CASE STUDY:
WEST AFRICA
EBOLA EPIDEMIC RESPONSE 2014

Course on Cooperation in Stability Operations,
August 2015

INSTITUTE
FOR DEFENSE
& BUSINESS

This page intentionally left blank.

PREFACE

The Center for Stabilization and Economic Reconstruction (CSER) of the Institute for Defense and Business in Chapel Hill, NC, regularly conducts a week-long course on Cooperation in Stability Operations for responders to crises. One day of the course is devoted to a case study of cooperation – or lack thereof – during a prior conflict or disaster. The following represents the conclusions of the case study used in August 2015: the response to the 2014 Ebola epidemic in West Africa, as seen from the perspectives of military, governmental, international organization, and humanitarian NGO responders.

The case study discussions operated under the Chatham House Rule, and therefore this summary deliberately does not identify individual commenters or their organization.

BACKGROUND

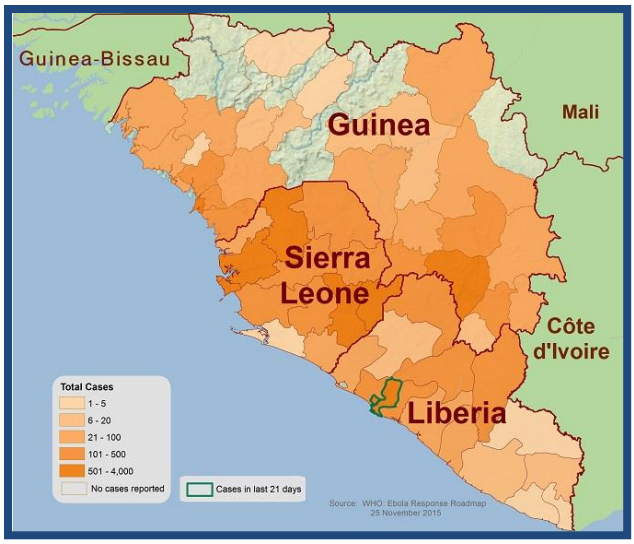
In March 2014, the first cases of Ebola emerged in West Africa in what was to become the largest outbreak of the disease since the virus' initial emergence in 1976. The epidemic was heavily concentrated in Guinea, Sierra Leone, and Liberia, affecting large numbers of people, and continued to spread amongst the three nations via porous borders and rapid infection in urban areas. Though the virus managed to travel outside of these three countries, it infected only small numbers in other nearby countries.

As with prior outbreaks of the disease in Africa, the affected countries had suffered chronically from fragile public health systems, generally poor governance, and local citizens' mistrust of government. When Ebola spread exponentially, the already wobbly systems further crumbled, adding complexity to a catastrophic health crisis.

Months passed before key global entities finally issued formal declarations that generated significant international involvement. The incidence of deadly hemorrhagic fevers like Ebola is not new in Africa, and traditionally had been confined to small and isolated populations, leading to quick containment of the disease, despite its brutal toll on the victims. In the spring of 2014, few recognized and acted upon the potential for the catastrophic dimensions of the Ebola epidemic; many organizations were cautious and chose not to rush to judgment.

Finally, on August 8, 2014, the World Health Organization (WHO), as the United Nations' (UN) lead authority on global health, declared the Ebola outbreak as a Public Health Emergency of International Concern. This global plea for assistance rallied responders already in the region, and galvanized the resolve of new players to contribute to the response effort. The UK and France, former colonial powers in Sierra Leone and Guinea respectively, took the lead in collaborating with the host nation authorities in those countries. The United States took the lead in Liberia, in recognition of the two countries' historical ties. Many non-governmental organizations (NGOs), other international donors, and private sector corporations that had been involved in West Africa for years with long-term commercial and development programs also deliberated on how to sustain their on-going operations and how their capabilities could support the relief effort.

