

POLICY BRIEF

SECURITY SECTOR ENGAGEMENT IN GLOBAL HEALTH CRISES

EBOLA IS THE LATEST GLOBAL HEALTH CRISIS TO STRAIN RESPONSE CAPACITIES AT NATIONAL, REGIONAL AND GLOBAL LEVELS. CAN SECURITY INSTITUTIONS MAKE A DIFFERENCE?

The largest outbreak to date of the Ebola virus disease (hereafter “Ebola”) occurred in 2014 in Western Africa, for the first time involving major urban as well as rural areas. By February 2015, 23’253 cases and 9’380 deaths were recorded¹. As the Ebola crisis deepened in 2014, there were calls for international military assistance. Security services were deployed from the United States of America (USA) in Liberia, from the United Kingdom (UK) in Sierra Leone, and from France in Guinea.

A Roundtable and Public Event discussing the role of the security sector in responding to Ebola and other global health crises, held in Geneva on 5-6 February 2015, included senior participants from the health and security sectors, with a personal briefing by David Nabarro, the United Nations (UN) Secretary-General’s Special Envoy on Ebola.

The challenges of the Ebola outbreak raise questions as to **which contributions local and international security institutions can and should make in response to global health crises**. The discussions generated some key conclusions:

- Views differ on whether and how the engagement of the security sector in response to health crises can support public health principles and add value. Lessons can be drawn from Ebola and other health crises, but are highly context-specific.
- The involvement of the security sector in health crises is now a frequent occurrence and has the potential to assist countries and the international community in responding quickly, efficiently, and effectively. Yet areas of concern remain, especially in countries where trust in the security sector is low.
- The involvement of the security sector should be managed through a whole-of-government approach under civilian public health leadership. This also applies at regional and global levels. The creation of an office of a national public health security advisor might prove helpful.
- Early and proper preparedness is key to facilitating rapid deployment in times of crisis. This includes prior agreements between health



David Nabarro, UN Secretary-General’s Special Envoy on Ebola, briefing roundtable participants on the lessons learnt from the UN involvement in the Ebola response.

- and security sectors and a systematic and joint approach to advance planning, rehearsals, stockpiling essential materials, as well as training at national, regional and international levels.
- All parts of the security sector have the potential to play a constructive role in averting and managing health crises, including: non-state armed groups (who are required to facilitate health care and medical support for populations living on territories under their control); intelligence services (who might provide early warning together with other actors); the police (who can assess local needs and provide targeted assistance through community policing); border guards (who might assist in controlling cross-border movements of infected individuals); as well as the justice sector, the penal system, and local justice and security providers.
- The involvement of security sector actors should also be matched with the inclusion of state and non-state oversight and management bodies. These bodies control security institutions and need to



Panel discussion with Lamine Cissé, Martin Schneider, James Orbinski, Robert Wah, Ambassador Yvette Stevens, Ruth Caesar (from left to right).

revise these institutions' mandates to allow for their participation in managing health crises. Also, security institutions are primarily accountable to these oversight and management bodies.

- When required, the legal framework should be adjusted to reflect new international or internal health-related roles of security institutions, and mandates must be adjusted to explicitly include preventive and responsive action to assist in the management of health crises. This includes the International Health Regulations (IHR) adopted by the Member States of the World Health Organisation (WHO).
- Internal doctrines and manuals of security institutions will need to be adjusted – and as a consequence, training, exercises, staff planning, and procurement will need to reflect these new tasks.
- The overall responsibility for health crisis management and the chain of authority and accountability of the security institutions engaged in crisis response need to be thoroughly understood and agreed upon by all actors involved. This also refers to the IHR and the role played by WHO.
- In countries where security sector reform activities (both national and/or internationally-sponsored) take place, such reforms should also adopt the security sector's preparedness (including equipment and training), in order to contribute to (a) managing health crises and (b) preparing for inter-agency cooperation inside and outside the security sector for a coordinated response. In fact, such cooperation might then also "spill over" into improved cooperation in other areas where security-sector-wide approaches are called for. Therefore, preparation for potential health crises could be seen and used as a catalyst for general security sector reform and security sector governance.

EBOLA: A DEADLY DISEASE... AND A THREAT TO HUMAN SECURITY

Ebola spreads by contact with body fluids from infected people. Prevention of transmission requires isolation procedures, while ensuring that human suffering is addressed compassionately. Engaging effectively with communities is vital, since fear and mistrust of those involved in the response to Ebola can thwart efforts to prevent transmission. The 2014 outbreak occurred in countries recovering from armed conflicts, with very poor health sectors and communities with a high distrust of the government. In addition to the tragic loss of lives, the Ebola outbreak had serious implications for human security and economic development in the affected countries.

Drawing on what many have considered an initially inadequate response by many actors, we need to learn how to build preparedness and response mechanisms at a global level to be better prepared in the future.

