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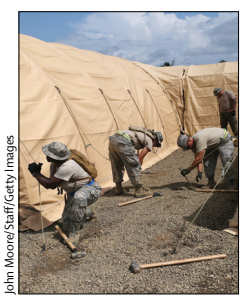
Civil–military cooperation in Ebola and beyond



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The 2014 Ebola outbreak in west Africa blurred the lines between a public health emergency and humanitarian crisis. In so doing, it highlighted serious problems with coordinating disaster responses. Civilian agencies were overwhelmed; several non-government organisations closed down their operations and exited the affected countries; and, although the health sector in Liberia stepped up, Sierra Leone and Guinea remained in disarray. Since then WHO declared Sierra Leone to be Ebola free on Nov 7, 2015,[1] and declared the end of human-to-human transmission of Ebola virus in Guinea on Dec 29, 2015.[2] At the time of writing, WHO expects transmission linked to the most recent Ebola cases in Liberia will be declared to have ended on Jan 14, 2016, if no further cases are reported.[3] Foreign and domestic military assistance proved pivotal to establishing an orderly response to contain the outbreak. However, despite the military's helpful role, some of its practices and results have also been criticised. Accordingly, a critical analysis is needed when we consider the Ebola response as a precedent for future civil–military cooperation in health.

Several high-level panels, including a *Lancet* report,[4] are examining the domestic and international response to the 2014 Ebola outbreak.[5] Central to the lessons learned will be the role that militaries had during this crisis. More than 5000 military personnel were deployed from the USA, UK, China, Canada, France, and Germany. These forces were seen by many as a game changer in the Ebola response.

We studied the effect of civil–military cooperation during the Ebola outbreak by conducting more than 70 semi-structured interviews between February and September, 2015.[6] Our respondents included local health workers, non-governmental organisation representatives, officials from international organisations, government ministers, ambassadors, and officers from both foreign and domestic militaries. We asked about what worked and what failed in Liberia and Sierra Leone. Based on this research, we outline just four key findings here that should be considered when thinking about the role of the military during global health crises.

The first finding is that several challenges arose from how the Ebola crisis was initially framed as a health emergency instead of a humanitarian crisis.[7] This situation created confusion in a number of responder agencies, resulting in ad-hoc and untried arrangements being created—such as the United Nations Mission for Ebola Emergency Response—rather than well-established humanitarian coordination systems and processes. The initial description of this outbreak as a health crisis was understandable, but, as wider social and economic consequences arose, there was a need to reconsider the event for what it had become—a humanitarian disaster—and respond accordingly.

The second finding is that the deployment of foreign militaries was key to convincing several non-governmental organisations to maintain or establish operations in the affected countries. Although Médecins Sans Frontières and the Red Cross were able to reprioritise their activities to care for patients with Ebola, many organisations found themselves unprepared for a crisis of this nature. Several closed operations and exited the affected countries. These organisations only returned or established operations once western governments announced that they were deploying military forces to help contain the outbreak.[6]

Third, it is important to note that most respondents found militaries open, engaging, and keen to learn. The services they provided in constructing Ebola treatment units and training health workers were well received, as was the medical care provided by a small number of military health professionals. The general consensus was that civil–military relations worked well in response to Ebola. Nevertheless, concerns were raised about the slow speed with which the militaries constructed Ebola treatment units, the risk aversion displayed by some forces (eg, refusing to transport infected patients), the absence of mission flexibility, and the masculine spaces of decision making that sometimes limited productive engagement.[6]

Fourth, no common framework was established for how different militaries operated during the Ebola crisis. The US military remained at arm's length, supporting

Liberia's Ministry for Health and Social Welfare via the United States Agency for International Development. The Liberian armed forces and security sector stepped back their response after the West Point shooting of a civilian.[8] The British military worked—in principle—under the direction of a civilian led by the UK's Department for International Development, but integrated some personnel within the Sierra Leone armed forces. Although some militaries provided clinical care, others refused even to transport biological samples and patients.[6]

Some governments now indicate that they are prepared to revise their military doctrine, incorporating civil–military cooperation in health as a regular activity.[9,10] However, the involvement of military personnel in such pursuits remains controversial and raises questions about their effects on humanitarian principles, personnel, and practices.[11,12] Civil–military cooperation during the 2014 Ebola outbreak proved necessary and helped the affected countries to contain the virus sooner, ultimately saving lives. But more evidence, analysis, and guidelines are needed about the types of health activities that military personnel can undertake in humanitarian crises before we witness, and need to respond to, another major disease outbreak.

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Building evidence to improve maternal and child health

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Giving children the best possible start in life is crucial to reduce health disparities.[1] One of the UK Government's efforts to support young children has been to adapt and assess the Family Nurse Partnership (FNP), a programme of prenatal and early childhood home visiting for vulnerable first-time mothers and their children. In *The Lancet*, Michael Robling and colleagues[2] report on Building Blocks, a multisite trial of the FNP in England. My colleagues and I[3,4] have developed and tested this programme previously in three randomised trials in the USA. We made independent randomised trials a prerequisite for international expansion when serving large populations, because knowing a programme's added value in new contexts is essential for guiding policy and practice.

In Robling and colleagues' pragmatic, open, individually randomised, controlled trial,[2] 1645 participants in community midwifery settings at 18 sites in England were randomly assigned to the FNP programme (823 participants received up to 64 structured home visits from early pregnancy until the child's second birthday, delivered by specially recruited and trained family nurses) added to usual care, and 822 received usual care alone. The Building Blocks trial is very well conducted, with objective measures, acceptable rates of completed assessments for most outcomes, and rigorous