Civil-Military Relations: A Focus on Health Emergencies and Epidemics

NGO-Military Contact Group Conference, 17 July 2018

Conference Report

Background

The **NGO-Military Contact Group (NMCG)** was established in 2000 and is chaired by the British Red Cross as a neutral convener. The NMCG brings representatives from across the British government, including the Department for International Development (DFID), the Ministry of Defence (MoD) and the Foreign & Commonwealth Office (FCO), together with the International Red Cross and Red Crescent Movement, humanitarian non-government organisations (NGOs), and academic and research experts to discuss civil-military relations.

"The NMCG is a space for frank and open discussions about operations and policies, with the ultimate goal of improving humanitarian outcomes for people caught in crises. It is not an advocacy platform, but it is hoped that its members will be able to take the discussions back to their organisations and make efforts based on new information that will improve humanitarian outcomes."[1]

The **NMCG meetings** take place three times per year and focus on civil-military relations at an operational level.

The **NMCG conference** is held every two/three years, building on the success of the triannual NMCG meetings, and serve as a high-level neutral platform for discussions on civil-military relationships with thought leaders, humanitarian practitioners and those working in crisis response from a range of sectors. It focuses on a strategic-level theme and seeks to review successes, challenges, and opportunities in civil-military relations, with the ultimate aim of improving policy, preparedness, and coordination in humanitarian responses for people affected by crisis.

The objective of the 2018 conference was to contribute meaningfully to the current global conversation on civil-military relations around global health emergencies and epidemics, from preparedness to response, with a view to achieving the best possible humanitarian outcomes.

Co-hosts

The **British Red Cross** is one of 191 National Societies within the International Red Cross and Red Crescent Movement, the world's largest humanitarian network. The British Red Cross has a permanent status as an auxiliary to the UK public authorities (including DFID) in the humanitarian field. It assumed the role of Chair of the NMCG in 2006 as an independent and neutral convener.

Chatham House, the Royal Institute of International Affairs, is an independent policy institute based in London. Each year, it runs more than 300 private and public events – conferences, workshops and roundtables – in London and internationally with partners.

Note on Conference Report

The Conference was held under the **Chatham House Rule,** which states: *"participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed."[2]* Therefore neither the identity nor the affiliation of the speakers or participants are referenced in this report.

To ensure that this report reflects the range and depth of knowledge shared during the Conference while remaining short and user-friendly, the authors have looked to reduce duplication between sessions and

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[1] Excerpt from the Terms of Reference of the NGO Military Contact Group
[2] https://www.chathamhouse.org/chatham-house-rule

speakers. Many themes emerge as cross-cutting across different sessions and, where this is the case, the key areas have been reflected in detail within the first session within which they occurred, rather than on a session-by-session basis.

The views and opinions expressed in this report are those of the speakers and do not necessarily reflect the official policy or position of either the British Red Cross or Chatham House.

Epidemic trends in today's world: epidemiological and geo-political scenarios

Over the past 25 years, there have been many changes in relation to responding to outbreaks of epidemics. The numbers of actors responding to epidemics has increased, especially after the 2014 West African Ebola outbreaks; there has been greater recognition of the capacity of local responders; and there have been major technological advances which have changed how data are gathered and communicated. All of this is against the backdrop of increasingly complex humanitarian disasters. It is important to understand how these changes affect the way civilian and military actors work together to respond to epidemics and public health emergencies. Global health security comprises two aspects that are important in discussing epidemics in relation to civil military relations. One is *individual health security,* which concerns a person's ability to access health products and services (including during epidemics and other crises) and the second is *collective health security,* which involves protecting societies from disease threats that cross national borders. The latter is often the type of security that industrialized countries want, in order to keep diseases away or respond to them rapidly when they occur.

An *epidemic* occurs when the number of infections in a defined community or region is higher than the expected normal. When new diseases emerge and surveillance systems are poor, it is often difficult to anticipate next steps or have an understanding of the number of infections. A *pandemic* is an epidemic that has spread across much of the world. A *public health emergency,* which can also be a humanitarian crisis, is the occurrence or imminent threat of widespread damage from many diseases or a single disease caused by bioterrorism, an epidemic or a pandemic, or a new and highly deadly infectious disease that poses a significant risk of widespread illness or death. A *public health emergency of international concern* adds the risk of spreading internationally and the likelihood that immediate international coordination and action is needed.

