Learning from Ebola to Improve Humanitarian Organizations’ Legal Preparedness for Future Epidemics

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EXECUTIVE SUMMARY

Every disaster response is laden with challenges for responding humanitarian organizations, and the West African Ebola outbreak of 2014-2015 came with its own unique set of issues. Indeed, the outbreak’s contagious nature and rapid spread across borders amplified many of the expected challenges in addition to presenting new ones. The international community was largely unprepared for Ebola's heavy impact but managed to respond. Now that the outbreak has been controlled, humanitarian organizations and governments alike are wise to learn from the Ebola response so that the international community at large can be better prepared for the next complex health response.

In Canada and abroad, organizations that deploy personnel to respond to a disaster are legally vulnerable: they are responsible for their personnel and owe them a legal duty of care through every stage of the response. If an organization fails to fulfill their duty and personnel suffer harm, it exposes the organization not only to a claim in negligence where it could be held liable for the harm, but also to reputational and financial risk. Thus, it is in all organizations’ interest to reach for a requisite standard of care and take all of the necessary steps to mitigate their liability. All humanitarian organizations take measures to make sure adequate protocols and procedures are in place to ensure the safety and wellbeing of its personnel abroad. The Ebola outbreak forced organizations to think through an added layer of complexity when mobilizing personnel. Some health outbreaks of epidemic or even pandemic levels require humanitarian organizations to approach and execute their duty through a specific lens.

There have been no negligence claims in the context of deployed personnel from Canada, although there have been claims made internationally. These claims were not, however, in response to deployment in an epidemic response. Nevertheless, the cases illustrate that humanitarian organizations are susceptible to these claims. This report aims to provide support to humanitarian organizations prior to deployment, as well as serve as a guide to the courts for what is expected of a reasonable organization in these circumstances.

How should organizations prepare legally for the next complex epidemic or pandemic? How can they assure themselves that they are navigating legal challenges efficiently? This report answers these questions by studying the response to the West African Ebola outbreak and identifies five critical areas in an epidemic response that demand special consideration when assessing the appropriate duty of care: 1) training of personnel; 2) communicating risk; 3) insurance; 4) medical evacuation; and 5) reintegration.

This report canvasses all five issues and provides options and considerations for future health outbreaks using insights gained from studying the Ebola response. The report intends to guide humanitarian organizations in Canada through these issues so that they can protect not only themselves, but also their deploying personnel. Likewise, governments and the judiciary are invited to use this report when developing policy or jurisprudence in the future that will impact organizations engaged in epidemic response.
BACKGROUND AND CONTEXT

Introduction

Responding to an epidemic or any kind of disease outbreak is an incredible task that requires immense coordination and preparedness. Humanitarian organizations generally assume significant risks in disaster response and face a complex web of legal challenges from its first actions to long after personnel have returned home. For example, organizations must always be cognizant of how protocols affect the human rights of their personnel and of the general population, and they must ensure that both foreign and domestic visa requirements are honoured.

Ebola is a severe viral haemorrhagic fever with a mortality of up to 90%. The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission (1). Ebola has been recognized for some 40 years, with more than 20 previously documented outbreaks, all of which were substantially smaller and localised in scale; however, there remains limited research on the virus and its spread in this latest outbreak proved unpredictable. While clinical trials began in 2015 on several candidate vaccines, including some developed in Canada, there is still no curative treatment.

The Ebola outbreak of 2014-2015 was quick and vast, and it posed both new and intensified legal challenges to humanitarian organizations looking to respond. While many Canadian organizations are recognised leaders in international emergency health operations, the severity of Ebola was new for many. Canadian organizations had not responded to an outbreak as large or severe as Ebola, and thus had to revisit their protocols and procedures for this unique event.

The West African Ebola outbreak was the largest and most complex of its kind since the virus was first discovered in 1976, in present-day South Sudan and Democratic Republic of Congo (3). Emerging in December 2013, screening and testing pinpointed Ebola as the ailment that killed a 2-year toddler in a Guinean rural community bordering Sierra Leone and Liberia. Following this initial case the West African Ebola outbreak rapidly spread across borders and affected ten countries worldwide, with the majority of cases concentrated in three West African nations: Guinea, Liberia and Sierra Leone.

Several humanitarian organizations were swift in their response to Ebola and sent support as early as March 2014. Response demanded very specific clinical management and medical protocols, such as the construction and management

“Because there was so little preparation, the world lost time in the current epidemic trying to answer basic questions about combating Ebola. In the next epidemic, such delays could result in a global disaster.”

Bill Gates
Co-Chair, Bill & Melinda Gates Foundation
of specific Ebola Treatment Centres ("ETCs"). The Ebola response hinged on a complement of different activities including: safe and dignified burials; community engagement and mobilisation; psychological support; surveillance and contact tracing; and case management and treatment. Even for experienced humanitarian organizations, case management was new. Furthermore, the speed of transmission meant that aid was unavoidably reactive rather than proactive, with treatment centers being erected as infected persons presented themselves.

Now, in the wake of Ebola, critical questions remain. How can organizations be more prepared the next time an epidemic strikes? How can organizations assure themselves that they are navigating legal hurdles effectively? How can it simultaneously assure the safety of its deployed personnel and meet the needs of the beneficiaries while also shielding themselves from liability? This report seeks to answer these questions by studying the international response to the 2014-2015 West African Ebola outbreak. It concentrates on identifying the considerations an organization should take to mitigate its liability by attempting to parameterise its legal duty of care towards its personnel in the following five areas:

- Qualifications, training, equipment and incident protocols
- Waivers of liability, assumption of risk and informed consent
- Insurance
- Medical Evacuation
- Reintegration

These five issues present unique challenges in complex health responses that do not necessarily arise in other emergencies. For each of these issues this report discusses how it was addressed during the Ebola response by various organizations and what a reasonable organization is expected to consider should another epidemic occur.

