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# The Next Ebola: Considering the Role of the Military in Future Epidemic Response

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### Introduction<sup>1</sup>

There are potential benefits to using militaries to deliver humanitarian assistance. These include their capacity for rapid, large-scale deployment. During infectious disease outbreaks such as the West Africa Ebola epidemic, these capacities may be important in the overall response, especially in contexts where health systems and governments are poorly resourced. However, the use of armed forces is also opposed by some actors. They have cited concerns that include: the erosion of humanitarian principles and the disruption of spaces in which other civilian partners work; a perceived conflict between military duty and medical ethics; an undermining of the social contract when external agencies deliver core services; a lack of cultural awareness among intervening military medic healthcare workers; and alleged excessive costs.

Chatham House hosted a roundtable meeting in London on 31 March 2017 to help inform the debate on military participation in future disease outbreak responses. The meeting, supported by the Rockefeller Foundation, included the presentation of recent Chatham House research on how the response was run in Sierra Leone, including the role of the military,<sup>2</sup> and was held under the Chatham House Rule<sup>3</sup> to provide opportunity for critical reflection on the ethical, operational and other challenges inherent to a civilian–military response to a public health emergency.

The meeting's primary objectives were to:

- Identify those aspects of the Ebola response which, if addressed, would have enabled more effective civilian–military cooperation and response;
- Consider the spectrum of a future UK response to an infectious disease outbreak in sub-Saharan Africa; and
- Explore the acceptability, potential and ability of a UK contribution to a civilian–military response, in line with the recommendation of the International Health Regulations (IHR) review committee that military medical teams be available for deployment to a significant outbreak.

The following summary reflects arguments and comments made by meeting participants, who included civilian and military representatives of the UK government, and members of NGOs, academic institutions, intergovernmental organizations and several other bodies.<sup>4</sup> The discussion, whether looking back at the West Africa Ebola epidemic or forward to the 'next Ebola' crisis, converged around six main themes. These themes are presented below, and followed by a round-up of the points most consistently made at the meeting.

### Prevention, preparedness, early warning and rapid response

Several comments were made around the continuum of outbreak prevention, preparedness, early warning and rapid response. It was acknowledged that disease outbreak preparedness starts with health system resilience, which not only helps alleviate the need for international support for outbreak containment but is also the most effective means of outbreak prevention. It was broadly agreed that resilience requires effective health system infrastructure; a sufficient workforce; robust health information systems and other public health measures; effective early-warning mechanisms (i.e. disease surveillance); identified

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<sup>1</sup> This roundtable summary was prepared by Samuel Boland.

<sup>2</sup> Ross, E., Honwana Welch, G. and Angelides, P. (2017), *Sierra Leone's Response to the Ebola Outbreak: Management Strategies and Key Responder Experiences*, 31 March 2017, Research Paper, London: Royal Institute of International Affairs, <https://reader.chathamhouse.org/sierra-leones-response-ebola-outbreak-management-strategies-key-responder#>.

<sup>3</sup> 'When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.'

<sup>4</sup> See Annex A for a complete list of organizations represented.

response triggers with civilian ownership; and adequate structures for reporting to the World Health Organization (WHO), as mandated by the IHR.

If a health system is resilient and disease surveillance structures function appropriately, public health preparedness will prevent the need for humanitarian intervention to an emerging disease threat. It was noted that, increasingly, this disease threat is not limited to the global south, given climate change and anti-vaccine movements; international trade and travel experts, as well as public health experts, argued that improving health system resilience, disease surveillance and overall public health preparedness everywhere must remain the primary focus of any disease outbreak response plan.

When prevention and preparedness systems fail, a rapid-response mechanism is required to efficiently contain and end the emerging public health crisis.

The WHO-coordinated Global Outbreak Alert & Response Network (GOARN), a collaboration of institutions and networks that pools human and technical resources for rapid outbreak identification and response, performs this function. However, interest in developing such capacity beyond GOARN has grown dramatically following the West Africa Ebola epidemic, as GOARN's staffing and deployment structures meant it could not sustain a high level of expertise for the duration of the outbreak. More than 20 other institutions are currently building some form of rapid support team (RST), though it is unclear to what extent they integrate and coordinate with GOARN and each other. Nonetheless, RSTs were considered an important addition to the global disease outbreak response toolkit.

