Be consistent with the UN developed and internationally agreed frameworks and guidelines for humanitarian assistance and R&D, notably the UN Humanitarian Reform and the Oslo Guidelines;
- b. Be developed in conjunction with the main stakeholders in HA and R&D (UN OCHA, WHO, IASC, ICRC, partners of the Global Health Cluster);
- c. Define the NATO military role in providing HA and R&D support in the context of the specific military medical moral obligation within, a) the military operational space, b) joint civil-military space, and c) humanitarian space, to include:
  - Indirect assistance capabilities such as reconstruction of destroyed medical facilities and public health care infrastructure.
  - Provision of exceptional (last resort) interim referral medical expertise (extended and critical care).
  - The ethos that military medical personnel, as legitimate carriers of the Red Cross and Red Crescent symbol and protected by the Geneva Convention, should act as the conscience of the engaged armed forces. The Medical Advisor should be the professional advocate and guardian of the Geneva Convention to (and for) the military Commander in the field.
  - Liaison with the WHO at global, national and local levels.

141. IMS, HQ SACT, and SHAPE should make use of the Global Health Cluster Guide when developing NATO Doctrine and Policy documents regarding medical civil-military interface or medical R&D and refer to its use within those documents.

142. NATO should make itself available to assist the WHO if they want to add a section on Civil-Military cooperation in the Global Health Cluster Guide.

### **Organization**

143. To construct a Medical Comprehensive Approach Mechanism for NATO, JALLC proposes the creation of a Joint Civil-Military Medical Coordination Board that will, by working intimately with UN OCHA, the WHO, and the leading NGO umbrella organizations, provide the structure for NATO to coordinate its contribution to HA and R&D and to define the roles and responsibilities in the military, joint and humanitarian engagement spaces.

144. NATO should encourage civilian organizations to take part in civil-military joint strategic board to define strategic civil and military (medical) HA and R&D objectives and monitor the ongoing efforts. For each mission, the civil-military joint strategic board should be able to:

- Prioritize needs assessments and requirements
- Advise military and civilian organizations through their chain of command in R&D matters
- Broker between Donors, Nations and the agreed comprehensive approach objectives in R&D

- Maintain long-term relationships to country-level health authorities.

145. For each operation, there should be a civil-military joint planning cell at the operational level that supports military conducted Medical Outreach programmes and harmonizes ongoing military operations and civilian activities. This joint planning cell should be complementary to UN agency entities such as UNAMA or OCHA country offices. The Humanitarian Assistance Coordination Cell employed by Joint Task Force Haiti is one model for this cell.

### **Planning**

146. For each operation, NATO should develop and commit to a strategic plan for its involvement in HA and R&D (such as the Afghan National Development Strategy) which clearly communicates specific milestones and deliverables, and includes a military exit strategy with a transition/handover to domestic and international civilian organizations. The strategic plan should provide a framework for operational level planning.

147. NATO medical planners should make use of the Global Health Cluster Guide and incorporate suitable elements of HISS-CAM into the Operational Planning Process.

148. At country level, military HA and R&D operations should involve/include the UN OCHA Civil-Military Coordination Liaison Officer as early as possible in the planning phase.

149. JMC and SHAPE should develop prearrangements/preplanning with the WHO (Health Action in Crisis) which would support ad-hoc disaster relief activities. UN OCHA should be informed of the development of such arrangements.

### **Interoperability and Information Sharing**

150. SHAPE should create strategic- and country-level medical R&D monitoring and advisory mechanisms in conjunction with the local national Ministry of (Public) Health, IOs (UN Agencies, ICRC) and IASC under the Global Health Cluster framework.

151. NATO should support and contribute to the creation of a universal HA and R&D lessons learned sharing tool preferably under the lead of an UN Agency, that allows promoting best practice and avoiding repeating mistakes.

152. NATO should ensure that civil-military information sharing at country and regional level does not compromise the security of civilian agencies.

153. NATO should ensure a common language and common understanding of widely used humanitarian definitions and terminologies. Whenever possible, NATO terms and definitions should be aligned with civilian terms and definitions. NATO should not create new definitions to describe humanitarian concepts.

### **Leadership**

154. NATO's CEP, EADRCC, and JMC should, in addition to their current functions, play a more visible and prominent role in achieving a comprehensive approach with humanitarian agencies represented in global clusters and should lead NATO's efforts in the public health sector.

