

LIBERIA

The Humanitarian Context

Between 30 March 2014, when the first Ebola case was confirmed in Liberia, and 14 January 2016, when the country was declared free of the virus for the third time, 4,809 people died. Countless other people also suffered directly or indirectly from the deadliest Ebola outbreak on record, which also affected Guinea and Sierra Leone, where 2,536 and 3,956 deaths were reported respectively. The real figures will never be known, but might be much higher due to the number of infected people who were never diagnosed and those who died from other illnesses without access to treatment.

The World Health Organisation declared the Ebola epidemic in West Africa a public emergency of international concern in August 2014, and an ad-hoc international coordination and leadership structure, the United Nations Mission for Ebola Emergency Response – the first ever UN emergency health mission – was created (it closed down in July 2015). The US led the international response in Liberia, deploying thousands of soldiers there, and committed almost \$2.4 billion to the response in West Africa as a whole – out of \$3.62 billion of total humanitarian funding.

The exceptional spread of Ebola in West Africa – much larger than all previous epidemics, both in terms of geographical scope, morbidity and mortality – was attributed to a combination of factors. Among the most cited were high population mobility among densely populated cities, dysfunctional national healthcare services, initial reluctance among locals to accept that the outbreak was real, and cultural practices – such as traditional burials – that involved direct contact with those infected.

During the first months of the outbreak, the number of international actors in Liberia was very small; organisations such as Médecins Sans Frontières (MSF) made repeated calls for the drastic scale-up of resources. After the summer of 2014, the deployment of US military personnel and international organisations changed the response landscape; funding commitments increased exponentially. The priority was to two-fold: to stop transmission of the virus in Liberia, Sierra Leone and Guinea through outbreak control measures, and to prevent the spread of Ebola to neighbouring countries and outside West Africa.

After two relapses since the first Ebola-free declaration, Liberia now faces the challenge of recovering from the damage caused by the epidemic, while keeping a close eye on a virus that may have become endemic to the region.

**The un-ness of an emergency:
A reflection on the Ebola response in Liberia¹**

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Introduction

In 1983, Kenneth Hewitt, a geographer and environmentalist, argued that the idea of crises as manifestations of ‘un-ness’² – unprecedented, unexpected, unpleasant, unimaginable, unmanageable, etc. – dominated how they were perceived and managed. As extraordinary events that belong in the ‘un-ness’ category, crises could only be dealt with by experts and managers using the latest technologies, while everyday human activities only made things worse. Thirty years after Hewitt exposed this techno-bureaucratic reductionism, the Ebola epidemic in West Africa was described using similar concepts of ‘un-ness’.

According to these concepts, never before had Guinea, Liberia or Sierra Leone experienced an Ebola outbreak (unprecedented); nothing had signalled that Ebola could spread from remote areas of Central Africa to other locations (unexpected); with no treatment available, the Ebola virus was condemning thousands of people to a terrible death (unpleasant); contrary to previous outbreaks, this time the infection rates overwhelmed the efforts to control the virus (unmanageable); looking at the infection rates, the rapid spread of the virus in three countries and a number of cases internationally, fears rose of a global epidemic (unimaginable).

Some of these ‘un-ness’ categories might be applicable to the Ebola outbreak in West Africa, especially since it was the first time the virus had been detected in the region, and it spread rapidly from rural to urban areas and between the three countries. The others, as this paper shows, were artificially constructed, shaping the perception and response to the Ebola outbreak in West Africa in accordance with narratives familiar from other epidemics in different historical moments and contexts:

Almost all epidemics were seen by contemporaries, for example, as being transmitted from person to person and as arising from particular, usually filthy, local conditions: notions of ‘contagion’ and ‘miasma’ of a

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more or less undefined kind, were combined. Again and again ‘stench’ lay at the root of the disease. Common social responses - and intellectual justification for them - followed from these assumptions. Flight from an infected place was usual, and had to be defended (or attacked) since it took people away from charitable, neighbourly or political duties. Carriers of disease were identified and scapegoats stigmatised: foreigners most often [...] since epidemic disease came from outside, but also inferiors, carriers of pollution of several kinds, among whom disease had its local roots - untouchables in India and ex-slaves in Africa, for example, or Jews at the time of the Black Death [...]. For their part, the inferiors themselves thought epidemics the consequence of plots by external enemies, or governors and elites, to ‘poison’ the poor.³

Therefore, neither the perception of nor the response to the Ebola outbreak in West Africa was unprecedented, but followed a well-known pattern that shaped the understanding of the emergency and the nature of the response – from national and international governments, humanitarian actors and individuals – as well as its timing and how its effectiveness was understood. This is not to say that the Ebola outbreak in West Africa was not exceptional. It was the largest and longest Ebola epidemic ever, due to the biological behaviour of the virus and also to a number of other factors. However, the *perfect storm* of ‘dysfunctional health services as the result of decades of war, low public trust in government and Western medicine, traditional beliefs and even denials about the cause or existence of the virus, and burial practices that involve contact with contagious Ebola-infected corpses’ referred to by Peter Piot – member of the team who discovered the virus in 1976 – is an insufficient explanation of the interplay of endogenous and exogenous factors involved.

Indeed, in order to build the epidemiological story of the outbreak in Liberia – the geographical focus of this report –, we need to connect the political, social and cultural factors of the country with a wider outbreak narrative: ‘the paradigmatic story’ that, according to Pricilla Wald, imagines threats and dangers, archetypes of carriers and victims, guilt, salvation and containment strategies. It is the combination of the two narratives that, as Wald argues, affects survival rates, determines infection channels, stigmatises or protects individuals, groups and societies, influences expert and popular understandings of the epidemic and defines priorities in the response.⁴

This report, based on desk and field research,⁵ presents a critical reflection on the factors that prevented a more effective humanitarian response to the Ebola outbreak in Liberia, and on the issues that shaped understandings of the effectiveness of that response at the national and international levels. Both the intended scope of the research and issues of feasibility determined the level of the analysis, placing some limitations on what could be covered but also offering the opportunity to address issues that are often absent from NGO

or United Nations reports. The report is neither a systematic analysis nor an evaluation of the effectiveness of the Ebola response in Liberia. Nonetheless, this paper looks at the response to the Ebola outbreak to try to understand the actions and also the omissions of international and national actors.

Fearful safety

After almost three decades in which the development of antibiotics and vaccines ‘greatly lessened the perceived threat of infectious diseases’⁶ in Western countries, the AIDS pandemic of the mid-1980s initiated the ‘second germ panic’⁷ of the century. AIDS was not alone; as other infectious diseases which could potentially lead to deadly outbreaks ‘emerged’, reinforcing the germ panic. The Ebola virus, with no treatment available and very high mortality rates, soon became a staple of the popular anxiety around epidemics in Western countries. Nevertheless, the fact that Ebola outbreaks were confined to remote rural areas of Central Africa made the virus more interesting for writers of popular science and horror books than for public health officials in the US or Europe, at least during the first years.

