Humanitarianism and Its Discontents: Ebola Response Revisited

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This study explores the links between the historical construction of Western humanitarian aid and the failure of their programmes. Evaluations of humanitarian responses identified three recurrent concerns in different emergencies that are relevant for this work. These problems refer to the lack of understanding of local contexts and cultures, the nonexistence of communication channels established with the affected communities, which thirdly translate into the inability to recognise local capacities as a starting point to develop ownership of humanitarian endeavours. The study argues that these drawbacks relate to an “unconscious ethnocentrism” that sometimes manifests as a “fully assumed sense of superiority” of Western humanitarian aid discourse and practice. Being a South American anthropologist with more than fourteen years of practice with a medical international non-governmental organisation (INGO) – Médecins Sans Frontières, MSF – provides the lived knowledge of these negative aspects and consequently, the motivation for this work. The focus of the study is at operational level, where repeatedly experiencing the misuse of resources and the incapacity to meet the needs of people (defined by the people themselves) definitely posed the question of operational change.

The case study of the ongoing Ebola Virus Disease (EVD) outbreak in West Africa describes the encounter of the Western biomedical humanitarian model with localised cultural models of construction and response to the epidemic. This EVD outbreak flags the limitations of the Western scientific model in two ways. First, it exposes biomedicine’s incapacity to solve this health problem given the failure to produce a cure or a preventive vaccine to the disease. Secondly, the classic standard humanitarian biomedical model to respond to EVD outbreaks proves unfit and slow to adapt to meet the challenges of the current West Africa EVD epidemic. There is recognition of the key role that societal determinants and lifestyle play in infectious maladies, affecting both their dissemination and control – i.e. burial practices, health-seeking behaviour and explanatory models for the disease. Even though this element is acknowledged and addressed in policy, there is no systematic inclusion of actions and resources to address social determinants in the actual response. People affected by the disease are rarely considered agents to contain transmission.

The study proposes a conceptualisation of an alternative inclusive analytical framework from where to create possible solutions to the persistent problems. Furthermore, this work aims to elevate the significance of the framework beyond the case study presented. It is the wish of this study to contribute to progressive reasoning on possible methods to analyse humanitarian emergencies and change the way humanitarians provide assistance.
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If I am submitting this piece is it just with respect to the time and energy people spent on me. I do not know if the piece meets the standards, uses good English or contributes to academic knowledge. What I can assure is that in these almost five years spent at HCRI I have widened my analytical gaze and opened new logical paths in my mind I did not know existed before. And it is not on a selfish note that I mention this. I am already applying all this baggage in what I do in my life. I am part of the humanitarian system; I contribute in the design and implementation of relief aid programmes. What you will read in this document comes from real life experiences, from the rage and frustration that pump incredible amounts of energy into my existence to continue going. Yes, to carry on doing, being as close as possible to people in extreme situations, learning from them and wisely maximising the use of the resources we both have to make things better. As good as they get, given the kind of world we have created. But certainly we can also change it for the better.

Independently of what will happen with this thesis, I have to say that your job, as academics, family and human beings is accomplished. You inspired and taught me, helping me to better serve humanity. Thanks for every minute you have spent in contribution to this achievement. The struggle continues, and victory is certain!!
“No problem can be solved from the same level of consciousness that created it…”

Albert Einstein

Introduction

Western international humanitarian aid\(^1\) is having problems to attain its purposes. The essential reaction to preserve human life when a crisis strikes proves complex and full of contradictions. Time and again evaluations to emergency responses, namely the Rwanda crises in 1994, the Indian Ocean Tsunami in 2005 and the Haiti earthquake in 2010, describe recurrent flaws related to the way operations are carried out. Despite being identified and addressed by practitioners and scholars, these missteps seem to persist. Why is this happening?

The following piece engages with this question. It aims to provide an answer from the premise that in order to comprehend how this type of assistance operates in present times, there is a need to understand its past. Therefore, it looks at the historical construction of this discursive form of aid and its practice, and the associated political contingencies linked to this constant failure. Situated at the epistemological intersection of theory and practice, it aims to contribute towards a better understanding of the representation of a specific discursive form of humanitarian assistance, the Western model of medical relief. It is concerned with the conception, organisation, and deployment of humanitarian measures within distinct geopolitical and cultural contexts. Sense can be made of current events in retrospective, creating a narrative that rationalises contemporary actions. This introspective process, grounded on the researcher’s practical work in humanitarian assistance, sheds light on key fundamental issues that explain analytical frameworks –the level of consciousness in Einstein’s words– of humanitarian organisations. Once this level of thinking is explored, the researcher aims to establish an intellectual distance from practice in order to define an engaged way to analyse and consequently modify performance. Following the quote at the beginning of this section, it looks at alternative analytical frameworks from where to create possible solutions to the persistent problems.

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\(^1\) This study focuses on the practical form of humanitarian aid. The words aid, response, assistance, action and relief will be used interchangeably in this piece, and all of them refer to the empirical aspect of humanitarianism.
This Western form of aid by discourse, loyal to the humanitarian principles of neutrality, independence, humanity and impartiality, provides life-saving temporal help to all human beings based on their immediate needs. This particular identity of the discourse, when put into practice, intends to “separat[e] humanitarian action from its contextual politicised environment” in the bi-dimensional framework of the humanitarian space of aid givers and receivers.² Donini³ recognises three facets of humanitarianism: an ideology, a movement and a profession. These facets are embodied at ‘macro’, ‘meso’ and ‘micro’ level. For him, ‘macro’ functions are “the deep undercurrents, power relations and values that humanitarianism articulates and transmits; ‘meso’ functions are those that relate to the political economy of humanitarian action and to the mechanics (rather than to the ideology) of globalisation; and ‘micro’ functions are those that relate to the motivations of the individuals who devote their energies to humanitarianism”.⁴ Macro functions relate more to the discursive form of humanitarian aid, and micro to the action of delivering the assistance, the practice of humanitarianism. Considerations regarding the nature of Western humanitarian aid and accounts of operations have proliferated in the past three decades.

Critics present humanitarian aid as limited, imperfect, misused or manipulated. There seem to be fractures between the different facets and levels in the way humanitarian aid functions. Research shows that the application of principled aid in the abstract humanitarian space is not so straightforward.⁵ The focus of this study is at ‘micro’ level, where critiques, among other features, repeatedly show friction at operational level, reflecting cultural insensitivity, poor accountability⁶ and bad technique among humanitarian agencies on the ground.⁷ Other critiques mention even the lack of presence of humanitarian aid agencies and organisations in certain countries with protracted conflict.

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³ Donini A. The far side: The meta functions of humanitarianism in a globalised world. Disasters, 2010; 34.
⁴ Donini, p.5220
⁶ Accountability seen as taking responsibility for one’s actions, being accountable to and respectful of beneficiaries and their communities, as well as being accountable for the resources one is entrusted with (Walker et al 2010).
⁷ Abu-Sada, 2012; Donini, 2012
contexts. These negative aspects directly affect the provision of assistance to those affected by humanitarian crises. Being a South American anthropologist with more than fourteen years of practice with a medical international non-governmental organisation (INGO) – Medécins Sans Frontières, MSF – provides the lived experience of these gaps and consequently, the motivation for this work.

During those years, I have experienced the reaction of different peoples to diverse critical situations in various contexts. I witnessed the way in which MSF and other Western relief providers analysed these “emergency” situations and consequently planned and organised the deployment of aid. Starting from the understanding of the situation, to the type of aid they considered people needed and the way in which this aid was being provided, this whole process often translated into failure to deliver such assistance. This recurrent situation provoked a constant questioning in my mind. Even though I was embedded in the organisation’s response programme, I remained very critical about the Western humanitarian approach to crises and to the people affected by those circumstances. Medical humanitarian missions are generally planned and centred around the application of certain biomedical protocols that respond to a health crisis defined by epidemiological statistics. These operations are very complex and require expert logistics, coordination and medical staff. It is relevant to remark that, in most of the missions I have worked in, I occupied diverse positions – such as logistics and coordination – whereas working as an anthropologist was a very limited option. Generally, this was not a position obviously needed to operate. Nevertheless, this situation has been gradually changing in the last years. From my perspective, while doing my work, I applied a critical but also constructive analysis rather than neutralist – as anthropologist defines. He argues that while a neutralist approach is intellectually preferable, the constructive one is proper when working in the field and some sort of change is expected as a result of research. Repeatedly experiencing the misuse of resources and the incapacity to meet the needs of people (defined by the people themselves) definitely posed the question of operational change.

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8 Healey S, Tiller S. Where is everyone? Responding to Emergencies in the Most Difficult Places. 2014
9 I have worked mainly with the Spanish section of Médecins Sans Frontières (MSF) since the year 2000.
11 Benthall, p. 157
In order to substantiate this personal participation, this study brings into play evaluations performed after three major relief responses. Namely, they are the responses to the genocide in Rwanda in 1994, to the Indian Ocean tsunami in 2004-2005 and to the 2010 earthquake in Haiti. International evaluation teams composed of professionals with diverse backgrounds performed the work. The three reports point at three recurrent reasons for failure, among others, that are relevant for this work. Firstly, the assessments refer to the lack of understanding of local contexts and cultures. Secondly, they explain how there were no communication channels established with the affected communities, which thirdly translated into the inability to recognise local capacities as a starting point to develop ownership of humanitarian responses. Situating the question posed at the beginning of the section –why is this happening? – the first objective of this study is to understand how history speaks to these three problems. The second is to explore different approaches to aid that may contribute to solve such deficiencies.

In a localised and practical manner, I addressed these three issues while doing my work. I have applied an alternative analytical framework to the humanitarian space –the arena concept– and adapted anthropological tools in my practice aiming to create operational room within the Western relief schema for aid recipients’ contextuality. As my analysis was immediately translated into actions in the field, my colleagues would experience the consequences of the application of these tools. The direct consequences were the creation of clear communication routes with a trustful, participative community engaged in the project development, which facilitated their access to our services. The success of a project is reflected in this acceptance.

There are two main reasons behind this choice of disciplines. One reason is the relevance of their methodologies and type of knowledge they produce in relation to the scrutiny of the three recurring failures this study addresses. Scholars from Wageningen University propose the concept of humanitarian arena as an option to the common humanitarian space conception of relief. The idea of humanitarian space restrains the understanding of aid as international humanitarian agents delivering services to victims of a temporary catastrophe, on the basis of humanitarian principles, with the objective of

saving lives and alleviating suffering.\textsuperscript{15} 16\textsuperscript{17} The concept of arena, “where a multitude of actors, including humanitarians and the disaster-affected recipients of aid, shape the everyday realities of humanitarian action”\textsuperscript{19} widens the analytical gaze. This framework levels the role of the affected in face of the humanitarians. It creates a space for them where they actively participate in the making of the relief response. Seeing relief through this lens provides a more comprehensive understanding of the power processes that occur during crisis responses taking account of all actors concerned with the situation (ibid). The study proposes a combined application of this vision with an anthropological approach – and the use of its tools, i.e. participant observation and ethnography – to aid practice in order to find an interconnected method to modify practice, and subsequently, policy. As Bornstein and Redfield\textsuperscript{20} affirm, “anthropology’s gift to the intersection of scholarship and practice lies in its ability to engage ambiguity, to recognise concrete events and forms of action that fall between conceptual divides.” At the same time, they argue that anthropology’s distinctiveness, the localisation of global narratives, sets as well the limits for its contribution in the form of an expanded field vision.\textsuperscript{21} The point here as well is to define which sub-discipline of anthropology would be appropriate for the task. Exploring the relation between the discipline –and sub-disciplines– and Western humanitarian aid, drawing from the development experiences, and the researcher’s practice, the study explores the possible need of a tailored “humanitarian anthropological framework” to be applied in the field of humanitarian action.

The other reason is the subjective understanding of the problem and possible solutions that guide this exercise. The positive results achieved through practice constitute the personal elements that justify the selection of the tools this study proposes. This study will draw from experiences presented as case study, where change situated at field level provoked policy change. The case study will analyse the process of transformation of the humanitarian response to Ebola Virus disease (EVD) outbreaks. It will do so firstly, by introducing the biomedical framework – the underpinning logic humanitarians apply to construct and respond to EVD epidemics. Secondly, the cultural model – the way people

\textsuperscript{16} Hilhorst and Serrano, 2010.
\textsuperscript{19} Hilhorst and Jansen, 2010: 1117.
\textsuperscript{21} Bornstein and Redfield, 2011.
perceive and respond to outbreaks—will be explained. Both models will be used to present the current largest ever recorded EVD outbreak in West Africa. The intention is to show how these two models are coexisting in the humanitarian arena, but not interacting. So, drawing from personal experience, an alternative approach already used in the field will be proposed to contribute to a more inclusive and effective delivery of assistance. The question this research intends to respond is how this knowledge generated in localised experiences could inform global humanitarian practices.

Despite all negative aspects attributed to relief aid, some critics assert that humanitarian aid ought to be protected and developed. There is room in the world for this type of assistance in times of crisis, but to them it is clear that a change is needed in order to be able to support the people undergoing extreme circumstances. There are two polarised positions, or pitfalls according to Donini, regarding relief aid. On the one hand the belief that increased awareness and respect for humanitarian principles is the key and, on the other, the certainty that there is no solution as no real change will ever take place in the way the system works. Falling for neither the ingeniousness of the former, nor the acrimony of the latter, this researcher as a practitioner herself, argues that a middle way should be explored. An approach that aims for a more informed, contextualised and inclusive form of aid, a form that sees its discursive form as a tool that ensures access to services for those in need. This work intends to create dialogue between humanitarian practice and academic analyses, where they speak and listen to each other to define a more realistic and effective way to provide assistance. The stand I take for this research is what Brookfield defines as reflective practitioner. I reflect my own contextually-specific ideas about what works in the field of humanitarian action and juxtapose them against research on humanitarian practice.

**Professional Practice: Critical Reflexive Thinking**

Critical reflexive thinking is an approach to research that bridges the professional and academic worlds. The process of reflexivity recognises the researcher’s impulse at the beginning of the research journey, drawn from life history, intuition as well as academic

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25 Terry, 2002; Walker and Maxwell, 2009; Donini, 2012
26 Donini, 2012.
literature research.\textsuperscript{28} The methodology must make sense to both academic analysis and practice, producing results that contribute to academic knowledge and informs professional practice.\textsuperscript{29}

The relationship between the researcher and the ‘objects’ of research follows that of doctor and anthropologist Didier Fassin, what he defines as distanced interiority,\textsuperscript{30} based on Plato’s cave allegory.\textsuperscript{31} Taking this spot as a starting point, the researcher moves in a slightly different direction, offering the possibility for new knowledge to be created, under the umbrella of the arena and “humanitarian anthropological” analytical frameworks as explained above. The reason why I refer to Fassin is because I somehow empathise with the critical position he assumes –as an anthropologist that has an internal understanding of the functioning of an emergency INGO– in his analysis of the relation between humanitarian aid and anthropology. Not to mention that his link to medical relief was also through MSF, where he was administrator from 1999 to 2001 and Vice-President from 2001 to 2003. I recognise the place he describes, located at the threshold of the cave – making allusion to Plato’s renowned metaphor. This position implies the capacity to easily move between the inside and the outside of a world that Fassin –same as I, decided to be part of and collaborate with, but always maintaining a critical distance. Furthermore, Fassin clarifies in his writing that his non-remunerated volunteer and non-member status within the organisation contributed to maintaining this independence.\textsuperscript{32} Personally, I do not share his claim. I was –and I currently am– a remunerated aid worker and I am a member of the MSF association. But these characteristics never acted as chains –in Plato’s allegory– and do not have any weight in my critical position; my independence and autonomy remain intact. The understanding I have of these facts is that it was my free decision to join this sector as a way of life, thus I can leave at my own discretion in the same way. I never felt obliged not to speak my mind. As a matter of fact, I always did. This is one of the reasons why I decided to continue my collaboration with the organisation for more than fourteen years.