RSTs, and those who fund and coordinate them, require watch lists curated with global disease surveillance data to effectively prepare their response to an emerging threat. For example, a US government agency, the Centers for Disease Control and Prevention (CDC), maintains a weekly disease outbreak bulletin; and the UK government has recently developed a weekly interdepartmental humanitarian early-warning note. However, these watch lists are not distributed or accessed in a comprehensive manner. Participants warned that the watch lists do not necessarily provide the information required by all rapid-response mechanisms, and that they are also necessarily limited by the quality of global disease surveillance data and global reporting structures.

Also, RSTs may not provide a number of other services, including rapidly scaled training, coordination structures and logistics needed at both the national and international level. To fill these gaps in Sierra Leone during the Ebola epidemic, the British military established military medical training facilities; these pre-deployment and in-country facilities were widely seen as an efficient and effective training tool. It was proposed that consideration be given to extending the use of UK training facilities to civilian responders.

It was agreed that the military (British and Sierra Leonean) also proved effective coordinators in the response; while the military does not have a monopoly on effective coordinators, the professional focus on adaptability and efficiency proved an effective and necessary addition to civilian coordination at a time when civilian agencies were overstretched. Participants agreed that the deep historical links between the British and Sierra Leonean militaries were crucial to the UK playing such a significant and effective supporting role, but said that it was unclear whether that level of military involvement would have been impossible without such a relationship.

One participant contended that it would not be possible to develop a country-by-country response framework, and others agreed that a generic planning framework or policy guidelines should be developed for rapidly assessing whether the context of a specific disease outbreak would benefit from

military support. It was proposed that this could parallel the Oslo Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief (Oslo Guidelines) if the challenges were felt to be sufficiently similar. Outbreak specialists contended that in any context military support to a disease outbreak response should be designed to complement civilian control under the IHR, and should be used as a last-resort mechanism when civilian resources and response structures are at risk of being overwhelmed. Some said that integration platforms, rather than military-specific response frameworks, are thus key.

### Force protection, risk appetite and risk management

The discussion revealed that prospective military support to future disease outbreak response is complicated by military force protection needs and questions surrounding military risk appetite.

In the West Africa Ebola epidemic, early calls by civilian agencies for military support were grounded in an assumption that the high risk tolerance of the military would ensure the value of military involvement, particularly in light of the very low tolerance for the risk of infection among some civilian organizations that departed the area. It was noted that the use by the British and some other foreign militaries of the army medical training facility in York, in the UK, to rehearse safe practices and ensure the suitability of those deploying enabled the military to be fully operational on arrival; in contrast, civilian organizations required a long in-country training time prior to becoming fully operational.

Some argued that the British military was in fact ‘in an era of risk aversion’ following intense media coverage of British casualties in Iraq and Afghanistan. It was noted that in the West Africa Ebola epidemic, there was little appetite from some corners within the British government and military to engage with a threat of this type; this was reflected in the conservative nature of the roles assigned to the British military. Risk assessments, which informed blanket force protection standards, were calibrated to the lowest-qualified individual. Thus, while there was wide agreement that the British military provided an invaluable partner in the outbreak response in relation to coordination and logistics support, it was noted that the scope of its activity was necessarily limited. For example, while military personnel did treat patients in the health worker Ebola unit, they were unable to perform certain other high-risk tasks that civilians calling for their involvement had initially hoped they would take on, such as the handling of dead bodies, community patient care and patient evacuation.<sup>5</sup>

Military force protection also needs to consider the risk to flexible-response capabilities for war-related threats, it was noted. With only eight C17 aircraft, for example, the British military would strain the flexibility and adaptability of its global traditional military engagements were it to devote transport resources to a future disease outbreak response. One member of the British military stated that the forces ‘simply don’t have the level of strategic reserve that a lot of external agencies think’. It was proposed that this could present a conflict of interest for any military asked to provide support to a future disease outbreak response, and that this is a consideration that civilian agencies do not face.

Participants from across the board said that if UK ministers and the British military can accept increased levels of personnel and capability risk in future deployments not involving warfare, the military would be able to play a more active role.

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<sup>5</sup> The British military was involved in the coordination of dead-body management, but UK military personnel did not themselves clear the bodies.

## Community engagement

Public health specialists and anthropologists argued that in a disease outbreak response, ‘understanding community is as important as virology’.

