MCDA Deployment in Natural Disasters and Health Crises

The Ebola Crisis

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Map of the affected areas
List of acronyms

AFRICOM : US African Command
CDC : Centre for Disease Control
CDDCS : Centre de Crise et de Soutien (part of French MFA)
CIMCoord: Civil-Military Coordination
CMCS : Civil-Military Coordination Section
DARPA: Defence Threat Reduction Agency
DART : Disaster Assessment and relief Team
DG ECHO : European Directorate for Humanitarian aid and Civil Protection
DfID: Department for International Development
DoD: Department of Defense
EUCP: European Civil Protection Mechanisms
FMA : Foreign Military Assets
GAO: US Government Accountability Office
IASC : Inter-Agency Standing Committee
JIATAF : Joint Inter-Agency Task Force
JFTH : joint Task Force Haiti
MCDA : Military and Civil Defense Assets
MITAM: Mission Tasking Matrix
MoD : Ministry of Defense
MSF: Médecins Sans Frontières
NGOs: Non-Governmental Organizations
OFDA: Office for Foreign Disaster Assistance
SECDEF : Secretary of Defense
SOFA: Status of Force Agreement
UN OCHA: United Nations Office for the Coordination of Humanitarian Affairs
UNMEER: United Nations Missions on Ebola Response
USAID: United States Agency for International Development
USG: United States Government
WHO: World Health Organization
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EXECUTIVE SUMMARY
The Ebola outbreak probably started at the end of December 2013/early January 2014 but went unnoticed in the deep tropical forest of Guinea where there were limited health structures and no health surveillance and reporting systems. As of 24 March 2014, at the time of the first confirmed cases, there were cases reported in Gueckedou, Macenta, Nzerekore and Kissidougou districts, and three suspected cases, including two deaths, were under investigation in Conakry. One week later, cases were identified in Liberia and Sierra Leone.

Diagnosis and decision-making

Despite the fact that the first confirmation of an Ebola Haemorrhagic Fewer (EHF) case is dated 24\textsuperscript{th} March 2014 as well as the call for action launched by MSF, the slow reaction of the World Health Organisation (WHO) allowed the epidemic to get partly out of control. It was only in August that the WHO declared the outbreak an international public health emergency and published a roadmap to guide and coordinate the international response, with the aim of stopping its transmission worldwide within 6–9 months. In September, the United Nations Security Council declared the EHF outbreak in West Africa a "threat to international peace and security" and adopted a resolution urging UN Member States to provide more resources to fight the epidemic. The WHO stated that the cost of combating the epidemic would be a minimum of $1 billion. Following the first suspected cases of Ebola in Guinea Forestiere (February 2014), the Guinean authorities requested support from the French army’s health services (especially to identify cases of the virus). The request was initially declined by the EMA (\textit{Etat major des armées}), as the crisis was civilian in nature and priority was given to military operations (Mali, CAR, etc.). It was only when Ebola started to cross borders that countries started to react at the highest level (President Obama, President Hollande and Prime Minister Cameron) and to mobilize MCDA and armed forces as these were seen as the best way to intervene fast and have an impact on the dynamics of the epidemic. However, the approaches taken by the different countries differed significantly.

The Ebola response and the use of MCDA in operational terms

France’s strategy was for a light military footprint, with a high level of engagement by French civilian actors and support to national institutions. The UK’s military involvement was much heavier, with a strong presence of Royal Navy ships and helicopters, and the high visibility of DFID/UK forces in coordination at all levels. As for the USA, President Obama announced the launch of Operation United Assistance in September 2014. Under the orders of the White House, the US USARAF/AFRICOM was in charge of supporting USAID in the coordination of logistics, training health personnel, and engineering support as part of the overall USG foreign humanitarian assistance/disaster relief efforts to contain the spread of Ebola. There was a resolute decision on the part of the US army to limit its coordination with the national armed forces and a strong USAID lead.

Health MCDA were key to the response in Guinea, Liberia and Sierra Leone. However, the response by France, the UK and the US, and the related MCDA deployments, differed significantly.

- The main involvement of the French MCDA was in establishing a treatment centre for possibly affected health personnel, organizing training and keeping a standby capacity to evacuate foreign patients back to Europe. Other means deployed by the French government were more civilian in nature, including the Health Reserve Corps (EPRUS) and research institutes such as the Pasteur Institute.
- In the UK, the strategy evolved rapidly from the initial deployment of a limited number of ten-bed health units by the armed forces after the Prime Minister decided to provide 600 beds in late September. This change in impetus meant that DFID went from a small deployment to a
100-strong Ebola response team. The UK military’s ten-bed units were replaced with 20-bed units, but these were focused purely on the needs of possibly contaminated international health workers. If beds remained, then they were opened to the public.

- The U.S. military sent as many as 4,000 service members to West Africa, with a focus on Liberia, where they provided medical, logistical and security support for an operation based on "urgency and speed". The Pentagon decided to take up to $500 million from existing funds within the Pentagon’s budget for the plan to fight Ebola. In addition to the provision of support to USAID in overall U.S. government efforts, U.S. military forces had a two-fold mission. Among the first orders was to build a 25-bed hospital for health-care workers who became infected with the deadly virus while working on the front lines of the Ebola outbreak. (This modular hospital was known in military parlance as an expeditionary medical support system). Simultaneously, the U.S. military initially planned to build and supply 17 treatment units throughout the West African countries affected by Ebola. However, they then focused their operations on Liberia. The enormous logistical military capacity was key to the provision of enough basic Ebola response kits to supply 400,000 households in Liberia in order to address an increasingly common phenomenon in which sick patients were being denied access to overflowing treatment centres and being sent home.

