



# **Learning from the Early Stages of the 2014-2015 Ebola Outbreak in West Africa**

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## Abstract

Public health emergencies that span country borders and continents point out weaknesses in the logic and structure of international relations among nation-states. They also speak to the power that non-state actors can bring to the table in order to shape policies and resolve problems. The recent spread of Ebola in West Africa is no different in this regard. However, responding to the Ebola epidemic of 2014-15 can also be viewed through lenses of public administration theory and practice that can both clarify and guide future efforts to control such crises. The current discussion seeks to explore these ideas in an effort to begin unpacking what happened during the early stages of this emergency (March 2014 through August 2014), and learn what might be done to respond more effectively during ones still to come.

**Keywords:** Ebola; Governance; Administration; Epidemic; Health

## Introduction

On August 8, 2014 the World Health Organization (WHO) declared the Ebola outbreak in West Africa to be an international public health emergency (Walsh and Sifferlin, 2015). Ebola is a disease caused by a virus that can lead to hemorrhagic fever and death. This was only the third time that the agency had invoked this standing for a disease since the term had entered into force as part of international health regulations in 2007 (Cowell & Cumming-Bruce, 2014). The first two times were for the H1N1 Flu epidemic of 2009, and the resurgent spread of Polio in 2014. And make no mistake that it had been invoked once again with good reason (Editorial Board, 2014).

The current Ebola crisis represents the largest known outbreak of the disease in history, and its first appearance in the West African region (Onishi, 2014; Walsh, 2015). When looking at the countries that were hardest hit, WHO has recorded over 28,295 confirmed, probable and suspected cases, with 11,295 confirmed, probable and suspected deaths, as of September 22, 2015 (WHO, 2015). There remains no validated and approved vaccine, or cure, to combat the disease (Cumming-Bruce & Cowell, 2014b).

The outbreak has taken a severe toll on the countries of Guinea, Liberia and Sierra Leone, primarily – with Senegal, Nigeria, Democratic Republic of Congo and Mali also experiencing much smaller infection rates that were more readily controlled. In addition, the United States, the United Kingdom, Spain, Germany and France have dealt with cases of the disease as a result of treating individuals who had been working in the West Africa region combating epidemics. In short, Ebola exploded on the African continent in a



manner never before seen, or prepared for. The unexpected virulence of transmission began with a single case identified as coming from Guinea in late December 2013. By March 2014 cases were being confirmed in Liberia, and by May 2014 in Sierra Leone as well (Sack, Fink, Belluck, & Nossiter, 2014). Once the disease spread to major cities such as Monrovia, Liberia and Freetown, Sierra Leone, it was ready to reach beyond Africa (Grady & Fink, 2014).

While bringing the caseload of new infections to zero remains the goal of response in all countries, success in driving down the outbreak in those most affected had been hampered by contextual concerns such as cultural barriers to certain health practices (Cumming-Bruce, 2014; Sack, Fink, Belluck, & Nossiter, 2014), anemic public health infrastructures (Flynn, 2014; Grady, 2014; Nossiter, 2014c), extreme poverty (Cooper, 2014b; and, Nossiter, 2014), and ongoing fear among exposed populations (Cooper, 2014; Nossiter, 2014b). Also directly impacting progress in the months leading up to August 2014 was a lack of visible leadership and political will among elected officials and power elites within the countries worst hit (Flynn, 2014). But the lack of reaction went far beyond the affected nation-states at that time (Kristof, 2014).

Word of the disaster was put out to the international community by the international non-governmental organizations (INGOs) tending to the epidemic's ill in late March 2014 (Grady & Fink, 2014; and, Baker, 2015). It was clear to those in the "hot zones" that the disease was departing from past patterns, and surging in ways that were dangerous and difficult to contain. The INGO "Doctors Without Borders" made the plight of the region quite clear from its work inside Guinea. Yet, early response to bring the disease to heel in a timely manner leading up to August 2014 was found wanting across sectors and levels of response. Western nations and international organizations failed to react when on the ground surveillance, in the form of international health practitioners, raised the cry of the affected people from national to global arenas. The price for this failure was the ravaging of the afflicted nation-states, and the threatening of those beyond the immediate reach of the disease.