**Ebola Virus and the International Response Landscape**

The Ebola virus, originally named after the Ebola River in the Democratic Republic of Congo, is often fatal if untreated. The virus is transmitted to humans through close contact with the blood, secretions, and other bodily fluids of infected animals such as fruit bats and chimpanzees. Following this, Ebola then spreads through human-to-human transmission via direct contact with the blood, secretions, organs, or other bodily fluids of infected people, in addition to the surfaces and materials contaminated with these fluids.

The “incubation period” is the time interval from infection with the virus to the onset of symptoms that can vary between two and 21 days post-exposure. People are not infectious until they develop symptoms of the virus. Early symptoms such as sudden fever, fatigue, muscle pain, headache and sore throat are not unique to Ebola, which is why diagnosing it can be so challenging.

The Ebola outbreak that began in December 2013 involved one of the deadliest strains: the Zaire species. This outbreak is...
considered by the World Health Organization (WHO) to be the largest and most complex since the virus was first discovered. In March 2014, the Guinean Ministry of Health notified the WHO of a “rapidly evolving outbreak” of the Ebola virus, and Liberia soon confirmed its own case. The Canadian Red Cross Society (CRCS) deployed its first staff person, a psychosocial support specialist, to Guinea on March 30 (5). Overall the CRCS deployed over 50 people and supported nearly 60 Ebola missions.

By mid-June, the Ebola outbreak was already the worst on record and by late June, Médecins Sans Frontières (MSF) estimated that the virus was actively transmitting in over 60 locations across West Africa, the majority in Guinea, Liberia and Sierra Leone (6).

On August 8, 2014 the WHO’s Director General declared the Ebola outbreak to be a Public Health Emergency of International Concern (PHEIC). This declaration is used to describe an “extraordinary event” that constitutes a public health risk to other States through the international spread of disease and could potentially require coordinated international response (7). The WHO began giving direction to national governments in accordance with the IHR (8). By this time, there had already been over 1,000 deaths.

In September, with governments and organizations struggling to keep pace with the spread of Ebola, MSF voiced its frustration to the United Nations (UN). Shortly after, the UN established a Mission for Ebola Emergency Response (UNMEER) to unify responders on the ground. By then, the outbreak was at its peak. By this point, many organizations were actively mobilising to send humanitarian professionals to support the response effort.

On December 29, 2015, the WHO declared the end of the Ebola virus transmission in Guinea and commended the international community for its response (9). Certain challenges were amplified during the Ebola response to a new level never experienced, making it a unique epidemic-response mission to organizations, including:

**Logistical battle** – There were Personal Protective Equipment (PPE) supply shortages and not enough trained staff to keep pace with the spread of Ebola (10). MSF called the outbreak “out of control,” and cited the lack of experienced staff to deal with the outbreak of this scale as its most significant limitation (11). The stigma, fear and perceived danger may have contributed to stock shortages as some countries were trying to stockpile personal protective equipment resulting in global shortages.

**Psychological and emotional effects for responding personnel** – The symptoms of the Ebola virus do not present immediately and so stresses can arise from fear of infection. Moreover, a curative treatment remains unverified (4). As Dr. Belhocine stated, “we know the virus is frightful, and capable of resurgence” (12). Additionally, some responders were also faced with stigma from the community upon returning home.

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“Experience should not be lost, now that the respite from the end of the epidemic is there.”

Dr. Mohammed Belhocine
head of WHO’s country office in Guinea

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High risk area, Kenema ETC, November 2014 - Jan Lindholm/IFRC
Fear factor at home – Ebola was widely documented in the media for much of 2014 and many Canadians were afraid the outbreak would make its way into Canada, especially after cases were reported in the United States. Partnered with the little knowledge of Ebola, fear added a new dimension to the response: organizations faced potential reputational risk and many delegates’ families and friends had hesitations regarding family members deploying.

Effective response depended on continual cooperation and communication between organizations, governments and deployed personnel. Likewise, it also depended on adopting a flexible approach, acknowledging at the outset that goals and strategies would likely change over time. Regardless of the epidemic at issue, the importance of taking this approach cannot be overemphasized.

METHODOLOGY

The research methodology for this report consisted of three main stages: literature review, key informant interviews and knowledge synthesis.

The literature review drew from a broad selection of academic articles, media releases and publications produced by the various international humanitarian organizations involved in the Ebola response. Using search words such as “Ebola,” “IFRC,” “international response,” etc., a comprehensive understanding of the response landscape was obtained. The intent at this stage was to identify any issues or themes that were common throughout the literature. Nine issues were ultimately selected based upon their prevalence in the literature, and were grouped into the categories highlighted in this report.

Key informant interviews were then conducted in order to identify, corroborate or refute new issues that were not identified in the literature review. Interview participants were purposively selected based on their association with international humanitarian organizations that responded to the Ebola crisis in West Africa. The participants were chosen due to their operational and legal experience in this area, and as such, were able to offer valuable insights.

