The Security Sector's Role in Responding to Health Crises

Lessons from the 2014–2015 Ebola Epidemic and Recommendations for the Mano River Union and Its Member States

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GLOBAL HEALTH CENTRE

The Geneva Centre for the Democratic Control of Armed Forces (DCAF)

CONTENTS

LIST OF ABBREVIATIONS

AFL	Armed Forces of Liberia
AU	African Union
CGSP	JS & Associates Centre for Governance and Security Policy
DCAF	Geneva Centre for the Democratic Control of Armed Forces
ECOWAS	Economic Community of West African States
EVD	Ebola virus disease
GHC	Global Health Centre at the Graduate Institute in Geneva
ICRC	International Committee of the Red Cross
JBSCBU	joint border security and and confidence-building unit
MATRA	multiagency threat and risk assessment
MRU	Mano River Union
PPE	personal protective equipment
SOPs	standard operating procedures
SSR	security sector reform
UK	United Kingdom
UN	United Nations
USA	United States of America
WAHO	West African Health Organization

INTRODUCTION

The outbreak of Ebola virus disease (EVD) in 2014–2015 in West Africa, particularly in Guinea, Liberia and Sierra Leone, resulted in more than 28,000 cases and over 11,000 deaths. Research and studies are more than ever before important now to help establish what occurred; what weaknesses were uncovered in the national, regional and global responses; what may be done to improve preparedness, early warning and response processes; and what may be done to strengthen responses and enhance resilience to such health crises in the future. However, the role of the security sector services and institutions in this crisis has not yet been systematically assessed. National security institutions – including police, border guards, community militias, customs, immigration, national security and intelligence, defence and military services – were closely involved in the response. In addition, as the Ebola crisis deepened in 2014 international 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, responding to calls for international military assistance.

Much can and must be learned from these experiences. With funding from the Swiss Federal Department of Defence, Civil Protection and Sport (DDPS), on 24–25 August 2016 the Geneva Centre for the Democratic Control of Armed Forces (DCAF) and the Global Health Centre (GHC) at the Graduate Institute in Geneva, in collaboration with the JS & Associates Centre for Governance and Security Policy (CGSP) in Sierra Leone, jointly organized a two-day roundtable-style workshop entitled "The Security Sector and Global Health Crises: Lessons from the 2014 Ebola Epidemic in West Africa" at the Bintumani Conference Hall in Freetown, Sierra Leone. This report is informed by the workshop's main discussions, outcomes and recommendations, which are expected to facilitate better preparedness to mitigate future epidemics. This will be achieved through collaborative and coordinated efforts between health and security sector communities, and directed at local, national and regional actors as well as the international donor community engaged in West Africa.

The workshop was organized as a follow-up to initial background studies and a series of roundtables and workshops organized by DCAF and GHC, bringing together the security and health sectors from the West African region, Switzerland and beyond ("The Security Sector and Global Health Crises: Lessons from the Current Ebola Epidemic", Geneva, February 2015; "The Security Sector and Global Health Crises", Geneva, October 2015; "Health Security, Sustainable Development Goals and the Role of Think Tanks", Geneva, November 2015; International Security Forum, Geneva, June 2016; and "Security Sector Engagement in Global Health Crises", NATO Headquarters, Brussels, June 2016). Results from research, consultations and expert discussions have been shared with the broader public and the Geneva-based diplomatic and international community in two public panel discussions ("Ebola and the Security Sector: Opportunities and Limits of Security Sector Engagement in Global Health Crises", Geneva, February 2015, and "The Health Sector Meets the Security Sector", Geneva, May 2015); and with practitioners and experts in the security and health sectors through the publication and wide dissemination of two policy briefs (Security Sector Engagement in Global Health Crises: A Brief for Policy-Makers, May 2015; and The Security Sector and Global Health Crises: Lessons and Prospects, June 2016), an article ("We need a Sustainable Development Goal 18 on global health security", The Lancet, Vol. 385, No. 9973, 21 March 2015) and participation in several expert consultations, policy events and advisory panels on lessons from the international response to the Ebola epidemic.

Within this context, the workshop in Freetown generated practical, hands-on knowledge on lessons learned from the perspectives of regional and national actors. There were over 60 participants, including experts from Côte d'Ivoire, Guinea, Liberia, Mali, Nigeria, Senegal and Sierra Leone, and

representatives from key regional organizations involved in the Ebola response, including the African Union (AU) and the Mano River Union (MRU), as well as additional researchers, Ebola Task Force coordinators at national and regional levels, and representatives of the diplomatic and international community based in Freetown. Participants shared practical recommendations to facilitate better preparedness to mitigate future epidemics.

The discussions focused on practical lessons learned from the Ebola crisis and generated recommendations for security sector actors' contributions to future preparedness and response capacity from the perspectives of the armed forces, police services, intelligence services, border management, local security actors, international security arrangements, national governments, societal actors, institutional and legal frameworks, and security sector reform (SSR) activities. The participants worked together in break-out groups and practical exercises on the relationship of health and security sectors; the roles played by security institutions; and the roles of bilateral, regional and international actors. The workshop culminated on the second day with a plenary during which the results from the parallel group meetings were presented and discussed, highlighting key lessons, challenges and recommendations from the interactive sessions. This report outlines the most important findings and suggestions that emanated from this expert meeting.

