

What the U.S. Military Could Bring to Bear in the Ebola Crisis

by Carl Osgood

Oct. 20—Were there a real President occupying the White House, the United States would bring to bear the full power of its capabilities to battle the Ebola epidemic raging in West Africa. He or she would treat the emergency “as if we were being invaded by a foreign foe,” as President Franklin D. Roosevelt said during his first inaugural speech in March 1933 with regard to the economic emergency. Roosevelt did, indeed, fully mobilize the nation to, first, meet the economic emergency, and then the war emergency that followed in the late 1930s. The first task was to determine what physically needed to be done to respond to the emergency, and then to mobilize the productive capabilities of the nation to meet those requirements, in concert with allied nations, where possible.

In the case of the Ebola outbreak, the U.S. military has expansive medical and logistical capabilities that could be activated starting within hours of the order being given. These include medical treatment and disease control, engineering and transportation capabilities that are desperately needed, now, in Liberia, Sierra Leone, and Guinea, where the epidemic has overrun the capacities of the governments to respond. Instead, the Obama Administration has responded with a slow-moving, minuscule military deployment that won't even be treating patients, or providing enough hospitals and beds for them, while leading members of Congress are focused on imposing travel bans to keep the disease out of the U.S.

Infectious disease expert Dr. Michael Osterholm, during an Oct. 19 appearance on Fox News Sunday, instead issued a call for a full military mobilization to meet the disease threat in Africa. “What I'm really concerned about is what happens in Africa,” Osterholm said, before the topic of a military mobilization even came up, “because as long as that infectious disease forest fire is burning, those embers are going to keep running around the world, regardless of whether we close the borders or not.”

Rep. Tim Murphy (R-Pa.), a key member of the House Energy and Commerce Committee, who is among those calling for a travel ban, noted that the U.S. military flew hundreds of thousands of tons of supplies into West Berlin during the Berlin Airlift in 1948-49, despite the ground travel ban imposed by the Soviet Union. “I agree with you on the Berlin Airlift, but that was all military,” Osterholm said. “If you're prepared today to give us hundreds of military planes that will fly in and out at will when we need them to move not only material but also people, then maybe I'll reconsider [the travel ban, which he otherwise opposes], but I don't see anybody in Congress telling us we're going to get hundreds of military planes.” Murphy acknowledged that the ability of the U.S. military to move goods and supplies is “pretty massive,” but he said he still wants to focus as much on keeping the disease out of the U.S., as he does on dealing with it in Africa.

U.S. Military Medical Capabilities

Since the three countries most deeply affected by the Ebola outbreak are all coastal countries, a great deal of work could be done from offshore to help control the disease. First and foremost, are the U.S. Navy's hospital ships, the *USNS Comfort* and the *USNS Mercy*. They each carry 1,000-bed hospitals, including 80 intensive-care beds, and 12 operating rooms, and are equipped with the full range of medical services; and since both ships were converted from retired oil tankers, they have very large capacity.

Secondly, the Navy's nuclear-powered Nimitz-class aircraft carriers and its amphibious assault ships carry extensive medical facilities, and while these facilities are generally oriented toward the day-to-day care of the ships' crews, they can be, and have been, deployed on humanitarian missions as well. Each Nimitz-class carrier is equipped with a 51-bed medical facility, which includes a single operating room, with a staff of 58



USAF/Sr. Airman Kayla Newman

The U.S. military has expansive medical and logistical capabilities that can be rapidly activated as soon as the order is given. Here, Airmen of the 633rd Medical Group board a C-17 Globemaster at Langley Air Force Base, Va., Sept. 26, 2014, to deliver humanitarian relief to Ebola-stricken African nations.

medical personnel, including doctors, nurses, and technicians.

The Tarawa-class amphibious assault ships have a similarly sized medical bay, but with four operating rooms. The Tarawa ships can also be expanded to 600 medical beds. The fact that both classes of ships operate aircraft, including helicopters, Osprey tilt-rotor aircraft, and even fixed-wing cargo aircraft (operating on the Nimitz-class carriers) means that they can support medical operations ashore, and evacuate patients for treatment aboard ship.

The only hospital ship being deployed to the Ebola hot zone, so far, is the Royal Navy's *RFA Argus*, which departed its home port in Cornwall for Senegal on Oct. 18. Unlike the *Comfort* and the *Mercy*, the *Argus* does not meet the Geneva Convention criteria for a hospital ship protected by international law, because it's armed, but it is equipped with a 100-bed hospital. According to news reports, the *Argus* is carrying a crew of 380, including 80 medical personnel and 3 helicopters, but Ebola-infected patients will not be treated aboard ship. Instead, it will be used "mainly to transport supplies and to ferry personnel," reported the BBC on Oct. 14.