The delay of the international organizations and individual countries to react was not just one of leadership, but it was also one of networking. The circuits among world organizations, nation-state governments, private sector companies and non-profit organizations at the national and international levels did not come to life in order to respond to the problem quickly - as had happened in Ebola epidemics of the past (McNeil, Jr., 2014b). This crisis fell on deaf ears, and the issue did not resonate beyond the lowest levels of response for far too long. As such, time was lost. Money was lost. Focus was lost. And, most importantly, lives were lost. The purpose of this paper is to consider why the virus was not stopped in the early stages of its eruption - from March 2014 through August 2014 - in order to learn lessons for the management of future epidemics.





## How Does Public Administration Theory Help Us Unpack the Problem?

Theories of New Public Management (NPM) and New Public Governance (NPG) offer ways to analyze response patterns in relation to efficiency and effectiveness, respectively. Both sets of public administration studies can be applied to important aspects of today's health care systems and policies, whether they impact on poor countries, wealthy countries, non-governmental organizations, or international governmental organizations. They also provide windows into visualizing how to provide equitable care for the ill, while at the same time protecting the security of the state. Policy makers have an obligation to address both concerns if they are to maximize social equity for the victims of epidemic disease, as well as those affected across its widening rings of impact.

Both NPM and NPG have travelled along parallel paths temporally. From the early 1990s through to the present they have each left their theoretical mark on the discipline and practice of public administration. However, there is little doubt that NPG was in the shadows of NPM for a good deal of this time. NPM focused largely on understanding ways to improve efficiency as part of the reinventing government movement through the application of accountability principles, transparency requirements and performance management systems (Osborne & Gaebler, 1993; Hatry, 2007; Hatry, 2010; Kettl, 2005; and, Kettl, 2009). On the other hand, NPG focused its energies and ideas externally. NPG examined the importance of relationships in improving government effectiveness. By looking into issues of co-production, partnerships and networks, NPG took the emerging realities of the hollow state and third party governance as the touchstone to stake its claims (Lynn, 2010; McQuaid, 2010; Osborne, 2010; and Pestoff and Brandsen, 2010). The underlying values of both theories are displayed in Table 1. When applied to the early stages of the Ebola emergency of 2014-2015, several issues are clarified.

TABLE 1: New Public Management and New Public Governance Values

NPM VALUES (efficiency)	NPG VALUES (effectiveness)
Accountability	Coproduction
Transparency	Partnerships
Performance	Networks
Focus on Internal Environment	Focus on External Environment

The three countries at the heart of the current Ebola emergency in West Africa are the central point of analysis in this paper. They are among those routinely listed as fragile states by international organizations or expert groups. Guinea, Liberia and Sierra Leone exhibit extreme poverty, collapsing or recently recovering public service systems, and struggling economies. These conditions are the reasons many observers saw them as unable to successfully rise to the task of addressing an Ebola crisis on their own. While having historically managed to work through smaller epidemics of Lhasa fever, Ebola required more than a patchwork system of hospitals and clinics due to the size of the outbreak – and its eventual location inside urban population centers. In short, there was no real reason anybody should have readily assumed that these three countries would be capable of answering the call to action on their own. NPM values might have been

internalized in these states, but had yet to be actualized, or come to fruition in terms of health service delivery mechanisms. Hoping for a response grounded in NPG values would have been much more on point.

From the earliest stages in 2014, it was clear that the three countries did not have adequate health care infrastructure to handle an outbreak of this kind. Certainly, if there was going to have been significant action taken in response to Ebola it would not likely have come from indigenous means alone (Kieny, Evans, Schmets, & Kadandale, S., 2014). Instead, what many hoped would happen was a rallying of support networks to address the emergency quickly and effectively. While these countries had suffered from having weak internal health and public sector mechanisms, what they did have were connections with more affluent nation-states, IGOs, INGOs and NGOs that many hoped would fill the void more quickly than what occurred. However, while existing, these networks proved anemic when pressed to recognize and react to warnings and cries for help early on in the event. Most famous of which was the heralding of a crisis to the international community by Doctors Without Borders, who were working on the ground in the region with precious few others, at the beginning of the initial wave of infections.