Today, epidemics can be caused by familiar pathogens – cholera, measles, dengue, yellow fever – or by new organisms or those that are new to us, but not necessarily new in the world, such as MERS coronavirus, or Nipah virus. Some pathogens can also change, spontaneously adapting to become more or less debilitating, deadly or transmissible, while others develop resistance to medicines, making it harder to control their spread. Also, symptoms such as fever, body pain, and headaches are common to many diseases, which makes it challenging for healthcare providers in the early stages of an outbreak to distinguish between different diseases with vastly different implications (e.g., Ebola vs malaria) quickly enough to optimize control.

The frequency of epidemics, and the number of emerging pathogens, appear to be increasing – however it is questionable whether this reflects a true increase or an improvement in surveillance. This is not only in urban environments, but also in remote rural areas where outbreaks may have occurred before but gone unrecorded.

Around 70% of new infectious diseases are zoonoses, where pathogens periodically cross the species barrier from their usual animal hosts to humans. Drivers of zoonoses include urbanisation, population growth, encroachment on animal habitats, and changes in land use that bring humans into closer contact with animals carrying pathogens that don't make them sick but make humans ill. Some such pathogens

can become established in the human population after crossing the species barrier, HIV being a notable example.

The migration of people and animals, as well as routine international travel, are also important. For instance, meningitis, and later MERS, has spread through mass migration events such as the Haj pilgrimage. Today there is an increasing movement of people; world trade has increased by five-fold since 1950 and 2 billion people cross an international border every day. The key is exposure – mixed populations travel from different backgrounds with different exposures, different immune states and different levels of vaccination coverage. People can also carry diseases and often move to and from areas with limited health care and poor housing.

Despite poverty decreasing globally, in some areas, particularly in sub-Saharan Africa, poverty is increasing or stable. Half of the mortality in these countries is from infectious diseases, particularly amongst the most vulnerable. If public health systems have broken down, the re-emergence of diseases that were previously controlled is likely.

Urbanisation and poverty are often linked, and this combination is increasingly an issue, particularly in Africa. Meanwhile, climate and environmental changes can also affect vector-borne diseases.

The financial and human cost of an outbreak can be staggering, and early response reduces the cost. The financial costs are two-fold: the costs to fight an outbreak and the loss to the national, and sometimes global, economy. Additionally, social disruption can arise when fear and distrust dominate in an emergency situation.

Visions of international response to crises

One speaker outlined four perspectives on international intervention in response to health and humanitarian emergencies. Ideally the need to respond should drive the decision to respond. However, in reality responses often reflect the political imperatives of the day as much as any normative values, and there is a lack of consensus in the international community on when and why it should respond.

The first perspective is driven by self-interest and represents the much broader, deeper disquiet of disaffected populations towards globalisation and neoliberal capitalism. From this, the view on humanitarian interventions leans towards: "We can but we won't."

The second vision views globalisation as something of mutual benefit – humanitarian but principally economic. It is informed by a notion of macro-economic growth: that healthy people lead to healthy economies and so investing in health is not only good humanitarianism, but good economics as well. Therefore, the perspective is: "We probably can and probably should" intervene. This ethos has dominated aid policies for at least two decades. However, it is in danger of collapsing if the first perspective remains and could mean that in the future aid will not be simply for humanitarianism and macroeconomic growth, but for the purpose of national security.

The third vision is that of a multipolar world that is not dominated by the West, but driven by a number of powers. It is encapsulated by the attitude: "Perhaps and increasingly we will act, but on our own terms."

Finally, there is the perspective of a regional power that, above global aspirations, will protect its regional interests: "If we will intervene, we will do it locally for our interests in the region."

This lack of a dominant narrative has led to what the Italian Marxist philosopher Antonio Gramsci calls morbid symptoms, the speaker said, where people do odd things without understanding why, based on a feeling that one should. Given that there are almost 200 million people who are in need of humanitarian assistance today, what is needed to better respond? Do we need to take a holistic view of intersecting global megatrends, urbanisation, and climate change?

From a civil-military perspective, there are a range of operational, strategic, conceptual and ethical issues that come up in pandemic response, such as deconfliction, the negotiation of the humanitarian principles and how to bridge cultures and languages. Below is a summary of discussion of some of the gaps and other challenges civil-military relations are facing today in responding to epidemics, pandemics and other rapid-onset health emergencies.

Challenges

Several challenges were discussed. Firstly, there is a major gap in appropriate civil-military coordination, foundational dialogue, and guidance for effective engagement. The World Humanitarian Summit global forum on civil-military coordination highlighted the need for coordination as part of a pandemic response to involve a robust forward needs assessment process, a structured coordinated preparedness phase to avoid ad-hoc deployment arrangements, and dedicated joint training exercises between stakeholders including INGOs, governments, and the military.

