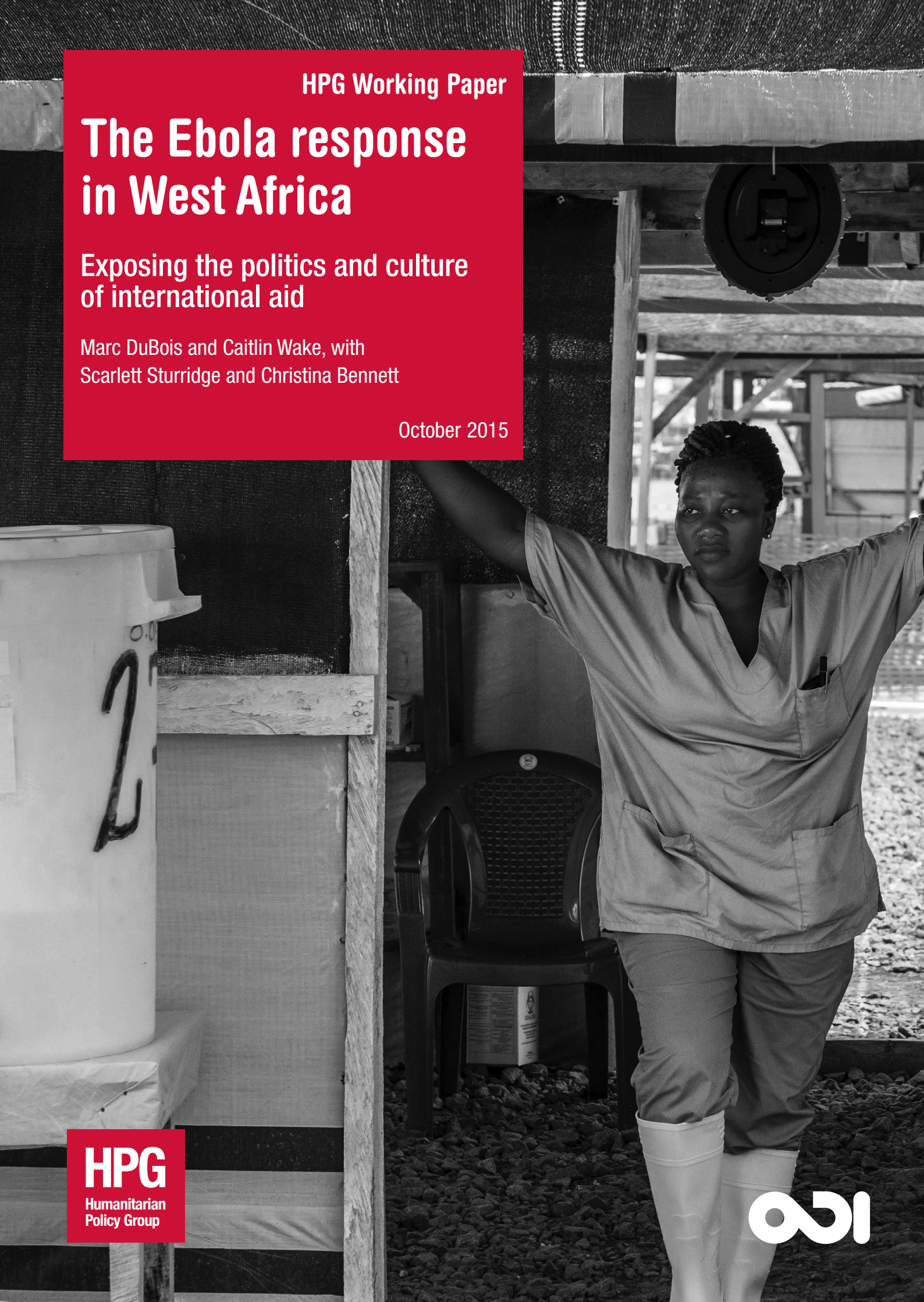# The Ebola response in West Africa

Exposing the politics and culture of international aid

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Acronyms

AGI	Africa Governance Initiative
AU	African Union
CAR	Central African Republic
CCC	Community care centre
CDC	Centers for Disease Control and Prevention
CERF	Central Emergency Response Fund
DART	USAID's Disaster Assistance Response Team
DFID	Department for International Development (UK)
ETU	Ebola treatment unit
EU	European Union
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IHR	International Health Regulations
IMC	International Medical Corps
INGO	international non-governmental organisation
IPC	Infection Prevention and Control
IRC	International Rescue Committee
MDGs	Millennium Development Goals
MERS	Middle East Respiratory Syndrome
MSF	Médecins Sans Frontières
NERC	National Ebola Response Centre
NGO	non-governmental organisation
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Cooperation and Development
OFDA	Office of US Foreign Disaster Assistance
PPE	personal protective equipment
SARS	Severe Acute Respiratory Syndrome
SMAC	Social Mobilisation Action Consortium
UNDP	United Nations Development Programme
UNMEER	United Nations Mission for Ebola Emergency Response
USAID	United States Agency for International Development
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organisation

Executive summary

This HPG Working Paper explores the systemic capacities and weaknesses that shaped the Ebola outbreak and response in Liberia, Guinea and Sierra Leone. In doing so, it aims to differentiate itself from the many evaluations that focus more heavily on operational issues, and instead seeks a deeper understanding of underlying systemic flaws, one which contributes to improved humanitarian effectiveness.

Pre-Ebola health systems: silos of success

It would be unfair to condemn Liberia, Sierra Leone and Guinea for being unable to deal with an epidemic that, by the summer of 2014, might have challenged the health systems even of wealthy nations. A more useful question is what happened *before* Ebola got out of control, both in terms of development efforts and early outbreak response. Systemic weaknesses in these countries' health systems and services – including insufficient funding, an inadequate workforce, poor infrastructure, shortages of medicines and supplies and weak health information and disease surveillance systems – all contributed to the spread of Ebola and undermined efforts to respond. Part of this failure must be laid at the door of international donors and their implementing partners. While all three countries have made progress in tackling specific issues, such as maternal mortality and HIV/AIDS, their health systems are heavily dependent on external aid, which emphasises target-oriented approaches and tangible impacts at the expense of a holistic vision of health systems in the round.

A 'criminally late' response

Widespread criticism has been levelled at the World Health Organisation (WHO) for its failure to recognise the potential severity of the outbreak and organise an effective early response. There was sufficient warning from agencies on the ground, but appeals for action went unheeded, leaving Médecins Sans Frontières (MSF) to address major medical needs essentially on its own, alongside a handful of smaller, less experienced agencies and overwhelmed government services. Ultimately, the failure of national and international actors to respond quickly enough in the early phase of the outbreak contributed to the failure to control the outbreak before it spiralled out of control.

Capacity, funding and coordination

Although meaningful support began to arrive in September 2014 – including significant funding pledges, international military and civilian deployments and the creation of the United Nations Mission for Ebola Emergency Response (UNMEER), the UN's first-ever health mission – humanitarian agencies struggled to translate energy and effort into relevant programme activities. Some issues speak to the more general situation at the time, with other large-scale crises in Syria, South Sudan, the Central African Republic (CAR) and Iraq, while others reflect deeper shortcomings in the aid system to do with capacity, funding and organisational bureaucracy. Individual fears of infection were magnified within organisations by the duty of care to keep staff safe.

Health versus humanitarian crisis

The fact that the outbreak was framed as a health crisis rather than a humanitarian one also had significant implications for the response. Not employing the 'humanitarian' label meant that the surge capacity, emergency funding and coordination structures typical of a large-scale disaster response were not triggered, and the formal cluster system was not activated across the board. While this had the positive effect of leaving national authorities to take the lead in the response, it also left many non-health non-governmental organisations (NGOs) unsure of how or where to engage. Treating Ebola predominantly as a health crisis, especially in the early stages, also meant that its wider implications, for instance for education, livelihoods, protection and political stability, were downplayed or ignored.

Trust, culture and community engagement

Issues around communication, community engagement and trust also marred the early phases of the response. Top-down communication sidelined the communities whose engagement was essential in enabling people to protect themselves and others from infection; reduce fear and mistrust of and resistance to health authorities and stigmatisation; prevent transmission of the disease; develop safe, supportive practices of care for the ill or those at risk of infection; and develop safe and supportive burial practices. The early stages of the

surge did not prioritise such engagement or capitalise on affected communities as a resource, but treated them more as a problem – a security risk, hidebound by culture, unscientific – to be overcome.

People, in particular rural populations, were stereotyped in the media as irrational, fearful, violent and primitive: as too ignorant to change. Such stereotypes feed paternalism and the view that Africans lack agency, are unable to help themselves and hence require foreign assistance. This dovetails with a self-perception of humanitarian action as 'saving' helpless victims – reinforced in turn by a media focus on the international response to Ebola, despite the evident fact that the vast majority of the effort on the ground was local. The result is a predisposition in the aid system towards control and an inflated sense of its own importance, rather than responses and strategies that engage with and rely on communities.

Politicisation and securitisation

While the humanitarian system both succeeded and failed in many ways to deliver on its lofty objectives in the Ebola response, it ultimately behaved as it is structured to behave. The underlying structures and drivers/incentives within the humanitarian and development aid system provide particular insight into the shortcomings and faults laid bare by the Ebola crisis. The system attempts to overcome these faults by improving its technical responses, but this cannot transform its fundamental structure.

In key Western nations, the outbreak was ignored until public fears that Ebola would hit back home combined with the need for individual politicians to 'act tough' during critical election years prompted major deployments, including military personnel. The securitisation of Ebola also pitted the human rights of individuals against the security of a public or nation and introduced a hierarchy whereby the security of some individuals would be protected at the expense of the rights and freedoms of others. Humanitarians must be better at assessing the pressures that give rise to counter-productive measures, and the degree to which national and sub-national political interests constitute one of the primary drivers of aid.

Conclusions

Ebola exposed much about the international aid community: dedicated, resourceful and diverse, as well as ill-prepared, donor-dependent and tested by the confrontation between technical approaches and the complexities of the socio-cultural context. Our analysis convinces us that understanding the power relations and culture of the humanitarian aid and global outbreak communities holds the key to ensuring that reforms address the causes rather than the symptoms of the problem. First and foremost, this will require a political rather than a technical analysis of what ails the humanitarian and development aid sectors, and solutions that tackle the underlying biases, trade-offs and political costs seemingly inherent to it.

1 Introduction

Disasters are not *naturally* catastrophic: they occur at the intersection between earthquakes, typhoons or disease outbreaks and the particular social, economic and political environment in which these events occur (Wisner, 2004). In today's world, with a $23 billion humanitarian aid system and substantial governmental and global public health capacity, the impact of disasters is largely determined by a second intersection, between vulnerable communities and the effectiveness of the response to their crisis.

The story of the Ebola outbreak and response in West Africa does not begin with the death on 28 December 2013 of Emile Oumnouno, the Guinean boy who has come to bear the unfair moniker of Patient Zero. Rather, the outbreak formed the tragic denouement of a pattern set in the preceding decades, in the specific contexts of Guinea, Liberia, Sierra Leone, and in the structures of the international aid and outbreak response communities. Scrutiny at the level of those systems is often muted by debate over the more technical aspects of outbreak response, or sidestepped in a more palatable narrative of blaming the 'unavoidable', such as war, poverty or culture.[1]

To date, the virus has infected more than 27,000 people, killing more than 11,000 and causing serious damage to the lives and communities of millions of others (WHO, 2015a: 4). It also sparked major interventions by both traditional and non-traditional aid actors, from the Chinese military to large pharmaceutical corporations. While the crisis has routinely been described as 'unprecedented' and 'exceptional', others have highlighted the ordinariness of many aspects of the disease in terms of its effects on education, health systems and food security, all typical features of 'template' humanitarian crises (UNICEF, 2015). At the same time, the Ebola crisis has presented an extraordinary challenge to the communities and organisations – local and international – engaged in a response defined by the remarkable, tireless engagement of tens of thousands of individuals, from exhausted agency directors to frightened village volunteers using broom handles to push plates of food within reach of stricken families. The battle against Ebola spotlighted what people can do. But humanity is not the de facto prime driver of the humanitarian system.[2] So Ebola also spotlighted what the humanitarian system *cannot* do. It cannot escape from the structures – its architecture and incentives – that often drive the system more forcefully than the needs of people in crisis. Nor can it escape from the politics of power which left the outbreak ignored for far too long.

This study proceeds from the belief that Ebola constitutes a valuable lens through which to analyse the performance of the humanitarian and outbreak response systems, and to examine the impact of aid efforts in the years prior to Ebola. Although ten countries have reported cases, the study is based on the three at the epicentre: Guinea, Liberia and Sierra Leone. The aim is to elevate discussion of the crisis and response above questions related to its technical aspects, aspiring to learn more about the systemic capacities and weaknesses that shaped the outbreak and response. Did efforts to address specific health targets, such as the Millennium Development Goals (MDGs), displace more comprehensive efforts to strengthen the health systems of these three countries? Will a renewed focus on health security – protecting healthy nations against epidemics – displace efforts to build health capacity to meet the daily needs of those without access to quality, affordable care? The next phase of the international and national aid response will require (re)building these three shattered healthcare systems and developing appropriate health security capacity. The goal should be to do better next time.

The report aims to differentiate itself from the many evaluations that focus more heavily on operational issues, and instead seeks a deeper understanding of

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1 See, for example, Liberian President Ellen Johnson Sirleaf: it was 'no coincidence Ebola has taken hold in three fragile states – Liberia, Sierra Leone and Guinea – all battling to overcome the effects of interconnected wars'. 'Letter to the World', October 2014.

2 The humanitarian system can be broadly defined as 'the network of interconnected institutional and operational entities through which humanitarian assistance is provided when local and national resources are insufficient to meet the needs of a population in crisis' (ALNAP, 2015a: 18).

underlying systemic flaws, one which contributes to improved humanitarian effectiveness. It is a particular concern that, in the Ebola response, we have seen many all-too-familiar shortcomings and mistakes. The outbreak has sparked numerous 'lessons learned' exercises, with notably intelligent recommendations, yet the need for a probing analysis of why lessons identified so often fail to become lessons learned has somehow been ignored.

1.1 Methodology

This report uses a qualitative methodology designed to identify key trends in the Ebola outbreak; the barriers to effective response; the perceptions of national and international actors; and the requirements for system-level change. Findings are based on primary and secondary data from three main sources:

1. Interviews: the team conducted 58 semi-structured interviews with members of the UN, NGOs, donor organisations, national responders, the private sector, the diaspora and academia. Most were conducted in person in Guinea, Liberia, Sierra Leone, the UK and Geneva between January and May 2015, supplemented with a limited number of telephone and Skype interviews. Responses were analysed using Max QDA software. A list of participating organisations is in Annex 2.
2. A desk review of literature from a range of sources including academia, think tanks, NGOs, governments, the UN and the media. Where possible, statements drawn from the literature were informed and supported by multiple sources.
3. Data from the UN, WHO and the World Bank was sourced, disaggregated and sorted according to need.

The team encountered several constraints in conducting interviews in Liberia, Sierra Leone and Guinea while the epidemic was ongoing. Movement and insurance issues meant that researchers were restricted to Monrovia, Freetown and Conakry, and were not able to visit affected communities or treatment facilities. These limitations affected data collection in Guinea in particular, and so the report focuses more on Sierra Leone and Liberia. Access to national actors was difficult, and as a result interviews were primarily conducted with international organisations. Finally, the rapid turnover of staff in affected countries meant that

some key informants had not been in West Africa for the duration of the epidemic. Even so, interviewees were generally able to critically consider and reflect on multiple phases of the outbreak and response. The ongoing nature of the crisis meant that there was only a limited amount of peer reviewed and academic research, and quantitative data (for example on number of cases and funding) was continuously changing, with different sources citing conflicting figures. As far as possible, we relied on UN and WHO figures for consistency.

Whilst the report refers to 'the outbreak' and 'the response', we recognise that neither was singular or static, but multiple and dynamic. Where possible we specify the phase of the response. It was also not possible to consider Guinea, Liberia and Sierra Leone in turn, or to comprehensively compare the outbreaks and responses in each country. Instead, the report considers overarching themes and specific examples from all three countries. We focus critically on the response in order to generate analysis that contributes to better preparedness and responsiveness for future global health crises. The response has been remarkable in many respects: our focus is not intended to discredit the Herculean efforts and successful work of the tens of thousands of people involved.

The paper is decidedly ambitious, arguably to a fault, and broaches a broad array of topics, themes and elements, from the common (humanitarian financing) to the culturally specific (white, not black, is the proper colour for a body bag), and from the conceptual (the conceptualisation of health) to the pragmatic (the importance of a good meeting agenda). Through it all themes begin to emerge, and the research leads to a set of interlinked conclusions which undergird the need for reform at the systemic level, and which cast doubt on the viability of useful yet familiar proposals for improvement and 'lessons learned':

- The interaction of three key factors – the financial power of donors, the compromised independence of NGOs and the lack of accountability to local people and communities – drives the humanitarian system in the direction of political interests rather than responsiveness and effectiveness.
- The international response highlighted shortcomings in agencies' capacity to engage with local communities and an insufficient understanding of the context. These difficulties

were compounded by the system's blindness to the workings of its own power and cultural dynamics.

- The degree to which the intentions and context of aid are (politically and socially) complex, yet theincentives within aid push in the direction of quantifiable, technical and decontextualised 'solutions'.
- Making transnational institutions such as WHO effective requires appropriate resourcing, leadership *and* political cooperation from member states, which protect their own interests from within and wield sovereignty as a barrier from without.

Finally, in its exclusively Anglo composition, in its foreignness to the context and in the difficulties it encountered in sufficiently involving nationals from the three countries concerned, the research team reflected the very aid system it sought to critique. We apologise for this serious omission. It was not a simple task to keep the people of Guinea, Liberia and Sierra Leone at the centre of our perspective. When we did, the Ebola crisis magnified our distance and our good fortune, and in doing so brought home the conditions in which so many in West Africa live.

1.2 Structure of the report

The report is organised into nine chapters. Chapters 1 and 2 provide the introduction and a concise overview of the Ebola outbreak and response. Chapter 3 then examines pre-Ebola aid efforts and the state of the health systems in Sierra Leone, Liberia and Guinea to provide historical context. The subsequent four chapters explore specific aspects of the response: Chapter 4 describes the challenges around sounding the alarm in the early phase of the outbreak, Chapter 5 explores the mechanics of the response, Chapter 6 provides an overview of strategy and coordination, and Chapter 7 focuses on community engagement, trust and the cultural context. Drawing on the information and arguments presented in these first seven chapters, Chapter 8 explores how the politicisation and securitisation of Ebola affected the response, and underlying issues of power and architecture, including the persistent problem of lessons identified but not, apparently, learned. Chapter 9 concludes the report.

