

18 **Military engagement in civilian healthcare in Uruzgan**

An ethical perspective

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Introduction

In 2006, the Afghan Research and Evaluation Unit (AREU) reported existing available health services in Afghanistan to exceed services provided at any time in the past. However, this applied mainly to cities and regions where health workers and the population were feeling secure. In Uruzgan, at that time, only half of the facilities planned by the Ministry of Public Health (MOPH) had been established and were functional (AREU, 2006).

Four years later, assessing the Dutch engagement in Uruzgan from 2006-2010, The Liaison Office (TLO) found the number of health facilities in Uruzgan to have doubled; partly encompassing unstable areas. Particularly, the upgraded Tarin Kowt hospital and its cooperation with the military hospital is mentioned as an important asset to provincial healthcare (TLO, 2010: 15). Although the additional clinics, staff, resources and capacity building mark improvements in healthcare, such developments foremost benefit Uruzgani living within the Dutch focus districts. Elsewhere, residents still face serious capacity limitations in healthcare and complain about unqualified or absent staff and unavailable medication (TLO, 2010: 16).

From the evaluations of both AREU and TLO, a void in the provision of civilian healthcare becomes manifest. Due to the expeditionary nature of their missions, the military are being confronted with the consequences and, although military health care's primary role is to conserve force strength, activities in the domain of medical assistance to civilians have become a significant component of military operations (Neuhaus, 2008). In fact, over the past decade, the majority of casualties treated by international militaries have been civilian patients. However, as expeditionary missions are conducted temporarily, the provision of military healthcare to civilians is inevitably only for the time being and therefore hardly sustainable.

Compounding the concerns about reconstruction principles, such as sustainability, operations in Iraq and Afghanistan have created a *renaissance of counter-insurgency thinking* in which the *winning of hearts and minds* to increase the legitimacy of the host nation authorities features prominently (Egnell, 2010). When looking at military engagement in civilian healthcare from the perspective of winning hearts and minds of the local population another set of concerns emerges. First, because this concept may be built on false causal assumptions regarding presumed links between stabilization and aid (Wilder, 2008). In reality, there are no indicators in health programmes –and neither in state-building programmes– that show whether or not the provision of improved health services contributes to a population's willingness to view its government more favourably (Waldman, 2007).

Also, although providing healthcare impartially to those in need forms the essence of the Hippocratic oath, it is debated whether medical military staff can avail of the necessary humanitarian expertise to perform this 'good deed' in the right way. Moreover, it is argued that in an environment as non-permissive as Uruzgan the military cannot afford to be distracted from obtaining their primary security objectives. As we will see, combining security and healthcare can and will lead to ethical dilemmas.

Against this background, this chapter attempts to identify some ethical concerns evoked by military engagement in healthcare reconstruction. By bringing empirical evidence to the ongoing debate in military and development communities we aim to shed some light on the central question if and how, from a military ethical point of view, military should be involved in healthcare reconstruction during stabilization and reconstruction operations in Uruzgan.

Military engagement in healthcare reconstruction; an ethical perspective

Most manifestations of military ethics and medical ethics respectively are fairly consistent as to whose interests are most important, though it seems that they point in different directions. If we, for instance, look at the medical oath, we see that the common denominator is that a doctor should work in the interest of his patients. Generally, parties outside the doctor-patient relationship, such as hospitals or governments are not mentioned. In this respect, the military oath differs; as a rule it stresses loyalty to a head of state, constitution, republic or people. The people at the receiving end, for instance, the local population in Uruzgan, are not included. Similarly, the value lists of various armed forces mainly mention values (such as courage, loyalty, discipline, and obedience) that further military effectiveness (Robinson, 2007), whereas the values of the medical profession give precedence to the patient and the doctor-patient relationship. If we, lastly, look at codes of conduct, we find that military codes of conduct are mostly about regulating the conduct of military personnel towards each other, whereas codes of conduct for doctors emphasize the

patients' interests. In brief, medical ethics is about patients and medical care, while the gist of the codes, oaths, and values in most militaries mainly pay attention to the organization and colleagues.