The World Health Organization (WHO) has traditionally led health coordination but organisationally it is at a crossroads with the need to regain and retain the faith and funding that has traditionally been placed in it. The West African Ebola crisis was a sea-change event that brought a lot of new partners and created challenges around who and how to organise a multi-country, multi-stakeholder response to an outbreak.

Collaboration and coordination between civilian and military actors has always been a challenge, especially as the two sectors don't always have the established mechanisms for coordination. There have been some steps forward. For example, while most military lack dedicated doctrine on roles in pandemics and rapid-onset health emergencies, since 2016, a number of countries, including the US, the UK, and Germany, make overt references to pandemics in their national military strategies.

Secondly, there is a major gap in knowledge and data on the dynamics and good practices for effective humanitarian civil-military coordination. In particular, there is a need for more varied context-specific case studies that can inform more simulation and response scenarios. There is also a need to better understand what military capabilities can be offered in the event of an outbreak; when and under what conditions these contributions can and should be made; and, critically, how the principle of "last resort" for the use of military assets should be realised. In a response at international scale, the principle of last resort can be upheld even when military support is within the first response.

There is also a need for investment in the surveillance of diseases, their conditions, and changes, in order to reduce the impact as well as to monitor the actual impact. This includes training people from communities to know about the diseases in their area, and sensitising the community in advance so that large outbreaks do not occur. Also needed are better ways to predict outbreaks, supported by the International Health Regulations (IHR); better diagnostic tools and an increased emphasis on research in advance of the outbreak.

There are gaps in how critical health surveillance data are shared between military surveillance systems and humanitarian and/or civilian organisations. During the 2014-2015 Ebola outbreak in Liberia, the US Department of Defence and the US Centers for Disease Control and Prevention (CDC) did not share their

data, setting a bad precedent. Generally, on the military side, there is a willingness to share data; the challenge is sharing the data-collection assets. While there are acknowledged sensitivities and ethical issues on data sharing within the intersection of the military and humanitarian sectors, including the need for humanitarian impartiality, data security and privacy, and the confidentiality of beneficiary data, the sharing of such data could be tremendously valuable. Additionally, there is a willingness to share military research, e.g., into epidemiological trends, predictive analytics and forecasting, and development of vaccines - but the architecture to facilitate this is lacking.

Thirdly, rapid-onset health emergencies have the potential to challenge some of the more comfortable conceptual silos – the conversation is often restricted to epidemics within natural disaster response contexts, despite the fact that 80% of outbreaks today occur within complex conflicts and emergencies. Therefore, it is important to remember that it is not just about the infectious disease circulating, but also all the other interrelated factors at play. Context is critical in these instances and there is a real danger of over-generalising lessons, specifically from Ebola in West Africa, to outbreaks such as the cholera epidemic in Yemen, where the international community were unable to respond due to security concerns, resulting in the deaths of 7000 people.

Fourthly, it is essential to ensure inclusivity and representation. Historically there was often an assumption that there was no local capacity and therefore epidemic responses needed to be driven from the outside. This is changing and today it is clear that working with local partners is not only is the right thing to do but it is the strategic thing to do and is a key to success. Despite this, current health security and civil-military discourses miss and/or deprioritise southern perspectives across all areas of NGOs, military, and government. This is particularly pertinent given the World Humanitarian Summit's focus on localisation. There are major bilateral and multilateral initiatives such as the Global Health Security Alliance or the United States Africa Command's (US AFRICOM's) disaster preparedness programme that are engaged with a range of African partner nations on epidemic and influenza capacity-building initiatives. Such initiatives can be greeted with scepticism by southern stakeholders, who perceive the priority of health multilateralism in the context of pandemics as being more on the transnational threats that infectious diseases pose to Western states rather than on national and regional epidemics, which are often seen as less of a priority. Perhaps the biggest gap in inclusivity and representation is the perspectives of affected community members themselves, who are at the heart of these outbreaks and yet are rarely consulted in the broader discussion on civil-military coordination, let alone in the health space.

Finally, there is the need to apply a systems theory lens to humanitarian affairs broadly and also specifically within the civil-military space. There is a lot of discussion, but not a lot of movement, towards truly integrated programming, which is the goal: when effective coordination of human resources, logistics, and knowledge enhances preparedness and strengthens the response to humanitarian crises both within the UK and internationally.

Lessons learned

Participants discussed several of the lessons learned from experiences of recent responses to epidemics and public health emergencies where civilian and military actors have worked together and determined that some areas require some further reflection, such as the legal and ethical perspectives regarding quarantine.

Quarantine

There is currently little evidence on the positive or negative impact of quarantine (the restriction of the movement of people) despite quarantine being implemented on several occasions in all three countries

worst affected by the 2014-2016 West African Ebola outbreak.