2 Chronological overview

The Ebola outbreak's first victim, a two-year-old Guinean boy called Emile, died on 28 December 2013. Guinea had never experienced Ebola, and health workers did not realise what they were seeing. The Ministry of Health raised the initial alert of an 'unidentified' disease on 14 March, but Guinea lacked laboratory capacity and samples had to be sent to France for examination, allowing the outbreak to smoulder undetected for three months. WHO officially declared the outbreak on 23 March 2014, but failed to acknowledge its size and potential severity, and the governments of Sierra Leone and Guinea continued to downplay the crisis.

On 30 March Ebola was confirmed in Liberia; by 31 March there were over 112 confirmed and suspected cases in Guinea alone, and MSF warned that the epidemic's spread was 'unprecedented'. The disease reached Sierra Leone on 25 May and Nigeria on 25 July. Sierra Leone declared a state of emergency in late July, and Liberia and Guinea followed suit in August. Sierra Leone introduced quarantines, roadblocks, lockdowns and curfews and enacted by-laws, for example attaching criminal penalties to Ebola denial, violations of movement restrictions and unsafe burials.[3] Attempts in August to impose a quarantine in the West Point neighbourhood of Monrovia in Liberia led to violence and the death of a teenager, prompting fears of government collapse (Onishi, 2014).

On 23 June MSF warned that the outbreak was 'out of control', but it was not until early August that its severity was properly recognised, with WHO declaring Ebola a 'public health emergency of international concern' on 8 August. By early September there was still no coordinated international response (WHO, 2014–15). MSF called for the deployment of military biological teams as 'a last resort, in the hope of bringing about rapid and concrete action at the field level' (Pérache, 2015). It was not until the middle of the month that the global response can be said to have launched, beginning with UN Security Council Resolution 2177. At the same time, on 17 September, US President Barack Obama announced the deployment of nearly 3,000 troops to Liberia under 'Operation United Assistance', mainly in non-medical functions such as logistics and construction (Bloomberg, 2014). The UK followed suit, announcing the deployment of 750 British troops to Sierra Leone. By this point Ebola had infected over 3,000 people and killed more than 1,500 (WHO, 2014–15).

The creation of UNMEER on 19 September reflected this turning point in the international response. Funding increased dramatically – by the end of the year over $2.89bn had been pledged and $1bn paid – and scaled-up programmes began to launch in October and November. New cases in Liberia peaked in late September 2014, but continued to rise in Sierra Leone and Guinea until late November and December. By mid-2015 all three countries were pushing to get to (and remain at) zero cases, and WHO projected the outbreak could be over by the end of the year (United Nations, 2015). At the time of writing, Liberia had been declared free of Ebola, Guinea had registered its first week without any new cases and weekly new cases in Sierra Leone had fallen to single digits (WHO, 2015b).

Numerous publications provide detailed timelines and analyses of the Ebola outbreak and response (MSF, 2015a; Plan, 2015; WHO, 2015c). The timeline here presents a concise depiction of key events and figures pertinent to the topics discussed in this report.

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3   Interview with Paramount Chief, Sierra Leone.

Timeline of the Ebola outbreak and response

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23 June 2014
Médecins Sans Frontières (MSF) says Ebola is 'out of control' and calls for massive resources

27 June 2014
The Global Outbreak Alert and Response Network (GOARN) steering committee calls for more forceful leadership by the World Health Organisation (WHO). WHO Director-General Dr. Margaret Chan takes over responsibility for the Ebola response

1 August 2014
A joint $100m response plan is launched by WHO and the governments of Sierra Leone, Guinea and Liberia

2 August 2014
American doctor contracts Ebola and is flown to the US for treatment

6 August 2014
Liberia declares a state of emergency; schools are closed and the worst affected areas quarantined

28 December 2013
Patient Zero dies of an unidentified haemorrhagic fever in Guinea

26 July 2014
WHO Director-General declares Ebola a Grade 3 emergency

21 March 2014
Laboratory tests confirm Ebola in Guinea and Ministry of Health declares the Ebola outbreak a day later

26 May 2014
Government of Sierra Leone officially declares an Ebola outbreak and the WHO sends teams to the country

14 March 2014
Guinea's Ministry of Health issues first alert

22 April 2014
By this date MSF has 350 staff working in Guinea and Liberia

Sources: MSF, 2014a; 2015a; 2015b; WHO, 2015b; BBC, 2014a; Reliefweb, 2015; Anderson and Oatis, 2014; Kennedy, 2014; O'Carroll, 2014; Bavier, 2015; Handley, 2015.

8 August 2014
WHO Director-General declares Ebola a Public Health Emergency of International Concern

16 September 2014
US government announces plan to deploy 3,000 medical and military personnel

8 September 2014
UK announces plan to send civilian and military personnel to Sierra Leone

19 September 2014
UN Mission for Ebola Emergency Response (UNMEER) is established

22 February 2015
Liberia lifts nationwide curfew and reopens borders and schools

26 September 2014
Cuban government announces plan to send 300 doctors and nurses to West Africa

26 February 2015
US military ends its mission to build Ebola treatment facilities in Liberia

31 October 2014
China announces plan to deploy 480 military health personnel to West Africa and construct a 100-bed treatment centre in Liberia

17 April 2015
Affected countries call for a 'Marshall Plan' of $8bn

9 December 2014
Doctors go on strike in Sierra Leone, demanding better pay and support

31 July 2015
UNMEER closes

September 2014

October 2014

November 2014

December 2014

January 2015

February 2015

March 2015

April 2015

May 2015
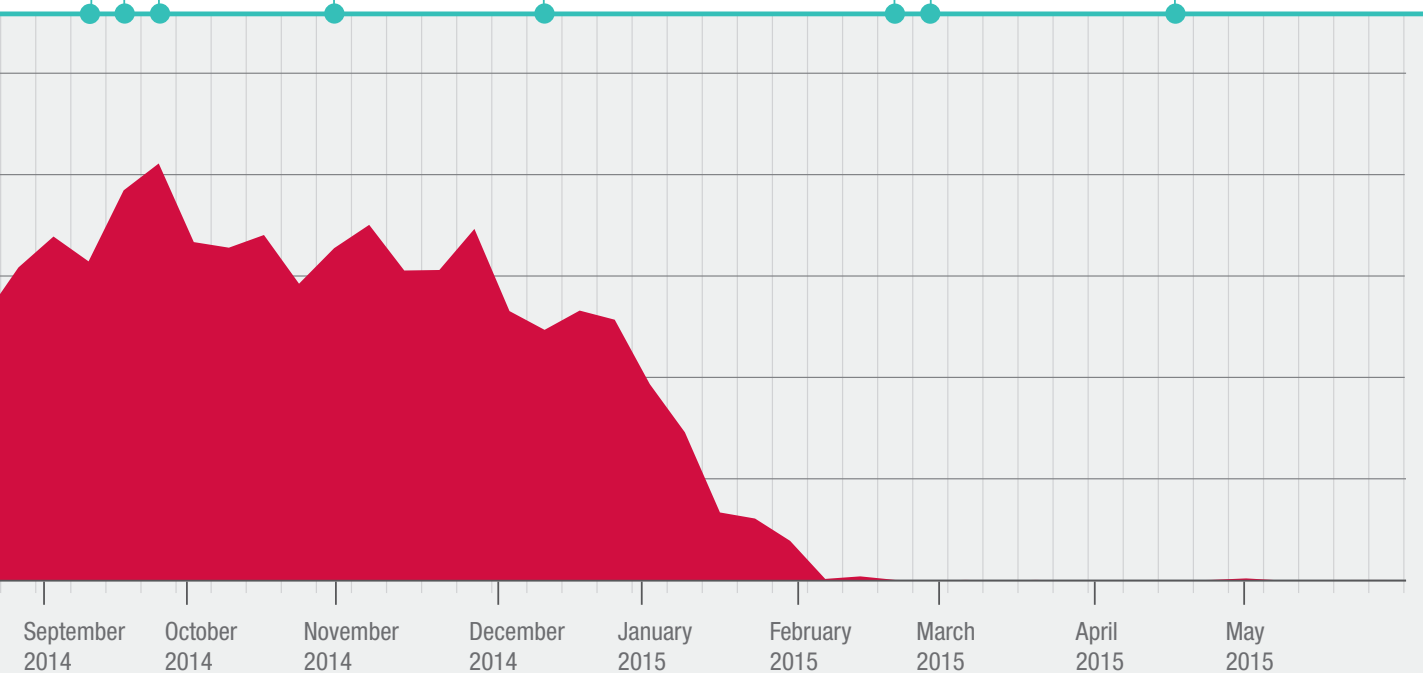
3 Health systems in Liberia, Sierra Leone and Guinea

I worked in the system before. Until 1997, the community surveillance system worked. There was a reporting system up to the local centre, and they all had a radio that could report on a weekly basis … But as the governance was not good, the levels of the community based system went down. So the levels of training went down. And the equipment deteriorated.[4]

This chapter discusses the state of the health systems[5] in Liberia, Sierra Leone and Guinea prior to the Ebola crisis. Many of the challenges discussed here – including poor infrastructure and shortages of health supplies and human resources for health – can be linked to the protracted and brutal civil wars in Sierra Leone and Liberia, which ended in 2002 and 2003 respectively. The conflicts disrupted disease control programmes and destroyed medical facilities; medical supplies were looted and health workers fled. In Sierra Leone the health system collapsed (Bertone et al., 2014), with only 16% of health centres still operational, most of them in Freetown (Gberie, 2005). By the end of the war in Liberia only 354 health facilities were operational, out of a pre-war total of 550 (Lee et al., 2011).

Since the end of the fighting both Liberia and Sierra Leone have enjoyed economic growth, relative stability and advances in social welfare. Despite these gains, health systems in all three countries were still among the weakest in the world (Kim and Rodin, 2014). As one Western diplomat in Liberia explained: 'The past decade was not so much about rebuilding, but of building, full stop.'[6] It would be unfair to be too harsh on these countries for being unable to deal with the epidemic as it first emerged in the eyes of the world

around the summer of 2014 – by then its extent might have challenged the health systems even of wealthy nations. The more useful question is what happened *before* Ebola got out of control. It is noteworthy that the outbreak was successfully contained in Mali, Nigeria and Senegal, while the Democratic Republic of Congo and Uganda have also recently halted outbreaks. In resource terms, it does not require a fully developed system to recognise an outbreak, sound the alarm and contain it.[7]

3.1 Key features of health systems in Liberia, Sierra Leone and Guinea

WHO identifies six building blocks of a health system (WHO, 2010):

1. Leadership and governance
2. Health workforce
3. Health information and data systems
4. Health financing
5. Essential medicines and supplies
6. Delivery of services.

There are significant deficiencies in all six of these areas in the three affected countries (Save the Children, 2015a). More specific research into the pre-Ebola health system in Sierra Leone found healthcare workers insufficient in quantity and quality, low levels of access to health facilities, weak communication and links between local, district and national levels of the health system and insufficient funding (Denney and Mallett, 2015a). Two specific areas of weakness contributed to the Ebola outbreak in Sierra Leone: poor infection prevention and control (IPC) measures and a palpable, widespread lack of confidence in the health system (*ibid.*).

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4   Interview with INGO doctor, Conakry, 24 April 2015.

5   A health system 'consists of all the organizations, institutions, resources and people whose primary purpose is to improve health' (WHO, 2010).

6   Interview with Ambassador Deborah R. Malac, Monrovia, 12 April 2015.

7   Interview with David Nabarro, UN Special Envoy for Ebola, Geneva, 24 February 2015.

Equally important, in terms of the Ebola outbreak, is the degree to which health care takes place outside formal government systems. All three countries have significant private health care, whether provided by government doctors or at corporate clinics funded by major corporations such as Rio Tinto (Guinea) and Firestone (Liberia). There are also active networks of health posts linked to faith-based institutions, and traditional healers, drug peddlers and birth attendants are common across all three countries. In Liberia in 2011, the reported ratio of traditional healers to the overall population was 1:500–1:1,000, compared with 1:125,000–175,000 for mainstream health professionals (Bills, 2011). In Sierra Leone in 2008 45% of women gave birth with the help of traditional birth attendants, a figure that rises to 77% in rural areas (DHS, 2008).

3.1.1 Levels and quality of health spending
Health spending loosely determines the number and quality of doctors, nurses, clinics, hospitals, medicines and supplies. Public and private health

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Ebola: citizens shoulder the burden of healthcare costs

Limited government expenditure on health care has contributed to inadequate public health services and a lack of trust in health systems.

Private

Government

Source: WHO, 2015d. Data for 2013.

Private health vs government expenditure

Guinea

| 64.2% | 35.8% |

Liberia

| 64.1% | 35.9% |

Sierra Leone

| 85.7% | 14.3% |

Ebola-affected countries have some of the lowest health spending in the world

Low government and private spending on health affects the number and quality of doctors, nurses, clinics, hospitals, medicines and supplies.

Source: World Bank, 2014. Data for 2013.

Total health expenditure per capita (USD)

Guinea
$24.80

Liberia
$44.40

Sierra Leone
$95.80

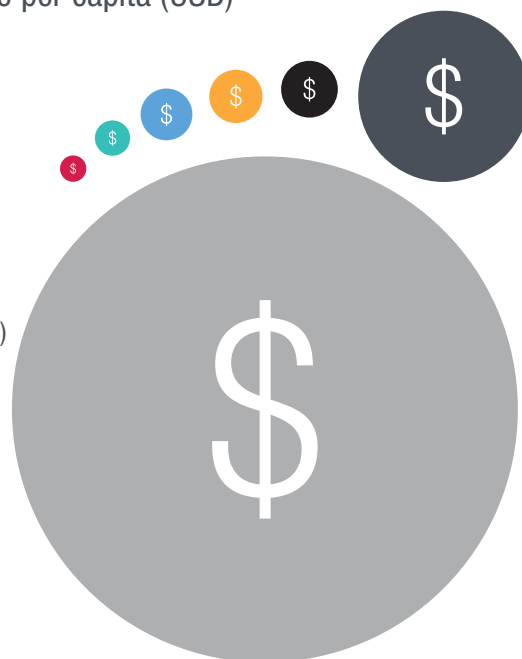**Sub-Saharan Africa** (avg)
$101.30

Nigeria
$115.00

World (avg)
$1,047.80

USA
$9,145.80

spending per capita in Liberia, Sierra Leone and Guinea, while increasing, is generally very low.[8] Although there has been a steady improvement over the past decade, government spending remains significantly below the WHO-recommended minimum of $86 per person required to provide the minimum package of essential health services (at $16 in Liberia, $14 in Sierra Leone and $9 in Guinea) (WHO, 2015c; WHO, 2015d).

Two interrelated factors seem particularly relevant to our understanding of the aid system and the Ebola outbreak. First, corruption figures prominently in all three countries, including in their health sectors (Transparency International, 2015). Prior to the Ebola crisis 48% and 40% of patients surveyed in Sierra Leone and Liberia respectively reported paying bribes to obtain health services. Transparency International asserts that 'health sectors in the countries affected and the humanitarian aid operations set up to tackle the disease were put at a terrible disadvantage in their efforts to combat Ebola because of corruption' (Transparency International, 2015). Second, health systems do not exist in a vacuum: they are highly dependent on the wider government financial structures, especially the financial apparatus. Frequent non-payment of salaries exacerbates human resource shortages and often leads to strikes. In Sierra Leone, low health worker salaries contributed to poor morale, strikes and demands for illicit payments (Amnesty International, 2009).

3.1.2 The healthcare workforce

We don't have enough health workers, doctors, nurses, drivers, and contact tracers to handle the increasing number of cases. Keiji Fukuda, Assistant Director-General for Global Health Security, WHO (WHO, 2014a).

WHO calls for a minimum of one health care worker (doctor, nurse or midwife) for every 439 people. According to the most recent data, Guinea, Liberia and Sierra Leone had (respectively) one health care worker per 1,597, 3,472 and 5,319 people (Save the Children, 2015a). Specialists were extremely

scarce (there were two paediatricians and zero anaesthesiologists in Liberia) and disproportionately concentrated in urban areas (Downie, 2012: 10). In Guinea, the capital Conakry had 15% of the population and 75% of health workers prior to the outbreak, while the Ebola epicentre of Guinea Forestière had 22% of the national population and only 9% of health workers (Garmer, 2015: 44).

Systemic issues undermine the ability of Sierra Leone, Liberia and Guinea to develop and maintain sufficient human resources for health, including conflict, 'brain drain' (over half of doctors born in Sierra Leone and Liberia now work in Organisation for Economic Co-operation and Development (OECD) countries (Sharples, 2015)) and low salaries. There is therefore a heavy reliance (especially in Liberia and Sierra Leone) on international partners (NGOs and faith-based organisations) to fortify the workforce, supplying personnel at the managerial level and training and paying for frontline workers. As noted, the local private sector also plays a major role in healthcare, as do traditional health practitioners.

3.1.3 Essential medicines and supplies

In the three affected countries, many years of underfunding have left the health systems critically short of the equipment [and] drugs needed to implement effective daily healthcare and infection control measures (Save the Children, 2015a).

In Guinea, severe shortages of basic medicines combined with the high cost of privately manufactured drugs led to the emergence of a black market in medicines (IRIN, 2009). In Sierra Leone in 2011 health facilities had on average only about 35% of the required essential drugs in stock (WHO, 2015f).

Shortages became acutely apparent during the Ebola outbreak, evident in the inadequate number of beds, personal protective equipment (PPE), disinfectant and basic medical supplies (Schnirring, 2014; Reuters, 2014). Logistical failures meant that supplies were at times not distributed to locations where they were needed. For example, in September 2014 there were 60,000 pairs of gloves in a central warehouse in Liberia, but no gloves were available in health centres (Save the Children, 2015a).

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8   Public and private health expenditure covers the provision of health services (preventive and curative), family planning activities, nutrition activities and emergency aid designated for health. It does not include water and sanitation.