A total of seven interviews were conducted with members from five organizations: CRCS, International Federation of the Red Cross (IFRC), MSF, SP and the Swedish Civil Contingencies Agency (Myndigheten för samhällsskydd och beredskap, or MSB). Interviews were conducted using a semi-structured interview guide that was organized around the issues identified through the literature review. However, each interview was intentionally conducted in a way that facilitated an open dialogue with the participants based upon their individual experience and expertise. Whenever possible, information obtained from interviews were cross-referenced and sourced from either internal or publicly available documents.4

Through the third stage, knowledge synthesis, iterative feedback from the CRCS and other key stakeholders was received. Using participants’ insights, certain legal barriers were identified as more complex than others in the epidemic response context, reducing the number of barriers from nine to five for this report. Part of this stage involved a workshop with the CRCS and several members of the Canadian Humanitarian Response Network, which concentrated on identifying best practices surrounding these barriers.
LEGAL CHALLENGES FACED DURING AN EPIDEMIC RESPONSE

Humanitarian response organizations are legally responsible for the health and safety of their personnel while they are deployed on an operation (10). This responsibility does not require that organizations eliminate every risk but rather that organizations take reasonable steps to mitigate the risk of harm to their personnel. In law, this obligation is known as the duty of care (13).

The duty of care in a complex health response roughly corresponds to what would broadly be required in other disaster or humanitarian response type situations. However, a complex epidemic response such as Ebola involves some separate and distinct considerations. In general, a duty of care is defined by identifying what a reasonable person or organization would do under similar circumstances (14). Given the relative novelty of this issue from a legal perspective, it will be necessary to import the operational and ethical considerations made by response organizations into the legal domain. Accordingly, the duty of care in a complex health response will be determined by assessing the general practices adopted by other organizations operating in this area.

In addition to the operational and ethical considerations made by organizations, there are a number of purely legal sources that will factor into a duty of care analysis. One potential source stems from national laws that regulate areas such as occupational health and safety. This factor may result in a conflict between laws, given the wide range of differing laws across jurisdictions. Nonetheless, it is critical that organizations

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Case: Workman v UMCOR, 320 F 3d 259, 264 (2003), USA (15)

Deena Umbarger was conducting relief work as an employee of UMCOR in East Africa when she was shot and killed by a gunman in Somalia. Her family subsequently filed a wrongful death suit against UMCOR in Washington, D.C. Part of the claim was that UMCOR breached its duty of care to Umbarger by failing to provide reasonable safety and security support while she was deployed. Ultimately, the court found that UMCOR was not liable for the death of Umbarger. This was primarily because she was aware and informed of the risks, and voluntarily assumed them.

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Case: Dennis v Norwegian Refugee Council (NRC), Norway (16)

Steve Dennis was shot and abducted on the Kenyan and Somali border. He subsequently sued the NRC, claiming that they were negligent by failing to follow adequate security protocols. The court found that the NRC breached its duty of care by failing to assess and communicate the nature of the risk experienced by Dennis and its other employees. Furthermore, the court also found that the NRC failed to provide an adequate degree of post-deployment support to Dennis, who suffered from Post-Traumatic Stress Disorder as a result of his experience. Dennis was awarded $680,000 in damages for the NRC’s breach of its duty of care.
understand the relevant laws governing the country to which they will be responding. Another source of law is jurisprudence: that is, decisions made by judges in various courts around the world. A number of international cases have assessed the duty of care that humanitarian organizations owe toward their deployed personnel, and although none are strictly within the context of an epidemic response, they do highlight some of the factors that courts will consider. The Workman and Dennis decisions above illustrate different principles in this regard.

The following five issues were recurring legal challenges that organizations faced when navigating their duty of care while responding to Ebola:

- **Training and Qualifications:** What are the specific training qualifications that deployed personnel require when responding to an epidemic and how is this training developed and obtained?

- **Informed Consent Process:** How can organizations communicate the nature and the scope of the risk involved for their deployed personnel? Is it necessary to secure informed consent from these personnel stating that they understand the nature of the risk involved?

- **Insurance:** What kind of insurance do organizations require in a response situation? Is it possible to fully shield the organization from liability with insurance?

- **Medical Evacuation:** If deployed personnel should become infected or otherwise injured or ill as a result of their deployment, what obligation do organizations have to medically evacuate them to their country of origin? Is there an obligation to repatriate the bodies of personnel in the case of accidental death?

- **Reintegration:** What kind of support does an organization need to supply to its personnel after they have returned from a deployment?

This list is not exhaustive, but it represents critical considerations that these organizations make from an operational, ethical and legal perspective in relation to deploying personnel. The remainder of this report canvasses these five issues in greater detail, with a view to highlight what is considered industry best practices and what should be expected of a reasonable organization in the circumstances.
1. QUALIFICATIONS, TRAINING, EQUIPMENT AND INCIDENT PROTOCOLS

Adequately trained personnel are essential to effective epidemic response, as are thought-out incident protocols. This section aims to describe what qualifications and training a reasonable organization will require and provide their deploying personnel. A reasonable organization must quantify at the outset what they will consider to be “adequate” for the purpose of deployment. It is important that this instruction be accessible to all personnel. This is especially true for public health emergencies, where the risk is two-fold: firstly, the personnel deploying is at risk, but so is the public at large, whether that be the population in the affected country or back in Canada.

Learning from Ebola

MSF was the first to deliver Ebola-specific training and many other organizations took their lead in developing their own. There are generally two types of personnel that respond in the event of an emergency: trained staff on the rosters of their respective organization prior to the outbreak, and personnel that come forward in response to a specific emergency. During the Ebola crisis, a significant number of personnel responded to the CRCS nationwide call to action, placing them in the second category.