In a little over 21 months, the United States' Centers for Disease Control and Prevention (CDC) reported over 28,000 Ebola cases that were suspected, probable, and confirmed. Nearly 40% of those cases resulted in deaths. By November of 2015, it appeared that the Ebola epidemic was in its final stage, with Sierra Leone declared "Ebola-free," and Guinea well on its way to joining Sierra Leone. In Liberia, Ebola has resurfaced with a small amount of confirmed cases, but there is hope that the local health officials will be able to contain the disease. It had been a gruesome battle against this disease and many of the "lessons observed" that emerged from the crisis were unfortunately not new to the global public health and humanitarian assistance communities.



Source: WHO Ebola Response Roadmap, 25 Nov 2015.

CHALLENGE #1: DIFFERING MISSIONS, INTERESTS, AND AGENDAS

When the Ebola outbreak hit the region, the response by humanitarian relief organizations was not uniform. Those already in the region, including some UN agencies, bilateral donors, and international NGOs, had to decide whether to shift gears abruptly. Some did, some did not. Other organizations rushed into the region, some for the first time as a crisis responder (as opposed to their traditional long-term development technical assistance work). Most of these responders came with different interests, mandates, and agendas. Many local governmental and civil society organizations also had political agendas or engaged in corrupt practices that in the course of time throttled effective relief and undermined trust. Many responders complained of unhelpful, competing agendas among several Liberian ministries and agencies. NGOs were also in intense competition with each other, vying for attention from their stakeholders. Donors touted their large contributions, but accounting metrics varied widely, making comparisons or aggregations futile.

Many large organizations, such as the UN and the US government, had different focuses and interests within different geographic "arenas" – subnational, national, regional and global. For the USG and its participating agencies, this required extensive coordination up and down the chain, from Washington to the village level and back. As Washington did not "own" the Ebola crisis, cooperating and sharing responsibilities across different entities, especially with the UN, and with other key nations, such as the UK and France, were also critical to effectiveness of the response. The UN itself had internationally accepted coordinating responsibilities that put it in a leading role across several dimensions, such as medical and logistics operations.

For the first time in an international humanitarian crisis, USAID and CDC shared responsibilities in the lead for the USG. However, CDC did not share the directive authority of USAID, the designated USG lead agency in international disasters. Moreover, CDC's learning curve in the Ebola response was steep, as its prior role in Liberia was assisting in capacity building for the Ministry of Health, and the Ebola event was the largest outbreak response in CDC's history. Its mandate quickly shifted to the tactical missions of enhancing contact tracing, data management, social mobilization and messaging, among other tasks. Some questioned CDC's ability to function in an operational, as opposed to technical, mode. The same critique was levied against the World Health Organization (WHO) as lacking in agile operational capacity.

The disease "ping-ponged" rapidly across borders and between rural and urban environments, which called for more intense cooperation among governments in the region than had existed heretofore. This included operations such as common training for contact tracing teams. It also required donors to coordinate their efforts to build governmental institutions, capacity, and resilience across the region. It is clear that zoonotic diseases are endemic to the African continent and require effective preparedness, prevention, and detection policies across a wide area. Governmental capacity of African nations must become more resilient, because the duration and extent of international intervention is often unpredictable. African governments that rely excessively on cooperation by outside responders will find themselves unprepared when individual responding organizations, for whatever reasons, pull out suddenly and prematurely.

One place to begin mitigating the impact of differing agendas is for international responders at the staff level to understand each other's organizational mandates and missions. Ebola responders praised their regular and frequent coordination meetings in the field, and the value of similar contacts on a regular basis between field and headquarters. This is especially important as some organizations prioritized large-scale hospital and health system capabilities, others posited importance at the village level, going door-to-door while clothed in personal protective equipment (PPE) to identify and track cases. Clearly, career professionals in crisis response should learn about each other's mandates and processes before a crisis hits. Discovering each other's organizational cultures in the midst of a crisis is inefficient at best.