Coordination

In France, the USA and the UK, inter-ministerial Ebola Task Forces were created, directly under the control of the Prime Minister’s office in France, under Whitehall control in the UK and with a direct link to the highest level of USAID and the DoD in the US. Despite its experience, the USAID coordinated response to Ebola in Liberia encountered a number of problems with other international armed forces, and even more so in relation to the national armed forces. At the operational level, the US army established a mechanism for tasking: the Joint Requirement Review Board (JRRB), very similar to the JOTF established in Haiti, in order to facilitate logistics.

Lessons learnt

In all the countries concerned, a number of lesson learning exercises were carried out. Due to the high visibility of the crisis, journalists, NGOs, academic circles and think tanks were involved in analysing and evaluating the response. In all cases, the military recognized that they underestimated the importance of engaging in better communication with these actors and, more globally with the civilian environment.

Several multi-stakeholder conferences were organized. It is interesting to note that the issue of military deployment is not even mentioned in the proceedings of the conference on lessons learnt organized under the auspices of the French MFA.

The importance of logistics is one of the key lessons learnt. An early deployment of logistical capacities was necessary, with enough engineering capacity to support it. However, they were challenged by the complexity of carrying out construction work, as they were not familiar with the types of materials available in Africa. More training is necessary on how to use locally available resources for contexts where large imports of sophisticated construction materials are not feasible, nor appropriate.
In the context of the first ever, partly out of control outbreak of a highly-contagious, deadly zoonosis the recourse to military capacities and MCDA was a way for governments to show their own populations that they were doing something it was also a key political element in the hands of the countries which deployed troops to demonstrate their support to the affected countries. These deployments partly followed key aspects of the MCDA Oslo Guidelines, in particular the need to operate under a civilian authority in day-to-day operations. However,

A series of key points should be noted;

- The decision not to use military personnel to directly provide medical treatment was widely appreciated
- In some countries, the military were rather heavy-handed in their approach to coordination.
- Even though the military forces were very efficient once they had been deployed, the delay in recognizing the seriousness of the situation and “red tape” in the Capitals were such that they were only fully deployed after the epidemic had peaked.

Military planning and rehearsals should be carried out to ensure a higher level of preparedness for a similar crisis in the future.
1. KEY INFORMATION ABOUT THE HEALTH CRISIS

The Ebola outbreak probably started at the end of December 2013/early January 2014 but went unnoticed in the deep tropical forest of Guinea where there were limited health structures and no health surveillance and reporting systems. As of 24 March 2014, at the time of the first confirmed cases, there were cases reported in Gueckedou, Macenta, Nzerekore and Kissidougou districts, and three suspected cases, including two deaths, were under investigation in Conakry. One week later, cases were identified in Liberia and Sierra Leone. Despite the fact that the first confirmation of an Ebola Haemorrhagic Fewer (EHF) case is dated 24th March 2014 as well as the call for action launched by MSF, the only early mobilization came from the GOARN (Global Outbreak Alert and Response Network). In line with standard procedures, key staff were rapidly brought to the area (lab technicians, physicians, epidemiologists, some foreign medical teams with experience in Ebola management from Uganda and DRC). Equipment was sent by the IFRC and the French Red Cross to support the Guinean Red Cross Society (labs and Personal Protective Equipment).

The slow reaction of the World Health Organisation (WHO) during this outbreak, which has been highlighted by many actors (including the WHO itself during a series of meetings in 2015), was due in particular to the time it took to recognise the dynamics of the outbreak and the need to scale up all elements of the response geographically and monitor the performance of control activities. This delay was very much politically motivated, as the Guinean Government itself did not want to raise the alert in order to avoid panic and a negative economic impact.

The ineffective and slow reaction of the WHO at the country and regional level was severely criticized by many observers. It was not until July 2014 (4 months into the outbreak) that the WHO started to take action. It convened an emergency meeting with health ministers from eleven countries and then announced a coordinated strategy to provide technical support to combat the epidemic. However, this was too little, too late.

In August, the WHO declared the outbreak an international public health emergency and published a roadmap to guide and coordinate the international response, aiming to stop ongoing Ebola epidemic within 6–9 months. In September, the United Nations Security Council declared the EHF outbreak in West Africa a "threat to international peace and security" and adopted a resolution urging UN member states to provide more resources to fight it. The WHO stated that the cost of combating the epidemic would be at least $1 billion.

The fact that the lessons learnt from the past EVF in Uganda and DRC were used in a very limited way (and largely only by MSF and part of the Red Cross and Red Crescent system during the first part of the crisis) resulted in:

- The spread of the epidemic from the original limited area around Guekedou (Guinea) to the three countries (Guinea, Liberia and Sierra Leone) and into the complex urban contexts of medium-sized and capital cities. The fact that there was considerable distrust of governments/authorities among the populations of the countries concerned, especially Guinea and Liberia, has to be factored in to understand the sociological and political perception of the outbreak (denial, resistance).
- A significant death toll, although the “worst case scenario” did not occur\(^1\). In the worst-case scenario, the two countries would have had a total of 21,000 cases of Ebola by September 30\(^{th}\) 2014 and 1.4 million cases by January 20\(^{th}\) 2015 if the disease had kept spreading without any effective methods of containing it. These figures take into account the fact that many cases go undetected, and there were estimates that there were 2.5 times the number of cases actually reported.\(^2\)

- The need to set up a large number of Ebola treatment centres and isolation wards, which represented a high cost and a significant hindrance for both local economies and the normal public health system (which was already weak).