As in the case of AIDS, popular awareness of Ebola was ‘shaped by the publishing and entertainment industries’,⁸ exacerbating the perceived un-ness of the virus. As early as 1987, best-selling author of medical thrillers Robin Cook published *Outbreak*, the story of the efforts of a doctor working for the Centers for Diseases Control and Prevention (CDC) to control an Ebola outbreak in the US. In 1994, journalist Richard Preston published the best-seller *The Hot Zone: The Chilling True Story of an Ebola Outbreak* – ‘one of the most horrifying things I’d ever read in my life’,⁹ according to Stephen King –, a non-fiction work that recreated apocalyptic scenarios of a disaster caused by an Ebola epidemic. One year later, the movie *Outbreak* (1995) adapted Preston’s book to the big screen and ranked first in the US box office on its opening weekend.¹⁰ In 1996, science journalist Laurie Garrett, author of *The Coming Plague: Newly Emerging Diseases in a World out of Balance* (1995), was awarded a Pulitzer Prize for a series of articles on the Ebola virus more informed but not less dramatic than Preston’s *The Hot Zone*.

These are just a few examples of a long list of fiction and non-fiction works that built the ‘epidemic of virus paranoia’¹¹ in little more than a decade. They presented Ebola (as they did with other emerging diseases) as an extremely deadly virus that might accidentally escape its *natural habitat* and reach the *civilised world*. They also represented Western doctors and soldiers as the only people fighting – and eventually defeating – Ebola, as opposed to Africans who were both powerless victims and involuntary accomplices of the virus. This distorted portrayal of Africans and Westerners was too common to be anecdotal, as the anthropologists Barry and Bonnie Hewlett explained:

Indigenous people's responses to Ebola are rarely mentioned, but when they are, images of ignorance, exoticism, and superstition emerge. The descriptions are seldom contextualised, and one is left with the feeling that an outbreak is controlled only through Western biomedical knowledge and technology, in spite of, not because of, the actions of local peoples.¹²

Such dramatised and inaccurate representations of the virus, compounded by the uncertainties of post-Cold War global society, fuelled the fear that an Ebola-infected person might take a flight from Kinshasa or Kampala to a Western city – as, according to the urban legend, it had happened when a gay flight attendant carried AIDS from Africa to the US¹³ – ‘taking advantage of new opportunities in a highly interconnected and mobile world’.¹⁴ Conversely, the representation of Ebola as a virus that belonged among ‘wild forests, poor African hospitals, bizarre cultural practices such as eating monkey meat and tribal rituals’,¹⁵ also made an outbreak in Europe or the US unthinkable for many.¹⁶ Moreover, the virulence of Ebola, a disease that killed too fast to allow the infected person to have contact with large numbers of people (in contrast to AIDS), was for some the guarantee that only short-lived outbreaks, not epidemics, were to be feared even in Africa.¹⁷

The Ebola outbreak in Kikwit, Zaire (today, Democratic Republic of the Congo), in 1995¹⁸ – the first to happen in a city – challenged the feeling of ‘fearful safety’, making international health authorities accept that the virus might reach urban settings and, potentially, travel outside Africa.¹⁹ Public health experts insisted on the need to strengthen international surveillance systems able to detect outbreaks of emerging infectious diseases – not just Ebola – even in places where they had never been present before.²⁰ Interestingly, the focus would be on early detection and containment, not prevention. The idea resonated with US security officials, because of the increasing concern that terrorist groups and *rogue states* might use emerging infectious diseases as weapons. Bioterrorism became ‘one of a number of asymmetric threats’.²¹

In the meantime, popular culture continued to reflect and nurture the uncertainty and anxiety of the post-Cold War world. The terrorist attacks of 11 September 2001 and the *War on Terror* gave rise to an increase in the number and audience of post-apocalyptic books, movies, comics, TV programmes and video games.²² Of all the variations of catastrophic scenarios, the zombie apocalypse was and still is the favourite of readers, audiences and gamers. The *dead biters* whose only *raison d'être* is to transmit a virus to the alive are no longer relegated to B-movie circuits, pulp fiction or mass-market paperbacks: *The Walking Dead* is often the most watched TV programme on Sunday night in the US,²³ Brad Pitt featured as an UN official fighting the living dead in *World War Z*, *The Last of Us*²⁴ sold over 7 million copies and is one the more popular

games for PlayStation,²⁵ 25 million people downloaded the game *Plants vs. Zombies* – a parody of the genre – in only two weeks,²⁶ and there is even a popular fitness mobile application called *Zombies, Run!*. In these films, books and games, the most – if not the only – effective measures against the virus and the infected are containment and, as a last resort, a sacrificial isolation or even destruction of the affected areas.

In sum, the increasing fear of bioterrorism and the popular representation of emerging viruses as ‘monsters without a face’²⁷ ran in parallel for almost three decades, creating the conditions for the securitisation of the response to Ebola outbreaks – as well as to other emerging infectious diseases. If the Ebola virus had *agency*²⁸ and no vaccine was available, the only option was to stop it on the ground through surveillance and containment measures. The international response to the Ebola epidemic in West Africa in 2014-2015 did not change that approach but put in place measures and resources commensurate to the perceived threat posed by an emergency of ‘unthinkable’ consequences. The *fearful safety* phase was over.

Interlude

In April 1995, a patient diagnosed with a typhoid-associated abdominal perforation was transferred to Kikwit General Hospital in Zaire (today, the Democratic Republic of the Congo). Two days after the surgical procedure, the patient, – a technician of the Maternity Hospital in the same city – died. Several physicians and nurses who had treated the patient died days later. By mid-May, laboratory tests confirmed the presence of Ebola virus in all the samples analysed, including those from the patient treated in the General Hospital, the doctors and nurses who had contact with him, as well as several other staff members of the Maternity Hospital, whose cases had been originally misdiagnosed as epidemic dysentery. It was the third time Ebola cases had been diagnosed in Zaire since the 1970s and, more worryingly, the first time the virus appeared in a highly populated area.²⁹

Neither the risk of the virus spreading to the capital – Kinshasa, a city of more than 4 million people, is only 500 km from Kikwit – nor the high number of Ebola cases, nor even the attention of international media after the death of 2 Italian nurses who worked in Kikwit General Hospital was enough to ensure that sufficient resources were allocated in time or appropriate protocols followed. As a report on the Médecins Sans Frontières (MSF) response explained, suspected cases were hospitalised in non-isolated areas of the General Hospital: ‘the majority of patients were lying on the floor of the ward, and family members walked in and out’.³⁰ To make things worse, ‘the staff (1 physician and 3 nurses), who had volunteered to care for the patients, were working without adequate protection’³¹ and, therefore, were highly

exposed to the virus and prone to infecting their family members. MSF also found that ‘the staff had not received salaries for months, the hospital was without running water or electricity, and no functional waste disposal system or latrines existed’.³²

A committee of national and international experts was created to manage the outbreak, including the government of Zaire, the Congolese Red Cross, the World Health Organisation (WHO), the US Centers for Disease Control and Prevention (CDC) and MSF. No health surveillance system existed in Kikwit, so it was necessary to improvise, combining health workers and volunteers. Appropriate isolation measures were put in place in the General Hospital, and the few local healthcare workers in Kikwit were trained in Ebola treatment in one-day sessions and received their wages. A central data registry processed all the information collected by surveillance teams in Kikwit and the surrounding areas, who went door to door to identify probable cases. Home isolation was advised before patients could be referred to the General Hospital, and families of probable cases were trained on risk reduction measures, as well as being monitored themselves for 3 weeks after the last contact with the probable cases or sick relative.

