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Civil-Military Relations in Health Crises: Literature Review and Key Recommendations

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Summary and key recommendations

Owens (2011, 2017) argues that 5 key questions lie at the core of civil-military relations:

1. Who controls the military?
2. What degree of military influence is appropriate in a given society?
3. What is the role of the military – merely to fight wars or to undertake a wider range of operations?
4. Who serves – is the military an obligation of citizenship and therefore tied closely to a society with limits on what may be asked, or a separate professional body with unlimited liability?
5. How does the structure of a society affect the efficiency of a military, including the willingness to use the military?

From reviewing the more specific literature on civil-military relations in health emergencies, this can be adapted for the purposes of developing a national Framework to the following 5 questions:

1. Who is in charge during an emergency? Are the military to support health authorities or to take charge of an emergency? And specifically what strategic and operational mechanisms are required to ensure collaboration is effective. The recommendation here is that the Framework emphasises the importance of establishing clear protocols for control of an emergency..
2. What are the coordination mechanisms enabling civil and military authorities to work effectively together? The recommendation here is that the Framework emphasises preparedness and that collaboration is tested, rather than relying on ad hoc responses once an emergency occurs
3. What is the role of the military in health emergencies – to provide support, security, what? The recommendation here is that Framework emphasises how the military can *support* rather than replace civilian health authorities.
4. Who should be covered by guidelines? Although there are a number of bodies operating to a lesser extent as quasi-military forces - including

civil defence forces, national guard, genadremerie and private security companies the recommendation here is that the Framework focus on armed services alone.

5. To what extent is context a variable or are there constant principles? The recommendation here is that the Framework recognizes national differences but that broad guidelines can be generated.

INTRODUCTION

This critical review of the literature is designed to support the WHO's development of guidelines for civil-military relations in health emergencies – a National Framework. It examined almost 100 documents on civil-military relations in the policy, academic and 'grey' literatures, falling into five categories:

1. The general literature on, and historic approaches to, civil-military relations.
2. Relevant international guidelines.
3. National policy statements on civil-military relations in health emergencies.
4. Reports and position papers from NGOs.
5. Refereed articles in academic and professional journals.

Despite the extensive literature on civil-military relations in general, there is comparatively little literature on civil-military relations in public health emergencies. At the heart of the literature is a tension between seeing militaries as possessing useful capacity and capabilities which can be harnessed in an emergency, and the risks involved in collaboration because militaries have different mandates to civilian authorities and may be perceived differently by communities.

This tension is seen most clearly in the distinct difference in the attitude the literature on cooperation during natural disasters compared to humanitarian crises. Key to the humanitarian literature is the preservation of humanitarian space through the principles of humanity, neutrality and impartiality. For this reason, international guidelines and NGO policy statements in particular tend to emphasise the use of militaries as a last resort. However, the literature on responses to natural disasters reveals a much greater willingness at a national level to use militaries at an early stage, often acting as first responders rather than last. This second literature emphasises the capacity and special capabilities of the military, while the expectation that such emergencies will be of comparatively short duration minimizes the risk to civilian authority posed by

the military's involvement. Although the growing number of national plans for public health emergencies frequently identify the need for multi-sectoral cooperation , collaboration with the military is rarely explicitly mentioned. Rather the emphasis appears to be on working with other civilian departments such as transport and interior. There is also some recognition that, during an epidemic, the military would prioritise preserving its own combat effectiveness and that, as a result, it might have little spare capacity to assist civilian authorities.

In addition to this underpinning theme in the literature, the more pragmatic issue of how effective cooperation might be achieved is also frequently addressed. The focus here is tends to be on the mechanisms for coordinating activities, and range from the question of when decisions might require the input of political leadership, to the merits of different forms of coordination, to who should have leadership responsibility and in what areas. The majority of the literature tends to agree that civilian public health authorities should retain a leadership role in a public health emergency, but that where the military have a special competence (for example in search and rescue) then they should have leadership there, and that political oversight should be strategic rather than operational. However, the precise *form* of cooperation varies according to national preference.