In the case of the Ebola outbreak, this quarantine covered those who had been in contact with Ebola patients. People were classed as high risk or low risk depending on the level of "contact" - low risk might be the contact of a contact. However, there were different ways of considering what "contact" is and therefore application was not consistent.

Quarantine was set at the household and/or village level; sometimes it was implemented by roadblocks or door-to-door searches, or the confiscation and destruction of goods, or coercion or arbitrarily restriction of peoples' movement. It was noted that it was called "voluntary quarantine" but that this was almost never the case; most of the time it was forced quarantine or containment, with consideration for the people outside, but very little for those inside.

Furthermore, it was proven to be potentially harmful to the control of the epidemic, as people hid and escaped quarantine and, as illustrated in Tonkolili, Sierra Leone - quarantine can cause social unrest and confrontation. It can also cause a loss of community trust and therefore can have a negative effect on the desired health-seeking behaviours. It was argued that community engagement is ultimately what leads to the end of an epidemic. However, today the traditional idea of "community" is in danger of being obsolete – now it is not simply people who live together geographically but also includes social media communities. When considering community engagement, therefore, there is a need to reflect the dialogical rhythm of how communities interact with strategies for engagement, including social media.

The sustainability of quarantining people, including the challenges of securing and resupplying enough food, as well as the unexpected and unintended consequences such as increased gender-based violence and teenage pregnancies, also need to be considered. While these consequences were unintended, they are not unexpected.

In the Democratic Republic of Congo (DRC), one lesson from West Africa that was applied was to locate the Ebola treatment centre far away from the general regional hospital in order to keep the hospital functioning as normally as possible. In the recent DRC outbreaks, a very assertive Ministry of Health (MoH) has taken full responsibility for the successes and for the failures of the response, which was applauded.

In cases where quarantine is used, there are also no, weak or little-known legal and operational frameworks to outline how the military, or others, should implement it. This hinders NGOs challenging quarantine, as there is no clear framework of accountability, as there is for, e.g., coercive medical practices. WHO is proposing the blue (national disasters), red (conflict) and green (pandemics) book approach, with guidelines on these three different contexts. It was reported that WHO is also in the process of developing a framework for civil-military cooperation in health emergencies, but that while this normative organisation is a good idea, it needs to be accelerated to an international level, crucially with military doctrine itself.

Context and framing

Civil-military relations are potentially more problematic in the context of epidemics than during other types of response. A context-specific approach is needed, in general – in a natural disaster where there is no conflict, humanitarians and military *collaborate*; in a full-blown war, they do not collaborate, but they *coordinate*, and they should always coordinate. However, in the event of an epidemic, objectives can be at odds with one another. The objective for medical humanitarians is to save lives and treat the individuals at the centre of the epidemic. The military, on the other hand, may have the objective of containing the outbreak, regardless of individual cost, for the benefit of the wider population. It was

proposed that there is a need to better understand the potential to work together in these complex cases so that the needs of people at the centre of the epidemic are adequately addressed.

How a response is framed also has the potential to affect the relationship between civilians and the military. For example, the Ebola outbreak in West Africa was framed as a global health emergency but rapidly became a medical humanitarian emergency. These are distinct but co-dependent spheres of governance, which can create confusion. While *global health responses* are state-centric and state-level mechanisms prioritise surveillance and preparedness with key actors including the MoH and WHO, the concept of neutrality here is understood as the equality of sovereign states. *Medical humanitarian responses,* on the other hand, focus at the individual level led by medical humanitarian actors such as Médecins Sans Frontières (MSF), the International Red Cross and Red Crescent Movement, and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), which respond to the needs of the people in a neutral and impartial way.

It was argued that the framing of the West African outbreak had three key consequences for the response:

Firstly, as a global health emergency there was a narrow path of dependency and the key actors were health organisations, so when WHO declared a *public health emergency of international concern* it blurred the lines of governance and WHO was seen as not delivering on its mandate.

Secondly, while domestic health systems were overwhelmed, the health framework still persisted and OCHA was not mobilised. Other health mechanisms were created to fill the gap – in this case, The UN Mission for Ebola Emergency Response (UNMEER), which took 4-6 weeks to set up. UNMEER represents a wider trend in global health of creating new institutions rather than utilising existing ones that have already been tried and tested. This approach created operational challenges through discrepancies and confusion between the UNMEER pillar approach and the established OCHA cluster approach. The UNMEER pillars of response also ignored the wider socioeconomic factors, which the OCHA cluster response mechanism would have included. UNMEER was based in Ghana and was not visible operationally – it offered no cross-country coordination; did not identify what was or was not working, or share lessons, even at the end of the mission.

