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# The Ebola Lessons Reader

What's being said, what's missing and why it matters

International Rescue Committee | MARCH 2016



# Introduction

A comprehensive review of Ebola reports offer valuable solutions, but they also perpetuate problems by ignoring fundamental realities.

The weaknesses of the global response to Ebola in West Africa from 2014 to 2016 not only cost tens of thousands of lives; it also hurt the credibility and confidence of the global health community. So it was encouraging that universities, think-tanks, the World Health Organization and other institutions took time to explore what went wrong and how we can all do better.

The resulting reports contain valuable, actionable insights. But collectively, their impact falls short of what could have been.

First, the sheer number and diversity of documents threaten to diffuse, rather than intensify, the focus on key issues. Similar recommendations, articulated differently, risk making consensus sound like cacophony.

Secondly, and more seriously, these reports reflect a persistent weakness of the global conversation about health systems: the erasing of politics. This includes the politics of poor, post-conflict countries, but also the politics of the UN, NGOs and the international aid world. These failures set the stage for a small Ebola outbreak to evolve into a catastrophic epidemic. The failure to anticipate and adapt to political realities then hobbled the response effort.

The reports—with the notable exception of the working paper by the Overseas Development Institute—perpetuate a simplified narrative of the Ebola epidemic. It focuses disproportionately on the top levels of the World Health Organization, while giving little to no scrutiny to other key issues and a complex ecosystem of players that carried out the bulk of the response.

Thousands of staff of the International Rescue Committee (IRC) participated in the Ebola response in Sierra Leone and Liberia, working with everyone from top decision-makers in WHO to front-line health workers and Ebola patients. We reviewed these reports with these responders in mind, the vast majority of them citizens of the affected countries. We owe it to them, and to the tens of thousands of people directly affected, to highlight the realities of the response that are in danger of being forgotten. We also owe it to the present and future generations that will be faced with the next deadly infectious disease epidemic.

## METHOD

### Report Analysis

We have selected reflections from key actors involved in the Ebola response. Our selection includes representatives from academia, think-tanks, NGOs, donors and the United Nations. We identified specific top-line recommendations assigned to actors and consolidated similar observations. Pages 4-9 include our review.

**Bill Gates.** [The Next Epidemic – Lessons from Ebola](#). New England Journal of Medicine 2015. April 9, 2015.

**World Health Organization.** [Ebola Interim Assessment Panel “Stocking Report.”](#) July 2015.

**Tony Blair Africa Governance Initiative.** [State of Emergency: How Government Fought Ebola](#). July 10, 2015.

**Overseas Development Institute.** Humanitarian Policy Group Working Paper. [The Ebola Response in West Africa: Exposing the politics and culture of international aid](#). July 10, 2015.

**The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola.** [Will Ebola change the game? Ten essential reforms before the next pandemic](#). The Lancet. November 22, 2015.

**Council on Foreign Relations.** [Lessons Learned After the Ebola Crisis - Darryl G. Behrman Lecture on Africa Policy with Thomas Frieden](#). November 24, 2015.

**Médecins Sans Frontières.** [Epidemics as Neglected Emergencies](#). November 25, 2015.

We chose to respond to the current reports rather than to start a new conversation. We want to build on the strong points of these reports and to fill in critical gaps. What's agreed upon and what's missing? What should the global community be doing more of or differently?

Our aim is to make our shared goal of “never again” less likely to remain a well-placed intention and more likely to become a reality.

# Summary of Findings

The reports we reviewed had strong insight and numerous — 74, by our count — recommendations, many of which are generally agreed upon. We have chosen to focus our attention on key issues that were not addressed.

## All eyes on the World Health Organization

The reviewed reports intensely scrutinize the World Health Organization's role and performance but fail to address basic questions about WHO's mandate. Most of the reports assume, in both their diagnosis and their prescriptions, that WHO is and should be an operational agency, rather than a norm-setting, coordinating agency. In reality, there are questions about whether it is feasible for WHO to be operational at a large scale, even with significant reforms. Another weakness of the reflections is a focus on the upper tier of the institution. There is almost no attention given to practices throughout the organization, such as those related to human resources, which heavily affect WHO's performance in epidemics. The various high-level committees and oversight bodies being proposed are unlikely to impact these practices.