Options and Considerations

The following recommendations are the basic requirements intended to guide an organization to ensure that they meet the requisite duty of care owed to their personnel.

- Only personnel with pre-existing medical qualifications should be assigned medical duties. Organizations can add additional requirements such as only retaining individuals who are licensed to practice medicine in Canada.

- Flexibility and collaboration is encouraged when training is being developed. The subject specific training must evolve as more information becomes available. However, the instructions must be communicated clearly and reflect realities of the situation.

- The training must reflect the nature of the disease and its epidemiological characteristics: is it airborne? Transmitted through bodily secretions? Through direct contact? Training should be based on industry standards for health responses and updated based on guidance from regulatory authorities such as the Public Health Agency of Canada (PHAC). It is also important that the training be catered towards the type of personnel and their expected responsibilities in the field: health professionals (doctors and nurses) do not necessarily require the same training as technicians or administrators.

- All staff should be briefed on security protocols and have a security briefing prior to deployment and then upon arrival. Ideally, all staff should also be trained for critical incident management, both in the field as well as in head office. Considerations include, for example, what is the protocol if someone’s suit has a tear, or if there is a security issue unrelated to the health crisis? It is important that the organization keep in mind all legal obligations under the Occupational Health and Safety Act.

- All equipment should be ensured as appropriate for the operation based on the nature of the disease: gloves, scrubs and any other equipment that is needed to increase the safety of the deploying personnel.
2. WAIVERS OF LIABILITY, ASSUMPTION OF RISK AND INFORMED CONSENT

Humanitarian organizations typically limit their liability in operations by having deploying personnel sign a document in which the individual deploying acknowledges and voluntarily accepts the risk of their mission. In some cases, the document can also include waiving rights to future legal action if the individual suffers harm while deployed. There are two purposes of the informed consent process: first, it enables an organization to clearly explain to a deployed personnel the risk that can arise should they choose to deploy; and second, it is meant to assist the organization in defending itself against potential legal action and liability pertaining to the risks involved with sending otherwise healthy people into a region burdened by a health emergency, security and/or other risks.

However, there is an inherent ethical tension that lies between the organization’s legal and moral obligations to support its deploying personnel on one hand and to minimize their liability on the other. The recommended approach is to ensure that liability is not mitigated at the expense of an employee. This can be achieved by taking the time to ensure deploying personnel fully understand what they are agreeing to and by providing them with an opportunity to consult a lawyer and speak with their family prior to signing.

Waivers are meant to ensure that deploying personnel are fully informed and appreciate the risks associated with their mission, and that they are assuming these risks voluntarily. This is important from a risk-mitigation perspective because it documents what the individual knew and understood. For example, the waiver ensures that the deployed individual understands the limitations of the employer in critical circumstances. Finally, it is important for delegates to know that they are under no obligation to deploy: this is another opportunity for the delegate to change their mind.

Whatever form this document takes, whether it be “informed consent”, a “waiver” or “disclaimer of liability”, it typically includes the following key items:

**Identification of Risks**
- A detailed listing of the types of risks an individual would be exposed to on their mission; for example, the risk of infection or kidnapping. The listing of the types of risks should be tailored to the specific mission as these risks will vary depending on the scope of the activities involved, location or site, and age and skill of the personnel deployed;
- The severity of the risks and potential outcomes such as ‘injury, up to and including death’; and
- What the organization can and cannot do in the case of risk materializing such as ‘limited medical facilities in the area’, ‘inability to medevac’ and ‘inability to repatriate bodies’.

**An Acknowledgement and Assumption of the Risk(s)**
- Deploying personnel confirm their understanding of and accept (assume) the identified risks, their severity and limitations of the organization to respond set out in the document.
- Can also include a waiver of rights.
Despite the informed consent process that organizations adopt, it is important to note that the law concerning enforceability of these documents is unclear and so organizations should not rely on them to fully absolve themselves. It is also unclear which jurisdiction would apply to a legal proceeding (regardless of if the governing law is identified because of the interjurisdictional nature of an international deployment); if the court where the proceeding was brought would even accept jurisdiction; to what extent the document would be enforceable (acknowledging this also depends on the specific drafting of the document); and if found to be enforceable, how narrowly such documents would be construed.

Learning from Ebola

Most organizations approached informed consent in a substantially similar way. For example, all CRCS deploying personnel received a one-on-one briefing by CRCS on: security, health risks/information while abroad, insurance coverage and evacuation, PSS benefits and family support tools, finance, CRCS’s Waiver and Release form (their version of informed consent) and the 21-day rest period that was included in their contract. This is what the CRCS calls the ‘Informed Consent’ process. Deployed personnel then signed the CRCS’s Ebola-specific informed consent waiver prior to deployment.

Most organizations emphasized to its deploying personnel that medical evacuation was unlikely due to the nature of Ebola, and there was a risk that they would not be repatriated. Others provided online resources to families so that they could be included in the conversation surrounding their loved-ones’ deployment.

For PLAN International (PLAN), Samaritan’s Purse (SP) and CRCS, a 21-day ‘rest period’ was included in the contract to ensure that the deployed personnel took the necessary time to rest post-mission recognising the stress that accompanies responding to a complex health emergency such as Ebola (10).

Options and Considerations

The following highlights the recommended practice for obtaining informed consent from personnel.