1. Civil-Military Relations

The literature on civil-military relations is extensive in scope, draws from a variety of academic disciplines (particularly in the social sciences), is theoretically informed, and empirically rich with both single and comparative case studies featuring prominently. At its heart is the dilemma or, in Feaver's term, *problematique* that militaries are essential to the preservation of the state, but are also potential threats to that state (Feaver, 1996). More recently, Owens (2011, 2017) has elaborated this dilemma into 5 key questions, which are at the heart of the literature:

1. Who controls the military?
2. What degree of military influence is appropriate in a given society?
3. What is the role of the military – merely to fight wars or to undertake a wider range of operations?
4. Who serves – is the military an obligation of citizenship and therefore tied closely to a society with limits on what may be asked, or a separate professional body with unlimited liability?
5. How does the structure of a society affect the efficiency of a military, including the willingness to use the military?

Thinking about this problem can be dated back several centuries: the Roman poet Juvenal's question of 'who guards the guardians?', and Plato's somewhat optimistic assessment of the trustworthiness of leaders in *The Republic* are often cited as examples from Western classical times. More significantly perhaps, the nineteenth century Prussian military strategist Carl von Clausewitz (1989 [1832]), articulated the distinction between civilian and military and placed it at the heart of his influential theory of war. This 'separation' theory remains hugely important, if not uncontroversial, even today (Schiff, 2009). Contemporary thinking about civil-military relations, however, finds its foundational texts in the work of US-based academics during the Cold War. Although Desch (1999; see also Feaver, 2017) argues that there have been a number of 'waves' of scholarship since then, as Owens (2017) comments, the two main approaches articulated by Huntington and Janowitz – an 'institutional' vs 'sociological' approach – have dominated subsequent thinking.

The first foundational text was Samuel Huntington's *The Soldier and the State* (1957). A political scientist by training, Huntington was concerned over the effect liberalism and peace would have on American military preparedness at a time of 'cold' war when preparedness was still required. His 'institutional' theory identified two main imperatives that shape civil-military relations: the external threat faced by a state (the functional imperative); and the ideology and legal frameworks of a state (the societal imperative). This leads Huntington to prescribe a bargain: that the military be allowed its independence in military matters, but that it serves the political priorities of the legitimate civilian authority in the state. If civilian authorities interfere in military decision-making, this would undermine the military's professionalism; while military interference in policy-making undermines democratic processes. Crucially, Huntington identifies professionalism as being the key to effective control of the military, rather than legal or institutional means of control.

Huntington's work was later, usefully developed by Feaver (2003; Owens 2017), who used principal-agent theory to analyse post-Cold War civil-military relations in the US. Derived from economics, principal-agent theory discusses power relations when one party (the principal) sub-contracts work to another (the agent). The resultant relationship is one characterized by negotiation, where the principal monitors actions and provides rewards, while the agent possesses resources (including specialist information) that the principal desires access to. Moreover, whereas Huntington offers a binary distinction between 'objective' and 'subjective' control dependent whether civilian authorities interfere or not in the military, Feaver uses his empirical work to expand this into a framework:

Intrusive civilian monitoring; military works.	Intrusive civilian monitoring; military shirks.
Un-intrusive civilian monitoring; military works.	Un-intrusive civilian monitoring; military shirks.

In contrast to Huntington's clear and fixed distinction between civilian and military sectors, the sociologist Morris Janowitz (1960) argued that relations were subject to change according to context. For Janowitz, the context of the Cold War had required civilians to become involved in military decisions, and militaries in political. In particular, nuclear weapons had made major war unlikely, with the result that militaries would become increasingly involved in more limited, 'constabulary' actions requiring greater and direct civilian oversight. Thus Janowitz rejected Huntington's idea of a bargain between civilian authorities and the military, arguing instead that civilian authorities should become involved in questions of *how* militaries act as well as *when* they should act.

2. International Guidelines

The most important international guidelines are those produced by the UN and its agencies and largely relate to foreign military involvement in humanitarian emergencies, rather than national responses to health emergencies. The key focus therefore is on humanitarian organisations and how the military might assist their work, rather than on health authorities. Despite their wider and international focus, these documents provide an important context to, and establish principles that inform, discussions on military involvement in health emergencies. The key documents are also clearly a product of the changed international environment after the end of the Cold War, when the restrictions imposed by a bipolar world order were lifted. Instead of superpower rivalry, the dominant narrative of globalization created a sense of mutual interest and shared humanity (Wheeler, 2002). This was reflected most clearly in the UN's 2005 'Responsibility to Protect' agenda (Bellamy, 2009), but also in a range of statements from world leaders articulating their wider responsibilities to help those in need.