These two different ethics, medical and military, can – and do – lead to conflicting loyalties in the case of medical professionals in the armed forces, for example when their presence during unlawful interrogation is presented, as in the interest of the detainee. In such cases, 'military medical personnel are placed in a position of a "dual loyalty" conflict. They have to balance the medical needs of their patients, who happen to be detainees, with their military duty to their employer' (Clark, 2006: 570). Dilemmas of a different kind arise when, for instance, medical personnel must choose whom to help first: a seriously wounded insurgent or civilian, or a somewhat less seriously wounded colleague. Research into the functioning of Dutch military medical personnel in Afghanistan showed that, although most military medical personnel believed they could deal with moral dilemmas adequately, their actual behaviour in dealing with dilemmas differed very much from person to person – for example, whether or not they should help the local population with medicine earmarked for own military personnel (Meerbach, 2009).

Generally, it thus seems that medical personnel facing such dilemmas do make decisions, and can account for these decisions afterwards. Military personnel attach great value to being able to, as they put it, 'look at yourself in the mirror,' and most medical workers deployed seem to pass that test. Yet, the question remains whether this specific criterion is any good in these cases, as the decisions made, and the arguments to defend it rendered afterwards, vary greatly from person to person. For instance, the fact that helping locals could undermine the local health system was seen as an important argument contra helping. Others, however, conversely argued, that helping locals increased good-will, and could thus lead to increased information and support from the local population (Meerbach, 2009).

Attempting to resolve such tensions of military health professionals, in offering a set of ten guidelines, the International Dual Loyalty Working Group (2002) pleads to prioritize medical ethics over military considerations (i.e., to be loyal to the patient, under all circumstances). The same applies to London et al.'s (2006) plea for a rights based framework, representing 'a priori moral reasoning that privileges the protection of vulnerable people from state-sponsored harm, no matter the alleged justification,' and for civilian oversight by means of 'a commission with membership that includes an adequate number of civilian health professionals skilled in ethical issues and human rights'. Benatar's and Upshur's plan (2008) for a 'totally independent' medical ethics tribunal to decide on dilemmas that occur boils down to the same thing: deliberations should be guided by the principles of public health issues solely. As such, these solutions are more a denial of the tensions than anything else.

Simultaneously, all authors offering guidelines putting medical ethic first are very much in line with the opinion of the World Medical Organization, as laid down in the *WMA Regulations in Times of Armed Conflict*, holding there is no difference

between medical ethics in war and in peace. This implies that 'if, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients'.¹ WMA policy fits the 1977 Geneva Protocol, stipulating that 'personnel taking care of the wounded shall ignore the nationality or uniform of the person they are taking care of' (Protocol I, 1977b, Art. 10, paragraph 453; Gross 2006: 137).

Both the WMA and the Geneva protocols seem to pursue a universalistic ethic (Gross, 2006) counting everyone, friend or foe, for the same in a context of violent conflict, where such an all-encompassing ethic proves difficult to live by. It may even be the other way round in the sense that the lack of such an all-encompassing ethic is at the root of war. It is therefore small wonder the WMA standpoint has been rejected as utopian thinking, as Michael Gross does in his *Bioethics and Armed Conflict* (2006). In war the principle of salvage (i.e., returning as many soldiers to duty as quickly as possible), not medical need, is, and should be, the guiding principle of all medical efforts. This is not only in the best interest of the military as a collective 'fighting force', but, ultimately, also in the interest of the survival of the political community it serves. War, hence, transforms medical ethics (Gross, 2006: 324).

Due to the shifting nature of warfare, from self-defence to humanitarian interventions, military necessity may come to play a less prominent role, as Gross concedes (Gross, 2006: 330). As things stand, however, whenever military doctors have to choose between their responsibility for their patients and military demands, and given the strong and exclusive emphasis on institutional loyalty in the military, occasionally, their obligations to their patients will be overridden by their sense of military duty (Clark, 2006: 577).