- The crisis becoming regional, spreading beyond the three most affected countries, with cases in the US and Europe.

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\(^1\) http://www.webmd.com/news/20141119/ebola-scenario-cdc

- the need to reshuffle the aid system with the very costly mobilization of military resources and the relatively expensive creation of a dedicated institution, the United Nations Mission for Ebola (UNMEER). UNMEER was established on 19th September 2014 after the unanimous adoption of General Assembly resolution 69/1, and the adoption of Security Council resolution 2177 (2014) on the Ebola outbreak. The Mission was set up as a temporary measure to meet immediate needs related to the unprecedented fight against Ebola. UNMEER was established with the following objectives, principles and assumptions:

<table>
<thead>
<tr>
<th>Operational principles</th>
<th>Objectives</th>
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<tbody>
<tr>
<td>Adopting a regional approach</td>
<td>Stop the outbreak</td>
</tr>
<tr>
<td>Centrality of national ownership</td>
<td>Treat the infected</td>
</tr>
<tr>
<td>Complement work of governments and partners</td>
<td>Ensure essential services</td>
</tr>
<tr>
<td>Clarity for national governments in what can be expected from the UN</td>
<td>Preserve stability</td>
</tr>
<tr>
<td>A singular UN system-wide approach in responding to Ebola</td>
<td>Prevent further outbreaks</td>
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<tr>
<td>A UN response that is specific to the need of each country</td>
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<table>
<thead>
<tr>
<th>Main activities</th>
<th>Key enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management</td>
<td>Logistics</td>
</tr>
<tr>
<td>Case finding, lab and contact tracing</td>
<td>Staffing and human resources? Training</td>
</tr>
<tr>
<td>Safe and dignified burials</td>
<td>Information management</td>
</tr>
<tr>
<td>Community engagement and social mobilization</td>
<td>Cash payments and coordination</td>
</tr>
</tbody>
</table>

(source: UNMEER)

2. OPERATION UNITED ASSISTANCE


The administration’s decision to involve the military in providing equipment and other assistance for international health workers in Africa comes after mounting calls from some NGOs — most prominently the international medical organization Doctors Without Borders³, which if often seen as the least likely to call for military intervention.

During the initial part of the US response, The United States spent $175 million responding to the outbreak and dispatched 100 experts from the Atlanta Center for Disease Control (CDC), among the largest deployments of agency personnel in its history. Global health experts and international aid groups claimed that charities and West African governments alone did not have the capacity to stem the epidemic and urged the White House to dramatically scale up its response.

In mid-September, nearly six months into the deadliest Ebola outbreak in history, President Obama formally announced that the U.S. military would lead the fight against the virus in West Africa. The U.S. military sent as many as 4,000 service members to West Africa, with a focus on Liberia, where they provided medical, logistical and security support. The administration sought an additional $88 million and finally asked for more resources to be made available. Separately, the Pentagon decided to take up to $500 million from from its budget (unsepnt funds) and use it for the plan to fight Ebola.

The DoD worked directly under of USAID in West Africa. U.S. military forces had a two-fold mission:

- supporting USAID in overall U.S. government efforts,
- responding to Department of State requests for security or evacuation assistance, if required.

Among the first orders was to build a 25-bed hospital for health-care workers who became infected with the deadly virus.

Simultaneously, the U.S. military initially planned to build and supply 17 treatment units in the different West African countries affected by the crisis. However, they then decided to focus their activities on Liberia. The enormous logistical military capacity allowed basic Ebola response kits to be supplied to 400,000 households in Liberia and thus address the increasingly common phenomenon of sick patients being denied access to overflowing treatment centres and being sent home.

By early October 2014, a General was in place in Monrovia to lead “Operation United Assistance” and head a regional command based in Liberia to oversee and coordinate U.S. and international relief efforts and a new separate regional staging base to accelerate transportation of urgently needed equipment, supplies and personnel. In addition, the Pentagon sent engineers to set up 17 treatment centres in Liberia, each with a 100-bed capacity, as well as medical personnel to train up to 500 health-care workers a week in the region. DoD personnel were not involved in providing direct care to Ebola-exposed patients, but were dispatched for tasks related to command and control, logistics support, engineering support, and training assistance. The Global Emerging Infections Surveillance and Response System, or GEIS, a division of the Armed Forces Health Surveillance Centre, supported the establishment of surveillance systems.

2.2. Issues at stake

Speed was of the essence in the fight against Ebola, but in view of the difficulties encountered by aid agencies to deploy enough staff and equipment, it took a long time before the health response was able to reach the required capacity. Rapid response implies that training of health-care workers is up and running quickly, that infrastructures are in place and equipment operational. The U.S. military, with its vast logistical capability, extensive air operations, and highly skilled medical corps, was mobilised to address gaps in the response. However, even the military needed time to set their operations in motion, and their hospitals only started to be operational when the epidemic had already peaked.

The president’s decision to enlist the U.S. military, whose resources were already under strain in response to conflicts in the Middle East, reflected the growing concern of U.S. officials that, unless greater force was brought to bear, the epidemic would wreak havoc on the continent.

The response was a whole-of-government Mission, as the US administration felt that only a broad range of capabilities could turn the tide of the epidemic. For instance, the United States Public Health Service Commissioned Corps deployed 65 Commissioned Corps officers to Liberia to manage and staff the hospital. The United States also set up several mobile laboratories with OFDA funding. The fact that cases were identified in the US and treated at the Evory hospital in Atlanta and the extremely strong emotion triggered some years ago by the thriller and related movie “Virus” was instrumental in pushing the Administration to activate military means. This shows the influence that public opinion and the fear of a domestic epidemic had on the decision to mobilise MCDA despite the fact that experts said the chance of an Ebola outbreak in the US was “a very low probability.”