Number of people per health centre

Liberia	Sierra Leone	Guinea	Ghana
88,496	79,365	24,096	10,320
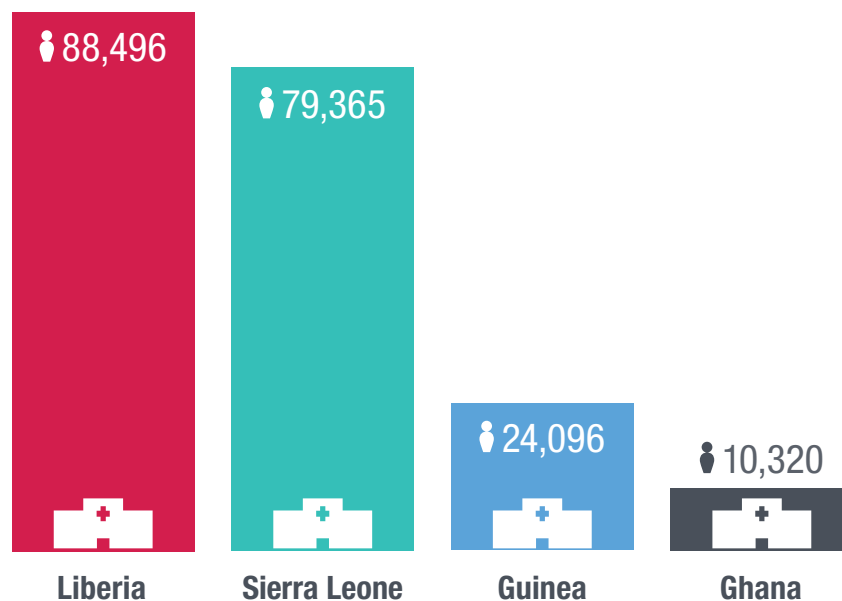
Source: WHO, 2015e. Data for 2013

3.1.4 Health information and data analysis

There was no real system at the level of the community. No alert system. Nothing that is activated.[9]

In 2005, prompted in part by the Severe Acute Respiratory Syndrome (SARS) outbreak in South-east Asia, 196 countries agreed to the International Health Regulations (IHR), whereby WHO works with governments to ensure the capacity to detect, report and respond to public health events (WHO, 2015g). A joint World Bank, African Development Bank and European Union (EU) report highlighted the poor pre-Ebola implementation of these regulations, noting that 'systems for early warning and response were inadequate, lacked necessary accountability and links with or support from national disaster management mechanisms and were not prepared to scale up response to this kind and scale of epidemic' (Garmer, 2015). There is consensus that the health information and disease surveillance systems of Guinea, Liberia and Sierra Leone were weak at best and non-existent at worst (WHO, 2014b; American Anthropological Association, 2014).

3.1.5 Health service delivery

Working health infrastructure is essential to service delivery. However, in all three countries, despite

initiatives to improve health infrastructure, hospitals, health centres and laboratories are few and far between, especially when compared to neighbouring countries, such as Ghana (Garmer, 2015; Save the Children, 2015a). Existing infrastructure is poor, with limited access to electricity and running water, even in many of the larger referral hospitals (Save the Children, 2015a); as one expert involved in the Ebola response in Guinea stated: 'They want us to put in place good infection control, and yet there is no running water in the hospital'.[10]

3.2 'Silos of success': progress towards the MDGs

Weaknesses in the health systems and services of Guinea, Liberia and Sierra Leone significantly hampered efforts to stem the spread of the outbreak. Yet it is also important to recognise that steps had been taken to reform and improve aspects of the health sector in these countries, and significant progress had been made towards meeting specific MDGs. For example, in 2010 Sierra Leone inaugurated the Free Health Care Initiative, making a package of basic health services free for pregnant

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9 Interview with NGO Director, Guinea, 23 April 2015.

10 Interview with Dr. Rana Hajjeh, CDC Ebola Response Team Leader, Conakry, 22 April 2015.

women, new mothers and children under five, as part of larger reforms designed to increase access to care and address corruption (Denney and Mallett, 2015a). By 2011 this initiative had contributed to a 61% reduction in maternal case fatality rates compared with the previous year, and a 214% increase in medical care for children under five (UNICEF, 2011). In Liberia, the National Health Policy (NHP), created in 2007, includes commitments to decentralisation, the suspension of user fees at primary and secondary level and increased health spending (Ministry of Health and Social Welfare, 2007). By 2009 the policy had yielded measurable results – for example, the number of working health facilities had significantly increased, with each facility serving on average 5,500 people, compared with 8,000 in 2006 (Lee et al., 2011).

Table 1: Childhood mortality (under-5 deaths per 1,000) (WHO, 2015m)

	1990	1995	2000	2005	2010	2013
Guinea	63	68	59	50	43	42
Liberia	23	20	21	15	11	10
Sierra Leone	46	41	40	41	35	34

Table 2: Maternal mortality ratio (per 100,000 live births) – Interagency estimates (WHO, 2015n)

	1990	1995	2000	2005	2010	2013
Guinea	1,100	1,000	950	800	690	650
Liberia	1,200	1,600	1,100	880	680	640
Sierra Leone	2,300	2,400	2,200	1,600	1,200	1,100

With regard to the MDGs in particular, significant improvements had been made on key morbidity and mortality indicators. For instance, child mortality (MDG 4) more than halved in Liberia between 1990 and 2013; in Guinea, maternal mortality (MDG 5) fell from 1,100 per 100,000 live births to 650, and from 2,300 to 1,100 in Sierra Leone (WHO, 2015h; 2015i). At the same time, however, target-oriented approaches pushed aid in the direction of vertical funding, narrow bands of attention and progress (such as the MDGs) and tangible impacts (such as building clinics or training staff), creating 'silos that overlook the broader needs of health systems, and bilateral and multilateral institutions have not made comprehensive health services their top priority' (Save the Children, 2015b). Parallel Overseas Development Institute (ODI) research looking at the 'dominant characteristics' of aid to Sierra Leone between the end of the war and the onset of the Ebola crisis (Denny and Mallett, 2015a) found:

1. A piecemeal, project-oriented approach to health sector rehabilitation and development, which privileged specific health problems (for instance related to the MDGs), and undermined the development of a more comprehensive approach.
2. A focus on the 'hard' dimensions of capacity-building, such as technical skills delivered through training and the provision of equipment, in the mistaken assumption of a straightforward relation-ship between knowledge and behavioural change.
3. A technocratic approach to capacity-building based on the simplistic assumption that deficits in the system exist because a 'certain input or condition is missing', which runs counter to current thinking on change in complex systems.
4. An emphasis on vertical programming, and hence limited support for reforming and strengthening the wider health system.

Research for this study supports these findings.

3.3 The impact of pre-Ebola health systems on the Ebola outbreak

The impact of the shortcomings discussed here on the ability of countries to respond to the Ebola outbreak was predictable and significant. Low numbers of health workers meant that many patients had to be turned away, forcing families to care for patients at home, putting them and their contacts at risk of infection (WHO, 2014a).[11] Longstanding issues around payment and employee satisfaction culminated at the height of the outbreak in December 2014 when doctors, nurses and support staff in Sierra Leone's third largest city went on strike, claiming that the government had not paid them the $45 a week hazard payment they were due (O'Carroll, 2014). Inadequate data centralisation and epidemiological expertise meant that data was not effectively analysed or shared (American Anthropological Association,

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11 Contrasting the three countries with Rwanda, which has 55,000 health care workers for a population of roughly 12m, World Bank President Jim Kim is unequivocal: 'If this had happened in Rwanda we would have had it under control' (Elliott, 2014).

2014), and significant time and resources had to be devoted to developing basic systems of data collection, sharing and analysis to inform key strategic decisions.[12] Laboratories in all three countries struggled to keep pace with the demand for case testing, resulting in delays in diagnosis and increasing the likelihood of transmission (Han, 2014). Hospitals and health centres were unable to cope with the increased demand for care, and 'suspected Ebola patients [were] isolated in shared rooms due to lack of infrastructure, further increasing the likelihood of infection' (Wurie, 2014).

The Ebola outbreak also raises questions about the success of projects specific to outbreak response: 'With full-scale simulation exercises and secured warehouses filled with disposable gloves and surgical masks, *preparedness* was the political rationale of the new century' (Lachenal, 2014a). Pre-Ebola aid investment in the resilience of affected countries included reportedly 'successful' measures towards the prevention and containment of infectious disease outbreaks.[13] For example, after cholera struck Sierra Leone in 2012 a comprehensive plan was put in place to integrate 'outbreaks of communicable disease of epidemic potential' into national risk reduction strategies. Attempts to employ the plan when Ebola struck were unsuccessful (Shepherd-Baron, 2015).

Above and beyond these systemic components, culture and practices within these health systems were profoundly important factors in determining performance. 'One of the reasons I knew it was bad is that the healthcare workers were getting sick,' explained MSF's former Head of Mission in Liberia, recalling her arrival in late June 2014. '[N]ot even the most basic IPC measures, like gloves, were in place in [major] hospitals like JFK hospital or Redemption.'[14] The importance of a well-resourced system goes beyond the utility of the supplies themselves. As a leading Liberian doctor who is actively involved in the Ebola response explains, over time the lack of gloves and water in health facilities gave rise to a culture and set of engrained practices that no longer reflected safe IPC.[15] WHO figures in late May showed that there were 881 Ebola cases and 512 fatalities among healthcare workers in the three countries (Economist, 2015). These deaths spanned the health workforce, from influential doctors to exhausted nurses manning distant outposts, and represent a preventable tragedy in and of themselves. They directly impaired the capacity of these countries to treat Ebola patients, and will leave an ominous gap for coming years. Indirectly, they increased distrust and avoidance of and resistance to health authorities out of concern that medical personnel were spreading the disease; they fanned fears of the disease ('if even the doctors are dying …'); and they drove medical personnel to fear and shun patients, thereby essentially denying medical care for non-Ebola ailments.

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12 Interview with Guinean INGO doctor, Conakry, 24 April 2015.

13 See for example Wustenschiff Forum (2014).

14 Interview with Lindis Hurum, Monrovia, 17 April 2015.

15 Interview with a leading Liberian doctor involved in the Ebola response, 15 April 2015.

4 Sounding the alarm

The response was 'criminally late', and thousands died because it was late.[16]

The failure of key international actors to raise the alarm and the failure of national and international actors to respond quickly enough in the early phase of the outbreak contributed to a 'criminally late' response and failure to control the outbreak before it spiralled out of control.

4.1 Early opportunities missed

When it first made international headlines in March 2014, the Ebola outbreak was described in two very different ways. On 31 March, MSF declared it 'unprecedented' (BBC, 2014b). The next day, in response, a WHO spokesman characterised it as 'relatively small' (WHO, 2015j). Though perhaps both factually correct, each represents the difference between an organisation designed to upset the status quo, and another designed not to ruffle feathers.

Judged by their actions and decisions, the states that govern and fund WHO did not value its capacity to mount an epidemic response. First, budget cuts had severely undermined WHO's implementation capacity and led to sharp reductions in its outbreak expertise and in its Africa crisis response team (Fink, 2014). Second, WHO funding was increasingly being earmarked by donors in line with their priorities; the proportion of earmarked funds rose from 50% in the 1990s to an estimated 77% by 2014–2015 (WHO, 2013). WHO's priorities shifted accordingly, with its legislative body repeatedly emphasising non-communicable diseases such as heart disease and cancer rather than infectious diseases (Sun et al., 2014a). As it admits, WHO was transformed from a global health leader to a service organisation whose proficiency lay in developing guidelines and providing technical advice (WHO, 2015k; Lee and Pang, 2014).

In addition to these capacity issues, the inherent tension between WHO's transnational remit and national

sovereignty blocked decisive action. Leaked emails and other reports show that WHO's Ebola expert in West Africa, Jean-Bosco Ndihokubwayo, recognised the severity of the outbreak: 'What we see is the tip of an iceberg', he wrote, adding, in capital letters, 'WE NEED SUPPORT' (Cheng and Satter, 2015a). Other emails show that WHO balked at the risk of angering the states involved. A memo sent on 10 June 2014 to WHO Director-General Dr. Margaret Chan stated that declaring an emergency – or convening a committee to discuss the issue – could be seen as a 'hostile act' by Ebola-affected countries (Cheng and Satter, 2015b). WHO denies that politics played a role (*ibid.*, 2015b), although the final report of the Ebola Interim Assessment Panel, the so-called Stocking Report released in July 2015, demonstrates and documents in detail how WHO, its member states and the politics of the global health system more generally created conditions conducive to the outbreak in the first place, and then failed to take action once its magnitude was known (WHO, 2015l). MSF's early appeals for help went largely unheeded, and most organisations continued to distance themselves from Ebola even after it became more evidently a crisis. Interviews for this study reveal that some INGOs already present in West Africa deferred to the technical expertise and designated authority of WHO. This deference seems to have played a particularly key role in ensuring the early silence of these agencies. Although UN Country Teams in Liberia, Sierra Leone and Guinea had strategies and contingency plans at the ready, they decided to wait and see what WHO and the governments concerned would do before acting on them.[17]

4.2 Ownership and responsibility

Some NGOs did not feel a responsibility to respond (early on) to Ebola because they were non-medical, or perhaps had some medical expertise but were unable to provide the level of clinical care Ebola demanded. However, as the epidemic progressed pressure to act grew, both from agencies' own staff and supporters and from outside sources, including

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donor governments.[18] These pressures collided with countervailing pressures to leave affected areas.[19] Many decided to stay: 'We cannot say that it is not our business. We have no specific mandate [for health], but when something like Ebola hits a country that we are working in, we cannot say that we do not respond'.[20]

The inadequate early response to the Ebola outbreak also highlights the lack of clear answers to difficult questions about who should have responded, in terms of the operational and leadership roles between and within organisations and agencies. In circular fashion uncertainty contributed to the slow uptake. As USAID's Disaster Assistance Response Team (DART) Team Leader noted: 'Who owns this crisis? I think this is like the debate we had years ago with IDPs … Whose crisis was this? If you can't answer that question in the beginning, you're getting off to a rocky start'.[21]

Beyond affected governments and WHO (which holds a specific mandate for addressing global health issues, such as this outbreak), who has the responsibility to respond, and what does that responsibility entail? The question applies to UN agencies, including the UN Country Teams on the ground in Guinea, Liberia and Sierra Leone, intergovernmental organisations (e.g. the African Union (AU)), NGOs and governments with the capacity to assist. It may also apply to actors in the private sector (e.g. pharmaceutical companies or mining firms working in one of the affected countries) or others with a contribution to make (e.g. universities with specialised tropical medical experience).

More broadly, ownership seems inseparable from obligation and from agencies' principled commitments. Yet obligation and commitment are undermined by the notion of charity – of generosity being governed by discretion. This tension has given rise to a substantial discussion of whether people in crisis have needs that can be addressed through charity, or whether these aid recipients are better seen as holding rights to assistance.

Human rights law arguably placed an obligation on other *states* to respond, given the special circumstances and the definitive inability of national authorities to protect their citizens' right to health. As Physicians for Human Rights puts it:

> *States that have the necessary capacity and funding are not responding to the specific needs with the urgency and resources required to bring this health crisis under control. International cooperation and assistance does not mean sending what you want, rather than what is needed. This is not about charity, it is about human rights* (Physicians for Human Rights, 2014).

In this case, Johnson Sirleaf's plea for international assistance should have triggered these human rights obligations. Consideration, let alone use, of the human rights framework at this level seems to have been largely overlooked, the entire issue now relegated to the more dominant discourse of aid/charity, in which nations exercise their benevolence rather than meet their obligations. This issue calls for further scrutiny.

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18 For example, Michael von Bertele, Save the Children's International Humanitarian Director, stated that the British government placed his agency under 'massive pressure' to build and manage an Ebola treatment unit in Sierra Leone (Boseley, 2014).

19 Interview with NGO Emergency Coordinator, Monrovia.

20 Interview with NGO Emergency Coordinator, Conakry.

21 Interview with Doug Mercado, Monrovia, 11 April 2015.

5 The mechanics of the response

In the beginning it was crazy. Bodies at the MSF ETU [Ebola treatment unit] and JFK. Every bed was full. Frustration was very high. People offloading bodies in the street.[22]

This chapter discusses specific challenges and blockages in the international response – including capacity, fear and risk and funding – to facilitate reflection and critique, both of the response and of the aid system more broadly. Perhaps the impact of the various delays can be better seen than explained, for instance in the visible gap between the number of beds and the number of people with Ebola (See 'Ebola reponse: out of sync with the outbreak', page 18). It is, however, equally important to recognise the many positive aspects of the Ebola response, and to acknowledge the considerable efforts made by the three governments affected.

Earlier recognition and action in the Ebola response would not necessarily have dramatically altered the outcome. Early recognition is an unqualified good step, but it isn't everything. The challenges faced by the Ebola response caused significant delays in translating recognition into action, and even with the substantial political will and funding brought by the major military deployments in the early autumn of 2014, sufficient help arrived only after the Ebola ship had sailed (Onishi, 2015).

Humanitarian agencies struggled on a number of fronts to translate energy and effort into relevant programme activities, both in content and scale. Coverage of the delays and obstacles is extensive (Save the Children, 2015a). Some issues speak to the more general situation at the time, such as the degree to which WHO was stretched, for instance with the emergence of polio in Syria and Middle East Respiratory Syndrome (MERS) in Saudi Arabia, and the pressure the humanitarian community was under in responding to large-scale crises elsewhere, in Syria, South Sudan, CAR and Iraq. Total requested funding to all emergencies in 2013 was a record $22bn (Grépin, 2015). Other issues reflect deeper shortcomings in the aid system, for instance to do with capacity, funding and organisational bureaucracy. Still others reflect the sheer challenge of confronting a situation without a tested formula for response, and in an atmosphere of fear unparalleled in a sector well-used to danger.

5.1 The international response: the good, the bad and the difficult

While the Ebola response has attracted much criticism for being late, expensive and beset by mistakes, it is important also to recognise its numerous successes. The early projections for the outbreak warned of a calamity of far greater magnitude, with the Centers for Disease Control and Prevention (CDC) projecting in September 2014 that, if trends continued without intervention or changes in community behaviour, cases in Liberia and Sierra Leone alone would top 550,000 by late January 2015 (1.4m if correcting for underreporting) (CDC, 2014). Clearly, a catastrophe was averted by a combination of international, national and community efforts.

More than 40 organisations and 58 foreign medical teams deployed an estimated 2,500 international personnel (1,300 foreign medical personnel) to over 60 specialised treatment centres in partnership with ministries of health and thousands of national staff (WHO, 2014–15). The international response included medical teams sent by China, Cuba, the AU, the UK and the US. Despite multiple dialects, appalling infrastructure and vast and difficult terrain, the intervention successfully created a web of networks that spanned nations, allowing information to be disseminated village by village. For example, through 76 partner organisations Mercy Corps in Liberia managed 830 public health trainers, who organised and trained 15,000 community educators, who equipped over 2m Liberians with lifesaving information about how to protect themselves and their families from Ebola (Mercy Corps, 2015).

