

The Politics Behind the Ebola Crisis

Africa Report N°232 | 28 October 2015

Table of Contents

Executive Summary.....	i
Recommendations.....	iii
I. Introduction	1
II. Pre-epidemic Situation.....	3
A. Liberia	4
B. Sierra Leone	5
C. Guinea	7
III. How Misinformation, Mistrust and Myopia Amplified the Crisis	8
A. Misinformation and Hesitation	8
B. Extensive Delay and its Implications	9
C. Quarantine and Containment.....	10
D. Ignoring Community Involvement.....	13
E. Opportunism and Corruption.....	13
F. Differing Degrees of Politicised Reactions	14
IV. Regional Mistrust	17
V. The International Aspects of the Ebola Response	19
A. Securitisation	19
B. Recreating the Aid System.....	20
C. WHO’s Shortcomings	21
D. Slow and Cumbersome Organisations.....	22
VI. Consequences and Lessons	24
A. The Risks of Stagnation	24
B. Governments Tightening Grip on Power.....	24
C. Lingering Instability?.....	26
VII. Conclusion	27
APPENDICES	
A. Map of West Africa	28
B. Map of Ebola’s Spread and Toll in the Worst-hit States	29
C. Acronyms.....	30

Executive Summary

At the Ebola epidemic's height in mid-2014, there were concerns social order in Guinea, Liberia and Sierra Leone could collapse. International mobilisation, notably after the UN Security Council declared the epidemic "a threat to peace and security" on 18 September, brought an extensive intervention and considerable progress. When explaining the dramatic increase in infections starting in March, observers mostly point to weak health systems, limited resources, population mobility, inadequate support and that the virus was largely unknown in the region, but lack of trust in the state, its institutions and leaders was also a major factor. Nor was the international community beyond reproach. It prevaricated, and mostly ignored early and clear warnings until the threat was perceived as global. Unless lessons are learned across all these issues, the next regional health crisis will be as needlessly costly and disruptive as the Ebola epidemic and pose a similar risk to international stability.

The virus initially spread unchecked not only because of the weakness of epidemiological monitoring and inadequate health system capacity and response, but also because people were sceptical of what their governments were saying or asking them to do. Lack of trust in government intentions, whether in the form of political opportunism or corruption, was based on experience. In its initial phase, many West Africans thought Ebola was a ploy to generate more aid funding or reinforce the position of ruling elites. And when Ebola proved real enough, political machinations and manipulation needlessly hindered the early response.

Initially information was not shared, and warnings were not disseminated widely enough. Countries hesitated to declare an emergency for fear of creating panic and scaring away business. Once they did so, their governments relied on the security services – their most capable, internationally supported institutions – but the early curfews and quarantines exacerbated tensions and alienated people whose cooperation was necessary to contain the epidemic. Officials in capitals also initially ignored local authorities, who were sometimes more familiar with traditional customs and accepted by their communities (with the exception of Guinée Forestière, where local authorities were no more familiar with local customs or trusted than the national government).

Despite huge investments in peacekeeping and state building in Liberia and Sierra Leone in the preceding decade and a significant UN and non-governmental organisation (NGO) presence, the region was ill prepared for a health crisis of such magnitude. Broader issues of national reconstruction, particularly in those two countries, combined with the prioritising of specific diseases, such as HIV/AIDS and malaria, contributed to produce stove-piped health sectors with abundant resources for those targeted diseases but resource-strapped health ministries overall that were particularly vulnerable to a health emergency. Aid organisations, with far better resources than the local ministries, also inadvertently undercut attempts at self-sufficiency.

It was only after the second wave of Ebola cases threatened the very stability of the affected countries that authorities took concerted action (with the help of NGOs, international agencies on the ground and donors), starting with the engagement of community leaders. Particularly in Liberia, they slowly learned what did not work and how to better communicate appropriate precautions and necessary cultural changes, eg, handling of deceased relatives, that finally helped bring the epidemic under control.

The international reaction was equally problematic and rightly criticised as dysfunctional and inadequate by many observers. Early warnings were largely ignored until cases began cropping up in the U.S. The World Health Organization (WHO), which had stalled for far too long on declaring an international health emergency, then proved incapable of mounting an effective response. The Security Council was forced to create a new body to scale up and coordinate operations – with variable results – the UN Mission for Ebola Emergency Response (UNMEER).

Lastly, the intervention may have exacerbated some risks in countries whose dysfunctional political systems not only hindered the response, but also posed serious constraints to a recovery. The arsenal of additional public health measures for use in an emergency, such as bans on public gatherings, that ruling elites acquired has potential to be misused for political gain. Although a return to open conflict in Ebola-affected countries is unlikely, a number of issues could provoke further unrest in them, from restrictions on opposition movements to simple further estrangement of civil society. This bodes poorly not only for democracy, but also for the region's response to the next health emergency.

Divorcing political consideration from the response to public health crises should be a priority. It requires transparency from governments, opposition groups and international organisations. As a first step, West Africa's still fragile states need to learn from and allay fears over actions taken against Ebola, as well as account for the use of Ebola-related resources. The movement toward greater regional cooperation, with regards to both transmissible disease and other transnational threats, is at least one positive development emerging from the crisis. Sustained international support is likewise necessary in the recovery process. Donors and implementers must also learn from their own failings during the Ebola response. The epidemic might not have been preventable; it certainly was controllable in the early stages. Avoiding a repetition requires addressing the errors of the past.

Recommendations

To definitively end the Ebola epidemic and limit the impact of the next health crisis

To the governments of Liberia, Sierra Leone and Guinea:

1. Make accountability an important component of the post-Ebola recovery strategy by increasing transparency in Ebola funding in all three countries and taking action over missing funds.
2. Build on civil society initiatives that bridge socio-political cleavages and help create a more collaborative approach to crisis response.
3. Strengthen health systems (especially for treatment of other diseases), including by investing in early warning, epidemiological capacities and adequate clinics and staff for the population.
4. Make clear distinctions between public health imperatives and actions that can be construed as giving political advantage to a particular region or party.
5. Encourage greater cross-border cooperation and information sharing on health crises and other transnational threats.

To the Economic Community of West Africa (ECOWAS):

6. Strengthen regional health surveillance, communication and coordination mechanisms.
7. Draw lessons from the Nigerian experience and establish or reinforce rapid-reaction teams to investigate and respond to possible epidemics.

To donors and the UN Security Council:

8. Pay close attention to the governance challenges that have undermined citizens' trust in their governments and institutions.
9. Support accountability and transparency regarding Ebola-designated funds, including audits by the governments of the three affected states.
10. Remain consistently engaged in the post-epidemic recovery process, including by delivering on pledges committed at the International Ebola Recovery Conference (9 and 19 July 2015).
11. Rebuild health structures and address diseases neglected during the Ebola epidemic by sustaining support long after media and political attention has shifted.
12. Ensure necessary support for the planned African Centres for Disease Control and Prevention. Conduct an independent review of the UN response (notably that of the UN Mission for Ebola Emergency Response, UNMEER) to determine what lessons can be learned for future regional operations.

**To the World Health Organization (WHO) Executive Board,
Health Assembly and UN General Assembly:**

13. Ensure that the WHO reform process creates an emergency unit with the capacity and ability to effectively coordinate the response to public health crises, with special attention to developing countries.
14. Insist on an independent review of the ongoing WHO reform process and hold officials at the country, regional and headquarters level accountable for fully implementing reforms.
15. Cooperate with wider humanitarian and health systems in Guinea, Liberia and Sierra Leone.

Dakar/Brussels, 28 October 2015

The Politics Behind the Ebola Crisis

I. Introduction

After 28,295 cases and 11,295 attributed deaths as of late September 2015, and with the West African epidemic seemingly winding down, there is cautious optimism that continued cross-border Ebola infections will not lead to a new crisis. Frantic reactions have subsided, and anxieties over a possible global health pandemic have faded. While the continued emergence of a few cases in September demonstrated that continued vigilance is required, it is time to take stock and draw lessons, so that such an event does not happen again or at least is handled better the next time.¹

Ebola put on prominent display the dysfunctions both of the three worst hit states – Guinea, Liberia and Sierra Leone – and of the international policies that were designed to help them. The weak health systems in the three countries have been widely examined.² Additional elements, including insufficient resources, a highly mobile population and lack of experience in dealing with Ebola, have likewise been highlighted.³ Much criticism has also been levelled at the WHO and the UN system.⁴ Less discussed, but the focus of this report, are the political factors that slowed both the domestic and international response, allowing the situation to spiral out of control, and that will be equally important to understand if West Africa is again faced with a grave public health emergency that puts its security and stability at risk.

All that should be contrasted to the decisive action taken by Nigerian authorities once they recognised Ebola. They had far more resources already available than the other countries, including rapid-reaction teams prepared to investigate and reinforce outbreak response for pathologies as diverse as cholera, measles, diphtheria and Lassa; moreover, the U.S. Centers for Disease Control (CDC) and Médecins Sans Frontières (MSF) had already done Ebola training for specific Nigerian health staff, and there was a very robust contact tracing mechanism.⁵

This report is based on research in Guinea, Liberia, Sierra Leone, Brussels, Dakar, Geneva, London, New York and Washington. That research included interviews with

¹ “Ebola Situation Report”, World Health Organization (WHO), 23 September 2015.

² For example, the “High Level Meeting for Building Resilient Systems for Health in the Ebola-affected Countries”, WHO, Geneva, 10-11 December 2014; and “Never Again: Building Resilient Health Systems and Learning from the Ebola Crisis”, Oxfam Briefing Paper, April 2015.

³ For example, “The International Ebola Recovery Conference”, UN, New York, 9-10 July 2015; “From Ebola to More Resilient Health Systems”, World Bank, Washington, DC, 17 April 2015; “Ebola Conference: From Emergency to Recovery”, European Union (EU), Brussels, 3 March 2015; “Recovering from the Ebola Crisis”, UN, World Bank, EU and African Development Bank (ADB), 2015, at www.undp.org, p. 8.

⁴ See, for example, the July 2015 “Report of the Ebola Interim Assessment Panel”, an independent panel that criticised the response of the WHO, UN Mission for Ebola Emergency Response (UN-MEER) and other UN entities. Also, Marc DuBois, Caitlin Wake, Scarlett Sturridge and Christina Bennet, “The Ebola response in West Africa: Exposing the politics and culture of international aid”, Humanitarian Policy Group, Overseas Development Institute, October 2015.

⁵ “Tackling and Preventing Ebola while Building Peace and Societal Resilience”, Civil Society Platform for Peacebuilding and Statebuilding (CSPPS), April 2015.

government officials, epidemiologists, health care providers, NGOs, journalists, humanitarian aid workers and UN officials, including from the UN Mission for Ebola Emergency Response (UNMEER) and the World Health Organization (WHO). All individuals cited agreed to go on the record.

II. Pre-epidemic Situation

Guinea, Liberia and Sierra Leone are fragile states, the latter two having emerged from long civil wars and massive post-conflict international state-building interventions. On the eve of the Ebola epidemic, encouraging social and political stability, along with consistent economic growth, contrasted with inadequate infrastructure and dysfunctional health systems.⁶ All three countries suffered from the resource curse – rich natural resources had long been extracted for elite and foreign profit, as opposed to being developed for the benefit of the majority. This contributed to a profound distrust of authorities who were unable to provide basic services, of which health care was only one.