\textsuperscript{29} Cole et al. 2011.
\textsuperscript{31} Details on Plato’s allegory on https://www.princeton.edu/~achaney/tmve/wiki100k/docs/Allegory_of_the_cave.html, last accessed September 2014.
However, there is an extremely interesting exercise one has to do in order to be able to constructively criticise the work the organisation does and pass a message that will translate in a positive impact. It is necessary to arrive to a degree of empathy with the organisation’s self-awareness, internal mechanisms and codes of communication. Authors refer to the humanitarian system’s “untouchability” due to its intentions to “do good”. It becomes complicated to criticise humanitarian action, as Didier Fassin explains “…its consensual force in the public sphere makes difficult to make acceptable a critique to humanitarian reason…The moral profit form the qualification humanitarian is such, that [...] sometimes [...] justify [ies] any action…who could be against the noble thought of saving lives?” Redfield agrees with this argument, explaining how urgent medical care acquires an aura of moral purity when lives appear to be at stake.

This particular stand the researcher aims to take is what places the institution and its members outside the (self-) attributed form of moral supremacy Fassin talks about in the previous paragraph. The mystical language of salvation and sacrifice used in their discourses is confronted here with the reality of survival of the organisation, its economic and political struggles, its internal strong hierarchy and the incongruent visions of the work they do depending on the level where the analysis is carried out – i.e. field level or headquarters level. One is able to experience all these domestic aspects when located inside the cave. This humanitarian enterprise is just another form of business. A business aimed at helping people undergoing extreme circumstances. Leaving aside moral and mystical discourses, political and economic constraints, to an extent, it has the intention to do good. Once resources have been deployed and humanitarians are in crisis-affected places, it is wise to best use those assets in benefit of the people enduring those circumstances.

Structure

This work is divided in two chapters. Chapter one begins by providing a selective historical, discursive and operational explanation of the Western approach to relief. In the Humanitarian Policy Group’s (HPG) research project ‘A Global History of Humanitarian Action’ researchers claim, “understanding the history of humanitarian aid helps understand

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31 Fassin, 2010
why it is the way it is today, and helps identify how it can, and maybe should, change in the future.”

Strong emphasis is placed on the literature that describes the visions of the recipients of aid, how humanitarians consider those views and the historical influence they may have had in the characterisation of the discourse. This particular analytical approach to the construction of the humanitarian discourse and its application will shed light on the historical power relations and dynamics that may have led to the justification of the dominance of certain institutional practices and types of knowledge. The piece will look at the knowledge validation systems applied in Western relief, the fractures that may exist between the facets and levels Donini refers to, and how these contingencies may as well contribute to the three constant reasons for failure.

Chapter two describes two frameworks to construct and respond to emergencies. Through the introduction of the case study of the ongoing Ebola Virus Disease (EVD) outbreak in West Africa, the study describes the application of the biomedical and the cultural model to the construction of the emergency and the consequent response. Following that, the section proposes the application of an alternative holistic framework for the understanding of epidemics and subsequent response. It introduces examples where this alternative approach was adopted with positive results, having an impact on policy. The published literature on the topic is reviewed as well as grey material—i.e. reports, evaluations and guidelines—produced by the actors responding to the crisis. This case study depicts the process that led to the change in policy. A critical analysis of the steps taken in this procedure will expose strengths and opportunities as well as challenges and implications of the use of this alternative approach. Lastly, this section proposes a conceptualisation of this framework applied to humanitarian aid that aims to elevate its significance beyond the example presented in this work. It is the wish of this study to be taken as a contribution to progressive reasoning on possible methods to criticise humanitarian assistance in a manner that facilitates the reception of those critiques and furthermore, provoke positive change in the way humanitarians provide assistance. The question is how far is the system willing to

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go in order to fulfil its broad objectives. How committed are humanitarian services providers to the cause? Is a redefinition of its rules and theoretical foundations a viable option? One of the characteristics of the international humanitarian system – the people that form it – is that they do not easily accept criticism, especially coming from sources outside the realm of humanitarian practice. Nevertheless, humanitarian workers are among the hardest critics of the system. But, as Ramalingam et al. explain, they also complain that evaluations and other learning exercises continually expose the same problems and acquaint with nothing new. Still, it makes sense that new potential pragmatic solutions could come from within as well. This chapter also investigates humanitarian organisational learning and knowledge production within the humanitarian community aiming to better understand these dynamics. Notwithstanding, it is important to recognise that many of the factors determining the success of humanitarian action – mainly at macro and meso levels – are beyond the direct control of humanitarians (ibid).

Chapter 1. A Portrait of Western Humanitarian Aid

Western relief aid’s nature is “to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of emergencies.” There are intrinsic characteristics that distinguish this Western form of aid from others. In its pure form, humanitarian action is intended to be short term. It is governed by four deontological principles: humanity, neutrality, impartiality and independence. Generally, these emergency responses manifest in the form of material relief assistance and services (i.e. healthcare, shelter, and water), emergency food aid (i.e. short term distribution and supplementary feeding programmes) and relief coordination, protection and support services (i.e. coordination, logistics and communications). The main providers of this type of assistance are governments, private humanitarian organisations (i.e. non-governmental organisations –NGOs– and the International Red Cross and Red Crescent Movement), and multilateral organisations (like the World Bank and the International Organisation for Migration – IOM). Most actors have their own set of policies, protocols and manuals that define the way in which this assistance is provided. Some of these tools are common to a larger group of aid providers i.e. the Sphere Handbook: *Humanitarian Charter and Minimum Standards in Humanitarian Response (June 2011 last version).* During responses, at the micro level, humanitarian workers of these major international actors deliver this type of assistance in the symbolic –and physical– humanitarian space. Spearin defines this space as “an environment where humanitarians can work without hindrance and follow the humanitarian principles.” In its physical dimension it refers for instance to refugee camps and humanitarian corridors where humanitarians deliver basic services. The metaphorical aspect invokes the room for manoeuvre of humanitarians to work without fear of attack in dangerous situations. Despite the fact that the effectiveness of humanitarian space has proven limited, it remains widely accepted as the expression and

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aspiration of humanitarian assistance. This study is interested in the application of this concept in practice. What are the implications of this understanding for the actors involved in a given crisis? The humanitarian arena framework will be used as a contrasting alternative to answer this question. Western humanitarian actors share the humanitarian arena with national actors, the affected communities themselves, and more lately militaries and the private sector. This chapter presents a historical account of these dynamics.

On the one hand, many are the challenges and difficulties humanitarians face—and faced in the past—to assist people in crises, namely geographical and security constraints that restrict access to affected communities. On the other hand, this form of relief is widely criticised. Criticism ranges from macro analysis of the manipulation and misuse of the humanitarian discourse to micro level technical evaluations of operations. At micro level, humanitarian action has been commonly condemned for the ineffectiveness of its practice and the lack of responsibility of aid organisations for the consequences of their actions.

Evaluations of humanitarian responses, like the evaluation reports for Rwanda, the Indian Ocean tsunami or Haiti show that humanitarian action has been unsuccessful in fulfilling its mandate. According to the reports, humanitarian responses have failed to protect the vulnerable, to alleviate suffering and to enhance wellbeing, human dignity and quality of life. Among other reasons, three repeated in all reports are of specific relevance for this study. Firstly, the evaluations point at the lack of understanding of local contexts and cultures. Secondly, they explain how there were no communication channels established with the affected communities, which thirdly translated into the inability to recognise local capacities as a starting point to develop ownership of humanitarian responses. Accountability rises as a major concern. This section looks at how

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52 Hilhorst and Jansen, 2010
humanitarians perceive accountability. For some practitioners it just means meeting the standards, as defined by Sphere, while others have a more inclusive understanding of being accountable.

These bullet point conclusions in evaluations are referred to as “lessons learned” within the humanitarian system. This is a very soft way to remove responsibility from aid workers and their organisations for the possible damage caused. In my personal experience within the humanitarian world, I have hardly seen any measures taken to hold humanitarian workers accountable as a consequence of project failure and the cost that it may entail for the affected people they aim to help. Once these “lessons learned” are made public, they normally act as motivators for the production of new research agendas, guidelines and manuals that propose solutions to the detected problems.\(^{59}\) For instance, working with local communities is recommended as a means of ensuring that relief and recovery policies and programmes are needs-based, reflect community priorities and avoid negatively impacting vulnerable groups such as women, youth, children and others at risk.\(^{60}\)

Notwithstanding, given the repetition of “lessons learned” from one relief operation to another, it seems like the internalisation of the criticism and further incorporation of these proposed solutions is not so straightforward. A chapter in this study is dedicated to looking into the particularities of the organisational learning process in the Western humanitarian aid sector. It examines the practical methods by which the humanitarian community takes forward these lessons learned from previous relief operations, putting relevance in the factors that affect this process of learning-internalising-moving forward. Drawing from personal experience, I would say that the humanitarian system has a particular culture and specific ways of processing information and developing operational choices. Both scholars and practitioners themselves elaborated on the topic from different perspectives, rather focusing in policy creation and implementation.\(^{61}\) This study addresses the need to understand the particularities of the system at the level of execution. It argues that it is important to tailor the outcome of the lessons learned—in the form of operational changes—to the actual functioning of the humanitarian system, with its strengths and weaknesses.

\(^{59}\) As an illustration see UNFPA series of publications on Culture Matters approach: https://www.unfpa.org/public/site/global/search-results?q=culture%20matters, last accessed 27\(^{\text{th}}\) December 2014
\(^{60}\) Rencoret et al., 2010:p.15.
This does not imply compliance; it is more about being realistic vis-à-vis the learning culture of the system.

In order to accomplish this, one of the aims of this study is to investigate what elements underpin and perpetuate these three recurring reasons for humanitarian action failure. For this purpose, this section looks at the historical evolution of the humanitarian system itself.

It examines how its configuration, modes of operation and progression have affected the nature of humanitarian action. The analysis aims to explore how certain facets related to the very identity of this form of aid are connected to these three recurrent limitations in particular. The chapter examines as well the drive and might that lead some humanitarians to take action. As Harrell-Bond\textsuperscript{62} explains, what happens in the personal interactions between humanitarians and people affected by the crisis at the micro level can be a microcosm for the ill-starred relations between (western) humanitarian ‘charity’ and its target populations. What goes wrong at this level both reflects and affects (infects) what is wrong at the macro level.

The interest of this research is first to address the institutional genesis of Western aid providers’ identity and discourse, and the consequential characterisation of their position and actions within the humanitarian arena in the 21\textsuperscript{st} century. A historical account of events will shed light on the understanding of the difficulties they face today.\textsuperscript{63} Following authors like Peter Walker and Daniel Maxwell\textsuperscript{64} and the ODI project “A Global History of Humanitarian Action”, this research also argues that this deeper awareness of the specificities of the international humanitarian system’s roots will contribute to putting it in a broader global perspective. Acknowledging the core elements of its distinctiveness will contribute to facilitate the recognition and engagement with other actors coming from diverse backgrounds,\textsuperscript{65} both at macro and micro level. At the same time it will promote a critical analysis of possible causes of programme failure related to the very identity of the humanitarian enterprise.

As the literature shows, the humanitarian landscape has been constantly evolving, changing and facing shifting realities, i.e. the demands of geopolitical changes, new forms of conflict, the development of technology and communications, and the worsening human consequences of natural hazards, to name a few. Yet, a historical critical reflection of the changing processes will show that, in general, the humanitarian system is rather reluctant to criticism and measured to transform. Nevertheless, the literature addresses particular moments in history where modifications took place. This section looks at the variation of the discourse, as well as the emergence of innovations that transformed relief operations. Special attention will be paid in pinpointing elements in the Western vision of the world that may have never changed through history, those identity features that might have a connection with the failure of the enterprise. In this line, the historical review is organised around these elements, from its origins to present time: “unconscious ethnocentrism”, “serving Western domination”, “new actors, new emergencies”, “standardisation and professionalisation”.

Next, the humanitarian discourse will be unpacked through three dimensions: time, space and operations. For the interest of this research, stress will be placed in the micro level, where individuals representing the different Western humanitarian actors deliver the medical assistance to the affected in the humanitarian arena. Two transversal interrelated factors that will also be scrutinised are power and knowledge. For Aronson there is “an asymmetrical power relation between Western knowledge and other forms of knowledge.” When this unbalanced association is operationalised, Western knowledge is the one that guides humanitarian operations. She explains how local knowledge is marginalised, stereotyped and sometimes romanticised or patronised. An anthropological analysis of power dynamics may help in the understanding of underlying structural factors impeding an adequate response to the needs of the most vulnerable. Such analysis may respond to questions like why resources and networking are not reaching those that need aid and why

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70 Aronsson, I., 2007.
certain groups are being neglected. Better comprehension of power relations that converge in the particular humanitarian arena will improve as well the appreciation of how they affect and are affected by the humanitarian response to the crisis.

Following previous studies on perception,\textsuperscript{71} this work tries to incorporate the viewpoint of the recipients of aid –or non-Western, non-white peoples– about humanitarian assistance. An interesting parallelism is established between the discipline of anthropology and humanitarian aid. In both cases, the inclusion of aid receivers’ perception in the analysis is the result of a change that responded to internal constraints. However, the ways in which those ideas are later on considered in each field greatly diverge. While anthropologists validate and incorporate that searched knowledge in all facets of their work, humanitarians still do not succeed to consolidate it with their own visions of relief. Maybe time is a relevant factor. It was at the beginning of the twentieth century when a methodological transformation in anthropology included the “native’s point of view, his relation to life…his vision of his world.”\textsuperscript{72} The humanitarian system is still kept back and cautious to systematically incorporate those ideas in their work. Given the nature of the piece, the emphasis is necessarily on those negatively viewed features of the discourse and practice. Notwithstanding, this is not to refute the positive aspects and contributions of Western relief aid to humanity, nor to entail either that humanitarian assistance can be described only in these terms or that the circumstances and conscious motives of all humanitarians correspond to those depicted in this chapter.

A Retrospective: Unfolding Western Approach to Humanitarian Aid.