Concerted efforts by national and international actors also led to a dramatic increase in the number of
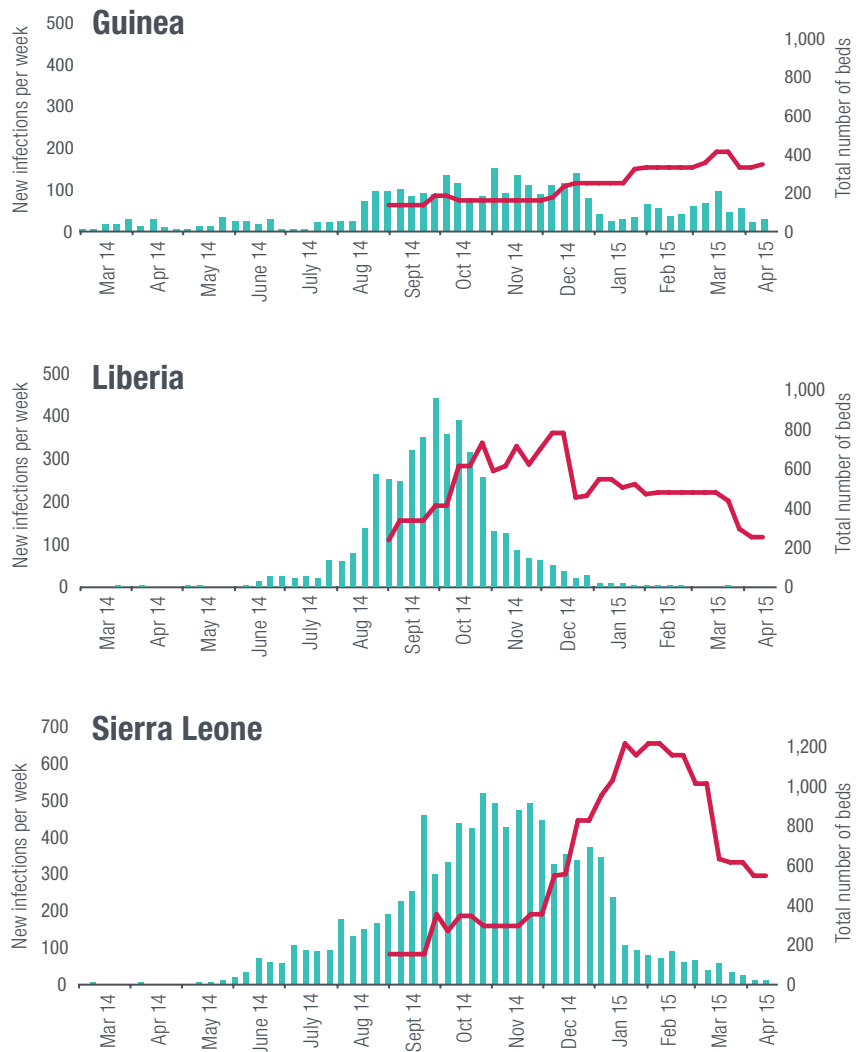
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22 Interview, INGO Emergency Coordinator, 12 April 2015.

Ebola response: out of sync with the outbreak

The Ebola outbreak had already begun to escalate in the summer of 2014, but the number of beds in treatment centres only picked up in the autumn of 2014.

━━ Confirmed new infections
━━ Beds

New cases of Ebola vs beds in treatment centres

Source: Global Ebola Response, 2015a.

isolation and treatment facilities in all three countries. By January 2015 Guinea had 250 treatment and isolation beds, concentrated in five ETUs; Liberia had 546 beds in 17 ETUs and six Community Care Centres (CCCs); and Sierra Leone had 1,046 beds in 19 ETUs and 26 CCCs. In addition, Sierra Leone had 49 isolation units with 998 operational beds (WHO, 2014–15). Healthcare personnel were trained in Ebola patient care and outbreak response, and volunteers received training in safe burials, sanitation and contact tracing. As of 10 October 2014 in Sierra Leone alone the UN Population Fund (UNFPA) had helped train 2,100 health workers as contact tracers and health supervisors (UNFPA, 2014). Organisationally, the outbreak pushed many agencies beyond their (niche) expertise and comfort zones, substantially expanding the scale and scope of experience residing in the aid sector.

5.1.1 Capacity

The Ebola outbreak overwhelmed the international epidemic bulwark as easily as it did the national systems which that bulwark was designed to support. First and foremost, there was a dearth of deployable clinical and epidemiological capacity, both nationally and within international UN agencies, NGOs and WHO: 'It was a fantasy, [Dr. Margaret Chan] argued, to think of the WHO as a first responder ready to lead the fight against deadly outbreaks around the world' (Fink, 2014).

MSF and a handful of smaller agencies, such as Samaritan's Purse, International Medical Corps (IMC) and Alliance for International Medical Action, took on a large share of the early response. Even major humanitarian organisations with significant health
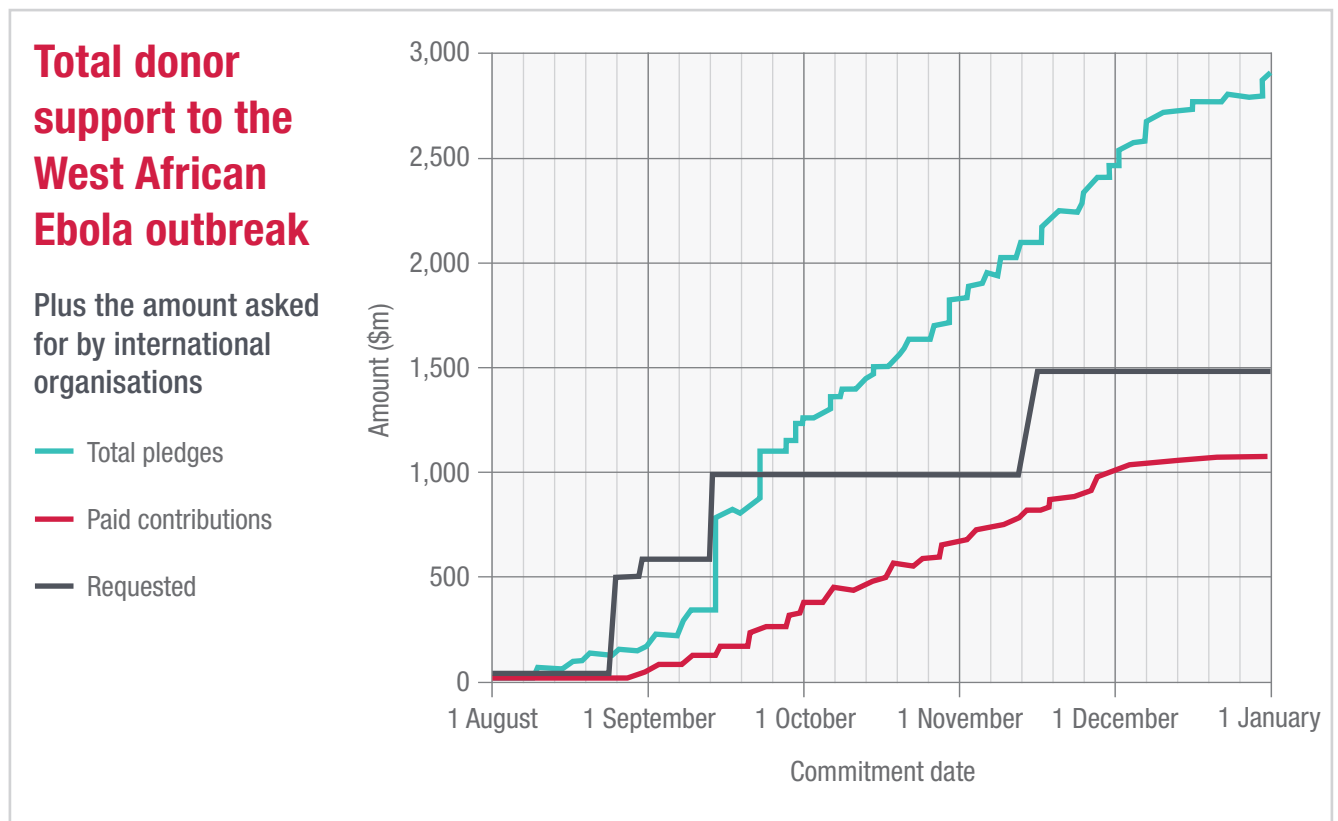
programming, such as the International Committee of the Red Cross (ICRC), Save the Children and CARE, did not possess the necessary specialist clinical capacity to react immediately to the crisis. As the UK government found, a 'capability gap currently exists in building and running specialist facilities necessary to deal with outbreaks' such as Ebola (House of Commons, 2015). According to the Department for International Development (DFID), this was 'due predominantly to the absence of organisations that had both the capabilities and willingness to deliver' (*ibid.*). Without experience in the necessary fields, organisations found themselves without sufficient staff or connections, a shortfall exacerbated by the necessity of short rotations for international staff working in the 'red zone' of patient treatment. In the Ebola response 'three weeks is the new two years', both in terms of length of deployment and burnout.[23]

5.1.2 Funding

Although the Central Emergency Response Fund (CERF) allocated more than $15m to UN agencies operating in the three Ebola-affected countries and in Nigeria between April and October 2014, funding

at this critical stage was too little and too late to match the scale and speed of Ebola. Estimates of need – one sign of the degree to which the outbreak was misjudged – rose rapidly: WHO figures jumped from $71m on 1 August to $490m on 28 August to $600m a week later, and by mid-September OCHA was estimating that the response would require $1bn. One year later, by contrast, the response had received a prodigious $3.75bn from a wide variety of donors, including governments, multilateral organisations, NGOs, foundations and the private sector (FTS, 2015a).[24] To put this in perspective, this is more than nine times the total amount of funding received for the appeal launched after the April 2015 Nepal earthquake, which killed over 8,500 people and made many more homeless (FTS, 2015b). Or, in terms of a local comparison, over 150% more than the $2.37bn annual government budget for the three countries combined (CIA, 2013).

Despite huge pledges by donors, payment was late or below expectations, or funds did not arrive at all, a point clearly illustrated by the figure below. According to OCHA figures, as of 15 July 2015 over $600m in

Total donor support to the West African Ebola outbreak

Plus the amount asked for by international organisations

— Total pledges

— Paid contributions

— Requested

Amount ($m)

Commitment date

pledges remained unpaid (FTS, 2015a).[25] Even after the Ebola outbreak was recognised as a direct threat to international security, it was two to three months before the funding began to flow. A UK government hearing criticised the 'time lag' between DFID recognising the need to act and actual disbursement (House of Commons, 2015).[26] Delays caused by the early lack of institutional funding were compounded by low public interest in the West, meaning that fundraising efforts on Ebola did poorly (Mohney, 2014).

It is a particular problem in outbreak response that slow-onset crises do not seem to attract public sympathy in the same way as sudden-onset disasters like earthquakes and hurricanes (Mohney, 2014). Aid agencies need to identify concrete steps to ensure that the aid industry is fit for the purpose of (non-mediatised) emergency response and intervention in the early stages of crisis. This includes financial reform. 'Emergency response requires rapidly disbursable and flexible (or un-earmarked) and needs-based funding to be effective and to respond to changing needs – but the current emergency financing mechanisms fail to provide this' (MSF, 2014a: 17).[27]

5.1.3 Fear, risk and duty of care

What blocked the International Community from deploying early and in large numbers? The biggest problem was the fear factor. Ebola as the equivalent of sure death.[28]

This is fear. In the Red Cross, there were experienced emergency specialists who were reluctant. If we can understand how scared the emergency [specialists] are, then imagine the people.[29]

Ebola reports and lessons learned written through the rational lens of hindsight fail to explain or, at the very least, acknowledge the complex role fear played in the epidemic, from individuals in affected communities to national and international NGOs and governments to critical industries such as airlines and insurance. Perhaps the most tangible impact of this fear for international aid agencies related to recruitment. Several times during this research key informants told us that they felt more at ease heading to Iraq, Somalia or Afghanistan than into West Africa – you can't 'catch' suicide bombers and give them to your family. International staff responding to the Ebola outbreak faced risks not only to themselves, but also potentially to their friends and families on their return home. The risks and fears of an individual were reflected within organisations, and then magnified by the duty of care to keep staff safe.[30] In terms of recruitment, this fear seems two-layered – the fear of Ebola itself, and the uncertainty of working beyond the boundaries of previous personal or organisational experience. Misfortune heightened these fears almost immediately when in July two doctors from Samaritan's Purse who had contracted the disease were evacuated to the United States.[31]

Nobody could provide a satisfactory answer to the simple question of what to do if a responder fell ill. The gravity of that question is expressed in the words of the UN Resident Coordinator in Liberia:

I am responsible for the security of 9,000 people, including all the peacekeepers. What kept me up at night: how would I deal with a symptomatic sick staff in Harper? There would be no way to get him or her here. We couldn't even transport a blood sample. Helicopter? Not accepted by our contractor. Road? Two days. No other ways. Duty of care of staff?[32]

Fear of Ebola created a situation where airline companies refused boarding to anyone with a fever (making it equally challenging to evacuate, for example, a severe case of malaria), and private air transport provided only a limited solution. Early on, MSF lobbied governments and the EU to ensure evacuation. Neither agreement nor money was a problem, but for

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25 Not all donors failed to fulfil their promises, and there are examples of good as well as bad performance: see FTS, 2015b.

26 Late, under- or non-payment is far from unique to Ebola. Oxfam estimates that, on average, donors give less than half of what they pledge to humanitarian responses (Deen, 2015).

27 Research by People in Aid concludes that emergencies require aid agencies to 'rapidly and effectively increase their resources – of people, money and materials – in the countries affected by an emergency. This ability to scale operations up … i.e., 'surge capacity' – is vital for fulfilling the humanitarian mandate' (Emmens, 2008).

28 Interview with Peter Jan Graaff, UNMEER Ebola Crisis Manager, Liberia, 11 April 2015.

29 Interview with INGO Head of Mission, Conakry, 21 April 2015.

30 Interview with INGO Coordinator, London, 11 February 2015.

31 Interview with Laurent Dufour, OCHA Team Leader, Liberia, 15 April 2015.

32 Interview with Antonio Vigilante, UN Deputy SRSG and UNDP Resident Coordinator, Monrovia, 17 April 2015.

several months no decision materialised, meaning no guarantee of a way out (Higgins, 2014). One significant circumvention of this problem came in the strategies of the US and UK governments to build treatment capacity in-country for health workers, at least ensuring a high standard of care. Although these facilities took time to build, the clinics in Kerrytown and Monrovia provided some reassurance to international and national health workers.[33] Another measure to reduce fear – and a key success of the intervention – was an extraordinary, express-track investment in training, led by the UK and US militaries and specialist organisations such as MSF, CDC and WHO.

Many barriers to humanitarian action lie beyond the control of humanitarian agencies themselves. Duty of care imposes limits, both positive and negative, on an employer. Working in crisis settings implies placing staff in situations of danger, which cannot be fully controlled through management. The decision to engage in West Africa led to lengthy discussions at headquarters regarding duty of care, where the urgency of the emergency collided with the necessity for NGOs to develop and then approve operating procedures governing their engagement. These time-consuming internal processes often went all the way to the board of directors.[34] As with med-evacuations, insurance companies balked at providing coverage for many agencies, or hiked premiums, placing another obstacle in the path of the response. One donor put it well: in an intervention of this breadth, it is the duty of governments, not NGOs, to find solutions to these problems, for example by agreeing to fund additional insurance costs or by acting as a guarantor in the case of emergency.[35]

5.2 The national response

I tell people all the time that despite our huge influx, this was the government's response plan. Yes, we had a say in it, and so did the UN, CDC and others. In the end of the day, it was their plan … Never the perfect plan, but it was their plan (Interview with Ambassador Deborah R. Malac, Monrovia, 12 April 2015).

The national responses of Sierra Leone, Liberia and Guinea were distinct in their structures and strategies. They evolved over time and reflected different national priorities and the different courses the outbreak took in each country. The three ministries of health chiefly responsible for the response were quickly overwhelmed by the size and complexity of the outbreak, and the need to marshal governmental resources beyond the reach of the ministry itself. Each country ultimately established a national task force or committee: the National Ebola Response Centre (NERC) in Sierra Leone, the National Incident Management System (IMS) in Liberia and the National Coordination Cell against Ebola (Cellule nationale de la coordination contre l'Ebola) in Guinea.

5.2.1 Sierra Leone
In Sierra Leone, an Emergency Operations Centre (EOC) under the purview of the Ministry of Health and Sanitation was established in July 2014 to respond to the Ebola outbreak (Global Ebola Response, 2015a). By October 2014 it had become increasingly clear that 'there was not enough logistical capacity within the Ministry to manage the response to the scale required' (AGI, 2015: 16) and the EOC was transformed into a separate structure, the NERC. The Minister of Defence and former military officer Alfred Palo Conteh was appointed Chief Executive of the NERC on special assignment, and its governing body was overseen by President Ernest Koroma (Government of Sierra Leone, 2014).

The NERC was staffed by both local and international civilian and military personnel. It operated as a command and control centre, developing national strategy and overseeing the response (including the pillars – case management, safe burial, etc. – of response and transition planning). District Ebola Response Centres were established towards the end of 2014 (USAID, 2014), decentralising the response while leaving national information management and coordination under the oversight of the NERC.

Sierra Leone tackled Ebola 'with the discipline and structure of a military operation' (AGI, 2015: 16), evident in national 'stay at home' days (referred to by some media outlets as 'lockdowns') (BBC, 2015), which required businesses to close and Sierra Leoneans to stay indoors. The stay-at-homes – intended to locate unidentified cases and educate citizens on Ebola

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33 Multiple interviews, Freetown, Monrovia and Conakry.

34 Interview, INGO representative, Freetown.

35 Interview, senior donor official, Monrovia, April 2015.

through door-to-door canvassing – passed without major incident, but were nevertheless controversial and were opposed by many donors and NGOs concerned that they could limit access to essential supplies and incite civil disorder (AGI, 2015).

5.2.2 Liberia

The trajectory of the outbreak in Liberia was marked by an early surge in the capital Monrovia in August 2014, followed by an early peak in late September – before the influx of international assistance – and a much earlier decline than in the other two countries. Many key informants believe that this is not mere chance – that the impact of the disease in Monrovia (over a quarter of the population live in the greater urban area) galvanised the Liberian government and people into action. A pre-existing Task Force within the Ministry of Health and Social Welfare reactivated in late March 2014, when the first diagnoses of Ebola were made, but the undeniable urgency of the situation forced changes that summer. President Johnson Sirleaf declared a state of emergency on 6 August, and on 10 August the Assistant Minister of Health and Social Welfare, Tolbert Nyenswah, was appointed head of the IMS. Structurally, the IMS is overseen by the Presidential Advisory Committee on Ebola and Restoration of Healthcare Services (PACE), which the president used to engage on issues with wider political or economic implications. Nyenswah can use PACE to escalate to the president matters that are outside the IMS's remit (AGI, 2015).