As soon as the outbreak was publicised, some voices in Kikwit denied that Ebola was the cause of the deaths, while some families concealed potential Ebola cases for fear of stigmatisation. The Government of Zaire decided to ban travel between Kikwit and Kinshasa as a first measure to avoid the risk of Ebola travelling to the capital. It was reported that around 3,000 people were camped out at the final road-block without food, water or shelter for several days, raising criticism about the use of road-blocks and forced quarantines in tackling the outbreak.³³

The arrival of the first health teams and protective equipment, as well as training for local healthcare providers and outreach (thousands of pamphlets explaining Ebola’s symptoms and basic protection measures were distributed by the Congolese Red Cross in Kikwit), meant the beginning of the end of the epidemic in Kikwit. After protective equipment was distributed and the isolation ward in the General Hospital was operating, only three more healthcare workers were infected and no further cases were reported among burial workers. The last death was reported on 16 July. A total of 315 cases were identified, with 81 per cent fatality rate between 6 January and mid-July 1995. 25 per cent of all cases were physicians or nurses.

A review of the Ebola outbreak in Kikwit concluded that the virus had the potential to reach densely populated areas and, even more disturbingly, that there had been a ‘3-month latency between occurrence of the first case in Kikwit, in January 1995, and recognition of the outbreak despite the presence of classic disease with clear chains of transmission, multiple hospitalisations, and a very high case fatality rate’. The review went on to say that ‘education and the use of personal protective equipment can rapidly interrupt ongoing

disease transmission’ and, therefore, emphasised the importance of even ‘rudimentary public health surveillance coupled with adherence to barrier-nursing precautions and infection-control practices’. The review also denounced the lack of preparedness of public health authorities to detect and prevent future large outbreaks, and declared that, ‘while recognising that the general lack of facilities and infrastructure remains the paramount problem in dealing with this disease, we also need to provide “field-friendly” mechanisms prepositioned at regional sites for rapid identification of infected individuals to anticipate outbreaks’.³⁴ On a similar note, MSF considered that ‘a major issue arising from this experience is the difficulty in controlling any severe disease outbreak in an area where the healthcare system is impaired and not functioning properly’.³⁵

The Ebola outbreak in Kikwit not only demonstrated that the idea that the Ebola virus was naturally confined to remote bush areas had been unfounded, but also revealed the potential limitations of a response mechanism reliant on epidemic surveillance and external medical assistance. Unfortunately, those lessons were not learned then, and had to be re-taught twenty years later in West Africa.

Patient zero³⁶

On 2 August 2014, Dr. Kent Brantly, a physician who contracted Ebola while working in Liberia for the NGO Samaritan’s Purse, was sent to a hospital in Atlanta, US. He was the first patient infected with Ebola to be treated on American soil. Only three days later, Nancy Writebol, a US missionary working in Liberia, tested positive for Ebola and was also flown to Atlanta. When Dr. Brantly and Mrs. Writebol were finally discharged from Emory University Hospital on 21 August, a total of 1,378 cases of Ebola virus disease and 694 deaths had already been reported in Liberia,³⁷ but only \$19,550 million had been committed by the US government to the Ebola response in West Africa. However, the case of Dr. Brantly – who was willing to make frequent public appearances, unlike Mrs. Writebol – changed the way Ebola was perceived in the US, transforming the outbreak from a distant emergency into a threat to the country. Indeed, the analysis of the media coverage of the Ebola outbreak in West Africa shows a considerable surge in the number of articles in print and online media, newswire stories, broadcast segments and tweets after Dr. Brantly was evacuated to the US.³⁸ Similarly, a poll conducted by the Harvard School of Public Health in mid-August concluded that 39% of Americans were concerned that there would be a large Ebola outbreak in the US within the next 12 months.³⁹ As one interviewee in Monrovia said, ‘Kent Brantly was patient zero’ for the US, the country that led and funded the bulk of the response to the Ebola outbreak in Liberia.

Of course, it would not be fair to explain the US government's decisions on the Ebola outbreak by considering just one factor, especially given that, days after Dr. Brantly arrived in the US, the WHO declared the epidemic in West Africa 'a public health emergency of international concern'.⁴⁰ However, the impact both symbolic and practical of Brantly's infection and treatment in the US was certainly major in that it materialised the fear of Ebola directly threatening the country. The response, as President Barack Obama explained in an interview to NBC on 7 September 2014, would aim to protect the American people through biosecurity measures:⁴¹

[It's going to be a US effort] as usual. And we're going to have to get US military assets just to set up, for example isolation units and equipment there, to provide security for public health workers surging from around the world. If we do that, then it's still going to be months before this problem is controllable in Africa. But it shouldn't reach our shores. Now, here's the last point I'm going to make. If we don't make that effort now, and this spreads not just through Africa but other parts of the world, there's the prospect then that the virus mutates. It becomes more easily transmittable. And then it could be a serious danger to the United States.⁴²

Eric Duncan, a Liberian visiting his relatives in the US, went to the Health Presbyterian Hospital in Dallas on 25 September 2014. He was suffering from fever, abdominal pain, dizziness and nausea. The doctors prescribed Duncan antibiotics and sent him home. Two days later, he came back to the hospital, but this time he was diagnosed with Ebola. Eric Duncan died on 8 October becoming the 'first laboratory-confirmed case of Ebola to be diagnosed in the United States'.⁴³ Two healthcare workers of the Health Presbyterian Hospital who provided care for Duncan tested positive for Ebola. One of them had taken a flight from Dallas to Cleveland, so the US health authorities traced all passengers and crew and put them on a 21-day monitoring period. Both nurses recovered and no Ebola cases were identified among the passengers of the flight.⁴⁴ Meanwhile, President Obama raised the rhetorical stakes by defining the outbreak as 'a growing threat to regional and global security'⁴⁵ during a meeting on Ebola at the UN.

Shortly after the virus had 'reached US shores' the US Department of Defense announced the deployment of up to 4,000 troops to Liberia to 'combat Ebola'.⁴⁶ By that time, two testing laboratories managed by the US Naval Medical Research Centre, with capacity to process 100 samples daily, were already functioning in Liberia. However, the Department of Defense made clear that 'our operations remain focused on four lines of effort: command and control, logistics support, training, and engineering support',⁴⁷

rather than on the health response itself. US Senator Rand Paul of Kentucky reacted to the announcement by accusing the White House and the experts of underestimating the threat of Ebola to the US: 'Can you imagine if a whole ship full of our soldiers catch Ebola?'⁴⁸ General John F. Kelly, chief of the US Southern Command, even said, 'there is no way we can keep Ebola [contained] in West Africa',⁴⁹ and warned of the possibility of Ebola reaching Haiti and Central America and provoking a mass migration of people crossing the US-Mexico border in trying to escape the virus or seeking medical treatment.

By the end of October 2014, when President Obama had appointed Ron Klain as *Ebola Czar*, and the US Government had committed \$350 million to fighting the outbreak in West Africa, with plans to build at least 17 100-bed Ebola treatment units (ETUs) across Liberia,⁵⁰ a total of 4,665 cases⁵¹ of Ebola and 2,705 deaths had already been reported in the country.

