EXECUTIVE SUMMARY

- Overall DFID was prepared for the Ebola crisis but resources to tackle it were not necessarily deployed in the right way or at the right time. This is highlighted particularly in the case of the Community Care Centres (CCCs), which were set up with beds for the purpose of isolation but by the time DFID and its partners had set them up the need had become much greater than beds. The CCCs also arrived just as the number of ambulances and Ebola Treatment Units (ETUs) increased, reducing the need for holding places of suspected patients and leading some policy actors to see them as redundant from day one.

- A critical issue during the Ebola crisis was trust, or distrust between the medical response teams and local authority and community institutions and vice versa. IDS researchers found that a mistrust of the ‘community’ and ‘culture’ by biomedical response teams in Sierra Leone places responsibility for disease transmission on individuals who are expected to reject ‘negative’ cultural behaviours such as communal eating or burial traditions, while failing to provide sufficient resources to those same individuals to enable their ‘appropriate’ management of the disease.

- When considering if the military was more efficient than NGOs, it is important to note that it wasn’t the military or the NGOs, it was both. NGOs delivered treatment centres, some contact tracing and mobilisation and the military and police were involved in security, checkpoints, quarantines and burials. In some situations where order was lost, for example in Kono where there were riots, there may have been no other option than to use the military. At the same time, given the relatively recent post-conflict context in Sierra Leone, people inevitably made connections between the disease, warfare and a militarised response. Heavy-handed military tactics played into local distrust and anxiety.

- To rebuild communities hit by Ebola, communities and civil society organisations need to own the process and outcome of decommissioning and decontaminating CCCs. Other important steps include strengthening primary health care at the community level, long-term support for children at school, reintegrating orphans into communities and supporting families and to find closure.

- Building health systems that can prepare and respond effectively to crises is a vital imperative to safeguard the health and well-being of local, national and global populations. Building resilient health systems over the longer term requires time, hard work, and political will. It is also requires social science to understand the sociocultural, economic, and political dimensions that play a defining part in
epidemics and pandemics. It is important for DFID to continue to play a positive role in incorporating social science into its understanding and learning for the future and to integrate social science during global health crises and avoid being playing a distance and delayed part of decision making and resource prioritisation.

- Reactive humanitarian health responses in countries with weak health systems have limitations. Resources need to be invested in basic public health measures that strengthen disease surveillance and reduce the risk of transmission of infections. Zoonotic spill over events can be contained if there is capacity for early detection, tracing of contacts and quarantine measures that are appropriate.

ABOUT IDS
The Institute of Development Studies (IDS) is a leading global institution for development research, teaching and learning, and impact and communications, based at the University of Sussex. Our work focuses around three key areas - reducing inequalities, accelerating environmental sustainability and building inclusive and secure societies - and we believe that the research knowledge we produce with partners can help accelerate global progress on these issues. IDS co-hosted a Platform to bring social science advice into the Ebola response. Through the Ebola: Lessons for Development Initiative IDS researchers engaged with key policymakers, NGOs and researchers involved in the Ebola crisis, and argued that there is an urgent need to look beyond the immediate, on-the-ground concerns of disease control and containment to consider the bigger and broader questions about international development. For further information on this submission please contact Sophie Robinson, External Affairs Officer at IDS at s.s.robinson@ids.ac.uk.

EVIDENCE

PART 1: UNDERSTANDING THE UNDERLYING STRUCTURAL CAUSES, THE RESPONSE AND CONSEQUENCES

1. How Ebola reached the stage it did
The Ebola crisis has revealed the consequences of deep-seated, unequal global social and economic relations that international development, as practised in recent decades, has had a role in creating. These embedded and persistent inequalities are the reason that Ebola was able to take hold in the way that it did. While the emergency response by global agencies had its failures, and should be addressed, the resulting crisis cannot be simply put down to a delayed or ineffective response by global agencies, it goes much deeper.

1 Briefing: Ebola–myths, realities, and structural violence - Wilkinson and Leach, African Affairs
2 Ebola – Exposing the failure international development – Amber Huff, Open Democracy
3 Ebola and Lessons for Development – Amber Huff, IDS Practice Paper
1.1 Deep-seated causes

The magnitude and persistence of the crisis exposed the hazards of living in a highly inequitable global political and economic system. It highlights the consequences that can emerge from patterns of structural violence that gross inequality and systematic underdevelopment engender. Guinea, Sierra Leone and Liberia have all been recovering from major ruptures in their socio-political and economic systems, including more than a decade of violent armed conflict in Sierra Leone and Liberia that spilled over into Guinea. These countries have attracted billions of dollars of foreign direct investment since the 1970s, yet this has primarily benefited the extractive industry without contributing to other economic sectors or social programmes.