The Liberian authorities invited international experts to work directly within government structures, and absorbed advice and support from 'MSF and WHO initially, then US CDC and later UNMEER – it worked because we created a relationship rather than a bureaucracy' (Global Ebola Response, 2015a). The violence in Monrovia in August 2014 prompted the government to take a less authoritarian approach which favoured community engagement, and management of the response was decentralised to four offices in different parts of the Greater Monrovia Area to allow for locally tailored interventions (AGI, 2015). The Liberian coordinators for each of the four offices were supported by advisors from international organisations (AGI, 2015). Smaller, localised teams enabled a nimbler and more rapid response; instead of organising around purely administrative districts, teams were divided into 'zones' that reflected historical community identities and ties.

Box 1: Management skills

Assembling expertise in health or infectious diseases did not in itself generate an effective outbreak management system. Numerous key informants stated that early crisis meetings were, essentially, dysfunctional: overly long or short, they yielded more frustration than tangible output. That situation improved over time. In Liberia, several key informants credited direct managerial support to individual members of the government.[36] That support materialised partly by accident due to the pre-Ebola presence of a team of advisors from the Africa Governance Initiative (AGI). Acting as part management consultant and part chief of staff, AGI staff helped the government assume its leadership function by reforming the management infrastructure, including rationalising the flow of information from subcommittees to leaders, agenda control, creating structure/templates for reporting and implementing a dashboard of key information.[37] The apparent value of this support raises the question why every major humanitarian response does not have integrated management coaching capacity, working behind the scenes to help national governments.

5.2.3 Guinea

In Guinea, where the outbreak originated, the number of new confirmed cases never went beyond 200 per week, less than half the peak figures in Liberia and Sierra Leone, yet cases have remained steady, persistent and dispersed (various WHO, 2014–15). Although larger than its neighbours in both area and population, Guinea received far less international aid and never achieved the kind of capacity seen in Liberia or Sierra Leone (Touré, 2015).

Dr. Sakoba Keita from the Ministry of Health was appointed Ebola coordinator in April 2014. On 13 August President Alpha Condé declared a National Public Health Emergency, and on 4 September appointed Keita head of the newly established

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36 Interview with Peter Jan Graaff, UNMEER Ebola Crisis Manager, Liberia, 11 April 2015.

37 Interview with AGI Advisor to the government of Liberia, 13 April 2015.

National Coordination Cell. Despite pledges by political parties to depoliticise the issue (Global Ebola Response, 2015a), deep political divisions hampered the response, particularly in opposition areas where distrust of the central authorities remained high.[38] Guinea decentralised its response in March 2015, setting up eight Regional Alert and Response teams, with French support, to improve contact tracing and progress monitoring (Global Ebola Response, 2015a).

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38 Interview with Guinean NGO Director, Conakry, 23 April 2015. See also Touré, 2015.

However, in June the persistence of the outbreak prompted Condé to declare a 'reinforced health emergency' in parts of the country (Medical Care, 2015).

The fact that each of the affected countries had developed their own response structures and plans could have been used as a basis from which to build an international strategy. However, the initial framing and approach by the UN, and in particular by UNMEER and its architects, meant that much of the UN response was irrelevant before it got under way.

6 Strategy and coordination

Decisions around strategy and coordination were based heavily on whether the outbreak was framed as a health crisis or a humanitarian disaster. While the key decision-makers we interviewed generally recognised the Ebola outbreak as a health crisis with serious humanitarian implications, or as a health crisis that had spurred a humanitarian crisis, the international response apparatus chose to label it in a way that segmented the response. As the Ebola Interim Assessment Panel found, 'many donors, governments, the UN and INGOs understood only either the health emergency or the humanitarian system' (WHO, 2015l). This chapter considers how the conceptualisation of the outbreak affected national and international response and coordination mechanisms.

6.1 Ebola as a health crisis: implications for strategy

In the final quarter of 2014 the response to Ebola saw a haphazard escalation of involvement by aid actors. Major medical needs were being addressed by MSF essentially on its own, alongside a handful of smaller, less experienced agencies, while a combination of national authorities, UN Country Teams and WHO unsuccessfully attempted to strategise and plan for a larger response. The few who sensed the potential seriousness of the outbreak were told to bide their time. Once the virus spread to Liberia and Sierra Leone, all three UN Country Teams drafted country strategies and contingency plans, but decided to wait and see what WHO and the authorities would do before taking action. Such plans were scuppered as soon as the UN decided to set up its first-ever 'global health mission', UNMEER. Resident Coordinators were told by their boss, the United Nations Development Programme (UNDP) Administrator, to stand down while UNMEER took over.[39]

The decision to mobilise a 'peacekeeping-like' mission in the form of UNMEER, as opposed to activating the

humanitarian response apparatus, was borne out of an agreement among senior UN figures to protect WHO's interests and relationships in the affected countries by framing the outbreak more palatably as a health crisis – not a humanitarian crisis – and by letting WHO lead the response. When it became clear that WHO had neither the capacity nor the ability to manage a crisis of this scale, UN Secretary-General Ban Ki-Moon appointed his own special envoy and mobilised the UN's muscular Department of Field Support to assemble a staff- and logistics-heavy mission to orchestrate the response.

UNMEER's initial strategy was developed with the UN's special envoy for Ebola and WHO. Affected countries were notably absent from these discussions. The strategy was based on three pillars of action: immediate outbreak response; enhanced coordination and collaboration; and the mobilisation of increased human and financial resources. Its focus was simple: control the outbreak in areas of intensive transmission using an approach coined STEPP:

1. Stop the outbreak.
2. Treat the infected.
3. Ensure essential services.
4. Preserve stability.
5. Prevent further outbreaks.

This included specific targets and timelines, which called for 70% of patients isolated and receiving care and 70% safe and dignified burials within 60 days of the Mission being rolled out. In both Guinea and Liberia these were achieved on time: in Sierra Leone they were achieved before the year was out. 'Implementation of this 70-70-60 plan succeeded in "bending the curve" of the outbreak and reducing to less than one the number of other people infected by someone with Ebola' (Global Ebola Response, 2015a; also see Annex 1).

While elegant in its simplicity, the strategy belied a jumble of strategic plans reflecting the complexity and unprecedented nature of the outbreak, which, by the time of UNMEER's establishment, was showing many of the indicators of a full-blown humanitarian crisis: curfews/emergency measures, schools closed, health

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39 Interviews with UN staff in New York and Dakar, September 2015.

systems largely off-line (for non-Ebola treatment), substantial disruption to the economy, agriculture and livelihoods, protection problems and serious political instability (see, for instance, UN Security Council Resolution 2177 of 18 September 2014). What is clear from UNMEER's five objectives is that it was focused on stopping the spread of a virus, not on the much broader crisis triggered by the outbreak.

Framing the outbreak as a health crisis had significant implications for the overarching response strategy.[40] First, the response focused primarily on health services to end the Ebola outbreak, at the expense of treating other illnesses (ACAPS, 2015): as a 2015 UNICEF report puts it: 'the Ebola outbreak has severely impacted the treatment of measles, malaria and other diseases, as well as acute malnutrition and HIV and AIDS' (UNICEF, 2015). In Guinea, for example, between August 2013 and August 2014 'primary medical consultations dropped by 58 percent, hospitalisations by 54 percent, and vaccinations by 30 percent' (UNDP, 2014). Findings from a recent study on malaria in Guinea estimate that 74,000 cases did not receive care at public health facilities due to the outbreak, suggesting that 'excess malaria deaths are likely to greatly exceed the number of deaths from Ebola' (UNDP, 2014). In Liberia, the percentage of women giving birth with a skilled attendant fell from 56% between April and June 2014 to 28% between July and September (ACAPS, 2015). A study of Moyamba district in Sierra Leone concluded that, while there had been 210 cases (81 deaths) of Ebola in Moyamba, 'the public health emergency is not the Ebola outbreak in itself but the consequences of it', noting a diversion of resources from general health care and marked declines in health service utilisation (Doctors of the World, 2015).

Second, the initial and prevailing categorisation of Ebola as a health crisis meant that non-Ebola assistance and protection activities were not initially prioritised. Issues related to livelihoods, education and protection were identified relatively early in the outbreak, yet comprehensive and effective mechanisms to address them were lacking, particularly prior to the surge of support in October 2014. This was compounded by the fact that non-health actors – often those with experience addressing issues such as protection and food security in complex crises – were not engaged in their areas of expertise to the extent they might have been in a 'traditional' humanitarian response. The outbreak and response prompted a recalibration of roles and responsibilities, which meant that some NGOs that typically worked on protection did not do so, while NGOs not usually involved in protection were thrust into a lead role.[41]

Third, even within the framework of a public health crisis, a medical/clinical approach dominated the early response,[42] and the strategy heavily favoured the construction of ETUs and increasing bed capacity (IDS, 2015).[43] NGOs responding to the crisis reported that projects focused on community sensitisation or contact tracing were not being approved in the early months of the scale-up, with NGOs instructed to take on treatment responsibilities.[44] 'In September, in response to donor pressure from [the Office of US Foreign Disaster Assistance (OFDA) and DFID] for Oxfam to undertake a more medically-focused intervention, the value of water, sanitation and hygiene (WASH) and community work was promoted but with no success until much later' (Adams et al., 2015). With reference to DFID: 'If you wanted to do treatment, you were fast-tracked through the donor process, but not sensitization … Donors became dogmatic about the 70 70 60 approach. Issues such as orphans and lack of safe maternal services were sidelined'.[45] Or: 'To get the grant with OFDA, we needed to build CCCs, but we didn't want to build more [because we knew the outbreak was changing]'.[46] While there was, in

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40 More difficult to quantify was the degree to which the extraordinary and unknown nature of Ebola, and the fear it provoked, caused the crisis to loom disproportionately large in perceptions, and hence gave rise to a strategy that de-emphasised other potential areas of crisis.

41 Interview with INGO Emergency Field Coordinator, London, 11 February 2015.

42 'When the number of people with Ebola was increasing rapidly, the focus was on … building safe and staffed beds, safe burials, and [finding/training health care workers]' (Global Ebola Response, 2015a: 26). 'There was so much attention on beds even though people knew that there was a need to change transmission' (interview with donor official, Monrovia, April 2015).

43 'The reponse strategy heavily favoured the construction of ETUs and increasing bed capacity, and early in the outbreak response neglected the importance of community engagement and contact tracing as a means of containing spread of the outbreak.' Interview with Dr. David Heymann, Head of the Centre on Global Health Security, Chatham House, London, 31 March 2015.

44 Interviews with INGO executives.

45 Interview with INGO Coordinator, London.

46 Interview with INGO official, Monrovia, 16 April 2015.

many instances, a well-founded rationale for the initial priorities set by donors (for example, ETUs and CCCs were prioritised to fill the significant gap in treatment; CCCs were part of the national plan in Liberia, which donors supported), the concomitant de-prioritisation of community engagement retarded progress in combating Ebola.

One study in Sierra Leone found that 'the Ebola strategy was heavily driven by the number of beds, an indicator that prioritised military logistics, engineers and medical solutions' (IDS, 2015). Such logic works in reverse as well – the strategy was heavily driven by the identity of the decision-makers. The imperative is to examine the processes and mechanisms, rather than condemn the decisions. The aid system should anticipate (and, hence, counter) that treatment specialists will first and foremost see a world of patients requiring treatment. In West Africa, one weakness in the way strategy was established was the lack of other expertise and organisations engaged with the Ebola response in the early stages, and hence a lack of diversity at the decision-making table.

6.2 Ebola as a health crisis: implications for coordination

Not conceptualising Ebola as a 'humanitarian' crisis also meant that the leadership and coordination structures typical of a large-scale humanitarian response were not triggered, notably the formal humanitarian cluster system. Launched in 2006 as an antidote to the lack of capacity in the response to the Indian Ocean tsunami and the lack of consistent leadership in Darfur, the humanitarian cluster system is meant to pre-designate global and country-level leadership for specific areas of response; coordinate all available international, regional, national and local capacity and expertise; and, in the absence of such capacity and resources, guarantee some level of response through the concept of 'provider of last resort'. Likewise, the Transformative Agenda, adopted by the UN's Inter-Agency Standing Committee (IASC) in December 2011, was introduced to improve the humanitarian system's performance in handling a multi-dimensional crisis, in particular by fast-tracking leadership and coordination support in a large-scale crisis. Among its protocols is the activation of a system-wide Level 3 (L3) emergency, which triggers the fielding of dedicated senior crisis managers, the

deployment of surge staff through an inter-agency rapid response mechanism, an immediate allocation from the CERF and a series of assessment and planning exercises (IASC, 2012). It also prioritises country-level engagement and accountability, including to affected populations.

The early declaration of an L3 emergency in Ebola-affected countries and the early and consistent activation of the humanitarian cluster system across all three countries (the humanitarian clusters were activated in Liberia) could arguably have provided additional leadership support to the UN Country Teams, including through the designation of country-level and, potentially, a regional humanitarian coordinator; scaled up both medical and non-medical health functions (Shepherd-Barron, 2015); and focused on the wider needs and societal and economic impacts of the outbreak sooner and with greater technical expertise. The assessment, planning and data collection and analysis initiatives it would also have triggered may have released early and substantial funds, including additional allocations from the CERF, for both medical and non-medical aspects of the response. However maligned, both by the large UN agencies (for usurping their power and control) and by NGOs (for being too UN-heavy), the clusters would also have offered the familiarity and predictability necessary when operating in the chaos of a fast-moving response.[47] Without them, many non-health NGOs found it difficult to know when, how or where to engage. When humanitarian clusters were activated in Liberia in September 2014, they were able to mobilise as well as feed into the national coordination 'pillars', which covered issues such as surveillance, burials, contact tracing and community awareness. 'Though there wasn't a completely clean fit between the international and national coordination mechanisms, the response was tidier, more information flowed and everyone had a better sense of where they fit in', said a senior UN staff member working in the region.

UNMEER's status as a new entity/invention forced it to define itself in the midst of a full-blown emergency (also known as building the plane while flying it, a common theme across this response), where major

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47 In the absence of the formal cluster system in Sierra Leone, NGOs in effect recreated it, for example setting up the DFID-funded Social Mobilisation Action Consortium (SMAC), a separate NGO communications platform to liaise with the NERC in Sierra Leone. Interview, INGO SMAC representative, London, 11 February 2015.

response actors, from donors and governments to INGOs, had little knowledge of its purpose, objectives or how to work with it. As late as March and April 2015, key implementing NGOs had little understanding of UNMEER's role and functions.[48] In fact, it was only in September 2015 that MSF, an NGO central to the response, learned that UNMEER viewed its coordination function as extending only to the UN, not to NGOs.[49]

Taken together, one result of these various factors is that NGOs – the actual implementers – did not see a place for themselves at the coordination table, or a representative there. This created a rift between those responsible for coordination and strategy and those primarily responsible for implementation. It also left NGOs, in particular non-medical NGOs, directionless in terms of contributing to the response, including via local knowledge and community networks. As a WHO official explained, 'Many of the key NGOs were outside the tent and they had been on the ground for years and had networks in the community'.[50]

Since the combined architecture of the national coordination cells and UNMEER, particularly through the end of 2014, were designed with country-level epidemic response in mind, they were less geared to coordinating a response to a regional disaster. UNMEER staff were never able to work with their counterparts in other countries, and potentially benefit from their experience in real time. 'There was so much to be learned from the response in Liberia, which was ahead of us in terms of reducing the number of cases, but there were no opportunities to interact with our Liberia counterparts. It was as though nobody had even thought to do so. It was a real disappointment for someone used to the standard coordination architecture in humanitarian response.'[51]

Not designating Ebola a 'classic', multi-sectoral, large-scale humanitarian disaster also may have had a positive effect by reinforcing national leadership of the response within each country's borders, particularly in regard to community programmes, call centres and coordination. Many key informants singled out the Liberian government in particular for the manner in which it assumed leadership.[52] As discussed in the previous chapter, in each country a national body led the response, with support from the international community, a model quite distinct from the 'neo-colonial' humanitarian responses during the conflicts in Sierra Leone and Liberia during the 1990s. As national disaster management teams replace the dominant coordination structures of the aid community, it is possible that not having a seat at the table, and feeling somewhat lost as a result, may represent the future norm for international NGOs. International NGOs and national authorities alike will need to retool the cluster system or develop new platforms in order to ensure better coordination of effort between them. This trend goes beyond strengthened leadership at the national level: it also reinforces a useful precedent for international actors. As one UN official put it: 'The Americans came in with big numbers and big money and could have come in with a big attitude and they didn't'.[53]

Much more could be said about the strategic choices and coordination mechanisms that inhabited the top echelons of the Ebola response. Likewise, the interrelationship between the top and the bottom – an Ebola outbreak tearing through communities – merits further documentation. In most humanitarian crises, these upper echelons are charged with shaping a response to the damage, to the suffering and needs of people. Here, with an active biological agent as the cause of the crisis, strategy and coordination must respond to suffering by providing services that meet basic needs, *and at the same time* control the spread of the disease itself.

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48 Interview with former INGO Head of Mission, Guinea; interview with INGO Ebola Response Coordinator, Sierra Leone.

49 Personal communication with Dr. Joanne Liu, MSF President, 27 September 2015.

50 Interview with WHO Official, Geneva.

51 Interview with then UNMEER staff member, Sierra Leone, September 2015.

52 As affected countries progress towards 'zero cases', they will confront a challenge common to the transition from disaster response to recovery: integrating the members and many functions of these powerful and well-resourced bodies back into the government at large, and in particular into ministries of health.

53 Interview with Peter Jan Graaff, UNMEER Ebola Crisis Manager, Liberia. Monrovia, 11 April 2015.

7 Community engagement, culture and trust

The early stages of the outbreak and response were marred by problems with communication, community engagement and trust. The predominance of top-down communication in the early stage of the response reflects the way the Ebola response initially sidelined community engagement as a critical operational tool. Early Ebola messaging and response strategies were symptomatic of this, and too often failed to meet the needs and realities confronting affected populations.