Lastly, in the absence of the normal humanitarian system being mobilised, the military was turned to as the next actor. Their presence encouraged civilian organisations to stay or to return, which was reportedly difficult to achieve given the fear and uncertainty around Ebola.

Governance and capacities

The governance of the Ebola response in Sierra Leone evolved throughout the crisis. The MoH initially led the response but was quickly deemed inadequate to continue to lead the response, with poor capacity, rife with corruption and not a credible source of information. This side-lining of the MoH created challenges later related to the willingness of its leaders to cooperate - in some cases, they reportedly even undermined the response (this was in contrast with the work and dedication of MoH clinicians, who were dying in high numbers and still going to work, at the local level). Post-MoH, the Office of National Security (ONS) was also considered as a potential leader of the response, but despite having a decentralised structure and a department for disaster and risk management, was also considered unsuitable. While the actual ask was not clear, the Sierra Leoneans then invited the British government to take the lead. A *combined joint inter-agency taskforce* was set up to organise all the British actors from across government – led by DFID, with FCO and the British military deputies, the response was set up as a civilian-led and military-supported operation.

One of the structures put in place was the National Ebola Response Centre (NERC) and the Minister of Defence was placed at its helm. Many of the early staff for the NERC were provided by The Republic of Sierra Leonean Armed Forces (RSLAF), which was seen as the only institution in Sierra Leone that was able to stand up during the outbreak. It had a 14-year history of defence engagement with the British military, which had been building the capacity of the RSLAF through close mentorship. The RSLAF undertook its traditional role of security as well as staffing the NERC and all the district command centres, initially in partnership with the British. It ran Ebola centres, supplied engineering support, managed dead body disposal, and took command of a lot of the response. While the force continued to be mentored by the British throughout the response, the RSLAF was critical to its success and was universally praised for doing an incredible job.

The apparent large difference in the ability of the MOH, ONS and RSLAF to stand up was notable in light of the fact that all three institutions had benefitted from international investment and capacity-building, with the MOH and ONS being supported by civilian agencies and the RSLAF by military. It was proposed that it would be interesting to consider whether there are lessons to be learned from the approach the military takes to defence engagement and capacity-building that can be applied to the civilian sector.

There was a source of tension over whether it was a British response with a Sierra Leonean face or a Sierra Leonean response with strong British support. There were also differences in philosophy, with the Sierra Leoneans leaning towards a more authoritarian approach to public health than the British, and with the military softening the approach that it otherwise could have taken, believing that a harsher approach would probably have ended the epidemic quicker, but with significant second and third-order consequences. Over time, relationships continued to improve and become more collaborative – perhaps as personalities changed, the capacity in Sierra Leone changed, or the outbreak simply being at a different stage.

In line with OCHA's guidelines - which include civil defence assets in the wider sense, not just the military - it is valuable to reflect on the involvement of the police in the response to health emergencies. Generally, the police would be one of the institutions considered within a response. In addition, reflecting on a global move in humanitarian policy from humanitarian, to development, to peace and security, it is likely that the police will take an increasing role. That said, it remains necessary to avoid the over-securitisation of health and ensure that populations can access health services without fear of the state, police or gendarmerie, and for the health space to remain un-politicised or securitized. In the case of Sierra Leone, the police were also embedded in the NERC but they were largely side-lined whereas the RSLAF were far more respected and trusted.

While the *combined joint inter-agency taskforce* was designed to be inclusive to NGO and UN actors, it was largely separate from the wider humanitarian community. Within the NERC, there were platforms for NGOs to plug in to, but they were not well used. There were also challenges at the district level in coordinating NGOs, whose activities were often determined by their donor relationships and were not always in alignment with the District Ebola Response Centres (DERCs), or what the overall response was trying to achieve. The DERCs' approach to this was hugely varied, with some DERCs getting very tough with the NGOs and others just letting them do whatever they wanted.

Reflecting on the organisation and management of the West African Ebola response reinforces the fact that civil-military engagement is context-specific and, as such, the Ebola response should not necessarily be the blueprint for civil-military engagement in health emergencies in other contexts. However, there is a need to continue to work to overcome the uncertainty, lack of understanding, and trust between the civilian and military communities including at the community level. Misinformation can be very dangerous; an example of this was the alleged no-touch care policy of the UK government, which

although un-evidenced, was widely believed and risked creating wider disjuncture in the civilian community.

UK preparedness: what are the current capabilities and capacity?

It was argued that for a medical response in the UK and internationally, one of the first and most important things is to map the *size of the shared operating space*. This refers to how well aspects of the shared operating space are known – are the cultures and equipment compatible across sectors and to one another, has training taken place to allow an easily evaluation of what can be done, and do actors know each other and know how those relationships will work? Often there is a shared operating space, but the size of it is not known.