1.2 World Health Organisation

From the outset, the international Ebola response lacked leadership, funds, equipment, and human resources. Despite warnings the, international reaction was slow and ineffective, particularly from the World Health Organization (WHO) where the first regional meeting about the outbreak occurred three months after detection was reported. The failures by the WHO, including delayed visas and payments and poor communication, occurred in the context of the job losses and funding costs that saw the WHO lose $1 billion in core funding after the financial crisis. Inaction at the Africa regional level of the WHO also led to failures after initial detection and has been attributed to political appointments which left the regional office technically weak and resistant to acknowledging the outbreak’s severity. Subsequently, there have also been numerous interim assessments of the WHO as recommended by the International Development Committee.

2. What could DFID have done quicker and better?

DFID was prepared but resources were not necessarily deployed in the right way or at the right time. This is highlighted particularly by IDS research fellow Pauline Oosterhoff in her evaluation for the DEC and in Pauline Oosterhoff, Esther Yei Mokuwa and Annie Wilkinson’s evaluation of Community Care Centres (CCCs). The CCCs were set up with beds for the purpose of allowing local people to voluntarily be isolated if they suspected that they had the disease. The CCCs idea came out of the Scientific Advisory Group on Emergencies-Ebola set up in September 2014, as a socially-informed and rational response to rapid levels of disease spread, and problems of access and resistance to ETUs. However, by the time DFID and its partners had implemented the CCCs the outbreak had reached a level whereby the need was greater than beds. They now had a role in contact tracing, community education and case management. Also, the CCCs arrived just when the number of ambulances and Ebola Treatment Units (ETUs) increased, reducing the need for holding places of suspected patients. Some policy

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5 DEC Ebola Crisis appeal response review – Pauline Oosterhoff (PDF)
6 Community based Ebola Care Centres – Oosterhoff et al (PDF)
7 Touch choices to reduce Ebola transmission – Whitty et al
actors therefore saw them as redundant from day one. Communities, however, appreciated the care for non-Ebola related health problems that CCCs provided.

2.1 DFID has strongly supported the role of social science in the Ebola response. This is important, given the evident significance of social and cultural factors in disease spread and community resistance to top-down outbreak control efforts. The Ebola Response Anthropology Platform (ERAP) supported by DFID through R2HC and co-led by IDS and LSHTM is being described as an example of ‘best practice’ engagement with social science within/by the UK government in relation to epidemics, and an important model for future pandemic preparedness. ERAP constituted a Social Science sub-group of SAGE Ebola, helping to shape policy in Sierra Leone. It provided rapid-response advice to government, international agencies and NGOs on issues relating to burials, movement, and communications, enabling these to be more socially and culturally appropriate and therefore effective. Internationally, the UN Special Envoy on Ebola personally appreciated and thanked ERAP members for their work, emphasising that the platform is well-known throughout the UN response system. The World Health Organisation drew ERAP work into the key scientific and policy/ethics committees shaping the Ebola response.

3. The Impact of Cultural Practices
Engagement of local stakeholders and communities is a key component of epidemic preparedness and response and that can only be done in the context of understanding local cultures and cultural practices. One of the main issues connected to cultural practices during the Ebola crisis was trust, or distrust between the medical response teams and local authority and community institutions and vice versa. Just as local populations have their own understandings of, and don’t trust hospitals and biomedical approaches; so medical response teams have their views of, and don’t trust ‘culture’, community institutions and local authority. Research by IDS researchers on the ground in Sierra Leone found that a mistrust of the ‘community’ and ‘culture’ by the biomedical response teams places responsibility for disease transmission on individuals who are expected to reject ‘negative’ cultural behaviours such as communal eating or burial traditions, while failing to provide sufficient resources to those same individuals to enable their ‘appropriate’ management of the disease. Essentially, this allocates disease responsibility to individuals without providing the wherewithal to make this feasible.

4. The role of the military and NGOs
When considering whether the military or NGOs were more efficient in tackling the issues on the ground, it is important to note that it wasn’t the military or the NGOs, it was both. The NGOs delivered treatment centres, some contact tracing and mobilisation and the military and police were involved in security, checkpoints, quarantines and burials. The military and the policy also played an important role in logistics and planning such as running the District Ebola Response Centres (DERCs).

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4.1. The combination of the RSLAF and UK military
As it was a chaotic environment, a quickly deployed model for coordination was needed and the combination of the RSLAF and UK military in Sierra Leone does seem to have contributed positively in some districts in the running the DERCs. In some situations where order was lost, for example in Kono where there were riots, there may have been no other option than to use the military. Where the police were involved in quarantines there were reports of problems such as police leaving posts because they had not been fed and the military may have been preferable in some cases as they had a stronger chain of command and greater organisation. At the same time, given the relatively recent post-conflict context in Sierra Leone, people inevitably made connections between the disease, warfare and a militarised response. Heavy-handed military tactics played into local distrust and anxiety.