As Boland et al (2018) comment, the proliferation of international guidelines on humanitarian emergencies is 'driven by the need to preserve "humanitarian" space and the essentially civilian nature of humanitarian responses, but it is also intended to provide cohesion and enhance effectiveness

and coverage'. Preeminent amongst these international guidelines is UN OCHA's revised 2007 *Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief* (OCHA, 2007). Originally agreed in 1994, these are usually referred to as the 'Oslo Guidelines'. Of particular significance is that the Oslo Guidelines identify core principles and concepts for the use of militaries in civil emergencies. Key amongst these are humanity, neutrality and impartiality:

> As per UN General Assembly Resolution 46/182 humanitarian assistance must be provided in accordance with the principles of humanity, neutrality and impartiality.
>
> - 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.
> - Neutrality: Humanitarian assistance must be provided without engaging in hostilities or taking sides in controversies of a political, religious or ideological nature.
> - 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.
>
> Source: OCHA (2007), para 20.

The Oslo Guidelines emphasise that military assistance should be a last resort, complementary to existing relief mechanisms and that assistance should not become dependent on military involvement. The Guidelines are also clear on civilian primacy:

> A UN humanitarian operation using military assets must retain its civilian nature and character. While MCDA may remain under military control, the operation as a whole must remain under the overall authority and control of the responsible humanitarian organization. This does not infer any civilian command and control status over military

assets. (OCHA, 2007, para 32 iii).

Similarly 'Humanitarian work should be performed by humanitarian organizations. Insofar as military organizations have a role to play in supporting humanitarian work, it should, to the extent possible, not encompass direct assistance, in order to retain a clear distinction between the normal functions and roles of humanitarian and military stakeholders' (OCHA, 2007: para 32 iv). Finally they draw a firm line on forces involved in conflict: 'As a matter of principle, the military and civil defence assets of forces that may be perceived as belligerents or of units that find themselves actively engaged in combat in the affected country or region shall not be used to support UN humanitarian activities (OCHA, 2007: para 23).

The Oslo Guidelines informed and then reflected the 2003 (revised 2006) UN *Guidelines on the Use of Military and Civil Defence Assets to Support United Nations Humanitarian Activities in Complex Emergencies,* often referred to as the 'MCDA Guidelines' (OCHA, 2006). Like the Oslo Guidelines, these emphasise the core principles of humanity, neutrality and impartiality, that the use of military assets must be a last resort, and civilian primacy.

Similar principles – especially of civilian control and of last resort - are also apparent in the 2004 IASC Reference Paper, *Civil Military Relationship (sic) in Complex Emergencies* (IASC, 2004). Established by the UN in 1992, the IASC coordinates the activities of UN and non-UN partners in humanitarian assistance. The significance of this Paper is that it is intended to provide general principles which will then enable the development of country-specific guidelines. Where the IASC Paper perhaps differs from others however is in its clear distinction between humanitarian workers and military personnel – and especially that the military not present themselves as humanitarian workers. Rather there is a division of labor whereby the military provide security for the humanitarian actors to provide aid and assistance. Nevertheless, there is at times a cooperative tone to the document – a recognition that coordination and

dialogue are important features of any operation.

The IASC's Reference Paper was followed in 2011 by the more directly relevant Position Paper on *Civil-Military Coordination during Humanitarian Health Action* (WHO, 2011). This Paper was produced by the IASC's Global Health Cluster, under the WHO's lead. The paper begins by acknowledging that 'over the last decade, military actors have been increasingly involved in relief activities' but that this 'poses specific questions regarding the extent to which their involvement has a positive impact' (WHO, 2011: 2). In particular, it notes that 'humanitarian organizations and military forces have different mandate' which create 'fundamental differences' – between the needs of the population and political/security goals. At the core of the issue therefore is identifying a way for civilian health authorities to engage with the military which does not 'dangerously confuse' the two mandates (WHO, 2011: 2-3). To do this the paper argues that:

There is a marked difference in the requirements for civil-military coordination of responses to natural disasters that occur in a peaceful environment and those that occur in the midst of complex emergencies.

Humanitarian actions should be guided by humanitarian principles and a proper assessment of the impact and evolution of the crisis and the corresponding needs of the population.