Military engagement in healthcare reconstruction; a developmental and military policy perspective

Besides concerns arising from the above-mentioned clash of two major bodies of ethics that may put military medical professionals to the test, both the World Health Organization (WHO) and AREFU, in stressing the importance of the *long-term nature* of reconstructing Afghanistan's health sector, refer to another set of concerns regarding military engagement in civilian healthcare. As military missions are planned on relatively short time horizons, the military can only provide civilians with temporary health care. Civilian organizations, on the other hand, and especially development organizations, are often to stay in the area for a period of five to ten years. Consequentially, civilian and military organizations face synchronization problems pertaining for instance to the extent of 'reasonable' progress during a certain time period (Rietjens, 2008). Besides, military units are primarily responsible for security. Whenever the security situation deteriorates, humanitarian and development reconstruction projects will be abruptly terminated.

According to Rubinstein (2009), short-term military reconstruction interventions can be inconsistent with and, even undermine, long-term development.

Humanitarian and developmental 'quick impact projects' undertaken by military units or civil-military hybrids to increase stability and legitimacy in Uruzgan, as well as the acceptance of the international presence, could indeed cause such risks. Although improving humanitarian and development situations is important, it is not the main objective of such hearts and minds activities (Egnell, 2010). In the health sector particularly, short-term engagements should be considered most carefully because improved health outcomes are reversible if access to services is interrupted, unlike for instance, gains in education.

Along more or less the same lines, and in addition to the clashing bodies of military and medical ethics, a second concern about military engagement in health reconstruction can be distinguished. The development community strongly voices the conviction that improved health care is an objective in itself worth striving for instead of being a means to achieve political stability (Waldman, 2007). Rubinstein (2009) argues that, by military engagement in healthcare reconstruction, both humanitarian principles as well as principles of (health) reconstruction, such as ownership, sustainability and capacity building risk to be sacrificed to attain military strategic advantages. In line with this argument, it has been indicated by the military that activities benefitting the safety of its own troops often will be favoured over activities aimed at improving grass-root security and reconstruction for the Afghan population (Rietjens et al., 2009).

Thirdly, NGOs report services run by or in conjunction with the military in Afghanistan can endanger the population as well as local and international service providers (Rubinstein, 2009; Rietjens and Bollen, 2008). Where insurgents understand a health intervention is designed for strategic purposes, health facilities and workers easily become a target, and the safety of development projects and personnel in the vicinity may be jeopardized (Rubinstein, 2009). In areas where the Taliban are more influential the challenges of implementation exceed the humanitarian and development competence of the military. In the Korengal Valley of Kunar Province, newly-constructed clinics were blown up by insurgents as soon as they were finished (Egnell, 2010).

Within the health sector, coordination constitutes a challenge and a fourth concern. Health outcomes are dependent on a range of inputs beyond the jurisdiction of the MoPH, particularly, education, water and sanitation and nutrition, and thus require coordination and cooperation between different parts of government and external institutions; something for which there is typically little incentive, finance or structure to manage (WHO, 2007).

At a global level, due to a lack of coordination, aid to fragile states tends to be volatile, because whenever external institutions do engage, they establish parallel systems rather than working through government, which in turn hinders future capacity building (WHO, 2007).

Lack of knowledge in both humanitarian and military communities on health-care seeking behaviour, particularly in remote and rural areas, constitutes a fifth concern. Considering the primary goal of healthcare is to improve the health sta-

tus of the population, host nation healthcare facilities should be used as much as possible. Geographical and security reasons aside, to date, there exists insufficient knowledge about the considerations and requirements with regard to seeking care outside the home; e.g. the ways in which decisions are made within households; financial concerns and the role and availability of alternative sources such as private providers or traditional healers in the marketplace (AREU, 2006). To address health-care reconstruction in Uruzgan, or in other areas, such insights seem crucial.