4.2. District Health Management Team staff
A potentially more important issue is about the involvement of the District Health Management Team (DHMT) staff. In Kenema in Sierra Leone, the response is notable for being DHMT led, and there the DERC (and military) are quite redundant. That is because the Kenema DHMT, run by a charismatic District Health Officer were organised before the DERC system was set up and CCCs were not built there. The Kenema example highlights the variance between districts as to the roles of local resources versus new structures and outside actors. Having local resources successfully involved as they were in Kenema, is valuable in terms of sustainability and building capacity for future outbreaks.

5. Funding
IDS has limited first-hand evidence to determine whether or not funding raised for the Ebola crisis was all spent or how it was monitored. There are indications however that ‘hazard pay’ paid to local health workers and lists of who was entitled to receive the pay were problematic and in Sierra Leone there were multiple ‘verification’ exercises where all staff had to go and present themselves to show they were real and were working. Reports from the ground in Sierra Leone also speak of a lack of flexibility and coordination to the spending, with many of the funded CCCs and Ebola Treatment Units coming online at the same time and staying open for months with very low numbers of patients, suggesting they weren’t all needed and that the funds may have been better diverted elsewhere.

PART TWO: WHAT FACTORS SHOULD BE CONSIDERED IN THE FUTURE?

As we have seen with Ebola, there is currently a tendency for responses to be reactive to crises. As each new disease threat emerges, prior threats are easily forgotten, and those in other regions can seem remote. Thus despite claims at the time, the lessons of SARS and Avian influenza have not fed as effectively as they might have into ongoing pandemic preparedness across the world.
For diseases of global importance, investments therefore need to be made with general, rather than specific, disease applicability in mind.

6. Rebuilding and recovering
Community engagement should underpin any approach in addressing such crises. There is a need to understand perspectives and experience from implementers, policymakers, and most importantly, communities, in all their diversity, and paying attention to differences of gender, age and wealth. These actors cannot work in isolation. Each group operates and lives within specific epidemiological, demographic and political contexts in the different districts, and these are important if we are to understand their shared and divergent views and interests.

6.1 When it comes to rebuilding the communities that have been hit by the Ebola crisis, there are several recommendations specifically from Pauline Oosterhoff, Esther Yei Mokuwa and Annie Wilkinson’s evaluation of CCCs that should be incorporated in any further plans:

- Ensure that community and civil society organisations own the process and outcome of decommissioning and decontaminating CCCs.
- Maintain capacity and integrate the reduced CCC workforce into public services
- Strengthen primary health care at the community level
- Support families and communities to find closure
- Document key lessons and innovations learned during this Ebola response

6.1.1 Now that the CCCs exist people want the materials and the staff and their new skills to be used to improve public health and educational services in their communities. People do not want to see the CCCs packed and stored far away until the next big outbreak.

6.2 Education
While all school children have been given a year’s free school fees, it is not clear what has been planned beyond that or how that has been funded. Alongside this, there is not clarity if there have been measures have been put in place to pay teachers to discourage them from charging students to supplement their incomes, as is common practice, especially after they have potentially lost a year of salary.

6.3 Reintegrating orphans into communities
The reintegration of orphans and survivors will depend very much on different districts. There are numerous NGOs running programmes to support this. In Kenema, GOAL\(^9\) was running an Observational Interim Care Centre to look after children whose parents were in treatment and then to place them with family members if that parent died.

\(^9\) Trying to halt the spread of Ebola – Goal
6.3.1 In terms of long term support it is not clear what has been put in place. Based on recent experience in Kenema of working with a survivor/orphan it is clear that institutional support is minimal. The support of extended families cannot be guaranteed (an aunt had come to live with this girl and her siblings but she had heard very little contact with other members of her family).

6.3.2 In Kono, however, the NGO Partners in Health were running a survivors programme and providing, quite a lot of assistance (not specifically aimed at orphans).

6.3 Reconstruction
The term ‘reconstruction’ is slightly problematic; the very high figures (20% and upwards) for pre-Ebola economic growth in Sierra Leone were to some extent illusory, growth was not stable, and benefits were not well distributed. The hit has not just been Ebola but also the dramatic drop in global iron ore prices\(^\text{10}\) which has seen the economy dive, and key companies go bankrupt (e.g. London Mining). Even in recent apparent boom years for economic growth, Sierra Leone suffered from basic lack of broad-based infrastructure and functioning health systems. Rather than re-building, it is therefore more appropriate to speak of ‘building differently’, through investment and development approaches directed to inclusive health systems, education and employment opportunities.