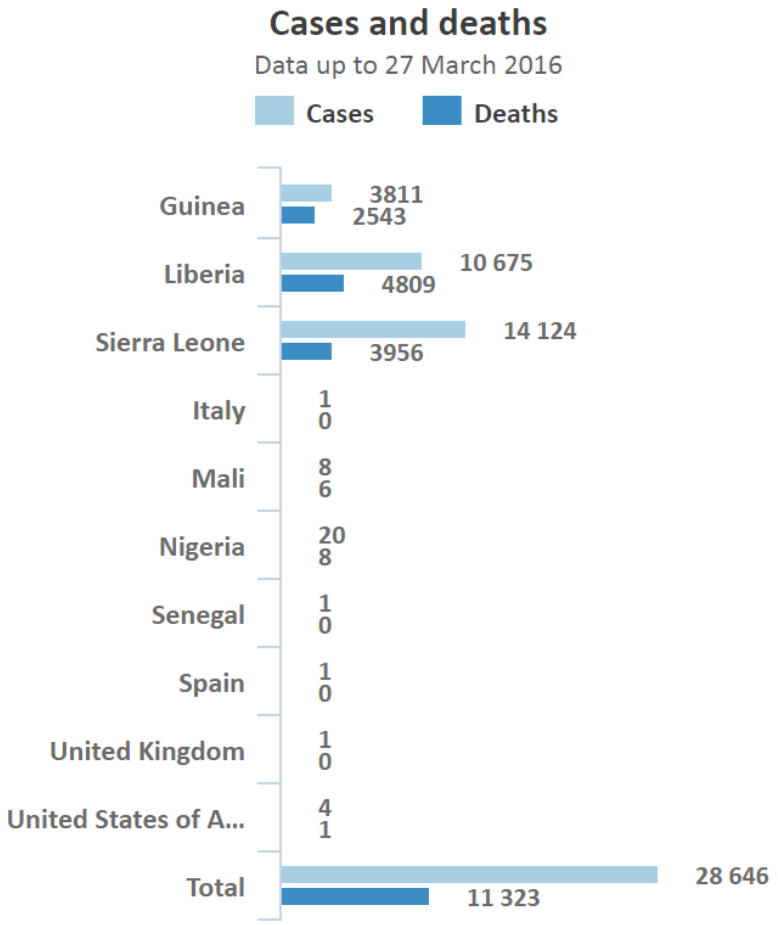

Table: WHO

MAIN LESSONS, CHALLENGES & RECOMMENDATIONS IDENTIFIED

On the Relationship between Health and Security Sectors

Health workers were at the forefront of the fight against Ebola, including doctors, ambulance drivers, surveillance officers, port health officers and laboratory technicians. Resource mobilization was critical, as a lack of trained and qualified medical and professional staff as well as material and logistics posed major constraints to effective responses. Weak infrastructure and poor accessibility to vulnerable communities were a further challenge. A subregional organization, the West African Health Organization (WAHO), was the first to deploy personnel in the three member states to reinforce national health workers at treatment centres.

There was a sharp increase in mortality and morbidity rates (also due to noncommunicable diseases); the breakdown of cultural and social fabric; shunning of traditional rites such as handshaking and family washing and burial of the dead; and stagnation of economic activities. People who showed symptoms similar to EVD yet whose test results were negative nevertheless faced stigmatization. Often they were still sent to treatment centres, where they were exposed to a high risk of infection.

The educational system came to a halt, and the school dropout rate, cases of gender-based violence and number of teenage pregnancies increased. Miscommunication and contradictory statements from the authorities led to mistrust between healthcare providers, government and civil society organizations. Many people turned to traditional healers and avoided hospitals as much as possible. Fears spread that viral specimens could be used for bio-terrorism. Moreover, the initial denial of the outbreak led to community resistance. The enforcement of by-laws and health regulations was challenging, especially those related to maintaining human rights while enforcing regulations and protecting life and property. It was also noted that in the absence of clear frameworks of roles and responsibilities during the initial outbreak, cooperation between security and medical personnel was weak. The capacity of correctional centres to prevent or control outbreaks of Ebola and other infectious diseases was highly inadequate, and the accommodation of new inmates and thus new risks of infection was a serious challenge. More security sector involvement was needed for crowd management and the protection of quarantined homes and treatment centres.

The health sector was seriously overwhelmed. There were too few holding centres to pre-screen new patients – although these were later built with support from other agencies, including the security sector institutions. Hygiene and medical materials to reduce the risk of infections were limited, and these too were later provided by other agencies. Medical centres and military hospitals had limited resources for both Ebola and primary healthcare support.

Furthermore, it was reported that the capacity to staff border crossing points was insufficient. More (security) personnel were required for tasks related to immigration and logistics. The military could sometimes compensate for some of these shortages, especially in the field of logistics, where they assisted other partners. Given the scarce facilities, the army's network of countrywide military intelligence bases could be used.

Within all member states there was limited understanding and information about EVD among the wider population, and traditionally held beliefs and perceptions hindered cooperation between health and security sector personnel and communities. Language and cultural barriers between communities and international support staff warranted the use of

interpreters, which contributed to low levels of trust between the two parties. Poor involvement of women in community engagement (women are normally seen as traditional caregivers) in the initial stages of the outbreak was glaring. Community involvement in general was not solicited at the start of the epidemic.

Despite the fact that the outbreak was politicized from the outset of the epidemic, governments as well as policymakers seemed to be unprepared in the eyes of the participants. In addition, there was a perceived lack of interest among the international community and foreign governments in pursuing research on EVD.

Map: Deutsche Welle

Recommendations on Improving Health Crisis Preparedness

A number of specific recommendations to national governments and regional organizations on improving health crisis preparedness emerged from the discussions, as summarized below.

Recommendations for national government agencies

1. Step up knowledge, information, education and communication activities on EVD and other potential global health emergencies.
2. Engage in regular and continuous sensitization with all communities, using all possible forms of communication.
3. Strengthen national and local health sectors by ensuring parallel structures are established that can simultaneously run both emergencies and routine activities.
4. Strengthen the health sector in remote border areas.
5. Improve feeder roads to vulnerable communities.
6. Ensure that every major hospital has at least one epidemiologist on staff.
7. Review terms and conditions of service for the health sector – for example, increase remuneration of health sector workers as part of retention packages.
8. Cover health workers and security personnel with adequate health insurance to ensure that they receive adequate treatment in case of on-the-job infection.
9. Put volunteer workers on payrolls to create an incentive for others to join.
10. Continue with mandatory hand hygiene instituted during the Ebola outbreak in schools and public spaces.
11. Secure access to clean water.
12. Sensitize civil society through the adoption of by-laws, including provisions on how to treat the deceased (washing, burial, etc.) in the context of a health emergency.
13. Establish and strengthen disaster-preparedness systems, including national institutions for disaster management.
14. Support the establishment of ambulance services at local levels.
15. Enhance decentralization and the devolution of power to local governments for the purpose of developing by-laws to address public health emergencies.
16. Mainstream gender equality in disaster-preparedness strategies.
17. Establish a resource mobilization plan.
18. Ensure governmental emergency supplies of food, fuel, etc. for exceptional circumstances and stockpile appropriate medical equipment, including personal protective equipment (PPE).
19. Review school curricula to include the teaching of mandatory life-saving skills.
20. Give civil society organizations a central role in public health emergencies.

21. Promote research on risk assessment in public health, together with evidence-based policy research.
22. Elaborate standard operating procedures (SOPs) to support collaboration and cooperation between local communities and medical and security personnel.
23. Provide individual and joint training and capacity building for health practitioners, specialists and security personnel.
24. Facilitate periodic simulation exercises to test health and security practitioners' level of preparedness in managing disasters. These simulation exercises should be jointly organized for medical and security practitioners, while external partners could participate and offer support.
25. Build synergies between the security sector and health communities. Both should be embedded in joint actions coordinated by a government-led agency.