Health sector spending had remained relatively stable prior to Ebola, and it was not simply a question of amounts of money but also how that money was actually spent.⁷ Broader issues of national reconstruction, particularly in Liberia and Sierra Leone, combined with the global prioritising of specific diseases (eg, HIV/AIDS, tuberculosis and malaria), contributed to produce stove-piped health sectors and otherwise resource-strapped health ministries with limited capacities particularly vulnerable to emergencies. Aid organisations, with greater resources than the health ministries, inadvertently undercut attempts at self-sufficiency. They had to try to fill gaps, because public spending on health care was discouraged in favour of privatised services.⁸ As important, because of corruption in local health services, it was easier for donors to support international organisations.

Non-strategic and un-sustained donations and philanthropic contributions by extractive industries (“corporate social responsibility”), charities and fickle donors also contributed to the fragmented, ad hoc nature of the health sectors in all three countries. They may have slightly offset interruptions in government revenue, but corporate philanthropic contributions were often non-strategic and, like foreign aid in general, could not make up for the sector deficiencies.⁹

⁶ Guinea, Liberia and Sierra Leone ranked 179th, 175th and 183rd out of 187 countries on the 2014 Human Development Index, at hdr.undp.org. Per capita health expenditure in 2013 was \$25, 44 and 96, respectively, compared to \$9,146 for the U.S. “World Development Indicators: Health Systems”, in “2015 World Development Indicators”, World Bank.

⁷ “Who has responsibility for Ebola? The IMF, the West, or unpleasant accounting?”, Chris Blattman, *The Washington Post*, 7 January 2015. For health spending, see WHO global health observatory and national health accounts, www.who.int.

⁸ Annie Wilkinson and Melissa Leach, “Briefing: Ebola – Myths, Realities, and Structural Violence”, *African Affairs*, 4 December 2014. Crisis Group Africa Report N°87, *Liberia and Sierra Leone: Rebuilding Failed States*, 8 December 2004, p. 5, warned about the perverse incentive system put in place by NGOs that were in effect running the health sector in Monrovia and much of Liberia after the war. Ten years later it contributed to Ebola’s spread.

⁹ Philippe Calain, “Extractive Resources and the Ebola Economy”, *African Affairs*, 13 January 2015. The private sector did make a considerable response to the epidemic. The Ebola Private Sector Mobilisation Group – companies with significant investment in West Africa – contributed funding and in-kind support; other companies gave to the Africa United Against Ebola Fund managed by the Africa Development Bank (AfDB); mobile network operators in Africa launched a service to allow their customers, to contribute \$1 (in local currency) to the Ebola Fund; major individual corporate donations included the South African MTN Group (\$10 million), Ikea (\$6.2 million), and Financial Prudential (\$6 million). Wealthy individuals gave money, including Mark Zuckerberg (\$25 million), Larry Page (\$15 million) and Paul Allen (\$100 million). “Ebola and the Private Sector: Bolstering the Response and West African Economies”, Oxfam, December 2014.

A. Liberia

Though the fourteen-year civil war ended in 2003 with Charles Taylor's departure, Liberian politics remained divisive and accountability elusive. Reconciliation was delayed, and there were more uncertainties than hope. The domestic image of President Ellen Johnson Sirleaf (in office since 2006) suffers from how she has handled reconciliation and allegations of her complicity in that civil war.¹⁰ The controversial recommendations the Liberia Truth and Reconciliation Commission (LTRC) submitted in 2009 were not implemented, among them for lustration and holding to criminal account present and former officials, including the president, a Supreme Court associate justice and several legislators. The political elites and some signatories of the Accra Comprehensive Peace Agreement that ended the conflict condemned the final LTRC report and its recommendations. Some threatened to resume fighting if criminal accountability was pursued.

The report and its recommendations were abandoned, creating an impasse on justice and accountability issues.¹¹ Reconciliation-related discussion was briefly revived in 2012, when the government's "Strategic Road Map for National Healing Peace Building and Reconciliation" was published, but that document focused on restorative, not retributive justice.

On the security front, the UN Mission in Liberia (UNMIL) pursued withdrawal plans and turned over additional responsibilities to the government in 2014. However, there were concerns withdrawal was premature, and a dangerous vacuum could result.¹² Tensions rose when the national election commission planned to conduct an election (for the Senate) for the first time with only limited UNMIL presence and UN support.¹³ Though the economy was growing at 6 per cent annually (from a very low base), financial resources remained quite limited, unemployment was high, and corruption was a major concern.¹⁴

The health sector presented a mixed picture. It showed some signs of recovering from the conflict, but also grim images of neglect and abandonment. As Liberia moved from an emergency humanitarian to development phase, medical charities that gave direct support were phasing out, and assistance was transitioning to indirect support, through the national budget. The health share of that budget, with aid and direct budgetary support accounting for nearly 65 per cent, grew strongly between 2012 and 2014, from \$38 million to \$60 million.¹⁵ But a critical requirement of the transition

¹⁰ "Beware viewing African leaders through gilded lenses", *The Globe and Mail* (Toronto), 20 September 2013; "Fellow Nobel peace prize winner criticises Ellen Johnson Sirleaf", *The Guardian* (London), 10 October 2012; Crisis Group Africa Report N°177, *Liberia: How Sustainable Is the Recovery?*, 19 August 2011. Johnson Sirleaf is a former member of the Crisis Group Board.

¹¹ Aaron Weah, "Hope and Uncertainty, Liberia Journey to End Impunity", *International Journal of Transitional Justice* (IJTJ), vol. 6 no. 2, 2012.

¹² Crisis Group telephone interview, diplomat, Monrovia, 13 March 2015.

¹³ UNMIL had a more visible role in the 2006 and 2011 post-war elections. UNMIL and the government designed a draw-down plan in 2012, much of which covers logistics, personnel and monitoring, especially at border posts. Over the past several years, the government has not included additional security responsibilities in the national budget.

¹⁴ Liberia ranked 94th of 175 countries and scored 37 on a scale from 0 (highly corrupt) to 100 (very clean) in Transparency International's "Corruption Perception Index (2014)".

¹⁵ Crisis Group interview, Dr Peter Coleman, chairman, Senate Health and Social Welfare Committee, Monrovia, 20 January 2015. Health minister under Taylor, he is also a professor at the A.M. Dogliotti College of Medicine, the only tertiary institution training physicians. Its most recent graduating class (75 doctors) was its largest ever.

was for the government to take over nurses and doctors previously employed by international NGOs and medical charities, where most had enjoyed higher salaries and better incentives. When only 3,500 of these 8,500 health-care workers were hired, three waves of protest resulted.¹⁶

Though systematic corruption and pillaging of health-care funds was a major problem, little was done, despite government pledges.¹⁷ Major hospitals lacked equipment; clinicians had little or no incentive to do their jobs well. Electricity was often unavailable in some places. Negligent health practices were common, and seeking hospital treatment was considered a 50/50 gamble on survival.¹⁸

B. Sierra Leone

Prior to the Ebola outbreak, Sierra Leone was emerging from a devastating civil war (1991-2002) and a decade of political instability and economic stagnation. Economic, political and institutional reforms, touted as a model, had created a semblance of stability and recovery.¹⁹ Major expansion in banking and mining in particular renewed confidence in the economy, with growth projections for 2015-2018 around 25 per cent of GDP.²⁰ However, progress was undermined by deep mistrust of government in opposition strongholds.

Political tensions had been high since President Ernest Bai Koroma won office in 2007. A northerner, he was accused of removing officials from the south and east. At least 200 top government officials suspected to be opposition sympathisers were dismissed. The opposition Sierra Leone's People's Party (SLPP), a World Bank report said, was trapped in "a politics of southern grievance".²¹ Complaints accumulated in the southern and eastern regions over the last five years in particular. The claim of the opposition leader, Brigadier (ret.) Julius Maada Bio, that the ruling party manipulated the 2012 polls, appeared to gain some plausibility from several incidents. In the lead-up to the vote, an SLPP parliamentarian, Foday Rado Yokie, was arrested

¹⁶ Crisis Group interview, Lee Gibson, physician and officer in charge, Schiefflin Clinic, Monrovia, 10 January 2015. Health workers initially refused to go to work and later went on a "Go-Slow Action". This paralysed hospitals and clinics across the country. The Senate and House Standing Committees on Health and Social Welfare tried to mediate but there was little progress until the president appealed to workers to return to work.

¹⁷ Aaron G. Buseh, *Empowering Resilience: Improving Health Care Delivery in War-Impacted African Countries: A Case Study of Liberia* (Lanham, 2008); "After Ebola: rebuilding Liberia's health care infrastructure", *The Boston Globe*, 17 December 2014; "Why Liberians Thought Ebola Was a Government Scam to Attract Western Aid", *The Nation*, 16 September 2014. Liberia's General Auditing Commission (GAC) documented wide-spread irregularities and financial malpractices in the accounting systems; www.gacliberia.com. "Liberia: Corruption is 'Public Enemy Number One'", www.allafrica.org, 20 December 2013; and "Liberia's public enemy no. 1: Fighting Corruption to Rebuild a Nation", *Consultancy Africa Intelligence*, 17 June 2013.

¹⁸ "Wrong Side of the Dice, Ballah Scott Death Shows Healthcare in Liberia is No Care at All", *New Narratives* (www.newnarratives.org), 6 September 2012.

¹⁹ "Sierra Leone's Progress 'Proof' of What Can Be Accomplished in Post-Conflict Period", UN Security Council 10937, 13 March 2013; "Tenth report of the Secretary-General on the United Nations Integrated Peacebuilding Office in Sierra Leone", UNSC S/2013/118, 27 February 2013.

²⁰ "The Agenda for Prosperity 2013-2018", Government of Sierra Leone, October 2012. For background, see Crisis Group Africa Reports N°143, *Sierra Leone: A New Era of Reform?*, 31 July 2008; and N°87, *Liberia and Sierra Leone: Rebuilding Failed States*, 8 December 2004.

²¹ "Election and Diversity Management in Sierra Leone", UN Economic Commission for Africa (UNECA), December 2011. "Sierra Leone", Amnesty International Annual Report, 2011. Richard Fanthorp and Chris Gabelle, "Political Economy of Extractives in Sierra Leone", World Bank, July 2013.

along with supporters after protesting an attack on an opposition convoy by ruling-party youths. The Supreme Court awarded two seats to the ruling party in the Kailahun and Kenema districts (the east), where the opposition had obtained at least 80 per cent of the vote.²²

The security sector was a bright spot. The previously renegade military was transformed into a disciplined force that participated in two UN peacekeeping missions.²³ Signifying the transition to post-conflict development, UN Secretary-General Ban Ki-moon visited in March 2014 to formally close the UN Integrated Peacebuilding Office.

