IASC
Inter-Agency Standing Committee

Global Health Cluster

Civil-military coordination[1] during humanitarian health action

Provisional version – February 2011

Foreword

The purpose of this position paper is to guide country-level health clusters on how to apply IASC civil-military coordination principles to humanitarian health operations. It addresses coordination between civilian humanitarian actors and official, internationally deployed military actors involved in crisis response work. It may also serve to guide humanitarian health actors that are coordinating with national militaries within their own borders and with civil defence and civil protection units.

The paper is provisional and intended to serve as the basis for discussions with a wide range of stakeholders including health cluster partners, military representatives, civil defence and civil protection actors, and other humanitarian clusters. It may be used as the basis for similar guidance developed by other clusters. It will be revised to reflect inputs from humanitarian agencies and developments in the area of civil-military coordination.

The relation between health humanitarian actors and non-state military groups is outside the scope of this paper.

Key messages of this position paper

- 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.

The Global Health Cluster, under the leadership of the World Health Organization, is made up of more than 30 international humanitarian health organizations that have been working together over the past four years to build partnerships and mutual understanding and to develop common approaches to humanitarian health action.

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1 The term **coordination** was chosen instead of other terms such as “relation” or “interaction” as it is the term used in IASC-endorsed documents on civil-military relations. In this framework, “coordination” is not intended to mean acting together for a common goal, but simply **establishing the most appropriate civil-military relation necessary to fulfil the humanitarian mandate in the specific scenario**. Some form of coordination is necessary even to simply coexist.

- 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 population.
- 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 complemented 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.

Introduction

Following natural or man-made disasters, humanitarian health organizations provide life-saving assistance to individuals and communities whose survival is at risk. This is a core component of the humanitarian community's mandate. Under international human rights law,[2] health is recognized as a fundamental right of the individual that must be protected in all circumstances. In addition, health is addressed in international humanitarian law provisions related to the protection of health facilities and personnel during war. These legal instruments also address the need for belligerents to take the necessary measures to protect and respect medical missions in all circumstances.[3]

The scenarios in which humanitarian health agencies operate are complex in terms of internal dynamics and interactions with external parties involved in the response. Over the last decade, military actors have been increasingly involved in relief activities in various settings, including sometimes providing direct assistance to crisis-affected populations. From a humanitarian perspective, this poses specific questions regarding the extent to which their involvement has a positive impact and, conversely, whether and how this involvement might affect humanitarian organizations' ability to respond impartially to the needs of the population.

Civil-military coordination problems are particularly relevant for the health sector. Health activities have historically been part of counterinsurgency military strategies. More importantly, rehabilitating the health sector is increasingly seen as key to ensuring the country's stability. This document analyses general civil-military coordination concepts and attempts to provide specific guidance to health actors on civil-military coordination during crises.

The problem

Humanitarian organizations and military forces have different mandates:

- Humanitarian organizations endeavour to provide life-saving assistance to affected populations based on assessed and documented needs and on the humanitarian principles of humanity, independence and impartiality.
- Civil defence and civil protection units are usually deployed in a humanitarian crisis on the basis of an agenda of the government to which they belong. As there is no agreed international definition for these categories (see box on *Civil defence and civil protection* below), the different mandates, modes of opera-

2 Article 25(1), *Universal Declaration of Human Rights of 1948*; Article 12(1), *International Covenant on Economic Social and Cultural Rights of 1966*.

3 For the protection of medical facilities: Art 27, the *Hague Convention 1907*; Article 19 I *Geneva Convention* and Article 37 II *Geneva Convention 1949*. For the protection of medical personnel: Articles 24 and 25 I *Geneva Convention, 1949*; Art 15 *Additional Protocol I to the GC, 1977*.

tion and natures (civilian or military) of these actors must be considered when identifying whether and how the humanitarian mechanisms on the ground will engage and coordinate with these actors.

- Militaries may be present in the context of a humanitarian crisis as combatants, they may have a specific mandate granted by the Security Council (peacekeeping, peace-enforcement or combat), or they may deploy internationally at the invitation or with permission of the affected government. Military forces may be deployed abroad or inside their own borders. While the specific mandate will differ in different settings, it is important to recognize that militaries are deployed with a specific security and political agenda or in support of a security and political agenda.