It was noted that in the West Africa Ebola epidemic, the British military had an established pre-crisis relationship with the Sierra Leone military that provided much of the local knowledge that the British military required to effectively respond, but that the application of this knowledge was limited by force protection measures that prevented the British military from interfacing directly with Sierra Leoneans outside the National Ebola Response Centre and District Ebola Response Centres.

Several civilian participants pointed out that many civilian agencies, which are not subject to such strict force protection measures, made little effort to engage and learn from Sierra Leoneans at the earliest stages of the outbreak. Indeed, while the British military openly acknowledged its lack of expertise in this context, many civilian public health experts assumed that they had all the knowledge and tools they needed despite the outbreak’s unprecedented and unknowable complexity and the specific cultural issues surrounding it. Such assumptions limited learning opportunities that could have provided information and knowledge crucial to the response, participants contended. The British military and some civilian agencies did involve anthropologists later in the outbreak to resolve some of these concerns, but early interventions often did not interface with those already on the ground. Participants viewed this as a key failing given that issues of cultural context and difficulties of community engagement can be overcome with established long-term relationships.

Several participants considered anthropology integration platforms an important addition to disease outbreak response toolkits, given the ability that anthropologists have to translate cultural contexts. This translation should not be limited to the development of locally meaningful messaging, but ideally should also include translation back to the language that international responders understand so that they can operationalize local knowledge, it was suggested.

It was argued that it may be easier for national military responders than for international military or international civilian responders to fill this role, provided that they are trusted and well received by civilians and have an effective working relationship with international responders. However, neither of these conditions can be assumed, given many examples where militaries are not trusted either domestically or internationally. It was accepted that the integration of anthropologists should be only one element of a comprehensive community engagement strategy.

## Decision-making within organizations

Another discussion theme focused on the need to assign responsibilities for types of decision-making, both within organizations and between them, and to maintain that delineation throughout a response. This means clearly defining which decisions should be made at which level, i.e. by those at the strategic, or political, level; those at the operational, or coordinator, level; and those working at the tactical, or field, level.

Several participants across the board recognized the challenges that political interests and demands pose to responding in technically rather than politically appropriate ways.

Participants said that in the West Africa Ebola epidemic, UK ministers were sometimes involved in British military tactical decision-making processes and that this created tactical uncertainty and friction for the

British military. This was not unique to the military, as some in-country civilian agencies also struggled to effectively delineate and delegate decision-making within their organizations. In another example cited, a requirement to conform to international medical standard operating procedures, despite the existence of locally appropriate tested and ready solutions, delayed the opening of much-needed Ebola treatment centres.

Meeting participants broadly agreed there is a need to ‘put control in the field’, saying that empowering local decision-making enables better tailoring of disease outbreak response mechanisms, messages and measures to local needs. It was argued that, to some extent, concerns surrounding community engagement can be mitigated if strategic, operational and tactical response structures are appropriately delineated.<sup>6</sup>

As militaries are highly structured, identifying where such delineation should occur between strategic, operational and tactical decision-making to this end is reasonably straightforward. However, it was argued that, particularly in a joint civilian–military exercise, such hierarchical design can facilitate intra-agency mission creep when delineation is not respected. It was proposed that smaller and more loosely hierarchical civilian agencies may therefore have a greater ability to unilaterally operate at the local level. But, it was noted, such delegation to the local level is difficult for both foreign military and civilian organizations when the risk appetite is low. The need for effective means of communication across the various levels within organizations was also acknowledged, with possible instruments including dedicated social media platforms, information hubs and dedicated liaison staff.

### Interagency coordination

It was suggested that just as placing responsibility for certain decisions in the right part of an organization is important, so is the division of responsibility among agencies. This was considered a first step towards better coordination and avoidance of duplication and competition between agencies.

Both civilian and military participants said that this requires a clear and respected mechanism for identifying organizational strengths, weaknesses and risk tolerance, and for assigning roles prior to a crisis emerging, so that coordination does not become competition. In turn, this requires peacetime interagency relationships, which could be nurtured through regular interagency training exercises. Such exercises would be valuable in establishing what role each agency would take and in creating interagency coordination links. However, several participants argued that due to high rates of staff turnover in many organizations, such exercises would need to occur with some frequency. Both civilian and military participants proposed that liaison officers should be integrated across organizations as permanent fixtures, so that interagency coordination in crisis is simply an extension of peacetime modus operandi.