155. NATO should formally recognize that UN OCHA is the leading agency for civil-military coordination in general and WHO the leading agency for coordination of healthcare.

### **Communication**

156. NATO needs to communicate its mandate, legitimacy and necessity to be engaged in HA and R&D activities to the local population as well as to HA and R&D relevant civilian organizations.

157. NATO should communicate mission deliverables and expectations, in order to avoid disappointment on the part of the hosting nation and its population. NATO should make its HA and R&D commitment visible and openly accountable.

### **Personnel and Training**

158. NATO and NATO Nations should develop a cadre of military personnel with humanitarian experience and education for employment in medical HA and R&D posts by:

- Developing minimum education/professional requirements for medical HA and R&D personnel.
- Developing training programmes that prepare military medical personnel in skills relevant to peace building.
- Accepting IO/NGO offers (e.g. from UN OCHA, Oxfam) to build awareness of humanitarian principles within NATO.
- Offering NATO R&D personnel the option to garner experiences as a “volunteer” in a humanitarian organization.

159. The Joint Warfare Centre (JWC) and NATO School Oberammergau should develop specific pre-deployment civil-military medical HA and R&D courses open to both NATO and IO/NGO attendees. (Examples are courses offered by the Center for Stabilization and Reconstruction Studies at the Naval Postgraduate School, Monterey, California or the bi-national Military Medical Support in the Humanitarian Arena Course in Germany and Netherlands.)

160. The comprehensive approach concept (for medical HA and R&D) should be formally developed and tested in the JWC exercise programme, along similar lines to those employed for the Deployed Joint Staff Element concept. Specifically, exercise scenarios should be included in the STEADFAST series where the interaction with UN OCHA and WHO Health Cluster would play a prominent role.

### **Proposal for Future Studies**

161. NATO should conduct a study on trends and assess the effects of militarizing medical care, e.g. MEDCAPs, offering medical care for information gathering or better cooperation, setting different criteria of eligibility for care to non-military patients, and the benefit and effect of Heart & Minds and Medical Diplomacy activities. The purpose of such a study would be to answer questions such as: Does the local population react with the expected appreciation? Can security be improved by such campaigns? What are the negative consequences of providing conditional help? The results of such a study could inform NATO in development of its long-term Strategic Concept with respect to the military medical part of the comprehensive approach.

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### **RECOMMENDED FURTHER READING**

JALLC found the following publications, already listed above, especially useful and pertinent in preparing this report and believes that they can provide a great deal of understanding to someone wishing to learn more on this topic:

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## Annex A

# Glossary of Acronyms

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|          |  |
|----------|--|
| AAP      | Allied Administrative Publication  |
| ACBAR    | Agency Coordinating Body for Afghan Relief   |
| ACO      | Allied Command Operations  |
| ACT      | Allied Command Transformation  |
| AD       | ACO Directive  |
| AJMedP   | Allied Joint Medical Publication   |
| AJP      | Allied Joint Publication   |
| AMedP    | Allied Medical Publication   |
| ANA      | Afghan National Army   |
| ANSF     | Afghan National Security Forces  |
| C2       | Command and Control  |
| CA       | Comprehensive Approach   |
| CEP      | Civil Emergency Planning   |
| CIMIC    | Civil-Military Cooperation   |
| CJMED    | Combined Joint Medical   |
| COMEDS   | Chiefs of Military Medical Services in NATO  |
| COMISAF  | Commander ISAF   |
| CSTC-A   | Combined Security Transition Command – Afghanistan   |
| DHA      | Department of Humanitarian Affairs   |
| EADRCC   | Euro-Atlantic Disaster Rescue Coordination Centre  |
| EAPC     | Euro-Atlantic Partnership Council  |
| EC       | European Commission  |
| FRAGO    | Fragmentary Order  |
| GIRoA    | Government of the Islamic Republic of Afghanistan  |
| HA       | Humanitarian Assistance  |
| HISS-CAM | <b>H</b> umanitarian imperative, <b>I</b> mpartiality and independence, <b>S</b> afety, <b>S</b> ustainability, <b>C</b> ompelling aim, <b>A</b> ppropriate, adapted, adequately informed, <b>M</b> inimal negative impact |
| IASC     | Inter-Agency Standing Committee  |
| ICRC     | International Committee of the Red Cross   |
| IFRC     | International Federation of Red Cross and Red Crescent Societies   |