When mapping the size of shared operating space one needs to consider: what planning assumptions each actor uses in order to inform thinking and readiness; how well civilians and the military know each other; what they can do well together without modifications; where modifications are needed; and how well understood the context is.

Assumptions vs realities

Within the UK, Exercise Cygnus 2016 undertook this process, bringing together the Department of Health, Public Health England (PHE), and the Cabinet Office to enable cross-government thinking on preparedness and response in the event of an influenza pandemic. Lessons included the need for additional considerations to inter-sector readiness and individual department readiness and that it was necessary to drill down into the exact actions that the military, police, fire service, local authorities, and the voluntary sector could take to keep systems running and to keep as many people alive as possible. It surprised many that these turned out not to be direct healthcare actions. The military actions included command-and-control components to co-ordinate the healthcare system if the NHS senior management were unable to work; and logistics, as previously tested within the junior doctor industrial action where the military provided drivers for the ambulance services.

Similarly, internationally, during the West African Ebola crisis humanitarians assumed that the military would have appropriate personal protective equipment (PPE) for Ebola because the military do bio-terrorism; and the military assumed medical NGOs would have infection control suitable for Ebola because they were medical responders. It was not appreciated until they were on the ground together in the Ebola treatment units that actually neither of them had large amounts of PPE appropriate for an Ebola-type outbreak. Therefore, the more training undertaken together, the more organisations can get to know each other, each other's kit, and can work around these kinds of issues in advance.

Preparedness activities

A recent joint exercise training in the UK between the ambulance service and the military highlighted the differences in their kit (military in intimidating black sci-fi-esque outfits vs. the ambulance workers' gas suits with faces visible through the visor) and allowed advanced consideration to be given to how the population might feel about the different appearances of the responders. This is an example of *communicative ecology,* which is the aspect of size mapping that looks at who people trust and how people normally communicate, including which communication channels are trusted. The people who are most trusted might be traditional healers or those providing pastoral support rather than the medical NGOs with whom the international health and response communities tend to more naturally engage with. These factors have an impact on by whom, how, and by which channels messages are shared. Communicative ecology could also be applied to civil-military relations to establish trust and communication between actors who speak the same language. For healthcare professionals, both in and

out of uniform, this is often easier but there is still a learning curve on both sides, particularly if the greatest assets that the military is bringing to a response are non-healthcare.

Similarly, *anthropology* or *human terrain mapping* explores staffing and skills. It considers issues such as if someone is a nurse are they always capable of hooking someone up to an IV? Is the medical kit that is assumed to be available to them actually available to them? It can also be used to consider the psychological impact on staff, for example UK-contracted carpenters, electricians, etc., who were seeing dead bodies on a daily basis during the Ebola response, having never worked in that kind of environment before. Timely mapping makes that shared operating space more predictable and contributes to better healthcare preparedness.

The operational space is also shaped by the legally binding IHR. Within the UK, PHE is the national local focal point for England under the IHR, is the second-largest national public health agency in the world, and is tasked with having both international and domestic plans on public health threats.

Procedures and considerations

If a public health emergency of international concern were declared, the UK would be alerted and the government would offer support from PHE, the health economy, and the military. The UK also has a framework for deploying emergency medical teams - Public Health Rapid Support Teams (PHRST) - for disaster relief response around the world. This is coordinated by UK Med, funded in part by DFID, and includes a register of people who have volunteered to be deployed and are trained to do so. The Memorandum of Understanding (MOU) between PHE and UK Med states that each PHRST deployment includes a public health person to do surveillance for infectious diseases. Additionally, there is also joint capability for deploying laboratories combining the two organisations' main focuses of clinical medicine, biochemistry and microbiology to provide a more effective collective response.

Within the UK, there are Local Resilience Forums (LRFs) within each of the 38 police areas. LRFs take a risk-based approach and provide a forum for multi-disciplinary responders to come together to rehearse the plans that have been developed and, most importantly, to understand each other's roles, responsibilities and capabilities. This includes establishing terminology, narrative and language at a local level, e.g., multiagency partners would previously talk about "health," which no longer exists as a single construct. It is noteworthy that it took the Civil Contingencies Act[3] of Parliament for blue-light responders within the same country to talk to each other, coordinate, and share information.