CHALLENGE #2: MISTRUST AND MISPERCEPTIONS

One of the more palpable impediments to cooperation in this crisis was the rampant lack of trust throughout the region, and across many dimensions. Mistrust existed prior to the Ebola outbreak, but multiplied exponentially during the crisis. First and foremost, local citizens—the principal victims of Ebola— distrusted governmental authorities. The legacy of civil war, endemic corruption, fear of the unknown, and tribal superstitions combined to reinforce local rejection of governmental and foreign intervention. The image of outsiders in "scary suits" approaching their dwellings itself was an obstacle to communication.

Similarly, international responders distrusted some governmental officials due to real or perceived allegations of corruption and incompetence. In return, local authorities resented foreigners' attitudes and practices. Trained African professionals felt undercompensated and ignored by international responders. Some health workers complained that they were underutilized after graduating from training.

Other types of misperceptions contributed to mistrust. Medical clinicians from NGOs and management for-profits found themselves collaborating for the first time in the field – and not understanding each other's "universe." Responders operating on short tenures, with rapid turnovers, created resentment among some professionals who felt they were constantly

re-inventing the wheel with newcomers. Data, always in short supply, was routinely suspect even when it was available. Mistrust of assessments based on local data multiplied if the underlying data were doubtful. Even a commonly used term of art such as "social mobilization" faced suspicions because its meaning was misinterpreted.

Misperceptions of roles and capabilities led to mistrust and resentment. NGO field workers who first encountered Ebola cases and warned of an imminent outbreak felt snubbed—and later justified— when other organizations disregarded their warnings. After the UN created the first ever emergency health mission, UN Mission for Ebola Emergency Response (UNMEER), other organizations groused that its mission was unclear, and lines of responsibility were blurred, all leading to an undermining of its authority and credibility. The operation of a Sierra Leonean training academy for health workers exemplified the dysfunction of participating stakeholders ignoring or overlooking each other's roles and responsibilities. Finally, those (like the military) who are required to fill in the gaps left by shortages of resources add to the atmosphere of mistrust when they are performing missions for which they are unskilled.

Of course, professional crisis responders understand that personal relationships account for everything in effective response. Building those relationships if they did not exist in advance was the best way to overcome mistrust. Some organizations, for example, actively worked to dispel misperceptions among local populations by conducting open engagements with local communities and among partner stakeholders. Once again open communication during a crisis is not as effective as doing so in "phase zero" or times of normalcy, but it helps.

In contrast to the above misperceptions, USAID and the U.S. Department of Defense (DoD) had developed over the past decade a very effective relationship – both formal and informal – that is based on trust, common understandings, and clear authority relationships. Through pre-established frameworks (see below), the two actors knew how to cooperate with each other during the Ebola crisis and what functions and tools to employ. Leveraging the combined capabilities of both DoD and USAID, these agencies maintain a high level of institutional trust that fosters cooperation as needed in disaster response efforts.

CHALLENGE #3: MAKING DECISIONS

Making decisions effectively in a complex and dynamic crisis environment requires collaborative systems at all levels. The stakeholders and participants in such structures must perceive the mechanisms as workable, legitimate, and adaptable, at all levels. Moreover, the lead agencies within each structure must have credibility and the right skills to earn the trust of others. In the Ebola case study, certain decision-making seemed to work relatively well—although with too much delay for some. CDC's early estimates fed President Obama's public decision to establish a US "whole of government" response, including military assets and capabilities. WHO's formal declaration of a Public Health Emergency of International Concern triggered the massive

international response. Implementation of these decisions, however, also requires planning and further decisions at lower levels, and in the case of Ebola some of those implementing decisions encountered delays as budgeting offices, planners, and logisticians geared up for operations. The US military's rapid involvement successfully addressed many of the immediate shortages that the slowness of the international response had produced. This rapid, massive response is one of the major benefits of military intervention in a complex disaster such as this. Even that intervention, however, was slower than some would have liked, due to the lack of sufficient data on which to base the military's deliberate planning decisions.