Sixth and finally, both within the military and the humanitarian community the utility of military engagement in humanitarian and development projects is questioned (Egnell, 2010). According to General MacKenzie 'soldiers are not social workers with guns. Both disciplines are important, but both will suffer if combined in the same individuals' (Adinall, 2006). Within the aid community also, this argument is strongly endorsed. There are two main reasons for this. First, the military often lack humanitarian expertise, experience and training to conduct these types of activities effectively. This lack of expertise means that although the military may command – part of – the necessary resources this does not mean they know how to put their resources to good use (Bollen 2002). As a result, military projects in the sphere of development and humanitarian affairs often underperform in terms of cost-effectiveness and sustainability (Egnell, 2010). Besides, by engaging in these projects, the military are blurring the lines between military and civilian actors. Both recipients of aid as well as the conflicting parties may find it difficult to distinguish between providers of assistance and combatants.

If the humanitarian community is associated not only with the intervening powers, but also with the political and military agendas of the larger intervention, the humanitarian space –access to suffering communities on both sides of the confrontation line, based on the humanitarian principles –risks being eroded (Egnell, 2010).

Health care activities performed by the Task Force Uruzgan

Treatment of local nationals

In many ways TFU personnel were confronted with injured Afghans whether or not as a result from conflict activity of international military or Afghan National Security Forces (ANSF). In such cases, typically, a commander forwarded a message including the location of the casualty, the nature of the injury and whether or not additional medical supplies were needed. This message consisted of nine rules referred to as the 'nine-liner'. Subsequently, a flow chart was followed offering three options: the injured person is (1) a member of ANSF requiring emergency aid; (2) a non-combatant injured by conflict activity with ANSF or ISAF troops; (3) a non-

combatant and the injury is unrelated to conflict activity. Non-combatants not only include the local population, but also media, contractors, personnel attached to UN agencies and humanitarian workers (Neuhaus, 2008).

Within the first option, the injured person was treated in the casualty chain of the Coalition Forces (ISAF or OEF). After treatment the patient was discharged or transferred to an ANA or civilian hospital, most often the provincial hospital in Tarin Kowt (TK). Within the second option the patient was also treated in the casualty chain of the Coalition Forces. However, after treatment he or she was either discharged or transferred to a local national or NGO hospital. When the injured person was a non-combatant and the injury was unrelated to conflict activity (the third option), treatment depended on the extent of emergency care required and the extent of spare capacity within the medical facilities of the Coalition Forces. If considered an emergency and capacity was available, the patient was treated within Coalition Forces' medical facilities. In any other circumstances the injured person was transferred to a local national or NGO hospital.

Resulting from these rules, every so often Uruzgani in need of medical attention could not be helped, even if the means to do so were evidently available. This posed moral dilemmas for military medical personnel involved that were solved in various ways (Meerbach, 2009). For instance, medical personnel decided to exaggerate wounds and categorize them as life- or limb threatening, or use means available abundantly anyway (bandage). Basically, medical workers had to choose between following the military line by abiding the rules, or act upon their medical professional ethic, taking a more lenient approach to military rules. One Dutch doctor somewhat overdid it by characterizing a harelip as life threatening (Bak, 2010).

Reasons for taking a fairly lenient view were diverse. For instance, an infant at the gate with non-life threatening appendicitis will, when sent away, develop a case needing emergency help in a day or so. Other, somewhat more expedient reasons were avoiding a lack of practice and boredom. Newer versions of the *Medical Rules of Eligibility* tend to be more specific in order to narrow down the room left for interpretation – something medical workers also seem to welcome (Bak, 2010). In general, in these rules the interests of their own military personnel (and Afghan National Security Forces personnel) outweigh those of the local population, and on a daily basis treatment of local nationals is refused or discontinued to keep enough capacity for coalition soldiers (Leemans and Van Haeff 2009). Such decisions are taken by the military commander, not by the doctor; the latter, who has a advisory role, is thought to be less prone to take the operational interests into account. Notwithstanding the fact that not all patients were eligible, in the Dutch-led Role 2 hospital approximately 90% of the patients treated were Afghans.