## JALLC Report – Not Bi-SC Endorsed

|        |   |
|--------|---|
| IJC    | ISAF Joint Command                                  |
| IMS    | International Military Staff                        |
| IO     | International Organization                          |
| ISAF   | International Security Assistance Force             |
| JALLC  | Joint Analysis and Lessons Learned Centre           |
| JFCOM  | Joint Forces Command                                |
| JMC    | Joint Medical Committee                             |
| JWC    | Joint Warfare Centre                                |
| KFOR   | Kosovo Force  |
| LLDb   | Lessons Learned Database                            |
| MC     | Military Committee                                  |
| MCDA   | Military and Civil Defence Assets                   |
| MEDCAP | Medical Civil Action Program                        |
| MOE    | Measurement of Effectiveness                        |
| MoPH   | Ministry of Public Health                           |
| NTM-A  | NATO Training Mission – Afghanistan                 |
| OCHA   | Office for the Coordination of Humanitarian Affairs |
| OEF    | Operation Enduring Freedom                          |
| PAR    | Population at Risk                                  |
| PRT    | Provincial Reconstruction Team                      |
| R&D    | Reconstruction & Development                        |
| RC     | Regional Command                                    |
| SACT   | Supreme Allied Commander Transformation             |
| SOP    | Standard Operating Procedure                        |
| UNAMA  | United Nations Assistance Mission in Afghanistan    |
| USAID  | United States Agency for International Development  |
| WHO    | World Health Organization                           |

## Annex B

# Lessons Learned Database Entries

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The following *Lessons* will be entered into the JALLC-managed NATO Lessons Learned Database (LLDb). While these are the lessons JALLC considers to meet the requirements for LLDb entry in accordance with the Bi-SC Lessons Learned Directive, they in no way represent the only important findings of this report. Therefore, readers are encouraged to read the main body of this report in its entirety to ensure all findings are fully taken into consideration. If readers of this report believe it brings to light other Lessons, they are encouraged to incorporate them into their own internal Lessons Learned process or add them to the NATO LLDb.

### LLDb Item # 1057

#### Medical Comprehensive Approach Mechanisms

##### Observation

There is currently no visible medical civil-military comprehensive approach mechanism in place which is capable of providing overall, holistic guidance to restore and develop a national/local civil and military health care system, to follow and monitor projects, and provide corrective directions if the projects are not providing the desired effect.

##### Discussion

Recognizing the increased number of military involvements in providing health care support to the local population and restoring/developing a national and military health care system, there is the question if the civilian aid agencies and military are harmonizing their objectives and activities and who should play which role in the military, joint and humanitarian spaces?

UN OCHA is the leading agency for civil-military coordination in general and WHO the leading agency for coordination of healthcare partners and the Oslo and MCDA Guidelines give a framework for military involvement in HA and R&D.

At the political level, and focused geographically largely on Europe, NATO's CEP, JMC and EADRCC provide the interface with the major international players. But at the strategic and operational level, neither doctrine nor structures exist for this purpose. There is no mechanism at the strategic level which would support coherent decision making and defining common (civil and military) medical reconstruction and development objectives.

Although NATO had a successful experience in coordinating in the short term with the host nation, international and other organizations during the Pakistan Earthquake relief effort, the structures that allowed this were ad hoc. For ongoing operations, such as ISAF, it has proven much more difficult to build up standing bodies that can coordinate and harmonize the activities of the various HA and R&D actors in theatre and their parent organizations out of theatre, and that would ensure progress toward common goals and prevent duplication of effort or working to cross purposes.

The Joint Coordination and Monitoring Board in Afghanistan was implemented in 2005 to oversee the high-level benchmarks according to the Afghan Compact. However, despite some NATO involvement in this board, its impact on ISAF's medical R&D mission objectives is insignificant.

As recommended in 2009 in the JALLC Multinational Medical Support Report, ISAF/PRT nations could create a Steering Group for specific areas, such as medical

support and health care. This would bring national donors, national troops and civilian stakeholders together in order to ensure the objectives are achieved.

Currently, support to the Afghan MoPH seems to be based on bilateral agreements with donors, civil aid agencies, countries and foreign forces rather than a common approach. There have been programmes to achieve a larger coordination effort but the degree of civil-military interaction has mostly depended on personal initiatives by the ISAF HQ/RC Medical Advisors. In consequence there were ups and downs in identifying coherent civil-military goals. There is a lack of continuity and accepted leadership with responsible action bodies when it comes to civil-military interaction on medical issues in Afghanistan.