The USG decision-making infrastructure was instructive. The White House appointed a senior official, or "czar," to oversee from the Washington perspective the efforts of the major USG agencies involved – USAID, CDC, HHS, State Department and DoD, among others. USAID is typically designated as the lead agency in disaster response, but in this instance collaborated with CDC as a co-lead of sorts. This dual relationship for coordinating a crisis response was unique and had to be built from scratch.

Within each African country, the US Ambassador was the face of the USG effort; as such, all USG agencies within each country, under the USAID lead, also coordinated with the Embassy. USAID's collaborative relationship with DoD utilizes the Mission Tasking Matrix (MITAM), a mechanism by which USAID validates and prioritizes DoD operations for the response. In the case of Ebola, that included providing food, water, and fuel, as well as mortuary, transportation, and contracting services, among other functions.

The UN's coordination infrastructure does not have directive authority, and hence decisions were perceived as weak, delayed, or non-existent. The UN cluster system, originally set up after the Pacific tsunami crisis of 2004-5, was activated for certain designated functions, such as medical and logistics, but was perceived to be painfully slow. Logistics capabilities were particularly spotty, and would have benefited from better collaboration and sharing of resources. WHO was praised for its technical prowess in public health and medicine at a strategic level, but criticized for lacking the operational and tactical expertise of stopping the spread of the disease in the field. The one-time UN construct of UNMEER failed to achieve a level of credibility and respect that it required to function effectively.

Most observers saw the Government of Liberia's crisis coordinating mechanism, the Incident Management System, as a success, especially when compared to their negative views of the performance and competence of some individual ministry officials. Beyond that critique, the three involved governments, Liberia, Guinea, and Sierra Leone, were unable – or unwilling—to cooperate even at the simplest level, to include land border, maritime, and air space management.

At the end of the day, the host nation is the final decision-making authority, unless it deliberately and transparently delegates that authority at some levels. Ineffective decision making by the host government can seriously

debilitate international humanitarian relief, especially for donor governments, militaries, and international organizations, who will usually not act without formal host nation approval. Tensions also arose between, on the one hand, private sector operators known for speed, agility, and efficiency, and on the other hand, host nation or UN agency project overseers whose slower regulations and approval procedures hampered rapid implementation.

Once again, cooperation worked better where formal meetings took place, and where informal personal relationships solidified communication and trust. In the fog of crisis, having multiple skill sets represented around the table allowed for effective problem solving. One of the biggest challenges to decision making among all professional groups arose from the paucity of accurate data. Of course, uncertainty is the watchword in such crisis environments. However, decisions were sometimes delayed in the tension between taking time to validate existing raw data, versus acting on initial incomplete data feeds, assumptions, and instincts.

Moreover, regular and efficient coordination between the field and headquarters is a must. This coordination proved particularly useful in validating certain field-generated contract modifications submitted to private sector partners before the changes were executed. Demands from field operators for such modifications are typically the case in dynamic, time-sensitive situations, and are often best validated by others first. At the same time, some participants criticized the amount of time devoted to burdensome taskings from far-away headquarters, such as preparing regular briefings and detailed "dashboards" for Washington stakeholders, taking away precious resources for field operations.

All of these meetings, coordination sessions, and forums should contribute to proper sequencing of operations and clarifying the roles of each participating organization in addressing them. Furthermore, not all such collaboration forums turn out to be productive, and if not, should be disbanded.

CHALLENGE #4: EFFECTIVE MESSAGING

Effective messaging was a key pillar of the Ebola effort: to local citizenry; to the broad responder community in the field; and back home to decision-makers, funders, and nervous publics. Messages should be consistent across these dimensions, or at a minimum not contradictory. Consistent messages build trust, notify populations about what to do and not do, and help build a stronger community of action among responders.

The Liberian government's public awareness campaign ("Ebola Must Go") helped build trust with a highly skeptical and misinformed population. The leadership of President Ellen Johnson Sirleaf was vital in this regard. The central government developed a messaging guide, with Frequently Asked Questions, that was distributed at stakeholder meetings. Those present were able to utilize consistent messaging; those who did not show up tended to issue their own messages. The government also organized stakeholder

phone calls to avoid redundancies and mixed messaging.