## Few eyes on anyone else

The reports give little scrutiny to other actors who provided the bulk of the response. While the reports primarily focus on WHO, other actors — including other United Nations agencies, NGOs, local communities and governments, militaries, donors, health workers and governmental public health agencies — played enormous roles, whether in people deployed, cases detected, technical support, coordination, bodies buried or money spent. Their strengths and weaknesses will determine how

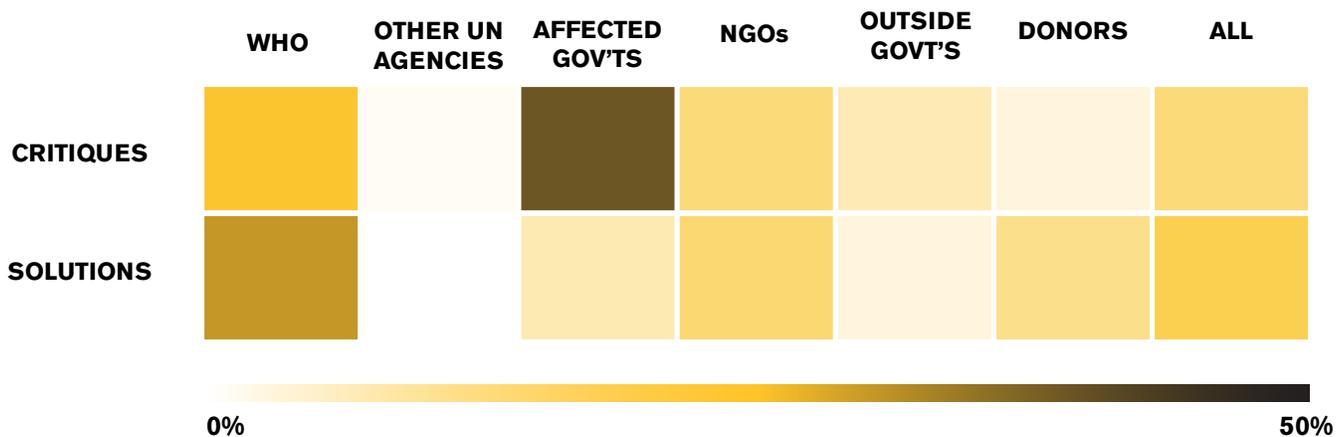
effectively we avert the next tragedy.

## Politics big and small

Collectively, the reports pay inadequate attention to the politics of the countries affected and of the international response. Ebola raised important questions, but missed the key one: not what governments or aid actors say or say they are going to do, but what people hear and what they do. This is what we call the politics of the response. For example, the reports focus on the delay of the response, but overlook the fact that governments and other actors were beginning large-scale efforts to respond and educate the public as early as April 2014. One of the reasons that these early efforts failed is because the public in affected areas did not trust the messengers. The reasons for this mistrust are complex, involving past and current sins, and political. Alternatively, successes against Ebola—and why the epidemic did not cost hundreds of thousands of lives, as experts feared at one point—were in large part thanks to actors who took into account political realities and cultural sensitivity, particularly around activities like community engagement and burials. These dimensions are glossed over in most of the reports. Similarly, several of the reports recommend health system strengthening, treating the issue as a technical one. Unmentioned are relevant political realities: weaknesses in governance, unpaid health workers and a decade of health system strengthening as an apolitical exercise. Mixing politics into public health makes for uncomfortable conversation, but we can't prevent another catastrophe without having that conversation.

## ANALYSIS OF EBOLA REFLECTIONS: WHO WAS THE FOCUS?

Challenges facing the governments of the affected countries were highly noted in the reviewed documents, but most critiques focused on technical weaknesses rather than politics or mistrust. Proposed solutions focused on external actors. Altogether, critiques and solutions tended to focus on the World Health Organization.