The militarisation of the response to the Ebola epidemic in West Africa (following the US, the United Kingdom announced that hundreds of troops, helicopters and a ship would be sent to Sierra Leone,⁵² and France confirmed that its army would build a hospital in Guinea⁵³) was coherent with the securitisation trend that had dominated the international approach to emerging infectious diseases since the 1980s. If the Ebola epidemic were a global security threat – even though no evidence of direct connection between modern epidemics and global security has yet been found⁵⁴ – then the US Army, with its \$650 billion-per-year running costs to justify, and its British and French counterparts (the former colonial policemen of Sierra Leone and Guinea) were the obvious choices to respond to the 'un-ness' of the emergency in West Africa, before it spread to the rest of the world.

MSF did not contradict that choice. In a speech delivered to the UN on 2 September 2014, Dr. Joanne Liu, president of MSF, requested a massive deployment of specialised medical units with expertise in biological threats in West Africa.⁵⁵ The medical humanitarian NGO justified this call on the grounds that 'fear of the unknown and lack of expertise in Ebola paralysed most aid agencies and donors',⁵⁶ leaving MSF as virtually the only organisation responding to the outbreak on the ground. However, as Kristin Sandvik pointed out, MSF's call also 'rationalised and re-emphasised the global public understanding of Ebola as an existential threat, where a military response had become the last straw [*sic*] after the failure of the international community and civil society'.⁵⁷

Fear management

On 30 July 2014, President Ellen Johnson Sirleaf of Liberia issued a statement declaring a state of emergency: all non-essential government staff would be placed on a 30-day compulsory leave, 1 August would be a non-working day

to allow for disinfection of all public facilities, all schools and markets would close, public amusement and entertainment centres were to be avoided, quarantines would be put in place when deemed necessary, cremation of all Ebola victims would be considered, and members of the government would restrict their international travel unless absolutely critical. The security forces were to enforce these measures.

The President of Liberia also expressed her gratitude to MSF and Samaritan's Purse for their efforts to reduce the impact of the epidemic, and to the Centers for Disease Control and the National Institute of Health of the United States for their technical support. It was not a very long list of organisations to be grateful to considering that 391 Ebola cases (109 confirmed, 181 probable, and 101 suspected), including 227 deaths, had been reported in Liberia by that date.

Samaritan's Purse decided to evacuate all of its personnel and hand over all of its operations in Liberia to MSF, after Dr. Brantly was infected with Ebola and repatriated to the US. Samaritan's Purse was not an exception. In fact, most international aid organisations, embassies and companies withdrew their international staff, in some cases closing offices and halting programmes in Liberia. British Airways, Delta Airlines and Kenya Airways had cancelled their operations by mid-August, and of the few Liberians who could afford to pay the high fares of Brussels Airlines or Royal Air Maroc – the only international airlines still flying to and from Monrovia – many left the country. The impact of this massive flight on the people of Liberia was bound to be devastating. President Johnson Sirleaf closed her statement with a direct appeal to citizens:

Finally, my fellow Liberians, Ebola is real. Ebola is contagious. And Ebola kills. All of us must all take extra measures announced by the Ministry of Health to keep ourselves safe. The government will do its part. But you must do yours. Denying that the disease exists is not doing your part to keep yourself and your loved ones safe. Hiding sick persons is not doing your part to keep yourself and your loved ones safe. Ignoring the signs and not reporting it to the health care authorities are not the ways by which we keep ourselves safe.⁵⁸

Ignorance, carelessness and superstition were repeatedly suggested as factors fuelling the spread of the virus in Liberia, Guinea and Sierra Leone and reducing the effectiveness of the medical response.⁵⁹ Could significant numbers of Liberians deny the existence of Ebola in their country even when people were dying in the streets? Were they so careless and superstitious as to ignore what was happening in front of them? Three interlinked factors should be taken into account in order to explain the attitude of Liberians during the

first weeks of the outbreak: denial of disease, lack of trust in the health services and, linked to this factor, lack of trust in the government and the authorities. In any case, none of these were uncommon, unprecedented or unexpected in an epidemic.

Denial of disease has been extensively studied and documented in medical literature and is considered a common reaction in order to cope psychologically with life-threatening health conditions. Similar to the *five stages of grief*,⁶⁰ there are five patterns of response to serious illnesses: seeking or using social support, focusing on the positive, distancing, cognitive escape-avoidance, and behavioural escape-avoidance.⁶¹ *Distancing* (namely, refusing to think about it, going on as if it is not happening, trying to forget the whole thing, etc.) is the most common strategy, whereas *cognitive escape avoidance* (for example, hoping a miracle might happen, wishing the situation would go away or be over, going along with fate, etc.) has been attributed to patients with less education, greater religiosity, and recurrent diseases.⁶²

Individual and community reactions to Ebola outbreaks are not exceptional in this respect, and before 2014 showed denial patterns similar to other illnesses and epidemics. Distancing and behavioural and cognitive escape-avoidance patterns were identified in a survey conducted with survivors of the 1995 Ebola outbreak in Kikwit, Zaire.⁶³ Before the diagnosis only 32 per cent of respondents suspected an Ebola infection when the first symptoms appeared; half of the survivors were afraid of being seriously ill and 47 per cent denied that possibility; while 80 per cent communicated their anxiety to a family member or a friend, 35 per cent tried to escape and 21 per cent were afraid of being accused by neighbours or even felt shame. During the acute phase of the illness almost all patients experienced fear. Some of them were afraid of the suffering (56 per cent), of dying (53 per cent) and of being separated from their families (41 per cent). Only 9 per cent downplayed their symptoms when asked by healthcare personnel.

While denial of Ebola was certainly a factor during the first weeks of the outbreak in Liberia, its importance was overplayed as an explanation for the spread of the virus. In fact, evidence shows that people's learning about the Ebola virus during the first two weeks of the declaration of a state of emergency in Liberia was significant.⁶⁴ Rather than denial, there was a consistent demand for accurate and practical information that neither the Government of Liberia nor international actors were able to provide during the first weeks of the outbreak. Moreover, misleading public health campaigns inculcated 'anxiety and relayed inaccurate information or guidance at a time of critical social learning'.⁶⁵

Another factor in the social context in which the Ebola outbreak occurred was the trust, or lack thereof, in public health services. This was a problem that existed before 2014 and that the Ebola outbreak made even more obvious. Suddenly, Liberians were told to trust blindly in a healthcare system that had

never had the capacity to provide appropriate healthcare before, and that, unsurprisingly, was overwhelmed by the outbreak.⁶⁶ Was going to a hospital or treatment centre after the first onset of symptoms the rational choice? Could Liberians be blamed for not trusting a low-quality healthcare system when doctors and nurses – even international staff – were being infected by the virus themselves?⁶⁷

For decades, researchers have tried to understand trust relationships between doctors and patients as a way not only to improve the quality of care provided but also to guide public health decisions. The *Trust in Physician Scale*⁶⁸ is one of several tools that assess the doctor-patient relationship. Using eleven sentences,⁶⁹ some positive and some negative in judgement, the scale determines to what extent patients trust their physician. These eleven points refer to five dimensions of trust that can be found in other models: technical and interpersonal competence of the physician; fiduciary responsibility and agency; control; disclosure; and confidentiality.⁷⁰ The issue of doctor-patient interpersonal relationships cannot fully be grasped without also considering the social dimension. If interpersonal trust refers to ‘the trust built through repeated interactions through which expectations about a person’s trustworthy behaviour can be tested over time’,⁷¹ then ‘any consideration of patients’ interpersonal trust in physicians must take into account the general atmosphere of social trust in health care institutions’.⁷² What was the level of social trust in health care institutions in Liberia before the outbreak? Despite the efforts to rebuild the health system to pre-civil-war levels,⁷³ looking at the extremely low numbers of health workforce, hospitals, and hospital beds per inhabitant,⁷⁴ we can only assume that social trust in health care institutions was low. As the director of a Liberian NGO said, ‘even now [May 2015, when the country had been declared Ebola-free] I wouldn’t know where to go if I get sick, because I don’t trust healthcare here’.