The origins: Unconscious Ethnocentrism

Suffering and the humanitarian gesture to alleviate it have long histories. Humanitarian action can be traced through hundreds of years of history across the globe.\textsuperscript{73} There are two main forms of humanitarian aid often mentioned in the literature. First, practices stemming from religious beliefs, like Christian ideas of charity and Islamic zakat – the duty to assist others. Second, actions aiming to minimise the impact of war, for instance the creation of laws of war (i.e. in ancient Greece and Rome, or the ones articulated in The Art of War by


\textsuperscript{72} Malinowski, B., \textit{Argonauts of the Western Pacific} New York: E.P. Dutton, 1922: p.25.

Sun Tzu in China – dated 500 B.C.).\textsuperscript{74} Albeit these global precedents, the contemporary international humanitarian system has its operational and institutional roots in European experience from the eighteenth century onwards.\textsuperscript{75} Authors\textsuperscript{76} present two key sources of practice and intellectual influence of the Enlightenment. Second, they refer to the practices of colonialism, where mainly British and French military, as well as religious medics played a part in colonial conquest and administration in Africa, India and Indochina.

Several academics\textsuperscript{77} agree on the fact that the most powerful event that has contributed to the blooming of modern humanitarian aid is related to the creation of the Red Cross in 1863. This episode was framed on European ethics and Christian values of compassion: the strong moral responsibility to reduce human suffering.\textsuperscript{78} In 1859, Swiss devout Calvinist businessman Henri Dunant witnessed the consequences of a battle between the French and Austrian armies in the town of Solferino (Italy), where thousands of wounded and dying soldiers were left on their own with no assistance.\textsuperscript{79} Dunant compiled his account of the events in \textit{Un Souvenir de Solférino}\textsuperscript{80} that prompted an international response and led to the creation of the International Committee of the Red Cross (ICRC). These events are considered as the turning point for war-related humanitarianism, the surfacing of its principles of humanity, neutrality, impartiality and independence and the emergence of international humanitarian law that crystallised with the adoption of the Geneva Conventions in 1949.\textsuperscript{81}

It is relevant to remark that not long after its creation, the symbol of the Red Cross started having problems of acceptance. In 1876, during the war between Russia and Turkey, the Ottoman Empire declared that it would use the Red Crescent on a white background in place of the Red Cross. While respecting the Red Cross symbol, the Ottoman authorities

\textsuperscript{75} Bornstein, E. Redfield, P., 2011.
\textsuperscript{78} Barnett M., 2011.
\textsuperscript{80} Dunant, H., Un Souvenir de Solférino, Imprimerie de Jules G. Fick, Geneve, 1862.
believed that the Red Cross was, by its very nature, offensive to Muslim soldiers. Benthall comments that there might have been a deliberate intention in the choice of emblem to "bear the connotation of Christian supremacy over the (Arab) ‘infidels’…but it is more likely that this choice was merely a result of unconscious ethnocentrism.” In 1929, the Geneva Conventions were amended and the Red Crescent emblem was formally recognised, together with the Red Lion with Sun of Iran. Cultural meaning associated to the emblems of the Red Cross movement, the argument of Western imprint in the structure of humanitarian law and the question of universality of human rights norms are intense debates that persist until present times. It is in this general context that in 2005 a new emblem –the Red Crystal– was adopted. The political and economic pressure from the American Red Cross that stopped funding the movement for five years pushing for the inclusion of the Israeli national aid society in the Red Cross movement was a decisive factor as well. The Israelis refused to change their red Star of David emblem and adopt the cross or crescent because of their heavy religious meaning.

This example shows internal discrepancies within the Red Cross movement linked to the meaning assigned to symbols by different member states. Coming from a European rooted organisation, it could just be again another manifestation of the unconscious ethnocentrism Benthall refers to. The use of this concept brings the Western humanitarian discourse into critical view.

**Expansion: Serving Western Domination**

From its origins until decolonisation, the colonial field served as a laboratory for the techniques of humanitarian action. The language of humanitarian action was both moral and medical, identifying wellbeing through species-level needs and health. Military and emergency medicine saw dramatic innovations, even calling for an ‘evidence-based action’, and took institutional form across the nineteenth century as areas of international

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82 The Red Cross was somehow linked to the Hospitallers, a military order which took part in the Crusades, the centuries-long series of military campaigns waged by Christians from Europe.
84 Benthall, J., 2007: 159.
85 Benthall, J., 2007: 159.
cooperation. Medicine became an important component of missionary work in African and Asian colonies. Like the aid provided in Europe, the first intended beneficiaries of this medicine were Europeans working in colonised territories. Nevertheless, treatments were later expanded to local populations, firstly aiming to promote conversion and secondly to protect colonial forces from disease. Notably at this time, colonialism was making use of anthropology to bridge the knowledge gap between Western and non-Western culture. The discipline emerged as a mode of understanding the subjects of European colonialism. Its goal was to ‘scientifically’ recognise what factors produced human ‘difference’ and facilitate the governance of these ‘primitive’ societies. Anthropology, as Lévi-Strauss explains, “is the science of culture as seen from the outside”. The ethnocentrism Benthall invoked linked to the Red Cross emblems is present as well in the way anthropology was perceived at that time. It is not until Malinowski’s Argonauts of the Western Pacific when a fieldwork approach that included “the natives’ point of view” was introduced into anthropological work. It can be affirmed that until present time, as it is reflected in the evaluations of humanitarian responses previously mentioned, the perceptions of local people were not taken into account in the work of humanitarians.

Both humanitarian assistance and anthropology were alien and imposed to their non-white subjects that had no power to question their application. It is relevant for this study to remark at this point the common roots and the historical moment when both branches of knowledge and practice converged for the first time. This shared background constitutes as well a backbone for coincident critiques to both fields of study and practice. Humanitarian aid and anthropology –equally based on European values– met in the field and were used to support a Western system of political, cultural and economic domination. Scholars and practitioners question the colonial power relations that informed and influenced –up to present times– their methodologies and raison d’être. The end of the Second World War, and later decolonisation period marked the emergence of a just development and a human rights discourse to “civilise” and end the suffering of the poor south. The post colonialists’ idea of development discourses as “unconsciously ethnocentric, rooted in

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95 Benthall, J., 2007: 159.
98 Bhabha, H., The Location of Culture, Routledge, New York 1994; Spivak G. Can the Subaltern Speak?“ In Cary
European cultures and reflective of a dominant Western world view…depicting the North as advanced and progressive and the South as backward, degenerate and primitive”⁹⁹ could be extrapolated into humanitarian aid. This analysis implies the understanding of the pre-existing relation between givers and receivers, the symbolic power implied in aid delivery. While there is a large volume of published studies that investigate power and development,¹⁰⁰ the relationship between symbolism, power and humanitarian action has not been so widely scrutinised. Nevertheless, recent years witnessed a growing interest in explaining relief through power analysis.¹⁰¹ The study of this affiliation will be addressed later in the document to shed light on the problem of recognition of local capacities and the development of ownership in humanitarian responses.

The idea of human dignity from now on becomes a fundamental element of human existence, widely used in claims related to human rights and ethics, serving as the companion to physical wellbeing in the humanitarian discourse.¹⁰² The end of the war spurred the creation of the United Nations Charter (1945), the adoption of the Universal Declaration of Human Rights (1948) and the Geneva Conventions (1949). Shortly after, some of the most relevant actors of today’s humanitarian system were created, i.e. Caritas, the United Nations High Commissioner for Refugees (UNHCR), and the United Nations Children’s Fund (UNICEF).¹⁰³ This expansion of aid to the South, academics argue, was not simply driven by sympathy for the suffering of its inhabitants; it also reflected Western interests to maintain influence in the ex-colonial territories.¹⁰⁴

**Privatisation: New Actors, New Emergencies**

The second half of the twentieth century –the 70s and the 80s Cold War decades– witnessed a remarkable increase in humanitarian responses worldwide. The mediated encounter with distant suffering started to play a significant role amid an era of controversy, where its alleviation became a central topic in the international moral

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¹⁰¹ Hendrie B. Knowledge and power: a critique of an international relief operation. Disasters, 1997 Mar; 21(1);
Hattori T. Reconceptualizing Foreign Aid. Rev Int Polit Econ; 2001 Jan;8(4):633–60; Bornstein E. The
¹⁰² Redfield, P., Bornstein, E., 2011.
¹⁰⁴ Davey, E., 2012; Redfield, P., Bornstein, E., 2011.
Key events that occurred during this period contributed to shape the contemporary humanitarian aid industry, strengthening the private dimension of humanitarian action. The institutional void, a consequence of the end of colonialism, in the (now called) Third World was promptly occupied by the superpower states—Russia and the United States—and also a large number of what James Rosenau calls “non-state actors” or “sovereignty-free actors” that coexist with state actors. The proliferation of these “non-state actors” was possible thanks to the improvements in technology and the democratisation of transportation that allowed individuals to expand their abilities and analytical skills. The importance of actors at this stage is determined by their capability to initiate and sustain actions rather than by their legal status or sovereignty. A typology of these actors includes international organisations, humanitarian agencies and INGOs.

This particular moment is a landmark for certain analysis of the conceptual foundations of what constitutes a humanitarian emergency. For Calhoun, emergencies are constructed as part of a broad social imaginary in which they are seen as exceptions to normal social life and global order: sudden, unpredictable, and carried strong moral imperatives for immediate action.

The humanitarian space is a power zone created by these humanitarian actors who exercise a form of “mobile sovereignty”. It is here where the “emergency imaginary” raises, in line with the institutional, discursive and cultural framework of the West. Calhoun explains how this imaginary shapes the definition and rhetoric of emergencies, the ways in which they are produced and recognised, and the organisation of the intervention.

For Pandolfi, the power these actors wield overlies bureaucratic procedures and negotiations. At the same time it generates and controls its own communications network.

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113 Calhoun, C., 2004; 373.
International actors choose to legitimise certain groups within the societies they aim to assist as lawful mediators between the global and local. Pandolfi\textsuperscript{115} speaks of the humanitarian system as a “machine that produces elites and power flows from top to bottom”. They provoke a cleavage in local communities, marginalising and “making invisible” large sectors of society. She argues all these actions are possible because they are justified by the “culture of the emergency.”\textsuperscript{116} Framed within these parameters, establishing communication channels with the affected communities – one of the three recurrent failures of humanitarian aid – in a participative manner would be a very difficult task.

The end of the Cold War period gave rise to a different typology of conflicts. In addition to the previous inter-state clashes, intra-state strife arose, provoking displacements of people within borders as well as massive population movements across frontiers.\textsuperscript{117} Human security and autonomist ethnic and religious conflicts joined international security, resulting in the United Nations (UN) Security Council creating a liberal peace through the authorisation of military (humanitarian) interventions in the new “complex humanitarian emergencies”. Duffield\textsuperscript{118} defines them as a conflict-related humanitarian disaster involving a high degree of breakdown and social dislocation and, reflecting this condition, requiring a system-wide aid response from the international community.

There is disagreement vis-à-vis the humanitarian aspects of this peace security agenda and state interests.\textsuperscript{119} Two other observable facts (among others) distinguish this age of humanitarianism: the growth in public awareness of humanitarian crisis due to the increase in media coverage of these events, and the incredible scale-up, professionalisation and standardisation of humanitarian operations by non-state actors framed on a human rights discourse.\textsuperscript{120}

The pictures of the Ethiopian famine in the mid-1980s preceded the “CNN” and “BBC” effect in the ’90s – i.e. Iraq, Bosnia, Somalia, capturing public attention, serving as a platform to increase the visibility and donations to humanitarian organisations, and

\textsuperscript{115} Pandolfi, M., 2006.
\textsuperscript{116} Pandolfi, M., 2006: 65.
\textsuperscript{119} Pandolfi, M.; 2000; Fassin, D., 2011.
mobilising international action (Barnett and Weiss, 2008; Cohen, 2001). Real-time coverage of humanitarian emergencies brought the misery of the unfortunate into the lives of the fortunate. This mediated knowledge passed through numerous filters before reaching the senses of the spectators. According to Cohen, Boltanski and Moeller, two institutions—mass media and humanitarian organisations—have appropriated human suffering. In some cases, the media select, filter and frame the issues they decide constitute “news”, and set the political agenda and consequently, the operational priorities. They “do not tell us what to think, they do tell us what to think about.” When the fleeing, starving, wounded unfortunates enter Westerners’ houses on primetime TV, they do it silently. There are more comments from and about Western actors—about their courage, exhaustion, and their feelings about the disasters—than what you can hear about the affected people themselves. Western actors use their words, but they do not have the affected people’s voices. As previously explained, there was an inflection point in anthropological fieldwork when the voice of the Other was included in the analysis. In the case of humanitarianism, they are the humanitarians themselves who became spokespersons for those who are deprived of public expression. They have the legitimacy that allows them to shed light on the hardships these populations go through as a consequence of injustice, famine and war.

This is part of the exercise of power Pandolfi refers to, which contributes to the creation of what Calhoun calls the “emergency imaginary.” Both authors argue emergencies are defined in Western terms. “Humanitarianism gives the illusion of a global moral community that may still be viable in a world where inequalities have reached unprecedented levels, and solidarity might redeem power.” Humanitarianism is treated as a symbol of what is good about the world, as the world’s superego, as suggestive of the possibility of a more humane world. These compelling representations of distant suffering,

121 Cohen S. States of Denial: Knowing about Atrocities and Suffering, Polity Pr; 2001 20;
produced by the co-depdant relation between the media and relief agencies convinced the donating public that something needed to be done to help the suffering strangers. Massive resources were dedicated to implement crises responses; more organisations were involved in cooperative projects, and emergency actions have grown to exceptional levels since the mid-90s. Private donations to INGOs have had a dramatic increase in the past twenty years.\textsuperscript{130} “Emergencies are easy to sell”\textsuperscript{131} and making a living out of the misery of others seemed to work quite well. The “humanitarian market” started to develop at this point. There was a proliferation of organisations battling for resources, absorbed by globalisation processes that institutionalise, rationalise, and started to professionalise their operations.

**Effectiveness: Standardisation and Professionalisation.**

Despite the increase in resources and notoriety, a big reform of the sector took place after the evident failure of the humanitarian response to the Rwandan genocide in 1994. One of the critiques in the report of the Joint Evaluation of Emergency Assistance to Rwanda\textsuperscript{132} is that the unprofessional and irresponsible manner in which the humanitarian response was carried out actually “contributed to an unnecessary loss of life.”\textsuperscript{133} Accountability was not a major concern up to this moment. As a reaction to that, a process to modernise, professionalise and standardise relief operations started giving birth to four initiatives: the Code of Conduct, the Active Learning Network for Accountability and Performance (ALNAP), the Humanitarian Accountability Partnership-International (HAP-International) and the Sphere project.\textsuperscript{134} This self-policing engagement was aimed at providing a framework for action as well as holding members accountable to a series of agreed principles and standards.\textsuperscript{135} In many cases, the performance of humanitarian agents is internally evaluated against the meeting of standards alone. There is an idea that standardisation is linked to accountability; therefore, the goal is to meet the standards.\textsuperscript{136} The Sphere project consists of a “set of universal minimum standards for what the victims of disasters need to acquire in order to survive.”\textsuperscript{137} It is designed to “improve the quality of

\textsuperscript{131} Barnett, M., 2011:42.
\textsuperscript{134} Walker, P., Maxwell, D., 2009.
\textsuperscript{135} Walker, P., Maxwell, D., 2009.
\textsuperscript{137} Walker, P., Maxwell, D., 2009.
the assistance provided to people affected by disasters, and to enhance the accountability of the humanitarian system and its response.”

