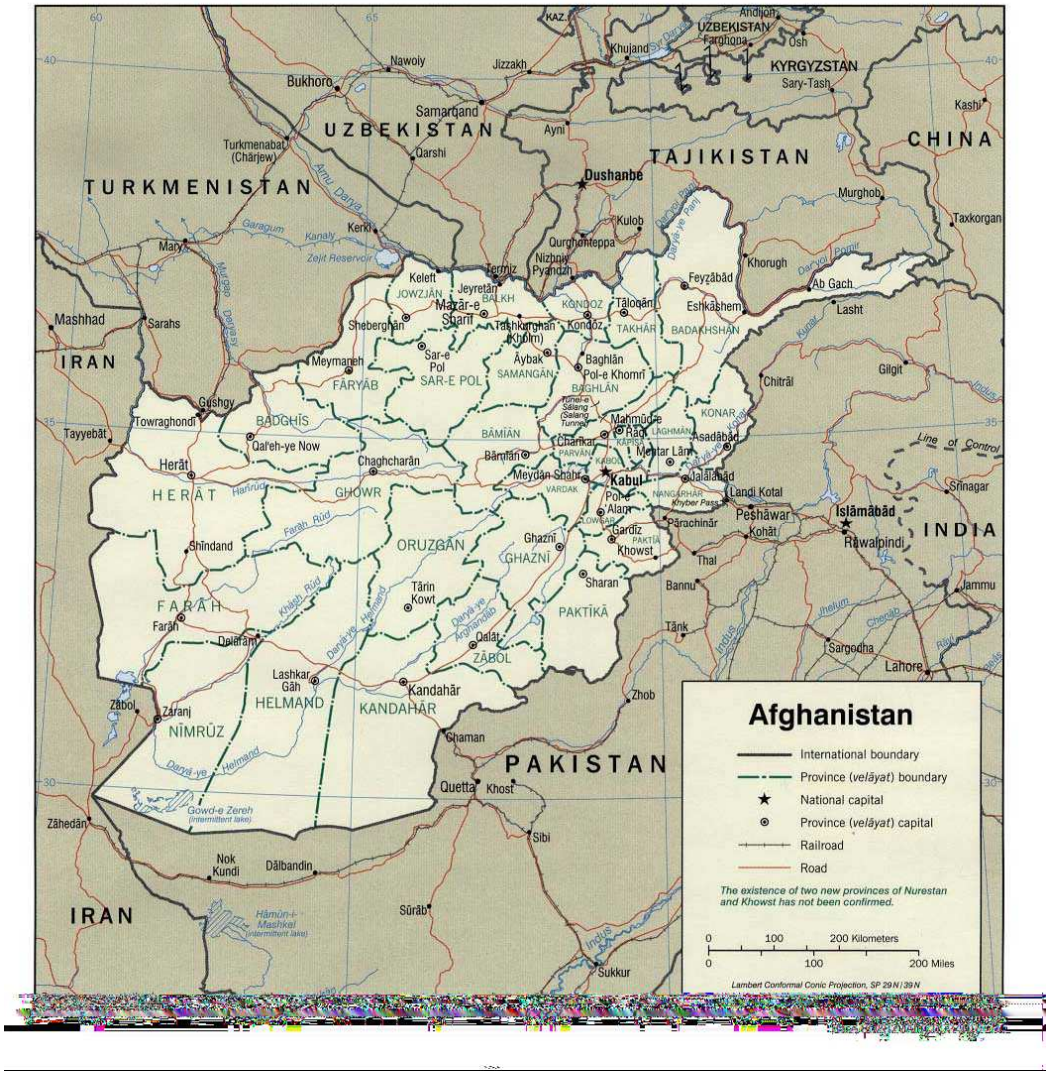
Civil-Military Coordination in the Health Sector
Afghanistan: A Case Study



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DRAFT 1

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Key to abbreviations

ACBAR	Agency Coordinating Body for Afghan Relief
ANA	Afghan National Army
ANP	Afghan National Police
ANSO	Afghanistan NGO Safety Office
AOG	Armed Opposition Groups
BPHS	Basic Package of Health Services
CFC-A	Coalition Force Command – Afghanistan
CGHN	Consultative Group for Health and Nutrition
CIMIC	Civil-Military Cooperation
CM	Civil-Military
CM-Coord	Civil-Military Coordination
COMIJC	Commander, ISAF Joint Command
COMISAF	Commander, NATO International Security Assistance Force
DMT	Disaster Management Teams
EPHS	Expanded Package of Hospital Services
GoA	Government of Afghanistan
ISAF	International Security Assistance Force
MEDCAP	Medical Civil Assistance Program
MEDSEM	Medical Seminars
MoD	Ministry of Defence
MoI	Ministry of Interior
MoPH	Ministry of Public Health
NATO	North Atlantic Treaty Organisation
NGO	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Assistance
OEF	Operation Enduring Freedom
PDC	Provincial Development Committee
PHCC	Provincial Health Development Committee
PRT	Provincial Reconstruction Team
PRT ESC	PRT Executive Steering Committee
QIP	Quick Impact Project
RC	Regional Command
SCR	Senior Civilian Representative (NATO)
SOP	Standard Operating Procedures
SRSG	Special Representative of Secretary General (UN)
SSR	Security Sector Reform
ToR	Terms of Reference
UN	United Nations
UNAMA	United Nations Assistance Mission in Afghanistan
UNHCR	United Nations High Commissioner for Refugees
UNSMA	United Nations Special Mission to Afghanistan
USAID	United States Agency for International Development
WHO	World Health Organisation

Executive summary

The traditional approach to civil-military coordination - i.e. through formal working groups - has not been effective in Afghanistan. In particular, it has failed to protect humanitarian principles in the context of the complex military presence in the country and a UN mission with an ambiguous mandate. As a result, formal civil-military structures have been replaced or complemented by bilateral and other relationships that have proved to be more effective in exchanging vital information between military and civilian groups and advocating for humanitarian principles.

Civil-military relations in Afghanistan are presently going through a disengagement phase. NGOs are increasingly dissociating themselves from direct contact with international military forces, preferring instead to be represented in coordination meetings through joint mechanisms such as the Agency Coordinating Body for Afghan Relief (ACBAR). This trend is expected to continue in the coming months.

Disengagement should not be taken to mean that all communication has ceased. On the contrary, civil-military relations in Afghanistan continue to function through many channels. In Kabul, prevails a bilateral approach with each organisation and agency having independent lines of communication with military counterparts. Outside the capital, each province appears to have a different civil-military framework tailored to the local context.

International military forces in Afghanistan comprise three main components under the same general command. The International Security Assistance Force (ISAF) is a multinational force under NATO command authorised by the Security Council. Operation Enduring Freedom (OEF) is a US-led counter-insurgency force. The Provincial Reconstruction Teams (PRTs) are civil-military units tasked to help the Afghanistan government extend its authority throughout the country. PRTs are the primary agents of the so-called “comprehensive approach” concept, a NATO strategic framework that aims at combining military, political and humanitarian/developmental activities towards the stabilisation of the country.

Each of the above three military components carries out some form of health activity. As part of a long-standing military tradition, the medical units of ISAF's national contingents conduct health activities aimed at winning the acceptance of the local population. OEF implements health activities as part of a “winning hearts and minds” counter-insurgency strategy. PRTs carry out different health activities both as a counter-insurgency strategy and as part of a wider rehabilitation and stabilisation effort within NATO's comprehensive approach concept. It should be stressed, given the considerable variations in PRTs across Afghanistan, that it is neither possible nor useful to treat them as a single entity.

<u>Health activities carried out by military personnel</u>

There is very little information available on health activities implemented by the military in either Kabul or the provinces. The information below has been collected mainly through interviews and limited secondary sources.

- Of the three military components, the PRTs are the most involved in health activities. Main activities include rehabilitating health facilities and distributing medical equipment. However, some PRTs have been reported to organised mobile clinics providing direct patient care and supplying drugs directly to health facilities.
- Within OEF’s counter-insurgency strategies, special forces carry out “Medical Civilian Assistance Program” (MEDCAP)This term refers to direct, time-limited health care services to communities selected for their military strategic value.
- Medical units of national contingents operating under ISAF also provide direct patient care.