The number one risk listed on the UK's National Risk Register's is pandemic influenza (as it has been for more than 15 years). At the scale of outbreak being planned for, the healthcare system would very rapidly become overwhelmed, not only by the numbers of sick people but also by staff being affected directly at the same levels as the general population or indirectly through family impacts such as bereavement and care for sick relatives. Given this, it is vital to learn from previous actions, including military engagement, and to build on existing mechanisms including that used by NHS England to request military support, rather than creating additional new mechanisms. While it remains important to engage in civil-military dialogue it is equally important to ensure that there is not too much reliance on the military. This is due to the fact that the military would be as affected as the rest of the population, may at the time have different priorities, or not be available within the UK. The mobilisation of specialist reservists within the UK would not be helpful as they would likely already be engaged in the response through their civilian roles.

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[3] https://www.legislation.gov.uk/ukpga/2004/36/contents

Relevant military capabilities

It was urged that it is critical to understand what the military capabilities and limitations are. Firstly, from a military perspective, domestic and international responses are very different – within the UK, military aid is provided to the civil authority via the request mechanisms mentioned. International responses, regardless of the type, are triggered via DFID. Each has different sets of doctrine, with doctrine on international responses largely based on disaster relief doctrine, not health emergency doctrine.

For health emergencies, the military has the capability to deploy high-readiness field hospitals, but, like all military medical capabilities, these are configured around the main military role (to treat soldiers). Field hospitals, military paramedics and field ambulances are therefore trauma-focused with appropriate trauma kit, equipment and training. This is not necessarily ideal for a pandemic flu or an Ebola response, given the limited or no training or kit focused on highly infectious patients. Similarly, the military has limited capacity in paediatrics and obstetric care. It would be possible to train the military to take on these tasks but that would limit the military's ability to respond immediately.

Similarly, the military's medical capacity can be limited in scale, e.g., the air transporter isolator that was used around 10 times in the West African crisis requires an airframe that is not in many aircrafts and so deployment is controlled at the highest level, with competing priorities for use. Similarly, deployable labs can provide remote and rapid diagnosis close to the patient but cannot process more than 10-20 patient samples.

The more complicated the response, the "heavier" the technology or equipment, the slower the deployment times for the military are likely to be. In addition, the Defence Medical Services – geared to high-tech, low-number solutions, not low-tech, high-number solutions – may not be the military support best suited to an epidemic response, though offering medevac capability may provide reassurance for the response community and is ethically important in recognition of the high-risk operating environment.

Also, there is IT software that could help support epidemiological experts in case mapping or mapping and coordinating resource allocations. 77x Brigade has communications expertise and is developing its capability around social media. However, this presents the question as to whether it is appropriate for the military to deliver public health messaging through social media.

Training is also as a capability. Military-to-military and military-to-civilian training with healthcare workers and civilian responders were both highly effective during the West African Ebola response and were delivered rapidly and at scale. Military-to-military training is in line with defence engagement, and defence healthcare engagement specifically, and could be an effective means to support epidemic preparedness.

However, more relevant and significant contributions might involve non-healthcare capabilities of the military, such as engineering, logistics and lift, as well as command and control, as previously highlighted.

Limitations of the military include the expense of military deployments, due to UK salaries, costs, travel, etc. The UK Treasury Guidelines state that the MoD can charge marginal costs and a MOU between DFID and the MoD outlines this. The general consensus is each department picks up its own costs, but there can be an agreement across ministries to cross-charge in special circumstances and this is decided at Cabinet Office Briefing Rooms meetings. More broadly considering response costs, if civilians deploy, there are costs associated with backfilling and there are also potential secondary impacts. For instance, if

NHS staff respond to Ebola overseas, will the UK have the capacity to respond if Ebola were to reach the UK?

Response: can civil-military relations contribute to better humanitarian outcomes?

Civil–military relations can contribute to better humanitarian outcomes in epidemics. However, it can be complicated, as the civil-military and the humanitarian space is not just changing – it is evolving.

It is generally accepted that, as the IHR state: "a more secure world that is ready and prepared to respond collectively in the face of threats to global health security requires global partnerships that bring together all countries and stakeholders in all relevant sectors, gather the best technical support, and mobilise the necessary resources for effective and timely implementation of the International Health Regulations."[4] This could be adapted to refer to "response to an epidemic or a pandemic."

It was argued that in Sierra Leone success came from good working relationships in all directions, with an appreciation for the complex environment and consideration for leaving something sustainable. Humanitarian aid is often longer-term and there is a need to work across government for long-term sustainability, acknowledging the "humanitarian–development nexus," and that after a crisis such as Ebola, it is not enough to simply go back to the status quo.