For readers in developed countries, the points comprising the *Trust in Physician Scale* may resonate with normal expectations of service in a clinic, an emergency room, or a hospital, as basic requirements in deciding whether to follow public health authorities’ advice. Unfortunately, none of those points of trust were part of the daily life of Liberians before and, needless to say, during the Ebola outbreak. So what were the chances of a medical response to an epidemic being effective in a context of deep mistrust between patients and healthcare services? Was it really unexpected that many Liberians were reluctant to seek treatment in the few hospitals and clinics that remained operational in the summer of 2014?

The need to reduce the risk of transmission between patients and healthcare personnel, due to the highly contagious nature of the Ebola virus, widened the trust gap. For many months the main contact Liberians had with healthcare was through ‘no-choice’ or even authoritarian measures,⁷⁵ such as quarantines, curfews, isolation, or cremations. While all interviewees in Liberia agreed that

exceptional measures were needed to tackle the outbreak, many expressed their reservations about how several aspects of the response were managed. For example, Liberian interviewees complained about the way Ebola treatment units (ETUs) were designed, with spaces of exclusion between patients and their families admitting no possibility of communication, even visual, between them.⁷⁶ As the director of a Liberian NGO said, ‘if community leaders had been invited to visit ETUs to see how people were being treated, popular mistrust would have rapidly decreased’. Regardless of the feasibility of such a measure, the fact was that failures in the management of information about patients, referrals, and deaths reinforced the popular mistrust and the perception of ETUs as dangerous places, to be avoided.⁷⁷

Lack of trust in the government and the state authorities is the third factor in the context of the Ebola outbreak in Liberia that must be appreciated. During the first weeks of the outbreak, a significant segment of the population thought that the government was exaggerating the Ebola threat in order to get US money, or simply paid no attention to the warnings coming from Monrovia.⁷⁸ Even if Ebola was real in Liberia, why should people follow the instructions of the government? While conspiracy theories played a role in creating resistance to the government’s instructions, it would be unfair to put the emphasis on that factor alone and forget the history of conflict, exploitation, poverty and social exclusion in Liberia. As one Liberian working for an NGO said, ‘we all thought Ebola was the excuse for the government to try to convince the US to give them more money’. Even when people accepted Ebola was real, many still believed that the ‘Ebola money’ was the main motivation behind the government’s decisions.

Even after communities in Liberia started to accept that Ebola was real, they still lacked the information and the resources to react. Reports and interviews conducted in Liberia for this study confirmed the frustration of communities during the first weeks of the outbreak at the limited information they received. An interviewee explained a common complaint: ‘the government just kept telling us that Ebola was real and how to identify the symptoms, but we already knew that! What we wanted to know was what we had to do if somebody in our family was infected. There were no ambulances, nobody answered our calls, and we had no idea about what to do’.

What kind of information did people request in Liberia? According to interviews in Monrovia and other reports, people demanded information on how to take care of sick people, isolation measures, quarantine management, how to administer community-based holding centres, how to transport sick people safely, how to isolate and bury corpses when burial teams were not available, personal and household hygiene measures, use of protective equipment and appropriate ways to disinfect their homes.⁷⁹ Contrary to the perception of Western media, of individuals and communities reluctant to change behaviours,⁸⁰ communities and individuals demanded the information

and resources needed to effectively protect themselves and do their part in tackling the outbreak.

Asked why public information about Ebola was so limited in Liberia between April, when the Ebola virus arrived in Monrovia, and the peak of the outbreak in August, most respondents assumed that fear had also paralysed the government, which simply did not know what to do either. Others believed that international health organisations had feared that more complete information would have led to individuals taking more risks in, for example, providing assistance to relatives and friends, when the ‘don’t touch’ approach was the most effective to limit the spread of the virus. Nevertheless, as all Liberians interviewed for this research confirmed, local people felt that while the ‘don’t touch’ policy might be effective in stopping the outbreak, it would not save their lives.

The fact was that with the exit of Samaritan’s Purse, MSF was the only international organisation treating Ebola patients in Liberia, with its capacity clearly overstretched,⁸¹ and the government’s National Task Force on Ebola could only watch the increase in the number of cases across the country. In fact, in August the government decided to impose quarantine in West Point, a shanty town of 70,000 people in Monrovia. The Government justified the quarantine as an appropriate measure to control the spread of the virus in the capital,⁸² although there is no conclusive evidence of the effectiveness of such measures,⁸³ while their negative impact on food and water security, access to employment, and stigmatisation has been documented.⁸⁴ Several interviewees agreed that quarantines were probably the only measure the Liberian authorities felt they could put in place to show they were in command: ‘since they have armies more elaborate than their healthcare systems, they used the army’.⁸⁵ The quarantine in West Point ended after ten days of clashes with the police, amid concerns about human rights violations.⁸⁶ From September 2014, the Government progressively abandoned forced quarantines, negotiating ‘self-quarantines’ with communities.⁸⁷

Between July and August, the CDC helped the Liberian Government set up the Incident Management System (IMS). The IMS in Liberia followed a model developed to respond to incidents throughout the US, centralising the overall emergency response, including the command, operations, logistics, planning, finance and administrative functions, as well as the scientific and public health response roles.⁸⁸ According to government sources, the IMS was not operational until September, but from that moment the authorities began to feel they were overcoming the fear and taking the first steps to control the situation.

Between July and August, communities in Liberia also began to overcome the paralysis of fear and to react. Even before the bulk of international assistance arrived in Liberia, communities began to mobilise. Kriterion Monrovia,⁸⁹ Flomo Theatre,⁹⁰ and the Liberian CSO Taskforce on Ebola⁹¹ are good examples

of the many Liberian grassroots organisations with no expertise in health or emergency response that took a step forward and started to work while most UN agencies, international NGOs, and donors were still in planning mode. Through awareness campaigns, radio soap operas, film screenings and theatre performances explaining not only how Ebola was transmitted and the risk of the virus, but also how to take care of sick people and the chances of survival, these organisations reached hundreds of communities before international organisations approached them. The messages of fear were transformed into positive messages of healing and empowerment. This work, which started as early as August 2014, was done by hundreds of students travelling from the capital to rural areas in rental buses after a basic training on Ebola, and thousands of volunteers in the communities. Community organisations also distributed food, water or chlorine donated by the government or individuals, and also helped contact tracing teams. One Liberian working for a grassroots organisation expressed what its staff found outside Monrovia, and what they managed to accomplish:

In most of the communities we visited, people told us they had never seen a single health worker. They didn’t have the slightest idea about what was going on, apart from the alarmist messages they listened to on the radio. They felt abandoned, scared and angry. We gave them a space to talk about how they felt and their concerns. We showed that it was possible to travel to even the most remote areas and work with the communities. Not a single volunteer was ever infected. That tells you a lot about the value of information and clear procedures. In August, MSF scaled up considerably the number of Ebola patients it could treat, adding 60 beds to its centre in Foya, Lofa County, and opening the largest treatment centre in Monrovia, with a capacity of up to 250 beds. In mid-September, two new ETUs were opened, one in Bong county – built by Save the Children and managed by International Medical Corps – and one in Monrovia – a 120-bed clinic built by the Ministry of Health in collaboration with WHO. Nevertheless, the number of patients still largely exceeded the capacity of the ETUs in Liberia. Some believed this showed the infection rate was still going up, while for others, the rise in diagnosed cases evidenced that Liberians had finally overcome their fear and mistrust, and were seeking assistance. Perhaps, the awareness campaigns were bearing fruit.