Content

Epidemic waivers should not be boilerplate and should be tailored to and informed by the event being responded to; indeed, specific clauses pertinent to the mission at hand should be included and described. As such, all waivers and debriefs should include information on:

- Security (both physical and political)
- Potential stigma following deployment and support services available
- Medical evacuation protocol, or lack thereof (see section on Medevac)

Process

Informed consent should not be given blindly: the individual deploying must have an opportunity to ask questions or obtain independent advice, legal or otherwise. It is imperative that organizations explain and read the informed consent with the individual deploying. Legal disclaimers alone do not preclude litigation from happening; so sitting down with the individual to explain and elaborate on the potential risks cannot be overemphasized.

Informed consent should also be ongoing. It is imperative that deployed personnel feel that they have the “right of refusal” at all stages of the response so that they can leave without prejudice. Individuals may feel pressure to remain committed to the response, despite personal hesitations. To counteract this tendency, all departments of the organization should adopt an open, confidential, consistent and supportive dialogue. Organizations should be open to the possibility that the content of the informed consent will change. Factors like insurance coverage, knowledge of the epidemic, method of transmission and the affected country may alter what should be included in informed consent over time.
Lastly, it is strongly encouraged that organizations encourage deploying personnel to speak to their families regarding the risks of deployment, even though there is no legal obligation to do so. One option is to offer a support system, both during and after deployment. Families frequently play an important role in an individual’s decision to deploy to an affected country, and organizations should act accordingly.

3. INSURANCE

Ensuring sufficient insurance coverage is a critical risk transfer aspect of risk management that should be addressed and considered for all operations. This can be a major challenge in a complex health response, as organizations must tailor their insurance policy to their specific security environment. Organizations responding in a disaster or conflict zone may be preoccupied with more typical security threats, such as violence or kidnapping; 460 aid workers, for example, were the victims of targeted violence in 2013 (17). However, every response is unique. In one survey, 29 percent of respondents reported encountering difficulties obtaining insurance during disaster response (18).

There are a number of reasons why it is difficult to obtain insurance. The first reason is that there is a wide range of domestic laws governing the requirements for response organizations to carry insurance. Consequently, organizations may struggle with navigating the diverse legal regimes governing insurance in the jurisdictions to which they will be responding. The second reason is the broad risk typology confronting humanitarian response organizations. A non-exhaustive list of the types of threats that organizations need to consider include the following: intentional violence; motor vehicle accidents; endemic and other diseases; mental and nervous disorders; and, kidnap, ransom and extortion. While these threats may remain present in a complex health response, there are additional security concerns that will require consideration.

Securing insurance for international humanitarian responses can also be challenging from an insurance underwriting perspective. Specifically, it can be difficult for an insurance company to predict what the next response will be and where in the world the response will be required. This is because insurers typically rely on historical claims and actuarial data when underwriting insurance coverage. Collecting historical claims and actuarial data for a response like Ebola can cause an insurance company great difficulty in gauging their overall claims exposure when calculating premiums that are commensurate to the risks involved. In fact, for some insurance companies, especially those that are not set up to provide insurance coverage on a worldwide basis, such operations will
Learning from Ebola

The Ebola outbreak presented unique challenges to response organizations looking to obtain adequate coverage. In contrast to other disaster response situations, the level of deliberate violence targeting aid workers was relatively low (19). Accordingly, the main concern in the Ebola context was what would occur if response personnel became infected with the virus. This worst-case scenario drove organizations to develop a robust insurance programme that would cover this contingency.

Options and Considerations

A comprehensive insurance program will typically require insurance at both the organizational and individual response worker levels. Although the specific terms may be different depending on the jurisdiction, these two general levels can be further subdivided into the following categories:

- **Public Liability Insurance (sometimes known as Civil Liability Insurance):** This form of insurance can provide protection to organizations under effectively two scenarios. The first includes vicarious liability situations, where a third party brings a claim against the organization for any harm that they may have suffered as a result of some action by the organization or personnel working for the organization. The second includes situations where the employee or volunteer of the organization makes a claim against the organization due to any harm or injury that he or she suffered (20).

- **Foreign Voluntary Workers Compensation (also known as Volunteers Personal Accident Insurance):** This insurance is relevant to personnel deployed in an epidemic response scenario (17). It will typically include medical expenses for deployed personnel should they sustain an accident or injury. However, the contraction of an endemic disease may not be automatically covered under one of these insurance policies; consequently, it is essential that organizations communicate the precise nature of the risk to the insurance provider. It will also typically include compensation benefits, should the individual be unable to return to their normal employment in the event of a disability or long-term illness.

- **Travel Accident Insurance:** This insurance serves to fill any gaps in a Foreign Voluntary Workers Compensation plan (17). While this compensation plan may only cover situations where the individual is “on the job”, a Travel Accident policy will provide coverage for accidents or illnesses regardless of when they occur. Furthermore, a Travel Accident plan should also include contingencies for medical evacuation, which will be covered in greater detail in the following section.

In addition, organizations should also undertake the following:

- Communicate the specific risks and concerns to the insurance provider. This obligation is continual: the adjuster must be informed if the nature of the risk or the response changes.
- Prepare to obtain policies from multiple providers in the event that no single insurance company will be able to provide a comprehensive plan.
- In the case of any new activity, an organization should ask if the deployment would be excluded under its pre-existing liability policy. Even if the answer to this question is ‘no’ it is advisable for organizations to provide notice to their insurer so that they are not in breach of disclosing a material change of risk to their insurer for a change in operations.