Recommendations for regional organizations, particularly the MRU

1. Develop a disaster-preparedness strategy at regional levels.
2. Facilitate and improve regional cooperation between governments in crisis management.
3. Intensify the global health crises research activities of the Economic Community of West African States (ECOWAS) and the MRU (through, e.g., a subregional centre for training and research to address disasters and emergencies), involving health and security professionals;
4. Institute subregional centres for disease control. Strengthen the implementation of global health security system regulations in the MRU Secretariat and its member states.
5. Adopt the Abuja Protocol on Public Health, and with it the commitment by member states in the MRU to dedicate at least 15 per cent of their national budgets towards the improvement of national health.
6. Explore alternative means of raising funds for health financing within ECOWAS/MRU member states.
7. Establish rapid-deployment teams within the WAHO.

On the Roles Played by Security Sector Institutions

A wide range of security sector actors played important roles. These included the national armed forces; intelligence services; police/gendarmerie services; border guards and border management; local security actors, including militias; international security arrangements; national governments; civil society actors (media, think-tanks, etc.); regional and international governmental organizations, including the United Nations (UN); and legal and parliamentary bodies.

The roles of the armed forces across the region were in general quite similar, but with some distinct differences. In the majority of cases the armed forces were involved in preventive activities: they were deployed to quarantine communities, prevent individuals from leaving or entering infected communities, and restrict movement across the borders of the countries in the region. In Liberia, the Armed Forces of Liberia (AFL) had to be deployed to meet basic security needs and provide security protection. They were responsible for the enforcement of quarantine and curfew, and manning of several checkpoints to slow down and stop the free movement of people in an attempt to halt the spread of the disease. In some instances the AFL made use of their firearms to disperse crowds and ensure basic public order during the Ebola outbreak – an overreaction that could be attributed to the fact that they were not well trained and were unaccustomed to handling such crises. For example, fear among the local population that a treatment centre could be a source of Ebola infections led to a fatal clash with the police. The treatment centre was located in a quarantined area in the centre of a town, and a community-led protest against the location of the centre resulted in the clash with the police.

In Sierra Leone, during the initial outbreak of Ebola, command and control of operations were problematic. However, after having learned from initial experiences, when called upon again the response from the military, for example to undertake a burial process, was very swift. The armed forces were also present as border guards at the forefront of the spreading epidemic.

The situation was similar in Guinea, where checkpoints to monitor body temperature and perform medical checks were installed at the border. The armed forces were tasked with offering protection to the population and health workers alike, providing logistical assistance, and transporting materials and medical supplies. Furthermore, the armed forces protected health workers sent by regional organizations. For instance, when AU health workers in Guinea were ambushed as the local community thought that they were spreading the disease, these personnel were airlifted to a secure place by the armed forces. Building trust between civilian agencies and the military was of paramount importance.

Among the challenges faced by the armed forces during their deployment was the danger of army personnel themselves becoming infected, with some losing their lives. They feared for their own survival, battling an invisible and unpredictable enemy. Military doctors involved in the treatment of Ebola cases were in great danger of becoming infected. Often, military hospitals were neither sufficiently equipped nor sufficiently capacitated.

During later stages of the epidemic, coordination and cooperation between the armed forces and the police of Sierra Leone started to improve; similar progress could be observed in Guinea. As the response to the Ebola outbreak progressed, collaboration between the community, police and military improved.

The involvement of the armed forces was highly beneficial for tackling the epidemic. First, the Ebola crisis demanded quick responses and great discipline in their implementation, and the armed forces command a higher degree of discipline than that displayed by civilian actors and the population at large. Second, military medical doctors were well trained, disciplined and able to cope with crisis situations. Thanks to their training, they were familiar with the protocols that needed to be observed and enforced. Third, military doctors displayed more discipline than many civilian health workers in civil hospitals. Some civilian health workers had to undergo treatment themselves

as trauma victims, and some fled the hospitals. Fourth, collaboration between civil and military actors could be established. For instance, in Guinea civilian and military coordination centres collaborated closely and exchanged information in daily joint briefings. Fifth, military personnel could assist regional actors: for instance, military and intelligence officers were attached to the deployments of health workers by the WAHO. They were embedded in these missions to provide logistical support and security advice.

Apart from the military's crucial role, police forces' involvement was also vital. In Liberia the national police had to be deployed. In Sierra Leone the police provided facilities, such as police training schools, to use as medical units. However, there was a lack of awareness and coordination between different police units. As a consequence, police personnel were often insufficiently equipped with protective gear. Regarding prisons and penitentiaries, precautionary measures were often inadequate. At the beginning of the outbreak, detainees were often added to prison cells with other inmates without being tested for EVD. Only after some time was it decreed that all prisoners should be tested before their confinement.

In Guinea there was inadequate training and no preparation for police officers dealing with EVD. As a result, the International Committee of the Red Cross (ICRC) started training the police on how to take care of police personnel exposed to Ebola. This type of training was unfortunately only offered to the police and not to the other actors who were in contact with infected individuals. Moreover, information sharing between the different units was insufficient. There was no effective regional cooperation of police actions in the context of the crisis and the sharing of information and lessons learned across countries was at best minimal, if it happened at all.

With regard to border management, the attempt to close borders was not effective in controlling the free movement of people, as the natural borders of countries in the region tend to be very porous. Logistical support to screen persons crossing borders was inadequate. Communication between the security services and border communities was poor. Also, each country managed its border closing differently. Some borders opened and closed erratically, based on other national interests. For instance, at the border between Côte d'Ivoire and Liberia remnants of armed groups still crossed over to Liberia to engage in illegal activities. To some extent, closing the border helped stop militia movements. In other instances, border crossings were closed in one direction and kept open in the other direction. Often the information flow on border closings was not coordinated. According to Protocol No. 15 of the MRU, the member states' border guards are supposed to meet on a regular basis to exchange information on border management issues. However, when EVD broke out most of these border management meetings were cancelled. Only the border units from Côte d'Ivoire and Liberia continued to hold joint meetings on the process of granting joint permissions for border crossings.

Three types of border crossings existed: class A, class B and class C. The former two were manned, whereas class C was not. In the case of class A borders, there were no emergency response units or emergency centres to house persons while checking them. There were no facilities to hold people for a few hours, which would have been necessary during the upsurge of border crossings. Checking, screening and tracing could thus not be done properly. On top of that, after the outbreak many people avoided class A and B crossings and moved unmonitored across borders. Given that several communities live on both sides of the border, the frontier traffic remained high even after the outbreak. Despite the fact that the MRU Protocol proscribes closing borders, both Guinea and Liberia temporarily and unilaterally closed their borders as a matter of last resort to curtail the further spread of the epidemic. In the case of Guinea, while people were allowed to cross borders, such permission was not given to vehicles; this made little sense, as it was people, not cars, who carried the virus.