Beneath the surface of policy and institutional reforms, there were early warning signs of malaise and deteriorating governance. While GDP growth increased from 3.2 per cent in 2009 to 5.5 per cent in 2013, corruption was also advancing.²⁴ Sierra Leone did not qualify for Millennium Challenge Corporation (MCC) support because audit reports consistently revealed financial irregularities and malpractice.²⁵ The government had not tracked service delivery expenditure since 2011, when its own Public Expenditure Tracking Survey Reports had consistently identified leakages, particularly in the health and education sectors.²⁶ This foreshadowed problems that were prominent in the response to Ebola, when the government's audit service found inadequate controls and payments that:

... exceeded Le14 billion [more than \$3 million] were made from the Emergency Health Response and Miscellaneous Accounts without any supporting documents. ... Further payments which exceeded Le11 billion [more than \$2.4 million] were made from the same accounts without adequate supporting documents.²⁷

Likewise, health service was very weak. There was a critical shortage of skilled staff: 0.22 doctors, 1.6 nurses and 0.22 midwives per 10,000 people, about one fifth of the WHO recommended standard for quality health-care delivery. Facilities were inadequate and inequitably distributed, prompting the ministry to build more but resulting in overstretched resources and poorly equipped clinics.²⁸

²² The court's decisions, citing electoral irregularities, including violence, reinforced perceptions of an institutional bias against opposition figures and parties. "Sierra Leone: Ruling party gains two-thirds majority in parliament", *Africa Review*, 29 November 2013; "Sierra Leone News: Const. 05 & 15 Election Petition rulings: High Court gives verdict to SLPP and votes to APC", Awoko (awoko.org), 26 November 2013; "Yes APC declared winner – but lost the elections", *The Sierra Leone Telegraph*, 23 December 2013.

²³ Lauren Twort, "Sierra Leone: A Post-Conflict Success Story?", Royal United Services Institute, 22 May 2013.

²⁴ "Sierra Leone country profile" (www.worldbank.org), 2013. Between 2008 and 2012, Sierra Leone improved on Transparency International's Corruption Perception Index from "very weak" to "weak", but it dropped after 2013.

²⁵ "MCC Board Selects Countries Eligible for Compacts and Threshold Programs", press release, Millennium Challenge Corporation, 10 December 2013.

²⁶ The health ministry was ranked in 2010 as one of the likeliest places in government to encounter corruption, "National Public Perception Survey on Corruption", Anti-Corruption Commission and Justice Sector Coordinating Office, June 2010. The GAVI Health Sector Support fund reported \$523,303 missing. "Audit of Health Systems Strengthening Support Dispersed Funds 2008-2010", GAVI (vaccine alliance) Secretariat, Geneva, Switzerland, April 2013.

²⁷ "Report on the Audit of the Management of the Ebola funds: May to October 2014", Audit Service Sierra Leone, (no date), at www.auditservice.gov.sl, p. 4.

²⁸ "Physicians density per 1000: data by country", in "Global Health Data Repository", WHO. For the standards, see "World Health Report", WHO, 2006. Crisis Group interview, health and sanitation ministry director, Freetown, 22 January 2015.

C. Guinea

Guinea arguably was most vulnerable. One of the rare African countries with annual GDP growth of less than 3 per cent, it has the region's lowest per capita health-care spending. Not having suffered a civil war, it attracted far less international support, though the Guinée Forestière area had been important in the conflicts in Sierra Leone and Liberia, as a recruitment area and refugee destination.²⁹

At the time of the outbreak, Guinea was in a political impasse. The 2010 elections, which brought President Alpha Condé to power, involved a worrying combination of large-scale appeals to political ethnicity, small-scale violence and mistrust in electoral institutions.³⁰ In an infamous incident, during the second round of the presidential contest, rumours circulated of poisoned water being distributed at a pro-Condé rally. Ethnic Peul/Fulani, supposed to be associated with Condé's main challenger, Cellou Dalein Diallo, were accused, resulting in ethnic clashes in several parts of the country.

"Three regions against one" was a recipe for the electoral success in 2010 of the Rally for the People of Guinea Rainbow (RPG), and the ethnic dimension has remained.³¹ "There are not two main political parties in Guinea", a politician said, "only two main ethnicities".³² The Malinké largely support Condé's RPG; the Peul/Fulani do the same for Diallo's Union of Democratic Forces of Guinea (UDFG).

As dialogue over electoral institutions between government and opposition was belated and unconvincing, there was little reconciliation. "Rather the opposite", an opposition spokesman complained. "President Condé has acted in a way to provoke frustration within certain parts of the population and increase cleavages between citizens". The 2013 legislative elections occasioned more protests, violence and repression in Conakry over feared government rigging.³³

The state's weakness is particularly evident in the health-care sector. The goal of ensuring "quality health care" by 2010 was outlined in the 2002 poverty reduction strategy, but reality lags far behind. 65 per cent of treatment costs are passed directly to patients. Urban centres are heavily favoured, particularly Conakry. With many isolated local health units lacking support, almost no supplies and staffed by under-, or even unpaid, staff, the majority of the country was poorly prepared for even an outbreak of endemic cholera, let alone Ebola.³⁴

²⁹ Crisis Group interview, Aziz Diallo, World Bank consultant, Conakry, 22 January 2015; fn. 6 above. Militias linked to former conflicts and small arms contribute to instability. Guinée Forestière includes the Simandou iron-ore reserves, important for national growth; \$45 billion in investment and infrastructure plans, notably by Rio Tinto, are expected to move ahead. Crisis Group Africa Briefing N°106, *Guinea's Other Emergency: Organising Elections*, 15 December 2014.

³⁰ Several dozen people died during protests in 2012-2013 and a number more in 2015.

³¹ "Trois régions contre une", Basse Guinée, Haute Guinée and Guinée Forestière against Fouta Djallon, is the strategy used by Malinké President Condé against his Middle Guinea, Fulani adversary, Cellou Dalein Diallo. For background, see Crisis Group Report, *Guinea's Other Emergency*, op. cit.

³² Crisis Group interview, Patrice Camara, Secretary General, Union Nationale pour le Renouveau (UNR), Conakry, 7 March 2015.

³³ Crisis Group interview, Aboubacar Sylla, Conakry, 18 January 2015.

³⁴ 60 per cent of all health workers are based in Conakry, where, the UN estimates, some 16 per cent of the population lives. "Guinea", www.data.un.org. Sékou Chérif Diallo, "Ebola: questions sur la déliquescence du système de santé guinéen", *L'œil de l'exilé*, 26 August 2014.

III. How Misinformation, Mistrust and Myopia Amplified the Crisis

Attempts to control the Ebola epidemic were a catalogue of missed opportunities and errors, interspersed with periodic successes. Failure to recognise the scale of the unfolding crisis and respond appropriately was critical, during both the first wave, in March 2014, when numbers were relatively low, and the second wave, the start of which in June of that year was largely missed, in part due to unreported cases crossing into Guinea and Liberia from Sierra Leone. Cases for all three countries peaked in the latter months of 2014, but new infections, although greatly reduced, have continued to be reported in 2015; one new case apiece was reported in Sierra Leone and Guinea in the first week of September.³⁵

A. *Misinformation and Hesitation*

While the first case was traced to December 2013 in Guinea, the disease was not identified as the Zaire Ebola virus strain until 22 March 2014. Initial information focused on risks of eating bush meat and, particularly, bats as a source of contagion. While not necessarily false, this quickly became distracting. Human-to-human transmission characterised the epidemic and remained the most difficult to control.³⁶ Contradictory, or at least unconstructive, messages were put out that simultaneously noted Ebola was both virtually always fatal, and all cases should be alerted to the health authorities. The result – fewer cases tracked and identified – was the opposite of what was intended. Families preferred to care for the sick themselves rather than banish them to treatment centres for seemingly guaranteed death.³⁷

Misinformation, including inaccurate mortality data, was a constant in the early stages. Even as Guinea's health ministry declared the outbreak on 22 March, followed shortly by ECOWAS ministers calling Ebola "a serious threat to regional security", its potential impact was underestimated.³⁸ Porous, populous borders linking three states and the fact that Ebola was unknown in the region and easily confused with other pathologies contributed to silent expansion. There was an assumption for several months that, despite their geographic spread, cases were declining in Guinea and Liberia. The assessment that there were no confirmed cases in Sierra Leone can now be seen as a particular failure. By the time the first case there was confirmed (at the end of May 2014), the situation was unmanageable. A "hidden outbreak" had re-crossed borders and "reignited the outbreak for its neighbours".³⁹

There are numerous theories to explain the delayed response to the first wave of Ebola and why the beginning of the second wave was missed. Prominent ones include health sensitisation messages that led to the intentional hiding of cases; con-

³⁵ For the latest and full cumulative data see "Ebola Situation Report", WHO, 9 September 2015.

³⁶ Wilkinson and Leach, *op. cit.*

³⁷ "How Ebola roared back", *The New York Times*, 29 December 2014.

³⁸ The ECOWAS Ministers of Mediation and Security Council called for a regional response to the epidemic at their 31st meeting on 25 March 2015, far earlier than other international organisations. "ECOWAS Ministers Call for Regional Response to Deadly Ebola Outbreak", www.reliefweb.int, 28 March 2014.

³⁹ An MSF press release (31 March 2014) that declared the outbreak "unprecedented" due to geographic spread was perceived as exaggerated and alarmist; see also, "Pushed to the Limit and Beyond", MSF, 23 March 2015.

cerns that Ebola treatment centres spread the disease; overconfidence in containing the threat, so not enough people were on the ground or those present left too quickly; and “poor flow of information”, complicated by cross-border coordination. However, it was the reported cases in Sierra Leone that eventually led to the massive numbers throughout the region.⁴⁰ That country’s officials have acknowledged that warnings were not disseminated widely enough, and “the damage from the disease could have been mitigated with early information”.⁴¹ Other analyses say information during this key period was “actively being hidden”.⁴² That officials were downplaying the impact by only reporting confirmed laboratory cases was apparent early on, but the under-reporting skewed perceptions and meant resources mobilised to fight the epidemic were initially limited.⁴³

Sierra Leone’s government was not alone in lack of candour. In Guinea, officials did not want to “scare away airlines and mining companies” and also were said to have discouraged NGOs and other organisations that sought to contain the epidemic.⁴⁴ MSF, the NGO that led calls for greater concern and assistance, was portrayed as opportunistic and exaggerating Ebola’s risk as a fundraising effort.⁴⁵ In Liberia, which was relatively transparent in acknowledging the disaster’s scale, citizens accused the government of exaggerating to get more aid.⁴⁶

Not only regional governments prevaricated during the first half of 2014. The WHO downplayed warnings that the epidemic was out of control from the outset; as late as 19 May, Ebola was only briefly mentioned at the annual World Health Assembly.⁴⁷ Until mid-year, only limited information was shared between countries, and both the domestic and international priority was to not spread panic among populations and investors.

B. *Extensive Delay and its Implications*

WHO internal documents from early June (since published) discussed that signalling the alarm about Ebola “ramps up political pressure in the countries affected and mobilises foreign aid and action”, but the organisation’s leadership was concerned about public relations and that a declaration of a public health emergency could also be seen as a “hostile act”, given the regional governments’ reticence and the likely economic impact. This proved prescient; after the WHO’s declaration, international

⁴⁰ “How Ebola roared back”, op. cit.; Crisis Group telephone interviews, disaster risk manager, 23 March 2015; ECHO, 9 January 2015.

⁴¹ Crisis Group interview, Sierra Leone diplomat, 26 February 2015.

⁴² Crisis Group interviews, diplomat, Monrovia, 13 March 2015; MSF, Brussels, 5 January, 16 February 2015.

⁴³ It is estimated cases were 200 to 300 per cent underreported, though numbers cannot be verified. Crisis Group telephone interview, UK Department for International Development consultant, 23 March 2015.

⁴⁴ “How Ebola roared back”, op. cit. At the start of the outbreak, President Condé “denied its seriousness and wasted crucial weeks that could have helped contain it”. He also publicly criticised MSF for its warnings. His health officials massaged the numbers to avoid scaring-off much-needed investors. “Ebola now preoccupies once-skeptical leader in Guinea”, *The New York Times*, 30 November 2014.