4. MEDICAL EVACUATION

Access to medical evacuation (also called “medevac”) is an important consideration for humanitarian organizations and personnel alike when responding to any emergency. It refers to relocating an individual to either: 1) a safe, proximate hospital in the region; 2) to a third country, or 3) back to their home country. Medevac is challenging because it cannot
guaranteed due to cost, geography and border control. Organizations need to prepare for potentially severe emotional and psychological impacts associated with not being able to guarantee medevac for their personnel.

Depending on the medical condition of the patient, evacuation from the region is possible via commercial transportation or by a private plane/’air ambulance’ equipped with medical facilities (including the ability to transport an individual with a transmittable disease, discussed below).

Commercial transport medevac with a medical escort is a far more economic option and is appropriate for patients that are in a stable condition. However, because it is of the utmost importance that the method of transportation chosen does not place the public at risk, it is not always a realistic option. If a deployed individual were to be infected, or suspected of being infected, with a transmittable disease (such as Ebola) commercial transport would be inappropriate. In this circumstance, the individual would either be treated locally or an attempt would be made to access the more expensive, less readily available ‘air ambulance’ medevac.

Air ambulance medevac in a complex health response is particularly challenging. It may be perceived that evacuation will contribute to the spread of the disease rather than to its containment. Examples of specific challenges include:

- **Equipment**: availability of special transporting equipment and the costs associated with acquiring it.
- **Insurance coverage and liability**: due to the limited availability of assets (10), the logistical concerns of landing a plane, the role of insurance and strategic concerns, it is nearly impossible to offer guaranteed medevac to deployed personnel (10).
- **Border control, airspace, refuelling and neighbouring countries**: depending on the circumstances, an individual will not necessarily be taken to his or her home country immediately, so permission to land in third party countries needs to be obtained. Third party countries will also be engaged for re-fuelling needs or air space (21). If the individual is evacuated to a third party country to receive care, it is unclear what visa requirements will need to be met, if any.

**Learning from Ebola**

Because Ebola is transmitted through bodily fluids, confirmed cases requiring air ambulance medevac needed to be transported in an airplane with a specialized chamber to avoid transmission. This limited medevac options for humanitarian organizations involved in the Ebola response as there were very few planes that were adequately equipped for Ebola-infected individuals. The lack of this asset highlights the importance for organizations to have alternative medevac

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**A Story of Medevac: Dr. Kent Bradley (21)**

Dr. Bradley, an American doctor working with Samaritan’s Purse Ebola effort in Liberia contracted Ebola during his work. Dr. Bradley required medevac; however, there were significant delays, which demonstrate well the types of legal barriers humanitarian organizations face with establishing air ambulance medevac. SP had emergency medical-evacuation service, but the insurance company hesitated upon learning Dr. Bradley had Ebola. SP turned to the USA government and military for assistance. Dr. Bradley finally obtained medevac through contacts in the State Department who reached out to Phoenix Air and the Center for Disease Control (CDC). Dr. Bradley faced additional challenges: countries in North Africa and Europe refused to grant air space clearance for a plane with an Ebola patient on board. Eventually, Dr. Bradley was evacuated using a CDC aircraft equipped with Aeromedical Biocontainment System technology to Atlanta.
options available. Additionally, sometimes international medevac is not the best option; care in the country of deployment may be deemed just as adequate or superior.

The CRCS informed all deploying personnel that there was no guarantee of medevac. It ensured it had a number of medevac options available and in a complex humanitarian environment that is ever changing, this is essential. This was explained to potential deploying personnel individually and thoroughly. They emphasized this point not only in their waiver of liability but also in their communications with interested personnel.

**Options and Considerations**

To mitigate liability, humanitarian organizations should clearly inform deployed personnel of the medevac options available. The appropriate medevac system to employ can only be best determined on a case-by-case basis; however, humanitarian organizations should take care to have several medevac options lined up. This is particularly important for complex health responses such as Ebola given the limited guarantee of air ambulance medevac.

The realities of medevac should be thoroughly explained individually to each potential deploying person, as opposed to in a group setting, since psychological stress can result. Individual attention reduces the pressure to agree to the medevac options prematurely, and affords individuals the opportunity to ask questions without concern of judgment from others.

A prudent organization should therefore consider the following:

- **Supply appropriate information**: ensure that deployed personnel are well informed of the risks and non-guarantees that come with medevac when having the deployed personnel sign their informed consent. Make sure that the complications of medevac are explained thoroughly in a one-on-one meeting.

- **Maintain constant communication with deployed personnel** regarding the availability of medevac and ensure that they are aware of the option to leave the affected area if they become uncomfortable with the medevac situation.

- **Maintain clear and consistent communication with family** of medevac’d deployed personnel.

**5. REINTEGRATION**

Reintegration concerns how far an organization’s liability extends upon the return of deployed personnel. Generally, it does not end when deployed personnel have returned home but may continue indefinitely depending on the circumstances (10).

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**No guarantee of repatriation of body**

Another important consideration that should be communicated to delegates and their families is the return of human remains to Canada. Sections 44-46 of the *Quarantine Act* regarding “Cadavers, Body Parts, and Other Human Remains” sets out that a Quarantine Officer who can deny human remains entry into Canada that might have or have a communicable disease listed in the legislation’s schedule. The schedule can be found at the very end of the *Quarantine Act*. Ebola is included in this list. The result is that a humanitarian organization cannot guarantee to their delegates and their families that if the situation were to arise, that human remains will be repatriated.
Complex public health responses can have a different impact on deployed personnel socially, emotionally and psychologically. Deployed personnel can also face stigma and experience fear when they return home, especially when the public believes that they may have been exposed to the virus. Indeed, many who responded to the Ebola outbreak reported having a unique experience upon return: they encountered stigma from friends and co-workers, and struggled with living in isolation (22). Humanitarian organizations should consider reintegration into the community and psychological wellbeing.