Corruption presented yet another problem. Corrupt individuals compromised security by taking bribes or favouritism. Just one person could ruin all the good progress achieved by careful screening. In the short term this could only be avoided through the enforcement of

stiff anti-corruption rules, and in the long term attitudinal and behavioural change must take place.

The national intelligence services were involved in different ways in tackling the epidemic. In Sierra Leone the country's intelligence services were used for contact tracing, especially along the border areas. In some cases people concealed and treated their sick family members at home and in isolation. Their concern was that if they reported cases of infection, they would be cut off from food supply. Furthermore, they wanted to hold on to their cultural and religious practices, such as ritual washing and burial of the bodies. Thus in many instances it was neighbours who called the authorities to report suspected persons who might have contracted the virus.

The intelligence services and informants helped to facilitate the monitoring of Ebola cases. It is essential to invest in contact tracing by building on the intelligence services' work. However, when it comes to information sharing there is room for improvement, and information sharing across borders in particular was not well developed. There was very little or no collaboration between the different national intelligence services. In part this can be attributed to the language barrier between francophone and anglophone West African countries. In border communities it is important to speak and understand local languages to collect and analyse information, and information collection was crucial for analysing the validity of rumours that circulated across these communities. As cross-border national security information sharing was almost non-existent, the MRU's ability to collect reliable information was also affected. Regional and national information sharing and coordination should be improved. While there should have been coordination meetings on information sharing between different security agencies, those discussions were held in earnest only very late in the crisis. Until then, discussions took place only on an ad hoc basis. In some countries bureaucratic bottlenecks impeded meaningful information sharing.

A positive example was Guinea, where a system was set up to include both health and security teams on the same e-mail list, thus providing an opportunity to report and share relevant information with both communities.

Security sector actors included not only the armed forces, police, intelligence services and border guards, but also local security actors such as chiefs, their armed groups, informants and vigilantes. There was little understanding as to what constructive roles they could play in this process. Yet there are reports of chiefs who had crossed borders to establish discussions. Also, traditional elders came together to talk about joint border issues. In one case, two heads of state joined the discussions. In the case of Côte d'Ivoire and Liberia, chiefs came together to discuss border, security, peace and reconciliation challenges. Lessons should be learned from cases of collaboration between local security actors across borders.

What was the role of national governments in tackling the crisis? In Guinea the national government failed to inform the public about the potential risk of EVD. Instead of anticipating the next steps, the government's measures were of a reactive nature. In Sierra Leone the government was briefed on the steps that had been taken to fight the virus in the different regions of the country. In Liberia the government's warning regarding the outbreak was released very late in comparison to Sierra Leone and Guinea. In Mali the structure and the means to respond to the outbreak in a timely manner were unavailable. The main problem was not only a lack of financial means, but also a matter of mentality: risk prevention and preparedness were not the government's main priorities. The government was inconsistent: on the one hand, funds were too scarce to be allocated for health crisis preparedness schemes, yet on the other hand, funds for arms proliferation never seemed to dry up.

In general, the national governments suffered (and still suffer) from a lack of trust by their people. As a consequence, even if a government correctly anticipated the risk potential of the outbreak and issued warnings to the population, the people reacted with disbelief. In addition to the lack of trust and credibility, the national governments had not put the necessary structures in place to deal with a health emergency. It was therefore impossible for the security

sector to react quickly. Furthermore, each national government tried to fight EVD on its own instead of trying to cooperate with neighbouring governments. Unfortunately, experts' numerous recommendations were not heeded, as all too often politicians refused to listen to them.

The implications of EVD could not be foreseen and society was unprepared when faced with the epidemic. Neither the populations nor their governments realized the level and nature of "violence" emanating from the disease. This utter lack of understanding of the disease and its impact had serious negative implications, which could have been minimized if affected populations were better informed about the nature of a potential epidemic.

The media, an important source of information for the population, spread damaging rumours and misinformation, such as the rumour that EVD was used as an instrument by the government to decimate the population. The media politicized the epidemic and reduced the urgency of the emergency. Thus constructive engagement with the media and other societal actors, such as border communities and their representatives, research institutions and non-governmental organizations, is required to prepare for and respond to health emergencies.

Despite society's lack of preparedness, civil society actors learned quickly and played important roles, including in the provision of food. Whenever people under quarantine asked for food, civil society was there to cover this basic need. Even if funeral processions were highly restricted during the outbreak, civil society allowed some of the traditional rituals to be maintained. Societal actors reportedly played a very important role in Mali, because they could reach a relatively large share of the population. Often, people used their own initiative to help the most vulnerable. Others served as intermediaries by passing the relevant information quickly to the right persons. Even (street) musicians could play an active role: when crowds gathered around them, informational leaflets and flyers as well as medicine could be distributed. In Sierra Leone there was a need for closer engagement of the police and the military with civil society; by reaching out to the population through societal actors, both the police and the military could rebuild trust with society.

Institutional and legal frameworks also need to be improved. While some countries (such as Sierra Leone) introduced by-laws at the local level immediately after the outbreak, other countries (such as Mali) introduced them only afterwards. The Sierra Leonean president consulted with parliament before declaring an international emergency. Subsequently, several local-level by-laws were adopted to regulate hygiene and the ritual washing of bodies, and infringements were sanctioned with high fines. The widespread practice of treating sick persons at home was banned. When proper legislation was in place, training on its proper implementation was required, including for security forces. For instance, a by-law required the burning of personal belongings of people who died from EVD, but in several instances this by-law was not understood and entire houses were burned down after EVD-infected inhabitants had passed away in them, leaving their surviving relatives homeless. Moreover, the 2005 International Health Regulations were often not implemented at the national level, as the funds required for their proper implementation were lacking.

The security sector was an effective agent in handling these health and emergency situations, and an important component in regional responses. On a national level, the security sector was part and parcel of the disaster response preparedness structure. Constructive collaboration with the health sector was crucial to facilitate effective and efficient responses to health crises and emergencies. This also suggests that preparedness for health crisis responses should be included in SSR activities.

Recommendations on Improving the Roles Played by Security Sector Institutions

A number of specific recommendations for the security sector in general, oversight agencies, police, border police, intelligence services, traditional leaders, security institutions' early-warning capacities, and support from international donors in improving the roles of the security sector in health crisis preparedness and management emerged from the discussions. These are summarized below.