# THE EBOLA LESSONS READER



ACTOR	CRITIQUES/OBSERVATIONS	RELATED RECOMMENDATIONS	OUTSTANDING QUESTIONS
WHO	WHO did not have the skilled human resources or capacity to respond to the outbreak.	WHO needs improved governance and leadership. <sup>1,2,5,6</sup> WHO should be made fit for emergency response. <sup>2,5</sup> WHO should develop a dedicated center for outbreak response with strong technical capacity, a protected budget and clear lines of accountability. <sup>5</sup> An independent UN Accountability Commission should be created to do system-wide assessments of world-wide responses to major disease outbreaks. <sup>5</sup>	Is the WHO supposed to be an implementer, a coordinator, a technical leader, or all of the above?  Why did a new coordinating mechanism, the UN Mission for Ebola Emergency Response, have to be set up in September 2014? Was it because the WHO faced difficulty hiring the right country representatives? Was it because the Ebola epidemic should have been immediately treated differently than a health emergency?
	WHO was not financed to respond to the epidemic.	WHO should be appropriately financed. <sup>1,2,5</sup> Gov'ts, in exchange for successful reforms, should finance most of the budget with untied funds in a new deal for a more focused WHO. <sup>2,5</sup>	
	WHO was overruled by politics, compromising its ability to alert the global community.	WHO country-level representatives must have independence and full support. <sup>2,7</sup> WHO needs a politically protected Standing Emergency Committee, which will make declarations. <sup>5</sup> The Global Health Committee, as part of the UN Security Council, should expedite high-level leadership and elevate political attention to health issues. <sup>5</sup>	
Other UN agencies	UNMEER was unsuccessful.	UNMEER is not the appropriate model mechanism for managing future large-scale health emergencies. <sup>2</sup>	Why was there little to no mention of UNICEF or WFP? (See p.12)

1. Bill Gates. [The Next Epidemic – Lessons from Ebola](#). New England Journal of Medicine 2015. April 9, 2015.  
 2. World Health Organization. [Ebola Interim Assessment Panel “Stocking Report”](#). July 2015.  
 3. Tony Blair Africa Governance Initiative. [State of Emergency: How Government Fought Ebola](#). July 10, 2015.  
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ACTOR	CRITIQUES/OBSERVATIONS	RELATED RECOMMENDATIONS	OUTSTANDING QUESTIONS
Affected Gov'ts	Governments did not support or enable early warning and detection.	<p>WHO needs to incentivize countries to report public health risks, i.e. financing mechanisms, lists of countries that delay.<sup>2,5</sup></p> <p>WHO members must adhere to the International Health Regulations (IHR).<sup>2,7</sup></p> <p>WHO must improve accountability for countries to identify/stop threats and improve assistance to those that don't.<sup>7</sup></p> <p>WHO should cost, and World Bank should finance, a plan for all countries to develop IHR capacities.<sup>2</sup></p> <p>Gov'ts facing an outbreak must put developmental priorities second to saving lives and preventing the spread of disease.<sup>6</sup></p>	<p>How can we make International Health Regulations a reality? Meeting these regulations will require sustained donor funding until governments have sufficient tax bases and functioning accountability mechanisms. Currently, there are no obligations for donors to help poorer countries meet these obligations.</p> <p>As far as IHR, what is or is not currently working in countries? For example, we recognize that detection and response is particularly difficult in low-resource areas. Can we target such areas and determine the building blocks and costs needed to improve it?</p>
	Governments required strong political leadership with clear accountability to the people of the country.	<p>Gov'ts must put top people in charge, assume responsibility and be seen leading.<sup>3</sup></p> <p>Aid organizations should support effective management systems that allow gov'ts to make the right decisions.<sup>3</sup></p>	<p>Are politics a taboo in public health? How did the political economy, both of the affected countries and the international global health community, positively and negatively impact the response? (See p.14-15)</p>
	Governments lacked human, financial or material resources.	<p>The global community must mobilize adequate external support for poorer countries.<sup>5,7</sup></p> <p>Gov'ts need to demand what is needed from the international community and then use all resources effectively.<sup>3</sup></p> <p>A list of necessary supplies to stop an epidemic could be developed, and experts could determine which items would need to be stockpiled/subject to commandeering.<sup>1</sup></p> <p>All countries should commit to managing a pool of volunteers in the case of the next epidemic.<sup>1</sup></p> <p>All countries could identify trained military resources that would be available for epidemics.<sup>1</sup></p>	<p>Why hasn't a global strategy yet been proposed to fund these capacities? Where can we strengthen existing resources and mechanisms? Examples of such mechanisms include distribution networks and stockpiles for vaccinations and networks of community health workers. Can existing resources be rationed more effectively through harmonizing structures like consortia?</p>

1. Bill Gates. [The Next Epidemic – Lessons from Ebola](#). New England Journal of Medicine 2015. April 9, 2015.  
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ACTOR	CRITIQUES/OBSERVATIONS	RELATED RECOMMENDATIONS	OUTSTANDING QUESTIONS
Affected Gov'ts	Governments were susceptible, and unable to respond, to Ebola due to weak health care systems.	<p>Resources need to focus on strengthening health systems in low- and middle-income countries for normal situations and epidemics.<sup>1,5,6,7</sup></p> <p>The int'l community must ensure that gov'ts invest in detection and response capacities and mobilize external support to supplement efforts in poorer countries.<sup>5,6</sup></p> <p>Donors must provide adequate resources to build effective emergency response systems as part of efforts to strengthen medical infrastructure.<sup>6</sup></p> <p>Recovery plans should be contingent on the ability of UN agencies, NGOs, donors and governments to articulate how they will build health systems differently.<sup>4</sup></p> <p>Int'l institutions such as the WHO must target this issue, i.e. financial investments and hands-on support.<sup>6</sup></p> <p>Aid actors should help national governments with limited capacity to translate contingency plans into reality.<sup>6</sup></p> <p>Gov'ts must agree to regular, independent, external assessment of their core capacities.<sup>5</sup></p> <p>Gov'ts must work collaboratively with int'l partners.<sup>3</sup></p> <p>Building the technical capacities of health cannot overlook other targets of capacity, such as politics and power.<sup>4</sup></p>	Is it realistic for an improved, but still weak, health system to handle a lethal infectious disease that challenged far more wealthy and established systems? Can health systems be improved to the required extent without addressing weaknesses in governance? (See p.14-15)

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ACTOR	CRITIQUES/OBSERVATIONS	RELATED RECOMMENDATIONS	OUTSTANDING QUESTIONS
NGOs	Aid organizations failed to acknowledge that context and politics mattered for seemingly technical aspects of the response.	Aid organizations must better understand the culture and political context for technical aspects of the response. <sup>3</sup>	Do NGOs fail to adequately consider politics in public health programs? (See p.14-15)
	NGOs coordinated poorly, whether amongst themselves or with the affected governments.	NGOs should support government structures instead of creating their own. <sup>3</sup>	Is there too little scrutiny of NGOs and their performance? (See p.12)
	NGOs already working in countries are slow to shift from developmental approach to an emergency. Their relationships with national governments make them less willing to highlight epidemics.	<p>Aid organizations that pledge themselves as emergency responders need to ensure they have the capacity to rapidly deliver services i.e. clinical care.<sup>3,6</sup></p> <p>NGOs need to be clear about what they can and cannot do.<sup>3</sup></p> <p>Int'l actors in the face of an outbreak need to place developmental priorities second to saving lives and preventing the spread of outbreaks.<sup>6</sup></p> <p>NGOs need to be flexible throughout the course of an epidemic to respond to evolving needs.<sup>3</sup></p> <p>NGOs need to examine the role of capacity, fear, risk and duty of care within their organizations and mitigate them.<sup>4</sup></p>	How did NGOs perform, beyond the delivery of clinical care? What difference did having long-term roots in the countries make? What crucial roles did local NGO staff play? What advantages did NGOs have over other actors? (See p.12)

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ACTOR	CRITIQUES/OBSERVATIONS	RELATED RECOMMENDATIONS	OUTSTANDING QUESTIONS
Data, Research & Development	Reliable systems for sharing epidemiological, genomic, and clinical data were not established during the Ebola outbreak.	Gov'ts, the scientific research community, industry, and NGOs must develop a framework to enable, accelerate, govern and ensure access to R&D. <sup>1,5</sup>  WHO should play a central convening role in R&D in emergencies. <sup>2</sup>  Foundations and tech companies could build an instantly accessible digital database. <sup>1</sup>	Did the aim for perfect data compromise the timeliness of the response? Should more focus be on working solutions, like minimum datasets? Could the WHO establish rapidly usable and deployable systems for data sharing during emerging outbreaks? This could include legal agreements, data formats, minimum datasets, standard operating procedures and baseline standards for ethical review.
	There was no process for developing accurate or adaptable diagnostic tests, drugs and vaccine platforms. Private sector organizations do not have incentives to shift resources away from more commercially viable projects to work on these tools.	Regulatory pathways for developing new tools and approaches should be clarified. <sup>1</sup>  Stockpiles or manufacturing capacity for therapies that might be effective in an epidemic should be established. <sup>1</sup>  Research funders should establish a financing facility for outbreak-relevant drugs, vaccines, diagnostics and non-pharmaceutical supplies. <sup>5</sup>	Can organizations be assigned to establish protocols and ethical parameters for testing drugs and vaccines, when needed?
Outside Gov'ts	Outside governments established unnecessary trade bans and travel restrictions that restricted the movement of humanitarian workers and supplies.	Incentives should be strengthened for science-based justifications for trade and travel restrictions. <sup>2,5</sup>  Independent flight and medevac capacity should be established. <sup>4</sup>	How can the media assist? Strong media endorsement of recommendations, and restraint from exacerbating fear, is critical to ensuring free movement of humanitarian workers and supplies.
	The deployment of international military forces securitized the response.	More attention is needed to the role of the security sector in health emergencies. <sup>4</sup>  Military support for emergencies must be under civilian control. <sup>4</sup>	Where did the military do good and where did they do harm? (See p.12)

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ACTOR	CRITIQUES/OBSERVATIONS	RELATED RECOMMENDATIONS	OUTSTANDING QUESTIONS
Donors	Donors allocated funding inflexibly and drove their own priorities.	Donors should incorporate flexibility into funding mechanisms and contracts. <sup>4</sup>	How did some key donors demonstrate flexibility? How did human resources decisions help their effectiveness? (See p.13)
	Donors severely delayed the disbursement of funding.	Donors must develop faster and clearer mechanisms to release funds in an emergency. <sup>6</sup>	Are there new mechanisms for rapid disbursement to respond to the next epidemic?
All	Top-down communication sidelined the communities whose engagement was essential.	WHO and partners must ensure that appropriate community engagement is a core function in a health emergency. <sup>2</sup>  Anthropological engagement will need to include actionable solutions and recommendations that foster more culturally acceptable messages and measures. <sup>4</sup>	Is effective community engagement possible without deep understanding of the political context and origins of mistrust? (See p.14-15)
	The response suffered from the lack of an effective systems approach that understood and coordinated all components of the response.	Systems must be improved through clearly defined roles, objectives and accountability of international partners and governments. <sup>1,3</sup>  Systems should include mechanisms for information to be collected and shared; ways for issues to be escalated; and consistent opportunities for experts to engage decision makers. <sup>3</sup>  The UN and WHO should explore how to strengthen the WHO's capacity, including which parts of the process it should lead and which should be led by others (i.e World Bank, G7 countries, NATO). The final arrangement should include a reserve corps of experts with the range of skills needed in an epidemic. <sup>1</sup>	Most broadly, we believe that affected countries must serve as the overall coordinators of action. The WHO and other UN agencies should focus on technical leadership and setting norms. International and local organizations should, in alignment with the broader strategy set by the national authorities, implement the response and be adequately funded to do so. We found that consortia served as effective harmonizing structures to improve efficiency, effectiveness, speed and scale of NGO work.

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Road to Foya, where the Ebola virus first crossed into Liberia from Guinea, October 2014. Photo by Peter Biro / The IRC

# Analysis

The global community owes it to those affected by the Ebola epidemic — and those who will face various epidemics to come — to examine gaps in our collective learning.

## All eyes on the World Health Organization

One common point in all the reviewed reports is a focus on the failings of the World Health Organization (WHO). The errors mentioned most often are the delays in grasping the severity of the epidemic and developing an adequate response. Several of the reports examined the international political issues behind those failures: the difficulty of making public health decisions in the face of political pressures from WHO's member states and the impact of reduced and earmarked funding on WHO's capacity to respond. The reports offer several solutions to insulate some key mechanisms from these pressures, which include unrestricted funding and the creation of decision-making bodies that are more insulated from political pressures. Unfortunately, for all of this scrutiny, the reports don't address confusion about WHO's mandate.

Many of the reports criticize WHO for its failure to mount an adequate response itself without addressing one critical reality: WHO has never been an implementer of large-scale public health interventions. This understanding was crucial in this epidemic, as it will be for future epidemics. Many WHO staff played important roles in fighting the outbreak and began implementing in the early part of the response out of necessity. But it was Ministries of Health staff, along with local and international NGOs, that led the vast majority of implementation. This included communicating with the public, finding cases and contacts, treating patients and burying the dead safely. Such activities require large numbers of staff, the ability to hire quickly and hold staff accountable for performance, a flexible and rapid supply chain and experience with field operations. The WHO was not conceived as an operational agency to carry out these functions.

WHO's value and strength at its best, and those of many other UN agencies, actually lies in its authority to set technical norms and lead coordination. It's a role that WHO has taken on, many times successfully, in areas from childhood diseases to nutrition, and during emergencies. Why, in this case, did WHO fail at coordinating,

to the extent that an entirely different coordinating mechanism, the UN Mission for Ebola Emergency Response, had to be set up in September 2014? Was it because of the difficulty in hiring the right country representatives? Was it because Ebola was more than a health emergency? What can be done to improve WHO's coordinating role in epidemics?

The Ebola response should also raise questions about the influence of the institution's human resources practices. Does a para-governmental approach to human resources, which includes lifetime tenure and generous benefits, discourage appropriate risk-taking while providing limited accountability for poor performance? These questions have not yet been answered.

While the reports reflect many actionable solutions to improve the WHO, they are disproportionately aimed at the upper levels of the institution. Most of the reports advocate for new committees or other bodies at the top levels of the WHO. These changes will not address a core problem common to the WHO, other UN agencies and governments during the Ebola epidemic: the inability to get accurate information in real time and the absence of feedback loops to inform leaders whether interventions were effective.

These issues were exacerbated by a reliance on contractual and rotating deployments. Staff couldn't stay long enough to sustain support for people on the front lines. When WHO did have staff who were well connected with local staff and well informed about what was happening in real time, they were remarkably effective. Two of the reports specifically point out that staff on the ground are, in reality, the decision-makers for timely action. We agree with the recommendation that highlights the need for better feedback systems that ensure that front-line staff are heard and able to make decisions. Changes at the leadership level are less important than changes in the structure of the organizations involved—WHO, but also many others—to develop leaders at the front lines.

## **Few eyes on anyone else**

The reports generally overlooked actors who did the bulk of the operational work in this epidemic — and likely will in epidemics to come.

**Non-governmental organizations.** NGOs play the key role of turning the theory of response into on-the-ground action. Yet critiques pay little attention to the advantages and systemic flaws in how NGOs work. Local and international NGOs hired thousands of staff, identified thousands of cases and buried tens of thousands of bodies. In terms of number of staff and people reached, they represented the bulk of the response. Since this is likely to happen again, their strengths, weaknesses and decisions deserve scrutiny. Why did they respond so late? What were the challenges in switching from developmental to emergency interventions? What difference did having long-term roots in the countries make? What crucial roles did local NGO staff play? What advantages did NGOs have over others in terms of links with communities, staff accountability and ability to work together to achieve national coverage? NGOs need more scrutiny and accountability than reflected in our review.

The reports that did look at NGO performance focused on the delivery of clinical care. Questions about medical response are important, but should be balanced to reflect the needs of an epidemic response. This includes clinical care, surveillance, health systems support and community engagement. At the IRC, we are proud of our accomplishments supporting the Ebola response but acknowledge that it unveiled our own internal weaknesses in emergency epidemic response. The IRC is working to develop systems to improve the rapid implementation of medical response for epidemics, which complements our added value: a long-term presence that focuses on community engagement and health systems.

One missed lesson relates to improving coordination. In both Sierra Leone and Liberia, the IRC worked with organizations — most of whom had long established footprints in the countries — to develop a consortium structure that improved efficiency, effectiveness, responsiveness, speed and scale. This structure allowed organizations to deliver interventions across the country in activities as diverse as contact tracing and safe burial. In Sierra Leone, the IRC led the Ebola Response Consortium, which included 15 organizations. Working with

six of those organizations and UNICEF, CDC and the Ministry of Health, the consortium was able to implement infection prevention and control and screening for Ebola across all of the country's 1,118 primary health care facilities in just eight weeks. Such consortia played a crucial role in fighting Ebola; well understood, they can support the government and WHO in future epidemics.

**Other United Nation agencies.** While ample attention has been given to the WHO and some to UNMEER, none of the reports include recommendations for other UN agencies that stepped outside their traditional scopes to play significant roles within the Ebola response. UNICEF is the global leader in social mobilization, a component of the response recognized as flawed. Likewise, UNICEF took a leadership role in scaling up community care centers in Sierra Leone and Liberia with mixed results. What could UNICEF have done differently? Does this failure suggest the need for reforms at UNICEF, just as they are being recommended for WHO? Likewise, World Food Program was stretched by efforts to establish internet connectivity and responsible for supporting food distribution for quarantined families. Concerns about poor stewardship of goods during the epidemic were understood to weaken public trust. A review of the Ebola response should examine these issues.

**International militaries.** International militaries played a variety of roles of need and consequence, which were not discussed with any depth. At their best, militaries provided large-scale logistical support for the construction and management of Ebola Treatment Units. The UK's military also provided significant support with the management of the District Ebola Response Centers in Sierra Leone to support the Minister of Defense, which became the leader of the National Ebola Response Center. The military was very helpful in improving command and control systems in Sierra Leone and improving the accountability of responders at the district level. However, their involvement in any community-level work, including the enforcement of quarantines, was seen as counterproductive or coercive. These measures exacerbated fear and contributed to transmission by spurring people into hiding. There is a long history of military involvement in epidemics, and militaries will likely be involved again. We agree with the recommendation calling for review of how militaries are used in future epidemics. Also, given that militaries represented a



An ambulance nurse in Kono, Sierra Leone, preparing to help a child into an ambulance. Photo by Laura Miller / The IRC

significant portion of foreign investment, a review on their value for money should also be conducted.

**Government public health agencies.** None of the reports adequately recognize the key contributions of governmental public health agencies. Government public health agencies like the US Centers for Disease Control and Prevention (CDC), the UK's Public Health England (PHE) and the Chinese Center for Disease Control and Prevention significantly contributed towards the Ebola response. This role was particularly important because these agencies worked in an area in which almost no one else was operating—laboratory testing. The three countries provided much of the technical staff who oversaw testing for the Ebola virus. The US CDC contributed the most staff members, including hundreds of people that supported various technical areas from infection control to surveillance. These agencies helped, but they also had shortcomings. Staff deployments were in some cases limited to less than a month. Some of these agencies have conducted internal reviews, but the public reviews summarized by the reports should provide for public and independent scrutiny of their role.

**Donors.** The most common critique of donors in the current reports discussed their delayed commitments and disbursements as well as their rigidity. This is again a simplified narrative that doesn't yield adequate learning. As with the other actors in the epidemic, donors made good decisions and mistakes. Some donors showed

flexibility in allowing NGOs to shift funds. This included the Department for International Development (DFID), European Commission's Humanitarian Aid and Civil Protection department (ECHO) and Office of U.S. Foreign Disaster Assistance (OFDA)/United States Agency for International Development (USAID).

OFDA/USAID allowed the IRC to redirect funds from the Ebola Treatment Unit to the reopening of Redemption Hospital, the only free hospital in Monrovia. This change allowed the IRC to help respond to the non-Ebola health emergency created by the epidemic, particularly at a period when Ebola cases were declining and sufficient Ebola treatment units were operating. And the hospital continued to prove to be an important investment — the hospital was able to identify a new case of Ebola when many Ebola Treatment Units were empty.

Another key learning, as with the UN and with NGOs, involves staff. DFID and OFDA/USAID, for example, were effective thanks to the decision-making of staff who had long histories in the countries, understood the political economy and effectively prioritized funding for public health. These lessons must be applied as donors continue to coordinate in the recovery period. Despite the fact that tremendous investment was poured into the health systems of Sierra Leone and Liberia to respond to Ebola, there is currently no clear strategy from donors as to how, if, and for long, they will invest in these systems.

## **Politics big and small**

**The reports pay inadequate attention to the politics of the countries affected, and of the international response.** Mistrust between the government, service providers, external actors, citizens and communities was one of the most important factors that shaped the successes and failures of the Ebola response. Yet the role of trust was only deeply discussed in one report; most of the reports confined themselves to calls for improved community engagement and context-appropriate interventions without delving into why community engagement was so unsuccessful, particularly early on, and why mistrust of government and health workers was so prevalent.

Ebola struck two post-conflict countries that have battled political, economic and social dysfunction in the wake of long, brutal civil wars. Authorities exacerbated the mistrust held by populations by struggling to provide life-saving services. Missteps during the epidemic, such as military quarantines and the failure to deliver on promises of ambulances and other services, only added to the legacy of past grievances. At times, NGOs contributed to this mistrust when they failed to adequately listen to, and communicate with, communities and tailor responses efforts based on feedback.

Conversely, some government officials and NGOs found ways to reach people. In Liberia, religious leaders were invited to join the burial teams at the request of communities. In Sierra Leone, communities asked the deceased to be buried in a traditional cloth. Both of these measures helped to significantly improve the reporting and safe burial of Ebola victims. Another example from Sierra Leone included the efforts of Dr. Mohamed Vandi, the Government District Medical Officer who tried to build trust in urban Kenema by aiming to visit every household in the city over a 14-day period to listen to the people's questions and provide them with answers about Ebola.

Given the fundamental role that trust played in the epidemic, it's essential that reviews devote adequate space to understand what helped and what hurt in building trust. Ebola raised important questions not what governments or aid actors say or say they are going to do, but what people hear and what they do. This is what we mean when we refer to politics.

One specific element that should have received far more attention is the issue of health worker salaries. The onset of the epidemic in Liberia coincided with a strike by health care workers to protest the failure of government to pay salaries.

At the height of the epidemic, health workers protested over the lack of hazard pay. In addition, governments were not able to supply sufficient quantities of basic protective gear. This lack of support resulted not only in the demoralization and death of health workers, but also further weakened public trust in health workers, who were occasionally viewed as perpetuating myths about Ebola to elicit funds. These issues were at the forefront of preoccupations, both for health workers and the population, yet were only mentioned in one report.

### **Many of the reports mention health systems strengthening, but as with mistrust, fail to delve into the political issues behind the problems.**

Recommendations generally agree on the need for strong health systems. But there is nothing new about calling for more investment in health systems: such calls have become a cliché of global health strategies of the last 20 years. The reports miss opportunities to ask more sophisticated questions about why past efforts have failed, and what we need to do differently.

Is it realistic to expect improvements of the speed and scale needed to handle diseases such as Ebola? No doubt, both Sierra Leone and Liberia have achieved progress in their health systems. Liberia is one of six countries in Africa to meet Millennium Development Goal No. 4, having reduced under five mortality from 220 deaths per 1,000 live births to 75 per 1,000 live births. But is there a leap in expectations between achieving improvements in basic metrics and asking a health system to handle a lethal infectious disease that challenged far more wealthy and established systems?

Can health systems be improved to the extent required without simultaneously strengthening broader governance institutions? Many of the reports fail to highlight the key role of governance. There are understandable reasons why authors chose to ignore this salient issue. But as a consequence, governance, acknowledged in WHO's own frameworks as the most foundational of the health system pillars, remains absent in both the analysis and recommendations section of all reports except those



Theresa Musa, a health worker, cared for Ebola patients at Sierra Leone's Bo Government Hospital throughout the epidemic. Photo by Lucy Carrigan

from AGI and ODI. One of those, by ODI, says what most reports, and indeed most health systems efforts, failed to recognize: that any effort to improve health systems can only succeed if it is based on an understanding of the politics involved, both within the countries being helped and within the international aid community.

Years of ignoring politics has led to a narrow, technical understanding of health systems strengthening which limited the effectiveness of public health efforts, and failed to address the concerns of citizens. The Ebola reports reflect that dilemma, but they help to perpetuate the problem, too. We need to find a way to talk about politics in these reports that is neither naïve nor presumptuous, arrogant or patronizing. One possible solution would be for more of the reports to be written by people from the countries affected by the epidemics or for the development of reports to consciously and actively involve nationals from the affected countries.

Another way is to start asking the right questions. Who are the decision makers? How are decisions made? Who are the powerless? What influence do certain groups have? How are resources distributed? Who benefits? Who is excluded? How does this impact trust?

Our understanding and answers to these questions should help determine what we do and how we act. This will be crucial not just for the next epidemic, but in the ongoing conversations to make “never again” a reality.

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FRONT: A street in Lofa, Liberia, featuring messages about Ebola at the height of the epidemic. BACK: The IRC's Emmanuel Boyah leads a discussion about Ebola in the hard hit town of Barkedu, Liberia. Photos by Peter Biro / The IRC



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