**Learning from Ebola**

Careful wording was used with and about returning personnel: there are subtexts with the words ‘quarantine’, ‘isolation’, and ‘rest period’ (22). For example, mandatory self “isolation” could create a certain level of fear that is not associated with ‘rest period’. The Canadian government did not find it necessary to impose quarantine on those who returned from working with Ebola in West Africa (10, 25), but imposed a 21-day self-monitoring period that was guided by PHAC (26-27). All organizations consulted had clauses in their contracts for a 21-day ‘rest period’ to be undertaken by all returning personnel, which extended the length of employment. This ensured that deployed personnel were comfortable taking three weeks of rest, rather than pressured to return to their ordinary work immediately.

During the 21-day rest period, CRCS’ personnel followed strict guidelines to self-monitor for signs and symptoms of Ebola in accordance with PHAC guidelines, such as monitoring temperature twice per day. They were also expected to follow the guidelines provided by the CRCS Travel Health team, which absorbed PHAC’s guidelines (10). The CRCS Travel Health team efforts included:

- Providing deployed personnel with a welcome home document outlining return home information and resources.
- Verifying that the deployed personnel made contact with their Medical Officer of Health and had received instructions on their 21-day assessment.
- Verifying with the deployed personnel what reporting schedule and/or active monitoring schedule their public health authority implemented (e.g., twice daily calls to weekly check-ins).
- Completing a standard health debriefing during the second week of the rest period.

**Options and Considerations**

To continue to mitigate liability when personnel return from an epidemic response and seek to re-integrate into society, humanitarian organizations should consider:

- **Rest Periods** should be clearly explained to the deployed personnel prior to departure and be built into his or her contract. The rest period ought to reflect the nature of the disease, international best practice and/or the government’s recommendations.

- The **contract** setting out the terms of the rest period should be carefully worded (“rest period” as opposed to “quarantine”). Ensure that all the expectations of the deployed personnel during this period, including duration, location and responsibilities, are outlined and explained clearly.
This report focuses on the efforts made to improve the experience of returned personnel from a Canadian humanitarian response perspective. The efforts and commitment of local personnel who are citizens and residents of hot zones should be noted. Although services for local personnel is outside the scope of this report, it should be noted that local personnel may also be in need of similar services and accommodations, and that they face similar if not more stigma and fear from their own communities.
Support networks for personnel and their family who are struggling with reintegration upon return is encouraged on an ongoing basis.

Alternative Accommodations should be made available post-epidemic response if deemed necessary. The conditions of the accommodations and the rules provided therein should reflect the individual’s health, dignity and human rights.⁷

Information for Employers: Because of the stigma and fear that deploying personnel may face upon their return, humanitarian organizations can help ease concerns of returned personnel’s employers by providing them with sufficient information regarding the returned personnel’s activities, the safety precautions taken to ensure their health, and the practicalities of the epidemic. Providing thorough and reassuring information can help control fear and stigma, and ease personnel’s return to their workplace.

In Canada, the Quarantine Act is relevant to this issue (28). It details the returning personnel’s rights as well as the organization’s responsibilities, both of which demand attention upon returning from an epidemic response. Please see the web appendix for a summary on the most relevant provisions of the Quarantine Act.

CONCLUSION

Humanitarian organizations owe a duty of care to their personnel while they are deployed. The humanitarian organizations must address potential risk and harm that could come to a delegate, and negotiate these risks with appropriate training, information and caution. While court decisions have addressed this issue from a broader disaster response perspective, the specific duty of care required during and after a complex epidemic remains novel. Accordingly, the precise criteria involved in a legal analysis of this subject remain uncertain.

Case: Dennis v Norwegian Refugee Council (NRC), Norway (23-24)

The court found that the NRC failed to provide an adequate degree of post-deployment support to Dennis, who suffered from Post-Traumatic Stress Disorder as a result of his experience. This failure amounted to a breach of the duty of care.

Stigma and fear upon return

Some delegates returning from complex health responses encounter stigma and fear in their home communities. Several CRCS delegates returning from their Ebola missions reported fears from employers, family members, friends and the community at large. For example, some reported that people were afraid to shake their hand. In the Ebola response, the CRCS supported education and awareness in Canada in an effort to reduce fears and misperceptions as well as ensured that returning personnel had adequate support available.
CONCLUSION

This report aims to address this uncertainty. Through a literature review and a series of interviews with organizations that responded to Ebola, this report identified industry best practices for five of the most complicated legal issues: training of personnel; communicating risk; insurance; medical evacuation; and reintegration. Best practices necessarily involve importing ethical and operational considerations, which are set out for each issue. The report now presents a range of options and considerations available to humanitarian organizations should they respond to a future epidemic.

Although the primary audience of this report has been the individual response organizations, the role of the government in any future epidemic response will be critical. In general, governmental agencies should serve as key partners with response organizations as each can leverage their specific skills and resources in an epidemic response. More broadly, the government can also act as a facilitator by providing clear guidelines with regard to protocol, insurance and response expectations.

The International Federation of the Red Cross and Red Crescent Societies has produced a series of guidelines called the International Disaster Response Laws, Rules and Principles (the International Disaster Response Laws (IDRL) Guidelines). These guidelines provide a coherent set of recommendations that governments can use to ensure that their regulatory framework facilitates and allows for proper international response during an emergency. Accordingly, the IDRL Guidelines are a useful framework that all governments should adopt to ensure a more efficient and effective response to future emergencies such as epidemics. Consequently, a subsequent report on how the Canadian government in particular can adopt the Principles and Rules in order to better respond to an epidemic in Canada and overseas should be drafted.