As 2014 wore on to the end of summer, and the emergency clearly worsened, a slow awakening took place. The United States, the United Kingdom and France all shouldered burdens relating to their former colonial clients. And the WHO began to move to the foreground as the vanguard agency of the United Nations in applying its expertise. Yet, for far too many it was too late. The time for mitigation and ongoing prevention had been squandered. What was left to do was chase down the horse long after it had left the barn. Not an enviable task for any of the parties involved. The point being, if there was going to be a means for shutting down the epidemic early it would have come from networks of agencies and countries stepping in to help eradicate the disease. This did not happen in a timely fashion. While the world might have hoped for a local strategy rooted in NPG values to challenge the virus, it was not forthcoming. Both the efficiency of governmental public sector organizations and the effectiveness of coordinated multi-player actions were nowhere to be found in the early stages of the crisis within the countries most affected. However, while the former was not widely expected to exist in any significant degree and therefore should not have been anticipated to kick in with significant impact, the latter was surprisingly absent in a time of need (Cowell & Cumming-Bruce, 2014).

Where the Ebola epidemic is concerned we see a situation where interaction across levels of political response from the local to the global was staggered. The give and take by actors across levels to shape and remake the human condition in relation to the virus had been slow, halting, and imperfect. Actors at lower levels of response did in fact funnel issues, ideas and pleas up, but not always successfully. In fact, in the early stages of the epidemic it is argued that actors at increasingly more responsible levels of the system quashed efforts to engage the disease and shifted narratives on the crisis (Tafirenyika, 2014). The question still crying out to be fully addressed is, “Why?”



## Using Concepts of Governance Failure as Tools to Understand the Response

In order to probe the underlying dynamics of this crisis, I will explore the role governance failures played in allowing it to grow seemingly unchecked in the early stages of its spread in West Africa. Governance failures provide a window through which the Ebola international public health emergency can be viewed, allowing us to parse categories of response worth further exploring in the future.

Robert Behn (1998) helps lay the groundwork for this analysis by outlining a series of governance failures that can be viewed individually, or in tandem, to explain public sector phenomena. They include the following areas of concern: *Organizational failure* – human organizations do not operate as machines; *Analytical failure* – limitations of human analytical abilities; *Executive failure* – limitations of a chief executive’s abilities to exercise their powers; *Legislative failures* – deliberately constructing confusing language, and incomplete deliberation involving the entire body; *Political failure* – limitations on checks and balances on stakeholders within democracies operating appropriately; *Civic failure* – individual citizens do not engage public policy or government in any meaningful way; and, *Judicial failure* – limitation of the courts ability to adjudicate decisions that will serve the common good.

It is important to note that Behn surfaced these categories in the context of arguing that this array of failures allows public managers the opportunity to step in and “lead.” As such, it seemed to me that there was a missing category to include in the list of governance failures presented – that of *Bureaucratic failure*. In other words, what if public managers chose not to lead us out of the other failures presented? This potential development would be a compounding characteristic that could further explain the development of a public sector problem.

To complete the discussion of governance failures for this paper I also believe that there is a broader category of *network failure* that requires attention in any 21<sup>st</sup> century analysis of multi-level, multi-sector, problem management than is articulated under the rubric of Behn’s *political failure*. In this new category, vertical *network failure* encompasses governance processes, and stakeholders, in transnational and global issue management. In essence it explores the limitations on actors to respond in concert to wide ranging problems of this nature. Beyond the notion of accountability within a particular country captured under *political failure*, this construction opens the notion of response and engagement to a broader web of actors involved within the looser confines of the international system. While not necessarily a category of governance failure that can be applied in all situations, where transnational and global problems arise *network failure* offers additional clarity to problem analysis than the category of *political failure* can fully attain. And in the case of health epidemics, it is essential (Paul & Sherrill, 2015).