7.1 Communication, sensitisation and messaging

While a plethora of communication tools were used to deliver Ebola-related messages – including newspapers, radio, billboards, drama, television, music and mobile phones (King, 2015) – our research reaffirms what other studies and news media have reported: particularly in the early stages of the intervention, much communication intended to fight Ebola in fact had the opposite effect. Some messages were inaccurate, while others created inaccurate perceptions. A good example concerns the consumption of bush meat. Properly cooked bush meat is not a threat and, while, zoonotic transmission may have been responsible for Patient Zero, the subsequent transmission to over 27,000 people was human to human. Beyond scaremongering and obfuscation, these early messages risked 'leading communities to believe that avoiding bush meat was more important than not touching dead bodies'. Overly negative messaging stimulated behaviour that favoured transmission. Messages such as 'Ebola kills', 'Ebola is incurable' and 'There is no vaccine' (Long, 2015) increased stigma, exacerbated treatment avoidance and steered people towards their families or traditional healers and away from distant treatment centres, from where return was not a prospect. As one Paramount Chief in Sierra Leone explained, 'People ran away from [health centres]

during Ebola because of messaging that the disease was incurable'.[54] Other messages bordered on the surreal: instructing people to isolate sick family members and call an ambulance sounds reasonable, except that only a fraction of the necessary ambulance or ETU capacity was available, and in some cases the sick died of starvation or malaria during home isolation.[55]

In some instances, the greatest defect in messaging was what was left unsaid.

> *Health sensitization efforts continue to emphasize the 'low-hanging fruit' of public health communications – What is Ebola? How is it spread? But community health messaging is essentially failing to provide the kinds of 'higher-order,' practical information and training that communities are desperate for – 'How do I manage a family of children, including infants and toddlers, in quarantine?' 'How do I transport someone to a hospital or clinic without promoting infection?'* (Abramowitz et al., 2015a).

Getting the message right does not mean it will be accepted. Compounding the mistakes in message content was the early failure to pay enough attention to the messenger. People listen to people they trust, which places a tactical emphasis on employing insiders (i.e. members of the community) rather than outsiders, especially outsiders accompanied by PPE-clad colleagues.[56] Only belatedly was there a recognition that 'trusted community leaders need to be front and centre in all phases of public health action' (Miliband and Piot, 2015).

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54 Interview with Paramount Chief, Freetown, 19 March 2015.

55 Interview, INGO Operational Director, London.

56 In some areas the disease itself proved to be the most effective messenger, its very visible lethality encouraging behavioural change in ways that the intervention had struggled to do.

7.2 Culture and community engagement

Social cultural context must take the lead in the any emergency. The social cultural context of the community has to take the lead. This has to be proactive, not reactive.[57]

Community engagement in the context of a health outbreak is essential to enable people to prevent themselves and others from catching Ebola; reduce fear, resistance to health authorities and stigmatisation; prevent transmission of the disease; develop safe, supportive practices of care for people who are ill or are at risk of infection; and develop safe and supportive burial practices. The early stages of the surge did not prioritise such engagement or capitalise on affected communities as a resource, but treated them more as a problem – a security risk, culture-bound, unscientific – to be overcome. One Sierra Leonean director from an INGO explained that 'as a social mobilizer and community worker, nobody listened to me, in fact if they draw up an agenda, I would be on the AOB'.[58]

Why was this? There is some concern that people, in particular rural people, were stereotyped as irrational, fearful, violent and primitive; too ignorant to change; victims of their own culture, in need of saving by outsiders (Jones, 2015). Though also due to budgetary, time and resource constraints, 'some of the current Ebola responses reflect problematic assumptions about local ignorance and capability' (IDS, 2015). They also reflect a false attribution to culture of problems that stem from the response itself: 'much of the community resistance is not related to indigenous traditions … but basic issues like people seeing family members taken away and never getting news about where they end up or how they are doing' (Lydersen, 2014).

In the late summer and early autumn of 2014, Ebola was not a story, it was *the* story. Even Islamic State could not compete. And with that story, another chapter was written about a 'dark continent', rife with famine, fantastical diseases, bushmeat cuisine

and roiling militia pillaging.[59] A good number of articles intelligently, and often angrily, critiqued this stereotype (Adesioye, 2014). The stereotype, though, is a controlling one:

Ebola has been exoticized, associated with 'traditional' practices, local customs, and cultural 'beliefs' and insinuated to be the result of African ignorance and backwardness. Indeed, reified culture is reconfigured into a 'risk-factor.' Accounts of the disease paint African culture as an obstacle to prevention and epidemic control efforts (Jones, 2015).

Research demonstrates the consequences: the international response 'views' local culture as an impediment and deploys a biomedical solution which 'places responsibility for disease transmission on individuals who are expected to reject "negative" behaviours such as communal eating or burial traditions, while failing to provide sufficient resources to those same individuals to enable their "appropriate" management of the disease' (Waldman and Mills, 2015).

Research also shows that these stereotypes feed paternalism, and a view that Africans lack agency and hence are unable to help themselves and require foreign assistance (Baker, 2015). This dovetails with a self-perception of charity-humanitarian action as saviour/solution, with beneficiaries as helpless victims – reinforced in turn by a media focus on the 'international response to Ebola' even though '99% of those fighting in the field are Sierra Leoneans' (Simons, 2014). The apparent result is a predisposition in the aid system towards control and an inflated sense of its own importance, rather than responses and strategies that engage with and rely on communities, and demand action from them. Anthropologists involved in previous Ebola epidemics, and in Guinea, Liberia and Sierra Leone during this outbreak, have documented how productive it is to take local perspectives on board (Abramowitz et al., 2015a).

Traditions are rarely inflexible; social learning and mutually acceptable solutions can be identified through collaboration between response teams and those with deep knowledge of the context (Abramowitz et al., 2015b; see also Richards et al., 2015). Some of the success stories from the Ebola response stem from precisely this kind of integrated approach between NGOs or national authorities

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57 Interview with leading Liberian doctor involved in the Ebola response, 15 April 2015.

58 Interview with INGO Country Director, Sierra Leone.

59 Interesting analysis points to the way the bush meat storyline reinforces racial stereotypes of a 'Dark Continent' (Seay and Yi Dionne, 2014).

and communities. In January 2015, Pujehun became the first Ebola-free district in Sierra Leone – an achievement attributed to a proactive district-led strategy, rather than decisive central government intervention (Hitchen, 2015). Community engagement in Lofa County, Liberia, was similarly successful (IRC, 2015: 2). These examples also mask a more important lesson: the call for community engagement in 'our' response reinforces the perception of a dependence on external intervention. In fact, research in urban Liberia demonstrated that delays and gaps in the Ebola intervention pushed communities to take action: 'In the absence of health, infrastructural and material supports, local people engaged in self-reliance in order to contain the epidemic at the micro-social level' (Abramowitz et al., 2015a).

There is no aspect of the Ebola response more evocative of the troubling gap – and the powerful potential – of culturally-sensitive community engagement than the issue of safe burials. Traditional burial practices involve a number of people touching and washing the corpse, and thus play a key role in virus transmission. WHO's vaunted 70-70-60 strategy for containing Ebola codifies the preeminent strategic importance of safe burial. A great body of news, research and opinion attests to the clash of cultures, from the recalcitrance of secret burials (Garrett, 2014a) to the way seemingly bland details (to the foreign eye) were actually freighted with symbolic value, such as the local importance attached to the colour of body bags.[60] As one key informant explained:

> *When it started it was again top down medical. You have the burial suits, the bags, and they first came in black – to our culture you put somebody in a black bag it is like you are poor, you are just somebody who dies in the street and they bag you up, people don't count you as an important person in society and you die miserably. So that's something cultural in Sierra Leone, and they [the burial teams] changed, then they learned that and they started using white body bags.*[61]

Traditional burials have little to do with tradition, as if they constituted a quaint ritual, exercised for the sake of tradition, like candles on a birthday cake. Traditional burials have everything to do with the

security and protection of the living, of the family. Rituals have been established to ensure the spiritual well-being of the family, for whom improperly buried ancestors pose compelling risks, and are crucial to the maintenance of extended families and hence access to farmland (Richards et al., 2015). At best, then, we must understand the West's scientifically-evidenced burial edicts as a paradigmatic example of 'inappropriate technology'.

The early instructions on so-called safe burial – rigid and unworkable – were, *in that context*, a textbook manual for unsafe burial that then had to be overcome by working with local religious and community leaders. The strictures of bio-medically safe burial jeopardised the lives and well-being of people in (at least) equal measure to the risks posed by picking up the virus. 'The washing, touching, and kissing of these bodies … can be deadly. But prohibiting communities from properly honouring their dead ones – and thereby worsening their distrust in medical professionals – can be deadly too' (Haglage, 2014).

This issue of 'culture' struck two underlying nerves in the Ebola response. First, the inappropriateness of applying a label of 'culture' to what more accurately involves a sharp inequality of power between the international aid community and the recipients of aid, who find themselves in crisis because of other types of inequitable power relationships in the first place. Second, the issue is not that the humanitarian community has a culture. The issue is that, within the humanitarian community's perception and analysis of crisis response, the visibility of 'their' culture contrasts with the invisibility of its own. Blindness to this reality gives rise to the hierarchical juxtaposition of its 'truth' versus their 'culture', resulting in a failure to take proper account of cultural differences and surprise when supposedly 'neutral' biomedical edicts generate resistance.

7.3 Trust

The Ebola outbreak could be described as an epidemic of mistrust: the flame of a virus hitting the tinder of suspicion. As one well-placed expatriate said: 'It shocked me that there was so much denial and resistance'.[62] Over the course of the Ebola response, the UN, NGOs and international media reported security incidents or other forms of refusal

60 White, not black, is the colour of mourning (Sun, 2014b).

61 Interview with Sierra Leonean INGO Country Director, Freetown.

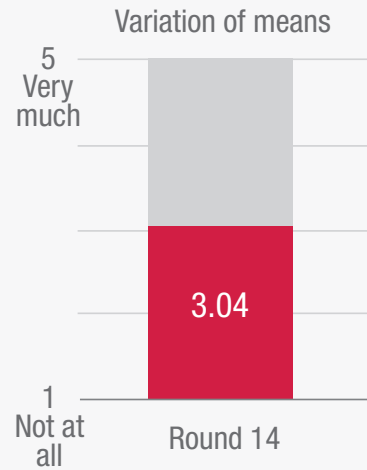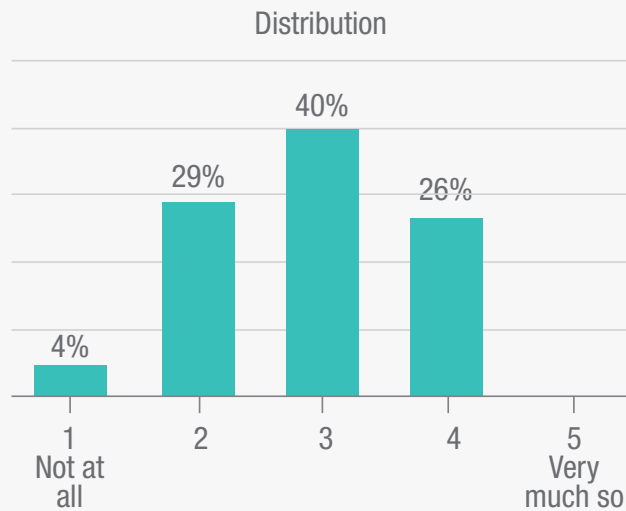62 Interview with INGO Coordinator, Monrovia 15 April 2015.

Perceptions

Data gathered by Ground Truth in Sierra Leone provides important insights into the perceptions of populations affected by Ebola and those involved in the response. The systemic weaknesses discussed in this chapter are reflected in the lack of faith frontline workers and citizens had in the health care system.
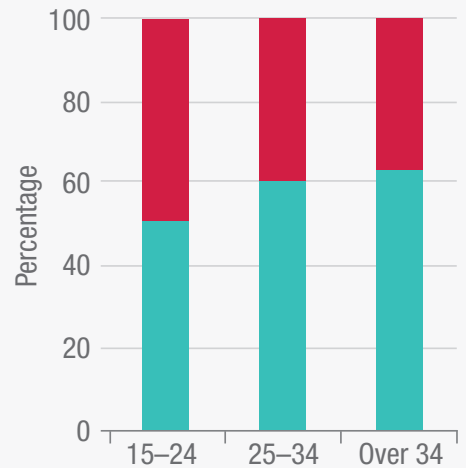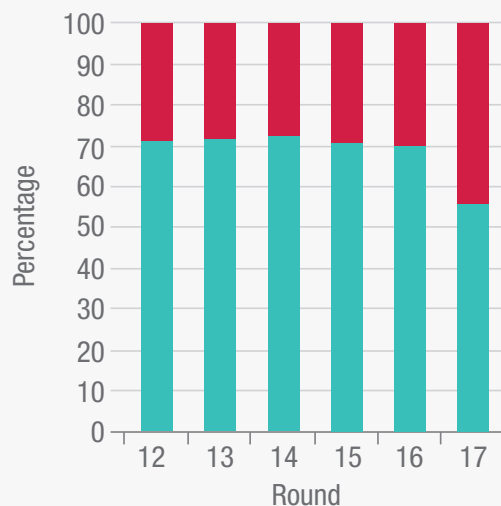
Frontline workers

Question 4:
Do citizens have faith in health systems?

Distribution

- 1 Not at all: 4%
- 2: 29%
- 3: 40%
- 4: 26%
- 5 Very much so

Variation of means

5 Very much

3.04

1 Not at all

Round 14

Citizens

Question 2:
Are people scared to visit health facilities for non-Ebola illnesses?

No 44% Yes 56%

Round 7

Male

Female

0%   50%   100%

Percentage (Round 12–17)

Percentage (15–24, 25–34, Over 34)
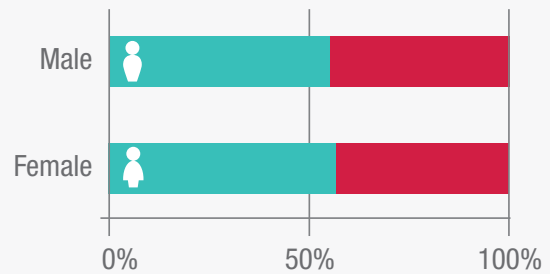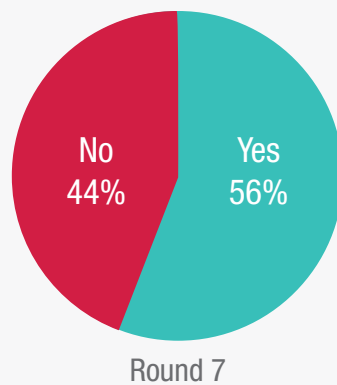
to cooperate. According to the Aid Worker Security Database (2015), at least three-quarters of attacks on aid workers in Guinea in 2014–2015 were associated with community resistance to the Ebola response. In one of the worst incidents, in September 2014, eight members of a community outreach team were attacked and killed in a remote area of Guinea (BBC, 2014b).

Such distrust – of national authorities, foreigners, strangers and the 'rational' bio-medical discourse of hygiene and safety advice – has been widely recognised and discussed in the context of the outbreak and response, but it should not obscure the effects of distrust moving in other directions, including within and between international and national actors, communities and individuals. This is evident in the way MSF's initial alarm regarding the outbreak was so easily dismissed as exaggeration, as one more INGO in the hunt for easy publicity. The use of armed force and quarantine measures, or the failure to consult with communities, are other manifestations of this distrust. Rather than the focus on episodes of violent resistance, a more telling indicator of popular distrust can be found in Liberia's 'Ebola is Real' campaign, in the necessity of having to convince people that Ebola was not a government scam or corrupt aid ploy. Alarm bells should ring whenever that is the requisite first step in outbreak control; in major aid recipient countries such as Liberia and Sierra Leone, the international community should not so easily dismiss these perceptions as a product of government corruption alone.

> *Popular suspicion of the motives of foreign organisations and government is rooted in a long history of slavery, civil war, extraction and more recently, commercial and non-commercial foreign development efforts often diverted into the pockets of government and non-governmental organisation (NGO) officials* (IDS, 2015).

As the International Rescue Committee (IRC) puts it in its lessons learned analysis of the Ebola outbreak, shortcomings in the response compounded 'a fundamental lack of trust between responders and the communities they were trying to assist. People … suspected darker, hidden motives behind the public health messages' (IRC, 2015). Although essentially correct in this point, IRC stops short of drawing larger conclusions. First, though distrust certainly compounded problems in the intervention, we must also understand how the intervention itself

generated and enflamed that distrust. Second, while IRC recognises that trust must be a prerequisite rather than an afterthought (IRC, 2015), it does not question why trust constituted an afterthought in the first place. After all, distrust and fear have always played a disruptive role in responses to Ebola and other haemorrhagic fevers.

7.4 The gold standard

The science is and was clear: 'aid workers fighting against Marburg … had one, clear priority in mind: to contain the epidemic and save lives *by isolating contagious persons and bodies as fast as possible'* (MSF, 2008; emphasis added).[63] Even if, unlike Marburg, there was no protocol for dealing with an Ebola outbreak of this scale, science tells us much about what works best: chlorine solution kills the virus more effectively than soap; avoid all physical contact with sick individuals, etc. These represent the gold standard. The question is whether the gold standard was the best approach in the specific context of the West African outbreak, or whether the perfect became the enemy of the good.

In the case of chlorine, how should issues of familiarity, ease of use, availability and acceptance be factored into decision-making? One key informant in Guinea spoke of the overemphasis on chlorine as opposed to soap, noting that, while everyone had soap, chlorine was distributed – and when it ran out people often stopped using anything at all.[64] Given the widespread use and availability of soap, the ease of explanation and lower costs, in the reality of rural West Africa soap would arguably have proven more effective.[65]

This question requires expertise and research to answer, as do its many correlates. Would major efforts at community sensitisation *prior* to isolation and treatment or corpse removal deliver long-run benefits in a large outbreak, even if these efforts slowed the response in the early stages? Or, given the scale of the outbreak and the vastly insufficient treatment facilities,

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63 One can ask whether that urgency actually worked against control and containment. Journalist Jeffrey Stern concluded that foreign treatment and sensitisation teams 'had come so fast that they had actually out-run their own messaging' (Stern, 2014).

64 Interview with INGO Coordinator, Conakry, 24 April 2015.

65 Interview with Professor René Migliani, Conakry, 21 April 2015.

should decreasing transmission through behavioural change (rather than through case isolation) have played a dominant role? 'We made a big mistake', declared Claudia Evers, MSF's Emergency Coordinator in Guinea: 'Instead of asking for more beds we should have been asking for more sensitization activities' (Hussain, 2015).