It was considered that such interagency links are particularly important between civilian and military partners, as the organizational structure, workplace culture and professional terminology differ between the two. Increased interaction (involving study periods, desktop exercises and possibly field exercises) is required so that each partner can better understand how the other operates and structures itself. These links generally exist between state development agencies and their respective militaries, but do not exist

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<sup>6</sup> ‘Strategic’, ‘operational’ and ‘tactical’ are levels of war. The strategic level is concerned with top-level political interests and broad objectives, the operational level is concerned with campaign planning to realize them, and the tactical level is concerned with campaign execution (i.e. the day-to-day activity as planned at the operational level). In relation to the West Africa Ebola epidemic, these levels can loosely be understood as the activity that occurred at the international, national and district levels, respectively, though strategic, operational and tactical structuring can be applied to the necessary division of labour of any organization and institution more generally. For a longer discussion, see Dunn, M. (undated), ‘Levels of War: Just a Set of Labels?’, Clausewitz.com, <http://www.clausewitz.com/readings/Dunn.htm>.

for many international organizations and NGOs, which perform the bulk of disease outbreak response activity.

Most participants agreed that for disease outbreak response operations, any supporting military should recognize that terminology appropriate for a conflict operation can cause unease among civilian partners. It was noted that with the Ebola epidemic in West Africa, where there was not an active conflict, many civilians raised concerns about terminology such as ‘command and control’ instead of ‘coordination’, ‘force protection’ instead of ‘staff safety’, or ‘battle captain’ instead of ‘operations manager’. One civilian participant argued that terminology focused on a perceived threat leads to punitive and authoritarian cultures of response, which some contend are not the most effective.

### Philosophy, perception, public relations and pragmatism

It was noted that many global health advocates supported the ‘securitization of health’ in the 1990s to shift resources from defence to global health rather than to bolster the presence of militaries and the security sector in the delivery of humanitarian aid.

Some civilian participants considered particularly extensive military support to humanitarian response to undermine the humanitarian principles of neutrality and impartiality. Also, militaries tend to be expensive, and both civilian and military participants said cost should be a consideration. It was considered important to note that the response in Sierra Leone, including the military’s role in it, evolved through trial and error rather than resulting from design. According to several participants, this experience shows that there is likely to be little value in designing a template for future civilian–military intervention in an outbreak.

There was universal agreement that disease outbreaks are far more complex than the medical problems they present, and that civilian medical and public health experts will remain best placed to resolve the latter. Both military and civilian participants said that non-medical challenges of coordination, communication, planning and logistics pose real difficulties to civilian responders, who do not necessarily have the capability, resources or authority to mount a centrally coordinated large-scale response to a disease outbreak.

Participants had mixed views on the utility of the Oslo Guidelines for planning military engagement in future health crisis response. The Oslo Guidelines outline how foreign military and civil defence assets can provide last-resort support to disaster response, but in many countries militaries are the only organizations with these capabilities and will thus necessarily be first-resort solutions. Thus, despite the challenges the use of militaries poses to humanitarian principles, several civilian participants said that humanitarian organizations need to reconsider their philosophy, with one participant saying: ‘Prejudices around who are appropriate actors ... are limiting our capacity to respond’ to disease outbreaks. Such hesitation was also mentioned in relation to the commercial sector, which in some cases could offer similar much-needed capacity.

In summary, it was broadly agreed that if a disease outbreak occurs within a permissive environment, and civilian prevention and preparedness systems risk being overwhelmed,<sup>7</sup> military organizational structure and organizational strengths in communications, logistics and coordination mechanisms have the potential to fill key gaps in a future civilian-led disease outbreak response.

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<sup>7</sup>It is unknown how disease outbreak response should or would occur within a kinetic non-permissive environment such as Syria.

### Conclusion

All participants agreed that the Ebola outbreak in Sierra Leone offered a unique context that contributed to the British military's success in supporting the response. The British military had a strong pre-crisis relationship with Sierra Leone; the country was not experiencing significant political turmoil; and Sierra Leonean people generally hold their own military and the UK – and its military – in high regard.

Nonetheless, participants noted that many of the challenges faced in the West Africa Ebola epidemic, and the solutions to them, are not dissimilar from those that arise in peace support operations and natural disaster responses, within which militaries are frequently considered to be valuable partners. Questions remain around the ability of international militaries to adapt their force protection requirements, to engage as needed at the local level, to empower on-the-ground decision-making, and to coordinate effectively with civilian and local military partners. However, it was noted that these issues are by no means unique to the military.