In the context of Robert D. Behn’s 1998 article, governance failures were specifically applied to the United States. However, in this paper I am expanding their application to western democracies writ large in the context of “donor states,” fledgling democracies in Africa, and both non-profit and international organizations. All categories of governance

failure provided herein will not apply equally across actors. The point is to explore the value of the categories in differing setting and use the results to identify specific governance concerns which were not only high impact in the Ebola crisis, but cross-cutting in a synergistic way. If governance failures cluster in the current scenario, perhaps there is a way to establish guidelines to model future multi-actor, cross-level analysis.

Table 2: Governance Failures and the Early Stages of the 2014-2015 Ebola Outbreak

<b>Gov. Failures/ Ebola Crisis</b>	<b>Guinea</b>	<b>Sierra Leone</b>	<b>Liberia</b>	<b>International Nonprofits</b>	<b>WHO</b>	<b>Donor Countries</b>
Organizational	X	X	X		X	
Analytical	X	X	X		X	X
Executive	X	X	X		X	X
Legislative				---	X	X
Judicial				---	---	
Political	X	X	X		X	X
Civic					---	X
Bureaucratic					X	X
Network	X	X	X	X	X	X

Key: “X” represents: category of failure; “---” represents: category does not apply to actor

Table 2 above attempts a first cut at parsing governance failures across actors, and levels of response, in the early stages (January 2014 through August 2014) of the Ebola public health emergency of 2014-15. As should be readily observable, Behn’s failure categories are being stretched – sometimes quite thinly. However, what I hope to uncover are common patterns of concern that combined to create the crisis.

What we see in the three African states most impacted by the virus is consistent failures of across a variety of categories, with the exception of civic failure and bureaucratic failure. Clearly, the population had not been silent in any of the countries suffering. And their cries only grew as public health measures proved inadequate, impinged on cultural practices, or became overly restrictive (Onishi, 2014b; Cooper, 2014b). However it must be noted that their trust in their own governments and leaders was far from overwhelming, increasing their sensitivity to issues of feared corruption or incompetence (Cooper, 2014b; Whitworth, 2014). Additionally, street level bureaucrats represented by local and national health workers did rise to the occasion as much as could be hoped for. It is true some fled, and some refused to work. However, their numbers were terribly impoverished to begin with and those who stayed did attempt to do their jobs (Cowell, 2014; Flynn, 2014; and McNeil, Jr., 2014). The negative examples, while true, are overshadowed by the great many that risked, and even gave, their lives to care for the ill (Nossiter & Solomon, 2014). Combined with the volunteer support from outside the region, it is difficult to claim that there was an absence of bureaucratic leadership in this regard – despite the documented cases of flight.





Across the three contiguous nation-states of primary interest however, despite the willingness of bureaucrats to attempt to lead, governmental public health entities showed organizational failure in the face of overwhelming caseloads. The rag tag systems of clinics and hospitals simply were too poorly equipped to manage such a catastrophe in its early going (Kieny, Evans, Schmets, & Kadandale, S., 2014). Analytical failure was also present. To begin with, nobody foresaw Ebola coming to West Africa. It had never happened before, and there was no preparation to deal with it in place. Once it emerged insufficient surveillance efforts at the local and national levels made it difficult, if not impossible, to get an accurate reading on the width and depth of the spreading epidemic (Editorial, 2014). Without adequate surveillance it became impossible to develop a well thought out strategic response.

Executive failure appeared in the guise of heads of state being unable to effectively manage a shredded response system, and galvanize national infrastructure to respond (Fink, 2014; Flynn, 2014; and, Hitchen, 2014). There was also an underplaying of the extent of the problem in the early going in Guinea (Sack, Fink, Belluck, & Nossiter, 2014: D1; Tafirenyika, 2014). And some questioned the slow response in Sierra Leone, given that there was two months of lead-time to begin preparations for a possible outbreak (Hitchen, 2014b). In Liberia, some state that it wasn't until August 2014 that the head of state fully stepped in to direct her country's response (Sack, Fink, Belluck, & Nossiter, 2014). All in all, the general feeling appears to have been one of rudderless states, poorly answering the call of the emergency and being perceived as having nobody completely in charge as things worsened (Sack, Fink, Belluck, & Nossiter, 2014).