Despite the fact that the US medical system was perfectly capable of containing the virus if any additional cases appeared, the epidemic began to be seen as a national security issue. The Defence Department increased support to the Health and Human Services and the Homeland Security departments. This support included a medical support team capable of rapidly augmenting Centres for Disease Control and Prevention capabilities anywhere in the country.
The DoD also focused on longer-term requirements to counter Ebola. To that end, the DoD requested $112 million for the Defence Advance Research Project Agency in its emergency funding request. The additional funds would support the development of technologies relevant to the Ebola crisis. This includes new research focused on utilizing the antibodies of Ebola survivors to provide temporary immunity for infected patients and the accelerated development and testing of new Ebola vaccines and diagnostics. These efforts complement existing development at the National Institutes of Health and the Defence Threat Reduction Agency (DARPA), which is uniquely positioned in the USG system to fulfil a critical role within the whole of government response, to contain and eliminate the Ebola outbreak.

2.2.1. Decision-making
Amid uncertainty about how the disease would evolve, and with CDC Atlanta producing alarming forecasts, a “no regrets” decision was made. President Obama announced the launch of Operation United Assistance in September 2014, allowing the military to support USAID and deploy MCDA. Fear and the political pressure to launch the operation were exacerbated by the first case of Ebola in the USA.

2.2.2. Needs assessment
The initial assessment of the situation was done mostly at a distance by the political level (White House) in view of the possible risk of contamination. It is important to recall that this was more a prediction than an assessment and was based on the first model developed by CDC, which forecasted more than 10 000 deaths in a short period. Then, at the field level, needs were assessed by NGOs and by the DART which then transmitted the information to the military.

2.2.3. Civilian capability gap analysis
The civilian capability gap analysis was done by the DART and CDC.

The importance of logistics was one of the key lessons learnt. An early deployment of logistical capacities was necessary, with enough engineering capacity to support it. However, as they were not familiar with the types of materials available in Africa, construction work was a challenge. More training is necessary on how to use locally available resources in contexts where large imports of sophisticated construction materials are neither feasible nor appropriate.

2.2.4. On-site coordination
USAID coordinated the USG response to Ebola. There were a number of coordination problems in relation to other international armed forces, and even more so in relation to the national armed forces in the absence of specific SOP to deal with the epidemic and coordinate the response. At the operational level, the US army established a mechanism for tasking: the Joint Requirement Review Board (JRRB), which was very similar to the JOTF established in Haiti. This facilitated the coordination of logistics by introducing a validation process. The JRRB met 3 times a week. USARAF, under AFRICOM, supported USAID in terms of logistics coordination, the training of health personnel, and engineering. There was a resolute separation of the American and national armed forces and a strong USAID lead.

2.2.5. Drawdown of assets and exit strategy
All air assets were withdrawn and military personnel were transferred back home or to other AFRICOM bases. This phase was not planned in accordance with the usual processes as it was unclear how the crisis would evolve.
2.2.6. Evaluations and lessons learnt exercises

The US takes the issue of learning from experience very seriously through After Action Reviews, and reviews by the Government Accountability Office (GAO) and the Congress. The last GAO report on the military and their role in development and humanitarian aid clearly states that “GAO recommends that DoD update its humanitarian assistance program guidance, improve data management, and conduct project evaluations, and that DoD, State, and USAID improve information sharing. GAO also suggests that Congress consider clarifying DOD’s role in humanitarian assistance efforts. DOD partially agreed with the recommendations, and State and USAID agreed with the recommendations addressed to them.”

There are also several interagency evaluation mechanisms, such as those launched by the Lead Inspector General’s office, involving the respective Inspector Generals of USAID, DOD and, for the Ebola response, HHS (Health and Human Services). The reports underlined the importance of the “whole of government” approach, with USAID being nominated as lead federal agency to coordinate the response. In September 2015, the Center for Army Lessons Learned produced a special bulletin extracting lessons from all kinds of US military sources, in particular from USARMAF and AFRICACOM. It is interesting to note that key lessons learned are about “humility” (avoiding an approach based on the idea that “we are the US army, we are very powerful”), institutional patience and the need to get out of a “warfighter mentality”.

In the US, there are also plenty of journalists, NGOs, academic circles and think tanks who are involved in analyzing and evaluating the response. The military recognized that they had underestimated the importance of engaging in better communication with these actors. Indeed, there was a general lack of engagement in communication with civilian bodies, and the deployment of a Civil Affairs unit took place late in the response.

3. THE UK MILITARY RESPONSE TO THE EBOLA CRISIS

3.1. Characteristics of the UK military involvement in the Ebola crisis

The international community was criticized for its slow response to the epidemic and DFID received its share of criticism.