The West Africa Ebola epidemic provides evidence that permissive contexts do exist within which militaries can be appropriate players in disease outbreak response. Meeting participants proposed that even in less receptive environments, militaries may be able to provide peripheral support to civilians for some activities, such as facility construction and training. Several participants said that, particularly considering these and the other unique strengths of militaries, objections to their inclusion may need to be reassessed if future disease outbreak responses are to operate as efficiently and effectively as possible.

### Summary of key points

The following key points emerged from the discussion:

- Disease outbreak response preparedness should begin with bolstering health system resilience and civilian coordination structures.
- A tool should be developed for rapidly assessing whether the response to a specific disease outbreak would benefit from military support.
- Militaries are well placed to rapidly scale up disease-tailored training, both to in-country and international medical responders, and should be considered as partners for this purpose.
- Consolidated outbreak watch lists should be distributed between all prospective civilian and military partners in a future disease outbreak response, in addition to the interdepartmental and internal watch lists currently maintained by several organizations.
- Pre-crisis military force protection frameworks should be adapted for non-conflict engagements, and include some degree of acceptable risk to both personnel and capabilities.
- Anthropologists should be included in civilian and military disease outbreak response teams, to leverage their insights into local culture and practices and engage communities more effectively.
- Militaries should be sensitive to the impact of their use of military language when working with civilian organizations.
- Platforms to educate the civilian and military sectors about each other's organizational structures and culture should be developed.
- Dedicated civilian–military liaison officers should be integrated across organizations as permanent fixtures, enabling civilian–military coordination in crisis to be simply an extension of existing interagency coordination structures.
- There is little value in developing a template for military integration into health crisis response, but consideration should be given to reviewing the Oslo Guidelines, with a focus on appropriate contexts for direct military engagement in disease outbreak response.

## Annex A: List of representatives

### **British government**

Ministry of Defence  
Department for International Development  
Public Health England  
Stabilisation Unit

### **Non-governmental organizations**

Anthrologica  
Médecins Sans Frontières  
Save the Children  
Africa Governance Initiative

### **Academic institutions**

King's College London  
London School of Economics and Political Science  
London School of Hygiene & Tropical Medicine  
University of Sheffield  
University of Sydney

### **Intergovernmental organizations**

International Committee of the Red Cross  
United Nations Mission for Ebola Emergency Response  
World Health Organization

### **Other**

International SOS  
Royal United Services Institute  
Sierra Leone National Ebola Response Centre  
US Army

## Annex B: Timeline of British military involvement in the West Africa Ebola epidemic

<b>Date</b>	<b>Event</b>
25/05/14	Sierra Leone declares first Ebola case.
30/08/14	President Koroma declares state of emergency.
08/09/14	WHO declares Public Health Emergency of International Concern.
02/09/14	MSF appeals for civilian and military support.
Early 09/14	Senior WHO officials and UK government determine British military is best placed to provide robust command and control.
18/09/14	United Nations Security Council declares outbreak a threat to global security.
20/09/14	Statement of UK policy: DFID to lead British response, with British military and military medical beds to serve as a magnet for civilian volunteers.
21/09/14	Operation GRITROCK deploys.
17/10/14	National Ebola Response Centre (NERC), under control of the Sierra Leone minister of defence, replaces Ebola Operations Centre.
21/10/14	British military medical regiment deploys to train local healthcare workers.
Late 10/14	Operation GRITROCK-supported District Ebola Response Centres (DERCs) are established across Sierra Leone.
05/11/14	Kerry Town Treatment Unit opens, a collaboration between Save the Children and the British military, funded by DFID.
09/12/14	British Royal Engineers prepare to hand over nine Ebola treatment centres.
20/12/14	British military reservists and Canadian military deploy to Sierra Leone.
03/15	Operation GRITROCK scales down, leaving command and control structures in place.
05/15	Operation GRITROCK personnel return to NERC and DERCs following a spike in cases.
07/11/15	Sierra Leone declared Ebola-free for the first time since the start of the outbreak.
13/11/15	Operation GRITROCK personnel leave Sierra Leone.
01/16	UK government civilian team leaves Sierra Leone; NERC and DERCs decommissioned, with responsibilities divided among government departments.