It is also important to reflect on the World Humanitarian Summit's localisation agenda[5] and its principle of "as local as possible, as international as necessary," which is critical in the case of health emergencies, as it is in all other areas of humanitarian response. Localisation in this case involves building the capacity of national health systems, not directly because of epidemics, but because of the impact on other diseases when the systems no longer work as a result of an epidemic. This necessitates looking beyond a vertical approach by disease. It also involves supporting and building the capacity of local actors, including the National Societies of the International Red Cross and Red Crescent Movement. They are a vital part of a whole of society's response through their roles as an auxiliary to their national government and as first responders at a local level, with an extensive volunteer network, which plays a key role in community mobilisation.

It could be argued that there is already enough policy to facilitate civil-military engagement throughout the epidemic phases. There are international laws – International Humanitarian Law enshrines the Humanitarian Principles and Human Rights Law recognises health as a fundamental right that must be protected. There are conventions, statements, policies and guidelines, including the Oslo Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief (Oslo Guidelines) and the Civil-Military Guidelines and Reference for Complex Emergencies (MCDA), which specifically address civil-military coordination in complex emergencies. Continuing to develop more policy runs the risk of becoming repetitive, with difficulties over taxonomy. Instead, there is a need to implement what is already there through planning and preparedness.

It was argued that while a broad approach applied globally might not be appropriate given the importance of context in any response, there are some things that will be consistent across the globe. Most important are that the military do not become the default first responders to health emergencies and epidemics, that responses remain *civilian-led and military-supported,* and that this lead be established in advance or at the very beginning of the response.

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[4] http://www.who.int/topics/international_health_regulations/en/
[5] https://www.agendaforhumanity.org

Due to the importance of context, it may be valuable to invest in regional approaches. If the military capabilities, the national disaster management authorities, the health systems, and regional differences are understood at a regional level, more predictable models or frameworks from a regional perspective could be developed. In Asia, many models exist and have been developed further into preparedness and interoperability exercises. Such exercises present a different challenge for humanitarians of how to be meaningfully represented, given the number of opportunities.

It could be valuable to develop a common framework, perhaps at a regional level, that brings together all stakeholders who respond to health emergencies and epidemics, determines lexicon and how to train and exercise together, uses predictable mechanisms within the sectors to achieve the best outcome when an epidemic occurs, and that harnesses what we already have.

Terminology is particularly important. There is a perception of unpredictability in response, with a reliance on personalities, whereas it could be argued that the only way to make responses more efficient is for institutions to be consistent and predictable – in their use of terminology, and in the consistent iteration and application of their principles throughout their engagement with others.

However, achieving predictability and consistency is increasingly challenging as more and more NGOs work across the humanitarian-development spectrum, defining themselves as multi-mandate and undertaking humanitarian, advocacy and development objectives. This is problematic from a humanitarian point of view and is especially challenging for the military and other partners, as such NGOs are seen as less predictable. In contrast, focused humanitarian organisations are able to work in very complex conflict settings, through the Humanitarian Principles. Yet, while there should not be any compromise on the principles, it is important to remember that they are for the purpose of supporting the alleviation of human suffering and therefore principled pragmatism is needed.

Other strategies to promote understanding of the different organisational perspectives (including diplomatic, economic and political perspectives) in advance of a crisis, such as the NGO-Military Contact Group conference, are helpful. Individuals and organisations need to set aside preconceptions, to come to the table with their unique capabilities, a willingness to increase understanding, and to engage in open and productive dialogue to learn and understand each other.

It was suggested that understanding, planning and preparedness could be augmented by human resource integration, e.g., an exchange of liaison officers. This is in place in the European Commission and the Directorate-General for European Civil Protection and Humanitarian Aid Operations' Emergency Response Coordination Centre (ERCC); in the West African Ebola crisis, a UK military officer was appointed as the liaison officer, who followed the crisis and supported civilian understanding of the military components. There is also an EU initiative to augment the European Emergency Response Capacity by creating a voluntary pool of different assets that member states might be willing to provide. The predefined assets include health assets, with medical experts, mobile labs and medevac. The ambition is to move this pool from being a more typical reactive EU Civil Protection Mechanism to a more proactive and preventive response mechanism working to scale up from small to larger needs.

The deployment of appropriate resources, both civilian and military, would be supported by proactive mapping of where epidemics are most likely to occur – there will always be black swan events that could not have been anticipated, but the hotspots are known and this information combined with the understanding of capabilities can, through preparedness, training and exercising, create a more predictable system. Within conflict-affected states, the humanitarian principles – particularly neutrality, impartiality, or the lack thereof – as well as the roles of formal military actors and non-state actors, will come to the forefront in a powerful way.

It will take a whole-of-society approach for appropriate epidemic responses to harness the capabilities of all actors beyond those mentioned in this paper. Global partnerships will be important, as will including the private sector, which played a critical role in the West African Ebola response, in these conversations in order that its capabilities are understood and utilised too.