7. Future pandemic preparedness
There is a call nationally, and globally to learn the lessons from the Ebola crisis. David Cameron has called for the UK to be better prepared with better research\(^\text{11}\), more drug development and a faster and more comprehensive approach to how we fight these things when they hit. Further, the G7\(^\text{12,13}\) stated that they are strongly committed to strengthening health systems through bilateral programmes and multilateral structures. While they are calling for the strengthening of multidisciplinary teams that will be prepared to respond to epidemics, we reiterate that understanding on cultural practice and community engagement has to be integral to any approach to rebuilding communities or response to an outbreaks in the future.

7.1 System-based, multi-sector approaches including social dimensions:
In the wake of recent pandemics (including SARS, H5N1 and H1N1 influenzas), and amidst scientific evidence of growing threats from emerging and re-emerging infectious diseases including zoonoses, building systems that can prepare and respond effectively is a vital imperative to safeguard the health and well-being of local, national and global populations.

\(^{10}\) Iron prices and Ebola in Sierra Leone result in economic slump – Mining Review
\(^{11}\) Prime Minister calls for wake up to the threat from disease outbreak – gov.uk
\(^{12}\) G7 Leader’s Declaration
\(^{13}\) IDS director responds to David Cameron’s call to the G7 to wake up on Ebola – Melissa Leach, IDS blog post
7.2 Yet such systems cannot rely on bio-medical and related sciences, public health and humanitarian action alone. The Ebolavirus epidemic has fundamentally underlined the importance of multi-disciplinary perspectives, including social sciences, in shaping and informing strategies if they are to be appropriate, acceptable and therefore effective. Initiatives such as the R2HC-funded Ebola Response Anthropology Platform (ERAP) mobilized research-based anthropological expertise at speed and scale to inform diverse aspects of humanitarian and public health policy and action at the height of the epidemic. Looking to the future, there is a role for platforms that can establish multi-disciplinary and multi-stakeholder capacities involving social science and community perspectives, in three main areas:

- Foresight – articulating possible future trends, interacting drivers (social, economic, political, ecological, biological), disease scenarios, uncertainties and policy options for mitigating risks and increasing resilience;
- Preparedness – ensuring that localities, countries and regions have appropriate systems and capacities in place to control outbreaks and prevent them spiralling into crises;
- Response – enabling rapid public health, humanitarian and related action in the event of a disease outbreak to be socially- and culturally-appropriate, and thus acceptable and effective.

7.3 Lessons from the earlier Ebola Platform, as well as the threat of diverse future epidemics, underline the value of being ready in advance. Networks, relationships, capacities and infrastructure for successful collaboration amongst social, medical, policy and humanitarian actors and perspectives in relevant regions need to be built ahead of future outbreaks, in order to help avert them and to be in position for rapid mobilisation if necessary.

7.4 There are likely to be some tensions between the pressure to make sure there are lots of antibiotics and anti-malarials available to help with differential diagnosis of viral haemorrhagic fevers in the future, however this may not be good for drug resistance\(^\text{14-15}\). However, more research\(^\text{16}\) is needed to understand the full picture.

7.5 Long-term planning
Building a resilient health system\(^\text{17}\) over the longer term requires time, hard work, and political will. Humanitarian health responses in countries with weak health systems have limitations. A focus on reducing maternal or infant mortality is important and delivers

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14 Addressing growing resistance to antibiotics – G7 is just the start – Gerry Bloom, IDS blog post
15 Addressing resistance to antibiotics in pluralistic health systems – Gerry Bloom et al, STEPS Centre Working Paper
16 Review on AMR
17 Ebola: Time to strengthen health systems and global health governance – Gerry Bloom, Hayley MacGregor and Anne Roemer-Mahler, IDS blog post; Strengthening health systems for resilience – Gerry Bloom et al, IDS Practice Paper
short term benefits, but it is inadequate in terms of efforts to build a health system resilient to shocks like Ebola.

7.5.1 Resources need to be invested in basic public health measures that strengthen disease surveillance and reduce the risk of transmission of infections. Zoonotic spill over events (when a human is infected by a virus or bacterium that normally affects another animal) can be contained if there is capacity for early detection, tracing of contacts and quarantine measures that are appropriate.

7.5.2 Much has been spoken about mistrust of the health system pre-Ebola, and also in the context of the current epidemic. Efforts at rebuilding must create institutions for trust, and explore partnerships with other sectors and formal and informal actors to provide services.

7.5.3 Attention must be paid to ensuring safe and quality care. This means putting in effort and resources to train and supervise and pay health workers, and to give access to safe drugs.

7.5.4 Engagement of local stakeholders and communities is also key, not only to future policy for epidemic preparedness, but also for the long term effort of building a resilient health system.