Political considerations eventually drove the Ebola response. On the 9th August 2014 the British Prime Minister, David Cameron, and the American President, Barak Obama, publically agreed that action should be taken. The UK Ebola response had a DFID lead and was based on a ‘whole-of-government’ integrated approach. On 2nd September 2014, Médecins Sans Frontières made an unprecedented call for military support and intervention. Operation GRITROCK, the UK military mission to combat Ebola in Sierra Leone, was established as part of this comprehensive cross-government response, with the first British troops arriving in Sierra Leone on 16th October 2014.
UK Military Asset Offer

<table>
<thead>
<tr>
<th>Asset</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sea Platforms</strong></td>
<td>Royal Fleet Auxiliary (RFA) Argus</td>
</tr>
<tr>
<td><strong>Helicopters</strong></td>
<td>3 x Merlin helicopters, transported on RFA Argus (led by Lt Cdr Earl Kingston, 820 Naval Air Squadron)</td>
</tr>
<tr>
<td><strong>Military Personnel</strong></td>
<td>750 + British military personnel, military medics, sailors, Royal Marines and aircrew. Objective: establish Ebola treatment centres, including the Kerry Town Ebola Treatment Unit.</td>
</tr>
</tbody>
</table>

Timeline of UK Military Operations: Operation GRITROCK

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>9th August 2014</td>
<td>The British Prime Minister, David Cameron, and the American President, Barak Obama, agree that action should be taken.</td>
</tr>
<tr>
<td>2nd September 2014</td>
<td>Médecins Sans Frontières call for military intervention</td>
</tr>
<tr>
<td>7th October 2014</td>
<td>Launch of Operation GRITROCK: British military troops prepare for Sierra Leone</td>
</tr>
<tr>
<td>16th October 2014</td>
<td>91 military medics from the British Army’s 22 Field Hospital arrive in Sierra Leone ahead of RFA Argus.</td>
</tr>
<tr>
<td>17th October 2014</td>
<td>RFA Argus deploys from UK waters.</td>
</tr>
<tr>
<td>21st October 2014</td>
<td>RFA Argus reaches Sierra Leone waters.</td>
</tr>
<tr>
<td>21st October 2014</td>
<td>150 military personnel, the majority of whom are medics from 35 Squadron fly from UK military airbase Brize Norton to Sierra Leone. Additional military personnel from the 5th Medical Regiment of the Royal Army Medical Corps, The Queen’s Own Gurkha Logistic Regiment, 1st Battalion The Royal Regiment of Scotland.</td>
</tr>
<tr>
<td>11th December 2014</td>
<td>Regular and Reservist tri-service personnel begin preparation training to deploy to Sierra Leone.</td>
</tr>
<tr>
<td>20th December 2014</td>
<td>An additional cadre of regular/reservist personnel deploy</td>
</tr>
<tr>
<td>March 2015</td>
<td>RFA Argus returns to UK waters</td>
</tr>
<tr>
<td>7th November 2015</td>
<td>UK’s Foreign Secretary makes statement congratulating the halt of the Ebola virus.</td>
</tr>
</tbody>
</table>

3.2. Key Issues

3.2.1. Decision-making

DFID was providing advice from April 2014, but as this advice was not picked up on the scale of the crisis was not anticipated. Consequently, Whitehall was seen to be on the back foot. Prior to this, DFID had been engaging with the MOD to see what could be offered from a medical perspective, which had resulted in very long drawn out discussions. The outcome of these discussions was that it might be possible to construct a 10-bed treatment unit, and plans had subsequently being drawn up. Additionally, MSF were lobbying the UK to construct a facility particularly focusing on international healthcare workers. This was considered an issue that was not being addressed, and was seen to be restricting the recruitment of international staff into the region.
Then came the first UK Government Cobra meeting, and the pace and scale of response changed dramatically: from a ten-bed unit to UK Prime Minister David Cameron’s order to provide 600 beds in late September. As one DfID respondent noted, “The response literally turned on a six-pence”.

Most key informants underlined that the Oslo Guidelines do not take into consideration the political imperative during decision-making. The weight of the political imperative in this case meant that the response would have progressed with heavy military involvement irrespective of the Oslo Guidelines; essentially use of military assets was the first resort plan. Deploying a field hospital, especially on a large Royal Navy or Royal Fleet Auxiliary (RFA) vessel – in this case RFA Argus – produced a strong and highly visible statement, both physically and through media channels. The political imperative outweighed the exponential cost of deploying RFA Argus with a roll-to hospital on board.

The decision to classify the response as a global health crisis rather than a humanitarian response presented significant challenges. Military respondents noted frustration in relation to coordination architecture, especially in relation to UNMEER. This was highlighted as a significant civilian capability gap.

3.2.2. Needs Assessment

The request for military assets came from DfID and was channelled to the MoD by the specialist Humanitarian Civil-Military Humanitarian Adviser who sits within DfID. To the MoD the adviser asks the question: “This is the problem set, this is the effect we want to achieve, what can you offer us?”

The main route into the MOD is through two departments: the Operations Directorate, which is a force generation cell (connecting to the Army, Navy and Air Force), and Military Strategic Plans. Military headquarters, Permanent Joint Headquarters (PJHQ), also becomes involved.

One of the key lessons during the Ebola crisis in this process, for both MoD and DfID, was to appreciate that DfID is incredibly small and flat in structure compared to the MoD, which is larger and very hierarchical. This meant that DFID were able to respond to issues at greater pace with better agility, in contrast to the lengthier military response.

The cross-government comprehensive approach is still in its infancy. It is very much personality driven whether individuals ‘get it’. The Ebola context is one of a number of examples where the MoD did not think to seek advice from DFID. DFID respondents believed this came from naivety on the military’s part, rather than resistance to a DFID lead, despite this still being quite uncomfortable for the military. The military reconnaissance mission to Sierra Leone included the commander and chief of staff, and involved 2/3 days of UK preparatory efforts before flying out, but no one thought to consult the DfID/Civ-Mil Adviser.