In the meantime, UN agencies and international NGOs also had to manage their own fear. Even the most experienced humanitarian workers were not immune to the fear of infection and their organisations struggled during the summer of 2014 to assess the potential reputational and security risks of their

participation in the response. For those organisations that eventually decided to respond on the ground, the challenge was not only to fill the positions,⁹² but also to manage the high international staff turnover⁹³ and the consequences of deploying ‘less experienced staff’.⁹⁴

In addition to the direct threat of the Ebola outbreak in West Africa and the direct threat to humanitarian personnel, the virus arrived in Liberia at a time when, as several representatives of UN agencies and international organisations confirmed, humanitarian actors were downsizing their operations in the country and in some cases closing their offices. ‘Uncertainty dominated the first months of the outbreak’, as expressed by a UN official in Monrovia, if only because most international aid organisations did not have health expertise in country and their regular programmes were suspended. The humanitarian director of an international NGO in Liberia acknowledged that ‘even the most experienced people in the organisation did not have the collective memory of how to respond to an epidemic, so we had difficulties in understanding which was our place in Liberia’. Not only the risks to the safety of the staff but also reputational risks were common concerns among international organisations in Liberia until the end of summer 2014. But then something changed, as explained by an interviewee working for an international NGO in Monrovia at the time:

We were still discussing internally if we should close the country office when our biggest donors started to put pressure on our head office to react. The fact that we did not have previous experience in health emergencies was not relevant for them. Our donors even asked us to run ETUs! As a result of that pressure we understood we had to accept the risk, so we started developing protocols and writing project proposals that matched our expertise.

Other humanitarian organisations in Liberia reported a similar internal process, from uncertainty and fear to acceptance and reaction, driven not only by donor demands but also by the understanding that there was space – and need – for more than just an emergency health response in Liberia. Nevertheless, as many interviewees belonging to international organisations in Monrovia conceded, the bulk of the international response arrived when the outbreak was already decreasing.

Containment strategy

The Declaration of the International Conference on Primary Health Care, held in Alma-Ata in 1978, affirmed that health is ‘a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity’.⁹⁵ As such, health is a fundamental human right and a ‘world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector’.⁹⁶ The *Alma-Ata Declaration* went on to state that primary healthcare should be based not only on the best medical science available, but also on socially acceptable and affordable practices ‘in the spirit of self-reliance and self-determination’.⁹⁷

The *Alma-Ata Declaration* was signed by 134 countries two years after the Ebola virus disease was first identified and, more importantly, before AIDS became a global epidemic. In the late 1970s, public health authorities in Western countries were mainly concerned with non-communicable diseases (cardiovascular diseases, cancer, chronic respiratory diseases and diabetes), thanks to the progress in the treatment of infectious diseases. The common belief was that since infectious diseases had been defeated in the developed world, epidemics, confined to remote areas of ‘Third World’ countries, could and should be contained through direct technical interventions detached from primary healthcare or even wider development considerations – in contradiction of the spirit of the *Alma-Ata Declaration*.

Thirty years after *Alma-Ata*, the Commission on Social Determinants of Health, set up by WHO, stated that the ‘unequal distribution of health-damaging experiences is not in any sense a “natural” phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics’.⁹⁸ Recurrent epidemics of communicable infectious diseases in poor countries were a prime example of that toxic combination of non-health factors at work, but such outbreaks on the periphery of the developed world were generally addressed solely with biomedical operations, against the letter as well as the spirit of the *Alma-Ata Declaration* and the recommendations of the Commission on Social Determinants of Health.

The international response to the Ebola outbreak in West Africa did not escape this containment logic. As soon as the virus was perceived as a global threat, which had overwhelmed the small group of organisations that had responded to previous Ebola outbreaks elsewhere during preceding decades, the reaction was to scale up the containment operation. The notion of the ‘unthinkable’ – the spread of Ebola outside West Africa –, inflamed by the virus paranoia ingrained in Western popular culture over those same decades, displaced all other considerations.

The narrative propagated by governments and international organisations did not necessarily contradict that paranoia. After months of neglect, the

words *Ebola* and *war* seemed consubstantial in the rhetoric and also in the decision-making – with, for example, defence departments across the world taking over many aspects of the response to the outbreak. Even the head of the United Nations Mission for Ebola Emergency Response (UNMEER), Anthony Bradbury, said during a briefing to the UN General Assembly in October 2014: ‘we are late, but it is not too late to fight and win this battle’.⁹⁹

The international response to the Ebola outbreak in West Africa did not arrive late, but right on time to contain the spread of the virus outside its ‘natural reservoir’ of impoverished countries on the periphery of the international system. In that sense, it was effective in preventing the spread of Ebola beyond Guinea, Liberia and Sierra Leone, three of the poorest countries in the world. UN agencies and international NGOs mobilised as soon as donor governments committed the funding requested and put pressure on them to respond. Fear of contagion in their territories and, in the case of the US, the UK and France, a certain degree of *post-colonial guilt* drove the response. By mid-October, \$500m had been allocated to the response in West Africa; by December the amount was over \$1bn. Although disbursement of funds was slow, international donors pledged more funds to the Ebola response than the amount officially requested.¹⁰⁰

WHO’s statement on 8 September 2014¹⁰¹ warning that international efforts to tackle the epidemic in Liberia needed to be scaled up ‘by three- to four-fold’ followed the sequence of decisions made in Washington, DC, and other capitals. WHO was right in September, but MSF had been right three months before when it asked for a massive deployment in West Africa.¹⁰² A substantial difference between the two appeals was that WHO used a global health security perspective and MSF a humanitarian one. (The former focuses on surveillance mechanisms and biomedical interventions to control emerging infectious diseases emanating from poor countries before they threaten wealthy countries;¹⁰³ the latter aims to save lives and alleviate the suffering of individuals in the poorer parts of the world where public health infrastructures are unable to provide assistance.¹⁰⁴)

In September 2014, WHO acknowledged that patients in Liberia were being turned away from ETUs and left with no option but to return to their houses without treatment, risking the lives of their relatives and neighbours.¹⁰⁵ Conventional control methods were not enough in Liberia, so WHO considered community engagement to be ‘the cornerstone of a more effective response’.¹⁰⁶ Interestingly, the UN health agency concluded that ‘where communities take charge, especially in rural areas, and put in place their own solutions and protective measures, Ebola transmission has slowed considerably’.¹⁰⁷