⁴⁵ Crisis Group interview, Dr Dansa Kourouma, National Council of Civil Societies Organisations (CNOSCG) president; Aboubacar Sylla, opposition spokesman, Conakry, 18 January, 2015.

⁴⁶ “Pushed to the Limit and Beyond”, op. cit.

⁴⁷ “How Ebola roared back”, op. cit.

support was mobilised, but health-security concerns led to more cancelled flights, closed borders and movement restrictions.⁴⁸

International mechanisms, such as the International Health Regulations, require states to report certain disease outbreaks. There are agreed benchmarks for specific diseases. However, even with better surveillance and the political will to declare a health emergency, a signatory state that lacks a functioning health system to begin with will have difficulty meeting the core requirements, and no instrument exists to resolve “disconnects between policy and reality” if a state is in denial about an epidemic or simply unable to fulfil its obligations.⁴⁹

Attention to Ebola skyrocketed when infected health workers returned to the U.S. and Europe in August.⁵⁰ The WHO declared a “public health emergency of international concern” on 8 August, but it was the end of the month before it presented a roadmap for controlling the epidemic.⁵¹ After months of minimising the risks, potential dangers were no longer seen as limited regionally, and military mobilisations by the U.S., UK, France and others, along with establishment of UNMEER, the UN coordination mission, followed in the coming months.

Focusing on the reasons for delay should not distract from the complications of organising a response to a particularly lethal virus for which expertise was limited and highly specialised. “Expertise”, an MSF regional operations representative said, “was needed that takes time and that doesn’t exist in the humanitarian world”. This was one reason why the affected states turned to their security services to take strong restrictive measures, but this held its own risks.⁵²

C. *Quarantine and Containment*

Use of security services in containing an epidemic has historical precedent, for both logistic support and maintenance of public order.⁵³ Given the dangers of a breakdown in public order, the inclination to enforce extreme public health measures such as mass quarantine (and be seen as doing something) can be strong, despite debatable effectiveness. Broad restrictions on population movements to control the Ebola

⁴⁸ This recognition of the risks as well as advantages of declaring an emergency contradict early claims that faulty intelligence was chiefly to blame for WHO’s delay. Crisis Group interviews; also “World Health Organization ‘intentionally delayed declaring Ebola emergency’”, *The Guardian*, 20 March 2015. More than 40 countries implemented trade and travel restrictions beyond those recommended by WHO and in violation of the International Health Regulations (2005). This created severe political, economic and social consequences for affected countries and barriers to receiving assistance. “Report of the Ebola Interim Assessment Panel”, op. cit.

⁴⁹ The regulations were adopted in 2005 and came into force in 2007; there are currently 196 signatories, including Liberia, Sierra Leone and Guinea. Wilkinson and Leach, op. cit.

⁵⁰ Crisis Group telephone interview, UK Department for International Development (DFID) consultant, 23 March 2015.

⁵¹ “Statement of the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa”, WHO, 8 August 2014; “WHO issues roadmap for scaled-up response to the Ebola outbreak”, WHO, 28 August 2014.

⁵² Crisis Group interview, Yann Lelevrier, MSF regional operations representative, Dakar, 3 February 2015.

⁵³ Plague, yellow fever, cholera and influenza have all provoked different forms of quarantine, reinforced by security services. A more recent example is the 2003 SARS epidemic, particularly in China where “repressive police measures” to stem the epidemic were considered necessary. Eugenia Tognotti, “Lessons from the History of Quarantine, from Plague to Influenza A”, *Emerging Infectious Diseases*, vol. 19, no. 2, February 2013.

epidemic could only be useful, however, if everyone respected the quarantine measures (nobody trying to escape, hide the sick, etc.) and contagious individuals displayed no symptoms, neither of which was the case. And while it is understandable that governments have limited means at their disposal, the danger is that harsh measures can provoke further unrest.⁵⁴

Imposing local quarantines to counter Ebola remains tricky, given the need to avoid provoking panic, denying services or unduly blocking commercial relations.⁵⁵ In practical terms, it has been almost unworkable in populated areas with porous, largely artificial borders and when even openness about the number of cases has been non-existent.⁵⁶ Restricting movement meant also severely restricting access to livelihoods, health care, food and water. Instead of facilitating identification of suspected cases, the impact was as likely to be evasion and ever greater suspicion of health-care providers, because quarantine, a health worker said, “makes people fearful, makes people flee and creates terrible conditions”.⁵⁷

Liberia declared a 90-day state of emergency on 6 August, following numerous security incidents the previous month, notably over the location of treatment centres, perceived poor medical treatment and improper burials.⁵⁸ The armed forces and the national police enforced curfews in parts of Monrovia. The most publicised incident was the 20 August shooting of unarmed demonstrators protesting the quarantine in West Point, an overcrowded slum neighbourhood in the capital. The “counter-productive” measures showed, UN experts concluded, that soldiers “without specific training to deal with civilians are inappropriate tools for such situations”. Actions such as enforcing quarantine violently and periodic harassment and extortion of individuals risked creating the impression the “armed forces are little different from the predatory armed forces of the past”.⁵⁹

President Johnson Sirleaf has acknowledged that using soldiers and police to quarantine entire neighbourhoods “created more tension in the society”. Indeed, it risked “alienating the very people whose cooperation she desperately needed to con-

⁵⁴ A bewildering array of terms was used, at times interchangeably, to refer to movement restrictions, including security and community-led quarantines, lockdowns, containment, confinement and isolation. Isolation refers to the medical seclusion of infected persons; quarantine refers to movement restrictions of those posing an unconfirmed risk. More broadly, quarantine can be better termed containment and is relevant to previous Ebola outbreaks in isolated areas as opposed to urban centres. Crisis Group interview, MSF field doctor, Paris, 5 January 2015.

⁵⁵ Quarantine has a long, chequered history of balancing health and commerce needs. There are also many examples of it providing a rationale for more nefarious motives. Duncan Mclean, “Gold, Fire and Gallows: Quarantine in History”, *History Today*, December 2014.

⁵⁶ Crisis Group interview, Rosa Crestani, MSF Ebola Task Force, Brussels, 16 February 2015. The Liberia-Sierra Leone border was described as 90 per cent unguarded and controls “typically forgotten for a wink and \$25”. Laurie Garrett, “The Monster in the Sea”, *Foreign Policy* (online), 29 December 2014.

⁵⁷ Crisis Group interview, Rosa Crestani, MSF Ebola Task Force, Brussels, 16 February 2015.

⁵⁸ “Final Report of the Panel of experts on Liberia submitted pursuant to ... Security Council Resolution 2128 (2013)”, S/2014/831, 24 November 2014. July 2014 security incidents included protests over the Ebola treatment centre in Montserrado County, the burning of the health and social welfare ministry’s Monrovia conference centre due to improper treatment of an Ebola victim and forced removal of bodies from a Lofa county hospital for traditional burial.

⁵⁹ *Ibid.* The same report called the perception “unfortunate and unfair, given that the [government’s] restructured armed forces, although imperfect, are fundamentally different”.

trol the epidemic”.⁶⁰ A shift to community-led quarantines took place, with relative consent of the affected, after the violence in West Point.⁶¹ Liberia thus stood out in learning from mistakes, showing relative transparency in acknowledging the disaster’s scale and in its requests for international help. After September, local mobilisation was effective in containing the virus.⁶²

From November 2014, Sierra Leone used quarantines regularly, ostensibly with standard operational procedures (SOPs) outlined by the National Ebola Response Coordination (NERC). Weaknesses highlighted early by Oxfam included a “disconnect” between SOPs and practice; providing those under quarantine with insufficient food, water and other basics; and lack of community response to requests for “contact tracing, access to care facilities and burial management”.⁶³

The government nevertheless persisted with movement restrictions, including a “lockdown” at the end of March 2015, during which six million people were essentially told to stay home, as volunteers moved door-to-door to identify potential new cases.⁶⁴ The virus’s persistence motivated regular and repeated quarantines, including with security enforcement and punishment. Facilitated by an army that was “extremely effective” and more widely respected, compared to Liberia’s, a repetition of events in Monrovia was avoided.⁶⁵ The degree to which this contributed to containing the outbreak or restoring confidence in the government is far from certain. The better option would have been surveillance and case-finding (the latter not without risk given how health-workers and treatment centres were perceived, but less panic-inducing than mass quarantine). Essential to this would have been to ensure existence of technical, logistic and staffing resources, so preparatory measures and follow-up could be carried out rigorously.

Given the problematic impact of its neighbours’ quarantines, it is curious that Guinea adopted a similar approach much later. Until the declaration of a 45-day “health emergency” in March 2015, it had avoided such measures, but new infections, combined with reports of individuals fleeing the “lockdown” in Sierra Leone, provoked the change. Affecting five prefectures in the west and south west, the declaration included the potential quarantining of health facilities in which new cases were detected and possible mass lockdowns.⁶⁶ As with Sierra Leone, its effectiveness remains to be ascertained.

It is not surprising that all three countries used security forces prominently to respond to the epidemic, as they had more soldiers and police than government health workers. Periodic overreaction was not limited to West Africa, however. International

⁶⁰ “Liberian leader concedes errors in response to Ebola”, *The New York Times*, 11 March 2015. “Ebola in Liberia: an epidemic of rumors”, *The New York Times*, 20 November 2014.

⁶¹ “Community Quarantine to Interrupt Ebola Virus Transmission – Mawah Willage, Bong County, Liberia, August-October 2014.” Morbidity and Mortality Weekly Report, CDC, 27 February 2015. West Point, a tiny peninsula jutting into the sea, has only two alleyways running down to it. Soldiers sealing it off essentially consigned the population to death by contagion.

⁶² Crisis Group email correspondence, UNMIL official, 30 September 2015.

⁶³ For more on NERC, see <http://nerc.sl/>. “Quarantines in Sierra Leone: Putting People First in the Ebola Crisis”, Oxfam, December 2014.

⁶⁴ “Ebola outbreak: Sierra Leone in lockdown”, BBC (online), 27 March 2015.

⁶⁵ Crisis Group interview, senior official, London, 16 January 2015; Lisa Denny, “Beyond the medical crisis: The politics of Ebola in Sierra Leone”, Institute of Development Studies, 15 April 2015. In Freetown, the information campaign was better, and everything was far more spread out, leading to less anxiety and desperation.

⁶⁶ “Guinea declares Ebola ‘health emergency’ in five regions”, BBC (online), 29 March 2015.

reactions oscillated throughout the crisis between a security response stoked by fear and portrayals of an epidemic with a limited impact on the developed world.⁶⁷

D. *Ignoring Community Involvement*

Despite regular international insistence on cultural sensitivity, strict guidelines with zero adaptation to local practices, for example on burials of Ebola victims, provoked resistance and avoidance, leading to more infections. Ignorance of local customs initially discouraged families from bringing the sick in for treatment and safe disposal of bodies.⁶⁸

Liberia's Lofa county has been cited as a model of local and international collaboration, including lengthy consultations with aid actors who had long been in the area. The population changed norms and cultural practices during the spike in infections (June 2014), as treatment centres became viewed as "not only a place to die".⁶⁹ The explosion of cases in Monrovia in August appeared to provide a shock that facilitated behaviour change throughout the country, unlike the virus's slow burn that continued to ravage the rest of the region.⁷⁰

Community structures appear to have been more respected than national ones across the region during the crisis and arguably produced better results with limited resources than the central governments. An ActionAid survey found that many respondents received more effective prevention messages from local authorities and that local bylaws for prevention and control of the disease were generally respected in most rural areas.⁷¹

Perhaps most problematic has been Guinea, where stigma and denial remain a problem. Sensitisation has been poor, and there is limited community involvement. Contentious politics has worsened over the course of the epidemic, and mistrust remains prominent. The assertion that only certain ethnicities were affected nourished conspiracy theories that Ebola "is a tool or some sort of political manipulation".⁷² Such suspicions were evident to a degree in all three countries (more in Guinea and Sierra Leone) and a major constraint to definitively halting Ebola's spread.