We need to review and learn from the organisations and instruments that local communities, national governments, regional organisations and the international community have at their disposal to address such crises. Coordination of all these efforts might exceed the capacities and resources of a single body like WHO; this is being reviewed by a recently appointed UN High Level Panel on the Global Response to Health Crises.

EXTERNAL RESPONSES TO EBOLA

On 25 March 2014, WHO released its first report on Ebola in Western Africa, when 13 cases in Guinea had been confirmed². Within two months, there were cases in Liberia and Sierra Leone. Médecins sans Frontières (MSF) was among the first to respond to the outbreak, signaling its concerns and establishing an isolation centre in Guinea in March 2014. In June, MSF declared the outbreak "out of control"³ and called for massive resources to help manage it. In September, MSF again called for more assistance, including military help⁴.

Despite the clearly deteriorating situation, in the June-August period, little or no support arrived and the technical responses were largely limited to the health sector. Since August 2014, many more organisations have joined the response. Major contributors included the African Union (AU); the Economic Community of West African States (ECOWAS); the Mano River Union; the European Union (EU); the International Committee of the Red Cross; the International Organization for Migration (IOM); high-income countries (including France, Germany, the Netherlands, Switzerland, UK, USA); low- and middle-income countries (including China, Cuba, Uganda); non-governmental organisations (NGOs) and professional bodies (including International Medical Corps, MSF, Save the Children, World Medical Association); the United Nations Mission for Ebola Emergency Response (UNMEER); WHO; and the World Bank. Involvement of external security forces in affected countries included contributions by the USA, UK, France, Germany, and the Netherlands. ECOWAS deployed military medical personnel.

WHY WERE WE UNPREPARED?

An effective response to the 2014 Ebola crisis was belated. This may reflect weaknesses in health systems, surveillance, and preparedness; the fact that Ebola was fairly uncommon in the region and was only slowly recognised as an emerging health crisis; as well as an initial reluctance to acknowledge the disease because this would have affected industry, trade, and tourism. Reliable monitoring systems for disease outbreaks did not exist – neither at community, national nor regional levels. International attention increased when it spread across borders in the region and further abroad.

Stigmatization of those affected, their families and communities compounded tensions between the public, health care providers, and poorly trusted governments and their security providers. People were unsure about using treatment and isolation centres. Effective communication between the affected populations and health care

providers did not exist and community involvement was not prioritized in the response.

The outbreak revealed flaws in the IHR and especially their implementation. The revised IHR 2005 emerged after an outbreak of Severe Acute Respiratory Syndrome (SARS) and recognition of the need for an international framework to quickly identify and interrupt disease outbreaks. However, without national capacities for surveillance, compliance with the IHR cannot be assured. In this case the outbreak led to a combination of a public health and humanitarian crisis at a large scale in very fragile states. Analysis is now needed to determine how the IHR and their implementation can be further revised, and in particular how constructive partnerships can be developed between public health, development, humanitarian, and security providers.

SECURITY SECTOR ENGAGEMENT IN HEALTH CRISES

ACTIVE, RESPONSIBLE AND EFFECTIVE ROLES FOR PUBLIC SECURITY SERVICE PROVIDERS

For some, it is only appropriate to use security sector institutions as sources of last resort when managing disease outbreaks. Others see their involvement as invaluable, but ask for reassurances about the terms and conditions of their involvement.

Despite often-expressed unease about the ‘securitization’ of health, during the 2014 outbreak the assistance of security institutions became necessary to prevent violence and protect citizens and response personnel. The different use of security institutions and the response of the population in the three countries require further analysis. At the same time, while early commitment of the security sector may have rendered the task of maintaining public order much easier, late commitment found social structures much closer to collapse.

Involving military forces in humanitarian as well as security operations in conflict or post-conflict areas proved to be particularly challenging. In such situations, security and humanitarian actors and their roles clash.

Discussions about the call for ‘white helmet’ medical corps as part of international responses has gained some currency, but the concept itself is not well defined yet. They might include well-trained and flexible security contingents, along with teams of doctors, nurses and individuals skilled in logistics, transport or engineering.

In addition to questions as to the time, nature, and conditions of engagement, disengagement is also a considerable challenge: health crises like Ebola do not suddenly disappear, but only gradually subside. At what point should security institutions disengage and leave the management of health crises to local, national, and international civilian actors?

SECURITY SECTOR CAPACITIES AND POTENTIALS

Security sector assets include human resources and capacities for rapid and large-scale logistics and for communications, transportation, engineering works, and maintaining civil order; and the ability to move and protect essential supplies effectively and efficiently anywhere they are needed.