Recommendations for security sector institutions in general

1. Introduce training for security institutions (especially the police and armed forces) in potentially affected countries (here Guinea, Liberia and Sierra Leone) on crisis management and engagement, for example by offering training-of-trainer courses.
2. Establish clear health safety guidelines for security personnel in all MRU member states.
3. Share experiences of reform processes among security institutions at a regional level.
4. Strengthen the role of the security sector (both security providers and oversight institutions) in handling public health emergencies.
5. Make disaster management part of the national security framework, with every country having its own health security unit.
6. Establish SOPs to facilitate the security sector's constructive involvement in preventing and managing health crises.
7. Offer training on the interpretation and application of local by-laws to avoid misunderstandings.
8. Expose local, national and international journalists and media to training on reporting and handling of emergency situations, as well as on responsible journalism.
9. Foster interaction among the media, other societal actors and the security sector.

Recommendations for security sector oversight institutions

1. For legislative bodies in the region, institute the implementation of legal frameworks that ensure the enforcement of public health emergency laws.
2. Strengthen and capacitate parliamentary oversight committees on defence and security to provide expertise on health security matters.
3. Give security agencies the mandate to provide emergency medical assistance for Ebola survivors (and survivors of other health crises), i.e. by utilizing the security sector for "stop-gap measures".

Recommendations for police services

1. Include crisis management in the training curricula of all police forces in the region.
2. Improve the relationship with civil society actors through constructive engagement.
3. Enhance the capacity of police forces on their responsibility to protect the public.
4. Train the police on proper medical screening procedures during public health emergencies.
5. Introduce the concept and practice of community policing to the MRU, which should then promote community policing among its member states.

Recommendations for border police services

1. Exert the requisite political will and policies to control human and vehicular traffic along borders of Guinea, Liberia and Sierra Leone through effective cooperation (joint border meetings, information sharing, etc.), especially in the event of a public health crisis in any of these three neighbouring countries.
2. Offer capacity building to border management officers.

Recommendations for intelligence services

1. Include requirements of the global health security agenda in the national intelligence requirements.
2. Capacitate intelligence services and ensure that they are well disciplined in carrying out their responsibilities in detecting and tracing health crises.

Recommendations for traditional leaders

1. Train local and traditional leaders on public health emergency rules, government procedures and regulations to enhance public health safety during a disease outbreak at the community level.

Recommendations for building early-warning capacities within the security sector

1. Devise strategies for security institutions to detect early-warning signs of a disease, identify a potential epidemic and act promptly in response to such information.
2. Enhance data collection and research on bio-terrorism through networking among countries.

Recommendations for international donors' security sector capacity-building programmes

1. Provide financial support, including from international partners, to facilitate reforms, training and capacity building.
2. Ensure provision of adequate funding by governments and international partners for health emergency operations, possibly through setting up dedicated trust funds.
3. Ensure efficient, effective and accountable management of donor aid. Use auditing to reveal clean practices and assure donor governments that their assistance reaches those in greatest need.

On the Roles and Perspectives of Bilateral, Regional and International Actors

At the onset of the outbreak there was much confusion about the roles of regional and subregional institutions (ECOWAS, MRU) and the continent-wide AU. The division of labour between these organizations, national actors and international actors was not clear. There were, however, exceptions. For instance, in Liberia ECOWAS and AU health workers and security personnel worked together towards a common objective under the leadership of national authorities. Health services were extremely limited, with little or no infrastructure in place; thus support from the international community was extremely helpful.

Countries that could rely on developed public health infrastructures, such as Mali, Nigeria and Senegal, were able to contain the spread of EVD quickly and effectively, and thus experienced considerably lower numbers of EVD cases than some of their neighbours.

There was corruption and misappropriation of resources, including national resources and those donated by international partners. This resulted in distrust of foreign actors in local institutions and processes. As a consequence, many foreign partners set up parallel structures that were not sustainable after the crisis, leaving behind a large capacity void.

There were attempts to work with the MRU Secretariat to set up SOPs for cross-border management. However, after a meeting with the MRU and partners, one of the international partners decided to opt for bilateral assistance instead. In addition, there was reportedly unconstructive competition between partners, including hijacking of local efforts and activities; and often undue insistence on one party's own expertise and use of its own approaches and templates in disregard of local needs, preferences and experiences.

In affected countries there was a strong feeling that the World Health Organization took much too long to respond (three months after the visible onset of the crisis), and that it waited too long to declare the outbreak a public health emergency of international concern. While regional organizations do have existing protocols, those were poorly reinforced in the region. The population were not properly informed and sensitized about foreign (especially American) troops, and false rumours about the reason for their deployment spread. ECOWAS and the AU deployed their health assistance missions separately. Despite the fact that the Sierra Leonean president had requested that health workers should be jointly deployed and work in close collaboration, this did not happen right away. On a bilateral level there was much collaboration between the AU, ECOWAS, MRU and single member states from across Africa and further abroad (including Europe, North America and countries such as Cuba and China). The UN Mission in Liberia and the UN Mission for Ebola Emergency Response utilized MRU structures.

In terms of the sequence and involvement of international security arrangements, regional international governmental organizations and the UN, experiences differ between Sierra Leone, Guinea and Liberia. Initially the national security institutions were at the forefront of crisis response, but at a later stage international security forces were deployed – the UK in Sierra Leone, France in Guinea and the USA in Liberia. They established their own command centres. In Guinea the ICRC was one of the first international actors on the scene; and unlike in other states it was not the military that was in charge of burial procedures, but the ICRC. It had to manage the difficult balance between allowing the relatives to pay their last respects and guaranteeing a quick burial to avoid disease transmission. At a person's death, the ICRC checked if EVD was the cause of death. If the result was negative (the deceased was not infected), a certificate was issued to the family that the body was safe for burial. If the deceased had been infected, transporting the body to another municipality was prohibited.

Transportation of the sick and deceased was a significant obstacle. Before the outbreak Guinea, Liberia and Sierra Leone all had ineffective ambulance services. However, as a result of the involvement of international actors, Guinea witnessed the distribution of several ambulance vehicles to the different regions. In Sierra Leone motorcycles were given to social workers. In Liberia both the

USA and China established several emergency response units. Other countries donated vehicles, equipment and humanitarian goods. In Sierra Leone there were emergency structures in place before the Ebola outbreak but these were not used during the crisis, as international partners decided to work in "new structures" and sidestep the structures that were already in place. To local authorities it was surprising that some international actors refused to work with existing structures.

Recommendations to Bilateral, Regional and International Actors

Invest in local, national and regional communication strategies

1. Assist national actors in their efforts to sensitize all affected communities through effective communication strategies.
2. Upgrade information, education, communication, and information and communications technology at national levels.
3. Invest in adequate information management during crises.
4. Offer sensitization to the population as well as to the army and other security agencies, as a lack of knowledge leads to slow and inadequate response.
5. Include gender-based violence prevention in disaster-preparedness strategies.