These fundamental differences at the core of the mandates – the needs of the population on the one hand and political/security goals on the other – guide the respective decision-making processes of humanitarians and the military. This can result in minor differences that still allow for cooperation (e.g. when responding to a natural disaster in a non-conflict setting) or major differences (e.g. those that may occur in combat settings).

Any confusion between the different mandates carries the risk that humanitarian aid agencies may be drawn, or perceived to be drawn, into conflict dynamics. Humanitarian agencies that are perceived as acting according to agendas other than their humanitarian mandate may lose their credibility in the eyes of other local actors as well as the trust of the population they are there to serve. This can severely affect their ability to operate and, ultimately, create security risks for their staff and for the aforementioned populations.

Identifying a way to engage with the military – one that does not dangerously confuse the two mandates – is at the core of the civil-military coordination challenge.

Civil defence and civil protection

While the Additional Protocol I to the Geneva Conventions of 1949 (AP I) lists the tasks that define "Civil Defence". There is no internationally agreed definition of civil defence or civil protection actors in terms of how they operate, what is their mandate or nature of the relationship with military or security forces of their countries.

While in some countries and regions, these terms may have developed distinct meanings; these terms are sometimes used interchangeably. This lack of clarity is reflected in the Additional Protocol 1 itself and is replicated in the interagency guidance on civil-military coordination. While the English version of the AP I and the Oslo Guidelines refer to "military and civil defence assets" and defines for the purpose of the guidance civil defence as "any organization that, under the control of a Government perform the functions enumerated in paragraph 61 of Additional Protocol 1 to the Geneva Conventions of 1949…," the French language versions of the AP I and *Oslo Guidelines* use the term "protection civile" in the place of "civil defence" throughout.

In the absence of any clear and internationally agreed definition it is critical to recognize that civil defence and civil protection actors are deployed in support of an agenda of the government to which they belong. The way in which humanitarian actors coordinate with civil defence and civil protection actors in a specific setting, depends on the specific nature of the civil defence and civil protection actors in that setting. It may be appropriate to include some of these actors in the humanitarian coordination mechanism itself, while in others the approach to coordination may more closely resemble the approach to coordination with military actors.

In light of this lack of clarity, this paper will employ the phrase "civil defence and civil protection" throughout.

Specifics

Role of the Health Cluster at global and country levels

The mission of the Global Health Cluster (GHC), led by WHO, is to build consensus on humanitarian health priorities and related best practices, and strengthen system-wide capacities to ensure an effective and predictable response.[4] The GHC looks at how civil-military coordination might affect humanitarian agencies' ability

4 Adapted from WHO, *Health Cluster Guide* (provisional version 2009) p 24.

to access affected populations and provide health assistance. It endorses adherence to IASC civil-military coordination mechanisms and guidelines.[5]

The country-level Health Cluster is a mechanism for participating organizations to work together in partnership to harmonize efforts and use available resources efficiently within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). It provides a framework for effective partnerships among international and national humanitarian health actors, civil society and other stakeholders, and ensures that international health responses are appropriately aligned with national structures.[6] The Health Cluster Coordinator (HCC) and Head of the Health Cluster Lead Agency facilitate the process of operationalizing civil-military coordination principles for the health cluster and adapting them to the local situation. Whenever necessary, the HCC and/or Head of the Health Cluster Lead Agency advocate with military and political actors for the preservation of humanitarian space and the adoption of health care delivery standards.

Purpose and target audience

This paper reviews the existing guidance on civil-military coordination and attempts to clarify how it applies to the health sector. It also identifies some gaps in the guidance and emerging challenges.

The document's target audience is health cluster participants involved in civil-military coordination. It is also intended to stimulate discussion within the overall humanitarian community and military counterparts.

Scope of the position paper

This document examines the relations between civilian humanitarian actors and official international military actors and/or civil defence and civil protection units involved in the crisis response. It may also help guide humanitarian health actors in their coordination with national military or civil defence units deployed within their own borders. The relations between health humanitarian actors and non-state military groups are outside of the scope of this paper.[7]

Definitions

For a list of definitions adopted for this document please see Annex I.

Status and modifications

This document is informed by and builds on the more general efforts of the United Nations (UN) and other humanitarian organizations to identify appropriate civil-military coordination modalities during humanitarian crises (See Annex II for a summary of the IASC-endorsed guidelines for civil-military coordination).