E. *Opportunism and Corruption*

Another manifestation of local distrust was the cynicism that accompanied Ebola's arrival. With state and foreign entities often viewed as self-serving, some at least considered the epidemic a scam to obtain aid money, which complicated sensitisation and mobilisation. Such attitudes were rooted in the prevailing widespread corrup-

⁶⁷ Auriane Guilbaud, "Le système sanitaire international face à l'épidémie d'Ebola", www.laviedesidees.fr, 9 December 2014. The foreign militaries used to facilitate the response prudently avoided public-order duties.

⁶⁸ Crisis Group interviews, 4 March 2015. This was also recognised in the Report of the Ebola Interim Assessment Panel, WHO, 7 July 2015.

⁶⁹ Crisis Group interview, diplomat, Monrovia, 13 March 2015.

⁷⁰ In Liberia there was "no time, it exploded far too quickly, the shock facilitated the change in behaviour". Crisis Group interview, Brice de le Vingne, MSF director of operations, Brussels, 5 January 2015.

⁷¹ Crisis Group interviews, 4 March 2015. "Knowledge Attitude and Practice Survey of Ebola in Bo and Kono Districts in Sierra Leone", ActionAid, August 2014.

⁷² Crisis Group email correspondence, Jérôme Mouton, MSF mission head, Conakry, 2 April 2015. "One year on: why Ebola is not yet over in Guinea", IRIN, 23 March 2015.

tion.⁷³ Ebola “business” came to refer to ways to obtain money meant to halt the epidemic. Guinean authorities no longer accuse international NGOs of opportunistic fundraising, but some predatory local NGOs emerged. Sensitisation activities were particularly open to abuse, as many phantom organisations registered with the national Ebola coordination agency.⁷⁴

It is still early for the kind of complete reading on the misuse of funds that accompanies the post-mortem of most humanitarian crises. Nevertheless, disturbing details have emerged. With the February 2015 publication of an audit report on management of Ebola funds between May and October 2014, Sierra Leone has gone farthest. It said about \$14 million could not be accounted for and raised questions about some senior officials who managed the epidemic, civil society leaders and contractors.⁷⁵ In response, the government promised a full investigation and that those misusing Ebola funds would “face the full force of the law”.⁷⁶

F. *Differing Degrees of Politicised Reactions*

Politicians used the crisis to further aims unrelated to the response. Opposition groups took advantage of lack of trust in the health system, and by extension in the authorities, to criticise the government. Officials and local representatives attempted to exploit the crisis in their own way.

In Liberia, where the emergency was most extreme in summer 2014, there was genuine concern for a breakdown of law and order. Initial recourse to the security services, such as the quarantining of West Point, “provoked a backlash among the population that is deeply distrustful of government”.⁷⁷ Internal unrest and violence would have been real risks if these measures had been maintained. Opposition elements seized on the opportunity to reiterate calls for the president’s resignation. Former warlord Prince Yormie Johnson argued the “government had not made a convincing case for curfew and had failed to act decisively to contain the spread of Ebola”.⁷⁸ Though the president appears to remain popular abroad, domestic disenchantment grew around her perceived manipulation of the crisis. A December 2014 ban on public gatherings, ostensibly to limit Ebola’s spread, led to charges its true purpose was to help her son’s senate campaign.⁷⁹

⁷³ “Ebola in Liberia”, op. cit. In descending order, Guinea, Sierra Leone and Liberia consistently feature in the bottom half (more corrupt) of Transparency International’s corruption index. See 2014 index at www.transparency.org.

⁷⁴ 47 dossiers were registered at the national level, primarily oriented toward sensitisation. Not all received funding. “Ebola business’ en Guinée: Quand le virus mortel aiguise l’appétit des ONGs mercantiles ...”, www.africaguinee.com, 24 September 2014; also, “One year on”, op. cit.

⁷⁵ “Audit report on the management of Ebola funds between May and October 2014”, Audit Service Sierra Leone, February 2015. Additional alleged irregularities included missing ambulances and misappropriated hazard pay. “Sierra Leone audit claims Ebola funds unaccounted for”, BBC (online), 13 February 2015.

⁷⁶ “A third of Sierra Leone’s Ebola budget unaccounted for, says report”, *The Guardian*, 16 February 2015. Responsibility for the recommendations has shifted from the Anti-Corruption Commission to parliament’s Public Accounts Committee. What action there may be is unknown.

⁷⁷ “Final Report”, op. cit. President Sirleaf acknowledged to *The New York Times* editorial board: “It did not take long to know that did not work.... It created more tension in the society”. “Liberian leader concedes errors in response to Ebola”, 11 March 2015.

⁷⁸ Ibid.

⁷⁹ “Liberian president’s ban on rallies is seen as political”, *The New York Times*, 7 December 2014. Despite low turnout, the 20 December elections generally passed without violence; the strong show-

The political establishment likewise traded accusations in Sierra Leone. The Ebola outbreak coincided with the rollout of the national census and a constitutional review process. In a context of deep mistrust across party and regional lines, communities that largely supported the opposition were concerned the government was trying to undercount them, with electoral and resource allocation disadvantages.⁸⁰ Tensions were not soothed when the information minister accused opposition parliamentarians in Kailahun of intentionally putting out messages to create resistance to government programs.⁸¹ Government indecision also hampered efforts. Health ministry officials admitted they hesitated to apply tough containment measures to Sokoma village and Kailahun in the early phases of the crisis. A senior official acknowledged there were delays out of fear quarantines in the opposition's heartland would be seen as repression.⁸² Much time was wasted on accusations and denials about the government's response.⁸³

Such problems persisted longest in Guinea. There was a "clear politicisation of the response", a UN official said, "with ethnic divisions becoming more pronounced".⁸⁴ In the most extreme and noticed example, a sub-prefect, health workers, journalists and an evangelical organisation employee were killed in Womey in October 2014 while conducting a health messaging campaign on Ebola's dangers, accused by villagers of intentionally spreading the disease. The urbanised elite reflexively blamed this and similar instances on backwardness. More ominously, the opposition was accused of intentionally hindering the response to prove "that the government had failed", and Ebola was "invented to stop or delay elections" or was a presidential ploy "to disseminate the virus in order to eliminate certain persons".⁸⁵

Simplifying these tragedies as the result of a gullible population swayed by the political elite ignores existing dissatisfaction. Combined with poorly crafted messages of near-certain death if infected by Ebola and stigmatisation of survivors, rejection of government health information in historically excluded or exploited regions becomes somewhat more comprehensible. Rumours were traded on all sides. The opposition was concerned that fighting Ebola reinforced government networks and facilitated recruitment of young militants to the RPG cause, while securing for the authorities significant international aid at the same time as public health restrictions

ing of opposition candidates was an indication of disillusionment with the government. "Incumbent candidates struggle in Liberia's Senate elections", Voice of America (VOA), 22 December 2014.

⁸⁰ "APC politicizes national census", NewsWatch Sierra Leone (online), 17 January 2015.

⁸¹ Bordering both Liberia and Guinea, Kailahun had the first reported cases in Sierra Leone and is considered an epidemic epicentre.

⁸² Information Minister Alpha Kanu radio interview, "Good Morning Sierra Leone" talk show, Radio Democracy FM98.1, Freetown, 15 January 2015.

⁸³ A senior health ministry doctor said the fight against Ebola would have been different if the epidemic had started in the ruling-party's northern stronghold. Crisis Group interview, 12 January 2015.

⁸⁴ Crisis Group Blog, "Ebola in Guinea: A 'Political' Epidemic?", 1 October 2015; telephone interview, Conakry, 20 March 2015.

⁸⁵ Military repercussions in the village reportedly displaced thousands. "The Fear of Ebola led to slayings – and a whole village was punished", *The Washington Post*, 28 February 2015. Among other incidents, the Société des eaux de Guinée has been accused in Koba of propagating the virus, and vehicles and buildings belonging to MSF and the Red Cross have been targeted. Reopening of classes was resisted in Malipan, Moyenne Guinée, with teams accused of attempting to infect students by infrared thermometers and chlorinated water. Crisis Group interview, Damatang Albert Camara, government spokesman, Conakry, 20 January 2015.

prevented its own demonstrations.⁸⁶ From the authorities' perspective, the opposition was behind the spread of disinformation meant to destabilise the government and discourage investors.

The irresponsible politicising of the response, by either side, was extremely dangerous. It partly explains the resistance in certain zones, for example Guinée Forestière, despite intensified sensitisation. More positively, though relatively late in the process, UNMEER organised a "Forum des forces vives de la Guinée contre Ebola", bringing together political parties, traditional and religious leaders and civil society representatives. Its final declaration focused on disconnecting the Ebola response from the "socio-political cleavages existing in the country, particularly during this pre-electoral period". Though not enough senior leaders attended, it set an important precedent.⁸⁷

⁸⁶ "How Ebola roared back", op. cit. "Quand l'épidémie d'Ebola devient une 'opportunité' politique", UDFG official website (www.ufdgonline.org), 19 November 2014.

⁸⁷ "Declaration", Conakry, 12 March 2015. Crisis Group telephone interview, UNMEER contact, 20 March 2015. Liberia's "national strategy – particularly the military's spearheading of a heavily centralised response, and the initial mixed messages of certain death – inspired fear much more than it created societal trust and cooperation". "Tackling and Preventing Ebola while Building Peace and Societal Resilience", CSPPS, April 2015, p. 24.

IV. Regional Mistrust

Distrust within the most affected countries was mirrored by regional suspicions. Prior to the outbreak, bilateral relations were relatively limited between the three neighbours, despite membership in the sub-regional Mano River Union. Although ECOWAS was among the first to warn of the wider implications in late March 2014, it closed its regional office early in the crisis.⁸⁸ Support was restricted to financing increased epidemiological surveillance through its health branch, WAHO (the West African Health Organization). WAHO also coordinated the arrival of volunteer health workers on behalf of the African Union (AU) and ECOWAS, the first group of which reached the affected countries only in December.⁸⁹

The AU eventually set up a funding mechanism and mobilised 835 health workers following the decision to establish an official mission in July 2014. However, in the early stages, the AU was “as guilty as anyone else in terms of neglect and mobilisation”.⁹⁰ Perhaps the most important impact of the epidemic as concerns the AU was the acceleration of the plan to form an African Centre for Disease Control (CDC) and Prevention in Addis Ababa.⁹¹

Ebola was the “first real crisis of the Mano River Union” since the Liberia and Sierra Leone civil wars, a UN official said, and the result was reinforced divisions, tensions and closed borders. The dangers of the compartmentalised approach, in which each state received aid bilaterally, with little interaction and information sharing, were visible in the poor surveillance and hidden cases of the epidemic’s early stages. With no effective national and transnational coordination mechanism, all three countries remain at risk of re-infection, even as the epidemic fades, he added.⁹²

The secretary general of Guinea’s presidency lamented that Liberia, Sierra Leone and Guinea “cooperated more effectively with the UN system, the U.S., France and UK, with MSF and CDC, than with each other”. Compounding the situation was a “colonial partition of support that exacerbated regional differences, reinforcing divisions in the Mano River Union”, the UN official said. With an associated finance system that cemented a country-by-country approach, the capacity for rapid cross-border action was limited, especially during the epidemic’s severest phase.⁹³

⁸⁸ International experts concluded: “The rapid spread beyond the rural areas confirms the absence or ineffectiveness of subregional mechanisms to tackle problems that may arise in these zones”. “Recovering from the Ebola Crisis”, *op. cit.*, p. 12.