Support for information gathering

1. Build capacity within intelligence services, so they are able to identify outbreaks and communicate potential and actual spillover across borders and neighbouring countries.
2. Invest in regional information sharing. Joint security and health sector coordination and monitoring groups in each country should produce reliable information sharing across MRU countries. It is important that intelligence services from the MRU region jointly collect information and share results.
3. Provide international support to facilitate intelligence cooperation and joint information collection and analysis.
4. Facilitate the generation and sharing of information in border communities. It is particularly important to make reliable information available to border communities and include these communities in information collection and analysis.
5. Ensure that immigration services and customs which engage with people who are crossing borders contribute to information gathering, and that this information is sent back to capitals and organizations responsible for information collection and analysis.

6. Invest in early-warning systems. For this purpose, experts from all security sector institutions need to be brought together for effective information collection and analysis. As an initial rudimentary early-warning system, periodic interactive internet meetings should be scheduled to collect and share information.

Support capacity building for health actors

1. Stockpile and (if needed) make available appropriate medical equipment, including PPE.
2. Invest in and strengthen national health sector preparedness initiatives.
3. Ensure that military health workers are actively involved in the treatment of health crisis victims, and involved from the outset in joint cross-sectoral preparations and training.
4. Urgently support the development and implementation of suitable rules of engagement and SOPs. The focus should be on the military's capacity to complement civilian actions, and on defined divisions of labour and phased hand-over procedures between the military, other security agencies and civilian actors, depending on the specific requirements of each situation and the evolution of the crisis.
5. Ensure that in addition to the strengthening of public health infrastructure, support is available for both civilian and military hospitals to be refurbished and better equipped, as they provide important services during crisis situations.

Support capacity building for security agencies

1. Provide adequate training and health disaster preparation to the police.
2. Provide the police with adequate logistical support. Closer contacts and better relationships with the population need to be promoted, particularly through community policing.
3. Ensure that police services across the region cooperate in training and information sharing, and that existing transnational crime units are reinforced.
4. Ensure representation of all security agencies (military, police, border management, intelligence services and others) in "joint monitoring groups".
5. Provide joint training of local security and health staff, as preparation for health crisis management has to be carried out jointly with other security sector actors and civilian health institutions.
6. Offer sensitization training on health-crisis-related challenges to members of international missions already in the country or about to deploy. Health emergency training should become a standard feature of peacekeeping operations' training.

Support border management activities

1. Carry out cost–benefit analyses of border closings.
2. Put in place procedures for improved coordination to facilitate joint actions in border management and closing.
3. Strengthen immigration and customs processes and infrastructures across borders.
4. Facilitate regional agreements on harmonization of border closing and opening. Ideally the MRU should take up this task, as this issue has already been discussed at the 2012 Abidjan Meeting of Heads of States.
5. Promote modern and professional integrated border management, and provide the right equipment for screening.
6. Enhance the interface with communities, develop modalities for regulating movement across borders, and facilitate joint meeting groups for coordination and collaboration with border communities and border agencies. Meetings between chiefs, local authorities, youth and other stakeholders are already taking place; but (financial) support for this dialogue is urgently required to ensure frequent meetings.
7. Offer training on national and regional immigration laws for border security, customs and immigration personnel.

Support capacity building for oversight institutions

1. Ensure support of parliaments and governments in SSR processes that reflect the need for the evolving role of security institutions in health crisis management.

Respect and support local leadership, ownership and sustainability

1. On the part of regional and international bodies, consider that deployment is in the first instance in response to national requests.
2. Recognize that the preferred sequence of responses moves from national to regional and then to international levels. If a national government does not act and instead rejects the offer of external assistance, regional organizations should become involved. In health emergencies, unlike cases of crimes against humanity, active intervention by international organizations should be avoided unless gross neglect endangers the population and neighbouring countries. The first responders should be national actors, followed by subregional or regional support, before international support is invited. Regional and international organizations need to offer support to and contribute to the empowerment of existing national bodies.

3. Honour the principle that affected countries must take the lead. A national coordination centre should support a national or local lead agency. This enhances commitment by national stakeholders and secures the necessary buy-in for effective response. These national coordination centres allow affected countries to deal with potential external donors themselves, without using international or regional organizations as middlemen who are tempted to enforce their own standards and preferences. Sometimes it is better for affected countries to maintain bilateral contacts, which can accelerate the decision-making process and the deployment of support capacities.
4. Focus on the challenge at hand and avoid competition for credit and attribution. All actors involved should subscribe to the values of mutual respect and partnership, and avoid claims of attribution and attempts to stand in the limelight of international (media) attention, thus creating counterproductive competition among partners.
5. Regarding the involvement of international security agencies, in cases where foreign troops or other international security agencies are deployed, sensitize the population about the role of international security arrangements and their intentions to ensure collaboration of the national government and the people. The role of international security agencies should be carefully defined, with clear-cut mandates and divisions of labour and an exit strategy. The exit strategy needs to be negotiated with local, national, regional and international actors to ensure a constructive hand-over of joint activities.

Support regional and subregional response mechanisms

1. Establish specific and well-defined roles and divisions of labour among continental, regional and subregional institutions, particularly for the AU, ECOWAS and MRU.
2. Enable constructive collaboration between regional and national bodies for effective future interventions.
3. Establish regional emergency funds, so that the AU, ECOWAS and MRU are able to move ahead without having to wait for emergency funding after a crisis has erupted.
4. On the part of regional organizations, coordinate national disaster management bodies to respond effectively to national health emergencies. Following the example of the UN Office for the Coordination of Humanitarian Affairs, it would be worth considering the creation of similar offices at the AU, ECOWAS and MRU.
5. Create a permanent regional crisis committee (possibly integrating existing humanitarian committees) to coordinate disaster and crisis response at the regional level. That body would operate during different phases (prevention, intervention, recovery) at different levels (national

and regional), focus on long-term action and preparation, and meet regularly.

6. Reinforce existing protocols of regional organizations, and adopt health protocols prescribing responsibilities, competences, measures and deadlines.
7. As regional centres of disease control, carry out research for the development of (health) protocols and SOPs towards prevention, intervention and recovery.
8. Establish regularly funded regional centres for disease control to study viruses and their strains, and the consequences of their spread.
9. Support the assurance of strategic government reserves of food, fuel, transport and logistics.
10. Build on existing structures, institutions and expertise. It is critically important to use existing institutions embedded in the community, strengthen them and build their capacities, as these structures will continue to operate after international partners have left. It is equally important for international and regional organizations to respect and take on board local expertise and experience. They should not take over, but contribute and support. In the face of foreign distrust of local institutions and processes, it should be communicated to partners and donors that it is not always necessary for money to flow to local institutions which do not possess the required accountability structures and procedures. However, organizations such as the MRU possess strong convening powers and serve as platforms for cooperation and coordination. External partners can contribute to and support MRU-initiated and MRU-hosted activities with the provision of food, hotels, transportation and other logistical necessities.

Support coordination at the national and regional levels

1. There should be coordination on security sector involvement in health crises by the MRU and national offices of national security.
2. Explore the option of an SSR framework and strategy, since one does not exist at the level of the MRU. Such an MRU SSR strategy could be based on the AU and ECOWAS frameworks, but adapted for the MRU and the need to incorporate health security provisions. An MRU SSR framework could thus be very innovative and take new threats (such as health threats) into account.

Support respect for international norms and principles

1. Ensure national and regional commitments to international humanitarian law, international human rights law, international legal instruments and the implementation of the Sustainable Development Goals.
2. Reflect UN Security Council Resolution 1325 in any new and revised legal framework determining future health crisis response and preparedness activities.

Support evidence-based research

1. Share research results and policy-relevant information among research institutions and think-tanks, and with the public and those involved in health disaster responses.
2. Encourage and support centres of excellence to carry out research on the development of protocols towards health crisis prevention, intervention and recovery.
3. Analysis and monitoring need to be conscious of gender, human rights and environmental issues.
4. Carry out research on Ebola survivors in partnership with government agencies (such as in the Liberia–US clinical cooperation known as the Partnership for Research on Ebola Virus in Liberia).

Support local communities and affected populations

1. Make provisions for children who have become orphans because of the epidemic.
2. Avoid stigmatization of survivors and families of victims.
3. Integrate women leaders and women's organizations at all stages of health crisis management.

Specific Recommendations to the MRU Secretariat and Its Member States

With the rapid rate at which EVD spread across the MRU border space (Guinea, Liberia and Sierra Leone) comes the realization that the sub-region needs to defend its borders more effectively against the spread of infectious human, animal, and plant diseases. This realization gives rise to the following questions: What can the MRU Secretariat with its partners do in the post-Ebola recovery phase to enhance border policing, security and management efforts so that it is better able to detect, prepare, prevent, and respond on time to any future global health security threat that might cross common borders? The following suggestions should inform future action:

1. **Map institutional capacities among the security and health sector.**
To be able to reduce the risk of future outbreaks and the development of global health crises such as Ebola effectively, the MRU Secretariat needs to carry out a mapping exercise to identify the strengths, weaknesses, opportunities and threats faced by security and health sector institutions, particularly those deployed along borderlands. Gathering and analysing such information can assist in developing joint training and capacity-building activities.
2. **Create a disease control and human security architecture.**
The MRU Secretariat, ECOWAS, the AU and its international partners, and leading non-governmental and humanitarian agencies need to assist member states in developing a robust disease control and human security architecture. This architecture would need to include support to strengthen border security management institutions.
3. **Adopt the concept and practice of stabilization.**
Stabilization involves a coordinated approach. There is a need to support policy dialogue consultations and meetings with national governments to ensure a coordinated and strategic approach to subregional prevention, preparedness, stabilization and response mechanisms. Such mechanisms need to be developed and adopted for the entire MRU space.
4. **Integrate planning and assessment processes.**
Security sector capacities need to be properly utilized, particularly their supporting roles to reinforce civilian public health capabilities. These involve formulating integrated and strategic planning and threat assessment processes, which in turn allow for more collective, timely, well-informed and well-structured responses to future outbreaks.
5. **Create a reliable international warning and response mechanism.**
It is important to establish a warning and response system that allows member states to respond as early as possible once affected members are willing to declare a crisis and accept the need for international assistance.
6. **Establish common training and capacity building.**
To be able to cooperate and work together effectively, both security and health sector institutions must standardize training and capacity-building initiatives across the MRU states. The elaboration of technical guidance notes or SOPs for security and health sector professionals, based on harmonized principles on the prevention of and response to global health crises, remains a critical task to be tackled as soon as possible.
7. **Provide advisory support.**
It is crucial to engage in the provision of advisory support as early as possible to strengthen the capabilities of national governments to make rational executive

decisions and support subregional approaches to future responses. It is furthermore important to facilitate the embedding of strategic advisers in ministries of health, strengthen their capacity and create opportunities for them to engage in health security issues at the national security council or cabinet level.

8. Strengthen cross-border population tracking.

It is essential for the MRU Secretariat to institute mechanisms that can enhance proper monitoring and tracking of population flows in border areas and at crossing points. Interventions must be multisectoral and manage mobility as an integrated component of the Ebola emergency response. Sustaining efforts to monitor and track mobile populations and generate data across common border communities or crossing points can help to create or improve understanding of regional mobility, which in turn can support the process of strengthening future health crisis preparedness and response.

9. Conduct border clusters diagnostic studies.

There is a need to seek support from partners and organizations such as the AU Border Management Programme, UN, African Development Bank and World Bank to allow the MRU Secretariat and its member states to conduct borderland diagnostics or multiagency threat and risk assessment (MATRA) studies. Findings from such assessments can be used to guide the security sector responses to health-related humanitarian crises, while avoiding the risk of potentially harmful consequences of the security sector's involvement. Feeding into SOPs, the recommendations from a MATRA report will help define the roles and responsibilities of security sector and health-related humanitarian crisis actors in border areas. Such research will inform future practices across common borders, especially those aimed at strengthening joint border security and confidence-building units (JBSCBUs).

10. Strengthen collaboration and partnerships in borderland communities.

JBSCBUs need to be strengthened through training and capacity-building initiatives, and more local actors should be included in the JBSCBUs. Non-state actors and local authorities bear the brunt of local security decisions, so it is important to strengthen local capacities in border communities to contribute to early warning, threat assessments and policy decisions in relation to surveillance, contact tracing and quarantine.

11. Improve information and communication.

There is a dire need to improve information and communication networks between national authorities and border communities. The MRU Secretariat must consider this a priority, especially in an effort to manage cross-border tensions that might arise from future outbreaks of public health crises such as EVD.

12. Sustain dialogue during emergencies.

The management of the Ebola crisis created its own tensions, at times resulting in violence and threats to the security and stability of the region. It is important that the MRU Secretariat and its local and international partners continue to provide a platform for trust and confidence building between national governments. This platform should also encourage, inform and support the affected local populations, raising their levels of awareness on the effects of the Ebola virus and helping to demystify misinformed perceptions about the epidemic. In addition, it is important for national governments and regional and international actors to support sustained dialogue initiatives to resolve tensions as they emerge.

CONCLUSIONS

The Ebola outbreak emerged in Guinea and rapidly evolved into a subregional phenomenon. This prompted the MRU's engagement to ensure a collective response by affected member states. Cross-border communities in the MRU tend to share similar cultures, customs and social bonds in addressing their day-to-day concerns, based on joint structures that exist at local and community levels. While a well-coordinated MRU subregional approach to the Ebola outbreak was urgently needed, the response was greatly delayed. This delay in the collective response exposed the limited capacity of national health systems, especially in regard to the infrastructure and facilities in border areas.