The model of community care centres (CCCs) – units run by community volunteers, where suspected Ebola cases could be isolated before they were transferred to ETUs or to local clinics – was seen as a *good enough* option,¹⁰⁸¹⁰⁹ once it was clear that ETUs – the best option – were not able to cope with

the high numbers of patients. In a shift that for some interviewees in Liberia demonstrated the capacity of actors involved in the response to adapt to an extremely difficult situation, and for others represented the adoption of a ‘sacrificial model’, several organisations such as Save the Children, PCI and Plan International decided to open CCCs across the country.¹¹⁰ An evaluation of the CCCs run by Save the Children concluded that ‘CCCs were introduced after local communities had engaged in their own processes of identification, triage, and isolation/quarantine’,¹¹¹ so by the time they were being constructed – an expensive process that took much longer than initially planned – the epidemic had already slowed. In sum, CCCs ‘did not achieve their initial public health goals’,¹¹² in part because of insufficient engagement with local communities and authorities and the failure to ‘keep pace with changes on the ground’.¹¹³

In October, WHO projected a catastrophic scenario of more than 10,000 cases weekly by mid-November in Liberia, Guinea and Sierra Leone.¹¹⁴ In a statement to the UN General Assembly, the Special Envoy on Ebola, David Nabarro, insisted on the idea that the outbreak was advancing ‘ahead of the control efforts’¹¹⁵ – and that therefore more doctors and nurses, and more money would be needed. This scenario was not only in contradiction of previous WHO analysis suggesting a decline in virus transmission, but was also soon called into question by the findings of two reports¹¹⁶ published by the CDC in November 2014 and later confirmed by other studies.¹¹⁷ According to the CDC, the number of Ebola cases reported in the ETU managed by MSF in Foya began to decrease substantially by mid-August, pointing to a general decrease in transmission of the virus in Lofa County.¹¹⁸ Similarly, the number of cases in Montserrado county and Monrovia showed a sharp decline after a peak in mid-September, according to ETU admissions (73 per cent decline), laboratory results (58 per cent less Ebola-positive results) and body collection (53 per cent decline).¹¹⁹ Moreover, by the end of October 2014 the beds largely exceeded the number of admissions of confirmed Ebola cases in Bong, Lofa, Margibi, Montserrado and Nimba.¹²⁰ Hans Rosling – a Swedish medical doctor, statistician and internet celebrity who arrived in Monrovia in October and spent several months advising the government of Liberia on data management and analysis – also confirmed that the outbreak was receding across the country. Rosling, who gained international fame with his original way of analysing and presenting data and statistics, said his task was to convince international organisations not to build more ETUs, because ‘the only thing you’ll show is an empty ETU’.¹²¹

In November 2014, taking into account the new data and the coverage in the US media of the decrease in the number of Ebola cases in Liberia,¹²² the US Defense Department decided that only ten of the seventeen units would be built, and that the maximum capacity would be of 50 beds, rather than the 100 beds initially planned. The Pentagon also decided to scale down the number of troops deployed in Liberia. By now, both the US government

and the international efforts to fight the Ebola in Liberia were ahead of the reality of the outbreak. As one international aid worker said, ‘the apocalyptic scenario didn’t consider the capacity of the communities to react’, but once the international aid machinery had started to move and the interests of dozens of organisations were at stake, it was not possible to downsize the response overnight. In fact, the aid worker continued, ‘many people in capitals weren’t happy when the new data about the decline in the number of Ebola cases in Liberia was published’.

Regardless of the findings from the analysis of the data, 21 ETUs were built and opened between October 2014 and February 2015.¹²³ Some of them received patients and treated confirmed cases of Ebola. That was the case, for example, of the ETU built by the Liberian Ministry of Defence in Congo Town (Monrovia), in which a Cuban team of doctors and nurses treated 198 suspected cases and 54 confirmed between November 2014 and March 2015.¹²⁴ Others, like the ETU built by the Chinese Government, a 20-room medical facility managed by 350 medical staff, only treated 10 confirmed cases during a six-month period.¹²⁵ Many others never treated a confirmed Ebola patient.

By the end of November 2014, when most of the ETUs were opened, the daily number of confirmed cases¹²⁶ was 10,¹²⁷ far below the bed-capacity and WHO predictions. In January 2015, only 25 confirmed cases were reported in Liberia.¹²⁸ From late March, daily reports consistently showed zero cases and most ETUs were in the process of being decommissioned or handed over to the Ministry of Health. The majority of the US Army contingent left Liberia in April 2015. The containment operation was over.

What controlled the epidemic, what ended it

Liberia was declared Ebola-free by WHO on 9 May 2015¹²⁹ after two consecutive 21-day incubation periods with no confirmed cases. Several interviewees, both Liberian and international, agreed that while the international response finished the Ebola epidemic in Liberia, the control of the outbreak was made possible by the reaction of the government and the population. As one international humanitarian worker said, ‘when the Liberians owned the response, the virus began to lose terrain. The country director of an international NGO even said, ‘it wasn’t us!’

These assertions would be supported by relating the consistent decline in the number of Ebola cases across the country from October 2014, even before most ETUs and CCCs were functioning, to the change in the behaviour of the population and the leadership of the government through the that took place in September. The change in communities’ behaviour, which was repeatedly cited as especially effective in reversing the upward trend of the outbreak in Liberia, should also be understood as a consequence of a change in the

behaviour of medical and humanitarian actors. As reported in Lofa County, ‘transparency in activities and engagement with the communities were central to the response strategy’.¹³⁰ For example, some ETUs were designed with materials that allowed seeing – even partially – what was happening inside. Families were invited to visit their relatives in the ETUs while observing all necessary safety measures. Burial procedures were conducted in the presence of relatives, in clearly identified, predetermined sites, and grieving ceremonies were held.¹³¹ Similarly, voluntary isolation, community self-quarantine, safe burial, and community-managed contact tracing were only possible when national and international actors approached communities and families in an open and respectful manner.¹³² (And indeed, such community engagement was only possible when basic, non-Ebola-related needs – livelihoods, medical or psychosocial assistance – were also discussed and met.¹³³) The Liberian government also learned the lesson of the controversial 10-day quarantine in West Point and – according to several sources – was subsequently keener to engage with communities through community-led taskforces, which proved very effective.¹³⁴ As a Liberian aid worker explained, ‘after the first phase of uncertainty, the government decided to use more carrots than sticks to convince people of the need to follow their instructions to stop the spread of the virus’.

The Ebola response in Liberia did not follow a single direction, but was the aggregation of disparate agendas. As one international humanitarian worker stated, ‘international organisations were trapped in their classic response models’. Indeed, some learned how to adapt their work, but most did not. For instance, a common complaint from Liberian respondents was that UN bureaucratic procedures were impossible to follow and not effective: ‘they just produced plan after plan, without going to the field and engaging directly with the communities’.

While acknowledging the challenge of responding to an outbreak of such a scale, most interviewees were especially critical of the effectiveness of the international response in consideration of the ample resources available in Liberia after the summer. However, taking into account constraints such as the extremely high staff turnover within international organisations, the very idea of ‘available resources’ would merit further analysis. As one international humanitarian worker said, ‘the cost-effectiveness ratio of the whole response was not good at all’.

The challenge of coordinating the efforts of multiple international aid organisations and donor governments with contrasting agendas was hindered by an ad-hoc coordination structure, namely the position of Special Envoy on Ebola and the UN Mission for Ebola Emergency Response (UNMEER),¹³⁵ built on top of, and to the detriment of, existing humanitarian bodies and mechanisms. The marginalisation of the UN Office for the Coordination of Humanitarian Affairs (OCHA) in the Ebola response is a case in point. In

truth, the coordination of the response in Liberia was criticised in almost every interview conducted for this study. Perhaps, as the Overseas Development Institute points out in its review of the Ebola response in West Africa, this was the *original sin* in the response:

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.¹³⁶

It was also true that in spite of the distance between many international organisations and the local people, the former's presence in the country 'gave us reassurance', according to a member of a Liberian grassroots organisation. An especially enthusiastic popular reaction followed the arrival of the US Army that many in Liberia saw as their saviours. The US government's decision to deploy thousands of troops to Liberia in September 2014 altered the dynamics of the response to the outbreak. The US Army had the expertise, the manpower and the resources, both material and financial, to make a difference in a context where there was a deficit of those. However, the effectiveness of the US Army work in Liberia should be assessed against more than the numbers of the deployment – \$385 million spent, 2,174 military personnel deployed in Liberia, 11 ETUs built, 1,539 healthcare workers trained, six mobile laboratories operated¹³⁷. What for the Obama Administration was a successful operation in terms of its own aims – to eliminate a potential danger to the US – left others complaining about what they felt was a limited engagement with the needs on the ground. Did the US Army put in place the biohazard containment operation and the full weight of its logistic capabilities in Liberia that the president of MSF International asked for at the UN in September 2014?¹³⁸ It is outside the scope and ability of this study to answer this question, but interviews in Liberia consistently revealed a scepticism among respondents when asked about the US Army's role. It had ticked many important boxes – building ETUs, setting up laboratories, and training local healthcare workers – and refused to get involved in other critical areas – such as the transportation of non-military personnel and blood samples. The perception was that, due most likely to a fear of contagion, the US Army's engagement was not commensurate with its capacity, and its operational flexibility was limited to scaling down its presence as soon as possible.

In the end, the Ebola outbreak also left an unknown number of collateral victims who didn't receive assistance in other needs as a consequence – those

who died because no treatment was available for diseases such as malaria, women who gave birth with no maternal health care,¹³⁹ orphans abandoned,¹⁴⁰ food-insecure households, and those suffering from the psychosocial impact – further limiting the effectiveness of the overall response. The almost exclusive prioritisation of the medical response meant that the specific needs of vulnerable groups, such as children, women, older people, people with disabilities and very poor households, were not addressed during most of the outbreak. Similarly, not enough attention was paid to Ebola survivors, burial teams, quarantined households, healthcare workers or families of those directly affected by Ebola who were stigmatised and excluded by their communities.¹⁴¹ It seems fair to ask which came first in the response, Ebola or Liberia.

Conclusion

Is the end of the Ebola outbreak in Liberia ultimately evidence of the effectiveness of the international and national response? Or should 4,807 deaths¹⁴² and the near collapse of an impoverished country be taken as evidence of ineffectiveness?

The construction of the 'outbreak narrative'¹⁴³ of the Ebola epidemic in West Africa has not yet been fully understood. The misapplication of the 'un-ness' categories to the outbreak shaped the initial international indifference to what was happening in West Africa, and a late and inappropriately containment-oriented response thereafter. There is no benefit in describing the Ebola epidemic in West Africa as unexpected, unmanageable, or unprecedented. Thousands of people suffered and died not because a killer virus travelled thousands of kilometres from its natural reservoir, but because of poverty, inequality and exclusion. As Priscilla Wald says, 'disease emergence is an urgent problem in the North not only, or even primarily, because disease may spread from the South to the North, but because of the role of the North in perpetuating the conditions of "thirdworldification"'.¹⁴⁴

There is no doubt that the international response was instrumental to ending the epidemic in Liberia, but it was also founded on the wrong assumptions, limiting its effectiveness from a humanitarian perspective. Excluding local people from taking ownership of the response proved to be a huge mistake, although it was not different from the exclusion a majority of Liberians experienced in their daily lives before the outbreak. The effectiveness of the actions of individuals and communities in Liberia in stopping the outbreak gave the lie to the image of Liberians as passive victims or even vectors in the transmission of the disease. As anthropologists have repeatedly explained, 'local peoples have cultural mechanisms or protocols to control epidemic diseases'¹⁴⁵ that have been demonstrated on many occasions, before external help arrived. Communities are even willing to modify the so-called ancestral

practices – such as burial practices – before any foreign expert forces them to do so.¹⁴⁶ When given information, resources and trust, Liberians were able to control the spread of the virus. This lesson might have been learned years before (for example after the outbreak in Kikwit in 1995) but was not; it should be learned now.

Similarly, that local people saw international healthcare workers and the government's efforts to control the outbreak in Liberia with mistrust was nothing new. As Barry and Bonnie Hewlett explain, 'international healthcare workers in every outbreak have been accused of starting, amplifying, or using the Ebola outbreak for their own profit or manipulation of local people'.¹⁴⁷ All this knowledge was available before the Ebola outbreak in West Africa and should have been applied in the response.

That MSF, CDC, national health authorities and a few other organisations were both left with the responsibility of controlling the Ebola outbreak in West Africa and at the same time ignored when they warned that the epidemic was out of control, is evidence of a considerable degree of systemic hypocrisy and collective negligence. This irresponsible inaction that lasted almost six months only ended when developed countries feared being directly affected by the virus. Similarly, some key actors now voice regret that the response arrived so late to West Africa, when the timing was a product of their own limitations, ill-designed decision-making processes and miscalculations.

The humanitarian system¹⁴⁸ also demonstrated a considerable lack of the responsibility, capacity, versatility, and autonomy necessary to effectively respond to the Ebola outbreak. Of course, fear, uncertainty and lack of experience with a health emergency of such dimensions have to be taken into account. However, it is legitimate to call into question the *humanitarian* credentials of a system that required half a year and the threat of a global catastrophe before responding to what was already a humanitarian crisis of huge proportions for those living in West Africa.

The question remains whether the Ebola epidemic in West Africa will be remembered as the outbreak that almost breached the walls that protect developed countries, or as the moment when we realised that there is something deeply wrong with a system that saves people's lives so that they can continue to live in extreme poverty and exclusion

ENDNOTES

1. Field research for this study was undertaken in Monrovia (Liberia) in May 2015. Interviews conducted by the author with representatives of the Liberian government (2), international donor agencies (2), United Nations agencies (5), Red Cross/Red Crescent Movement (1), international (13) and national (9) NGOs and civil society organisations in Monrovia from 21 to 30 May 2015. Given the availability of recent relevant research on community views about the outbreak and the response in Liberia, the author made a conscious decision not to interview affected groups or individuals in Liberia to avoid potential stress and harm. While this study focusses on the Ebola epidemic in Liberia, the analysis of the international response may be applicable to Sierra Leone and Guinea. The content of this report does not reflect the opinion of Save the Children UK. Responsibility for the information and views expressed in the report lies entirely with the author.
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