It is about people’s rights, in particular the right to life with dignity. Barnett argues that these rights also pertain to business ethics, where beneficiaries are seen as consumers, having the same rights as consumers do with the service provider. My first question would be how these consumers complain to the provider, as they do not have a say in crisis responses. Not only, as Fassin previously explained do humanitarians become spokespersons for those undergoing emergencies, but they also define what their needs are. The conceptualisation of victim according to Meredith dispossesses people from potential and active identity, which deprives them from public expression. The second question would be, in case they find a way to express their criticism, where do beneficiaries address their grievances, do organisations have mechanisms in place to deal with this kind of issues? In my personal experience, I have not seen such dynamics taking place during humanitarian responses.

After 11 September 2001, the mission of “saving” failed states – a threat to themselves and others, and now breeding ground for terrorists – intensified, and humanitarian aid was used as part of “winning hearts and minds” strategies to convince communities of the positive aspects of military invasion to their countries. For Fassin and Pandolfi, even dressed up in the cloak of humanitarian morality, intervention is always a military action – in other words, war.

Anthropologists were sent to field missions to “bridge the communication gap” between the army and the communities. Criticism points out that they were providing intelligence instead, that helped the military target the local population. For the American Association of Anthropologists (AAA), the work of anthropologists in these circumstances violates the AAA Code of Ethics and they categorically disapprove it.

This type of humanitarian-military interventions complicated the work of other humanitarian aid providers, like INGOs. Neutrality was even more at stake than in

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138 The Sphere Project, Minimum Standards, 2011.
140 Barnett, M., 2011.
previous periods, as aid was purposely used strategically for other ends than the humanitarian venture; aid agencies and INGOs became part of war dynamics and economies.\textsuperscript{147} The management of security during missions became a major concern for humanitarians. Events like the direct attacks to humanitarian organisations in Iraq, Afghanistan, and Sudan, to name a few, were a wake-up call.\textsuperscript{148} Practitioners saw the need to understand the interpretation recipients of aid had of Western relief. Several studies on perception of humanitarian aid\textsuperscript{149} show how for the large part of local communities that participated in the research there was no distinction among international actors providing relief, i.e. the military and INGOs. Additionally, those were not the only actors providing relief in the humanitarian arena. The emergence of “non-traditional” actors – from non-OECD donor countries, to diaspora communities and local actors with diverse views and practices, is changing the space humanitarians used to work on. Despite the complexity of the arenas where humanitarian aid lands, and the problems to operate aid agencies experience, humanitarians fail at contextualising their analysis, planning and deployment of relief.

In 2005, after the difficulties experienced during the Indian Ocean Tsunami response, Jan Egeland (Under Secretary General for Humanitarian Affairs and Emergency Relief Coordinator) commissioned the Humanitarian Response Review\textsuperscript{150} to tackle the failures in the international responses to humanitarian crises.

The main findings in the report show that

the speed, quality and effectiveness of humanitarian responses were inadequate, and that no common basis existed for assessing and comparing levels of need. Levels and techniques of funding were also found to be inadequate.\textsuperscript{151}

The reaction provoked a major reform in the system, the Humanitarian Reform Agenda. This restructuring introduced a number of new elements to enhance coordination, predictability, accountability and partnership in humanitarian operations.\textsuperscript{152} The Cluster

\textsuperscript{147} Heyse, L., 2003.
\textsuperscript{151} Cosgrave, J., 2007.
Approach was one of these new elements. Clusters are groups of humanitarian organisations, both UN and non-UN, in each of the main sectors of humanitarian action, i.e. water, health and logistics. They are designated by the Inter-Agency Standing Committee (IASC) and have clear responsibilities for coordination. Evaluations have analysed the cluster approach and its functioning as a whole, as individual clusters as well as from the perspective of particular stakeholders. In general terms, they all tried to respond to the question of worthiness of such great investment in energy, time and money. All reports found both improvements and benefits of its application in the context of humanitarian reforms as well as shortcomings and challenges. One of the main critiques of the approach is the exclusion of national and local actors. Steets et al point out that the implementation of the cluster “often fails to link with, build on, or support existing coordination and response mechanisms. Among other reasons, this is due to insufficient analysis of local structures and capacities before cluster implementation, as well as a lack of clear transition and exit criteria and strategies. As a result, the introduction of clusters has in several cases weakened national and local ownership and capacities. Furthermore, most response clusters do not use or promote participatory approaches.” Among the recommendations related to this specific issue they include carrying out context analysis, identifying partners in national and local authorities and allowing the involvement of local communities and civil structures.

On 12 January 2010 an earthquake of 7.0 in the Richter scale hit Haiti. It is estimated that some 223,000 people were killed, 300,000 injured, and more than 2 million displaced. In response, one of the largest relief operations since the Indian Ocean tsunami was launched. As of January 2011, there were at least 45 evaluations done on different aspects of the international response. Haver explains how, once again, many of the key findings are previously learned lessons that were not internalised, such as “listen to Haitians; support local initiative; work better with the government.” When the international community was prompted to respond to the humanitarian consequences of the landfall of Typhoon Haiyan (or Yolanda) in the Philippines in early November 2013, some

humanitarian workers took the initiative to circulate ten key lessons borne out in previous evaluations even before the starting of operations. How do humanitarian organisations incorporate those lessons? In order to answer these questions there is a need to dig within the organisational learning process as well as the knowledge production and validation system within the humanitarian community.

An Introspective: Acknowledging the Current Status of the Humanitarian System

According to ALNAP’s report on *The State of the Humanitarian System*, in 2012 there were an estimated total of 274,000 humanitarian workers worldwide. They reckon the workforce has a 4% annual growth. Despite the global financial crisis that slowed down the monetary income, it is a field of almost 17 billion in funds. This blooming of the system has incorporated diversity among humanitarian agents, which carried along a deeper fragmentation of humanitarian response. These actors have different approaches to humanitarian aid.

Currently, there are intense debates among academics and practitioners regarding the limits of humanitarian action. One of them refers to whether humanitarians should seek to transform –to develop– the places where they work or whether they should restrict their work to crisis management. Another debate points at whether their work should engage political questions and rights-based language or should be limited to provide life-saving aid. Different Western organisations have diverse approaches and they stand at very opposite ends of the line. Whereas some –like the ICRC and Médecins Sans Frontières (MSF)– intend to maintain a sharp boundary between relief and development, others –like CARE, Oxfam, World Vision, and Save the Children– see their duties lying in both domains. Stoddard and Donini sub-divide this conglomerate according to historical trends and traditions. The authors group Western humanitarians into “Dunantists”,

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“Wilsonians”, and solidarists. The first group, they explain, align themselves with the principles of the Red Cross – i.e. ICRC or MSF; the second is predominantly composed of US-based INGOs which see their role in accordance with their country’s foreign policy, like CARE and World Vision; and finally, the solidarists are concerned with the root causes of the crisis, adding advocacy, human rights and justice objectives beyond life-saving actions – i.e. Oxfam.  

At the micro level, these distinctions are reflected in two major types of responses to crisis. On the one hand, emergency agencies like the ICRC and MSF, concentrated on relief and life-saving, tend to respect the core principles of humanitarianism standing outside politics (nevertheless, this point is highly debated by critics), not questioning causes and consequences, and creating a humanitarian space where aid workers could provide assistance to victims. They prioritise action before thinking, the Kantian duty-based imperative to act that disregards consequences. Nevertheless, the témoignage (witnessing) policy adopted by MSF differentiates the two organisations.

On the other hand, there are other agencies that would sacrifice those principles in the name of providing help and social justice, in longer-term projects. This two antagonistic positions mark one of the core debates in humanitarian aid. The question often posed is, when does suffering end? For some, humanitarians should focus on the provision of life-saving aid to victims during emergencies, always based purely on needs. For others, they should also target the structural causes that put people at risk. Another major element of controversy within the system is the incorporation of “new” actors in the humanitarian arena: the military and the corporate sector. Some organisations put into question their role as they may have political or economic objectives underpinning their action, which in turn hinders impartial assistance to all people affected by the crisis. Others stress the impact their presence has on the security of the people related with the programmes – both staff and beneficiaries. Even so, some scholars consider their presence as crucial for the

169 See Brauman, R.,La Médecine Humanitaire, Presses Universitaires de France, 2011.
172 Daccord, Y., 2013.
future of the enterprise.¹⁷⁴ For instance, Pape¹⁷⁵ explains how a pragmatic Standard of Humanitarian Intervention may guide decision-makers on when to intervene militarily to stop governments from targeting their own citizens. Kennedy¹⁷⁶ argues as well that humanitarians should become more pragmatic, should do more to acknowledge and take responsibility for the costs as well as the benefits of their work. He proposes that humanitarians “foster our will to power and embrace the full range of our effects in the world.”¹¹⁷⁷

Nockerts and Van Arsdalsdale¹⁷⁸ refer as well to a “pragmatic” form of humanitarianism. Research shows that Western practitioners do not constantly follow these principles and standards of humanitarianism.¹⁷⁹ Nockerts and Van Arsdalsale¹⁸⁰ explain their ‘theory of obligation’ in the intersection of the ‘morally possible’ and ‘materially possible’, where a ‘pragmatic humanitarianism’ arises. It occurs as principled guidelines from the humanitarian discourse at ‘macro’ level merge with achievable actions at the ‘micro’ stage. As Duffield¹⁸¹ explains, the day-to-day work in the field somehow detaches practitioners from the macro functions. In fact, humanitarians struggle with this double dimension of universality (by discourse) and a kind of localism (the reality of each relief operation), being pushed by the assumed ‘moral obligation’ to ‘do something’ to respond to the needs of those who are suffering.¹⁸² Another relevant aspect that plays an important role in the deployment of aid is related to the motivations individuals have when they decide to become humanitarians. Ranging from humanitarian tourism, career path, thirst for adventure, to guilt and shame, humanitarian workers –especially in field positions– have lost track of their mandate as humanitarians. This multidimensional motivation source is a challenge when devising efficient approaches to action and efficient approaches to evaluation.¹⁸³

¹⁷⁴ The Humanitarian Futures Programme based at the King’s College London works for the positive inclusion of the military and the private sector in the humanitarian system. See http://www.humanitarianfutures.org/projects/, last accessed 27 November 2013.
¹⁸¹ In Tschirhart C., 2011.
¹⁸³ Calhoun C. The imperative to reduce suffering: charity, progress, and emergencies in the field of
The imperative to adapt relief operations to context-specific realities sometimes compromises the very principles of humanitarianism and discredits its standards even if humanitarians hardly recognise this fact. Indeed, the dangerous predicated dichotomy between ‘aid givers’ and ‘relief takers’ largely misrepresents the negotiated nature of the humanitarian enterprise. As Nockerts and Van Ardsdale argue, the reality in the field during an emergency response creates a sort of functional humanitarian practice that can even question the Western humanitarian model. But still, no dramatic changes take place at the level of policy. There is no systematic incorporation of this localised “pragmatism”. Is it maybe that this type of knowledge does not pass the validation mechanisms of the humanitarian system?

Knowledge and Power in Humanitarian Practice

It is in the understanding of which practices and knowledge are dominant in a relief intervention, and which subordinate, that an analysis of the real power effects that relief interventions produce should be grounded. Life-saving humanitarian aid is based on Western medical practice. The Western positivist approach to evidence-based medical knowledge is considered for many as the only valid epistemic voice of medicine. But even in the practice of modern medicine Malterud found deficits of knowledge: a gap between theory and practice. In her article, she claims that “[c]onstructing the narrative from patients stories cannot be transformed to biomedical variables.” Scientific medicine deals with diseases and pretends to describe human illness in terms of objective, universal facts, missing the interaction and interpretation of the encounter with patients as individuals in specific contexts and realities.

During a medical relief operation, this conception of medicine may face other understandings of science and systems of knowledge, as well as dissimilar response protocols and appreciations of disease, health and cure in the created humanitarian arena.
Postcolonial theorists Said,\textsuperscript{190} Bhabha\textsuperscript{191} and Spivak\textsuperscript{192} studied the colonial discourse and the production of knowledge about the Other.\textsuperscript{193} Taken from Said’s elaboration on Orientalism,\textsuperscript{194} Othering (drawing on Foucault and Gramsci) can be defined as the process of construction of dichotomy between oneself, in this case marked by a positive, civilised, rational, disciplined and superior Western identity\textsuperscript{195} and the Other. Said explains, “Orientalism was ultimately a political vision of reality whose structure promoted the difference between the familiar (Europe, the West, “us”) and the strange (the Orient, the East, “them”). This vision in a sense created and then served the two worlds thus conceived. Orientals lived in their world; “we” lived in ours. The vision and material reality propped each other up, kept each other going.”\textsuperscript{196}

This kind of knowledge production about the Other is valid in humanitarian aid. The constructed identity of the Other humanitarians have as dependent on the ‘us’ (the West) can be explained by the notion of subaltern that Gramsci elaborated and later on Spivak\textsuperscript{197} expanded. She argues that “subalterns cannot speak,” not just because they do not have the possibility to do so, but because they are not able to articulate their interests. As previously mentioned, humanitarians become spokespersons for those who are deprived of public expression, they have the “legitimacy” that allows them to shed light on the hardships these populations go through as a consequence of injustice, famine and war. As Spivak\textsuperscript{198} did in her work, it is relevant to analyse the conditions and obstacles of subaltern representation. Said\textsuperscript{199} also remarked that Othering refers to the act of emphasising the perceived weaknesses of marginalised groups as a way of stressing the alleged strength of those in positions of power. As Sardar\textsuperscript{200} explains,

knowledge is a form of power. It gives authority to possessors of knowledge, and dominant knowledges close off spaces for the articulation of alternative knowledge forms. Knowledge has been, and to large extent still is, controlled and produced in the North…the real power of the North lies…in its power to name, represent and theorize.

\textsuperscript{191} Bhabha, H., 1994.
\textsuperscript{192} Spivak, G., 1988.
\textsuperscript{194} Said, E., 1978.
\textsuperscript{195} Hall S. The Spectacle of the Other. Discourse Theory and Practice: A Reader 2001.
\textsuperscript{196} Said, E., 1978: 43-44.
\textsuperscript{197} Spivak, G., 1988: 104.
\textsuperscript{198} Spivak, G., 1988.
\textsuperscript{199} Said, E., 1978.
In line with this reasoning, Aronsson argues that there is “an asymmetrical power relation between Western knowledge and other forms of knowledge.” When this unbalanced association is operationalised, Western knowledge is the one that guides humanitarian operations. She explains how local knowledge is marginalised, stereotyped and sometimes romanticised or patronised (ibid). In order to avoid this haunting of local knowledge, Aronsson proposes to treat “the knowledge produced in local participation as any other knowledge and put it in the main narrative of knowledge production.” She stresses the importance of the impact of the application of such knowledge in the project outcomes. Her ethnocentric, results-oriented argument takes for granted the fact that the Western scientific model is the one to follow and other forms of knowledge need to be questioned, scrutinised, certified, and applied to meet the goals defined by that approach. The asymmetrical power relation she critically recognises in humanitarian aid also transpires in her writing. But maybe in practical terms this position could represent a starting point towards change.

For Foucault, not only is knowledge always a form of power, but power is implicated in the questions of whether, in what circumstances and by whom knowledge is to be applied or not. Nevertheless, he remarks, the exercise of power is not always negative, it also “creates and causes to emerge new objects of knowledge and accumulates new bodies of information.” What matters in reality, he claims, is the effect that power has on our environment and behaviour. For Foucault, power can only be exercised; it cannot be possessed. Power is a field of force that exists within social realms, as in human sciences. He stresses the importance of focusing in the processes by which subjects are constituted as effects of power rather than in the motivation of particular groups in the exercise of domination. Scientific discourses, according to Foucault, produce power effects by dividing the totality of Man into distinct ‘subject-domains’. Once alienated, these domains become objects for the elaboration of scientific ‘knowledge’ and targets of intervention for institutional practices. In his work, Foucault is concerned with the moment these

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204 Foucault, M., 1980.
domains become subject of scientific knowledge, in relation to the social technologies that flourish to regulate and control them, what he defines as bio-power.  

Rabinow, cited in Hendrie explains that it was in the eighteenth century when

\[\text{[f]or the first time in history, no doubt, biological existence was reflected in political existence…life and its mechanisms [were brought] into the realm of explicit calculations…A proliferation of technologies ensued [concerning] the body, health, modes of subsistence and habitation, living conditions…Methods of power and knowledge assumed responsibility for life processes, and undertook to control and modify them.}\]

Foucault established a parallel between bio-power and the birth of human sciences during the nineteenth century. Human sciences reflect a tendency for normalisation and account for the division between what is considered ‘normal’ and ‘pathological.’ They serve to categorise behaviours, thoughts and desires along an unusual to desirable continuum and develop a body of knowledge, which promotes the establishment of comparative norms, designed to manage individuals, understand their desires and predict their behaviours. This body of knowledge yields expert discourses that are appropriated by health professionals. As a result of their scientific knowledge, health professionals are granted authority over patients by the state; they set up the priorities in the medical field. This translates as well in how Western medical humanitarian actors define emergencies and how to respond to them.

Barbara Hendrie’s article that draws on the work of David Keen in famine and relief in south-western Sudan in the 1980s examines the forms of power in the humanitarian medical response to the famine in Ethiopia in 1984 in refugee camps in south-east Sudan. Both authors apply Foucault’s work in their case studies, examining the exercise of power ‘concretely and in detail’ at different levels. They explore how the dominance of the ‘seemingly benevolent official’ Western discourse on famine –a disaster event, manifest in starvation– and how to respond to it –primarily save lives and secondarily restart food production– contributed to define the forms that power assumed, by prioritising certain kinds of knowledge and the application of certain kinds of

\begin{itemize}
  \item Hendrie, 1997.
  \item Hendrie B., 1997:69.
  \item Foucault, M., 1980.
  \item Hendrie B. Knowledge and power: a critique of an international relief operation. Disasters, 1997 Mar; 21(1):57–76.
\end{itemize}
institutional practices, and bracketing out alternatives.\textsuperscript{213}

In this case, famine is ‘alienated’, in Foucault’s terms, as a subject of scientific knowledge, and historically-specific and locally-based processes of famine are ‘bracketed out’–for Duffield\textsuperscript{214} ‘functional ignorance’\textsuperscript{215}– not compromising the worthiness of the aid response and its ‘untouchable’ humanitarian goals. Famine is regulated and controlled by humanitarian institutions that approach the refugees as ‘victims’ with no agency. This conceptualisation and de-contextualisation in the case of Tigrayan refugees in eastern Sudan, “led to a failure to anticipate a large-scale repatriation movement, and no provision of rehabilitation necessities to households returning to their land.”\textsuperscript{216}

Beristain\textsuperscript{217} asserts that Western biomedical protocols need to be adapted to local circumstances. He affirms that situations that require immediate action represent a challenging ambiguity for Western medicine practitioners. They are faced with the call to respond to individual, community and societal needs balancing theoretically sound approaches with meaning systems and customary practices different from their own. However, this analysis does not take into account pre-existing power relations. When faced with a natural hazard or man-made disaster that causes a crisis, medical humanitarian organisations are almost faced with the compelling moral pressure to ‘do something.’\textsuperscript{218}

What to do is debatable and depends on the discursive construction of the idea of that particular crisis, and the way in which a precise discourse about the crisis may be linked to the domination of certain kinds of knowledge and the proliferation of certain kinds of institutional practices. Humanitarian medical discourses, as part of Western medicine, as Malterud\textsuperscript{219} and Hendrie\textsuperscript{220} argue, focus mostly on the biological manifestations of the crisis, paying unconsidered attention to the specificity of the context in which it develops and the means by which it progresses. Once institutional procedures –for the different

\textsuperscript{213} Hendrie B.,1997: 58.
\textsuperscript{215} Duffield, M., 1996. He explains: ‘[b]y focusing criticism on relief activity while eschewing analysis of the crisis, complex situations are depoliticised and presented as technical issues. While it is acknowledged that aid agencies often contain perceptive individuals, in organisational terms this situation is tantamount to a condition of functional ignorance. It is increasingly evident that the aid technocracy is structurally incapable of understanding the situations in which it works. This ignorance, however, is functional. As argued above, it is the means by whereby organisational power is made manifest and unaccountable (Duffield 1996: pp. 189).
\textsuperscript{216} Hendrie B.,1997: 74.
\textsuperscript{219} Malterud, K., 1995.
\textsuperscript{220} Hendrie B.,1997.
types of medical crisis—establish their legitimacy as mechanisms for saving lives, they can be applied to any situation where the same type of crisis occurs. As Malterud\textsuperscript{221} and Helman\textsuperscript{222} explained, Western medicine deals with diseases. In medical terms, this is the logical framework that surrounds the creation of tools to be applied to humanitarian responses. A certain disease causes pre-established medical conditions that need to be handled according to biomedical protocols. In the same line, the consequential needs other types of crises provoke on people are predetermined as well. In this way humanitarian practices are standardised, based on those identified needs that are generalised.

Power analysis applied in a medical ‘humanitarian arena’ may contribute to identify ‘new bodies of information’ generated by the encounter of diverse knowledge systems. The analysis distinct the weight each actor has in the deployment of the response according to the power they exercise. Furthermore, a question to pose is whether this newly generated ‘local’ knowledge will transcend borders and be incorporated to an international body of knowledge to improve humanitarian missions. Is participation viable in humanitarian responses? Authors argue that Western agencies are often inflexible and unwilling to learn from potentially more effective non-Western approaches.\textsuperscript{223}

\textit{Meeting Standards = Being Accountable}

As Hendrie’s example clearly shows, emergencies are approached by humanitarians as events, alienated as subjects of knowledge from their specific contexts, and susceptible to the application of standardised practices designed to save as many lives as possible. One of the initiatives aiming to improve the performance of the system after the failure in Rwanda was the creation of the Sphere project. Critiques of the Sphere project are mainly related to the relation between standards and context, where relief agencies programme their work based on technical aspects rather than on social realities.\textsuperscript{224} The people in need have no voice, as Sphere presumes that bodily needs have little variation from place to place. It is more important to have the advice of Western professionals and experts that could talk for them and express what they really need.\textsuperscript{225} This homogenisation produces a set of models,

\textsuperscript{221} Malterud, K., 1995.
\textsuperscript{222} Helman, C., 1984.
guidelines and kits – i.e. Ebola kit, or hygiene kit – in order, mainly, to speed up the aid delivery in the exceptional time of the emergency, and to facilitate and professionalise the work of humanitarians.

Kits are groups of items prepared ahead of aid responses that contain what experts in the different fields consider essential to have on the ground when responding to emergencies. They started with medical and logistic material, to facilitate the work in medical emergencies. A perfect example is the Viral Haemorrhagic Fever (VHF) – Ebola – kit composed of different modules, which allow a team to start activities to manage an outbreak for two weeks. The kit can be ordered in total or by different modules, according to the needs. The material included covers the set-up of an isolation unit\textsuperscript{226}, outreach activities, surveillance and management of suspected, confirmed and deceased cases.\textsuperscript{227} The use of this Ebola kit makes the work of humanitarians easy. With a simple code the order is placed from the field to be processed and dispatched from the logistics centre without any discussion about content or quantities, avoiding time loss. Later on, kits were expanded to distribution items, i.e. support kits, shelter kits, cooking sets, hygiene kits. Many problems arise with the distribution of these kits, as the items they contain are standard. More often than not they do not fulfil the dissimilar needs of human beings living in different areas of the world, with diverse climate conditions, environments and habits. If the response to Ebola is analysed as treating a disease that provokes a medical condition, the standard kit approach works fine and suits the purpose of a quick response. On the contrary, if the analysis focuses on treating people affected by the disease, other elements need to be included in the planning and implementation of the response. Placing people at the centre of analysis and gaining knowledge of locality, specificity of context, social and cultural aspects, just to name a few, is essential to better understand where and how these affected individuals – addressed as “target population” in humanitarian terms – as social beings, live their daily lives. Acknowledging the forces and structures that influence their behaviour and decision-making, as in seeking health care for instance, is crucial to plan and deploy a contextualised relief programme that people could relate to and easily access. The contribution of using anthropology’s tools to this aspect is evident, given the nature of the discipline.

\textsuperscript{226} Isolation units are the places where sick people with EVD are taken care of, separated from people who are not sick.
\textsuperscript{227} See MSF KIT, VIRAL HAEMORRHAGIC FEVER 1 team/15d.
For some humanitarian analysts, meeting the standards translates into being accountable.\textsuperscript{228} As Derderian\textsuperscript{229} indicates in her article in HAP, recent research and initiatives of donors, practitioners, and analysts point to the failure in reaching these long-established standards. Walker and Russ\textsuperscript{230} argue that professionalism within the sector arises as a way to ensure standards. A group of scholars and policy-makers\textsuperscript{231} are pushing to establish an international professional apparatus to promote the quality and integrity of this workforce. They point to the creation of an association, to develop core competencies and to create a universal certification system for aid workers.

A study commissioned by ELRHA\textsuperscript{232} conducted by Walker and Russ\textsuperscript{233} evaluates professionalisation in humanitarian aid as training for humanitarian workers. The study, where 1500+ humanitarian workers were consulted, showed that more than 90% of them considered the professionalisation of the humanitarian sector as something positive, that would contribute to enhance the quality of humanitarian assistance. The problems encountered by the paper point to the lack of coordination and cohesion between the standards, training courses, and investment that are on offer, framed by a gap in the understanding of the (Western) humanitarian sector as a whole: the number of humanitarian workers is unknown. The report claims that the professionalisation of the sector can bring benefits to both receivers and providers of aid. However, there are limits to how far these benefits can be taken. Local affected people do not take part in this exercise. Humanitarian workers would be “professionalised” according to policies and rules set by the powerful Western aid system, from the top down.

Furthermore, the professionalisation of humanitarian aid is highly debated in the humanitarian world. Scholars such as Hopgood\textsuperscript{234} predict the imminent arrival of the logistics expert US company Wal-Mart for operations in humanitarian missions. He claims

\begin{footnotesize}
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\item[228] The 2010 HAP Standard in Accountability and Quality Management. 2010.
\item[232] ELRHA, enhancing learning & research for humanitarian assistance is a collaborative network dedicated to supporting partnerships between higher education institutions in the UK and humanitarian organisations and partners around the world.
\end{itemize}
\end{footnotesize}
that although they provide an effective service in terms of speed and volume, outsourcing to private companies in humanitarian aid “means confronting stark trade-offs between lives saved and the ethics of emergency relief and protection.” In the era of globalisation, the growth of the sector and neoliberalism has opened the door to professional private firms and the logic of business into the humanitarian arena. In that sense, it means subcontracting private companies that specialise in certain aspects of relief operations in order to maximise the outcome. In the example of Wal-Mart logistics, it would mean to deliver relief goods to more people and faster. The author questions where the disinterested motivation, philanthropic and compassionate aspects, as well as the particular operating procedures and non-substitutable ends of the humanitarian endeavour –by discourse– stand in this case. In line with Hopgood’s argument, Fiona Terry\(^{235}\) suggests

if humanitarian action has been reduced to a logistical exercise, better to contract a supermarket chain to deliver aid with the protection of DSL (Defence Systems Limited) and at least avoid the humanitarian pretence.

On the practitioners’ side, there are mixed opinions, as positive aspects of professionalisation and standardisation are recognised, but at the same time, a certain caution is applied. For Bernard Kouchner,\(^{236}\) in agreement with Hopgood point regarding the values of humanitarian work, volunteerism should remain untouchable, to avoid becoming ‘bureaucrats of charity’. Nevertheless, reality shows that in the professionalised humanitarian system of today, the use of the word volunteerism to refer to the work humanitarians do is more an ornament statement than a real intention, even for Mr. Kouchner himself. Big agencies and INGOs –like ICRC, MSF, UNICEF and Oxfam– hire highly qualified personnel to work in their programmes.

Professionalism, according to Rony Brauman,\(^{237}\) improves humanitarian action effectiveness, and at the same time reduces proximity to technique and creates greater distance between the giver and the receiver. It is clear that professional skills –i.e. medical, water engineering and architecture– equip humanitarian workers with the aptitudes to respond to crises. What Brauman\(^{238}\) refers to as creating distance between givers and receivers, is the increase in bureaucracy professionalisation implies. Accountability to donors, as part of the professionalisation package, demands the writing of reports, data

\(^{237}\) Brauman, R., 2004
\(^{238}\) Brauman, R., 2004.
collection, and preparation of presentations, all tasks that demand time for their creation. This distribution of time means less informal interactions with local groups. This has a direct impact in the legitimacy of the organisation in the place where they operate and the security of its workers. The less aid workers are exposed to the different actors present in the emergency response, the greater the mistrust and questioning of their presence in the crisis area. Certainly in medical responses data collection provides the ground for an evidence-based evaluation of practice and its corresponding improvement, at least in pure medical practice terms. The literature presents no answer to the question how is professionalisation improving the response in real terms from the perspective of the said “beneficiaries”?

In addition, the search for accountability has decisively contributed to processes of professionalisation and standardisation that go beyond the logic of “homogenisation and universalism”, embedded in a discourse of rights. In fact, new examples of standardisation such as the “Sphere” project allude to rights and duties when establishing “minimal requirements” in the assistance of populations in crisis independently of their context, origin and background. Criticisms of the Sphere project are mainly related to the relation between standards and context, where relief agencies programme their work based on technical aspects rather than on social realities. Compliance with the standards is measured through programme evaluation. According to Bradt\textsuperscript{239} humanitarians apply different approaches to evaluation, like the scientific (relying on quantitative measures), the deductive (relying on anthropological and socio-economic methods) and the participatory (relaying on the views of programme beneficiaries). The aim of evaluating is to generate knowledge that will contribute to reorient humanitarian practice in light of its findings.

**Humanitarian Organisational Learning**

Regarding the absorption of knowledge by the humanitarian system, Ramalingam et al\textsuperscript{240} argue that there is a main emphasis put on the institutional resilience of humanitarian organisations and agencies in the way in which the analysis of the response preparedness and execution is being carried out. In order to better comprehend the way humanitarians relate to their environment, the meaning of the language the humanitarian system uses in their discourse will be unpacked through three dimensions: time, space, and operations.


Linguists and anthropologists\textsuperscript{241,242} argue that language—and the words that constitute it—have a direct link to the way we perceive the world. The approach Western humanitarianism has to relief sets up operational priorities and modalities. According to Donini\textsuperscript{243} the Western humanitarian movement “constitutes the dominant, multi-billion dollar, visible face of humanitarianism. It dictates the language and the rules of the game of humanitarian action.”

Many are the disciplines of human sciences that are interested and influenced by the study of language—i.e. linguistics, anthropology, philosophy, sociology and psychology. Linguist Ferdinand De Saussure\textsuperscript{244} and symbolic anthropologist David Schneider\textsuperscript{245} coincide in the argument that it is relevant to study the words and meanings that represent things or symbols, and not the symbols alone. Schneider\textsuperscript{246} defines language as

a system of symbols and meanings… Insofar as a word is the name for something, and insofar as the word names—among many other things—a cultural unit or construct, one might conclude that culture consists of the language; that is the vocabulary, grammar, and syntax, or the words and their definitions and their relationships to each other.

Harris\textsuperscript{247} affirms that language is no longer regarded as peripheral to our grasp of the world we live in, but as central to it. Words are not mere vocal labels or communicational adjuncts superimposed upon an already given order of things. They are collective products of social interaction, essential instruments through which human beings constitute and articulate their world. Furthermore, Boroditsky\textsuperscript{248} works on establishing how different languages might impart distinct cognitive abilities. She claims that empirical evidence for this causal relation has recently emerged indicating that one’s mother tongue does shape “even the most fundamental dimensions of human experience: space, time, causality and relationships to others.”\textsuperscript{249}

Therefore, introspection into the humanitarian language may contribute to an understanding of the Western humanitarian approach to operations. How do Westerners

\textsuperscript{241} De Saussure, F., \textit{Cours de linguistique générale}, ed. C. Bally and A. Sechehaye, with the collaboration of A. Riedlinger, Lausanne and Paris: Payot;1916.
\textsuperscript{242} Schneider D. \textit{American Kinship: A Cultural Account}. Chicago; London: The University of Chicago Press; 1968.
\textsuperscript{244} De Saussure, F., 1916.
\textsuperscript{245} Schneider, D., 1968.
\textsuperscript{246} Schneider, D., 1968:3.
\textsuperscript{249} Boroditsky, L., 2011:64.
view humanitarian operations? The starting point of this analysis is the very definition of humanitarian assistance. The literature consulted shows that there is not one characterisation of humanitarian aid. Nevertheless, certain words –or concepts– are common to diverse definitions. This study uses the critical analysis of the definition by Hilhorst and Jansen. They describe Western humanitarian assistance as loyal to the humanitarian principles of neutrality, independence, humanity and impartiality; it provides life-saving temporal help to all human beings based on their immediate needs after an emergency. This particular identity of the discourse intends to “separat[e] humanitarian action from its contextual politicised environment” in the bi-dimensional framework of the humanitarian space of aid givers and receivers (or victims). From this conceptualisation, there are three dimensions that are of particular interest for this work. The first dimension is time. Related to this aspect, the element to scrutinise is the characteristic of temporal assistance humanitarians provide to the immediate needs of people affected by an emergency. The second dimension is space, defined by the location where this action takes place, in the created humanitarian space of aid providers and victims. Finally, the operational modality the system adopts is the third dimension this study aims to investigate. Within the Western aid system, different organisations have distinct priorities, according to their mandate and raison d’être. They manipulate the definition to fit their particular case and set up operational priorities.

Distinctive interest groups in the international humanitarian system have a definition of their own for the common language even if they stem from a common vision of aid. On the practitioner and policy-maker side, different actors adapt the explanation of the nomenclature according to its application in particular sectors (i.e. donors, refugees, migration, protection of civilians, disasters, International Humanitarian Law (IHL)). By doing this, different humanitarian actors intend to agree in common terms for their specific sector in order to facilitate dialogue, coordination of practical work, evaluation and reporting among its members. On the academic side, scholars elaborate broader definitions of various humanitarian terms, universities create their own vocabulary in different

scientific disciplines and thinktanks contribute to the explanation of humanitarian language.253

Most of these technical definitions leave no room for the aid recipients’ characterisation of humanitarian language. This has relevant consequences, mainly in the practice of humanitarianism. More often than not, concepts are unlikely perceived at the two ends of the aid delivery chain (the providers’ and recipients’ sides), which translates in a different picture of the event by both parts. When an international humanitarian relief operation is launched, along with it comes a set of labels and assumptions that define the situation aid providers are responding to, only in terms of the international humanitarian system.260 Social sciences research input feeds humanitarian aid actors’ reflections on the elements of their discourse, consequently having a certain effect in how they will approach them in practice. Meredith261 mentions as an example how academics called for a better understanding of the term *victim*, questioning its assumed comprehension in the humanitarian world. Research and literature on the topic have shed light on the unfixed nature of the signifier *victim*, discussing its different uses as an identity or status […] promot[ing] an informal but critical, and therefore engaged but cautious, reading of discourses about *victims* […] help[ing] to understand the dynamics of social relations and identify some of the stakes involved, as well as the groups or individuals who either defend and claim the victim identity for themselves, reject it, or attribute it to others.262 She asserts that this information has acquainted the ICRC –at different levels– of the care required when using the term. At the same time, by applying this insight, the aid worker could see “beyond the *victim* label and recognise other identities projected by a person, such as *teacher, community leader or parent*.”263 This is just an example that illustrates how humanitarians –especially practitioners– are sometimes keen to incorporate relevant knowledge contributed by scholars in order to be more effective in their work.

259 OECD. *Glossary of Key Terms in Evaluation and Results Based Management*, 2002.
262 Meredith, VM., 2009:264.
263 Meredith, VM., 2009:265.
In the last fifteen years, aid workers have started to gain interest and realise the need for social science research in humanitarian aid.\textsuperscript{264} Many are the critics of humanitarian operations failures in disasters with numerous actors and several crises.\textsuperscript{265} The environmental changes occurring at that time demanded deep analysis and strategic change in the way humanitarian relief was operating. Even so, scholars recognise that the humanitarian system is not very good at taking action to reform itself despite it openly accepting criticisms.\textsuperscript{266}

Ramalingam et al.\textsuperscript{267} argue that organisations have their own mandates –self-imposed definitions of the kind of assistance they provide– which determines the lens through which they see humanitarian aid.\textsuperscript{268} It is difficult to acknowledge the needs of people from a holistic perspective while they are searching for the ones that meet their competences. This limits the focus to an internal view of the capacities needed to respond. Lessons learned from previous experiences often result in recommendations to adapt technical practices to meet the new demands. Post-evaluations are error correction targeted, evaluating how well, or otherwise, the event was dealt with. This single-loop\textsuperscript{269} learning is practitioner focused and detects deviations from the standards, it does not seek to generate new and different ways of operating or evaluate the adapting capacity to changing environments. As Einstein states in his quote at the beginning of this document, “no problem can be solved from the same level of consciousness that created it...” How to trigger change in the approach humanitarians have to the work they do? If the way they understand their self (the giver) and the Other (the receiver) transforms, most probably there will be changes at all levels. The root of the problem, Hoffman and Weiss\textsuperscript{270} argue, is that

\textsuperscript{268} For details on the different types of aid organisations please see the section: An Introspective: Acknowledging the Current Status of the Humanitarian System on p. 29.
humanitarian agencies are learning disabled – they do not possess the capabilities or cultural inclination to process information, correct errors, and devise alternative strategies and tactics. This can ingrain simplistic and misconceived policies.

Nevertheless, Slim\textsuperscript{271} argues that it is less about policy, but more about practice. Organisations and agencies may have excellent policies on file, which they never incorporate into practice. The case study presented in the second part of this study clearly shows that even though changes in policy take place as a consequence of practice, this does not imply that the policy will be respected in following applications.

As Argyris\textsuperscript{272} explains in their business model of organisational learning, the double-loop learning reflects on the organisation’s policies, practices and norms in order to re-design processes, products and methods to create new ways of doing things, responding to changing contexts. But still, these changes occur framed within the historic-philosophical identity of the Western humanitarian system, the same level of consciousness. The most complex form of gaining knowledge is the triple-loop learning that questions the whole rationale of an organisation, its structure, culture and practices. This is the type of learning that brings about thorough transformations.\textsuperscript{273,274} Figure 1.1 graphically describes the three levels of learning.

**FIG 1.1 THE THREE LEVELS OF ORGANISATIONAL LEARNING**


\textsuperscript{271} Slim, H., 2006.
Scholars in general focus on elaborating on functional aspects of the humanitarian enterprise. For instance, there are certain authors\textsuperscript{275,276,277} who agree that best practice is based on evidence, especially for certain disciplines. There is an intention within certain sectors of the humanitarian community to develop an evidence-based humanitarian aid.\textsuperscript{278} “The hypotheses and conceptual models of what happens in a crisis are still far too poorly developed to allow us to be truly evidence based”, asserts Peter Walker.\textsuperscript{279} Medicine had the same problem, he explains, until Archie Cochrane’s 1972 book *Effectiveness and Efficiency: Random Reflections on Health Services*, captured the massive change in approach, which now dominates medicine.\textsuperscript{280} It was in September 2011 that the Cochrane Collaboration organised the first Evidence Aid Conference, where issues like the need for evidence in disaster response, the measurements of indicators in humanitarian emergencies, and the availability and quality of data in disasters were discussed.\textsuperscript{281} For Walker, humanitarians are not clear yet about what to measure, to diagnose, and proscribe in a crisis, as they do not know how to fully interpret these measurements and learn from the evidence. “Humanitarian assistance needs its own evidence-based revolution.”\textsuperscript{282} Bradt\textsuperscript{283} refers to important queries in humanitarian aid that are not testable in the evidence-based science format. He recalls issues related to security, the needs and conditions of the receptors of aid and the reasons for programme failure as not easily manageable within evidence-based systems, “it is impossible to calculate the magnitude of unmet need.”\textsuperscript{284} Nevertheless, he suggests a way to cure that problem, if “progress towards minimum (Sphere) standards is quantitatively addressed.” That seems like an easy to reach solution, as meeting the standards –defined by humanitarians themselves– means to meet the needs of populations. Nevertheless, there might be other unmet needs, but as they are not known by humanitarians, they do not take part in their checklists. As Kennedy\textsuperscript{285} 

\textsuperscript{278}http://www.alnap.org/what-we-do/evidence
\textsuperscript{279}Walker, P., 2009.
\textsuperscript{280}Walker, P., 2009.
\textsuperscript{283}Bradt D., 2009.
\textsuperscript{284}Bradt,D.,2009: 14.
\textsuperscript{285}Kennedy, D., 2004:xxiii.
affirms “[t]he desire to work from expertise can lead us to underestimate what expertise cannot tell us – or to mistake ideological preferences for shrewd hunches about best practice.” The Sphere handbook states that it “do[es] not provide guidance as to how to implement a specific activity.” On the other hand, there are also structural characteristics of the humanitarian system that constrain the application of evidence-based decision-making. For instance, contrary to medicine, the tendency in humanitarian aid is to depend on personal judgements –eminence-based– over evidence-based judgements. This aspect is linked to the high turnover of field staff within the system. When people leave from missions they take with them their experience and knowledge. In addition, it is extremely difficult to generalise the evidence-based lessons learned and arrive to overarching conclusions given the intricacy of humanitarian emergencies. Despite evidence informs the process, all these setbacks show that evidence-based decision-making may not ensure the success of the project.

When providing humanitarian medicine, it is important to take into account the way in which the programme is delivered, as there might be specific localised needs –that may have to do with other aspects than the medical consequences of the crisis– to address in the different facets of the project. There are specific responses in which evaluations of the programme resulted in radical changes in the approach, planning, implementation of projects, and even in policy. The modification of the response to nutritional emergencies is an example of this.

Nutritional interventions normally consisted of general ration distribution to the whole of an affected population; blanket supplementary feeding to all members of an identified risk group; and targeted dry supplementary feeding centres for moderately malnourished and therapeutic feeding centres for the severely malnourished. In difficult contexts, many of the therapeutic feeding centres were hard to set up and did not achieve an adequate coverage of all the severely malnourished, translated in little overall impact on mortality. Scholars and humanitarian agents working in nutrition realised this approach

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287 Bradt D., 2009.
290 Bradt D., 2009.
was not fitting and was ineffective. Slowly and cautiously different organisations started to develop a new model to address this type of crisis. It took until 2007 for the UN through its agencies WHO, UNICEF, WFP and the UN system Standing Committee on Nutrition to publish a joint statement, based on evidence, regarding the benefits of a community-based approach to nutritional emergencies. The community-based approach involves timely detection and treatment of severe acute malnutrition in the community. The principles behind community-based therapeutic care develop public health integrated models, and create a continuum between emergency and development, a “holy grail” of humanitarianism. They empower communities to cope more effectively with crisis and with transition back to normality.

Some scholars conclude that the internal divisions and controversy are weaknesses that will affect the real capacity the humanitarian system has to face external challenges. An increasing humanitarian caseload, changes in the nature of crises, and a renewed assertiveness of host states as a result of increased resource scarcity, rising inequalities, economic and geopolitical shifts, the effects of population growth, climate change and the shifting nature of violence entail challenge for the present humanitarian system. Labbé and Hoffman and Weiss consider the finite financial resources, the believed universality of the Western enterprise, the importance given to standardisation and coordination and the difficulties in institutional learning in humanitarian agencies as other aspects of concern when looking at the future of the enterprise.

A Prospective: Jutting into the Future: Overcoming Weaknesses

Evaluations of humanitarian responses show that humanitarian action has been unsuccessful in fulfilling its mandate. The following three reasons repeated in all reports

293 Collins, S. Changing The Way We Address Severe Malnutrition During Famine. Lancet 2001; 3.
are linked to the premises mentioned in the previous sections. Firstly, the evaluations point at the lack of understanding of local contexts and cultures, secondly, the inability to establish communication channels with the affected communities, which thirdly translated into failure to recognise local capacities as a starting point to develop ownership of humanitarian responses. Some scholars and practitioners argue that the real key for future success in humanitarian operations is for humanitarian actors to be able to plan to context and to establish good communication channels on the ground and network. The professionalisation of the enterprise, as well as the development of standards and coordination humanitarians built up in the last decades is necessary. Notwithstanding, these improvements will only be effective if they meet certain criteria. Firstly, they have to be flexible and able to adapt to the changing context. Secondly, they must recognise the different actors present in the arena – and their capabilities to respond to the crisis in order to finally incorporate the different approaches to the response into a combined effort.

Some scholars argue there is a need to (re)shape the operational methodology through innovation. In their technocratic approach, technology is considered as a critical element that is already changing the way humanitarian aid is being delivered and the level of participation of the affected (i.e. the use of social networking or cash transfer programmes as part of relief). Yet, they stress that the social context where technology is applied matters, and if one does not understand it, the use of technology may have a counterproductive effect. To illustrate this statement, Walker uses the example of the Pakistan earthquake of 2005. In order to deliver much needed cash to the affected, the money was distributed in the form of 300 US dollar prepaid cards to be cashed in the cashpoints installed in the camps. The cultural context in Pakistan, he explains, is rather difficult for women and children. In the patriarchal system of the country women are not allowed to receive cash cards, they are given to men. Women need to control the household economy because they are the ones who buy the food. By taking this power

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301 Innovation: Modern innovations theory derives from early twentieth-century capitalism, based on individual firms aiming to develop new products through investment in research and development (R&D), or exploit new markets. Innovation involves three main challenges: (i) ensuring the capacity for potential users to recognise innovation; (ii) fostering organisational adaptiveness and agility to incorporate innovation into organisational processes and outputs; and (iii) sensitivity to the culture and context of those partners and beneficiaries who might be affected by innovations. in Humanitarian Futures Programme, http://www.humanitarianfutures.org/tools/key-definitions, last accessed 13 November 2014.
over consumption away from women, the humanitarian response rendered women more vulnerable and reinforced the male dominating system.

Concretely, at the level of MSF, there seems to be recognition of the need to address the issues of contextualisation and community participation. The 2014-2017 operational strategy of MSF Spain points at exploring “alternative approaches including community involvement and better interaction with the population.” Furthermore, certain actions demonstrate that this seems to be a tendency in the MSF movement. For instance, all operational sections of MSF (Brussels, Paris, Amsterdam, Geneva and Spain) have a position created to specifically work in the social aspects of humanitarian missions. Depending on which section, it ranges from a more medicalised “patient education” perspective to a “community-based model of intervention” approach. The intention is there, and the opportunity is huge. Still, there is a lot of work to be done, mainly internally, to bring about real change in the way humanitarians think of emergencies and respond to them. One of the big areas the organisation is investing in is operational research, exploring alternative models of intervention for medical humanitarian aid. These investigations delve into the socio-cultural aspects of the affected and of relief itself. There seems to be openness for the inclusion of social scientists within the organisation.

Conclusion
This section described how fundamental moments in the history of humanity as well as geo-political realities shaped –and are shaping– the international humanitarian system in discourse and practice. Despite considered to be universal, the grandiloquent ethical humanitarian discourse proved to be a one-sided discourse. From its origins stemming from European ideals and interests rooted in nineteenth century Christian charitable ethics, humanitarianism was aimed to help victims of conflict in European territories. This was the cradle of Western humanitarianism, as we understand it today: an activity regulated through rules and frameworks, provided by specialised institutions. These organisations worked interconnected with scientific technical domains such as medicine, public health, hygiene and engineering, rather than with human and social sciences. This humanitarian aid emerged to be deployed in the Western world during the specific period of the expansion of industrial warfare. Indeed, in the first half of its history, Westerners and close neighbours were the only beneficiaries. Humanitarianism was a European enterprise.

An “unconscious ethnocentrism” in the words of Benthall\textsuperscript{305} and McEwan,\textsuperscript{306} better say a “fully assumed sense of superiority”\textsuperscript{307}, or lack of attention to cultural diversity manifested soon after the creation of the Red Cross in 1864. The use of the emblem was considered offensive to peoples who related it with, and did not share, European religious values. During the European colonisation period, humanitarian aid expanded its frontiers. In the form of missionary medicine –and hand in hand with anthropology– it was used as a tool to help in the conversion and governance of the conquered peoples. At this point there was recognition of the “other” and a clear need to understand local context and culture. But the intention was not to establish bidirectional communication channels nor empower the conquered. On the contrary, the information obtained and trust gained was to be used by the European colonisers to make informed decisions to ensure domination and control of the territories.

By the second half of the twentieth century, framed in the context of decolonisation, liberation struggles and the growth of the UN and “non-state actors” (NGOs) in the humanitarian arena, the humanitarian discourse developed to include Western concepts like human rights and social justice. Humanitarianism now was going beyond life-saving, targeting as well the deep causes of crises. It was during the Cold War period that private humanitarian NGOs proliferated. The “culture of the emergency”\textsuperscript{308} emerged, where the “sudden crises” defined by these actors, demanded an immediate response. These new actors knew no limits in sovereignty. This form of power continued to be exercised and multiplied by the media effect during the post-Cold War era. Humanitarian organisations and the media delineated operational priorities. At the same time, the UN Security Council authorised humanitarian interventions under the umbrella of a peace-security agenda. The continuous expansion and growth of the humanitarian system brought along an increased focus on the quality of humanitarian assistance. Evaluations performed on responses to major crises –i.e. Rwanda, the Indian Ocean tsunami– gave birth to organisational initiatives aimed to improve the \textit{performance of the system}. These processes were centred on standardising and professionalising the delivery of aid, always framed within a Western schema.

\textsuperscript{305} Benthall, J., 2007.
\textsuperscript{306} McEwan, C., 2009.
\textsuperscript{307} Prof. Bertrand Tahite, suggested the change in the term used. 16 February 2015.
\textsuperscript{308} Pandolfi, M., 2000, Clahoun, C., 2010.
The literature critically shows the limitations of a system that continuously fails to reflect and incorporate the complexity and diversity of global realities. Scholars argue that these limitations have a dramatic impact on the nature of humanitarian action. The use of the humanitarian imperative to attain other goals is a companion element in the history of Western relief. This is a key feature that links with the three recurrent reasons for failure evaluations describe. Humanitarian operations’ raison d’être is to assist people caught in crisis. Not placing the people undergoing those circumstances at the centre of analysis undermines the humanitarian mission. Locating other elements as priorities –like politics, economics, organisational mandates, or personal aspirations– has consequences in all facets and at all levels of the humanitarian mission.

At the macro level for instance, this is evident when the Security Council approves a humanitarian intervention. Some scholars define this type of assistance as war disguised in a help costume. At the meso level, the political economy of humanitarian aid shows how INGOs and aid agencies compete for survival and perpetuation. The humanitarian imperative is no longer the main drive that moves this gigantic, professionalised apparatus that makes operational decisions based on internal politics and economic realities. Finally, at the micro level, the motivations individuals have when they decide to become humanitarians may be completely different to the intention to reduce suffering. Ranging from humanitarian tourism, career path, thirst for adventure to guilt and shame, humanitarian workers –especially in field positions– have lost track of their mandate as humanitarians.

Nevertheless, this seems to be a good time for change. Starting from the micro level, the example of recent transformation inside a medical humanitarian INGO demonstrates that there is an opportunity. Personally, as part of the organisation, I will work towards this transformation, patiently accompanying the process, using the organisation’s own knowledge validation system to revolutionise the way emergencies are conceptualised and responded to. The following chapter narrates the case of the humanitarian response to Ebola Virus Disease outbreaks. The section shows how this process took place –and is still underway– and its consequences in the control of the epidemic.

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309 Fassin, D., Pandolfi, M., 2011.

The previous chapter presented a historical analysis of the construction of the Western humanitarian identity and how this character influences the way in which relief operations are carried out. The study connected the distinctiveness of the sector with the three recurrent failures evaluations describe. Their vision is guided by a series of principles and standards developed in the last century that set up operational priorities for medical humanitarian responses. The medical humanitarian aid sector –as part of the Western medical field– has precise conceptual frameworks based on positivist evidence-based practices of knowledge production and validation. Medical scientific knowledge, humanitarian charters, policy guidelines, protocols, and academic papers are some of the sources of formal knowledge that feed this medical and humanitarian discourse. In every medical humanitarian response this evidence-based knowledge and its practices encounter other actors, perceptions, realities and discourses based on diverse systems of knowledge. Failure to understand, communicate with and recognise the capacities of the local people, their context and culture, more often than not translates into making improper unilateral decisions about the implementation of the project. Consequently, these actions have a direct impact on the success of the humanitarian mission and on the lives of the affected people. In order to illustrate this process, this chapter presents a case study of the construction and response to EVD outbreaks. The question posed is if the three repeated failures of the humanitarian system are to be found in this particular case as well.

On 26 March 2014, the Guinean government was to declare what turned out to be the largest EVD outbreak in history. The first “index” case was traced back to December 2013. After one year, the disease had spread from the south of Guinea to Sierra Leone, Liberia, Nigeria, Senegal and Mali in Africa. Outside the African continent, there were cases in Spain, the United Kingdom, and the United States. As of 21 January 2015, official data estimates that 21,724 people have been infected and 8,641 have died as the situation continues uncontrolled.\textsuperscript{310} Never before had the EVD spread so widely and contaminated and killed as many people. Until now, these very lethal outbreaks were confined to remote rural areas with a small number of people. In these scenarios, the response led by the

Ministry of Health (MoH) of the affected country with the collaboration of a few international organisations –namely MSF, WHO and the CDC– would achieve total control of the epidemic within four to five months. The expertise in the management of EVD outbreaks leaned on these three organisations. In particular, there was only one organisation that had the knowledge of and expertise in the management of treatment centres and patients: MSF. Incurring in these activities demands the immediate availability of resources, including financial, human and material. MSF built this expertise in EVD driven by its identity as a medical humanitarian organisation and its financial independence. As part of their operational strategy, the organisation decided to allocate funds to have the capacity to quickly respond to this kind of emergencies. The spectrum of knowledgeable organisations capable to respond to EVD outbreaks is quite narrow; therefore the size of the response has limitations. What happened then with this particular epidemic? What makes it different from the others? Was the classic biomedical response protocol for EVD inappropriate? The current EVD epidemic flags the limitations of this expert knowledge. There is a ceiling in the capacity of these organisations to respond to these highly demanding outbreaks.

The section searches answers to these questions through the analysis of the frameworks behind the construction and the response to the epidemic. Two narratives frame the understanding of and reaction to epidemics at the distinct stages of the outbreak: the biomedical model and the cultural model. The section starts by introducing the humanitarian biomedical model, its scientific definitions and explanations of the disease, the modes of transmission as well as the response protocols. Following that, it explains the cultural model; the way people perceive the epidemic, the explanatory models of disease and the consequent response to those ideas. In order to analyse the community response to the outbreaks, this chapter relies on historical and anthropological investigations of responses to epidemics to identify shifts in the cultural models that influence and provoke behavioural change. The case study shows how powerful actors –i.e. governments and international organisations– mobilise the narratives in particular contexts to selectively justify lines of intervention and response. Furthermore, the case depicts how geographies and politics of blame around epidemics emerge and are justified, and at the same time feedback to shape the dynamics of the disease itself. Bringing together these distinct ways of knowing, an alternative framework to the understanding and response to EVD is proposed.
This section draws on empirical knowledge of EVD responses. Two reasons explain this choice. One is the intrinsic characteristic of relief work: action. The practice of humanitarian aid is activation of all theoretical considerations regarding humanitarianism. From the study of practice and the success or failure of variations to standards, conclusions and recommendations arise that may influence theoretical reflections on relief. The other reason is the personal experience of the researcher. As previously explained, I work with MSF, one of the international organisations that developed a practice of responding to these outbreaks. I have been working on viral haemorrhagic fever (VHF) outbreaks since 2006, when I worked in the Bundibugyo EVD outbreak in Uganda. Currently, I am involved in the West Africa EVD response and the personal narrative of this experience is shared as part of the case study. I have participated in the EVD response in Nigeria, Mali, Guinea and Sierra Leone. Applying Benthall’s critical constructive analysis while doing my work allowed for change to take place as the intervention unfolded. The time is right for change to occur, as it is the first time humanitarians face a situation like this. Up to the present time, no protocol has been created based on the biomedical model to respond to this particular kind of epidemic. Throughout my field missions, I was many times caught into Nockerts and Van Arsdale’s theory of obligation, doing what was materially possible and required by the situation while respecting the biomedical protocol. This generation of new knowledge was translated into practice on the spot. Nevertheless, this drop in the ocean is certainly not enough. Debates and dilemmas were, and still are, present in the arena. Discrepancies between medical practitioners on patient care as well as among implementing agencies regarding community participation in the response are common issues. This research shows how these current controversies impact the construction and the response to the outbreak, by standards of both models, as they unfold. The case study exposes the capacity of humanitarians to contextualise the response strategy at field level (single-loop learning). At the same time, it exposes the slow process of policy modification (double-loop learning) and the inability of the humanitarian apparatus to alter the logic of epidemics and adapt the response according to the development of events at practical level (triple-loop learning).

The Nobodies

Fleas dream of buying themselves a dog, and nobodies dream of escaping poverty: that one magical day, good luck will suddenly rain down on them – will rain down in buckets. But good luck doesn’t rain down, yesterday, today, tomorrow or ever. Good luck doesn’t even fall in a fine drizzle, no matter how hard the nobodies summon it, even if their left hand is tickling, or if they begin the new day on their right foot, or start the New Year with a change of brooms. The nobodies: nobody’s children, owners of nothing. The nobodies: the no-ones, the nobodied, running like rabbits, dying through life, screwed every which way.

Who are not, but could be.

Who don’t speak languages, but dialects.
Who don’t have religions, but superstitions.
Who don’t create art, but handicrafts.
Who don’t have culture, but folklore.
Who are not human beings, but human resources.
Who do not have faces, but arms.
Who do not have names, but numbers.
Who do not appear in the history of the world, but in the crime reports of the local paper.

The nobodies, who are not worth the bullet that kills them.

Eduardo Galeano
EVD Outbreaks Construction and Response: Biomedical Model

The approach humanitarian medicine has to outbreak diseases includes both an altruistic, international vision of care and a sense of urgency.\textsuperscript{313} The humanitarian component of the equation, by discourse, incorporates notions of good, evil and moral obligation.\textsuperscript{314} It operates in a global stage, with a high degree of mobility and scope, but at the same time with a minimalist understanding of “life” as its sense of welfare points at physical survival, not at any social fulfilment.\textsuperscript{315} Humanitarians do not address root causes of what Galtung\textsuperscript{316} calls \textit{social injustice or structural violence}. Maybe we can say their work provides at least a \textit{fine drizzle for the nobodies} in Galeano’s terms, although that statement could also be disputed, as the effects of aid depend on how this assistance is provided. The sense of urgency is a key factor that determines the way humanitarians work. In the case of outbreak response, the goal is to arrive on site as quickly as possible, with sufficient equipment to be effective. Certainly, the standardisation of aid and the creation of “kits” as seen in Chapter 1-- contribute to the endeavour. But, this is just a contribution, one component of a much more comprehensive effort. The mantra is simple, the faster they respond, the more lives would be saved. The medical aspect of humanitarian medicine is based on a Western evidence-based approach to health and illness. Scientific medicine deals with diseases. Therefore, the existent scientific knowledge of the EVD –i.e. reservoir, epidemiology, transmission modes and clinical features– sets the base for the creation of response protocols for outbreak control.