It is important to differentiate between roles, tasks, and capabilities of different elements of the security sector, which include defence, law enforcement, correction, intelligence services, and institutions responsible for border management, customs, and civil emergencies. In addition to the

military, it also encompasses the police, border guards, local and village militias; the judicial sector; and actors playing a role in managing and overseeing the design and implementation of security, such as ministries, legislative bodies, and civil society groups; customary or informal authorities; and private security services. Each security sector actor has its specific roles, responsibilities and training requirements. Security sector engagement ideally involves step-by-step escalation, first with local or village militias and community police involved in the affected areas; border guards subsequently brought in to control movements; national military called on later if the crisis deepens; and finally regional or global actors may need to be engaged. While deployment might follow different stages of the crisis, preparation must take place beforehand, and in unison.

Each security institution has its own comparative advantages when managing health crises. For example, the police can work closely with communities: during the Ebola outbreak in Liberia, community policing activities included working with youth centres; helping deliver food; assisting those stigmatised; and helping to protect victims and their homes. Moreover, a productive police partnership was developed with UNMIL peacekeeping forces, an international actor.

Both national and international military forces offer a variety of services, such as in Western Africa, where they were important in helping establish Ebola treatment centres, logistics and transport for supplies; in training of local health workers; and in stabilization to help create conditions for international humanitarian action.

The contributions of military medical corps are especially crucial where local health system capacities are very limited. They are also experienced with diseases that are not often seen in the general public, but present a danger to troops who might become exposed to them in their theatre of operations. Military involvement in medical research has in fact contributed greatly to the development of vaccines against, for instance, Yellow Fever and influenza⁵; and the US military has invested considerably in Ebola research to be able to protect its troops from possible bioterrorism threats.

Intelligence is a critical factor both in detecting the onset of a disease outbreak and in monitoring its course. To prepare for future outbreaks, there is a need to develop information gathering systems, to which military intelligence could potentially contribute. In a context of low trust such involvement requires very careful consideration from a public health perspective, as experiences with contact tracing showed in the Ebola outbreak.

REGULATION AND COORDINATION OF SECURITY SECTOR ENGAGEMENT IN HEALTH OR HUMANITARIAN CRISES

It is important to ensure civilian control of overall response, including the contribution of security institutions. Furthermore, strong coordination of security institutions with relevant civilian authorities is vital, in order to optimise complementarity, manage trust, and ensure respect for people's rights, dignity, cultures, and the need to be well informed.

The health sector is usually first to be asked to take responsibility in outbreaks; and only when problems occur the issue ascends the political ladder, triggering the involvement of other actors, including the security sector. This is less than ideal: decisions may then be taken more due to anxiety (e.g. restricting people's movement) than to public health needs or an objective threat, creating a vicious cycle of public unrest and stronger response.

LOOKING TOWARDS THE FUTURE

In dealing with global challenges like Ebola, **new types of relationships are required between the health, development, humanitarian, and security sectors**. Their development should be **informed by evidence from research**; recent **experiences with cooperation**; the design of **new modes of interaction**; requirements for **implementation and training**; and their implementation accompanied by **training of key actors** to ensure better preparedness for and capacities during crisis response.

At the same time, new relationships and new activities should respect the do-no-harm principle – and avoid negative repercussions of health crisis management on regular public health provision and the management of already existing crises (such as polio, malaria or HIV/AIDS). As well, collaboration between civilian and military actors must not be allowed to lead to militarization of civilian security providers or the further entrenchment of military control in fragile states with struggling democratization processes.

New types of relationships depend on successful behavioural change, requiring updated training designed with the help of new understanding. Improving on structures, capacities and relationships

Regulations applicable to the broader security sector could be built on the Oslo Guidelines on the use of foreign military and civil defence assets in disaster relief, which in their current form focus on the military:

- Military and civil defence assets should be seen as a tool complementing existing relief mechanisms, in response to the acknowledged "humanitarian gap" between the disaster needs and the resources available to meet them.
- All relief actions remain the overall responsibility of the Affected State and should be under overall civilian control.
- Foreign assistance by security services should be provided at no cost to the Affected State.

that already exist requires a thorough understanding of what worked and what did not, drawing lessons from past responses to health crises. This implies a detailed research agenda that needs to cover every aspect of the governance, management, implementation, and evaluation of responses to health crises at national, regional, and global levels.

Training activities need to include how different sectors should work together to tackle a health crisis. Intersectoral training of officials at national, regional, and global levels should include understanding and flexible responses to lines of authority and responsibility; developing a shared understanding of terminology that may have a different meaning for different groups; and imparting skills in the effective use of communication tools to build trust among health and security providers, and between them and affected communities. Simulation exercises will be an important part of such training.

Most urgently, opportunities should be seized to include – and drive – the issue of security sector engagement in response to health crises within major international political forums – for instance during the upcoming G7 meeting hosted by Germany in June 2015; and the UN Special Summit on Sustainable Development in New York in September 2015.

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