The humanitarian/developmental health community's key concerns regarding the military's involvement in health activities are:

- Military actors establish health facilities without consulting and coordinating with the Ministry of Public Health (MoPH) or other relevant health partners. This tends to leave these health facilities outside the national health system and therefore without appropriate funding, staff and supplies.
- Often, these health facilities do not conform to the national health plan, are built in unsuitable locations, and do not meet MoPH building standards.
- There is a lack of transparency concerning the cost of conducting health activities and the resources used in this area by military actors.
- The medical equipment donated does not comply with MoPH guidelines, and national staff are often unable to operate it.
- Donated drugs are not on the MoPH's essential drug list and are thus unfamiliar to national health care providers.
- MEDCAP activities are not planned according to health needs and tend to raise the population's expectations concerning what the national health system can provide.
- On several occasions, soldiers in uniform have conducted health activities inside health facilities.

The frequency of the above incidents appears to have decreased over the past six to eight months, possibly as a result of sustained advocacy efforts.

Concerns over the safety and security of health facilities and personnel remain. There appears to be a correlation between international military personnel carrying out health activities in or nearby health facilities and threats or direct violence to these facilities and their personnel. Even the mere physical rehabilitation of a health facility has, on some occasions, triggered an attack from opposition forces.

Table I - The international presence in Afghanistan and the health sector

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Sept 11 – Terrorist attacks in the US October 7 Anglo-American bombing of Afghanistan **Operation Enduring Freedom starts** **ISAF established**	November **PRTs endorsed** by president Karzai	October, **ISAF mandate expanded** to the whole Afghan territory	October, 19 PRTs established December, PRTs Executive Steering Committee established	ISAF troops increase to 20,000		February 22, PRT ESC **Policy Note 3** "PRT coord. and intervention in hum. assistance"		August, **New Command Structure of Intl. Military Forces.** ISAF & OED under the same commander	July, **SOP on military medical engagement** released
	UNAMA established SC RES 1401 **OCHA leaves Afghanistan**	SC RES 1510 SC RES 1455	Presidential elections SC RES 1563 SC RES 1536 SC RES 1526 May, Save the Children Report on PRTs	18 September provincial and parliamentary **elections** SC RES 1623 SC RES 1589	SC RES 1707	SC RES 1776 SC RES 1746	SC RES 1806 SC RES 1817 SC RES 1833 June 2008 Guidance on coord. between armed actors and humanitarian clusters in Afghanistan	Presidential Elections SC RES 1868 SC RES 1890 **OCHA re-enters Afghanistan**	Parliamentary elections SC RES 1917 CM Coord WG disbanded In Kabul CM Coord WG in Jalalabad transformed into a Small Contact Group
Maternal Mortality Ratio 1600 deaths per 100.000 live births **U5 Mortality Rate** 257 per 1000 live births **Infant Mortality Rate** 165 per 1000 live births **access PHCS** 9% of population	BPHS process starts	March, **BPHS adopted** by the MoPH		July **EPHS adopted** November 2005 **BPHS revised**	**U5 MR** 191 per 1000 live births **IMR** 129 per 1000 live births **MMR** 1600 deaths per 100.000 live births **access PHCS** 65% of population		**U5MR** 161 per 1,000 live births **IMR** 111 per 1,000 live births **MMR** 1600 deaths per 100.000 live births **access PHCS** 68% of population		**2013 target** **U5MR** 167 per 1,000 live births **IMR** 115 per 1,000 live births **MMR** 1264 deaths per 100.000 live births **access PHCS** 90 % of population

1. Background and objectives

The response to humanitarian crises, once carried out by a limited number of organizations with specific mandates, now involves countless numbers of actors. An increasing number of NGOs, foundations and private commercial firms are joining what was once the domain of traditional humanitarian institutions such as UN agencies. Moreover, military actors under diverse institutional and legal umbrellas have become the primary agents of pacification, stabilization and reconstruction efforts. The mandates of different institutions have become blurred: what once were typically civilian activities, such as the provision of relief assistance, have often become part of the military agenda. Private companies are increasingly carrying out safety and security work that was once the exclusive domain of military personnel.

In this evolving framework the Global Health Cluster is leading the development of a position paper on civil-military coordination in humanitarian health action. The need for such a document arose amid concerns that interactions between health organizations and the military could hamper humanitarians' ability to access affected populations and provide health assistance according to the principles of humanity, neutrality and impartiality.

The work presented in this document is part of this process. Its purpose is to build field-based knowledge by analyzing how civil and military actors interact in Afghanistan, and how their interactions affect the health sector.

The **objectives** of the case study are to:

- Analyze the interactions between civil and military actors in Afghanistan and their effect on the provision of health services to the Afghan population.
- Review the key characteristics and evolution of health activities carried out by a selected number of PRTs.
- Include the findings of this case study in the above-mentioned position paper being developed by the Global Health Cluster.

2. Methodology

The work was conducted in three phases over a period of around 30 days:

- Desk study: review of the relevant documentation, preliminary identification of informants; preparation of draft interview plan.
- Field mission: visit to Afghanistan from 14 July to 4 August 2010. Field trip to Jalalabad, capital of Nagarhar Province, from 1 to 2 August 2010.
- Data consolidation and preparation of first draft of the case study.

The documentation reviewed can be roughly grouped as follows: academic articles; field reports; operational guidelines; documents produced by relevant institutions and organizations; on-line documentation. (See Annex I for a selected bibliography.)

Interviews were conducted individually, apart from three occasions when group interviews were conducted to make the best use of the limited time available. Overall, 46 individuals from UN agencies, international military forces, NGOs, academics, donors and the MoPH were interviewed. (See Annex II for a list of key informants.)[1]

To avoid limiting the scope of this study, the author interviewed a wide range of key informants, both in terms of their professional roles and their affiliations. A "general interview guide approach" was adopted to ensure that the same areas of information were collected from each informant, at the same time allowing for a certain degree of freedom and

[1] 15 individuals specifically asked not to be included in the list of informants or to be mentioned in anyway in the case study.

adaptability in the information shared by each individual. (See Annex III for the interview plan.) Interviews lasted between 40 and 90 minutes.

3. A note on terminology

The semantics around civil-military relations are not straightforward. Different actors tend to attach different meanings to the same word; this can often lead to misunderstandings and wrong assumptions when attempting to engage in a discussion or analysis of the subject. It may be useful to clarify how different actors define the key concepts covered in this case study.

Within NATO, operational interactions between military forces and civilian entities are labelled **civil-military co-operation (CIMIC)**, defined as:

> *The co-ordination and co-operation, in support of the mission, between the NATO Commander and civil actors, including national population and local authorities, as well as international, national and non-governmental organisations and agencies.*[2]

CIMIC does not differentiate among different civilian actors. Civil-military interaction is viewed as a tool to support military objectives, e.g. force protection and acceptance, and intelligence gathering.

The UN has developed and endorsed the concept of **civil-military coordination (CM-Coord)**, defined as:

> *The essential dialogue and interaction between civilian and military actors in humanitarian emergencies that is necessary to protect and promote humanitarian principles, avoid competition, minimise inconsistency, and when appropriate pursue common goals. Basic strategies range from coexistence to co-operation. Coordination is a shared responsibility facilitated by liaison and common training.*[3]

This definition is the cornerstone of a set of guidelines on the relations between civil and military actors developed within the UN system and endorsed through an inter-agency process. (See Annex IV for an abstract of these guidelines.) CM-Coord aims to ensure that the core humanitarian principles are safeguarded when civilian actors interact with military personnel in a humanitarian context. CM-Coord focuses on the relationships between humanitarian organizations and official military forces (i.e. those of a state or regional-/inter-governmental organization that are subject to a hierarchical chain of command).[4]

Neither of the above definitions grasps the complexity of the Afghan scenario. Civil-military interactions in Afghanistan have different dimensions that go beyond a strictly defined humanitarian sphere and that cannot be framed by the traditional CIMIC approach. For this reason, this paper uses more generic terms such as civil-military relations or civil-military interactions that better encompass the complexity of the situation in Afghanistan.

4. A new chapter in the international presence in Afghanistan: description and role of relevant actors

During the Taliban regime (1996-2001) Afghanistan was relatively absent from international geo-political discourse. The September 11 attacks on the United States dramatically changed the situation, and Afghanistan was once again high on the international agenda. Reaction to the terrorist acts was swift. On 7 October 2001, Anglo-American forces aerial bombed the

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[2] NATO/EAPC (2003) AJP-9 NATO Civil-Military Co-operation (CIMIC) Doctrine, _____ (2004) The Charter of the Provincial Reconstruction Team Executive Steering Committee Par. 102

[3] 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.

[4] Ibid.

country. Thus began Operation Enduring Freedom (OEF) that, with the ground support of the Northern Alliance force, aimed to topple the Taliban regime.[5]

The Bonn Agreement of 5 December 2001, negotiated without the Taliban, created the initial framework for a political and stabilization process based on three main actions: the formation of a Transitional Authority led by Hamed Karzai; the establishment of the UN Assistance Mission to Afghanistan (UNAMA) to help the Transitional Authority navigate the difficult political process and rebuild the country; and the deployment of a multinational military force to establish minimum security conditions.

The stabilization strategy adopted by the international community followed the so-called liberal peace-building model, with a focus on building and reinforcing the legitimacy of the Karzai government through the creation of a constitutional framework and the organization of general elections.[6] At the same time, considerable efforts were made to reinforce and build the institutional capacity of the Afghan state through technical assistance to its ministries and institutions.

The security agenda has followed two main lines: establishing control over the territory by deploying an International Security Assistance Force (see below) and creating and training the country's own security forces (military and police). The international community has also had to respond to massive humanitarian needs in a country devastated by decades of civil war.

It is beyond the scope of the present work to account for all the organizations and institutions currently working in the country. However, as the response to 9/11 has shaped the country's present political landscape, a description of some of the main actors is helpful to understand the complex civil-military relations in the country.

4.1 The different souls of the military presence in Afghanistan

The **INTERNATIONAL SECURITY ASSISTANCE FORCE (ISAF)** was established in 2001 under the Bonn Agreement. ISAF's mandate is to help the Afghan government maintain a safe and secure environment with the full involvement of Afghan national security forces.[7] Initially, ISAF's mandate was limited to Kabul and surrounding areas. In October 2003 its mandate was expanded to encompass the whole of Afghanistan.[8] From a legal point of view, ISAF is a multinational force authorized by the United Nations Security Council under Chapter VII of the Chart and therefore able to use force to fulfil its mandate.

ISAF reorganized its command structure in August 2009 to bring more consistency to a military effort that was generally considered fragmented at best, if not downright incoherent.[9] At present ISAF has two headquarters in Kabul:

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5 The Northern Alliance is a military-political umbrella primarily composed of three non-Pashtun ethnic groups - Tajiks, Uzbeks and Hazaras. It was created under the leadership of the charismatic Ahmad Shah Massoud after the Taliban seized power in 1996. During the Taliban regime the Northern Alliance controlled some 5% of the Afghan territory around the Panshir Valley. The alliance played the role of 'land force' in the early stages of Operation Enduring Freedom.

6 The first presidential elections were held in 2004; parliamentary elections followed in September 2005. The latest presidential elections of August 2009 raised significant doubts regarding their legitimacy.

7 ISAF was first established by UN SC Resolution 1386/2001 as envisaged in Annex I of the Bonn Agreement and upon the invitation of the Afghan Interim Authority.

8 UN SC Resolution 1510/2003.

9 There was general consensus among military and civilian informants interviewed regarding the fragmentation of the chain of command and communication lines of the international military presence. On the new ISAF command structure see MCCHRYSTAL, S. A. (2009) *Initial United States-Afghanistan (USFOR-A) Assessment*, DIANE Publishing. INNES, M. (2010) A new command structure in Afghanistan. *Foreign Policy*. March 18.

- A higher headquarters (COMISAF), commanded by a 4-star general (General Petraeus at the time of writing). COMISAF is responsible for synchronizing ISAF's operations with those of Afghan institutions and international organizations. It has overall command of both ISAF and US forces (OEF) in Afghanistan.
- An intermediate headquarters called ISAF Joint Command (COMIJC), which executes tactical operations and is taking over responsibility for Regional Commands and Provincial Reconstruction Teams (see below).

ISAF has five Regional Commands: Capital, North, West, South, and East. Each Regional Command coordinates the civil-military activities carried out in its area by the military components of the PRTs. Leadership of each RC is entrusted to a specific nation: Germany for RC North**;** Italy for RC West; France for RC Capital; the Netherlands for RC South; and the United Sates for RC East. (See annex V – ISAF Structure.)[10]

Although under the same general command, ISAF operations and mandate are distinct from those of **OPERATION ENDURING FREEDOM**. OEF is a US-led counter-insurgency mission that reports directly to COMISAF and enjoys significant independence. From a legal point of view, OEF's presence in the country is acknowledged but not authorized by the UN Security Council. Its presence in Afghanistan is regulated by bilateral agreements between the US and the Government of Afghanistan.[11] OEF's initial objectives included the destruction of terrorist training camps and infrastructures, the capture of al-Qaeda leaders, the termination of terrorist activities in Afghanistan, and the removal of the Taliban regime. It is now also involved in counter-narcotics operations and the training of Afghan forces.

PROVINCIAL RECONSTRUCTION TEAMS (PRTs) were introduced in Afghanistan in 2002 adding a new element to a more "traditional" international military presence in post conflict.[12] They are civil-military units, initially conceived by the US-led coalition forces when the coalition was planning to shift from combat to rehabilitation. PRT's mandate is to help the Afghanistan Government to extend its authority in order to facilitate reconstruction efforts and the development of a stable and secure environment. They are the primary agents of NATO's "**comprehensive approach**" concept, a strategic framework that aims at combining military, political and humanitarian/developmental activities towards the stabilization of a country. At the time of writing, there are 26 PRTs in Afghanistan. Twelve are led by the United States, two by Germany, and one each by Canada, the Czech Republic, Hungary, Italy, Lithuania, the Netherlands, New Zealand, Norway, Spain, Sweden, Turkey and the United Kingdom. PRTs are located according to ISAF's military needs. (See annex V – Map of the location of PRTs.)

The PRTs' broad mission has not been translated into a detailed mandate. The structure and operations of individuals PRTs have been forged by the cultural approach of the leading

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[10] As of January 2010, ISAF's total strength was approximately 84,150 troops, broken down as follows in the Regional Commands: 6,150 (Capital); 5,750 (North); 4,400 (West); 43,900 (South); and 23,950 (East). The 43 troop-contributing countries are: Albania, Armenia, Australia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Canada, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Jordan, Latvia, Lithuania, Luxembourg, Macedonia, the Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Singapore, Slovakia, Slovenia, Spain, Sweden, Turkey, Ukraine, the United Arab Emirates, the United Kingdom, and the United States. (Source: ISAF website). At present the number of troops has been increasing to up to 130,000 following the "surge" decided by the Obama administration.

[11] ISAF was mandated to cooperate with Operation Enduring Freedom in 2003. The Security Council "*Calls upon* the International Security Assistance Force to continue to work in close consultation with […] well as with the Operation Enduring Freedom Coalition in the implementation of the force mandate". SC RES 1510/2003.

[12] The establishment of PRTs was officially announced and endorsed by President Karzai in November 2002.

nation, the caveats and rules of engagement given to national contingents by contributing States, and the situation on the ground in the province of operation.[13]

An attempt to create a coherent framework and coordinate PRT activities was made in 2004 with the establishment of a PRT Executive Steering Committee **(**PRT/ESC**)** chaired by the Afghan Ministry of the Interior and given the power to issue 'Policy Notes' for all PRTs.[14]

4.1.1 A few considerations concerning the PRTs

As the PRTs vary greatly in their approaches, it is neither possible nor useful to treat them as a single entity. At one end of the spectrum, there is the Northern European approach (i.e. Sweden and Norway) with a strong civilian influence and a clear organisational division between the military and the civilian components. At the other end is the American approach, where the military overshadows the civilian component. Considerable variations in the financial resources available to each PRT have been reported; it was not possible to determine the resources available to each PRT with any precision). A detailed analysis of the differences among PRTs would require extensive field visits. However, a few general observations can be made.

Despite the establishment of an executive steering committee, PRTs continue to operate independently of each other, disconnected from any national reconstruction framework. They are more responsive to their lead nation than to ISAF headquarters in Kabul. Most informants interviewed stated that there was a disconnect between military structures at central and regional/provincial levels, and that information from Kabul was slow to reach the periphery.

The structure of the international military presence in Afghanistan appears to foster fragmentation. Local governors interact directly with PRTs, bypassing the central level. Moreover, relations with provincial authorities and the needs of local leadership appear to significantly influence PRTs' decisions on what to do and where in terms of reconstruction activities.

PRTs are perceived quite differently within the health community. There is a significant divide between international and national health actors regarding PRTs and their activities. Generally, international actors tend to be more guarded towards the PRTs, whereas national actors, in particular the MoPH, tend to consider them as a legitimate partner and a useful resource that, if appropriately channelled (i.e. according to national health guidelines), can make a valuable contribution to the health sector. Similar differences on how the PRTs are perceived have been recorded among NGOs providing basic health services in the country.

4.2 The international civilian presence in Afghanistan: an overview

The **UNITED NATIONS ASSISTANCE MISSION IN AFGHANISTAN (UNAMA)** was established in 2002 with a dual political and humanitarian mandate.[15] The mission was tasked to accompany the political process that started with the Bonn Agreement: this includes human rights protection and promotion, rule of law and transitional justice, and the organization of elections. UNAMA was also mandated to assist in the implementation of humanitarian relief, recovery and reconstruction activities. This dual mandate is apparent in UNAMA's structure: under the overall leadership of the Special Representative of the Secretary-General, two

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13 Eroen identifies 4 models of PRTs, American, German, British (Nordic) and Turkish ERONEN, O. (2008) PRT models in Afghanistan: Approaches to Civil-Military Integration. *CMC Finland Civilian Crisis Management Studies*, 1, 5

14 _____ (2004) The Charter of the Provincial Reconstruction Team Executive Steering Committee

15 Security Council Resolution 1401/2002

Under-Secretaries have been appointed, one in charge of political affairs, and one responsible for relief, recovery and reconstruction.

UNAMA has absorbed the two UN agencies that were previously active in Afghanistan: the Special Mission to Afghanistan (UNSMA) launched in July 1996, and the Office for Coordination of Humanitarian Assistance to Afghanistan (UNOCHA), that was operating in Afghanistan since January 1993 with a relief and reconstruction mandate. UNAMA's mandate has been extended until March 2011.[16]

As per UN Security Council Resolution 1917/2010 UNAMA's responsibilities regarding relations with military counterparts are:

> To strengthen the cooperation with ISAF and the NATO Senior Civilian Representative at all levels and throughout the country, […] in order to **improve civil-military coordination**, to facilitate the timely exchange of information and to ensure coherence between the activities of national and international security forces and of civilian actors in support of an Afghan-led development and stabilization process, **including through engagement with provincial reconstruction teams and engagement with non-governmental organizations**.[17]

It should be noted that "civil-military coordination" in this framework does not have the same meaning as the UN's definition contained in section 3 above. The Resolution clearly states that the aim of coordination with the military is to guarantee coherence between the activities of security forces and those of civilian actors. This contradicts the civil-military coordination guidelines endorsed by the United Nations Inter-Agency Standing Committee, which aim to ensure that the core humanitarian principles are safeguarded when civilians interact with the military in a crisis area.[18]

The United Nations **OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS (OCHA)** re-entered Afghanistan in January 2009 with the aim of "coordinating effective and principled humanitarian action". This includes taking the leadership on civil-military coordination in an attempt to tackle the inherent contradiction between UNAMA's political and humanitarian mandates. During the author's mission to Afghanistan in August 2010, OCHA was in the process of hiring staff. It plans to open sub-offices in all five regions where ISAF regional commands are deployed.

There are a large number of **NONGOVERNMENTAL ORGANIZATIONS (NGOS)** implementing a variety of activities. It is worth mentioning two NGOs that play a major role in civil-military relations.

The **Agency Co-ordinating Body for Afghan Relief (ACBAR)** is a network of national and international NGOs set up to share information and expertise and coordinate NGO activities. Although it does not represent all NGOs, it is an influential body. Notably, it represents NGOs in civil-military coordination meetings, especially when they do not wish, for safety reasons, to be directly associated with military personnel.

The **Afghanistan NGO Safety Office (ANSO)** is an independent project that aims to inform and advise humanitarian organizations on security conditions across Afghanistan. Its goal is to help NGOs deliver vital assistance by ensuring they have access to reliable independent information about their geographical areas of operation.[19] ANSO provides some of the most in-depth and accurate analysis of the security situation in Afghanistan. As part of its mandate, it relays information from the military to NGOs on planned military activities and other security information.

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16 UN SC Res 1917/2010

17 Ibid. Par 5(b)

18 Ibid Par. 6(c)

19 ANSO website

4.2.1 The ambiguity of UNAMA mandate and humanitarian action

UNAMA has a typical peace-building mandate in a post conflict scenario (technical assistance to the government, elections etc.). However, Afghanistan cannot be defined a post-conflict country, on the contrary there are entire regions under control of the Opposition Armed Groups with high intensity clashes with ISAF and US-led forces.

The inherent ambiguity in UNAMA's mandate has led to the perception that it is a political actor sustaining the government that is at present a belligerent in a conflict situation. This ambiguity appears to impact on the whole UN system. Most informants interviewed - including UN personnel – stressed how this negatively affected UN humanitarian agencies and contributed to a reduction in humanitarian space. Several informants and some authors (e.g. Donini 2010) call for the humanitarian component of the UN's work to be separated from the integrated mission in order to re-establish a clear distinction between the UN's political tasks and the work of its humanitarian agencies.

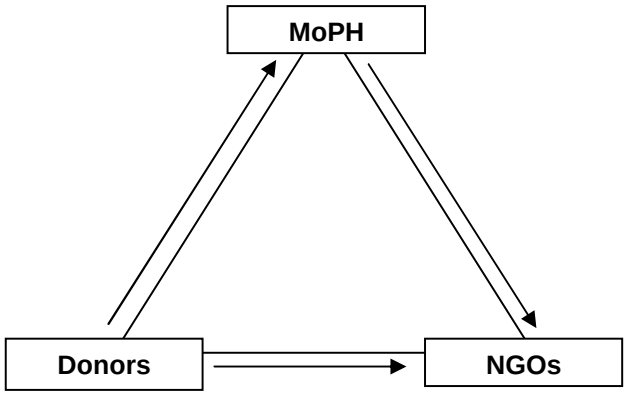
5. A brief description of the health sector and its actors

The present structure of the health sector in Afghanistan is a direct consequence of the government's very limited capacity to provide services throughout the 1990s. The constant instability and war have taken a heavy toll on the health system in terms of destroyed infrastructures and lack of trained personnel. Until 2001, most health services were provided by NGOs, with limited, if any, coordination by the MoPH. By the time the Taliban regime was toppled by the US-led coalition in 2001, 80% of health facilities were directly managed or supported by a NGO.

In the post-Taliban period the MoPH developed a Basic Package for Health Services (BPHS) and an Essential Package for Hospital Services (EPHS).[20] The first comprises a standardized package of basic health services to be provided in all primary health care facilities, with a focus on vulnerable groups (women and children). The second provides guidance on how to staff and equip hospitals as well as design a referral system that integrates the BPHS into the hospital system.[21] The MoPH's overall aim was to standardize basic health care and ensure equitable access to health services, especially in underserved areas. The cornerstone of this strategy was a strong partnership with the NGOs that were already providing health services in Afghanistan.

The health system in Afghanistan is based on three pillars (see diagram below):

The health system in Afghanistan



[20] The BPHS were adopted by the MoPH on March 2003, the EPHS on July 2005.

[21] Description taken from BELAY, T. A. (Ed.) (2010) *Building on Early Gains in Afghanistan's Health and Nutrition Sector: Challenges and Options*, Washington D.C., World Bank. Pages 9 and 10.

- The MoPH plays the role of steward, setting policy guidelines and subcontracting service delivery to NGOs.
- Three main donors fund the health system. The European Commission provides direct support to NGOs, USAID directly finances the MoPH, and the World Bank finances the national budget.[22]
- The sub-contracted NGOs provide basic health services in 31 of Afghanistan's 34 provinces, following MoPH policies and guidelines.[23] NGOs are required to provide data to the national Health Information System.

This system has allowed the Afghan health sector to make considerable progress. Over the past six years there has been a sharp increase in the number of facilities providing primary health care, and a reduction in under-five and infant mortality rates. (See Table I above.)[24]

5.1 NGOs implementing BPHS and humanitarian action

NGOs implementing the BPHS have a formal agreement with the MoPH, making them de facto governmental agencies implementing a governmental programme. Many of these NGOs also provide humanitarian health assistance as needed. Thus, the identity between humanitarian, rehabilitation and developmental health organizations is blurred, with the same NGO often covering the whole portfolio.[25] This may raise doubts regarding NGOs' ability to project an independent and impartial image vis-à-vis different local actors, in particular armed opposition groups.

Interestingly, there was a consensus among the NGO representatives interviewed (confirmed by other informants) that being part of the national health system and delivering BPHS does not affect how local populations and authorities perceive the independence and impartiality of individual NGOs. Several reasons for this were proffered:

- NGO can be contracted by the government but health activities can be branded as non-governmental.
- Representatives of NGOs, the military and the UN stated that armed opposition groups possessed a sophisticated analytical capacity and were able to distinguish between organizations providing impartial (i.e. based on needs) health services, even if through a governmental programme such as BPHS and organisation acting as agents of military and political agendas.
- Lastly, to use the words of an informant "BPHS are vital for communities and the Taliban needs the support of communities; they will not target services that provide assistance to their constituency."

In fact, BPHS is being implemented in several provinces and districts that are under the control of the Taliban or other armed groups, without this being a source of major problems.[26] Taking into account all the constraints to operating in Afghanistan, there was consensus

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22 These 3 donors support more than 90% of BPHS and EPHS programmes.

23 In 3 provinces BPHS are implemented directly by the MoPH in the framework of a World Bank scheme.

24 DUGUÉ, M. (2008) Study of Health Care Financing in Afghanistan *Project 2008/152.431, Framework Contract: LOT 8 Health*

25 For example BRAC, a Bangladeshi NGO implements programmes that go from health and education to micro-finance and agriculture. The issues of the blurred identity of NGOs is well portrayed in DONINI, A. (2009) Afghanistan: Humanitarianism under Threat. *Briefing Paper*. Feinstein International Center.

26 Several representative of NGOs interviewed were not comfortable in disclosing the exact location where BPHS are implemented. However, this fact has been confirmed by all informant contacted.

among informants that "humanitarian behaviour"[27] still provides some form of protection to NGOs working in areas controlled by armed opposition groups.

6. The civil-military relations system

It is extremely difficult to analyse the above subject, given the lack of an overall framework for civil-military relations and their consequent fragmentation into working groups, bilateral contacts, and sector-specific meetings and other initiatives. However, a key distinction can be made between central and provincial levels.

6.1 Civil-military relations in Kabul

Until April 2010, the **Civil-Military Working Group** meetings co-chaired by ACBAR and OCHA constituted the main coordination mechanism. A wide range of humanitarian actors and ISAF representatives attended the meetings, mainly to exchange information between the humanitarian community and NATO. However, the NGO community stopped attending the meetings, which they considered to be, in the words of several informants, "irritating" and a "non-working group". A key reason the NGO community gave for its disengagement was that the military personnel attending the meetings were seldom, if ever, able to address the issues and problems raised during the discussions.

Since the end of the formal working group meetings, most civil-military interaction in the capital takes place bilaterally, with each organization engaging with the military on specific issues and problems.

For the health sector, WHO engages with the military on specific health issues. For example, implementation of a polio vaccination campaign served to open communication channels at the highest level with COMISAF and insert health issues into the military agenda.

The Health Cluster coordinator also acts as an interface between the health humanitarian community and ISAF, acting to some extent as a buffer between the military and Cluster members that do not wish to have any direct contact. In this regard it should be noted that ISAF's medical component has been asking for some time to become a full member of the Health Cluster. Their request has been rejected, and an ISAF medical representative is invited to cluster meetings only on an ad hoc basis to address specific issues related to coordination between armed actors and humanitarian clusters (see para. 6.3 below).

The Consultative Group for Health and Nutrition (CGHN) also provides a framework for civil-military interaction. Its members include senior MoPH staff and representatives of other government ministries, UN agencies, donors, principal NGOs and ISAF. The CGHN's aim is to oversee the policy and operational aspects of health service provision.

6.2 Civil-military relations at regional and provincial levels

There are civil-military coordination meetings in all five regions where ISAF is present (see para. 5.1 above). Very little was reported on if and how these meetings work. However, during the author's mission to Afghanistan, OCHA was in the process of building up its presence in the country and was planning to assign a civil-military coordination officer in each city with an ISAF Regional Command.

Most civil-military relations take place at provincial level, mirroring the fragmentation of the international military presence in Afghanistan described in previous sections. There is no single method of coordination, and each province has developed its own system. For example, in Kandahar there is a Civil-Military Forum that is attended by the military (ISAF and PRT) and UN humanitarian agencies, but not by NGOs.

[27] One of the informants interviewed so defined the behaviour of NGOs acting according to humanitarian principles.

In Jalalabad, NGOs have withdrawn from the UNAMA-hosted Provincial Civil Military Working Group over concerns about the Taliban's rising presence in the province and the dangers of being seen to be associated with the international military forces. UNAMA has transformed the working group into a Civil Military Small Contact Group. ACBAR attends meetings on behalf of the NGOs in the province. To safeguard the security of participants, the group produces no written records of who attends the meetings or the topics discussed.

There are other coordination mechanisms at provincial level that provide a framework for civil-military interaction. For example, the **Provincial Development Committees** (PDCs) chaired by provincial governors serve as fora to address priority needs in the provinces. Lists of priority projects are presented to PDCs; members can then volunteer to take responsibility for specific projects.[28] PRT representatives attend regularly PDC meetings.

Provincial Health Coordination Committees (PHCCs) coordinate the activities of all stakeholders towards achieving MoPH priorities, particularly the delivery of the BPHS. The PHCCs are chaired by the Provincial Directors of Public Health,[29] and ire also attended by PRT representatives, although not in all provinces.

The above two committees should be considered as coordination systems aimed at bringing all stakeholders together to identify resources and allocate responsibilities rather than as civil-military coordination structures in the normal humanitarian sense. They are included in this study to reflect the complexity of civil military interactions in Afghanistan.

6.3 Civil-military coordination documents in Afghanistan

Two sets of guidelines have been developed to regulate civil-military relations in Afghanistan:

a. Guidelines for the Interaction and Coordination of Humanitarian Actors and Military Actors in Afghanistan (endorsed on 20 May 2008 by the Civil-military Working Group);
b. Guidance Note on Coordination Between Armed Actors and Humanitarian Clusters in Afghanistan (issued on 15 June 2008).

The first document is aimed at creating a framework for all stakeholders (civil and military) on how to conduct and adapt their relations according to the local context and the UN's civil-military coordination guidelines.[30] The second is directed at humanitarian clusters, and provides practical guidance on whether and how to interact with the different components of the military, again with reference to the UN guidelines.

The fragmentation of civil-military relations in Afghanistan makes it difficult to assess if and how these guidelines are being applied in day-to-day civil military relations. It is worth noting that only four[31] of the 46 informants interviewed spontaneously mentioned the UN's local and/or overall civil-military guidelines as a source of guidance. When asked directly, however, all informants said they were aware of them.

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[28] PDC are generally attended by UN, the Land Department, ACBAR, donors and PRTs representative. PDCs are organised in thematic working groups such as Health & Nutrition, Education, national Resource Infrastructure (water), Agricultural &Rural Development, Social Protection, and Private Sector.

[29] The Provincial Director of Public Health is the local representative of the MoPH.

[30] The main CM guidelines developed within the UN system are: IASC (2008) Civil-Military Guidelines & Reference for Complex Emergencies. OCHA (2007) Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief - Oslo Guidelines. United Nations. OCHA (2001) Use of Military or Armed Escorts for Humanitarian Convoys: Discussion Paper and Non-Binding Guidelines.

[31] From ISAF, UNHCR, OCHA and one NGO.

There was a general agreement that the international guidelines, while outlining the principles of civil-military coordination, provide little practice guidance to humanitarian actors working in Afghanistan. Moreover, the international guidelines contain little information on the policy to adopt regarding the National Afghan Force that is becoming an increasingly important presence in Afghanistan.

Lastly, PRT/ESC Policy Note N.3 on "*PRT Coordination and Intervention in Humanitarian Assistance*", issued in 2007 and updated in January 2009, provides "direction as to how PRTs are to engage in disaster relief efforts at the provincial level and how to support provincial Disaster Management Teams (DMTs). This aims to promote effectiveness and efficiency as well as preserving humanitarian space". The policy note refers to the principles outlined in the UN's main civil-military coordination guidelines as well as those developed for Afghanistan. Considering the fragmentation of the PRT system previously described (see para. 5.1.1), it is reasonable to assume that adherence to Policy Note 3 will vary greatly from province to province. The policy note was used to guide civil-military coordination efforts following the earthquake that hit Jalalabad in April 2009. As a result, there was no direct distribution of relief items by the US military to the population.

6.4 ISAF Guidance on Military Medical Engagement

In July 2010 ISAF issued standard operating procedures (SOPs) covering the military's engagement in health activities.[32] The SOPs are addressed to all military forces including troops operating under OEF and PRTs. They stress that the health sector is primarily the responsibility of civilian authorities (MoPH and sub-contractors), and they make it clear that the military should engage in health activities only in a supportive role and under specific circumstances (e.g. as a last resort or when directly asked by civilian authorities).

The SOPs aim to ensure that harmful military involvement in health activities is avoided (see section 7 below) and that any involvement that does occur respects principles such as do no harm, the sustainability of activities, compliance with national health guidelines and coordination with main health actors.

It is clear that ISAF, OEF and the PRTs will continue to be involved in health activities in Afghanistan. Rehabilitating the health system is considered crucial to "building closer relationship between the Afghan Government (including Afghan military forces) and the local population" (see para 25 of the SOPs) and therefore to the success of the counter-insurgency effort. Seen in this context, there is an unavoidable tension between the document's stated aim and the mandates of humanitarian organizations.

However, it appears that ISAF has been on a steep learning curve in terms of understanding the position of humanitarian organizations. The document specifically recommends avoiding direct patient care. It underlines the necessity of adhering to the national health strategy, acknowledges that ISAF is neither neutral nor independent, and recommends avoiding entering health facilities and or engaging in other behaviour that might endanger the safety and security of health actors.

While these SOPs are undoubtedly useful, their practical application nation-wide will probably require a sustained training and advocacy effort targeting PRTs and national contingents.

6.5 Trends in civil-military relations

At present civil-military relations are going through a "disengagement phase" with NGOs either detaching themselves from formal coordination mechanisms with international military

[32] REES, A. (2010) Standard Operating procedures 1154 - ISAF Guidance on Military Medical Engagement in Health Sector Reconstruction and Development. NATO/ISAF.

forces or participating only through representative bodies (i.e. ACBAR). Not all NGOs agree on this 'disengagement' approach at central level. However, at provincial level there is a consensus that engagement with international military forces should be kept to a bare minimum. This disengagement is actively encouraged by ACBAR and by ANSO, both of which stress the importance of avoiding direct involvement in civil-military coordination, arguing that, at present, NGOs have more to lose than to gain from participation in such activities.[33] The NGOs' disengagement, which began around March/April 2010, is probably directly linked to the deteriorating security situation. It is expected to continue in the next months.

With the end of the meetings of the Civil-Military Working Group, UN agencies have also partly disengaged, at least at central level. Disengagement should not be taken to mean that all communication has ceased. On the contrary, civil-military coordination continues through many bilateral and multilateral channels. However, the more traditional civil-military coordination approach, through formal working groups, seems less viable at present.

Conversely, NGOs have begun engaging with (or are being more open about) armed opposition groups. It is reasonable to believe that the civil-military framework in the coming months will involve opening more and more negotiations with these groups in order to gain access to populations living under their control. During the author's visit to Afghanistan, OCHA was just starting to expand its presence in the country, and it is difficult to assess what role it will play in this new turn of events. However, it is reasonable to believe that it will work to increase the operational humanitarian space in areas controlled by armed opposition groups. Several NGOs indicated they would welcome OCHA's assistance in this regard.[34]

There is a general consensus that there have been fewer health sector incidents involving international military forces over the past six to eight months, partly as a result of sustained advocacy efforts by civilian organizations.

Informants almost unanimously attributed the fast turnover of military personnel as a major reason for weak civil-military relations. The humanitarian community's briefing and advocacy work, and the efforts that go into establishing positive relationships, are lost when military personnel finish their period of duty and new personnel arrive. In the words of one informant, "the moment we start to obtain positive results, we have to start everything again from zero".

Most of those interviewed said they anticipated more and more problems and incidents with the Afghan security forces (both army and police). Many expressed concern that civil-military coordination and communication systems lacked specific tools to specifically address national security forces and that this type of relations will probably become the core of civil-military relations.

7. Health activities carried out by the military

During the author's visit to Afghanistan it was not possible to collect precise data on either the kinds of health activities carried out by the military or the material and financial resources it contributes to the Afghan health system. The information that follows was gathered mainly from interviews and from the limited secondary data available.

All armed forces traditionally conduct some type of health activity to foster local acceptance of their presence. NATO has used the PRTs to implement its 'comprehensive approach',

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33 ANSO (2010) Quaterly Data Report. *January - March 2010.*

34 On 1st July 2010 a consortium of 31 NGO active in Afghanistan wrote a letter to John Holmes, at the time Under Secretary General for Humanitarian Affairs urging OCHA "to strengthen and protect humanitarian space; ensure that humanitarian coordination is proactive, accountable, inclusive and appropriate to improve effectiveness of the response; and to prioritize strengthening OCHA's information management capacity". Source: http://www.alertnet.org

integrating developmental work into its overall intervention strategy. In this framework the health sector has strategic importance: it is considered crucial not only for the success of the counter-insurgency strategy but also for the stabilization of Afghanistan.

The following paragraphs broadly describe the main health activities carried out by the military in Afghanistan.

The **SPECIAL FORCES (**under both NATO and OEF), run the Medical Civil Assistance Program (MEDCAP). This usually involves the direct, time-limited provision of health care services to communities selected for their military strategic value. MEDCAP is always implemented within an overall counter-insurgency and intelligence gathering framework: its main objective, in other words, is unrelated to health. The special forces also run medical seminars (MEDSEM) that basically consist of health and hygiene training sessions for selected community members. MEDSEM adheres to the same military philosophy as MEDCAP. [35]

Most **ISAF NATIONAL CONTINGENTS** have their own medical units, which have varying medical capacities. Some have full field hospitals.[36] These medical units are deployed first and foremost to treat soldiers. Any spare capacity is used to provide direct health care services to the people of Aghanistan. This has reportedly included randomly distributing drugs to local communities and donating medical equipment directly to health facilities.

The military's direct health assistance to local populations in conflict settings is not uncommon. In Afghanistan it is often based on military health personnel's desire to 'do good'. However, these health activities are largely unreported and uncoordinated with the national health system, and their scope and impact are lost in countless personal anecdotes and stories.[37]

PRTs are the military units primarily involved in health activities. They participate in health coordination mechanisms at provincial level, where they are perceived - and treated - as partners by some health actors. On the other hand, they are not part of the health system and their coordination with other health actors reportedly varies from good to absent. Information regarding PRTs' involvement in health activities is mainly anecdotic. In Kabul it was not possible to find systematized information regarding health activities implemented by PRTs.

Reports indicate that PRT personnel have also been involved in MEDCAP and other "winning hearts and minds" activities such as the distribution of free medicines. On more than one occasion, these activities have carried out in health facilities where NGOs are implementing the BPHS. In addition to these counter-insurgency strategies, PRTs are regularly involved in other activities such as:[38]

- Constructing and renovating health facilities;
- Training civilian and military health care providers;
- Donating equipment, supplies and ambulances to health facilities;
- Assisting with public health education programmes;
- Assisting with emergency disaster response efforts.

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35 MEDSEM approach was presented during a conference organised by ISAF/MEDAD on "The Military and Health Sector Development", 7-10 July 2010.

36 Like the US, UK, Jordan and Germany.

37 For example, the German Hospital in Mazar had massive influx of patients; a referral system was set-up the entrance of the hospital to filter the in-flux of patients. It was later discovered that the person in charge of the referral was actually asking money to patients to admit them inside. Or, the Americans have been reported to conduct mobile clinics in Zabol province contacting an international NGO to discuss 'best practice' in this field.

38 In January 2010 the MoPH conducted a survey with NGOs implementing partners to ascertain the types of health activities carried out by PRTs. The genereal results were presented at an ISAF conference in July 2010, and are included in this document. However, the precise data collected through the survey have not been not made public.

Obtaining a precise picture of PRTs' involvement in the health sector would require an-depth field study of all PRTs; even then, the overall picture might remain unclear.[39]

The concerns of the humanitarian/developmental community and, to a certain extent, the MoPH regarding PRTs' involvement in health are:[40]

- Military actors establish health facilities without consulting and coordinating with the Ministry of Public Health (MoPH) or BHPS implementing partners. This tends to leave these health facilities outside the national health system and therefore without appropriate funding, staff and supplies.
- Often, these health facilities do not conform to the national health plan, are built in unsuitable locations, and do not meet MoPH building standards.
- There is a lack of transparency concerning the cost of conducting the health activities and the resources used.
- The medical equipment donated does not comply with MoPH guidelines, and national staff are often unable to operate it.
- Donated drugs are not on the MoPH's essential drug list and are thus unfamiliar to national health care providers.
- MEDCAP activities are not planned according to health needs and tend to raise the population's expectations concerning what the national health system can provide.
- On several occasions, soldiers in uniform have conducted health activities inside health facilities.

The above concerns were gathered from informant interviews and from the presentations made by two NGOs at a recent a conference organized by ISAF ISAF/MEDAD.[41]

The informants mostly agreed that the frequency of the above incidents appears to have decreased over the past six to eight months. In particular, coordination has improved and MEDCAP activities have decreased. On the other hand, there has been an increase in the number of incidents involving national security forces, including threats to health personnel providing health care to members of armed opposition groups.

Several informants stressed that PRT activities - particularly the rehabilitation of water networks and health facilities - were useful and important, provided they were properly coordinated with health authorities.

7.1 Impact on the health sector

It is obvious that military actors are conducting indirect and direct health activities in Afghanistan as it is obvious that they are going to continue to do so in the near future. Given the scarcity of data, it is difficult to assess the impact of the military's health activities on the country's health system with any degree of certainty. Nonetheless, the following concerns have been raised.

First and foremost there are serious concerns regarding the safety and security of health staff and facilities. There is near-unanimous consensus that close association with international military forces increases the risk of security incidents involving armed opposition groups. When military personnel carry out "winning hearts and minds" health activities inside or near public health facilities, this increases the risks of these facilities and their personnel being

[39] During the author's visit to Jalalabad, she interviewed both the Provincial Health Director and local PRT staff. She was unable to obtain detailed information concerning PRTs' activities.

[40] Presentations made by BRAC and AHDS at the conference "The Military and Health Sector Development", 7 to 10 July 2010.

[41] Ibid.

targeted by armed groups. Even the mere physical rehabilitation of a health facility has, on certain occasions, triggered an attack.

Moreover, the military's involvement in health activities generates confusion and blurs the identity of civilian health care providers. In the words of an informant: “there is too much confusion, it is difficult to understand who does what and why ... NGOs able to present themselves with a strong civilian and humanitarian identity risk a lot less.”

Other concerns relate to the impact of the military's involvement on the overall health system. Although some health indicators have improved with the implementation of the BPHS and EPHS, the country's health system remains fragile and uneven.[42] While the international military presence is not the cause of these weaknesses, both governmental and nongovernmental organizations have raised concerns that PRTs' health activities might exacerbate inequities in the health system because:

i. PRTs are located according to military needs, not the health needs of the local population.[43]

ii. There are considerable variations between PRTs. Some, managed by rich countries, expend considerable resources in their areas of operation. Others have fewer resources.

Given the inconsistency among PRTs, and the lack of coordination described in previous paragraphs, it is clear they will do little to improve inequalities in the health system.

Health actors also raised concerns that uncoordinated health activities such as MEDCAP and random drug distributions tended to raise local populations' expectations concerning the type and amount of services provided by the MoPH. The BPHS is designed to make the most of scarce recourses by focusing on high-impact health interventions targeting the main health problems in the country. Supplementing this basic package with health actions driven by other priorities can create frustration and a lack of trust in the health system. Moreover, drug distributions tend to be more supply driven than based on needs. Often, drugs are not on the unknown to local health care providers, and are prescribed to patients without a real understanding of their appropriate use.

8. Conclusions and Recommendations

Afghanistan is fraught with ambiguity and fragmentation:

- ambiguous mandates of the international military and the civilian presence;
- fragmentation of international and national actors, activities, and lines of communication and coordination.

There is no unique framework for civil-military relations in the country. Instead, there are a multitude of mechanisms in Kabul, the provinces and the five regions where there is an international military presence.

The traditional approach to civil-military coordination - i.e. through formal working groups - has not been effective in Afghanistan. In particular, it proved unable to protect humanitarian principles in a complex context with a strong international military presence and a UN mission with an ambiguous mandate. **The formal Civil-military structures have been reinforced or directly by-passed by bilateral channel of communications and other form**

[42] The average population per BPHS facility can greatly vary from province to province. E.g. Urzugan province 52,000 per BPHS facility; Jawzjan province, 5,500 per BPHS facility. Data 2008 from WHO presentation to NATO JMT Plenary, 5-6 November 2009.

[43] E.g. In Daikondi Province a representative of the local community has been reported as saying: “We are victims of peace! No conflict; no PRT; no resources."

of ad-hoc relations that proved to be more effective in guarantying a vital exchange of information between military and civilian and provided a channel to advocate for humanitarian principles.

At present civil-military relations are going through a "**disengagement phase**" with NGOs detaching themselves from formal coordination mechanisms with international military forces, or participating in these meetings only through representative bodies. It is expected that this phase will continue and will characterise the relations with the international military forces.

International Civil-military coordination guidelines, while clearly outlining the guiding principles, provide little practical guidance to humanitarian actors operating in Afghanistan. The development of country-specific guidelines partially amended this. However, the Civil-military coordination trends are moving away from the traditional international military – international civilian relations. In **Afghanistan the relations with National security forces (Army and Police) will become more and more important in the Civil-military relations arena.** Still, this is an area where little reflection has been made internationally as well as nationally.

- *The process of identifying communication strategies in order to advocate for humanitarian principles to National security forces should start as soon as possible.*

Security scenarios were and remain volatile in Afghanistan with provinces experiencing violent conflict and provinces relatively stable and with local dynamics evolving fast. The civil-military relations system appear to have been adapting to this situation given that the majority of Civil-military interactions occur at regional/provincial level.

All international military components present in Afghanistan carry out some form of health activities. The medical units of ISAF national contingents provide health assistance to the population as part of a long standing military tradition of implementing activities that facilitate 'force acceptance'; OEF implements MEDCAP as part of a "winning hearts and minds" counter-insurgency strategy; the PRTs implement different kind of health activities both as counter-insurgency strategy and as part of a wider rehabilitation and stabilisation effort.

There is a **lack of information regarding what the PRTs are doing in the health sector**. What is being done, where and with what resources is difficult to know. This impedes an assessment of the positive or negative impacts such activities have on the Afghan health system. Locally, good coordination experiences with positive outcomes have been reported, as well as negative episodes of uncoordinated health intervention carried out by military.

Notwithstanding some local positive experience, **the way the PRTs' system is structured**, with the fragmentation and lack of coordination that it entails, **is not geared toward addressing the inequalities of a health system** that is struggling to provide basic health care to the population.

- *At provincial level data collection on military health activities should be strongly encouraged. The Health Cluster, through its members, is in a unique position to lead activities in this sense.*

Within the international military forces there are different sensibilities regarding the relations with civilians' counterparts and regarding the respective roles and mandates in the health sector. In this regard, there is space for constructive dialogue with the military to limits incidents and advocate for humanitarian principles. However, it should always be considered that ISAF structure and PRTs independence of action makes difficult to ensure that whatever it is decided in Kabul it is actually followed and implemented at regional and provincial level.

- *In the Afghan framework, the SOP on Medical Engagement in Health Activities drafted by ISAF are a useful tool for damage prevention/reduction in the health sector.*
- *A strategy to spread the contents of the SOP on Medical Engagement in each PRT and national contingents should be encouraged and supported*

A correlation has been reported between international military forces being associated to health facilities and security incidents and threats to the same facilities and personnel working within.

- *Separation and distance of any military or political activity from health structures and facility should be strongly advocate at all level in the military hierarchy by the WHO and the MoPH.*

There is a general consensus that **in the past 6/8 months, incidents in the health sector with international military forces have been gradually reducing**. To some extent, the continuous advocacy done by civilian organisations to international military personnel has resulted in some positive outcomes.

- *Communication lines with the military should always be maintained in order to constantly advocate for the protection of health facilities and personnel.*

BPHS are implemented in several provinces and districts that are under Taliban or other opposition groups control. Interestingly, the fact the NGOs are implementing a governmental programme does not affect their capacity of working in opposition controlled area. On the contrary, Taliban and other armed groups are keen to ensure that the population under their control can access health services.

The ambiguity and fragmentation of the Afghan scenario renders difficult to humanitarian actors to project an image of independence and impartiality. Despite this, a behavior driven by humanitarian principles on the part of health organisations and institutions is still able to open humanitarian space and facilitate access offering some, even if limited, protection from the conflict dynamics.

Annexes

Annex I - Selected Bibliography

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WHO (2005) Civil Military Cooperation. *Conference on the Health Aspects of the Tsunami Disaster in Asia*

Annex II – List of key informants

(In alphabetical order)
A total of 46 informants were interviewed. A number of them specifically asked not to be included for security reasons. It was therefore decided not to circulate the list of names.

Annex III – Interview scheme

Interviews were conducted informally. No recording device was used; notes were taken manually and reviewed every evening.

During group interviews, regular, brief summaries of the discussion were made, inviting participants to confirm the interviewer's understanding was correct. When sensitive topics were broached or strong opinions were voiced by participants, the interviewer asked the other members of the group for their consensus (or lack thereof) on the specific issues raised.

In general the scheme below was followed. (Not all questions were proposed to all informants, and the order in which the various topics were approached varied from interview to interview.)

A. Acknowledgment and appreciation of the time dedicated to the interview.

B. Presentation of the terms of reference and background of the case study.

C. Questions related to the mandate/activities of the organization/institution in Afghanistan.

D. Questions related to the informant's involvement with formal or informal civil-military coordination activities with either international military forces or international civilian organizations.

Description of the activity; the informant's personal assessment of its effectiveness in attaining the organization's objectives; appraisal of the attitude of the military or civilian counterpart; etc.

E. Questions related to the impact of activities carried out by military personnel on the work of the organization/institution.

F. Questions related to specific incidents with military personnel (if any).

G. Questions related to health activities directly carried out by military personnel.

H. Questions related to relations with national security forces (army and police).

I. Questions related to health activities carried out in areas controlled by armed opposition groups.

J. Questions related to incidents involving armed opposition groups.

K. Questions related to a general assessment of the situation in the country or province.

L. Conclusion of the interview with a final question such as: do you think we have covered everything or you think there is something else to add.

Annex IV- Summary of Civil Military Coordination Guidelines

The humanitarian world has produced a significant volume of documentation aimed at providing guidance on civil-military coordination. This body of work arises from the concern that civil-military relations, if not carried out within specific limits, can threaten the humanitarian community's core values of humanity, impartiality, neutrality and, consequently, its ability to operate. **It is generally recognized that associating too closely with military actors can leave humanitarian organizations and their staff vulnerable to political manipulation**, undermining how they are perceived and affecting their credibility as neutral partners. It can even increase the risk of direct violence against humanitarians.

The key recommendations to defuse these risks, contained in various IASC-endorsed guidelines, can be summarized as follows:[44]

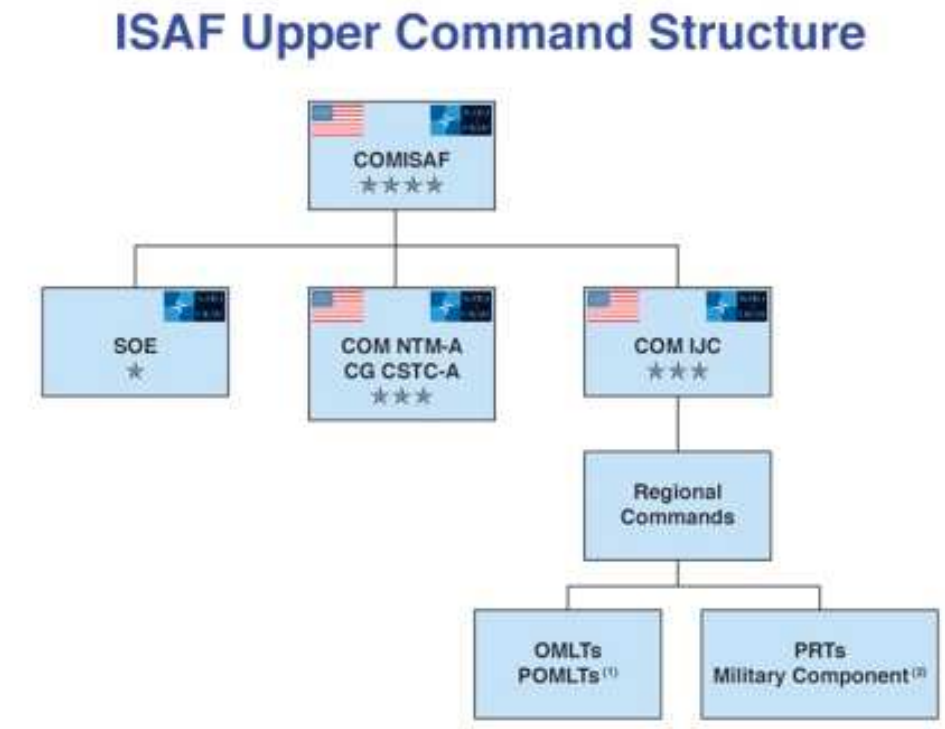
1. Maintain a clear distinction between the roles and functions of humanitarian community and those of the military.
2. Humanitarian operations that use military assets must retain their civilian character.
3. Military assets must be used only as a last resort.
4. As a matter of principle, the military and civil defence assets (MCDA) of belligerent forces actively engaged in combat shall not be used to support humanitarian activities.
5. Any request to use military assets must be made by the Humanitarian/Resident Coordinator.
6. Humanitarian work should be done by humanitarian organizations. The military should avoid direct assistance unless it is for the sole purpose of providing life-saving assistance.
7. The use of MCDA should be planned so as to be limited in time and include a clear exit strategy in order to avoid creating a dependency on military support.
8. Countries providing MCDA should respect the UN's codes of conduct and humanitarian principles.[45]
9. As a general rule, humanitarian convoys should not use armed or military escorts.[46]

[44] The guidelines listed in this annex have been summarise from the following documents: OCHA/ECHO (2008) United Nations Civil-Military Coordination Officer Field Handbook. IASC (2008) Civil-Military Guidelines & Reference for Complex Emergencies. OCHA (2007) Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief - Oslo Guidelines. United Nations.

[45] UN codes of conduct can be found in: "W**e** are United Nations Peacekeeping Personnel – UN Standard of Conduct" *A*lso: "Ten Rules Code of Personal Conduct For Blue Helmets" http://ocha.unog.ch/ProCapOnline/docs/library/UN%20Blue%20Helmets%20Codes%20of%20Conduct.pdf. The core of humanitarian principles are contained in: **"**the code of conduct for the international red cross and red crescent movement and non-governmental organisations (NGOs) in disaster relief" www.icrc.org/web/eng/siteeng0.nsf/htmlall/code-of-conduct-290296

[46] OCHA (2001) Use of Military or Armed Escorts for Humanitarian Convoys: Discussion Paper and Non-Binding Guidelines.. Exceptions to the general rule are allowed within specific benchmarks.

Annex V – ISAF Command Structure



(1) Operational Mentoring and Liaison Teams (OMLTs) and Police Operational Mentoring and Liaison Teams (POMLTs)
(2) The civilian component of a Provincial Reconstruction Team (PRTs) is run by the ISAF nation leading the PRT

Annex VI – Map of the location of PRTs in Afghanistan