Humanitarian actions should not be used to advance security and/or political agendas.

In complex emergencies, military forces and humanitarian actors have different agendas, strategies, tactics, mandates and accountability frameworks.

Internationally deployed military forces involved in peace operations or disaster response should provide direct or indirect health assistance to civilians only as a last resort, i.e. in the absence of any comparable civilian alternative and to meet the critical needs of the affected population.

Health services provided by military actors must be in line with the assessed needs of the affected popu- lation.

All actors – civilian and military – involved in the provision of health services should follow the national government's health priorities and plans. In complex emergencies, national health plans must be com- plemented by health information from areas that may not be under the control of the government, as well as by work plans prepared by the international humanitarian community.

Humanitarians must constantly review the evolution of the crisis and, when necessary, adapt civil- military coordination modalities to emerging conflict dynamics and new roles played by the military.

Maintaining humanitarian identity is paramount. Humanitarian actors should be aware of the perceptions of stakeholders and how different degrees of civil-military coordination may change local perceptions of their impartiality.

Source: WHO, 2011: 2-3

The Paper is also clear that different contexts require different approaches, and produces a risk assessment in terms of cooperating with the military across 4 scenarios: peacetime, peace-keeping, peace-enforcement and combat (WHO,2011: 8-9). It is worth noting that these are different *military* scenarios rather than different *social/governance* scenarios, which would add a different set of variables.

In contrast to these documents which originate in the UN system and which reflect a humanitarian orientation, NATO's *Military Policy on Civil-Military Co-operation[CIMIC]* (NATO, 2002) provides a good example of guidelines originating from the military. Yet here as well civilian primacy is emphasized for the delivery of humanitarian (including health) assistance. The document is explicit that 'The military will normally only be responsible for security related tasks' (para 11a) and will only undertake additional support tasks which have been jointly agreed between the military command and civil authorities. In 'exceptional circumstances', when the civilian authorities are absent or unable to act, then the military might take on those tasks which are usually the responsibility of the civilian authority, but even in these circumstances responsibility must be handed back as soon as possible (para 11b and c). In accessing civilian resources 'every effort' will be made to avoid a negative impact on local populations, and 'all practicable measures' will be taken to avoid compromising the neutrality and impartiality of humanitarian organisations (para 11 d and e). The document also emphasizes the importance of transparency and effective coordination to avoid tensions developing between civilian and military organisations (paras 15-19) and the role of NATO's Military Committee in providing guidance not only for operations but for training and exercises (para 20b).

This 2002 document was agreed in the aftermath of the humanitarian operations in the Balkans during the 1990s. NATO operations in Afghanistan, which began in August 2003 and finished in December 2014, saw the development of a somewhat different approach (see for example Kilcullen, 2006). During conflict and counter-insurgency operations, such as those in

Afghanistan, NATO began to emphasise a 'comprehensive approach' whereby CIMIC was incorporated into a strategies to win the battle for hearts and minds: 'Modern conflict solutions demand much more than just defeat of the military opponent. NATO believes that a comprehensive approach is the most appropriate way to answer these threats and challenges' (NATO, 2013: ix). This shift of emphasis is clearly seen in the 2013 *Allied Joint Doctrine on Civil-Military Co-operation* AJP-3.4.9:

> On one hand, military personnel at the tactical level will carry out CIMIC tasks … directly contributing to the military effort as 'boots on the ground'. On the other hand CIMIC tasks will be carried out by personnel not directly linked to CIMIC staff functions. The planning of military action demands CIMIC input, as does all other military work within and outside of the mission area. *The multiple dimensions of modern military operations are all influenced by CIMIC, as their focus is on the civil environment.* Not everything in the military is CIMIC, but CIMIC can play a key role within NATO's contribution to a comprehensive approach. CIMIC's contribution and influence has to be visibly present at all the levels of responsibility of the Alliance. (NATO, 2013: vii emphasis added)

As with the 2002 document, coordination (or 'unity of effort') is emphasized, but in somewhat different terms: 'Whilst liaison is a two-way process, *military forces* invariably have greater capacity for liaison than civil actors and as such *are normally able to take the initiative in establishing liaison mechanisms* which help to establish an effective overall unity of effort' (NATO, 2013: 0302 b(1) emphasis added). However, the doctrine also makes clear the importance of 'civilian primacy and ownership' and operating within the law, both to establish trust and transparency and also to avoid a dependency on the military by the civilian authorities (NATO, 2013: 0302 d and e). What is clear is that AJP-3.4.9 is not a humanitarian guidance document but a warfighting doctrine, where CIMIC forms part of a comprehensive approach and where the perceptions of local population shape what actions the military should undertake as part of a war winning strategy.

Reflecting on both the humanitarian and warfighting requirements, the European Commission in 2018 emphasised the importance of context in determining the form of civil-military relations:

> The changing nature of modern conflicts, natural disasters and

> crisis situations has gradually called for various forms of civil-military coordination for humanitarian operations…. Coordination can be challenging and depends on context. Each crisis is different and a case-by-case evaluation is necessary to safeguard the humanitarian space and ensure that humanitarian aid remains independent and neutral. Basic coordination strategies range from co-existence to cooperation. The former, focused on de-confliction and minimising inconsistency, is typical of conflict settings with military involved in active combat. The latter is focused on harmonising a combined response and could be adopted in natural disasters. (EC, 2018)

Although acknowledging that the military may possess unique capabilities and assets vital to humanitarian operations, the EC remained firmly wedded to UN OCHAs Guidelines, emphasising both civilian control and last resort (EC 2018).

Finally, the WHO's Guidance on *Public Health Responses to Biological and Chemical Weapons* (WHO, 2004) addresses civil-military relations in a different context again. Here, the emergency services (police, fire and EMS) are explicitly identified as first responders, and the military as having a specific but limited role in ensuring their own operational effectiveness in the face of a chemical or biological attack (WHO, 2004: 54). The Guidance encourages authorities to view such attacks as a public health emergency, and that procedures and resources should be based on (implicitly civilian) responses to other forms of public health emergencies rather than constructing a 'completely new and independent response system' (WHO, 2004: 55).

3. National Plans

This section explores a range of national (and in one instance, sub-national) plans for health emergencies, and in particular national plans for outbreaks of communicable disease, drafted across the two decades since the Millennium. This geographic and temporal range allows the identification of consistent themes and issues. It should however be noted that these are sometimes a sub-set of wider plans for national emergencies, which may cover a range of scenarios from accidents and natural disasters to terrorism. This is the case, for example, with the September 2016 Australian *Emergency Response Plan for Communicable Disease Incidents of National Significance,* which is explicitly described as a 'hazard specific sub-plan' (AHPPC, 2016: 5). The focus of this Plan is clearly on the health sector, clarifying roles and responsibilities during an outbreak. Although mention is made of the need to liaise with other sectors (e.g.

p.8), the list of other Government departments which 'may require coordinated actions' does not include the military (p.13). Responsibility for declaring an incident lies with the Health Protection Principal Committee (AHPPC) and in particular the Australian Chief Medical Officer, which also leads in decision making on levels of response and coordination.

In contrast the Italian *National Plan for Preparedness and Response to an Influenza Pandemic* (Ministero della Salute, 2011) gives the Prime Minister and Health Minister a much greater role in decision making over response levels. These responses are firmly embedded in a detailed legislative context, and include provision for surveillance, response and protection of essential services; but as with the Australian Plan, this Plan is part of a wider set of regulations, in this instance the Italian Civil Protection regulations. Similar to the Australian Plan, no explicit mention is made of cooperation with the military – although there is a possible implication of military involvement through the phrase 'other interested parties' (p.27), this is far from clear. Instead, the Plan focuses on actions by the Ministry of Health and the Department of Civil Protection.

Similarly the 2005 Japanese *Pandemic Influenza Preparedness Action Plan* talks of 'sharing information with other government bodies', but does not explicitly mention the Self Defence Forces. Instead the focus is on the role of the Ministry of Health, Labour and Welfare (MHLW, 2005). This approach is shared in the Nigerian government's Lassa fever outbreak preparedness plan (Fatiregun and Isere, 2017). Nor does the 2004 New Zealand *National Health Emergency Plan: Infectious Diseases* mention the military in its 'target audience' (Ministry of Health, 2004: 1.5), while the South African *National Guidelines in Epidemic Preparedness and Response* are focused on the Department of Health, with no explicit discussion of military engagement (DoH RSA, 2009). At a more regional level, in a presentation by Dr Uma Nagpal (Manager of Communicable Disease Control for the Department of Health in KwaZulu-Natal), mention is made of the importance of coordination and therefore of liaising with 'external authorities', but no specific mention is made of the military in this context (Nagpal, no date).

In contrast, when the Ghanaian *National Preparedness and Response Plan for the Prevention and Control of Ebola Viral Disease* emphasizes the need for multi-sectoral cooperation, this is realized by representatives of the Ministry of Defence being included in the National Coordinating Committee and on the National Technical Coordinating Committee. However, these are part of a lengthy list of government Ministries to be involved, and it is not clear if these are

necessarily serving military or civilian members of the Ghanaian MoD. Moreover, the Plan clearly states that 'the [Ministry of Health] shall be the lead sector ministry responsible for establishing systems for surveillance, situation monitoring and assessment activities of the outbreak in humans' (Republic of Ghana, 2014: 25).

Although the 2011 *UK Influenza Pandemic Preparedness Strategy* also explicitly discusses the military, this is to make it clear that their priority will be to focus on maintaining operational effectiveness since military personnel would be equally vulnerable to infection. The UK Strategy is explicit that planning should not assume that the armed forces may have spare capacity to provide assistance. However, *when* civil capacity is exhausted and *if* all other options have been explored, then the Ministry of Defence *might* provide assistance but only *if* it has spare capacity to do so (DoH UK, 2011: 60, emphasis added).

4. NGO Position Papers and Reports

A variety of NGOs have produced reports or position papers on civil-military relations. These are largely from a humanitarian background and therefore address health cooperation within the context of humanitarian assistance. A good example of this is the position paper from CARE International (CARE, 2009). This paper is explicitly framed in the context of increased military involvement in humanitarian emergencies and especially 'the challenges represented by the integration of humanitarian response (sic) into an overall military and security concept' (CARE, 2009: i). For CARE, this creates a problem in that humanitarian and military organisations have 'different mandates, competencies, objectives and modus operandi, which should not be confused' (CARE, 2009: i). To address this, CARE identifies 5 organisational principles: distinction between CARE and the military to preserve the humanitarian space; the humanitarian imperative of the right to assistance for all victims of disaster; the 'overriding concern' of preserving the safety and security of CARE staff; that CARE act impartially; and that appropriate consultation and communication be established with the military (CARE, 2009: 2-3). The latter point is of especial interest and is developed (pp.3-4) into three 'levels of civil-military interaction': content analysis and preparedness planning; dialogue; and coordination and cooperation. What is clear from this is CARE's concern that operating alongside the military may compromise its humanitarian principles and that safeguards need to be in place to prevent this from happening. The hallmark of its position therefore is that of distancing itself from the military whilst keeping channels of

communication open.

VENRO's 2003 position paper on civil-military cooperation in humanitarian aid also notes the increased involvement of the military in delivering humanitarian assistance, and that they 'have different tasks and mandates and are guided by different goals, interests and approaches' (VENRO, 2003: 18). It responds by emphasizing the principles of humanitarianism, neutrality and impartiality for NGOs and by introducing the principle of subsidiarity – that 'armed forces can render humanitarian aid on a subsidiary basis' (VENRO, 2003: 4-5, 15-16 and 18). Similarly the ICRC notes the increased involvement of militaries in humanitarian operations, but argues somewhat pragmatically that, because this is a recurrent feature of humanitarian crises, developments that enable effective cooperation and coordination should be welcomed (Studer, 2001: 367). Nevertheless, distancing is again advocated – 'if the dividing line between humanitarian and military action is blurred, the very concept of humanitarian action… risks being undermined' (Studer, 2001: 367). As a result it recommends a form of distanced cooperation which it sums up as to 'do better, separately' (Studer, 2001: 380). In particular, it notes (perhaps presciently, given subsequent developments in Iraq and Afghanistan) 'the danger of humanitarian efforts becoming integrated into a political process and thereby themselves becoming politicized' (p.372). It therefore argues against armed escorts in hostile situations lest the ICRC be perceived as allied with the escorts rather than neutral and impartial (Studer, 2001: 381). The ICRC concludes that 'the greatest contribution that the military can make to humanitarian action is to restore order and security', thereby enabling humanitarian actions to take place.