⁸⁹ In addition to a cumbersome and limited emergency funding mechanism, ECOWAS has also been criticised for overreliance on the “weak and inadequate health institutions in the affected member states”. See “Human Security in Practice: Securing People from the Threat of an Epidemic – What can we Learn from the ECOWAS Response to Ebola”, *Strategic Review for Southern Africa*, vol. 37, no. 1, pp. 190-199, May 2015.

⁹⁰ Factsheet, African Union Support to Ebola Outbreak in West Africa (ASEOWA), 26 January 2015. Crisis Group telephone interview, international health official, 10 September 2015.

⁹¹ With the support of the U.S. CDC, the Addis Ababa-based African CDC coordinating structure will eventually supervise five regional centres and “monitor public health, respond to public health emergencies, address complex health challenges, and build needed capacity”. “African Union and U.S. CDC Partner to Launch African CDC”, press release, CDC, 13 April 2015.

⁹² Crisis Group telephone interview, Conakry, 20 March 2015. The crisis also reflected neo-colonial relations: the UK concentrated on Sierra Leone, the U.S. on Liberia, France on Guinea.

⁹³ Kiridi Bangoura, “La riposte contre l’épidémie de fièvre à virus Ebola en Guinée”, *Forum Paix et Sécurité*, Dakar, December 2014. Crisis Group telephone interview, Conakry, 20 March 2015.

This remains a concern. Cross-border surveillance is still not good enough; regional division reflects internal schisms within each state, and reliance on international support is habitual. The World Bank and Mano River Union members have agreed to strengthen sub-regional disease surveillance and response, but donors must ensure the mechanism is adequately and sustainably supported.⁹⁴

⁹⁴ “Concept note for the Security Council briefing on peace and security in Africa: the global response to the 2013 Ebola virus disease outbreak”, S/2015/600, 5 August 2015.

V. The International Aspects of the Ebola Response

A. *Securitisation*

A security-oriented focus, in part an effort to control fear and panic as well as maintain public order, was perhaps necessary, but risked producing the opposite effect, driving people to go underground or hide infected family members.⁹⁵ The impulse to disengage from infected areas also had regional implications, as public health preoccupations were coupled with security concerns. Each affected country's borders were closed, and a broader containment attempt was enacted. Most airlines halted flights, with companies from Ghana and Morocco the exceptions. It was more difficult for people from affected countries to obtain visas, and health workers returning from the region were often quarantined.⁹⁶ Businesses withdrew, and trade largely ground to a halt, with dramatic economic consequences.

More broadly, Ebola's dangers were explicitly framed in "national and international security terms". The UN Security Council declared the epidemic "a threat to international peace and security", the first such designation for a health crisis time since HIV/AIDS. In the U.S., whose vision and strategy for "Global Health Security" seamlessly integrates risks of bio-terrorism and infectious disease, politicians and military officials equated it with "hard" security threats.⁹⁷

The U.S. deployed 3,000 troops to Liberia in September 2014, President Obama said, due to the "profound political, economic and security implications for all of us".⁹⁸ The assumption was that strong U.S. command and control and logistics capacities would reinforce the response during a period of panic and uncertainty.⁹⁹ The deployment was beneficial, and its political symbolism also mattered. The Americans were eventually followed by UK and French deployments in Sierra Leone and Guinea respectively.¹⁰⁰ There are, nonetheless, risks associated with the wider securitisation of

⁹⁵ The troops deployed to West Africa supported logistics, construction, transport, etc, and were not directly involved in treatment. That Ebola is a highly problematic infectious disease goes some way to explain the "militarisation" of the response, an infectious disease expert said – more specifically the perception that were no organisations other than armed forces could have done this kind of deployment. Body fluids are extremely infectious; most of those with symptoms die unless in a sophisticated intensive treatment unit. An outbreak of any size requires massive measures that include rapid establishment of treatment centres with full health-worker protection and related equipment; staff experienced in such a disease are rare. 100 suspected cases would probably swamp London's resources, the expert noted. Crisis Group email communication, 8 August 2015.

⁹⁶ Crisis Group interview, Mark Harrison, professor, Oxford University, director, Wellcome Unit for the History of Medicine, London, 15 January 2015.

⁹⁷ Resolution 2177, 18 September 2014. (In 2000, Resolution 1308 declared that "the ... [HIV/AIDS] pandemic, if unchecked, may pose a risk to stability and security".) Margaret Chan, the WHO director general, highlighted Ebola's "threat to national security well beyond the outbreak zones"; U.S. President Barack Obama spoke of the "growing threat to regional and global security". Yanzhong Huang, "The Downside of Securitizing the Ebola Virus", Council on Foreign Relations (online), 25 November 2014. "Global Health Security – Vision and Overarching Target", U.S. Department of Health and Human Services (2015).

⁹⁸ "Citing security threat, Obama expands US role fighting Ebola", Reuters, 16 September 2014. Most of the soldiers arrived after the epidemic had peaked in late September; the first U.S. military-supported treatment centre opened in November. The UK sent 750 troops to Sierra Leone.

⁹⁹ It also supported the placement of all national Ebola actors under one roof in Monrovia. Crisis Group email correspondence, UNMIL official, 28 September 2015.

¹⁰⁰ Crisis Group telephone interview, aid official, Washington, March 2015. Cuba sent more than 256 health professionals to the three affected countries. "More Cuban doctors and nurses arrive in

international public health.¹⁰¹ The implication that health interventions can “only be justified in terms of their impact on security”, a global health expert said, raises questions as to how much attention will remain as the epidemic winds down.¹⁰² Rebuilding health structures, including addressing diseases neglected during the Ebola epidemic, will require sustained support long after media and political attention has shifted.

B. *Recreating the Aid System*

UNMEER’s creation on 18 September 2014 – with no end to the epidemic in sight and concerns Ebola could lead to state collapse in three countries – was almost unprecedented. Intended as a “singular UN system-wide approach in responding to Ebola”, its mandate and structure bypassed existing UN agencies. The focus was on containing the outbreak, though ensuring essential services and preserving stability were also included.¹⁰³

Despite a large UN presence in the region, no part of it, including WHO, which ideally should have been the lead agency, was capable of managing the regional response.¹⁰⁴ The UN country teams were considered “development not humanitarian” specialists.¹⁰⁵ UNMIL in Liberia, despite its important peacekeeping role since 2003, had no health services mandate. Though its personnel were “providing health care in both emergency and non-emergency situations prior to the Ebola outbreak”, they were not trained for a public health operation. The immediate response to the Ebola outbreak was rather to “remove peacekeepers from the frontline in delivering medical assistance”.¹⁰⁶

Critics contend UNMEER had the wrong format but acknowledged it “at least had the authority that existing UN agencies did not have and was better positioned for internal coordination amongst them”. Despite acting as a “hugely expensive umbrella”, based far from the scene in Accra, it provided a sorely lacking regional emphasis that “promoted cross-border views”.¹⁰⁷

west Africa to fight Ebola”, *The Guardian* (online), 22 October 2014. China sent 480 military medical staff. “China to send elite army unit to help fight Ebola in Liberia”, Reuters, 31 October 2014.

¹⁰¹ U.S. forces were largely deployed under U.S. Agency for International Development (USAID) auspices. Multiple interviewees highlighted that concerns over the mixing of humanitarian and military priorities did not materialise.

¹⁰² Crisis Group interview, Yanzhong Huang, senior fellow for global health, Council on Foreign Relations, New York, 26 January 2015.

¹⁰³ Operational principles, main activities and objectives are detailed in Ebolaresponse.un.org.

¹⁰⁴ “The Ebola response in West Africa”, *op. cit.*, pp. 25-27.

¹⁰⁵ These include WHO, OCHA (Office for the Coordination of Humanitarian Affairs), UNOWA (UN Office for West Africa), UNDP (UN Development Programme), UNMIL (UN Mission in Liberia), UNAIDS (Joint UN Programme on HIV and AIDS), IOM (International Organization for Migration), WFP (World Food Programme), UNIDO (UN Industrial Development Organization), UNOPS (UN Office for Project Services), UNHCR (UN High Commissioner for Refugees), and UNICEF (UN Children’s Fund). Crisis Group telephone interview, disaster epidemiologist, 23 March 2015.

¹⁰⁶ The U.S. took a lead role in developing the Liberian health sector from 2010-2012, seemingly to little effect. Crisis Group email correspondence, regional expert, 6 October 2015. “Healing or Harming? United Nations Peacekeeping and Health”, International Peace Institute, March 2015. The Philippines withdrew its peacekeepers completely from Liberia.

¹⁰⁷ Crisis Group telephone interview, UN official, Conakry, 20 March 2015; interview, diplomat, Monrovia, 13 March 2015. Despite its late arrival, UNMEER reached the area when the epidemic’s trajectory was still unknown.

While the intent cannot be faulted, discarding existing structures and lessons from previous emergencies raised serious questions. WHO's assessment panel concluded: "UNMEER was not very successful in the affected countries" due to its "unwieldy" structure and two-month delay in setting up operations at the height of the epidemic. The panel also criticised lack of engagement with the existing UN cluster system for interagency cooperation and recommended "against the establishment of a United Nations mission for future emergencies with health consequences".¹⁰⁸ Adding another administrative layer did little to clarify the multiple crossing mandates in Ebola-affected countries. Nor did it correct weaknesses in the emergency response resulting from the small number of operational actors, and it delayed activities due to limited private reserves and multiple donors channelling funds through the UN agencies, which essentially acted as gatekeepers for their dispersal.¹⁰⁹

C. WHO's Shortcomings

WHO failings are most important for analysis of the international response to the epidemic. UNMEER was one of several reactions to those failings, as is a proposed internal reform process. Flaws include the political- rather than merit-based nomination of staff to key positions (particularly for country representatives), incoherence between levels of the organisation, insufficient expertise in the family of virus to which Ebola belongs, little ability to coordinate a complex international health crisis response and lack of flexibility in its emergency response.¹¹⁰ WHO's weak leadership and funding mechanism, however, are central to understanding its poor response capacity.

Much like UNMEER, the earlier creation of UNAIDS had been symptomatic of a lack of confidence in WHO to manage global health emergencies. Other vertical programs that focus on specific pathologies, like the Global Fund to Fight AIDS, Tuberculosis, and Malaria, were designed as partnerships between governments and donors (and civil society). Run by boards, they had a total budget of roughly \$4 billion in 2013.¹¹¹ They have become the norm, but, a diplomat said, they do "not help the health system as a whole", because with 80 per cent of WHO funding now earmarked for specific programs, there is less budget for programs that are not donor

¹⁰⁸ "Report of the Ebola Interim Assessment Panel", op. cit. The cluster system was the result of a process of humanitarian reform initiated in 2005 to improve coordination in emergencies, specifically to "improve the effectiveness of humanitarian response through greater predictability, accountability, responsibility and partnership". The confusion over how a public health emergency fits into the humanitarian system was evident in the "non-role of OCHA that refused to play its traditional coordination role". Crisis Group interview, Marc Poncin, former head of MSF Guinea mission, Geneva, 27 May 2015.