The U.S. Army also has deep institutional medical

capabilities which go far beyond the current tiny deployment of a 25-bed hospital in Liberia, which the Army, itself, won't even be manning. The Army's medical command has two basic functions—to provide for the day-to-day health needs of its soldiers, including on operational and combat deployments, and to be able to respond to the medical conditions existing in countries where U.S. troops might be deployed. The second function includes the ability to respond to infectious disease outbreaks, a capability which dates back to the aftermath of the 1898 Spanish-American War.

The Army's medical capability is embedded in units

at all levels, from the combat medics in infantry companies, to the forward surgical teams at brigade level, to the combat support hospital (CSH) at higher levels. The CHS is a 248-bed deployable facility, with a staff of about 500 people, which, according to Army medical doctrine, has to be maintained ready to deploy within 72 hours of receiving an order; it's designed to move quickly. The CSH is normally configured to respond to the types of conditions that are expected to be found in combat and other operational-type situations, but presumably, it can be tailored for specific situations, including those characterized by infectious disease outbreaks.

Such deployments would be supported by the Army logistics system, which would keep the CHS and other deployed medical units fully supplied with medical supplies, food, water, and power. The Air Force's huge fleet of military cargo aircraft would provide the logistical link between the deployment and support bases in Europe and the U.S. That fleet currently consists of 223 C-17 Globemaster IIIs, about 50 C-5 Galaxys, and approximately 350 C-130 Hercules aircraft. The C-17 has a cargo capacity of 160,000 pounds, the C-5, 270,000 lbs and the C-130, 45,000 lbs.

An example of how an emergency military deployment would work can be found in President Bill Clinton's "Operation Support Hope" of July-August 1994. Hundreds of thousands of refugees from Rwanda's civil war fled to Goma, Zaire (now, Democratic Republic of Congo) but were threatened by a cholera epidemic. Clinton ordered the Pentagon to mobilize to provide freshwater for the refugees, and as a result, an estimated 500,000 lives were saved. U.S. Army water purification units, with the troops to operate them, were providing 100,000 gallons of water daily, and were, along with French troops, distributing that water to the people in need. The equipment included water pumps provided by the San Francisco Fire Department. The logistics line stretched from the United States, through Frankfurt, Germany to Goma, and was provided by U.S. Air Force C-5 and C-141 transport aircraft. The operation was described in detail, in the Aug. 19, 1994 issue of *EIR*, by two *EIR* reporters who traveled to Goma aboard one of the U.S. C-5s.¹

What Little Is Being Done, Instead

In contrast to what could be done were a full-out mobilization to be ordered, what is actually being done is moving slowly and is clearly woefully inadequate in the face of the magnitude of the emergency. The timeline for the military deployment, as reported by the Department of Defense and U.S. Africa Command, is as follows:

- On Sept. 16, President Obama, in a speech at the Centers for Disease Control and Prevention (CDC) in Atlanta, announced that he had directed U.S. Africa Command to establish a joint force headquarters in Monrovia, Liberia, to be commanded by Maj. Gen. Daryl Williams, deputy commander of U.S. Army Africa. The DoD's role in the U.S. government re-



USN/Photographers Mate 2nd Class Troy Latham)

The U.S. Navy's hospital ships, the USNS Comfort and the USNS Mercy, each carry 1,000-bed hospitals, with 80 intensive-care beds, and 12 operating rooms, and are equipped with the full range of medical services. Here, the Mercy is anchored off the coast of Manila, the Philippines.

sponse was primarily to support USAID and the CDC in West Africa, to build an intermediate staging base in Senegal, and provide engineers to build Ebola treatment units and a facility for training up to 500 health-care providers a week. As of Sept. 7, 4,366 cases of Ebola, with 2,218 deaths, including 1,137 in Liberia, had been reported.

- On Sept. 19, the first U.S. C-17 aircraft arrived in Liberia, with equipment and personnel to begin to prepare the airport in Monrovia to receive supplies and equipment. Pentagon spokesman R. Adm. John Kirby announced that two more C-17s carrying 145 personnel would be arriving over the next couple of days.