The ICRC's pragmatism is reflected in CARITAS Internationalis' position that 'the issue… is not whether Caritas agencies should relate to military actors at all, but rather to establish what the appropriate relationship should be, and where the boundaries should lie' (CARITAS, 2006: 3). Reiterating the observation made by others that there has been a 'marked increase' (p.3) in the involvement of military forces in humanitarian operations, CARITAS argues that 'a basic principle is that the humanitarian actor must maintain the lead role for humanitarian action in any situation' (CARITAS: 2006: 8). In terms of operational principles, CARITAS emulates the ICRC's position of distancing itself from the military and that it should use armed escorts only as a last resort and in exceptional circumstances (CARITAS: 2006: 10-12).

5. Academic and Professional Literature

Although the general academic literature on civil-military relations is large, that specifically focusing on the health dimension is much less substantial and does not feature prominently in the major debates on civil-military relations (see for example Bruneau and Matei, 2012). Similarly, although there is some professional literature from both the public health and military sectors, this is equally limited in scale. Nevertheless, both the academic and professional literature is clearly developing, with a largely empirical focus often linked to policy prescriptions. A notable exception is the work of Kamradt-Scott and Smith (2018), which through comparative analysis attempts to provide some more generalizable conclusions. This aside, the (often implicit) theoretical foundations for the literature are drawn from elsewhere, especially the more general literature on civil-military relations, military science or medical ethics, rather than developing a specific theory for military assistance in health emergencies

The academic and professional literature generally – though not exclusively - falls into three categories: that focusing on civil-military relations in natural disasters, that focusing on disease control and outbreaks, and that focusing on the military providing health assistance during conflicts. Of these, the latter is perhaps the least significant for this review, since its concern is less on civil-military relations than on how health assistance has been or can be used to support a strategic/political strategy in conflict (Kauver and Drury, 2012; McInnes and Rushton, 2014; Thompson, 2008; Wilensky, 2004).

The literature on civil-military relations during natural disasters is however more directly relevant. As a number of commentators (e.g. Desch, 1996; Goodman, 1996) note, national military involvement in responding to natural disasters is much less controversial than in other areas. This is partly because of the limited time scale, which means that the military's involvement is of relatively short duration and therefore not threatening to the civil order. Indeed, rather than being problematic, Goodman argues that military involvement can be instrumental in improving civil-military relations, provided it does not replace civilian actors, lead to excessive institutional prestige for military or take the military away from its core mission.

Illustrative examples of empirical research on civil-military relations in natural disasters are Madiwale and Virk's (2011) work on the 2010 floods in Pakistan, and Hall and Cular's (2010) work on the 2006 mudslide in the Philippines. Madiwale and Virk note the 'significant operational and co-ordination role' (p.1085) played by the Pakistani military in 2010, not least as first responders,

and how this fits into a broader pattern with regard to natural disasters - both inside Pakistan and elsewhere. Although noting the potential for political and security concerns to override humanitarian, they are nevertheless broadly supportive of the actions taken by the Pakistani military during the floods. In particular they note the capacity and experience of the military in being able to deal promptly with the emergency, and that this prevented greater loss of life. In contrast, civilian aid agencies 'faced significant challenges in scaling up their operations… [and] tended to be concentrated in larger towns and areas' (p.1094). Nevertheless, difficulties were faced over different understandings of the crisis particularly over whether this was a natural disaster or 'complex emergency') and over effective guidance for civil-military relations (though this was mainly in the form of possessing a nuanced understanding of the issues rather than being ignorant of international guidelines). Overall, Madiwale and Virk suggest that the military and civilian agencies should play complementary roles: that the military serve as first responders, using their specialized assets to evacuate the vulnerable and distribute relief to isolated populations; while civilian aid agencies use their specialized knowledge and access to international networks to prevent a humanitarian catastrophe, minimize hunger and reduce the risk of disease outbreaks (p.1095).