The change in political impetus meant that a 100 strong DFID Ebola response team was created. The proposed UK military ten-bed unit was replaced by a 20-bed unit, but was purely focused on international health workers. If beds remained then they would be opened to the public. The DfID Humanitarian Civil-Military Adviser was attached to the DFID Ebola Team for the duration of the response.

It was ground-breaking that MSF asked for UK military support. However, the UK/DfID Humanitarian Civil-Military Adviser’s advice to MSF was to be very careful about what they asked for. Ultimately this advice rang true as MSF did not receive what they requested (front line military medical assistance); instead they received a coordinating civil-military HQ formation, the Joint Inter-Agency Task Force (JIATAF).
3.2.3. Civilian Capability Gap Analysis

Assessments highlighted that there was a lack of capacity in the Emergency Response Centres (ERCs), lack of capability on the UN side, and lack of capability and capacity on the Sierra Leonean government side. Discussion between the MOD and DFID’s Humanitarian Civil-Military Adviser led to the MOD suggesting an Afghanistan-style Provincial Reconstruction Team, which the Civ-Mil Adviser vetoed. Eventually the idea of the JIATAF was developed, which was considered to be a better fit as it was smaller (50-person strong), and more agile, to coordinate efforts. The military were considered to be very good at coordination/coherency, therefore the aim of the JIATAF was to bring of the different capacities together to try and get coherence and coordination to the problem. After many meetings at MOD, agreement was eventually reached that the MOD would staff this capability. DFID then worked with MOD to develop the JIATAF.

3.2.4. On-site Coordination

Differences in culture and work processes were very apparent, especially within the JIATAF. DFID emphasised to the MOD that they needed to keep as much as possible unclassified, and that they must talk to NGOs and vice versa. Everyday briefings were to include the NGOs. It was apparent that NGOs did not understand military culture or how the military worked, despite years of civ-mil engagement. For example, the NGOs believed evening up-dates were for discussion, but for the military evening up-dates were short, sharp, and punchy, with no discussion. DFID continued to take the lead, e.g. the JIATAF, MoD decided to put a First Star Brigadier in charge, which meant DFID had to rapidly place a the equivalent of a 2 Star officer into the JIATAF to ensure the hierarchy of levels was correct.

There were significant civil-military cultural clashes - the MoD demanded “gold plated solutions”, which was a huge source of frustration for DFID. For example, the MoD got sophisticated welfare packages, which no DFID staff got. The MOD’s main priority was to avoid any soldiers being contaminated, which was not DFID’s central consideration. The Civ-Mil Adviser maintained that the military are much more comfortable in a military environment and do not necessarily understand the role of the aid sector: “The grown ups ‘get it’, they have to ‘get it’ if they want to progress, but I’m not sure young Captains and junior Majors ‘get it’”.

While the US military, in their response to the crisis in Liberia, were kept at arms-length and buffered behind USAID, who in turn supported the Liberian Ministry of Health and Social Welfare (MOHSW), the same was not the case with the UK in Sierra Leone. Political re-organization by Sierra Leone’s President Koroma resulted in the closure of the Emergency Operations Centre (EOC) led by the Ministry of Health and Sanitation (MOHS), and the creation of the militarized National Ebola Response Centre (NERC) led by the Minister for Defence. The Republic of Sierra Leone Armed Forces (RSLAF) were heavily involved in NERC coordination, with the support of the UK’s armed forces. This, in turn, generated a particularly militarised and “masculinised” environment (Karmradt-Scott et al, 2015: 12; 16).
3.2.5. Drawdown of Assets

The military Theatre Capabilities Review (TCR) process looks at levels of troops and advice is collated on whether troops need to be increased/decreased. Unusually, the DFID Humanitarian Civil-Military Adviser was invited to take part in this process in Sierra Leone. It became clear that it is very easy to start operations but hard to shut them down, “especially when there’s a medal involved”. The military wanted to continue a certain level of operations, without understanding the strategic direction of travel. The DFID Civ-Mil Adviser had to fight relatively hard with the MOD to make the point that various capabilities were not needed any more, and that numbers could be reduced.

The drawdown of assets took place in phases over a period of 5 months. This was planned and thought through, but there was always a concern on the aid side that if the epidemic flared up again it would not be possible to bring the assets back. The focus of operations shifted to training Sierra Leoneans to look after themselves.

3.2.6. Evaluations and Lessons Learnt Exercises

Open-access UK government reports were very limited.

- A report by the PAC Public Accounts Committee has recently been finished, and will soon be finalised and made public.
- DFID Sierra Leone have just commissioned a piece of work on the Ebola response in order to support whole-of-government lesson learning.
- A number of different NGOs commissioned their own evaluation on their operations.
- The classical DFID-led assessments of value for money and measures of effectiveness took place.
- Several issues emerged.
- A lack of UK military training and experience in HADR was especially apparent. There was a distinct lack of understanding of the politics and risks involved in using military assets. The military may “just want to help”, but this has both intended and unintended implications.
- There was a need to pause and think about the problem and the strategy to adopt, rather than rushing in and thinking later. It is important to resist pressure to respond straight away (especially from the media) as this can lead to non-compliance with the Oslo Guidelines.
4. FRANCE’S MILITARY ACTION ON EBOLA IN GUINEA


The French military involvement in Guinea for the Ebola response must be seen as part of the holistic response of the French Government which was decided at the highest level of State.

France provided almost €40 million in bilateral aid (€75 million if multilateral aid is included), to respond to the Ebola Crisis. The predominant focus was on Guinea, with which France has strong and long-standing bilateral relations.