Medical Civil Affairs Patrols (MEDCAPs) and medical engagements

MEDCAPs and medical engagements constitute the most obvious military engagement in healthcare. 'A MEDCAP is a patrol or a clinic conducted by a tactical com-

mander using available ISAF, ANSF and Afghan Government (GIROA) medical staff, in remote areas where usually NGOs have no access'. Together with Dental Civil Affairs Patrol (DENTCAP) and Veterinary Civil Affairs Patrol (VETCAP) this composes the village medical outreach. MEDCAP is commonly used in NATO as the generic term for clinical assistance patrols to local nationals in remote or disaster-affected areas. While popular with most military contingents during the first years of the operation in Afghanistan, the TFU carried out almost no MEDCAPS.

A medical engagement refers to a medium or long-term medical assistance project without direct patient contact. Typically, a medical engagement may be a public health engineering project (construction of a clinic), an environmental management activity, a health education or clinical mentoring project, or a project involving the distribution of health-related 'consent-winning' items (e.g., spectacles, shoes or vitamins). TFU personnel carried out various medical engagements. The TFU Role 2 hospital provided the TK hospital with medical equipment including X-ray and sterilizer systems. If capacity permitted, hospital personnel also trained Afghan doctors and nurses in a wide range of specialties such as surgery, radiology and anesthesia. Being part of TFU's Reconstruction Task Force, the Australian engineers were particularly active in (re)constructing medical facilities such as TK hospital, a medical training centre of AHDS and a basic health centre in Sorg Murgab.

A third way of executing medical engagements was through so-called Functional Specialists Health. These Dutch reserve officers, often with large health management experience, were deployed within the Provincial Reconstruction Team. They initiated and were involved in several projects, mainly focusing on health publicity and the prevention of diseases. Examples include projects that were aimed at improving living conditions, safe and accessible drinking water and hygiene and sanitation.

According to ISAF's standard operating procedures MEDCAPS and medical engagements offer an opportunity to build trust with the Afghan people, develop ANSF medical and CIMIC public health capability, and assist GIROA to deliver demonstrable benefits. The primary objective of MEDCAPS and medical engagements is to provide practical assistance to the local population to promote support for ISAF and GIROA. A secondary objective is to improve the health of the population, in line with GIROA's public health strategy. It is said in ISAF's guidelines that all MEDCAP and medical engagement activities are planned in conjunction with the provincial Director of Public Health (DPH) to avoid duplicating services, and also to avoid confrontation with NGOs contracted by GIROA to implement healthcare in that province such as AHDS. This unfortunately is not always the case and many of such activities are still carried out in isolation of local government or NGOs.

MEDCAPS and medical engagements are at first glance humanitarian efforts that can be subject to dual loyalties, insofar as they are not undertaken as something worthwhile by itself, but as something that should help to attain the goals of a particular mission. This ambiguity might well be the Achilles heel of these mili-

tary medical efforts. For instance, a report on a US Medical Civil Action Program (MEDCAP) in Iraq in 2003 states that:

A MEDCAP is commonly used to mean engagement with the local community through the direct provision of healthcare in order to win the “hearts and minds” of the civil population (ISAF HQ, 2011).

Understandably, the operational objectives were pacification of threats to US forces and community stability by showing cooperation in humanitarian deeds. Counter to intuition, the provision of medical care only was a collateral benefit. The recognition that the task primarily was one of public relations was philosophically important to all parties involved (Malish et al., 2006).

However, helping locals with an eye to furthering operational goals is for sure a source of tensions for medical personnel, since their ethic prescribes that patients are important as such, and that care should be provided independently of what is in it for us.