Further complicating matters, and suggesting political failure, it was feared there might have been an original unwillingness to engage the disease in order to not dissuade mining and airline companies from staying involved with the countries (Nossiter, 2014d; Sack, Fink, Belluck, & Nossiter, 2014; Tafirenyika, 2014). Some citizens in the region also decried executive manipulation of the crisis as a government ploy to force international donors to spend more (Cooper, 2014b; Sack, Fink, Belluck, & Nossiter, 2014). Political failure also appeared in other ways. In Liberia, some ministers and civil servants fled the country leaving behind confusion and holes of accountability (Cowell, 2014; McNeil, Jr., 2014). With little evidence of systemic checks and balances pushing heads of state to respond more forcefully and quickly to events on the ground, it is indeed hard to say who was in control of what. In short, the values of NPM appeared to be inadequately rooted in these three settings. To expect them to suddenly deepen, and then both stabilize and steer these states, would have been foolish. And, indeed, such values did not manifest in implementation mechanisms that saved the day.

With the foregoing failures combined, we can begin to see that vertical network failure in the case of the three African states under review at least partially resulted from an inability at the national level to propel the crisis on to the agenda of the international community. As noted above, it has been noted that wariness about frightening off foreign donors, investors and tourists, who provide economic support to these struggling economies, was at the heart of a delay to ask the international community to step up its involvement. Here we see how both executive and political failure within countries can





intersect with vertical network failure on an international scale. When the actors inhibiting political accountability are both internally and externally based it is likely that there will also be vertical network failure to contend with, as those same actors will influence broader decisions in problem response as well. That said, key players in the web of actors beyond the three worst hit nation-states were also guilty of inaction (Siddons, 2014).

It is at this juncture of discussing network failure that the experience of international non-profit organizations working to control the emerging epidemic needs to be spotlighted. Their story offers evidence that the values of NPG, which should have come to the fore with a vertically networked response, did not. As noted earlier in the paper, the primary independent entity working in the region was Doctors Without Borders. While certainly not alone in their efforts (Samaritan's Purse was also quite active in the region early on), this organization was perhaps the best equipped, and ready, to address the crisis as it was unfolding. In March 2014 the alarm was indeed sounded directly to the WHO by Doctors Without Borders. But it apparently fell on deaf ears. Among the reasons for this appears to be the lack of a confirming voice within the leadership of the affected countries themselves, at that point in time (as noted above in the areas of executive and political failure). Here we see the beginning of the synergy that thwarted early response to the disease. Without authoritative voices being raised in concert, the cries of a few INGOs and the citizenry could not rise above the din of daily global discourse to be recognized and acted on. In short, the people inside the countries, the street-level-bureaucrats, local and international non-profits on the ground, and the executives of the country needed to raise the alarm together if there was going to be any hope of activating broader networks of response to react and provide aid.

Looking at the sluggish response of WHO in the early going of this crisis is also instructive. Examining Table 2 points out a number of governance failure zones for consideration. In all areas of the chart, the WHO was found to struggle. Some posit that organizationally WHO did not respond quickly to the developing Ebola storm due to budget cuts that stripped it of key personnel, and key decisions internal to the IGO that refocused its resources away from viral diseases of this kind (Busby & Grepin; Editorials, 2014; and, Youde, 2015). This breakdown spilled over into analytical failure as the organization became unable to adequately foresee changes on the ground as they were emerging in Guinea, Liberia and Sierra Leone (Fink, 2014). Executive failure is also tied to these shortcomings, as the Director General of WHO at the time was unable to remain in comprehensive control of the workings of the agency's six regional organizations to support its mission (Busby & Grepin, 2015; Sack, Fink, Belluck & Nossiter, 2014; Youde, 2015).