CDC was part of the "social mobilization" pillar in the Liberian Ministry of Health's incident management infrastructure. That subcommittee experienced some coordination issues among the internationals who participated in its work, and tried to mitigate the impact of mixed messaging. For example, at the outset, some messages read, "if you are sick, stay home"; others said, "if you are sick, call this number" – the latter being a source of confusion if the victim had no telephone.

USAID's Disaster Assistance Response Team (DART) had responsibility for coordinating messages across the USG team of agencies. The CDC's task, through its headquarters in Atlanta, was to assure messaging back to US populations at home, especially in view of the incidence of Ebola cases arriving in the United States. CDC's responsibility also extended to updating Congressional staffs and other stakeholders and partners in the US. Any lack of consistency among these messages became quickly exploitable, and grounds for criticism, whether by the media, Congress, or others.

The WHO and International Organization for Migration (IOM) partnered with the Ministries of Health in various nations in the region to develop consistent, credible, and informative messaging. One of the principal challenges in this cooperative effort was identifying the best channels for conveying the messages effectively. Few citizens in all three victim nations could read – hence the limited value of billboards and flyers with text on them. Television, telephone, and internet messaging was more effective, but still limited in impact to segments of urban populations. Therefore these organizations also identified well frequented locations, such as marketplaces, and well respected interlocutors, such as village elders or local religious leaders, in order to spread the MOH's instructions and notifications.

TAKEAWAYS

Following are the key lessons that participants highlighted to mitigate these challenges:

Understanding Differing Missions and Mandates

- Regular and frequent coordination meetings during the Ebola response provided forums for the participating organizations to gain institutional knowledge of one another and to work through their differing agendas.
- Not attending such meetings might have had some short-term benefit for the individual, but hampered achieving mutual awareness of each other's mandates and coordinating actions to avoid gaps, redundancies, and miscommunications.
- Conversely, working with familiar faces on a routine basis provided continuity and more effective communication in the collaborative response effort.
- Pre-crisis communication and cooperation – through education, training, exercises, and simulations – improves the ability of crisis responders to network effectively during the event with counterparts from other organizational cultures. This would be

particularly valuable for private sector practitioners who are usually left out of "interagency" or international training and exercises.

Dispelling Mistrust

- Building personal relationships, especially at the village level, was an indispensable step toward eliminating mistrust of government and outsiders.
- Devoting scarce time and resources to community outreach paid off in the medium term in order to restore faith in health care providers, and dispel cynicism about governmental institutions.
- Long-term development programs should emphasize the value of transparent, accountable governance systems in building trust with constituencies and with international partners for future crisis events.

Making Effective Decisions

- The USG's appointment of an Ebola "czar" helped to coordinate decision making across agencies in Washington and to enhance unity of effort in USG headquarters-field communications.
- The UN Global Cluster system provided a useful venue for deliberations, but was limited in its ability to produce rapid decisions.
- Liberia's Incident Management System proved to be very successful and could be adapted for future crises. However, cross-border communication and cooperation among neighboring nations needs substantial work.
- International responders should work to sustain the host-nation's authorities, especially when, in the aftermath of a crisis, the local government does not hold the capacity or capability to make important decisions. Rebuilding legitimate host nation authority should be a hallmark of international intervention.
- The communication lines between the field and headquarters staffs should remain open and cooperative to ensure both human and material resources are used wisely.

Distributing the Right Message

- Developing and monitoring consistent messaging amongst the many responders is imperative for a more effective impact both in the field and back home.
- Responders should listen to experienced local practitioners in order to identify and utilize effective communications channels to reach segmented target populations.

For more information on the course in Cooperation in Stability Operations (CSO), the Center for Stabilization & Economic Reconstruction (CSER), or the Institute for Defense and Business (IDB), please visit www.IDB.org or contact Amb. (Ret.) David Litt, Executive Director, Center for Stabilization & Economic Reconstruction, at Litt@IDB.org or (919) 969-8008.