The perception of success of the MEDCAP II programme widely diverged between operational and medical personnel. Command had no means by which to judge the quality of medical care or the effects of the care on popular opinion. As such, numbers-treated became the rubric by which success was measured, and thus, the goal of future iterations. Medical personnel, on the other hand, became disillusioned. Physicians were hobbled by limited histories, scores of healthy “patients”, the absence of diagnostic testing, and, most importantly, the lack of follow-up. Some believed that the programme ‘violated basic ethical standards of medical care’ (Malish et al., 2006).

What is more, often such efforts have a short-term focus, are more concerned with the quantity of people reached than with the quality of care provided, and have the effect of undermining the trust of the local population in their own healthcare system (Alderman et al., 2010).

Support to humanitarian organisations

Today, most military acknowledge MoPH’s national and provincial-level medical programmes such as the basic package of health services and the essential package of hospital services, as well as the implementation of these programmes by NGOs such as AHDS, Cordaid and Healthnet TPO. TFU has been supporting international and Afghan humanitarian organizations in multiple ways. First, providing direct and indirect security TFU units enabled humanitarian organizations to carry out medical activities such as vaccination programmes. Many view the provision of security to be the military’s principal role in humanitarian assistance, in which there is no overlap between military and civilian competencies and domains (Rietjens and Bollen, 2008).

Secondly, humanitarian organizations were financially supported. The Royal Netherlands Embassy allocated several million Euros on health programmes exe-

cuted by NGOs. AHDS and Cordaid spent this money on e.g. TK hospital, the construction of community and basic healthcare centres, a training course for midwives and the purchase of an ambulance for the Chora region. Healthnet TPO primarily focused on mental healthcare, both through training courses as well as through the development of a monitoring system. These programmes were communicated and coordinated by development advisors within TFU's Provincial Reconstruction Team.

Thirdly, TFU has offered technical and logistical support to humanitarian organizations, including housing of humanitarian employees, as well as providing assessments on the health situation and technical knowledge and expertise on the aforementioned functional specialist healthcare.

Such activities differ from MEDCAPS and medical engagements in that they facilitate and enable the work of humanitarian organizations, instead of being mainly carried out on the military's own initiative.

Practice and principles: a discussion on military engagement in healthcare reconstruction

In his article on dual loyalties of military medical personnel, medical ethicist Peter A. Clark poses the question whether there is 'a need for guidelines to (...) assist military medical personnel in dealing with the issue of "dual loyalty"' (2006: 571), and if so, what these guidelines might be. To begin with the first, easy answer: it seems evident that, insofar as they are not there yet, guidelines are needed. The picture Clark sketches of military doctors assisting in Abu Ghraib and Guantanamo bay suggests so, while the experiences of Dutch military medical personnel in Uruzgan point in the same direction.

Regarding Clark's second question we conclude this chapter by presenting some topics that should be included in the debate on comprehensive guidance for military medical personnel facing the choice whether or not to engage in healthcare to civilians.

Notwithstanding military rules of eligibility, the treatment of non-combatants with injuries both related and unrelated to conflict activities poses several problems. Foremost, ISAF's medical services are to support the mission by treating military, that generally are fit, healthy and young people as opposed to local national patients that include the elderly, children and the disabled; the kind of patients, obviously, the military casualty chain has not been designed for. In 2006, many children were treated in TFU's Role 2 hospital, despite lacking support of Dutch politicians and military staff. To extend proper care military nurses and doctors needed special medication, food and rooms to temporarily house the patients' relatives. These needs have been dealt with in a pragmatic and ad-hoc manner.

As a comprehensive set of medical rules of engagement shared by all expeditionary military contingents is lacking, largely, in treating non-combatants military

healthcare providers adhere to their own national protocols. Therefore, the degree and nature of care extended and the number of patients treated vary considerably amongst the troops of contributing nations. Whilst the Dutch referred all non-combat and non-critical patients to the local provincial hospital, the US hospital in Uruzgan abided by less strict rules, thereby attracting many local nationals preferring US military healthcare over the care provided in the provincial hospital.