Beyond the need to evaluate what works best in any given context, it is necessary to understand the degree to which the culture and architecture of the intervention help determine the strategic and tactical choices made. One risk is that gold standards act as a form of risk transfer or a tacit shifting of the blame ('we told them what to do and they didn't do it'). A culture of risk-aversion may also play a role. Gold standards are always defendable as such; to deviate from them in order to improve cultural effectiveness – a choice, in rural development terms, for 'appropriate technology' over the best technology – attaches risk to the decision-maker, for example the risk of a family falling sick because soap did not work well (as opposed to the externalised risk that the village sprayer will not use the chlorine properly).[66]

At the interface between NGOs and individuals, we need to unpack the role of the specialist/expert – establishing the gold standard involves an exercise of power. As Dr. Sakoba Keita, the head of the Ebola response in Guinea, concludes:

> *We have not taken sufficient account of community involvement in the crisis, especially in the aspect of compliance with customs. This disease interferes with some of our customs, such as burial rites, group meals, etc. It was therefore necessary to have community participation. At first it was too* professional *and actions were misinterpreted and led to violence … If we had done that since the beginning, we would have taken much less time to make an impact.* (Global Ebola Response, 2015b; emphasis added).

7.5 Lessons not learned

Ebola exposed the dangers of not getting it right when it came to engagement with the local community: into an atmosphere of intense distrust and fear, early efforts inserted news of an incurable killer disease, using foreigners (international and national) to tell remote villages about Ebola without telling them what they could do about it, and PPE-clad teams removing villagers who were never seen again. The resulting amplification of distrust, fear and resistance all boosted rather than reduced transmission. In terms of understanding the socio-cultural context, one Liberian medical leader stated that 'we essentially become a vector because they are going to run and hide and amplify the transmission'.[67] At the very least, the lack of 'culturally appropriate messaging' missed the opportunity to encourage communities to adopt effective anti-transmission behaviours (Episcopal Relief and Development, 2014).

The difficulty lies in understanding why agencies acted as they did in West Africa despite well-established humanitarian best practice, well-established communications best practice and well-established lessons from previous outbreaks of haemorrhagic fever. MSF's own experience reveals the clarity surrounding these lessons, for example in its evaluation of a 2005 response to Marburg's disease in northern Angola (MSF, 2005). There, Dr. Armand Sprecher, who played a key role in the current Ebola response, concluded 'I think that one of the most crucial, yet most neglected, elements is communication and sensitization. If you don't do that right, everything else falls apart' (MSF, 2005). Scientific evidence distilled from the Ugandan Ebola experience provided field-tested lessons for working with the community to overcome fear and stigma (CORDS, 2014). Ample knowledge and experience, but to what end?

The simple lesson is that we know many of the lessons. Bad practices have been critiqued at the highest level, and better practices have already been articulated.[68]

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66 The debate over CCCs reflects this 'perfect versus good' dichotomy and the issue of cultural sensitivity. Certainly less robust in terms of care and infection control, and therefore risky in the eyes of biomedicine, how much weight needs to be given to the fact that communities trusted them, and often did not want their loved ones shipped off to a distant ETU? Note here that the location of 'blame' shifts, from a CCC with high mortality rates to villagers who have hidden their sick.

67 Interview with a leading Liberian doctor involved in the Ebola response, Monrovia, 15 April 2015.

68 See, for example, the IASC evaluation of the response to the Haiti earthquake, which noted that 'The international humanitarian community … did not adequately engage with national organizations, civil society, and local authorities. These critically-important partners were therefore not included in strategizing on the response operation, and international actors could not benefit from their extensive capacities, local knowledge, and cultural understanding' (IASC, 2010).

An imperative follows: examine more critically how and why the messages and methods went so awry in the early months of the outbreak. Such inquiry is not a witchhunt for who made the mistakes. Rather, it should examine the *process* by which messages were developed, and the process by which certain agencies became responsible for communications.[69]

69 And it raises the issue of accountability. What have been the consequences for some of the mistakes made? If (aside from WHO) consequences remain unidentified, what does that tell us about the culture and practice of the aid system? It suggests that, in the mindset of charity, good intentions offset the fact that such errors occurred *again*.

For example, the 'media working group' in Monrovia included no representatives from the Liberian media (Campbell, 2015). Further, 'international agencies claimed to be "partnering" with local media while using them mainly as paid platforms to disseminate messages' (Campbell, 2015). But that imperative is not enough, for it ignores the recalcitrance of the aid system in absorbing its own lessons, and its consistent performance in terms of community engagement. In that light, these problems sound very little like issues of technical competence and poor decision-making, and very much like issues of power and culture within the international aid system.

8 Politicisation and securitisation

Humanitarianism, not just war, has now become the continuation of politics by other means (Rieff, 2011: 254).

The inaction that characterised the early stages of the Ebola outbreak exposed a lack of overall responsibility. This was well-summarised by MSF International President Dr. Joanne Liu: 'For months, ill-equipped national health authorities and volunteers from a few private aid organisations bore the brunt of care in this epidemic. There is something profoundly wrong with that' (MSF, 2014b: 21). We accept the spirit of Dr. Liu's declaration that Ebola revealed something 'profoundly wrong' with the system. At the same time, we reject the implication that the humanitarian system simply malfunctioned. While the humanitarian system both succeeded and failed in many ways to deliver on its lofty objectives, it behaved as it has repeatedly behaved because it behaved as it is structured to behave. Ebola thus returns us to the criticism that the humanitarian system 'lacks both the capacity and the agility to meet the multiple demands that have been placed upon it … while often being hamstrung by external political forces' (ALNAP, 2015a: 10; WHS, 2014).

8.1 The drivers: money, power and politics

8.1.1 The accountability deficit
Money and political power reside at the top of the humanitarian aid architecture. At the global level, largely, that means OECD governments and the publics they represent.[70] At the local level a similar monopoly of money and power resides in the 'cartel' of UN agencies and Western organisations.[71] In the Ebola outbreak, the largesse of these donors, and the power

that key donors held over many of 'their' NGOs, eventually led to a multi-billion-dollar intervention that has stopped Ebola's geographic spread and brought the outbreak under control. That praise should be tempered, though, as the power of that same money was previously used to weaken WHO's outbreak response capacity, and its early absence blocked a timely response to the outbreak.

The top-down nature of the aid system compels implementing agencies to look up, turning their backs on people and needs on the ground. As ALNAP concludes, '[o]ne of the main problems in the humanitarian sector today is that there are no consequences for operational agencies when they fail to meet the expectations of other actors (except for donors) and, hence, no "real" accountability between aid agencies and many of their stakeholders' (ALNAP, 2015b). Efforts to improve accountability produce an enormous investment in policy but little improvement in practice. As ALNAP (2015a) has found, 'rhetoric for accountability and for shifting power to affected people is strong in the sector' but the practice 'continues to lag behind' because 'actors outside the traditional power structures of the humanitarian system have little real influence over humanitarian financing and programming' (ALNAP, 2015a).

Donors themselves appear to understand this: 'Today's humanitarian system is arranged around supply … Therefore, the natural tendency as played out in current response plans is to think in terms of what goods and services can be supplied, rather than what would actually empower people to cope more effectively with current and future shocks and what they actually want' (Scott, 2014: 16–17). The system attempts to overcome this by generating a succession of improved mechanisms/procedures/ guidelines, for example to better assess needs, improve accountability or enlist the participation of local people; build a proper water system; or give instructions on how to use countless technical checklists. These measures may improve some aspects of performance, but they cannot transform the system's fundamental structure.

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70 For 2013, roughly 75% of the global total of $16.4bn in humanitarian funding came via donor governments and the EU institutions, of which 86% originated within OECD countries (GHA, 2014).

71 National and local NGOs form an essential part of the humanitarian response, but in 2013 directly received only $49m – just 0.2% of the total international humanitarian response (GHA, 2015: 55).

8.1.2 The influence of domestic politics

Rich nations generally show only marginal interest in outbreaks until the microbes seem to directly threaten their citizens, at which point they hysterically overreact (Garrett, 2015).

Key aspects of the Ebola intervention can be understood as responses to public opinion. Over the course of September, profound inaction gave way to a global surge to stop Ebola. With major declarations from the UN Security Council (raising the possibility of 'unrest, social tensions and a deterioration of the political and security climate'),[72] President Obama, Prime Minister Cameron and the global machinery turned their focus on Ebola. But to what did America, Britain and the many other governments that ultimately contributed respond?

The world's most powerful nations chose to ignore Ebola's deadly explosion in West Africa until the threat reached their own doorsteps (Garrett, 2015; MSF, 2015b). The implications are that Guinea, Liberia and Sierra Leone held little strategic interest: that some lives are more valuable than others (Phillips, 2014). The Ebola response exhibited this combination of self-interest and domestic politics in various ways, some quite telling, for instance in the deployment of US and British military personnel almost exclusively in very low-risk non-medical functions. Given the shortage of skilled medical personnel, the absence of the kind of major military medical intervention called for by MSF reflects the potential for political damage should a soldier die from Ebola. So pilots who had seen combat in Afghanistan and Iraq were not permitted to fly helicopters carrying blood samples to a lab for urgent testing (MSF, 2015b: 14). Instead, the outbreak's front line was manned by NGOs with no previous experience or expertise. Pressure from back home also played a role in the decision to build ETUs out of bricks and mortar, rather than materials that would have allowed much more rapid, though less photogenic, results.[73]

Insufficient attention has been paid to how governmental donor agencies and mechanisms respond to the interests of individual politicians or the pressures of opposition politics in their home societies. National interests do not wholly explain why terms of engagement essentially precluded UK and US military interventions from providing direct

medical care in the Ebola crisis; why flight bans were imposed and returning health care workers quarantined; why agencies continued to honour contracts to build unnecessary ETUs; or why then Australian Prime Minister Tony Abbott declared that his country would send no health workers into 'harm's way' (Withnall, 2014). Rather, these decisions are better explained by very real threats to politicians and their parties. In this vein, there is a need for research looking into the impact of election politics on the Ebola response; as November 2014 mid-term elections loomed in the US and a May 2015 general election was on the horizon in the UK, this was perhaps not the time for a political faux pas. Did the political need to 'act tough' influence the decision to deploy such a prominently militarised response? Humanitarians must do better at assessing the pressures that give rise to counter-productive measures, and the degree to which sub-national political interests constitute one of the primary drivers of aid.

8.2 Securitisation and militarisation

Ebola entangled the humanitarian response with the strategic and political interests of Western governments. The West African 'battleground' more closely resembled integrated approaches in Afghanistan than, for example, the aid response in South Sudan. The virus was deemed to present an 'existential threat requiring actions outside the bounds of normal political procedure' (Clinton and Sridhar, 2015). Through the deployment of international military forces and the imposition of coercive control measures by the governments of Guinea, Liberia and Sierra Leone, the response was essentially securitised. In Sierra Leone, the Secretary of Defence was placed in charge of the national outbreak response. In the US, the government was told that Ebola would pose a national security threat in the event of state collapse in West Africa. Given that Ebola is not easily transmissible (unlike, for instance, an airborne avian flu), it enlarged the envelope of when the security apparatus would be engaged to fight a virus (Clinton and Sridhar, 2015).[74]

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72 UN Security Council Resolution 2177, 18 September 2015.

73 Interview with donor official, 26 March 2015.

74 Critics consider this securitisation to have been based on exaggerated fears of social crisis and meltdown (Huang, 2014; de Waal, 2014), echoing previous justifications for troop deployments in humanitarian crises. In the aftermath of the Haiti earthquake, for instance, 'fears of insecurity led to a militarized response that concentrated too much assistance in certain parts of the capital, poured money into defence and security measures when it would have been better spent elsewhere and often treated survivors as threats rather than people to be helped' (Katz, 2015).

The troops the US and UK eventually deployed were largely logisticians and construction engineers, not the biomedical teams MSF had called for when it appealed for help in September 2014 – the result of a set of decisions and strategic calculations that warrant public inquiry in both countries. They contributed to improving coordination, logistics, supply, the training of health care workers and the construction of ETUs (Pérache, 2015), and were instrumental in setting up specialist treatment clinics in Monrovia and near Freetown, designed to handle health care workers and expatriates infected by Ebola.[75] Although key informants (not to mention the media) raised questions regarding the time and cost it took to build and operate these facilities, they did at least provide a measure of reassurance to organisations with staff in affected countries.[76] They also provided tangible evidence to the people of Liberia and Sierra Leone that major efforts were being made to stop Ebola.[77]

The securitisation of the response pits the human security of an individual against the security of a public or nation. At the extreme, it flips humanitarian compassion on its head, turning the sick and afflicted into 'objects of fear and stigma' (de Waal, 2014): threats to be controlled in the interests of protecting the nation. While the human rights implications of the coercive measures introduced in Guinea, Liberia and Sierra Leone were clear – as early as September, for example, Human Rights Watch explained that quarantines did not meet the relevant legal standards and called for coercive measures to be replaced by social mobilisation (HRW, 2014) – human rights concerns were largely obscured by the lopsided attention placed on the hoped-for benefits of security measures in stopping transmission. As Ebola spread, it exacerbated the tension between patient care and the dictates of public health: between what is good for the sick individual in front of you, and what is good for the larger society behind her. With bodies piling up and the number of patients accelerating away from the number of treatment beds, the intolerable choice between treatment and containment, between patient care and patient isolation, became acute. As a

powerful driver of the global response, health security thus resulted in, or at least reinforced, the early strategic primacy of containment.

The successful containment of Ebola has been perceived as a victory for securitisation, in contrast to the aid system's failure. As an example of this kind of thinking:

> *So if there is another epidemic on this scale … it may be necessary to involve the Security Council and military forces again, given the seeming success of their involvement over the past four months. UNMEER was started from scratch in September and the whole UN system pulled together to send the personnel to staff it. But after the missed opportunities when Ebola first emerged in Guinea last year, it was the securitisation of efforts to fight the disease that provided much needed momentum to this international effort* (Burnett, 2015).

This 'victory' carries us further in the direction of health security being located within an overarching *national* security framework, as opposed to its original intent, where health was conceptually treated as one component of *human* security. What Sandvik (2015) calls the 'post-Ebola narrative of military victory' also minimises the role of nationals, health care workers and humanitarian actors in the response, with 'important strategic consequences for patterns of funding and intervention in future health emergencies' (Sandvik, 2015). More broadly, the trend points towards the increasing insertion of militaries in disaster relief – an important justification for the existence of such massively expensive preparedness as an important exercise of 'soft power'. These interventions trace the progressive, twofold conversion of humanitarian crises into security concerns, and security assets into 'humanitarian' responders.

There is an insidious circularity here. First, the 'successful' replacement of civilian actors and 'victories' over threats such as Ebola reinforce a 'political and/or popular perception of militarized responses as the only "effective" response to health emergencies' and 'detrimentally impact investment in basic health care and related information systems' (Sandvik, 2015). Second, government budgets are finite. Global military expenditure, prioritised both in poor countries like Guinea, Liberia and Sierra Leone and in powerful nations such as the US and

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75 Note also criticism that the terms of engagement for the US military in Liberia were highly risk averse, for instance barring the military from using helicopters to transport blood samples or even healthy staff who had been involved in treatment of Ebola patients.

76 Interview with INGO executives, 23 February 2015.

77 Interview with OFDA official, Freetown.

China, is part of the reason for underspending and underdevelopment in health systems, and also partly explains inadequate humanitarian logistical capacity (see e.g. de Waal, 2014). Put simply, the military are required to fill civilian capacity gaps because of decades of investment in security, and disinvestment in healthcare. It should be no surprise that '[w]hen you have a lot of relatively well-equipped soldiers and a small number of poorly-equipped doctors and nurses, you go with your soldiers' (McGovern, 2014). On these points, the humanitarian sector, including MSF, which called for military intervention, has been silent. The necessity, then, is for a dual analysis of the military's role in humanitarian action from the perspective of its humanitarian (rather than political) effectiveness and efficiency; and of the feasibility of establishing substantial global civilian humanitarian logistics capacity, to reduce dependence on the military.

8.3 Humanitarian health and health security

Over the past two decades there has been a concerted effort to build safeguards against just such an outbreak as Ebola. In its landmark 2007 report, WHO spelled out the world's post-SARS aspirations and actions towards health security. In *A Safer Future: Global Health Security in the 21st Century*, it defined global public health security as 'the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries' (WHO, 2007: ix). Much as WHO's output was steered towards the interests of wealthy donor nations, critics of the actual direction of global health security argue that it reflects 'a worldwide shift of public health focus from disease prevention towards the biosecurity of wealthy nations, their preparedness for disease outbreaks and protection of their economic interests' (Hooker et al., 2014).

By way of example, the refusal of the Indonesian authorities to turn over to WHO viral samples of H5N1 bird flu in 2006 was deemed a violation of its legal obligations under the IHR treaty (Lakoff, 2010). Yet the Indonesian government perceived ethical and national issues with compliance, as it would force them to surrender Indonesian assets (citizens' viral samples) in the name of efforts to produce a vaccine that would remain unaffordable and hence of little benefit to Indonesians (*ibid*.). In effect, they rejected the double standard and hence questioned the very legitimacy of the IHR.

The outbreak may also mark a first escalation in what will prove to be a battleground between health security, humanitarian health and the authority of transnational institutions. Thinking in terms of health security raises fears that the next epidemic will also not be prevented. Thinking in humanitarian terms, by contrast, shifts our gaze elsewhere, to the fear that the people living in these three countries will continue to suffer or perish because they have some of the worst health services on the planet. The former conceives of diseases as the problem to be addressed, given their potential to harm wealthy nations in an extraordinary outbreak, while the latter focuses on the ongoing suffering of those living (predominantly) in the developing world, where inadequate health systems leave them victim to frequent illnesses (Lakoff, 2010).

Humanitarian and global health organisations must defend against the value of health becoming dependent upon its utility to the security of others. Unless challenged, the Ebola response will inadvertently jeopardise that value, as efforts to improve the health of both poor people and broken systems will increasingly require a justification in terms of their impact on security (Huang, 2014). Given funding dependencies, national ministries and aid organisations will be forced to pepper their health project grant applications with references to health security benefits. In other words, it will be the global health community that devalues health and health responses.

9 Conclusion

Ebola exposed much about the international aid community: dedicated, resourceful and diverse, as well as ill-prepared, donor-dependent and challenged by the confrontation between technical or scientific solutions and the socio-cultural context. The outbreak challenged the people of Guinea, Liberia and Sierra Leone and the international community at a most fundamental level. The diagnosis is clear: 'global health governance structures are inadequate, the international commitment to bolster pandemic preparedness and response capacity in poor countries is tardy, and the global support for strengthening health systems is still weak' (UNDP, 2015: v). Our analysis is the same, and convinces us that understanding the power relations and culture of the humanitarian aid and global outbreak communities holds the key to ensuring that reforms address the causes rather than the symptoms of the problem. First and foremost, this will require a political rather than a technical analysis of what ails the humanitarian and development aid sector, and solutions that tackle the underlying biases, trade-offs and political costs seemingly inherent to it.

Put health security above sovereignty

The Ebola outbreak demonstrates that, to be effective, outbreak control in the interest of global public health will often need to trump national authority. This raises two issues: the tension between sovereignty and institutions (like WHO) possessing transnational authority; and legitimacy as a precondition for the exercise of transnational authority. In response to the outbreak, there have been multiple calls for a beefed up global outbreak response team. This would need to have some degree of autonomy or risk being ignored or bullied into silence. In turn, that implies accepting that the edicts of an international epidemic may be incongruent with national interests and may also prompt defensive measures (e.g. flight bans, trade embargoes) that are counterproductive but politically popular. It is difficult to imagine governments, especially powerful governments, agreeing, for example, to lift flight bans or rescind quarantines on returning health workers in the event such measures were prohibited by an international body. Where sovereignty and health security are at odds, sovereignty has always been shown to dominate.[78]

Tackle the high costs of raising the alarm

If WHO is ever to be effective in fighting outbreaks such as this, it must develop the willingness and capacity to ruffle feathers (O'Carroll, 2015) and weather the backlash. At the same time, governments must engage with WHO in a manner that validates its role and responsibilities, and makes clear that WHO must champion public health over national interests. The governments of Guinea and Sierra Leone in particular blocked efforts to sound the alarm and downplayed or denied Ebola risks (MSF, 2015a). At the same time, it is important to recognise that effective outbreak control and response threatened many legitimate state interests. There was justified concern that news of the outbreak would damage the reputations of affected countries, causing long-term loss of pride, trade, tourism and investment, with potentially serious economic and political implications. These injuries may far outstrip losses due to an outbreak, especially one controlled early. 'Countries are reluctant to declare things in a public way because they have to shut down their borders, they cannot export, people cannot travel. It is a lot more than controlling disease' (Save the Children, 2015a).

Address the fear factor

Further analysis is needed to examine the political and operational costs of fear, including the hidden costs. The Ebola intervention suggests a significant risk that international outbreak response will grind to a halt due to factors beyond the control of the aid system. For example, despite the very rare geographic spread of the disease beyond West Africa, Ebola raised fears that air travel to stricken countries might become impossible.[79] Looking forward, such irrational reactions must be factored into strategic planning, as they will impose serious constraints on

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78 Interview with Dr. David Heymann, Head of the Centre on Global Health Security, Chatham House, London, 31 March 2015.

79 Two unmentioned heroes of the Ebola intervention: Royal Air Maroc and Brussels Airlines, both of which maintained direct flights.

operationality. It is as simple as this: any future global epidemic strike force will be useless in the absence of a dedicated, independent flight and medevac capacity that is protected against public health measures taken by sovereign states, such as flight bans. Beyond technical and operation-focused lessons learned, organisations involved in the Ebola response should critically consider how issues surrounding capacity, fear, risk and duty of care manifested themselves in the response, and what concrete steps can be taken to mitigate them in the next health crisis.

For example, there is an opportunity cost when operational directors must spend time lobbying insurance companies and airlines, or when MSF, CDC and WHO officials divert significant resources into 'managing fear and often hysterical public opinion' in parts of the world far from the epidemic, yet crucial to the response (MSF, 2015b: 19). More importantly, there should be an inquiry into how fear, panic and politics combined to produce policies such as flight bans and quarantines that threatened to undercut efforts to fight the disease, or even increased the risk of transmission.

Understand agency and culture

The culture of the aid system made it blind to the specificity of its bio-medical worldview, and its intolerance of, essentially, spirituality. Different forms of knowledge, culture and values are organised into a hierarchy, with 'universally applicable expert knowledge' privileged and 'local, "unscientific" knowledge' denigrated (DuBois, 1991).

The cultural tensions highlighted (again) by the Ebola crisis are a reminder of the crucial need to widen the humanitarian skill set and involve a more diverse range of actors, including anthropologists and anthropological analysis, into the humanitarian architecture. Sharon Abramowitz, an anthropologist conducting research related to the Ebola response, has noted that, while there has been a belated recognition of the need to include anthropological analysis in decision-making, no meaningful shift has taken place in the way international response mechanisms engage with anthropologists, and they have yet to be substantively integrated into the response architecture.[80] Taking the time to stop and think – to comprehend via dialogue, engagement and sociological research – runs counter to the humanitarian impulse to act, to focus on today, to be driven by an ethos of hard action in the

midst of a 'permanent state of emergency' (Müller, 2014). Knowledge, however, requires translation. A 25-page ethnographic history of burial practices may be interesting, but is of little use to medical/WASH teams struggling in the face of a rapidly expanding epidemic.[81] Anthropological engagement will need to include actionable solutions and recommendations that foster more culturally acceptable messages and measures. Critically, there is a need to guard against employing anthropologists as a silver-bullet solution to the frequent disconnect – poor representation, dialogue, accountability – between the international intervention and the local context and communities.

Tackle the system, treat the disease

Since Ebola crashed into the living rooms of the West, policy-makers and politicians alike seem to have rediscovered the importance of healthcare systems. Whether this translates into action depends on whether a heightened focus on health security and epidemic response muscles out ambitions to build robust health systems in places like South Sudan, Haiti or Sierra Leone, and whether efforts to build health systems will be more successful in avoiding the drivers that encouraged project-based aid and the creation of 'silos of excellence' in health in the first place. At the very least, tackling health systems in the poorest parts of the world will require a substantial alteration in the workings and organisation of donors, implementing partners (for humanitarians, especially during post-conflict periods, as Liberia and Sierra Leone demonstrate) and governments.

'Ebola must be a wake-up call for international donors to ensure that they are supporting all countries to build comprehensive health systems, ones that can tackle all health threats, not just their chosen priorities' (Save the Children, 2015a). That bromide is most certainly true. However, the overriding difficulty lies in the complexity of the task at hand. For example, improving the human resource situation in West Africa has, to put it mildly, proved a challenge. Personnel who receive training thereby have the qualifications to leave the country, so there is significant out-migration of medical personnel.[82] It is especially difficult to recruit skilled

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80 Telephone interview with Sharon Abramowitz, 23 April 2015.

81 MSF doctor Armand Sprecher, public presentation, MSF Scientific Day, 8 May 2015.

82 It is claimed that there are more Liberian physicians in the United States than in their own country (Downie, 2012: 10), and the House of Commons IDC has declared that it is 'alarmed that such a high percentage of nurses and midwives from Sierra Leone are working in the UK' (House of Commons, 2014a: 35).

staff to work in rural areas, reinforcing a vicious cycle whereby a lack of development impedes efforts at promoting development (Downie, 2012: 11). Moreover, 'capacity-building' tends to focus on the technical, ignoring crucial '"softer" less visible dimensions of capacity' (Denny and Mallett, 2015b: 3). There is also the complex issue of corruption, the corrosive effects of which were so detrimental to the Ebola response. Intractable in the short/medium term, politically sensitive or even dangerous, corruption has often been ignored by development NGOs working on the ground as long as it remains external to their projects. The overly narrow, technocratic approaches to pre-Ebola aid thus ignored the complex mutual dependence between good governance, legitimacy and successful development (Denny and Mallett, 2015a).

Embodied and empowered by global initiatives such as the MDGs, well-funded by governments and philanthropists and championed by aid agencies, vertical programming has succeeded by circumventing the failures of the aid system which preceded and prompted it. The Western donor (governmental and philanthropic) and NGO approach to healthcare in Africa has increasingly focused on targeting specific diseases, such as AIDS, malaria and Guinea worm, meaning concentrated attention on the disease itself rather than the health system. On this point, Lachenal offers the withering criticism that a decade of successes in terms of healthcare in Africa has been 'at the expense of African health systems and the people working in them' (Lachenal, 2014a). We need not discredit vertical approaches in such blanket fashion. The Ebola crisis reinforces the need for *both* health systems *and* specialised capacity – while also offering a warning against offsetting one against the other.

Our findings suggest that the recently pledged $3.4bn Ebola recovery plan for Guinea, Sierra Leone and Liberia (McKay, 2015) should be contingent on the ability of UN agencies, INGOs, key donors and national governments to articulate how they are going to build health systems differently than in the past. How will the Ebola recovery effort maintain a focus on the long-term goal? How will implementers – highly modulated aid organisations working in a highly modulated sector – work if not on a modular, project by project basis, even though studies demonstrate that 'capacity does not simply "aggregate upwards"' (Denny and Mallett, 2015b: 2)? How will donors and implementers alike maintain funding while moving away from tangible, 'sexy' targets and short-term

expectations of success? The nature of the task and the drivers of aid have once before pushed attempts at building health systems towards vertical, project-based approaches. The people in Guinea, Liberia and Sierra Leone require that history not repeat itself. The publics, politicians and INGOs who ultimately control aid, however, have different requirements.

Prioritise prevention over cure

As aid budgets come under increasing pressure, Ebola exposed a regressive and seemingly intractable trend: in the absence of strategic interest or mass empathy in the face of (heavily mediatised) suffering, political commitment and hence donor funding at scale will not materialise. This constrains aid efforts in many of the strategically unimportant corners of the world, as it did in this part of West Africa prior to September 2014. As Ebola showed, these forces constitute a severe impediment to the timely prevention of crises.

Political and financial dynamics create a tendency towards cure, rather than prevention. The well-foreseen, slow-onset famine in south-central Somalia in 2011 provides a well-documented example.[83] There is ample condemnation of powerful nations for not responding early enough. Commitments to do so – vows of 'Never Again!' – satisfy today's demands for action, but the root causes of the problem remain. Instead, aid agencies should change course, and base their emergency response strategies on the assumption, verified once again by Ebola, that sceptical Western publics and domestic politics will continue to curtail early or preventative action. The NGO community's habit of blaming inaction on the lack of donor funding makes for a poor alibi given the consistency of the problem. On the donor side, there is no need for new promises or policy reform, 'merely' implementation of existing commitments: the Good Humanitarian Donorship (GHD) initiative, established in 2003, calls for donors to ensure predictable, flexible and timely funding in proportion to needs (Principles 5, 6, 12) (GHD, n.d). Continued pressure on donors to release funding that is fit for purpose, as agreements such as the GHD intend, is one step. But the sector must also develop a financing strategy that reflects the reality of inadequate institutional donor funding for emergencies.[84]

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83 There, aid agencies faced with growing food insecurity were unable to mobilise timely funds until the eruption of a full-blown nutritional crisis (Hillier and Dempsey, 2012).

84 New mechanisms have been launched (e.g., CERF, START), but have yet to alleviate the problem.

Strengthen impartiality and independence

Funding in the context of the Ebola response exemplifies two perennial and much-discussed bugbears in humanitarian action. The first is the degree to which humanitarian funding is not flexibly allocated or impartially applied. The second relates to funding allocations based on donor priorities, and the implications this has for humanitarian response generally, and more specifically for the independence of NGOs and other implementing partners.

If the tardiness of Ebola funding created typical delays in operationalisation, the atypically open exercise of donor power helped to strong-arm reluctant NGOs and agencies into fighting the outbreak. According to one donor official interviewed for this study, '[w]e had to pull a lot of NGOs into this … We had to call on the phone and do some arm twisting'. Key donors also imposed their strategic choices on their implementing partners, notably prioritising the construction and management of treatment facilities. As a result, many NGOs were pushed – both by their commitment to respond and by donor pressure – to repurpose themselves in order to respond to Ebola, accepting roles and performing operations that were new to them. This in itself might be considered a positive. In the bigger picture, though, compromising humanitarian independence in this way reinforces the practice of NGOs being used as 'force multipliers' in support of the strategic security interests of donor governments. Even if one applauds the ends here, the similarity of means to the highly politicised use of humanitarian aid in Afghanistan, for example, must be rejected. In West Africa, agencies' financial links to major Western donors did not have negative security implications. This may not always be the case. The risk that a Western-financed outbreak intervention may be blocked in a context hostile to the West – for instance if MERS became widespread in Iraq or North Korea – represents a critical systemic weakness.

To act impartially by reacting to the suffering of those *most* in need – often those caught up in emerging situations (e.g. cholera outbreak, forced displacement, mounting malnutrition) – and to do so in the immediate term requires an independence of means, foremost financial. One solution may be to build greater flexibility/contingencies into funding mechanisms and contracts. For example, contractual obligations could include a precise definition of the work to be done *and* the requirement that the NGO respond according to

the principle of impartiality within the defined target population (i.e. to an emerging crisis situation). In order to get the contract, perhaps an NGO should have to demonstrate that it held sufficient in-house emergency funds to allow it to react impartially up to a certain amount, with due consideration to the differences between UN and NGO funding (the former has greater access to unearmarked funds) and the specific capacities of smaller or local NGOs.

The grant/contractual obligations that govern so much NGO output effectively negate the capacity of the aid system to adapt as situations change. The rapidly changing epidemiology of Ebola underscored this functional defect, leaving treatment facilities to be built that would never see a patient. 'What we are doing now we were not doing three months ago. But our apparatus, the funding apparatus – the flexibility put into grants, and following up on our grants – cannot change so fast'.[85] The number of ETU beds peaked on 8 February 2015 at 2,044 units (Global Ebola Response, 2015a) – far more than enough capacity for the 128 new cases reported the following week (WHO, 2014–15).

The World Food Programme (WFP) has built in some financial flexibility by improving its financial risk assessment capabilities, allowing it to move forward earlier than other agencies, before contracts are signed and the money is guaranteed. This involves a sophisticated analysis, *prior* to grant proposals being approved, of the likelihood of their being approved, and then taking risks accordingly.[86] Potentially applicable to many NGOs, this financial risk assessment requires further documentation and discussion in aid circles. At most, though, it eases rather than resolves the problem.

Final thoughts

Trying to understand the Ebola outbreak in West Africa recalls the parable of the elephant and the six blind men,[87] where each man touches his hand to a different part of the elephant, and thereby draws a different conclusion as to its nature. The Ebola outbreak has

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85 Interview, OFDA official, 20 April 2015.

86 Interview, Denise Brown, WFP West Africa Regional Director, Conakry, 16 April 2015.

87 In the parable, they launch into a heated argument over who is right, until a wise man tells them they are all wrong, and all right. In the world of research, of course, there is no equivalent of the wise man.

prompted a mammoth of a response: local, national and international action that spans far more than three countries, the entirety of the international aid system, the international public health and health security systems, US and UK military deployments and months of media frenzy, followed by what one commentator has termed a 'research epidemic'.[88]

Our research has ranged over a great number of issues, and yet it leaves many fundamental questions unasked. One concerns the virtual quality to many elements of how aid works. Conferences, workshops, policy papers and speeches about accountability or community engagement, for instance, do not in themselves deliver on these ambitions. In similar fashion, the Ebola outbreak exploited the degree to which key components of the very regulations enacted to avoid such an outbreak held more virtual than actual potency. We must ask how much aid work (perhaps especially at HQ level) produces satisfaction/reward on the part of the humanitarians involved in its production, and the degree to which that constitutes a significant driver of initiatives (i.e. psychological as well as organisational dynamics). We must also explore to what extent the convoking

of worldwide conferences on rape or hammering out regulations to prevent outbreaks or conducting well-resourced research – such as the paper you're reading now – constitute an end in themselves, achievements that garnish kudos and thereby reduce the pressure to effect the very changes all this work seeks to achieve.

An examination of the performance of the system often sidesteps critical ethical issues in its focus on effectiveness. The ease with which security imperatives trumped human rights warrants more extensive treatment than we can give it here, and the jarring inequality between the international community and national and local communities raises yet again uncomfortable questions of power and powerlessness. To ask for and spend billions of dollars on belated cure after months of neglected prevention is a moral issue, not simply a question of effective funding mechanisms. Finally, this ultimately successful intervention contained a myriad of small experiments, decisions costly and not, efforts that saved lives brilliantly and lost them unnecessarily. That is the nature of humanitarian aid just as it is the nature of welfare or education reform in Western nations – with the proviso that, in the absence of any meaningful accountability, the people of Guinea, Liberia and Sierra Leone had precious little say over much of what happened to them, and even less redress for the things that went wrong.

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88 John Edmunds, Dean of Faculty of Epidemiology & Population Health, LSHTM, Speaking at MSF Scientific Day, 8 May 2015.

Annex 1

Excerpt from *Global Ebola Response, Making a Difference: Progress Report 2015*, May 2015 (p. 26)

The global Ebola response can be summed up as a focused yet flexible strategy that successfully adapted to the evolution of the outbreak and became increasingly decentralized over time. The first iteration of the strategy brought together the 'Accra Response Strategy', agreed by Health Ministers from eleven West African countries on 2–3 July 2014, and the 'Ebola Response Roadmap' published by WHO on 28 August 2014. The 'Accra Response Strategy' was based on three pillars of action: immediate outbreak response interventions; enhanced coordination and collaboration; and scale-up of human and financial resource mobilization. The WHO Roadmap emphasized the use of complementary and controversial approaches for use in areas with intensive transmission to 'take the heat out of the outbreak' with specific targets and timelines.

The contents of these two strategies were reiterated in the UN STEPP strategy, which was developed jointly with the Presidents and Governments of the affected countries in the first two weeks of September 2014.

It formed the basis of the Overview of Needs and Requirements for the UN system and partners developed jointly by OCHA and the Office of the Special Envoy and launched in Geneva on 16 September 2014.

The elements of STEPP are to:

- Stop the outbreak;
- Treat the infected;
- Ensure essential services:
- Preserve stability; and
- Prevent outbreaks in countries currently unaffected.

Each of the five elements in STEPP is broken down into the mission-critical public health actions and enabling activities that are required to make the response work. STEPP provided an enduring, broad and flexible framework for operations.

Over time, different elements of STEPP were prioritized. When the number of people with Ebola was increasing rapidly, the focus was on the first two elements of Stop and Treat or 'ST': this meant building safe and staffed beds, introducing safe burials and finding and training healthcare workers.

Annex 2 Research participants

The research team interviewed at least one individual (and in many instances more than one) affiliated with the following organisations:

Action Against Hunger, Africa Governance Initiative, Africa Research Institute, Alliance for International Medical Action, Centers for Disease Control and Prevention, Council on Foreign Relations, DFID, Médecins Sans Frontières, Ebola National Coordination Committee (Guinea), Emergency Ebola Anthropology Network, GOAL, International Council of Voluntary Agencies, Immerse Learning, International Rescue Committee, King's College London, London School of Hygiene and Tropical Medicine, Mercy Corps, Ministry of Health and Sanitation (Sierra Leone), National Incident Management System (Liberia), OCHA, Oxfam, Paramount Chief (Sierra Leone), Plan International, Red Cross (various national societies), Restless Development, Rio Tinto Mining, Samaritan's Purse, Save the Children, UNDP, UNMEER, USAID/OFDA, US Department of State, WHO, WFP.

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