The body's legislative arm, the World Health Assembly, did not act in the face of prior health emergencies to develop means of response that would have enabled them to become better prepared for the Ebola outbreak of 2014-2015. Political failure can be seen in the willingness of the agency to cater to other issues sponsored by donors, rather than focusing on crises of this nature that should have taken precedence (Fink, 2014). Clearly, without constant pressure from below, there was no reason for the IGO to

awaken. Finally, bureaucratic failure existed too. There is little record of those working within the organization forcing its hand into action in the early stages of the emergency. Indeed, inaction from the time of the warning being received from Doctors Without Borders (March 2014) until an International Public Health Emergency was declared (August 2014) is strong evidence that leadership was not successfully exhibited among the managers within the agency either. The cumulative result of these findings was the inability to activate the international network that could have rallied to the cause of the West African countries in need. Indeed, WHO only presented its strategic “Ebola Response Roadmap” for addressing the crisis at the end of August 2014 (Cumming-Bruce & Cowell, 2014).

The conditions that prevented the West African states, and their attendant NGOs and INGOs on the ground, from successfully raising the alarm to the international community are echoed at the level of the key IGO who should have initiated reaction worldwide. A lack of executive leadership and vertical networking ability deepened the Ebola problem, prolonging its gestation period through to emergency. As a result, donor states were also further slowed on engaging the issue.

While reaction from potential donor countries, and the United States in particular, increased rapidly after the WHO declared an International Health Emergency in August 2014, their reaction pattern was unimpressive up until that point (Cooper & Fink, 2014; Landler & Sengupta, 2014). In fact, it is argued that the arrival of ill health care workers into America and Europe is what spurred both the WHO, and interested donor countries, to finally respond with force to the issue – not the spread and suffering of the disease in West Africa. Boundary spanning, monitoring and surveillance failed to stimulate much engagement in the international community up until that point. For all intents and purposes the potential donor countries in the early stages of the emergency were paying cursory attention to these developments, at best.

## **Conclusion**

In this paper I have explored the underpinnings of the early stages of the West African Ebola outbreak by focusing analysis through theoretical lenses of New Public Management and New Public Governance, while applying a practical assessment of actions taken using an array of governance failures categories. The findings offer a way into better understanding the managerial, leadership and networking challenges that took place while responding to the emergency when it was at its most strident – from March 2014 through August 2014. As has been documented, later stages of the emergency through to the present exhibit more success in reducing many of these problems - and the disease itself – across the levels of response (AGI, 2015).

This review suggests that a series of interconnected governance failures, often across actors, led to an inability to mitigate or contain progression of the disease in the early months of the emergency. As the cases mounted, organizational, analytical and executive capabilities were found to be wanting in the countries hardest hit by Ebola (failures of NPM values, essentially). These issues also could be identified within WHO, and among



donor states. Additionally, these problems were exacerbated further by political and vertical network malfunctions (failures of NPG values). Combined, we are able to trace the breakdowns that allowed this outbreak to become so severe. With NPM values compromised from the beginning, NPG values should have been engaged with vigor. If there were to be any hope of redressing the spread of Ebola in the first half of 2014, a concerted effort from actors within and outside of West Africa would have been required. This did not happen until far too late, and the terrible human suffering that resulted speaks for itself as a caution to not ignore such concerns in the future.

### **About the Author**

Dr. Peter Mameli is an Associate Professor at John Jay College of Criminal Justice in New York City, USA. He received his Ph.D. in Political Science from the Maxwell School, Syracuse University and his MA from the University of Colorado at Boulder. He has served as the Director of the Protection Management program, Coordinator of the undergraduate Public Administration program, and Director of the Saturday Masters of Public Administration program at different times while at John Jay College. Prior to working in the Department of Public Management, he held positions with the New York City Council, the New York City Board of Education and the New York City Office of Management and Budget. Professor Mameli's current research interests include studying the impacts of globalization processes on public administration, transnational crime and the oversight of public sector organizations. Recent projects have focused on such topics as government surveillance operations, national data protection authorities, international crime statistics, the impact of the Arab Spring on Middle East and North African public sectors, and transnational human trafficking. Some of his articles have appeared in *Law & Policy*, *Crime, Law and Social Change*, *Critical Issues in Justice and Politics*, *International Public Management Journal*, *The Public Manager*, and *Human Rights Review*. In 2011, Dr. Mameli and his co-authors published, *Security and Privacy: Global Standards for Ethical Identity Management in Contemporary Liberal Democratic States*.

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