Whereas, in the short-term, military healthcare activities may seem to meet local needs, when delivered inconsistently these may conflict easily with reconstruction principles such as sustainability and capacity building. Moreover, when future military contingents are not able to maintain comparative levels of care, civilian expectations may be thwarted eliciting security risks for own troops. Also, the inconsistent delivery of healthcare may adversely affect local people's health status.

As a result of ongoing violence or renewed conflicts refugees create a specific subset of medical problems with high mortality rates, deprivation and disease. Women, elderly people and children prove to be most vulnerable. Upon arrival in refugee camps, epidemics, infectious diseases and malnutrition take their toll. Military health care, by its nature, cannot be expected to cope with the health needs of refugees and IDPs. However, at the request of governments and in close collaboration with the aid community the military can be involved in extending emergency relief (Bollen, 2002).

Military activities in the field of MEDCAPS and medical engagements fit into Egnell's (2010) categorization of hearts and minds operations as 'a distinct category of tactical activities, separated from traditional military tasks'. Such operations use military resources to provide carefully targeted support to local communities to increase campaign authority and legitimacy instead of impartial alleviation of human suffering or development. Such hearts and minds projects are also described as part of 'short-term military necessity'; something to balance against long-term considerations such as rule of law, providing an acceptable steady state, and the success of the campaign as a whole (UK MoD, 2004).

Wilder (2008) points out the contemporary interpretation of winning hearts and minds in a setting of comprehensive approaches to stabilization and peace building has created a number of questionable assumptions regarding the links between stabilization and aid. First, it is assumed that reconstruction efforts have stabilizing effects on conflict. It is thought that aid will lead to economic development which in turn, will bring about stability. Second, aid projects are assumed to help win the hearts and minds and thereby increase support for the host government and for the international presence. Third, extending the reach of the Afghan government is assumed to contribute to stabilization. This is explicitly expressed as the PRTs' objective. However, Wilder's research in Afghanistan indicates that these causal assumptions underlying the non-coercive hearts and minds approach may be false (Wilder, 2008).

In addition to the lack of evidence regarding the effectiveness of hearts and minds projects and the doubtful assumptions in directly relating stabilization to aid,

any justification of post-conflict healthcare reconstruction based on its contribution to development or political stability is considered instrumentalist and risky. First and foremost, because achieving an improved health status for a population is an end in and of itself, instead of a step on the way to attaining political goals (Waldman, 2007).

A second risk is run whenever investments in healthcare are used for 'winning hearts and minds' by devoting resources to visible projects at the expense of sustainable system-building activities. Except for support for a host country's health services for its own military, across the development community, the military's approach is perceived to be short-term and tactical, project- rather than systems-based. Military-generated projects are criticized for not being linked to building a coherent system of services, and for not being oriented towards building the MoPH's capacity or a long-term vision that links healthcare facilities with staffing needs. Moreover, in insecure environments, military engagement in health reconstruction activities can undermine the safety of health workers (Rubenstein, 2009).

Last, approaching health reconstruction as a means of conflict prevention can distort policy and spending decisions by way of concentrating on programmes and projects that appear most connected to conflict resolution. This can then undermine comprehensive capacity development to improve population health based on principles of equity and non-discrimination (Rubenstein, 2009).

In conclusion, we add that military activities in the realm of direct or indirect security, specifically when backed by civilian populations and institutions do not conflict with nor add to ethical and policy concerns as mentioned in sections 2 and 3. On the contrary, as the question of what is ultimately responsible for most mortality and morbidity in states transitioning from conflict towards stability may be better answered by violence, political instability, poor governance and abject poverty than by diseases and epidemics (Waldman, 2006).

Note

- 1 The WMA policy is available at: <http://www.wma.net/en/30publications/10policies/a20/index.html>.

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