Similarly, Hall and Cular (2010) identify the military as playing a central and early role in responding to the 2006 mudslides in southern Leyte. A distinctive feature of this response was that military and civilian sectors attempted to coordinate their responses, rather than one being in overall control, as outlined in national emergency plans. Sectors would take the lead only when they had obviously superior capabilities - for example, the military possessed superior capabilities in terms of search and rescue operations and in transport. What was also apparent however was that these 'superior capabilities' were not exclusive to the military - some civilian agencies also had specialized or niche capabilities where they could take the lead. Despite the degree of 'institutional maturity' and 'fairly developed standard operating procedures' (Hall and Cular, 2010: 82) in the Philippines, difficulties were still experienced not least because this level of expertise in coordinated operations was not shared across all responding agencies. Finally, the 2006 mudslide, like the 2010 floods in Pakistan, also involved external military actors, which although providing additional capacity further complicated the response both politically and operationally.

The most directly relevant literature however is that on disease prevention and control. Hui Ma and colleagues, for example, detail the manner in which

China's civilian and military cooperation has 'successfully prevented numerous severe epidemic situations' (Hui Ma et al, 2016: 1). Their work emphasizes: tight operational-level collaboration based on joint working mechanisms, both between departments and across multiple sub-areas – from epidemic data-sharing to joint disposal; how practices have become normalized as well as institutionalized; how information is shared directly and regularly; and how specialized teams have been incorporated into national planning, including for emergency rescue and NCBR response. This joint working mechanism approach is described as 'each department is responsible for itself, coordinates with the other departments, and jointly implements the prevention measures under central unified leadership' (Hui Ma et al, 2016: 2).

While Hui Ma and colleagues focus on plans, other work examines responses to disease outbreaks, specifically the 2014-16 West African Ebola outbreak and the 2015-17 outbreak of Zika in Latin America (and especially in Brazil). On Ebola, perhaps the most significant work is that of Kamradt-Scott, Harman, Wenham and Smith (2015, 2016). Although they are broadly positive about the military's 'helpful' role, neither are they above raising concerns. In particular, they note that 'the involvement of military personnel in such pursuits remains controversial and raises questions about their effects on humanitarian principles, personnel and practices' (2016: 105). They especially note the manner in which the lines between a public health emergency and a humanitarian crisis was 'blurred' during the Ebola outbreak, which meant that established humanitarian systems and practices were sometimes overlooked in favour of novel, ad hoc and untested solutions. Although the deployment of foreign militaries from September 2014 on reassured rather than deterred a number of NGOs, and the attitude of the military - 'open, engaging and keen to learn' (2016: 104) – assisted in developing positive civil-military relations, nevertheless, the crisis revealed inconsistent practices amongst the deployed militaries and the lack of an agreed framework for action.

Whereas Kamradt-Scott and colleagues do not question the humanitarian motivation of deploying military forces to West Africa during the Ebola crisis, Pinheiro de Oliveira's (2016) critical analysis of Brazil's use of its military during the Zika outbreak suggests the possibility for more complex motivations:

> By deploying the Armed Forces to combat the virus, Brazil had the opportunity to practice domestic militarized humanitarianism, to build strong civil-military relations and improve the Armed Forces reputation, especially after the

> contradictory success of the "pacification" of Rio's *favelas* by the military. (Pinheiro de Oliveira, 2016: 92)

The overt militarization of Brazil's response was, for Pinheiro de Oliveira, a form of biopolitics; that is, a means by which the state could demonstrate its concern for its people and thereby generate a 'useful and docile citizenry'. Although the role of the army was well-received, its use was performative – that is, for an internal political purpose of establishing the reputation of the armed forces and of the idea of the 'good soldier' (Pinheiro de Oliveira, 2016). Nevertheless, the majority of academic research on the issue offers qualified support for greater collaboration, generally identifying the additional capacity and rapid deployment to dangerous situations which the military can offer, while also noting risks to the humanitarian space and the need for effective coordination mechanisms (Snyder, 2016).

Although most texts focus on disease outbreaks, offering empirical accounts of what happened perhaps accompanied by some policy prescriptions, a rather different discussion is provided by Ratto-Kim and colleagues (Ratto-Kim et al., 2018). This discusses how the US military have been at the forefront of vaccine development to ensure the combat readiness of their forces worldwide. US military involvement includes historic work on diseases such as small pox and yellow fever, as well as ongoing work on diseases such as malaria, zika, HIV and dengue. Recent risks over bio-terrorism have also led to research on vaccines against agents such as anthrax. Although the work is focused on what the military considers it might need for its forces to remain effective when deployed, the spillover effects into civilian use are obvious, as well as the capacity represented by this R&D resource for identifying and developing responses to novel disease outbreaks.

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