Civilian operations

- Opening of an Ebola treatment centre in Guinea’s Forest Region (€5 million). The Ministries of Health, Foreign Affairs and International Development, and Defence were tasked with the project, which was implemented by the French Red Cross. The centre was scheduled to open in November 2014;
- Support for the establishment of a Pasteur Institute in Guinea (€4 million) to diagnose haemorrhagic fever and train Guinean biologists;
- Supply of medical and personal protection equipment to Guinea;
- Deployment of experts and healthcare personnel to help care for patients and boost laboratory capabilities;
- Strengthening of basic healthcare services in Guinea’s Forest Region (€10 million);
- Strengthening the coordination of the response to Ebola, notably by making an expert available to the Guinean government;
- Support for food security in Guinea, through a contribution to WFP (€500,000).
- Dispatched teams of experts, as well as doctors from EPRUS (Health Emergency Preparedness and Response Agency). The armed forces’ medical branch arrived in Conakry to build a treatment centre for medical staff;

Operations under the military

Although the first idea announced by the French President was a full-fledged military field hospital, this idea was re-evaluated due to the reluctance of the Guinean authorities to see the old colonial power fully redeploy but also in relation to the costs involved.

The decision was thus to engage the French military in the creation of two specialized but still temporary institutions: a training centre for medical personnel (Centre de Formation des Soignants or CFS) and a treatment centre for affected medical personnel (Centre de traitement des soignants (CTS) close to Conakry.

Opened in early December 2014, the CFS facilitated the training of nearly 200 people by 7 Guinean doctors under the supervision of the French Military Health Service (Service de Santé des Armées).

The CTS, which became operational on January 23rd 2015, took care of 28 medical staff, among which 6 were Ebola positive. 3 were finally released after the confirmation that they were not infected and 3 others remained for a much longer time under favipiravir, until final release.

From the summer of 2014, the French Army acted as a full member of the Inter-ministerial Ebola Task Force both in Paris and Conakry. This involvement took several forms:

- Keeping evacuation capacity on standby with a strengthened departure position thanks to a dedicated rehabilitation landing strip in Guinea;
- Keeping a reception capacity in the Begin Military Hospital close to Paris
- Deploying a 130-strong contingent in Guinea including 70 people from the French Army Health Service and from the Valbone Medical Regiment supported by 20 service men from
the 2nd Dragons de Fontevraud Regiment, specialized in Chemical, Biological, Radiological and Nuclear (CBRN) interventions and a 40-strong military, planning, coordination and logistical capacity.

4.2. Issues at stake

Several issues seem to have been key in the decision-making process at the Presidential level:

- Political and economic ties with Guinea
- Fears of transcontinental contamination. There is quite a lot of movement from West Africa to France, and there were fears that cases would emerge in France. Of the 480 suspect cases identified, 17 were possible cases, but none were confirmed positive.
- As the French army is heavily involved in a military operation in Mali and the wider Sahel region (Serval and Barkhane), the first case of Ebola in Mali (a young girl detected in Kaye on 25th October 2014) raised several questions about the level of exposure of the French Military.

4.2.1. Decision-making

Following the first suspected cases of Ebola in Guinea Forestiere (February 2014), the Guinean authorities requested support from the French army’s health services (especially to identify cases of the virus). The request was initially declined by the EMA (Etat major des armées), as the crisis was civilian in nature and priority was given to military operations (Mali, CAR, etc.). Instead, the MFA put the Guinean authorities in touch with the Pasteur Institute based in Dakar. After several Ebola cases were confirmed, the Guinean authorities continued to request French military and medical personnel. The decision to deploy forces was made when Ebola started to cross the border with Mali, where there is a strong military contingent, and when the risk of transcontinental contamination became alarming. The decision to mobilize the health services of the French army was taken at the highest level of the French state (on September 17, 2014). The personal relationship between F. Hollande and A. Kondé partly explains the positive answer to the Guinean request.

Needs assessment

The initial assessments were carried out by MSF and the French Red Cross which started to activate their advocacy mechanisms in view of the gravity of the developing situation. The first Civil-military reconnaissance mission was carried out by a team from the French Embassy which included its military attaché. Then a multi-disciplinary evaluation mission came from France to fine-tune the needs assessment and report back to the inter-ministerial emergency cell (hosted at the CDC, MAEDI). Further information about the fast-changing situation then came from the teams deployed in the field.

4.2.2. Civilian capability gap analysis

The response focused on sending unarmed military personnel, externalising the treatment of patients to the French Red Cross (CTE in Guinea Forestiere), and supporting Guinean bodies, notably through the national Coordination body. Another objective was the establishment of evacuation channels, for French nationals, as well as for the staff of French NGOs (both international and national). This implied the establishment of flight paths, especially from Guinea Forestiere to functional international airports.

The military and civil defence assets deployed by the French were geared towards strengthening local capacities, while those of the US and UK were of a more substitutive nature (11 Ebola treatment centres were opened by the US military).
In Conakry, the CTS was mainly aimed at supporting the work of Guinean health staff, while Guinean health workers were also trained by the military health services and a civil defence unit in Manéah (CFS, Centre de Formation des soignants). On the issue of evacuation flight paths, coordination was put in place with the Guinean civilian aviation and UNHAS. This included the inspection of landing strips and a protocol for securing the aircrafts transporting patients.

Apart from the mobilization of the military health services, other types of support involving military personnel included: the facilitation and negotiation work of the Military Attaché (permanent posting at the French Embassy), logistical support and technical supervision for the rehabilitation of landing strips for evacuation, the deployment of a health adviser to the National Coordinator, Dr. S. Keita, the deployment of civil defence units to build or upgrade Ebola treatment centres (Kérouané, Forécariah, Beyla), and the training of voluntary personnel (Boffa-Kafiliya).

### 4.2.3. On-site coordination

An inter-ministerial Ebola Task Force was created, directly under the control of the Prime Minister’s office. Based in Paris, it included the Foreign Affairs, Defence, Interior, and Health Ministries and the French Development Agency, and coordinated the support provided to the Guinean authorities. The French army provided support to the inter-ministerial task force. This had financial repercussions and any amount spent by the French Army had to be billed to the MFA. Due to the high cost of the MCDA deployment, the tasks given to the military had to be clearly defined.

At the field level, the decisions made by the inter-ministerial cell were implemented and coordinated by the Ambassador and his staff. In terms of civil-military coordination, the French military attended the regular meetings of the national coordination body (two to three times a week). On these occasions, relationships with the various IOs and NGOs were rather formal. Closer coordination ties were established in the field on an *ad hoc* basis (providing medicines or equipment) based on geographic proximity and personal relationships (French Red Cross, UNHAS, WFP). Perhaps surprisingly, the level of mutual understanding with MSF was described as being quite good. For instance, the French military reconnaissance team supported MSF in negotiations when an MSF delegation was under attack from traditional leaders (Bozo) and when they had to relocate and expand a CTE in the face of hostility from the local authorities (Macenta).

### 4.2.4. Drawdown of assets

From the beginning of the operation, the deployment of French forces was to be limited to 9 months, i.e. up to August 2015 (with different turnover times between strictly military and military health personnel). Still, it was during this period that the Paris-based Ebola task force and the CPCO decided to totally dismantle the CTS. Among the main reasons for this decision was the fact that the CTS was conceived for the specific use of the French military health services and run according to their functional standards. What is more, the site occupied by the CTS had to be reinvested for its initial use by the Guinean air force.

Although no handover plan had been detailed beforehand, regular dialogue with the French military Commander may have encouraged MSF to open a new CTS in the aftermath of the French military forces departure. This “improvised” handover helped to ensure the continuity of care and support to the Guinean health personnel. During the drawdown of military assets, collaboration with civilian actors played an important role in relation to the site decontamination certification process. Based on a protocol validated by the military health services and WHO, the Guinean MoH agreed to certify the proposed protocol and its application, thus releasing the French army of any future liability.

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4 In France, these units consist of military personnel who answer to the French Ministry of Interior.
4.2.5. **Evaluations and lessons learnt exercises**

A multi-stakeholder conference was organized as a lessons learnt event under the auspices of the French MFA. Several issues were discussed during this exercise, including:

- **The issue of “first entry” in the field:** what is the strategy, what are the funding expectations, what level of human resources can be assumed to be necessary, what is the level of knowledge of the context prior to deployment?
- **The sharing of responsibility:** How is it framed between national and international actors, military and civilian, state and non-state, global (UN) and regional (ECOWAS) levels, etc.

It is interesting to note that the issue of the military deployment was not even mentioned in the proceedings of this conference.

**5. CONCLUSION**

Political considerations with regard to public opinion, public health risks across continents and homeland security clearly influenced governments and led to the decision to mobilise MCDA in the three cases. A “no regrets” approach was adopted despite the costs and complexities involved.

The importance of logistics is one of the key lessons learnt. An early deployment of logistical capacities was necessary, with enough engineering capacity to support it. However, they were challenged by the complexity of carrying out construction work, as they were not familiar with the types of materials available in Africa. More training is necessary on how to use locally available resources for contexts where large imports of sophisticated construction materials are not feasible, nor appropriate.

Given that this was the first ever large scale outbreak of a highly-contagious and deadly zoonosis affecting a large geographic including urban settlements, and that it was not fully under control, the mobilisation of MCDA was an effective way of showing domestic opinion that something was being done. This was also a key political element in the hands of the countries which deployed troops to demonstrate their support to the affected countries. These deployments complied with key aspects of the Oslo Guidelines, in particular the need to operate under civilian authority in day-to-day operations.

A series of key points should be noted:

- The decision not to use military personnel to directly provide medical treatment was widely appreciated;
- The footprint of the military in terms of coordination was very heavy in some countries, but less so in others;
- Even though the military forces were very efficient once they had been deployed, the delay in recognizing the seriousness of the situation and “red tape” in the Capitals were such that they were only fully deployed after the epidemic had peaked.

It will be important to include scenario planning and rehearsals by military personnel for large scale health crises and deadly outbreaks to ensure a higher level of preparedness for a similar crisis in the future.
ANNEX:
list of consulted documents


CDC; Estimating the Future Number of Cases in the Ebola Epidemic — Liberia and Sierra Leone, 2014–2015 http://www.cdc.gov/mmwr/preview/mmwrhtml/su6303a1.htm?s_cid=su6303a1_w


MSF, 2015, Pushed to the Limit and Beyond, A year into the largest ever Ebola outbreak, MSF, http://www.msf.org.uk/sites/uk/files/ebola_-_pushed_to_the_limit_and_beyond.pdf

OCHA, Response Plan for Ebola Outbreak - Overview of Needs & Requirements (inter-agency plan for Guinea,


WHO Executive Board (2015), Ebola: ending the current outbreak, strengthening global preparedness and ensuring WHO capacity to prepare for and response to future large-scale outbreaks and emergencies with health consequences, Special Session on Ebola, EBSS/3/CONF./1 REV.1, WHO, 11 p.
The INSPIRE Consortium supports DG ECHO in developing policies through research, workshop facilitation and the dissemination of results.

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