Together, organizations and governments can learn from the Ebola outbreak to equip themselves with the legal tools necessary to respond to future public health disasters.
REFERENCES


(22) Lauren Geenen and Andrew Paterson. Interview with Brent Davis and Ian Stokes (Samaritan’s Purse). October 29, 2015.


ENDNOTES

1 Note that while this report refers to Ebola as an epidemic, it is intended to apply to both pandemic and epidemic responses.

2 Prior to an emergency, organisations ensure their deploying personnel are trained and deployment ready (medical clearance, compliance documents, etc.)

3 This individual assessed the psychological impacts of Ebola in the affected communities/populations and developed a plan of action for response as well as trained and supported volunteers to implement the plan.

4 All interviewers were contacted prior to publication to authenticate the nature of their comments.

5 This section is written from a legal and insurance perspective.

6 Please note that these options are not listed in order of preference. Priority to a certain option should be made on a case-by-case basis.

In any response the determination of where to house returning personnel should be made on a case-by-case basis and informed by a thorough risk/benefit analysis. For example, if the disease is transmittable, such as Ebola, one risk of housing staff in a hotel is an associated potential reputational risk should someone fall ill within their 21-day rest period. On a severity versus probability risk analysis the severity is high – in terms of damages (legal, financial and reputational); however the probability is low because if returning personnel were suspected of having the disease it is likely, and recommended, that they are treated differently (monitored in hospital). The risk of transmission would be rated as low probability, high risk. In a risk matrix it would be weighed against the mental health benefit of permitting delegates to stay in a more public environment with better facilities. All risks and benefits of the two options would be mapped out to permit operations to make an informed decision. The Residential Tenancies Act does not explicitly require tenants to disclose health concerns to landlords, but in a situation such as Ebola is in the best interests of all parties to be forthcoming with any landlord regarding the use of a rented property as an accommodation for a rest period.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Delegate</td>
<td>CRCS specific term</td>
</tr>
<tr>
<td>Duty of Care (29)</td>
<td>The duty of care is the legal obligation that organizations and individuals owe towards others. More specifically, organizations and individuals can be held liable for a breach of the duty of care where their negligent conduct results in a loss or injury to another.</td>
</tr>
<tr>
<td>Epidemic (30)</td>
<td>Epidemic refers to an increase, often sudden, number of cases of a disease above what is normally expected in the population in that area.</td>
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<tr>
<td>Humanitarian Organization</td>
<td>This refers to the whole range of organizations that may respond to an international emergency including epidemics. This includes international, non-governmental organizations, response organizations, Red Cross Red Crescent Movement and humanitarian organizations.</td>
</tr>
<tr>
<td>Informed Consent Process</td>
<td>The processes by which an humanitarian organization will sit down and go through the waiver/informed consent with their delegate. This is qualified as a process because it is more than simply passing the waiver to the delegate; it involves explaining all the clauses, risks, allowing for questions and concerns and addressing them.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Medevac</td>
<td>Medevac refers to the medical evacuation of personnel who have become sick or injured while deployed.</td>
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<tr>
<td>Pandemic (30-31)</td>
<td>Pandemic refers to an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.</td>
</tr>
<tr>
<td>Personnel</td>
<td>This term encompasses all response personnel inclusive of staff, volunteers and delegates.</td>
</tr>
<tr>
<td>Roster</td>
<td>Database of delegates who have completed the initial training of the organization.</td>
</tr>
<tr>
<td>Public Health Emergency of International Concern (PHEIC) (32)</td>
<td>The World Health Organization has the power to declare a Public Health Emergency of International Concern in accordance with the International Health Regulations. Specifically, a Public Health Emergency of International Concern means an extraordinary event which is determined, as provided in the International Health Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response.</td>
</tr>
<tr>
<td>Quarantine (28)</td>
<td>Quarantine means the restriction of activities and/or separation from the general population of suspected persons who are ill so as to halt the possible spread of infection or contamination. In most countries, only the government has the authority to order individuals to be quarantined. Quarantine is to be distinguished from isolation, which can either be self-imposed or recommended by the deploying organization.</td>
</tr>
</tbody>
</table>
Additional Resources

Books


Currie JH. Public International Law. 2nd ed. Toronto: Irwin Law; 2008.

Legal Cases and Legislation

Anns v Merton London Borough Council, AC 728 (HL 1978).

Corruption of Foreign Public Officials Act SC 1998, c 34.

Customs Act, RSC 1985, c 1 (2nd Supp).


Personal Communication


Andrew Paterson. Interview with Nadia Khoury (International Federation of the Red Cross). November 12, 2015.

Lauren Geenen and Andrew Paterson. Interview with Brent Davis and Ian Stokes (Samaritan’s Purse). October 29, 2015.

Meagan Dutchak and Lauren Geenen. Interview with Dr. Lauralee Morris (Canadian Red Cross). November 10, 2015.
**APPENDIX**

**Reports**


**Websites**


The Aid Worker Security Database [Internet]. Humanitarian Outcomes; [cited 3 Oct 2015]. Available from: https://aidworkersecurity.org

**Other Sources**


Canadian Red Cross. Summary of protocols for Canadian Red Cross delegates and staff working in Ebola-Affected countries in West Africa [cited 2015 Oct 12].