Despite these limitations, the MRU Secretariat proved to have a useful role in addressing cross-border threats such as Ebola. However, to recover from the recent outbreak and prevent future ones, the Secretariat will require funding and advisory support. The MRU Secretariat must also build regional health security advisory support capacities. International assistance should help train and enhance the capacities of health and security institutions to work in a collaborative manner in detecting, preventing and responding to future outbreaks

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ANNEX A: Workshop Programme

Regional Workshop on "The Security Sector and Global Health Crises: Lessons from the 2014 Ebola Outbreak in West Africa"
24–25 August 2016, Bintumani Hotel Conference Centre, Freetown, Sierra Leone

Wednesday 24 August 2016

09:00–10:30 ***PLENARY:*** Formal Opening Session

Chair
Dr Shekou M. SESAY, Former Donor Aid Coordinator, National Ebola Response Centre

Welcome Remarks
Mr Oliver B. M. SOMASA, CGSP
Mr Jonathan SANDY, CGSP
Dr Albrecht SCHNABEL, DCAF/GHC

Opening Statements
Mr Ishmeal TARAWALLY, National Security Coordinator, Sierra Leone
Rev. Ms Linda I. KOROMA, Deputy Secretary-General, Mano River Union, Peace, Security, Health and Gender Affairs

Keynote Address
Hon. Dr Abu Bakarr FOFANAH, Minister of Health and Sanitation, Sierra Leone

10:30–11:00 ***Group Photo***

11:00–12:30 ***PLENARY:*** Project Overview, Activities and Findings So Far
Dr Albrecht SCHNABEL, DCAF/GHC

12:30–14:00 ***Lunch***

14:00–15:30 ***PARALLEL BREAK-OUT GROUP MEETINGS***
Discussions of Key Project Questions
Group work: "Relationship of Health and Security Sectors"
Group work: "Roles Played by Security Institutions"
Group work: "Roles of Bilateral, Regional and International Actors"

15:30–16:00 ***Coffee/Tea Break***

16:00–17:30 ***PARALLEL BREAK-OUT GROUP MEETINGS***
Discussions of Key Project Questions
Group work: "Relationship of Health and Security Sectors"
Group work: "Roles Played by Security Institutions"
Group work: "Roles of Bilateral, Regional and International Actors"

18:00–20:00 ***Reception***

Thursday 25 August 2016

09:00–10:30 ***PARALLEL BREAK-OUT GROUP MEETINGS***
Key Priorities and Actions
Group work: "Relationship of Health and Security Sectors"
Group work: "Roles Played by Security Institutions"
Group work: "Roles of Bilateral, Regional and International Actors"

10:30–11:00 ***Coffee/Tea Break***

11:00–12:30 ***PARALLEL BREAK-OUT GROUP MEETINGS***
Key Priorities and Actions
Group work: "Relationship of Health and Security Sectors"
Group work: "Roles Played by Security Institutions"
Group work: "Roles of Bilateral, Regional and International Actors"

12:30–14:00 ***Lunch***

14:00–15:30 ***PLENARY: Reporting Back from PARALLEL MEETINGS***
Group presentation: "Relationship of Health and Security Sectors"
Group presentation: "Roles Played by Security Institutions"
Group presentation: "Roles of Bilateral, Regional and International Actors"

16:00–17:00 ***CLOSING PANEL***

Chair
Dr Shekou M. SESAY, Former Donor Aid Coordinator,
National Ebola Response Centre

Closing Keynote Address
Rev. Ms Linda I. KOROMA, Deputy Secretary-General, Mano River Union,
Peace, Security, Health and Gender Affairs

Closing Remarks
Mr Jonathan SANDY, CGSP

17:00–18:30 ***Reception***

ANNEX B: List of Workshop Participants

Regional Workshop on "The Security Sector and Global Health Crises: Lessons from the 2014 Ebola Outbreak in West Africa"
24–25 August 2016, Bintumani Hotel Conference Centre, Freetown, Sierra Leone

Guinea

- Mr Sow Mohamed ALIMOU

Liberia

- Mr Cecil B. GRIFFITHS
- Mr Nii Nortey Addo PROSPER
- Dr Joe WYLIE

Mali

- Col. Omarou MAIGA

Nigeria

- Dr Jibril YAHAYA

Senegal

- General (Rtd) Lamine CISSE

Sierra Leone

- Mr Alpha ABU
- Mr Sylvester Musa AMARA
- Mr Jonathan BAKER
- Ms Michele BORNSTEIN
- Ms Adenike COLE
- Mr William COLE
- Mr Josephus A. K. DUMBUYA
- Ms Kadi FAKONDO
- Ms Aminata FOFANAH
- Ms Mariama Khai FORNAH
- Ms Eleonora GENOVESE
- Mr Chris IARA
- ASP Dr Saidu B. JALLOH
- Col. Sessegnont JEAN
- Dr D. S. Cyril KAMARA
- Mr Joseph Honor KAMARA
- Mr Nabie A. KAMARA
- Mr Raymond Bai KAMARA
- Mr Mohamed KANNEH
- Dr Brima Patrick KAPUWA
- Mr Samuel KARGBO
- Lt Col. Madice KEITA

Sierra Leone

- Mr Abdul KOROMA
- Ms Gibril A. KOROMA
- Rev. Ms Linda I. KOROMA
- Ms Nasiru Dinn KOROMA
- Mr Victor Sanpha KOROMA
- Mr Ibrahim KUMBASSA
- Mr Sinneh MANSARAY
- Dr Abu Biaoboko MINAH
- Brig. Gen. Daniel MOORE
- Mr Stephen NGAUJAH
- Dr Mary OKUMU
- Mr Mohamed PABAI
- Mr Mohamed PABAI (Jr)
- Ms Victoria PARKINSON
- Mr John Vandi ROGERS
- Mr Edward SAMADIA
- Mr Amadu SANDY
- Mr Jonathan SANDY
- Mr Stephen SANDY
- Mr Marbey SARTIE
- Ms Samuella SESAY
- Dr Shekou M. SESAY
- Mr Denis SIMBO
- Mr Oliver B. M. SOMANSA
- Ms Haja SOVULA
- Mr Ishmael TARAWALLY
- Mr Jerry TARBOLO
- Ms Mary TURAY
- Mr Emmanuel YAMBASU

Switzerland

- Ms Haja Ahma ABDULLA
- Dr Albrecht SCHNABEL
- Ms Usha TREPP

United Kingdom

- Lt Col. Andrew Garrow

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