- On Sept. 23, fifteen U.S. Navy SeaBees arrived in Monrovia to begin site surveys prior to building the facilities that the U.S. would be providing.

- On Sept. 26, airmen from the 633rd Medical Group boarded C-17 aircraft at Joint Base Langley-Eustis in Virginia to go to Monrovia, to build the 25-bed treatment center for health-care workers treating Ebola patients.

- On Sept. 30, the materials and equipment for the 25-bed hospital arrived in Monrovia.

1. See "[Operation Support Hope](#): focus on emergency infrastructure."

- Also on Sept. 30, Kirby announced that Secretary of Defense Chuck Hagel had approved the deployment of 700 soldiers from the 101st Airborne Division to become the headquarters staff for the overall military deployment. They will arrive in late October. At the same time, the Army will deploy another 700 soldiers from various engineering units throughout the United States to supervise the construction of 17 Ebola treatment units, conduct site surveys, and provide engineering expertise.

- On Oct. 3, Kirby announced that two mobile testing labs manned by personnel from the U.S. Naval Medical Research Center had become operational over the previous 36 hours. He also said that the first two Ebola treatments centers would be ready by the end of October.

- On Oct. 7, sixty airmen from the Kentucky Air National Guard arrived in Senegal to set up an Aerial Port of Debarkation at Léopold Sédar Senghor International Airport, which will be able to receive and process cargo flown in on C-5 and C-17 aircraft for distribution into the affected areas.

- On Oct. 8, Kirby announced that about 100 Marines with 2 KC-130 and 4 MV-22 aircraft from the Special Marine Air-Ground Task Force-Crisis Response Africa would go to Senegal and then on to Monrovia to provide logistics support until U.S. Army personnel arrive later in the month to take over that mission.

- On Oct. 16, Maj. Gen. Daryl Williams reported that construction of the 25-bed hospital had been completed, and that it would be staffed by medical personnel from the U.S. Public Health Service. The military has also provided two mobile labs which are now doing Ebola testing, with four more on the way.

- Oct. 19, Maj. Gen. Gary Volesky, commander of the 101st Airborne, left Senegal for Monrovia, along with 30 of his troops. Volesky will be taking over command of the joint headquarters by the end of the week.

- Oct. 20, the World Health Organization reported 4,555 deaths from Ebola out of 9,216 cases. The size of the outbreak has doubled in only six weeks. The main accomplishment of the U.S. military deployment reported, so far, is that the U.S. testing labs have cut down the time required for analysis of blood samples from as long as 24 hours to as few as 3.

A press officer for Operation United Alliance, as it's now called, told *EIR* in an email, today, that the schedule for constructing the 17 Ebola treatment units calls

for the first 3 to be completed in the first half of November, the second 3 by the end of November, and the next 4 by mid-December.

Limited Logistics Support

But the U.S. military deployment just doesn't include the large-scale logistical support that experts such as Dr. Osterholm have contended is needed to meet the emergency. Osterholm has said that what is required, is to treat the outbreak as if it were a concentrated biowarfare attack, which implies the deployment of thousands of medical personnel, with full biohazard protection, along with all of the logistical support that such a deployment would entail, and that's just not happening.

According to further email responses to *EIR*'s questions provided by both the Joint Force Command and the CDC 2014 Ebola Response/Emergency Operations Center, the Ebola treatment centers are being built according to specifications provided by the CDC. "We are working" with the local health ministries, the WHO, and aid agencies "to rapidly increase the number of Ebola care facilities providing medical treatment for Ebola patients; identify and track potential contacts; coordinate improved laboratory capability and capacity; educate communities about the risks of Ebola virus transmission; and strengthen local public health emergency management capabilities and capacities," the CDC Center said. "We are currently using appropriate biosafety precautions necessary for protecting responders. We are assessing the outbreak and the response on an ongoing basis and will make adjustments as appropriate."

As for logistical support for the ETUs (Ebola Treatment Units), including water, the Joint Force Command said that "the U.S. military is providing non-medical resupply for a number of Ebola Treatment Units" which "includes food and water for medical staff." However "medical resupply is the responsibility of the organizations that run each facility."

For its part, the CDC Center said that, as part of the interagency approach, "we are working to rapidly increase the number of facilities and beds, and the amount of supplies required to treat Ebola patients locally and ultimately reduce death rates for Ebola. We are also taking other community-based measures to contain the outbreak and prevent the spread of disease. We will continue to monitor the outbreak and adjust our response activities."