¹⁰⁹ Crisis Group interview, Yann Lelevrier, MSF regional operations representative, Dakar, 3 February 2015; "The Ebola response in West Africa", op. cit. Governments were also slow. The House of Commons criticised the "time Lag" between DFID recognising the need to act and actual disbursement. "The UK's response to the outbreak of Ebola Virus Disease in West Africa", House of Commons Committee of Public Accounts, 11 February 2015.

¹¹⁰ "A l'OMS, le virus Ebola sonne l'heure des grandes réformes", *Le Monde* (online), 26 January 2015; "[WHO]: Too big to fail", *The Economist*, 13 December 2014; "Report of the Ebola Interim Assessment Panel", op. cit.; Crisis Group interviews, March 2015, August 2015.

¹¹¹ "Funding and Spending", The Global Fund to Fight AIDS, Tuberculosis and Malaria, (www.theglobalfund.org), 23 January 2014.

priorities.¹¹² Emergency capacity has suffered, even if crises like the Ebola epidemic are easier to address during their early stages.¹¹³

Beholden to the same member states that approved large budget cuts, WHO is built around “a culture of consensus rather than leadership”.¹¹⁴ Bureaucratic and structural inertia hampered its Ebola response. WHO leaders were reported to be concerned about angering the authorities and economic damage. States will almost certainly remain reluctant to give even limited decision-making power to such an international actor, including because of the damage not only an epidemic, but also a false declaration of an epidemic could cause.¹¹⁵

At a 25 January 2015 WHO emergency session, gathering criticism was partially pre-empted by proposed reforms. These included reaffirmations of its central role in health emergencies, an emergency contingency fund and pledges to improve international cooperation, develop vaccines and drugs faster and reestablish a rapid response team. While the degree to which these reforms can address the broader dysfunctions remains to be seen, especially given the director-general’s limited control of WHO (relative to its Executive Board), more immediate technical concerns will be tested in the next health emergency. Despite its mandate to provide “leadership, oversight of health security and coordination of international responses”, scepticism about its political will and technical capacity remains. According to an international health expert, “quick, nimble and flexible, are necessary traits in responding to a crisis, [but] they are not what comes to mind when thinking of the WHO”.¹¹⁶

D. *Slow and Cumbersome Organisations*

Critiques of international and local national government response should not ignore that relatively few organisations were able to act quickly; even after the August 2014 declaration of a “public health emergency of international concern”, most continued to lack response flexibility. In a mid-2014 report that did not integrate Ebola into its analysis, MSF described a broad reticence to intervene in emergencies, not simply resulting from absence of resources, though this is a perennial issue. The UN system, acting as donor, coordinator and implementer, bears partial responsibility, but so do other donors and NGOs. Recurrent problems include “slow and cumbersome” humanitarian response, many fewer actors when security and logistics constraints

¹¹² Crisis Group interview, Inter-ministerial Ebola Task Force, foreign ministry, Paris, 16 February 2015. “World Health Organization: Too big to Fail”, op. cit. Oxfam also noted this 80:20 ratio. That 20 per cent for the rest of its activities represents one third the budget of the U.S. CDC. “Improving International Governance for Global Health Emergencies: Lessons from the Ebola crisis”, OXFAM discussion paper, January 2015. CDC’s 2015 budget request was for \$6.6 billion. “Budget Request Summary – Fiscal Year 2015”.

¹¹³ Nine of twelve emergency response specialists were laid off in the years preceding the outbreak. “How Ebola roared back”, op. cit.

¹¹⁴ Crisis Group interview, David Heymann, Centre on Global Health Security (Chatham House), professor, infectious disease epidemiology, London School of Hygiene and Tropical Medicine, chairman, Public Health England, London, 15 January 2015.

¹¹⁵ “Email: UN health agency resisted declaring Ebola health emergency”, Associated Press, 20 March 2015. For example, see the problems of H1N1 (“swine flu”), about which the WHO was accused of being alarmist, resulting in the large-scale purchase of vaccines by states.

¹¹⁶ “Al’OMS”, op. cit. Crisis Group interview, February 2015. “Improving International Governance”, Oxfam, op. cit.

are heavy, bias toward easily accessible areas rather than where needs are greatest and over-reliance on local actors.¹¹⁷

Lack of flexibility after Ebola programs began to be implemented in late 2014 was a particular challenge. Funding had increased significantly, but rapid operational adjustment as the epidemic evolved was difficult. Even as cases began to drop in October, treatment centres were being built.¹¹⁸ The space would have been essential if the epidemic had continued to grow, but it reflected the old problem, not the actual one. Recognition that safe burial practices required as much attention and support as treatment facilities was an essential shift that came too slowly.¹¹⁹

¹¹⁷ “Where is Everyone: Responding to Emergencies in the Most Difficult Places”, MSF, July 2014.

¹¹⁸ Funding was an early problem, but perception of Ebola as a tangible threat led to increase in support of all kinds. “UN Ebola trust fund gets \$100,000, almost \$1 billion needed”, Reuters, 17 October 2014. It is unknown what caused case reduction, though “public behaviour changes, greater availability of beds, increased efforts to control infection and more safe burials have all contributed to the decrease”. “Pushed to the Limit and Beyond”, op. cit.

¹¹⁹ Crisis Group interview, aid official, Washington, March 2015.

VI. Consequences and Lessons

A. *The Risks of Stagnation*

Ebola's direct socio-economic impact is easiest to analyse, but the long-term consequences are uncertain. Liberia, Sierra Leone and Guinea are estimated to lose at least \$1.6 billion directly in 2015 GDP due to the epidemic.¹²⁰ According to Oxfam, this will include measurable aspects such as “reduced production, diminished trade, disrupted agriculture, output forgone, higher fiscal deficits and rising prices”.¹²¹ There will also be a significant indirect impact. “Aversion behaviour” applies both to individuals at risk of infection and investors reticent to return. Collapse of the job sector, formal and informal, accompanies the losses, compounded by falling world iron prices.¹²²

The tension between the Ebola response and regular health services should not be underestimated. Health workers' and the public's fear and distrust must be overcome, while resources are limited. Vertical international funding of specific pathologies and medical services in each country complicates the situation.¹²³

Resuming basic health services is essential, given the missed vaccinations, chronic diseases and absent maternal care. Improving the sector, including better surveillance and emergency response, is even more difficult due to the death of nearly 500 regional health-care workers. 75 per cent of immunisation programs may have been interrupted, leaving an additional 20,000 people vulnerable each month.¹²⁴ The health sectors in the most-affected countries were struggling before Ebola, and mortality from illnesses such as HIV, tuberculosis and malaria was significantly higher than normal during the epidemic.¹²⁵ Renewed investment could potentially have a positive longer-term impact on curbing other illnesses, if better targeted than before. The new African CDC could also make an important contribution.¹²⁶

B. *Governments Tightening Grip on Power*

At the epidemic's height, in summer 2014, there were fears for stability, including of West Africa as a whole, but governments tightened their grip, with several international interlocutors noting “authoritarian inclinations” in some countries of the

¹²⁰ “Ebola: Most African Countries Avoid Major Economic Loss but Impact on Guinea, Liberia, Sierra Leone Remains Crippling”, World Bank, 20 January 2015.

¹²¹ “Ebola and the Private Sector”, Oxfam, op. cit.

¹²² “The Economic Impact of Ebola on Sub-Saharan Africa: Updated Estimates for 2015”, World Bank Group, 20 January 2015. “Ebola's Legacy: After the Passing”, *The Economist*, 3 January 2015.

¹²³ Laurie Garrett, “The Monster in the Sea”, op. cit.

¹²⁴ “Pushed to the Limit and Beyond”, op. cit. There were 778,000 at-risk children pre-Ebola, 1,129,000 eighteen months later, “Ebola could cause thousands more deaths – by ushering in measles”, Wired (online), 15 March 2015.

¹²⁵ A Doctors of the World report estimated that more people died in Sierra Leone “not from Ebola but as a result of the response to it”. It also highlighted the significant increase in malaria-related deaths and maternal and infant mortality. “Too many dying in Sierra Leone as result of Ebola response not virus itself – report”, *The Guardian*, 28 April 2015. A study published in *The Lancet* estimated 74,000 fewer malaria cases were diagnosed in Guinea in 2014, largely due to Ebola. “Effect of the Ebola-virus disease epidemic on malaria case-management in Guinea, 2014: a cross-sectional survey of health facilities”, 23 June 2015.

¹²⁶ The AU and the U.S. CDC have accelerated plans for creating an “African CDC” in Addis Ababa, eventually to be expanded into five continent-wide regional offices. “Disease Detection gets a Boost with Plans for a CDC in Africa”, National Public Radio, 14 April 2015.

region.¹²⁷ Periodic violence flared in all three most affected countries, but Ebola provoked distinct national responses, and different risks have manifested themselves. The manner in which each country has stepped back from the brink provides the best indicator of long-term consequences.

In Liberia, where the initial blow was perhaps most severe, a health crisis transformed into a state-security crisis, the UN after-action report concluded, because “the country lacks mature institutions with the resilience to respond adequately to internal or external shocks”. More importantly, the “militarised” response demonstrated the “country’s fragility and persistent governance challenges, together with its citizens’ deep distrust of state authority”.¹²⁸ Small steps to regain that trust should include accountability for Ebola donations, building confidence in the health sector and a clearer distinction between public health actions and those perceived as providing political advantage.

In Sierra Leone, the epidemic was used to suppress political protests linked to the firing of Vice President Samuel Sam-Sumana. Already expelled from the ruling All Peoples Congress (APC) Party, he was accused of “orchestrating political violence” in Kono and starting a new party. Opposition calls for “civil disobedience” were met with a reminder of the Ebola emergency, meaning no public gatherings could take place.¹²⁹ There have also been worrying signs of media self-censorship over use of Ebola funds, and the state of emergency is prolonged.¹³⁰ As in Guinea, however, there was a civil society initiative aimed at depoliticising the Ebola response and improving accountability for Ebola spending.¹³¹ This helped increase public confidence.

In Guinea, electoral-preparation controversies took on fresh life after the independent national electoral commission (CENI) announced presidential elections for October 2015, before local elections due in 2016’s first quarter. The opposition objected, arguing previously-elected local officials had lost legitimacy, were all controlled by the ruling party and would be key players in fraud. Ignoring the ban on protests, which was officially justified for a time by the Ebola epidemic, the opposition organised demonstrations. These occasioned some violence by both protesters and security forces, with several protesters killed and dozens wounded.

Aided by international facilitation, the opposition cut a deal on 20 August in which the authorities committed to adjustments with respect to the local authorities,

¹²⁷ Crisis Group interviews, February-March 2015; “Ebola’s Legacy”, op. cit.

¹²⁸ “Final Report”, op. cit.

¹²⁹ “Sierra Leone opposition calls for civil disobedience over VP sacking”, Reuters, 22 March 2015. The most recent extension of the 90-day state of emergency was announced on 25 June 2015, “Sierra Leone announces new curfew to halt Ebola”, *Business Day* (online), 28 June 2015. Public gatherings are now permitted, but mainly for non-political or non-contentious issues. Crisis Group email correspondence, Sierra Leone civil society activist, 9 October 2015.