The newly established Health Cluster is a coordination structure set in the framework of UN Humanitarian reform. It exists at the global, national, and local level. The military currently does not participate, mainly due to security reasons.

As the civilian organizations and NATO are currently both developing guidelines and policies, there is a risk that they will develop independent approaches that turn out to be incompatible in practice. For example, the Health Cluster Guide (HCG) was recently published and simultaneously NATO is developing a doctrinal paper on Medical Civil-Military Interface (AJMedP-6). Despite their interrelation, unfortunately both documents were not harmonized at the crucial early stage. As part of developing its comprehensive approach, NATO needs to make the case for involvement in wider international developments to ensure that its military contributions are in line with the desires of the international community.

### Conclusions

NATO needs to focus on the creation of effective medical comprehensive approach mechanisms at all levels to overcome a lack of continuity and enhance, accepted leadership and responsible action bodies in medical HA and R&D.

The use of military medical for HA and R&D requires that military medical have the capability to interact with the civilian agencies. NATO military medical capability is currently not set up to facilitate this spectrum of necessary interaction, especially at the strategic and operational levels.

### Recommendations

NATO should recognize that UN OCHA is the leading agency for civil-military coordination in general and WHO the leading agency for coordination of healthcare partners and the Oslo and MCDA Guidelines provide the framework for military involvement in HA and R&D.

To construct a Medical Comprehensive Approach Mechanism for NATO, JALLC proposes the creation of a Joint Civil-Military Medical Coordination Board that will, by working intimately with UN OCHA, the WHO, and the leading NGO umbrella organizations, provide the structure for NATO to coordinate its contribution to HA and R&D and to define the roles and responsibilities in the military, joint and humanitarian engagement spaces.

NATO needs to communicate its mandate, legitimacy and necessity to be engaged in HA and R&D activities to HA and R&D relevant civilian organizations. NATO should make itself available to assist the WHO if they want to add a section on Civil-Military cooperation to the Global Health Cluster Guide.

NATO's CEP, EADRCC and the JMC could play a more visible and prominent role in achieving a comprehensive approach with humanitarian agencies represented in global clusters and should lead NATO's efforts in the public health sector.

NATO should encourage civilian organizations to take part in civil-military joint strategic boards to define strategic civil and military (medical) HA and R&D objectives and monitor ongoing efforts. For each mission, the civil-military joint strategic board should be able to:

- Prioritize needs assessments and requirements
- Advise military and civilian organizations through their chain of command in R&D matters
- Broker between Donors, Nations and the agreed CA objectives in R&D
- Maintain long-term relationships to country-level health authorities.

NATO should develop a civil-military joint planning cell at operational level that supports military conducted Medical Outreach programmes and harmonizes ongoing military operations and civilian activities. This joint planning cell should be complementary to UN agencies such as UNAMA or UN OCHA country offices.

Military HA and R&D campaigns on country level should involve/include the UN OCHA Civil-Military Coordination Liaison Officer as early as possible in the planning phase.

### **LLDb Item # 1058**

#### **The Use of NATO's Medical Capability for HA and R&D**

##### Observation

Some lessons from natural disasters suggest that military medical capabilities are not best suited to provide first hand medical aid.

##### Discussion

Some lessons from the Tsunami and Pakistan Earthquake demonstrated that the military's medical capability is not best suited to provide direct medical aid in natural disaster situations. At the NATO Operations Medical Conference it was recognized that the lack of paediatrics, obstetrics, gynaecologist and family/elderly practice as well as the military-designed medical equipment were not meeting the initial requirements of a population after a natural disaster. Additionally there can be a negative impact on the local health care system when external aid is delivered directly and for too long. For example, it was reported in Afghanistan that local physicians and pharmacists had to close their services because the local population chose to use free foreign-provided medical care instead.

The Oslo Guidelines are the most comprehensive framework for military involvement in HA and R&D and under their principles the military would be justified in:

Providing ongoing HA under circumstances such as:

- When the security situation is so bad that no other organization can operate in the area to alleviate suffering.
- When the medical situation poses a direct danger to the military (epidemic disease outbreak or suffering caused by or that benefits the enemy).
- When civilian agencies are not responsive enough.

Providing R&D under circumstances such as:

- When the lack of medical infrastructure directly impacts meeting the operation's goals—much as military engineers will rebuild a destroyed bridge so troops can use it but, as an ancillary benefit, the bridge also provides passage to the local population.

- In assisting host nation government agencies in building up a medical system for their own military forces.
- When requested by competent civilian authority (e.g. UNAMA or GIRoA in ISAF) and where no civilian organization has the required capability.

Despite shortfalls in their ability to provide direct medical help to the population, military forces still possess certain specific capabilities that are not available, or not available in the required quantity, among civilian relief organizations during a disaster situation. Logistics capability, large numbers of transport aircraft, especially helicopters, communications, and C2 capabilities are some examples. Particularly the last one is something HA organizations have frequently commented positively on. The military, with its predefined C2 structures, can more quickly establish order out of chaos and build the coordination and communication links necessary for cooperation with all involved organizations.

Additionally, the military has particular expertise and strength in supporting establishment of an indigenous medical capacity for military forces up to ministry level and in the systematic mentoring of indigenous health professionals/administrators.

NATO does not need to develop its own capability in the areas where it is weak, such as paediatrics, obstetrics, gynaecology and family medicine and equipment specifically for HA, rather it needs to try to support humanitarian agencies' trained personnel with disaster kits.

These specialized teams need help, first in providing transportation, supporting their logistical needs and establishing communication platforms, and second by NATO developing complementary capabilities such as referral hospitals in collaboration with NGOs and disease surveillance, facilitating civilian organizations by providing civil-military liaison officers and providing medical-specialized early reconstruction capability (such as medical engineering).

Many national Red Cross Organizations and NGOs have already established special prearrangements with their domestic military in order to avoid time consuming ad hoc negotiations in emerging situations.

### Conclusions

It is generally considered that most civilian medical relief organizations have stronger skills in primary care than the military. Nonetheless, when military medical core competencies are combined with their inherent rapid deployability, self-sufficiency, and strong C2 structures, military medical resources can be an extremely valuable asset in the first chaotic days of a major disaster. International agreements support the use of military for HA and R&D under certain circumstances, as long as the military plans to hand over to civilian organizations in the long run.

NATO needs to seek to establish special frameworks with international civilian organizations which would facilitate its response to large scale emergencies by developed prearrangements.

### Recommendations

JMC and ACO should develop prearrangements/preplanning with the WHO (Health Action in Crisis) which would support ad hoc disaster relief activities and UN OCHA should be informed of the development of such arrangements.

NATO capability to engage in medical HA and R&D should:

- a. Be developed in conjunction with the main stakeholders in HA and R&D (UN OCHA, WHO, IASC, ICRC, partners of the Global Health Cluster);

- b. Be consistent with the UN developed and internationally agreed frameworks for humanitarian assistance and R&D, notably the Health Cluster Guide;
- c. Define the NATO military role in providing HA and R&D support in the context of the specific military medical moral obligation within a) the military operational space, b) joint civil-military space and c) humanitarian space, to include:
  - Indirect assistance capabilities such as reconstruction of destroyed medical facilities and public health care infrastructure.
  - Provision of exceptional (last resort) interim referral medical expertise (extended and critical care).
  - Liaison with WHO at global, national and local levels.

NATO HA and R&D missions should always:

- Be limited in time and with a clear exit strategy.
- Be separated from any other military objective.

### **LLDb Item # 1059**

#### **Civil-Military (Medical) Information Management**

##### Observation

There has been an improvement of sharing relevant NATO documents with civilian organizations. Nevertheless, more information needs to be shared than is currently being shared.

##### Discussion

Maintaining the public's trust throughout an emergency or disaster requires transparency which characterizes the relationship between the emergency managers and the public. Transparency means allowing the public to view the processes of information gathering, risk assessment, and decision-making that are associated with controlling risks. Transparency is only possible with good information management and communication. In this way, information management and communication are cross-cutting endeavours which need to be integral to the work of disaster management experts and organizations.

Sharing information between military and civilian counterparts is often hampered for numerous reasons. The biggest hindrance to establishing better information sharing is transparency, both in the way the military attempts to share information and in civilian organizations understanding of how the military works.

Another key concern is that civilian organizations that are seen to be exchanging information with the military may themselves become targets by association. A US JFCOM white paper<sup>57</sup> suggests that exchange of information with NGOs through national development organizations or IOs might act as a buffer layer between the military and civilian aid organizations, in order to avoid direct association. This system should ideally overcome reluctance/complexity of sharing information with each other.

NATO and some nations have invested in closing information gap between civilian and military organizations.

What has improved?

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<sup>57</sup> U.S. Joint Forces Command (USJFCOM), "Emerging Challenges in Medical Stability Operations, White Paper," October 4, 2007

- Promising initiatives have created civil-military information sharing platforms such as the military or governmental platforms “Lessons without Borders” (US), “Civil-Military Overview” (CIMIC Fusion Centre NATO/Civilian) and “Harmonieweb.org” (US). However, civilian organizations have made it clear that they are reluctant to use those sites if they are not fully open. Therefore, preferably, NATO needs to support Lessons Learned and information sharing initiatives by interacting on well established sites such the “reliefweb” / “onerespouse.info” or develop platforms in conjunction with civilian stakeholders.
- The area of disease surveillance and the reaction on epidemiological outbreaks has proven to be a good example in the interaction/cooperation between civilian and military. The collection and sharing of epidemiological data (between CSTC-A and Afghan MoPH) and the joint civil-military Quick Reaction Team of the WHO are considered as best practise. However the development of NATO’s new Disease Surveillance System could and should be expanded towards international civilian organizations such as WHO, centres for disease control (US/Europe) and national systems to share such information on web based networks.

Nevertheless persistent gaps remain such as:

- Little sharing of lessons among NATO, troop contributing nations and civilian organizations. Lack of any civil-military lesson learned mechanism.
- Insufficient communication of what the population of the hosting country can expect from NATO's medical capability. Specifically, the HA and R&D commitment requires visible and openly accountable activities in order to avoid disappointments by the population which could have an impact on the perception about the presence of NATO troops in theatre. At the tactical level, patients with unrealistic hopes of treatment by military personnel will go away disappointed, creating a larger negative impact if their expectations were not met by the military.
- NATO is using technical language and definitions which are sometimes defined and perceived differently by civilian counterparts. The use of the term “Humanitarian Assistance” in military missions and objectives is in contrast to the military role, which is per se not as a HA actor despite supporting humanitarian activities.
- A lack of awareness in civilian organizations about military hierarchy and responsibilities. With the different missions ISAF/OEF and different structures within ISAF (HQ, IJC, RC, Task Forces), PRTs and CSTC-A, it is not easy for civilians to find the right military counterpart. For example the lack of understanding of the military structure and system in Afghanistan led some civilian organizations to regard the PRTs as their main military counterpart in Afghanistan, rather than anyone at HQ ISAF.

### Conclusions

Information management and communication are crucial to ensuring transparency and earning trust from the public and civilian organizations.

There are a number of areas in which the civilian and military actors can routinely share information regarding medical HA and R&D. Particularly, medical HA and R&D efforts would benefit from military and civilians openly sharing lessons learned and disease surveillance data.

NATO needs to ensure it uses common language and has a common understanding of widely used humanitarian definitions and terminologies.

### Recommendations

NATO should communicate mission deliverables and expectations, in order to avoid disappointment on the part of the host nation and its population. NATO should make its HA and R&D commitment visible and openly accountable.

A universal HA and R&D lessons learned sharing tool which allows promoting best practice and avoiding repeating mistakes should be created.

Civil-military information sharing systems should be developed at country and regional level which do not compromise the security of civilian agencies.

NATO's new Disease Surveillance System could and should expand links towards international civilian organizations such as WHO, CDC, ECDC, national systems and share this information on web-based networks.

NATO should avoid using the same terms used by civilian when the definitions is military oriented. NATO should harmonize language used in civil-military relevant (policy) documents with the UN CIMIC, UN OCHA and IASC terminology.

## **LLDb Item # 1060**

### **Military Medical HA and R&D Expertise and Training**

#### Observation

There is a lack of military medical experts and expertise to support medical HA and R&D projects

#### Discussion

The key remit of military medical support in HA and R&D is staff capacity building within the ministry of public health or regional governmental level and the local military medical service, which requires sound background in public health, social science and preventative medicine in developing countries.

The military medical professional background and expertise of most of medical staff deployed for medical R&D does not translate to the necessary education for HA and R&D. Many also lack understanding of the complex relationship with and among humanitarian agencies in complex emergencies. Their lack of cultural awareness and lack of sensitivity to feedback concerning people's perception of their actions also has an impact on their ability to provide coherent and long-term oriented medical R&D advice and strategy.

UN OCHA and Oxfam have offered to train the military in humanitarian principles. Additionally, exercises such as the STEADFAST series and experiments such as the Multinational Experiment series can support the development of expertise for a comprehensive approach to restore the medical sector in areas of conflict.

#### Conclusion

Most military medical staff do not have the necessary education, professional background, and expertise for ongoing medical HA or R&D. The most significant shortcoming is the fact that there is a lack of understanding on the part of the military of the complex relationship with and among humanitarian agencies in complex emergencies.

#### Recommendation

NATO and the Nations should develop a cadre of military personnel with humanitarian experience and education for employment in medical HA and R&D posts by:

- Developing minimum education/professional requirements for medical HA and R&D personnel.
- Developing training programmes that prepare military medical personnel in skills relevant to peace building.
- Developing specific pre-deployment civil-military medical HA and R&D courses open to both NATO and IO/NGO attendees. Examples are courses offered by the Center for Stabilization and Reconstruction Studies (CSRS) at the Naval Postgraduate School, Monterey, California or the bi-national Military Medical Support in the Humanitarian Arena Course in Germany and Netherlands.
- Formally developing and testing the concepts discussed in this paper in the JWC exercise programme, along similar lines to those employed for the DJSE concept.
- Accepting IO/NGO offers (e.g. from UN OCHA, OXFAM) to build awareness of humanitarian principles within NATO.
- Offering NATO R&D personnel the option to collect experiences as a “volunteer” in a humanitarian organization.
- Creating exercise scenarios to be included in the STEADFAST series where the interaction with UN OCHA and WHO Health Cluster would play a prominent role. (JWC and ACO responsibility).
- Prioritizing recruitment of medical personnel with R&D and strategic global health expertise.

### **LLDb Item # 1061**

#### **Military Medicine – Moral Need to Act versus Hearts and Minds**

##### Observation

Heart & Minds and MEDCAP campaigns serve military objectives which might be in contrast to the principles of delivering humanitarian aid.

##### Discussion

There is a moral need to act, to use military medical capability when means and capabilities are available, to initiate relief activities as necessary. Health professionals within the military and civilian organizations share common ethical values and principles, which ease civil-military interaction and understanding.

However, recently, more and more nations perceive medical care as a generally non-controversial and cost-effective means to be used by the military to support national or global interests. However, the use of military medical for R&D is very controversial among civilian organizations. Specifically the provision of direct medical assistance to a local population by uniformed and probably armed health personnel is causing the main concern.

MEDCAP were used in NATO theatres to provide medical support by military personnel to the local population as a commander's tool to win heart and minds. Their use might go beyond serving purely local health needs. Some military medics complained about the misuse of the originally “humanitarian” intention when MEDCAP was combined with an attempt to gather military intelligence.

Lessons gained in ISAF RC South concluded that MEDCAPs were neither providing lasting health care benefits to the local population nor supporting the MoPH in creating a sustainable health care system. Furthermore, MEDCAP has the potential to compete with the indigenous health care providers, with the impact to disrupt rather than

enhance local health care capabilities. SHAPE Medical Advisor has recognized MEDCAPs as ethically unacceptable and as contravening international humanitarian principles and advises against their use.

With the tendency towards militarization of health care support within military operations due to the requirements to focus towards the military campaign, military health care is at risk of losing its impartiality and fundamental humanitarian values which are bound to the Geneva Conventions and Protocols. Military medical personnel, as carrier of the Red Cross symbol, have an additional perceived moral obligation and commitment towards human rights. There might be a special role for medical officers to act as the guardian of the Geneva Conventions within military campaigns.

#### Conclusion

There is a moral obligation to provide appropriate support in the humanitarian arena which might differ from the military objective of using military medical capabilities to win people's hearts and minds. Nevertheless, NATO needs to be aware of the importance and impact of the level of public health to peace and social stability.

#### Recommendations

NATO should trigger a fundamental discussion on a specific ethos of military medical personnel and their moral obligation as carriers of the Red Cross symbol and their impact on doctrine, planning and operational campaigns.

Along with the Legal Advisor, the Medical Advisor should be empowered to act as professional moral advocate and guardian of the Geneva Conventions to (and for) the military Commander in the field.