This position paper is a work in progress that may be revised to take account of inputs from GHC partners and other humanitarian agencies as well as developments in the area of civil-military coordination.

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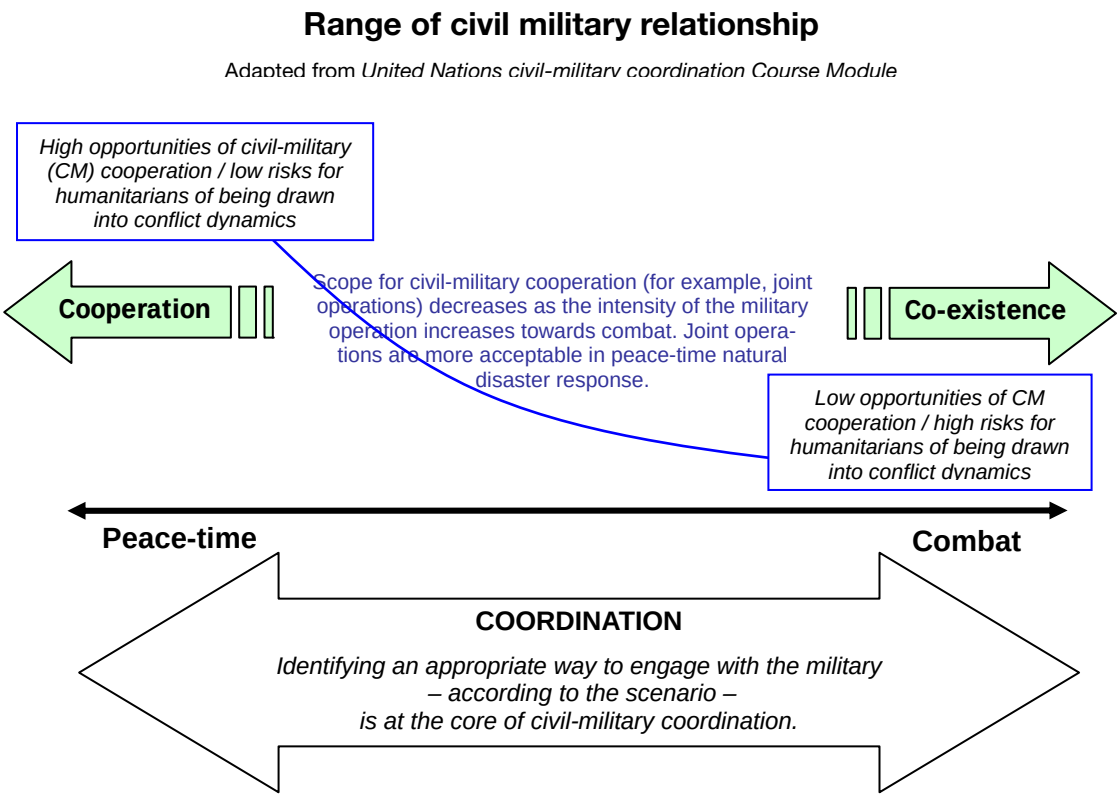
5 The focal point for UN civil-military coordination in the United Nations System is the Civil-Military Coordination Section (CMCS) of OCHA. CMCS often deploys a UN Civil-Military Coordination Officer to advise the Resident Coordinator on the establishment of a field-effective mechanism. The specific features of civil-military interface mechanisms can vary from crisis to crisis. The most common interface mechanisms are: Civil-Military Operations Centre (CMOC); Civil-Military Cooperation House (CIMIC House); Humanitarian Operation Centre (HOC). *UNDAC handbook* 2006, Chapter L. (See bibliography annexed for a list of relevant guidelines and documents).

6 Adapted from WHO, *Health Cluster Guide* (provisional version 2009) pp. 28-9.

7 The GHC acknowledges that non-state military actors can greatly impact the capacity of humanitarian organizations to access affected populations and to provide effective assistance. The decision not to include this typology of military actors in the scope of this document was taken to avoid dilution of focus and to maintain the same approach used by the more relevant guidelines approved by the IASC. IASC (2008) *Civil-military guidelines and reference for complex emergencies*, p 7. For field practice related to non-state military actors see *Humanitarian negotiations with armed groups: a manual for practitioners and guidelines on humanitarian negotiations with armed groups* available online at: www.reliefweb.int.

Civil-military coordination scenarios



Different scenarios call for different approaches

A better understanding of the mandates and agendas of all actors in a complex emergency is essential to ensure proper coordination.

Regardless of the setting, some form of civil-military coordination is always necessary. How this coordination is operationalized depends on the situation. It must follow IASC guidelines and be balanced by sound pragmatism aimed at guaranteeing that the health needs of the population are met, the humanitarian space is not undermined, and the impartiality of the humanitarian community is not compromised.

There is a marked difference between responses to natural disasters that occur in a peaceful environment and those that occur in the midst of complex emergencies.

Civil-military coordination in relatively peaceful environments, while not without problems, can increase the capacity to assist affected populations. In these settings, there can be "a common goal and [...], **cooperation** may become possible".[8] For example, military assets can fill gaps in the international humanitarian response, particularly as regards transport and logistics.

During armed conflicts, however, there is an increased risk that interaction with military actors will jeopardize the impartiality of humanitarian actions. These settings can differ greatly, a critical distinction being "whether the military group with which humanitarians are interacting, has become, or is perceived to be a party to the conflict or not".[9] In such cases, simple **co-existence** is the appropriate civil-military modality.

In specific situations international humanitarian law obligates occupying powers to fulfil certain humanitarian obligations. As stated in the 4th Geneva Convention of 1949, "the occupying power takes over all responsibilities of the previous government. The occupying power is obliged to supply food and medicine (Article 55), maintain hospitals, and public health and hygiene (Article 56). In these settings, some confusion of roles

8 IASC (2004) *Civil-military relationship in complex emergencies - an IASC reference paper*. 28 June. Par 12.

9 Ibid. Par 8.

is difficult to avoid. This, however should not be considered as 'humanitarian work' but rather as the fulfilment of humanitarian obligations".[10]

The IASC civil-military coordination documents present four scenarios: (1) missions in a peacetime setting; (2) peacekeeping; (3) peace enforcement; and (4) combat.[11] (See Annex III, description of civil-military coordination scenarios).

Health partners' behaviour and modalities of coordination with military counterparts must be adapted to the specific scenario and the particular mandate and rules of engagement of military actor/s. In this regard, the following issues should be noted:

- **Different scenarios are not always clear cut.** Over the past decade, the peacekeeping troops' mandate has expanded beyond the simple use of force for self-defence to encompass elements of enforcement, with UN Security Council resolutions specifically authorizing peacekeepers under Chapter VII of the UN Charter "to take all necessary measures" to fulfil specific areas of their mandate.[12] This trend has served to reduce the differences between peacekeeping and peace enforcement. An analysis of any scenario must go beyond official labels and review the detailed mandate of peacekeeping forces as spelled out in UN Security Council resolutions and other official documents.
- **Elements of different scenarios can be present at the same time.** For example, when a conflict-affected area is hit by a natural disaster, or when different international interventions follow parallel tracks. By way of an example, both combat forces (Enduring Freedom) and peacekeeping/peace enforcement troops were present in Afghanistan from 2001 to 2003.
- **The mandate, strategies, and tactics of military actors, as well as of the civilian component of international missions, can change over time.** For example, in Afghanistan, the International Security Assistance Force went from peace-enforcement to counterinsurgency operations. In Sierra Leone in 1999, a traditional peacekeeping mission (UNOMSIL) was replaced by one authorized to use force well beyond self-defence (UNAMSIL).

Within a UN peacekeeping framework are the so-called integrated missions that represent a modality in which peacekeeping operations are planned and implemented (See Annex IV, Briefing note on integrated missions).

These variations call for constant reassessments of the mandate, mission, legitimacy and local acceptance of the international military presence.

Civil-military coordination and the health sector

The matrix below (see table pp 8–9[13]) sets out the potential risk levels and risks to both humanitarian health agencies and the military. For the humanitarian health community, the risks relate to the actual or perceived impartiality of health humanitarian actors and the extent to which their involvement in civil-military coordination can endanger humanitarian principles and the effectiveness of health care. The matrix is intended to be an analytical tool. It does not fully describe the types of health activities that may take place in each scenario, nor does it attempt to list all possible scenarios. Health clusters in countries should adapt the matrix to the specific context.

The matrix has been organized based on two assumptions: (1) as a general rule, direct health assistance shall be carried out only by civilian humanitarian health agencies; and (2) the more military actors are entrenched in the conflict dynamics, the more the two worlds – military and humanitarian – should be kept separate in order to safeguard the actual and perceived impartiality of humanitarian actions.

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10 *UNHCR and military, a field guide*, page 33. available online at http://www.unhcr.org/refworld/docid/465702372.html

11 The scenarios are taken from UN CM Coord Course Module as reported in IASC (2008) *Civil-military guidelines & reference for complex emergencies*, page 24.

12 Chapter VII of the UN Charter spells out the Security Council's powers to maintain and "restore international peace and security". It allows the SC to "determine the existence of any threat to the peace, breach of the peace, or act of aggression" and to take military and non-military action necessary to tackle the situation.

13 The matrix has been adapted from a presentation made by Patricia Kormoss to the NATO Joint Medical Team in November 2009.

The colours in the matrix represent the levels of risk:

- **Green** = low risks to actual and perceived impartiality of humanitarian actors, with strong opportunities for health humanitarian actors to cooperate with military for the benefit of the affected population.
- **Orange** = medium risks as the benefits of using military assets should be assessed against the protection of actual and perceived impartiality of actions.
- **Red** = high risk of negative impact to actual and perceived impartiality of humanitarian actors.

The matrix should be read bearing in mind the following principles:

- **Military assets should be used only as a last resort** (i.e. in the absence of any comparable civilian alternative and to meet a critical humanitarian need) and civilian alternatives should always be sought. The use of military and civil defence assets should be planned to be limited in time and include a clear exit strategy in order to avoid creating dependency on military support;
- To allow coordination to take place, a **channel of communication always should be maintained with the military** in order to make the most of opportunities for cooperation, if possible and appropriate, and, when simple coexistence is the only option available, to advocate for humanitarian principles.

For the purposes of this matrix, the following definitions apply:

Indirect Assistance is at least one step removed from the population and involves activities such as transporting relief goods or relief personnel. Indirect assistance also includes the infrastructure and logistical support that assist the creation of an environment in which health activities are possible and health risks are mitigated.

Direct Assistance is the face-to-face distribution of goods and services.[14] It includes core health functions that do not require face-to-face relation with beneficiaries.

14 The definitions of the types of assistance are taken from the IASC (2006) *Guidelines on the use of military and civil defence assets to support United Nations humanitarian activities in complex emergencies* – March 2003 – Revision I, January 2006. It should be noted the IASC guidelines foresee three forms of assistance: direct assistance, indirect assistance, infrastructure support. These categories have been simplified in the present document, and infrastructure support has been integrated into indirect assistance.

ıry involvement in health action by scenario and typology of task

health humanitarian actors to cooperate with military for the benefit of the affected population. Orange = medium risks as the bene-
ainst the protection of independence and impartiality of actions. Red = high risk of impacting on humanitarian principles).

Peacetime ons in non-conflict related events)	**Peacekeeping***	**Peace-enforcement**	**Combat**
Low risk	Low risk	Low risk	Low risk
. Military involved in the provision of ıd sanitation should comply with the ı humanitarian standards.	Medium risk		HIGH RISK
. Military involved in the provision of ınd in the construction of camps :omply with the minimum humanitarian ds.	Medium risk		HIGH RISK
Low risk	In certain situations only the military possesses the appropriate means of transport (e.g. helicopters) to reach isolated populations. If possible all parties to the conflict should engage in a discussion to limit the risk that the use of military assets will affect the perceived impartiality of humanitarians.		
. Emergency preparedness and con- planning needs to be done in consul- th the military and civil de- otection units.	Low risk	Low risk	HIGH RISK
Low risk	Medium risk. Only if it is possible to ensure that information is collected consistently with the HIS and promptly shared with health authorities.	HIGH RISK	HIGH RISK
. Military should coordinate with civil- h authorities (national and/or interna- avoid duplication of initiatives and health care standards.	Low risk	Medium risk	HIGH RISK Health facilities should be kept separate from the military.
Low risk	Medium risk. Only if it is possible to ensure that the equipment provided is consistent with national health guidelines.		HIGH RISK Health facilities should be kept as distant as possible from military actors involved in active combat.