¹³⁰ Journalist Mustapha Dumbaya said, “journalists have a lot of questions about how parliament is spending the millions of dollars donated for Ebola, but at the moment they are scared to ask ... they are worried they might be arrested. Under this state of emergency, the government doesn’t need to explain if it makes an arrest. Accountability has been shelved”. Interview with Sierra Leone radio published in “Amid Ebola outbreak, West African governments try to isolate media”, Committee to Protect Journalist (CPJ), 27 April 2015.

¹³¹ “Civil Society Concerns about rising Political Tension in Sierra Leone”, press release, civil society coalition 15 March 2015. Health Minister Miatta Kargbo was dismissed by President Koroma in August 2014, “[i]n order to create a conducive environment for more efficient and effective handling of the Ebola outbreak”. “Sierra Leone’s health minister fired over Ebola”, *Africa Review* (online), 30 August 2014.

the electoral commission and the electoral registry. Implementation was controversial, however. On 11 October, Condé was re-elected in the first round with almost 58 per cent of the votes. The opposition took part in the election but refused to acknowledge the result. Once more, there was some violence, with ethnic undertones, before and after the vote.¹³²

C. *Lingering Instability?*

A return to open conflict in the region is unlikely at this stage. However, as West Africa's civil wars recede into the background, neither their legacy nor the fragility of the region should be underestimated. The extreme danger the Ebola epidemic created may have passed; the small number of new cases that continue to appear do not compare with the second half of 2014. Nevertheless, a number of issues could provoke further unrest in the countries affected by the disease.

Cross-border infections highlighted porous borders; maintaining stability depends on effective governance in neighbouring states, cooperation and information sharing. Insecurity can easily spread.¹³³ Liberian mercenaries fought on both sides of the recent Côte d'Ivoire conflict and could still be used by disgruntled politicians in the region to settle scores and exact government concessions.¹³⁴

A persistent criticism of the Liberian government has been the few punishments meted out for corruption. Reopening of the impunity debate is a potentially positive impact of the epidemic. Given international support during the Ebola crisis, the government was reluctant to make comments that could be perceived as "anti-justice".¹³⁵

In Sierra Leone, frustration at government handling of the epidemic and the emerging constitutional crisis over the vice president's sacking have yet to manifest themselves in major unrest. But as in Liberia, Ebola heightened political tensions that, if left unchecked, could further endanger post-conflict recovery.

Guinea is of particular concern. Opposition parties have considerable organisational capacity, and the latest electoral standoff has not reduced tensions. Combined with a polarised ethnic component, communities could easily be mobilised if they feel unfairly treated.¹³⁶ The country needs de-escalation of tension and improved electoral institutions before the next polls.

¹³² "Guinea President Conde wins election with 58 of vote – official", Reuters, 17 October 2015; "Guinea's Conde wins re-election as opposition vows protests", Agence France-Presse, 17 October 2015.

¹³³ Many of the more than 100,000 supporters of the former Ivorian president, Laurent Gbagbo, who fled to Liberia following his defeat in the post-election conflict in April 2011 have remained. Both the UN and the Ivorian government have stated that some have conducted cross-border attacks to destabilise western Côte d'Ivoire. Martin Roberts, "Liberian lawmaker's warning over Ivorians' incursions underlines threat of renewed militant attacks in border areas", IHS Jane's Country Risk Daily Report, 10 June 2015. See also "Liberia struggles with violence along insecure Ivory Coast border", Agence France-Presse, 24 May 2015.

¹³⁴ The noted cross-border incursion and attack was the third in the past year; in this case two government soldiers were killed. "Peacekeeping: Liberia Still Simmers", Strategy Page (online), 22 January 2015. 70 per cent of former combatants are mining gold and diamonds, a large, low-wage workforce contributing little to national reconstruction and development. "Ebola, Liberia, and the Cult of Bankable Projects", *Ethics and International Affairs*, vol. 29.1, Spring 2015.

¹³⁵ "Ebola in Liberia", op. cit. "Africa: European arrests of Liberian war crime suspects refuel impunity debate in Liberia", www.allafrica.com, 12 March 2015.

¹³⁶ Two confirmed cases of Ebola were reported in the week to 20 September, both in Guinea. "Ebola Situation Report", WHO, 23 September 2015. Each party tends to insist on its lack of ethnic bias but accuses adversaries of the opposite. Extreme examples include 2012-2013 electoral violence in

VII. Conclusion

Despite the Security Council having declared Ebola “a threat to peace and security” and subsequent warnings of state collapse, a meltdown has not occurred. Democracy has been damaged, however. The epidemic provoked measures interpreted as political expedients, and with the detection of new cases showing there is still a risk of the epidemic reigniting, emergency measures are being maintained in the name of public health. The potential for abuse remains, as ruling elites and opposition groups have, at different times, politicised the response to the point where “political instability [is] impacting on Ebola response rather than the inverse”.¹³⁷

In the longer term, rebuilding trust in state institutions presents its own challenges. Transparent reckoning of both actions and use of Ebola-designated resources would be a useful start. The international community, beginning within the UN system, including the WHO, should constructively engage regional governments in this by frankly assessing its own failings. Finally, continued support is essential for rebuilding the shattered health sectors, but also for reforming systems of governance that played a key role in hindering the response. The Ebola crisis has receded from the international spotlight but remains in the region, along with many of the factors that facilitated spread of the virus. Continued vigilance is required.

Dakar/Brussels, 28 October 2015

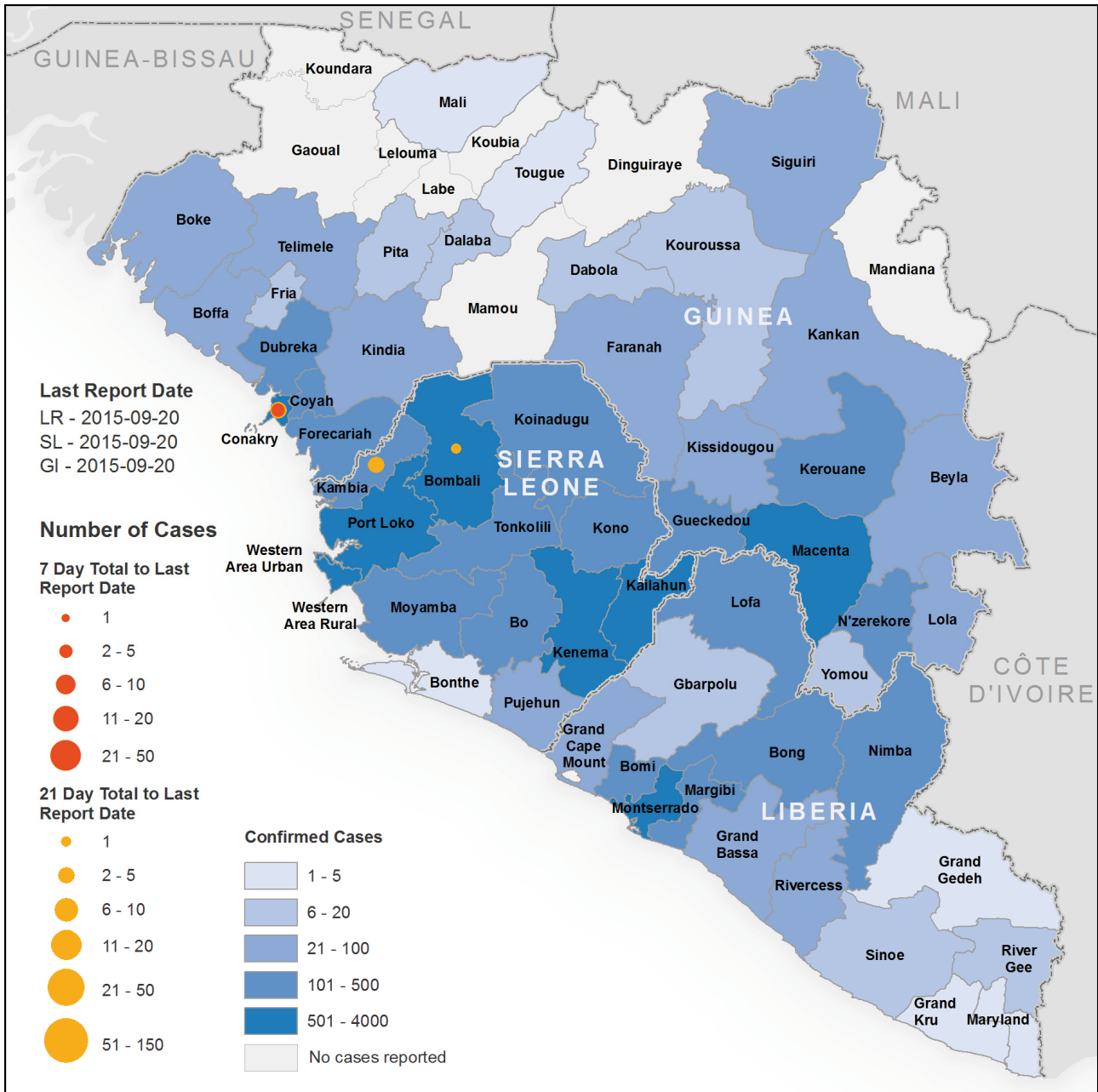
Conakry (mostly Fulani victims) and more recently in Guinée Forestière. Crisis Group Report, *Guinea's Other Emergency*, op. cit.

¹³⁷ “Ebola’s Legacy”, op. cit., speaks of an “erosion of democracy”. Crisis Group interviews, August-September 2015.

Appendix A: Map of West Africa



Appendix B: Map of Ebola's Spread and Toll in the Worst-hit States



<http://apps.who.int/ebola/current-situation/ebola-situation-report-23-september-2015>

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Appendix C: Acronyms

AfDB	African Development Bank
APC	Sierra Leone All People's Congress
CDC	U.S. Centers for Disease Control and Prevention
CENI	Guinean Commission Electorale Nationale Indépendante (Independent National Electoral Commission)
CNOSCG	Conseil National des Organisations de la Société Civile Guinéenne (National Council of Guinean Civil Society Organisations)
DFID	UK Department for International Development
ECOWAS	Economic Community of West African States
FAO	Food and Agriculture Organisation
GAC	Liberian General Auditing Commission
GAVI	Global Alliance for Vaccines and Immunisation/Vaccine Alliance
GOL	Government of Liberia
IASC	Inter-Agency Standing Committee
IHR	International Health Regulations
IMF	International Monetary Fund
LTRC	Liberia Truth and Reconciliation Commission
LURD	Liberia United Reconciliation and Development
MODEL	Movement for Democracy in Liberia
MSF	Médecins Sans Frontières (Doctors Without Borders)
NERC	Sierra Leone's National Ebola Response Coordination body
RPG	Rassemblement du Peuple de Guinée (Rally of the Guinean People – Rainbow)
SLPP	Sierra Leone's People's Party
UDFG	Union des Forces Démocratiques de Guinée (Union of Democratic Forces of Guinea)
UNAIDS	United Nations Programme on HIV/AIDS
UNECA	United Nations Economic Commission for Africa
UNMEER	United Nations Mission for Ebola Emergency Response
UNMIL	United Nations Mission in Liberia
UNSC	United Nations Security Council
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization