Australian Government
Australian Civil-Military Centre

Quick Impact Workshop – Outcomes
Early considerations on civil-military responses to emerging diseases (Ebola as a case study)

The Australian Civil-Military Centre (ACMC) is an Australian Government initiative to improve Australia's effectiveness in civil-military collaboration for conflict and disaster management overseas. ACMC's Quick Impact Workshops seek to support civil-military-police capability and understanding through multiagency engagement, case studies and shared information.

Overview – The international response to the Ebola outbreak in West Africa

In August 2014, the United Nations (UN) Security Council declared the Ebola virus outbreak in the West African subregion a 'threat to international peace and security'. The UN's request for assistance from member states resulted in the mobilisation of technical expertise, medical capacity, humanitarian assistance, and military and civil defence assets. The Australian Government contributed approximately $45 million to the international Ebola response, including the management of an Ebola treatment centre in Sierra Leone contracted to Aspen Medical, and a regional Ebola response preparedness package focused on the Asia Pacific. Other countries, including affected states, responded in a variety of ways, some through civil-military intervention. The United States (US) and United Kingdom (UK) provided a civil-military health response in Liberia and Sierra Leone respectively.

The Ebola outbreak has again raised concerns (arising from SARs – Severe Acute Respiratory Syndrome, H1N1 influenza, etc.) about the potentially devastating impact emerging diseases pose to human and economic welfare. The response in West Africa has highlighted the need for robust regional health architecture, and indicates a likely role for the military (either within affected states or through international assistance) following an outbreak or pandemic in our region.

The unfolding of the crisis—initially a health response and then a ramping up as this became more than a health crisis—enabled Australia to build its response accordingly, including the development of National Health Guidelines to manage domestic preparedness and management arrangements at the border. Notably, the Australian Defence Force (ADF) had a minimal role in this instance, but would likely be involved in a health crisis response in our region.

ACMC Quick Impact Workshop – Early considerations on Civil-Military responses to emerging diseases (Ebola as a Case Study)

On 11 February 2015, 37 representatives met from across government (Australian and international), civil society, private sector and the ADF, to draw on the experiences and observations of Australians who have been part of the response to the Ebola crisis in West Africa.

The following key observations were drawn from the workshop presentations and discussion.

Key observations

International and regional health architecture

Global health architecture – The global health architecture is increasingly seen as not 'fit for purpose'. There is a global capacity gap in response mechanisms for global infectious disease outbreaks, including in coordinated planning, decision making, resource sharing, resource management, and communications and information management. The current reform of the World Health Organization (WHO) may go some way to address this; however, it will remain a technical/standards agency with emergency response dispersed across the organisation.

Health security risk in the Indo-Pacific region – Under-developed and stretched health systems in the region make Australia's immediate neighbourhood particularly vulnerable to a major health security risk. The Indo-Pacific region has experienced increased travel, trade and urbanisation based on recent economic growth. At the same time there are concerns with increasing drug resistance to malaria and tuberculosis in the region. Australia is working to help strengthen regional cooperative mechanisms for health security to address these and other potential health risks.

Operational learnings

Stakeholder relationships – Work should continue to proactively build and nurture relationships in non-crisis periods. Well established, long-term relationships were central to ensuring Australia was able to respond effectively, both domestically and internationally. Relationships between the federal and state and territory governments were important, particularly in Australia's early response when the focus was primarily on domestic protection and information to travellers.

Bilateral relationships with international governments, military-to-military cooperation, and international and domestic health partnerships all contributed to the successful outcomes of the response in West Africa. Civil society engagement was crucial. The Red Cross and Medecins Sans Frontiers were key first movers and were operating on the ground instantly. They were quickly supported by international advocates (including the US and UK) and were direct in their expectations and advice about where Australia could and should best support other efforts.

Private sector engagement – It is becoming increasingly clear that the private sector is an active responder in crisis situations. The Ebola treatment centre established by Firestone Natural Rubber Company in Liberia became a best practice example of a quick and effective response. The Australian Government's engagement of Aspen Medical to deliver services in Sierra Leone also highlights the flexibility and availability of the private sector to support a government crisis response. Building understanding and partnerships with the private sector, both domestically and overseas, would enhance Australia's ability to respond more effectively to crises in the region.

Command and control structures – The establishment of the United Nations Mission for Ebola Emergency Response (UNMEER) and insertion into affected countries saw some confusion about mandates and responsibilities. Clear lines of responsibility and reporting must be established from the outset if a mission is to operate effectively. For Australia, this means ensuring robust interagency coordination structures, as well as governance mechanisms for working with international partners. Effective command and control arrangements are essential to avoid duplication and counterproductive effort.

Interagency coordination – The Ebola crisis underlined that Australia's interagency planning and response is highly effective. The Inter-departmental Emergency Task Force (IDETF) model is well developed and works well. The Department of Foreign Affairs and Trade's (DFAT) coordination of overseas responses is central to managing Australia's international assistance efforts. However, it is also important to note that line agencies may be called on to lead (e.g. in this case the Department of Health), and good practice indicates that early centralised coordination of effort is essential, including early identification of lead agencies and points of contact. This process supports coordinated planning, timeliness of decision making and coordination of resources.

Planning and preparedness – Tactical off-the-shelf contingency plans play an important role in operations, but there is a requirement for strategic flexibility and agility in planning. Early in the Ebola response, the Australian Government established clear direction on priorities. However, as international priorities and responses changed, it was important for civil-military agencies to be flexible while strategic direction was being realigned with international partners.

Good practice also indicates that there is a need for long-term transition planning in every crisis. In the case of Ebola, Sierra Leone and other affected countries will have to grapple over coming months with a false economy that has been generated by substantial hazard-pay for medical teams, as well as dealing with the recovery of mainstream health systems.

Communication management – The media response in any crisis will deal with perceptions more than reality, as was the case with the Ebola crisis, particularly in local communities and regarding international travel. Effective crisis management requires careful attention to messaging, media management and communications. These are necessities in achieving a successful outcome and must be factored in at the start of every crisis response.

Media and messaging – Media pressure in a crisis can lead to ineffective allocation of resources, particularly if it leads to 'being seen to act' taking priority over good planning and the coordination of response efforts. Crisis responders, both government and non-government, need to establish as quickly as possible common clarity of vision as the basis of their respective engagement with domestic and international media.

Information sharing – A common theme in recent crisis responses is that information management, data analysis and sharing knowledge is increasingly important in interagency international operations, and increasingly complex. Protocols and procedures for multi-stakeholder communication management and information sharing should be incorporated in all crisis management planning.

Cultural sensitivities and gender consideration – The international Ebola response highlighted the importance of gender, civilian protection and cultural considerations, particularly in areas such as women's healthcare, and safe and dignified burials. Every crisis response needs to take account of cultural sensitivities and gender considerations. Rapid identification and protection of the most vulnerable in the community (e.g. pregnant and lactating mothers) should be a priority.

Learning from others – The Ebola response in West Africa highlighted several best practice models from across civil society, the private sector, UK and US military, and government. The UK and the US responses, led by DFID and USAID respectively, chose to deploy substantial military assets in West Africa. There is potential to consider these models as a template or framework should an ADF response be required in the region. The sharing of lessons reports domestically and internationally maximises opportunities for continuous improvement.

Managing resources – Placing the right people in the right jobs is essential and experienced human resources are fundamental to effective outcomes. Effective coordination of resources on the ground in overseas operations is also key. For infectious disease outbreak, there are considerable duty of care issues relating to deployments. The management of resources should include robust arrangements for the wellbeing of personnel.

Alignment of strategic priorities – The priorities of the Australian Government are unlikely to fully align with those of the host nation, the international community, the UN or non-government organisations. In formulating policy advice to the government, Australian agencies need to articulate how our contribution/s can do the most good, while balancing the needs and expectations of the wide range of interested parties.

Engagement with the UN – The effectiveness of UN missions is contingent not only on their internal leadership, but on national and international engagement with those missions. This means that national agencies need to expose their staff to UN training programs and multinational UN focused exercises. It is too late to build this capacity once an operation has commenced. More staff need experience in providing operational leadership for complex missions, including where the source of authority may be unclear or non-existent.

Conclusion

The ACMC's role in identifying lessons from interagency international operations is growing. Each crisis and operation is fundamentally different but our experiential learning indicates similarities in many areas. Robust planning, integrated and straightforward advice and central government coordination are the key lessons arising from recent operations. A common phenomenon in recent Australian operations has been the different agencies placed in the lead or co-lead of an interagency response. For example, the Department of Health played a lead role in Australia's response to Ebola in West Africa, the Australian Federal Police led Australia's mission in Ukraine, and the Joint Agency Coordination Centre (under the Department of Infrastructure and Regional Development) led the search for MH370. Australian agencies can learn from these operations and increase their preparedness to lead future Australian contingencies.

What next

The ACMC will provide these observations to senior government representatives on the ACMC Strategic Advisory Panel to help inform future civil-military planning and preparedness.

A summary of workshop presentations and a list of attending organisations are below. The workshop program, PowerPoint presentations and speaker biographies can be found at www.acmc.gov.au.

Summary – Workshop presentations

Australian Government Response (Domestic)

Ms Julianne Quaine, Assistant Secretary, Ebola Response Taskforce, Department of Health

The Department of Health (Health) was monitoring the Ebola West Africa outbreak from the first report of an Ebola death in Guinea in March 2014. While the Ebola case was reported in March, the death had actually occurred months earlier and had been attributed to 'unknown causes'. The WHO has been criticised for not acting sooner but the delayed report was probably due to the limited medical knowledge of Ebola in Guinea at the time, given Ebola cases had not occurred in West Africa previously. From April to May 2014, Ebola cases continued to spread through Guinea, Sierra Leone and Liberia; however, the risk to Australia was assessed as low.

The WHO declared the disease a 'Public Health emergency of International Concern' in August 2014. Health quickly developed National Public Health Guidelines to respond to a case and designate specific hospitals for the care of a case in close consultation with state and territory governments, and worked with Australian Government border agencies—the Department of Immigration and Border Protection, Customs and the Department of Agriculture—to deliver announcements and enhance screening of incoming passengers from the three affected countries. Public communication messages were also placed on the Department of Health's website. Australia was considered well placed to manage what was assessed as a low-risk Ebola outbreak (as had been seen in East Africa in 2009).

Things changed dramatically in October 2014 with the first confirmed cases in the United States on 30 September 2014, followed quickly by other cases outside Africa. Health increased its domestic response with enhanced screening at airports (instituted travel history cards, signs and border assessment, including temperature measuring), detailed infection management guidelines for clinicians, communications strategies, and a 24-hour call line for travellers. Media interest was intense and this was managed through a comprehensive media strategy.

The domestic response leveraged existing relationships with state and territory governments, and other federal agencies including the Department of Immigration and Border Protection, Customs and the Department of Agriculture. Since August 2014, over 1,500 incoming passengers have been identified as a potential risk and assessed through this complex collaborative effort. The importance of existing relationships at the local, national and international level, with government and non-government stakeholders, has been essential to the effectiveness of Health's domestic response efforts.

Australian Government Response (International)

Mr Bill Costello, Assistant Secretary Health and Environmental Safeguards and Head of Ebola Taskforce, Department of Foreign Affairs and Trade (DFAT)

The United Nations established the Medical Ebola Emergency Response (UNMEER) as the first UN emergency health mission under UN Security Council Resolution 2177 on 19 September 2014. The United Nations called on member states to respond. The Australian Government established an Interdepartmental Committee (IDC) in August 2014, co-chaired by Health and DFAT. The IDC has met weekly since September 2014 with representatives from a wide range of border and central agencies. Medical expertise is provided by the Chief Medical Officer and Surgeon-General, ADF.

DFAT managed the Australian Government response in West Africa, and noted that Australia's response to the Ebola outbreak was more 'whole-of-government' than any other recent crisis. An early observation was the challenge presented by the competing priorities of different sectors; the civil society response focused on treatment of the disease at the source, while the government response focused on domestic preparedness (through the state/territory health systems), consular

preparedness, border protection and eliminating import risk. The professionalism and goodwill of all involved was, and continues to be, essential to balancing these competing priorities.

Early in the crisis, DFAT established bilateral partnerships with the United States and United Kingdom for the management of the Ebola response in Liberia and Sierra Leone respectively. DFAT worked closely with a range of partners including international governments, the consular networks, and civil society organisations. Notably, the International Federation of Red Cross and Red Crescent Societies and Medecins Sans Frontieres have provided on-the-ground Ebola treatment in West Africa from the start of the outbreak. DFAT contracted Aspen Medical to support the Ebola treatment unit in Sierra Leone in support of the UK efforts.

DFAT led the advice to government on preparedness in response capacity for our region, with input from Emergency Management Australia, Department of Defence and other agencies. It was observed by several agencies that providing coordinated advice would have been easier through a more formalised planning mechanism. The Department of the Prime Minister and Cabinet drafted the Regional Response Contingency Plan, again with significant (albeit not formally coordinated) input from subject matter experts across government. Australia's ability to coordinate at a whole-of-government level has grown considerably with recent whole-of-government crises such as the downing of Malaysia Airlines Flight MH17. Coordinating regular IDCs and IDETFs has become business as usual in Australia's crisis management. However, there is still work to be done to establish appropriate fora as soon as possible in any crisis to coordinate integrated responses to government.

The Australian response had minimal ADF involvement. The ADF does not have the medical capacity to deliver Ebola services in West Africa, but would certainly be called upon to a larger degree in a regional health crisis. The ADF did, however, provide planning support to the United Kingdom and United States in line with standard mil-mil planning cooperation.

While Defence was minimally involved in the West Africa response, a regional outbreak would necessitate a heavier ADF commitment, particularly with medical evacuation capacity. The United Kingdom and United States chose a military focused response in West Africa and there is potential to consider these models as a template for a regional military response. The DFAT presentation included insights into global, regional and interagency lessons. These have been incorporated in the key observations.

The UN Experience

Ms Louise Robinson, Director In Situ Training, WHO Training Coordinator for the West Africa Ebola response, UNMEER

To facilitate rapid recruitment and deployment into the region, the United Nations Medical Emergency Ebola Response (UNMEER) organisation was replicated in each of the three affected countries (72 people per country, with significant senior level staffing and at high cost to donors). Rapid recruitment across the UN system did not necessarily reflect the technical skills required to respond to a public health emergency, and this model was ultimately reviewed to better reflect the realities on the ground and the value-add of UNMEER. The mission appeared burdensome when overlaid onto an existing coordinating mechanism of weekly government incident management fora, cluster, sub-cluster, inter-cluster, bilateral and standalone entities. Initial guidelines on case management, infection prevention and control, and dead body management were developed in situ with guidelines differing on key health requirements and approaches to contact tracing, active case finding, case management and safe burial. Training became cross-cutting, diffuse and diverse, with all sectors and sub-sectors responding to the crisis using various training models to build capacity in their area of expertise.

Organisational information management was particularly difficult with an overload of data flowing in from numerous sources at district country and national levels in piecemeal fashion. There was little analytical capacity to extract meaningful information from data collected and this function may have been better placed in the hands of the UN Office for the Coordination of Humanitarian Assistance (UNOCHA). The mandate for information management, however, was assigned to UNMEER.

Unclear roles and responsibilities became an issue with the increasing range of stakeholders: WHO provided the technical lead; UNMEER was established with a clear UN mandate but was not operational for some time; and Ebola treatment centres were rapidly established in Sierra Leone and Liberia through the United States and United Kingdom military (managed by

ministries of health and international medical organisations), and by Aspen Medical for the Australian Government. The number of stakeholders added to complex administrative issues and multiple levels of engagement.

Training health care workers was an initial priority for the national government as qualified health care practitioners were in demand at the peak of the crisis. Over time the demand for trained personnel has decreased as the number of infectious cases has decreased. This presents a risk for maintaining a core group of trained personnel as a preparedness measure at national and provincial level. Other issues included the treatment of non-Ebola health care (for example childbirth) in the affected regions. Non-Ebola health cases were not treated with the same priority resulting in increasing mortality rates, particularly infant mortality, and health care resources for county level hospitals and health care centres became a UNMEER priority, as did the establishment of a pharmaceutical pipeline and delivery chain to the county health office.

Messaging became crucial in affected communities with village leaders becoming the custodians of the mobilisation effort to recognise and respond to Ebola. However, some local entities were understandably scared and rumour was rife. Some community members believed health workers were responsible for bringing Ebola to their districts and that Ebola was a cover-up for organ theft. Managing media and community-level awareness became a large part of the response effort, particularly sensitive issues involving religious customs of laying on hands and dignified burials without cremation.

The initial response effort by Firestone Natural Rubber Company, a subsidiary of Bridgestone Corporation, is considered to be resourceful, effective and innovative, and can be considered a template for future private sector response efforts. Management mobilised its workforce and set up an incident management system with decision making capability. Firestone's comprehensive response and onsite medical facilities enabled them to be Ebola-free for four months, protecting their Liberian workforce, operations and economic and social interests.

Observations from the field

Mr Thanh Le, Director Ebola Taskforce, DFAT

The international Ebola response did not meet the two key requirements for effective crisis management: clear command and control arrangements, and robust information management. Also crisis management for a disaster of this type is unlike any other: there is no infrastructure damage, the crisis is still underway (assistance arrives to control the crisis as opposed to rectifying damage), response efforts are fully resourced, and there is a clear end goal (zero cases as opposed to years of stabilisation recovery). This type of crisis management can therefore challenge traditional humanitarian assistance and disaster relief (HADR) mechanisms.

The response in West Africa lacked coordination among stakeholders, partners and the host country. Information management and planning timeframes were also issues; for example, the Centre for Disease Control's (CDC) epidemiological data was collated on a Friday, WHO data was collated on a Sunday, yet government data requirements were identified on a Monday. This meant that information collation was out of sync with end-user requirements. While financial resourcing was good, it seemed that experienced planners and human resources were missing. The UK model of deploying a small multidisciplinary team to oversee planning and operations management is worth further investigation.

There were three parallel (but disconnected) operations in different regions: the WHO/CDC supported District Ebola Response Centre; a UNMEER approach with international agencies; and the military/government led response by the United States, United Kingdom and supported by Australia. While some agencies seemed unprepared for this type of crisis response, others presented best practice models (e.g. the facilities at the Hastings Airfield Base). Parallel operating tracks also meant there was increased risk of mission creep and duplication. The role and purpose of the UNMEER was not clear on the ground and this caused a level of confusion and unmet expectations.

The response to the Ebola outbreak was focused on clinical medical treatment, but it should have been broader. The response effort should have included a strong community focus and strategies to change, or at least suspend, traditional community practices. Medical treatment was one part of the response, but more should be done to address the transmission of the disease and behavioural contributors. The Red Cross's whole-of-community approaches were exemplary in this way.

Sierra Leone is a permissive environment following 10 years of conflict. While corruption, poverty, poor governance and healthcare exist, the country has existing infrastructure. There is a social imperative to reintroduce normal community functions like schools and markets, as idle communities can bring about political unrest. There is a growing concern about the long-term impact of the international Ebola response in Sierra Leone. With high levels of international resourcing, hazard

pay alone has injected an additional $3.5 million into the community since the crisis began. This payment will cease in coming weeks as Ebola cases reduce, and there are increasing concerns for to the socio-economic impact of the abrupt termination of payments. Long-term recovery planning will need to factor in economic stabilisation.

Observations from Aspen Medical
Mr Leo Cusack, Operations Manager, West Africa

The British Royal Engineers constructed seven purpose-built Ebola treatment centres (ETC) in Sierra Leone. The ETC at Hastings Airfield Base was originally intended to be managed by the Sierra Leone armed forces but, with the agreement of the Sierra Leone Government, it was handed to the Australian Government for management by Aspen Medical. Aspen provides recruitment, training (in Australia and Sierra Leone), credentialling and induction of medical personnel for the ETC.

There has also been a dedicated focus on community, particularly the reintroduction of Ebola survivors into their communities. Survivors are provided with a certificate and are encouraged to place a handprint on a specially-erected wall outside the ETC. The wall's growth provides a visual reminder that Ebola is being actively managed and many people survive.

Aspen now operates five Ebola treatment facilities in Sierra Leone and Liberia. Staff ratios (numbers, hours and rotation) are managed carefully, with CSO and Aspen operating between four and eight-week shifts depending on staff arrangements. The Aspen management team includes a number of ex-ADF serving members who bring a degree of military operations and logistics experience. This experience, combined with private sector health professionals, government contract, IDC oversight, and military evacuation capability has provided an effective response on behalf of the Australian Government. Relationships with all stakeholders, both in Australia and in West Africa, have been actively managed and have been a major contributing factor to the success of the Australian response.

DFAT's coordination role was key to ensuring a successful, efficient Australian response.

Workshops Attendees (Agencies)

Aspen Medical

Australian Civil-Military Centre

Australian Council for International Development

Australian Federal Police

Caritas Australia Department of Health

Department of Foreign Affairs and Trade – Stabilisation and Recovery

Department of Foreign Affairs and Trade – Humanitarian Division

Department of Foreign Affairs and Trade – Australian Civilian Corps

Department of Foreign Affairs and Trade – Health and Environmental Safeguard Branch

Department of Foreign Affairs and Trade – Ebola Taskforce

Department of Defence – Defence Legal

Department of Defence – Joint Health Command

Department of Defence – Joint Operations Command

Department of Defence – Military Strategic Commitments

Department of the Prime Minister and Cabinet

Embassy of the Republic of Korea

Emergency Management Australia

Red Cross Australia

UK Embassy

US Military Exchange Officer