This section explores where biomedical responses to EVD outbreaks stand regarding the three failures evaluations describe as recurrent in humanitarian relief – namely, the lack of understanding of local contexts and cultures, the failure in establishing communication channels with the affected communities and the inability to recognise local capacities and develop ownership of the response. The section does so by critically presenting the case study of the current West Africa EVD outbreak outlined by the biomedical model.

**EVD Main Features**

EVD and Marburg haemorrhagic fever (MHF) are viruses of the family of the Filoviruses (thread-like).\textsuperscript{317} These viruses cause severe disease in human and non-human primates


\textsuperscript{314} For a fuller explanation of the humanitarian discourse, please see Chapter 1.

\textsuperscript{315} Redfield, 2008: p. 148.


\textsuperscript{317} MSF, 2008.
with a high case fatality rate (CFR) in humans ranging from 25% to 90% depending on the virus subtype and availability and nature of medical care. The current epidemic has sparked a heated debate regarding the impact of care in mortality rates depending on the level of care offered to patients. The statistics show that the CFR among EVD patients treated in their home countries in Europe and the US is 16%, while for the ones treated in West Africa it is 57–60%. According to practitioners on the ground (Dr. Paul Farmer from Partners in Health (PIH), Dr. Tim O’Dempsey from the Liverpool School of Tropical Medicine and Hygiene (LSTMH) and Dr. Morten Rostrup from MSF) the level of care provided for EVD patients in Africa is not enough. Dr. Farmer states that there is “no capacity to safely deliver excellent supportive care.” Further in the document, this burning issue will be developed, evaluating the possible relation between poor-quality care and people’s reluctance to go to the Ebola Treatment Centres (ETCs).

Despite its virulence, Ebola virus is regarded as a fragile organism. Scientific evidence from Sagripanti et al. Lytle and Sagripanti and Mitchell and McCormick shows that they do not live longer than a few days outside a body as well as having a high susceptibility to chlorine solutions and sunlight. So far, five species of EVD have been identified: Zaire ebolavirus, Bundibugyo ebolavirus, Tai Forest ebolavirus, Sudan ebolavirus and Reston ebolavirus. EVD was first detected in 1976 in North Zaire (currently the Democratic Republic of Congo (DRC)). It was a Belgian scientist (Peter Piot) who gave the name Ebola to the disease due to the proximity of the outbreak to the eponymous river. Since this first outbreak, between 1976 and 2012, the disease was confined to isolated rural areas in the Congo basin in Central Africa (see Fig 2.2).

Biography of EVD Outbreaks

Outbreaks caused by these viruses represent a major public health threat in sub-Saharan Africa, but at the same time they have affected a relatively small number of people until

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the ongoing EVD outbreak in West Africa (see Fig. 2.1). On 25 March 2014, the Guinean Ministry of Health (MoH) and the World Health Organization (WHO) reported the origin of what would turn out to be the largest EVD outbreak ever recorded in four south-eastern districts in Guinea: Gueckedou, Macenta, Nzerekore and Kissidougou. There are two remarkable aspects of the current EVD epidemic. First, the size of the outbreak by far surpasses the total number of cases reported in all previous EVD outbreaks combined (see Fig. 2.1).

**FIG. 2.1 DEMOGRAPHICS OF EVD OUTBREAKS**


Second, this is the first recorded EVD outbreak in Western Africa, marking a geographical shift from previous ones. Not only has the virus moved much further west, it has also shifted from rural areas to urban environments. Although scientific research on MHF and EVD was not extended until the last outbreak started, the possibility of occurrence of EVD in West Africa was already predicted. Peterson et al. used ecologic niche modelling of outbreaks and sporadic cases of filovirus haemorrhagic fever (FHF) to provide a large-

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325 [http://origin.glb.cdc.gov/mmwr/preview/mmwrhtml/mm6325a4.htm?_s_cid=mm6325a4_w](http://origin.glb.cdc.gov/mmwr/preview/mmwrhtml/mm6325a4.htm?_s_cid=mm6325a4_w), last accessed 24 February 2015.
scale perspective on the geographic and ecologic distributions of Ebola and Marburg viruses. Their research predicted that EVD would occur in the humid rainforests of central and western Africa. A meta data study conducted by Pigott et al\textsuperscript{127} after the current outbreak started has updated predictions about where in Africa wild animals may harbour the virus and where the transmission of the virus from these animals to humans is possible. Fig 2.2 shows the reported outbreaks of EVD from which the distribution model was forecast.

**Fig 2.2 Geographical EVD outbreaks distribution**


While information regarding the natural maintenance cycle or reservoir of the Marburg or Ebola virus is not yet certain, some studies identified some species of bat in tropical Africa as carriers.\textsuperscript{328} Pourrut et al\textsuperscript{329} collected 1,390 bats in Gabon and the Republic of Congo,


both in epidemic regions and in three regions where neither human outbreaks nor animal mortality due to EVD has been reported. Zaire Ebola virus IgG (antibody) was detected in 40 bats, distributed across all the study sites. The evidence presented thus far supports the idea that bats are probable natural hosts, and as well confirms Peterson et al.\textsuperscript{331} modelling, suggesting that there might be unrecognised outbreaks in unmonitored areas. In addition, an epidemiological study that determines the frequency and distribution of filovirus seroprevalence in certain human groups in Central African Republic carried out by Gonzalez et al.\textsuperscript{332} seem to demonstrate that Ebola viruses circulated in Africa between the 1500 isohyet north and south of the equator, which corresponds to the limits of the rain forest/forested savannah domain. The EBO virus strain from the Taï forest of Ivory Coast has been found in the same ecological zone as its most closely genetically related EBO-Zaire strain. The limited divergence between the two strains and their association within the same forested zone may suggest a common origin, since the Ivorian forested massif was at one time part of the Congolese rainforest from which it became separated during the last glaciation (16,000 years ago).

The evidence presented in these studies sets ground for a potential explanation to how the disease started in southern Guinea. Possibly, the Ebola virus was already present in the region where the outbreak took place (Guinée Forestière). Investigation results published by Baize et al.\textsuperscript{333} demonstrate that the causing agent of the current outbreak was identified as being, like the Tai Forest strain, a separate clade of the Zaire ebolavirus. Scientists are beginning to understand the different types of filoviruses and their geographic reach. Maybe what is being detected now is only a small fraction of events in which they cross over from animals to humans.\textsuperscript{334} More investigation needs to be carried out to understand the Guinea strain transmission patterns and behaviour. Is the unprecedented spread a consequence of a mutation of the virus?

Some practitioners\textsuperscript{335} think it might be due to the fact that it emerged in an area where people were unfamiliar with the disease and how to control it, facilitating its spread to

\textsuperscript{334} Pourrut, X. et al., 2007.
urban centres. For some analysts the reasons behind the scale of the disaster lie beyond scientific or cultural epidemiological discussions. This study draws attention to the narratives that construct the West Africa outbreak and proposes alternative explanations, linked to global and national political-economic inequalities, narratives of exploitation, and poverty. Following Galtung’s conception of *structural violence*, Farmer and Wilkinson and Leach argue that Africans – the nobodies according to Galeano – suffer from EVD epidemics because of asymmetrically powerful national and international structural forces that cause poverty, suffering and inequalities. This argument will be unpacked throughout this chapter as it underpins as well the three recurrent reasons for the failure of humanitarian responses as explained in Chapter 1.

Outbreaks most likely result from a combination of favourable conditions associated with animal demography, ecological phenomena, viral factors and human behaviour. Pigott et al. explain that there is some indication that the frequency of EVD outbreaks has increased since 2000. The study explains some of the reasons for these outbreaks growing more frequent, widespread and larger in size. The human population living within the EVD niche is much larger, increasingly urban, more mobile and better internationally connected than when the pathogen was first observed. They conclude that it is not the virus coming to humans; it is the other way around, as we are invading the spaces where it naturally exists, getting in contact with viral hosts and unwittingly transporting the viruses around the world.

In the forest eco-system, primates have long been known to suffer filovirus infections, both MHF and EVD, with significant mortality reported by research. This high CFR combined with their declining populations indicate that great apes are likely dead-end hosts for the virus and not reservoir species. Humans get infected by coming into

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341 Pigott, D.et al., 2014.


contact with the blood of another mammal through either hunting or butchering of animal carcasses. Other studies also affirm that zoonotic transmission may take place by direct contact with the blood or saliva (by eating bitten fruits) of infected bats. Once the first human (or more) is infected (called the index case) human-to-human transmission can occur. A close degree of contact is required for secondary transmission to take place. Certain community activities are usually associated with hotspots, such as family home care, traditional burial practices that involve washing and preparing the infected corpse. The relation between African culture and EVD denotes a racialisation of the disease in Western rhetoric. This relation will be explored later in the document.

Other amplification points are healthcare settings where infection control precautions are not in place. People are exposed by being in direct contact with infected bodily fluids, such as blood, urine, excreta, vomit, saliva, sweat, mother’s milk, and sperm, as well as with fomites from an EVD sick individual. These infected fluids can then enter the body through different routes of infection such as orally, via the conjunctivae, through a break in the skin or thanks to a penetrating object, such as needles or razor blades. The conditions required for transmission are culturally and contextually dependent; a good understanding of the particularities of the outbreak contributes to quickly restricting secondary transmission. As the number of cases increases, the ability of healthcare systems to control the further spread diminishes and the risk of a large outbreak increases.

The WHO and CDC empirically defined the incubation time for EVD as between 2 and 21 days. Only when an individual becomes symptomatic, can the disease be transmitted. Clinical diagnosis is complicated given that starting symptoms, such as tiredness and weakness, headache, nausea, vomiting and diarrhoea, are similar to common tropical diseases like malaria or typhoid. Research done on incubation periods for different EVD outbreaks shows that typically, there is an abrupt onset of symptoms 6 to 12 days after exposure to the virus. According to new research conducted by Haas, the

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344 Pigott, D et al., 2014.
346 MSF, 2008; CDC, 2014.
347 Pigott, D et al., 2014.
21 days quarantine value should be reconsidered as the current EVD outbreak is presenting evidence that this might not be sufficiently protective to public health.

**Care for EVD patients**

Once the infection occurs, the virus affects the host blood coagulative and immune defence system leading to severe immunosuppression. Patients receive intensive supportive symptomatic care to assist the immune system in the fight against the virus. The systematic care protocol for EVD patients includes the provision of intravenous fluids (IV) and balancing electrolytes (body salts), maintaining oxygen status and blood pressure, as well as the treatment of other infections if they occur. The earlier these treatments are provided, the higher chances they may have a positive impact on the outcome.\(^{353}\) As stated at the beginning of the chapter, the current EVD epidemic opened a controversy related to medical care for EVD patients.\(^{354}\) On one side, the question raised by practitioners is how far medical care could go, especially when the provision of certain treatments may expose health staff to a high risk of contamination. According to the WHO’s Road Map situation report of 21 January 2015\(^ {355}\), a total of 828 health workers have been infected in Guinea, Liberia and Sierra Leone. Out of those, 499 have died of the disease. Dr. Armand Sprecher from MSF\(^ {356}\) explains:

> In specific moments we did not have enough staff to manage IV hydration safely when there were a great number of patient admissions. This meant that IV fluid management had to be temporarily suspended or restricted, as was the case in Monrovia in September. It was not just a matter of performing this safely, but also of having enough team members to carry out the necessary monitoring, follow-up of fluid hydration for patients and good infection control. When a member of staff became infected, then fear had an impact, and sometimes led to more restrictive care immediately afterwards. MSF teams strived to quickly overcome these barriers, and returned to normal levels of individualised care with the minimum of delay.

The systematic protocol for EVD patients seems to have different levels of care. The availability of these different types of care depends mostly on geographies, the region or

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\(^{352}\) Haas, C., 2014.


country where care is delivered. Dr. Rostrup\(^{357}\) showed that as of 5 January 2015, out of the 24 cases treated outside Africa, only 4 died (16% CFR). As of 21 January 2015, the CFR in the three intense transmission countries (Guinea, Liberia and Sierra Leone) among hospitalised patients is 57-60\%.\(^{358}\) In an interview with Amy Goodman,\(^{359}\) Dr. Farmer commented regarding the relation between the health system level of development and CFR:

\[\text{[w]e’re talking about medieval-level health systems and a modern plague that’s going to spread. And when we can overlap modern medical systems and modern public health systems, then we can see what the case fatality really would be.}\]

In a very politically correct manner, Dr. Sprecher\(^{360}\) describes the factors he claims have contributed to the low CFR in non-African settings:

\[\ldots\text{the experimental treatments, an excellent baseline health status, good nutritional reserves, genetic difference, intensive care nursing, and access to mechanical ventilation, renal replacement therapy, and monoclonal antibodies. However, little is known definitively if one factor can point to the decisive intervention or therapy that saved them, but the capacity to provide individualised high-quality care is certainly important.}\]

Intensive care nursing is mentioned as a key factor. The limitations in the number of staff available to provide care partially illustrates Dr. Farmer’s\(^{361}\) point about the lack of capacity to deliver excellent supportive care. Surely it is not only one factor. The explanation may be inferred when combining the factors and place them into historical perspective. Due to historical reasons, post-colonial West Africa is what Shields\(^{362}\) refers to as marginal zones. These places have been “left behind” modernity not only because they are “out-of-the-way”, but because they also are the “Other” pole to the great European cultural centre.\(^{363}\) This othering process –as explained in Chapter 1– implies the superiority of the Western identity. In this superiority, argues Duffield,\(^{364}\) resides the power to decide over the life (and death) of populations, the nobodies. This analysis draws from Giorgio

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\(^{357}\) Presentation for the MSF-Spain Association, Barcelona, 7 January 2015.


\(^{363}\) Shields, R., 1991:3.

\(^{364}\) Duffield M. Racism, Migration and Development: The Foundations of Planetary Order. Prog Dev Stud., 2006;1:68–.
Agamben’s bare life concept. Bare or natural life is the exception to what is considered as valid life. The power to decide this exception relies on sovereign power. “Deciding the exception constitutes a juridico-political space (nation-state) where anything becomes possible; it is even ..permitted to kill without committing homicide…” Such life, however, is more than an abandoned subjectivity destined to bear sovereignty’s ordering; it is constitutive of political order itself. For Arendt, the functioning of this architecture produces both rights and rightlessness. The territorial basis of the nation-state has ensured that “…human rights were protected and enforced only as national rights.” The argument of “country of origin” is the one used by humanitarians and Western governments when asked about individuals’ rights to access to **excellent** healthcare for EVD patients:

It is clear; expats go back to their countries of origin to receive treatment. What is the controversy there? It is their right to receive proper medical attention. No one will dissent with that affirmation; the right to health has been enshrined in international and regional human rights treaties as well as national constitutions all over the world. Nevertheless, there might be disagreement in the implicit acceptance of the existing – and long standing – disparities of access to healthcare. Dr. Margaret Chan, WHO director general comments on what this EVD outbreak tells us about the world and the status of public health, “the outbreak spotlights the dangers of the world’s growing social and economic inequalities. The rich get the best care. The poor are left to die.” This violation of the human right to health is, according to Farmer a symptom of deeper pathologies of power, linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm. West Africa encompasses some of the world’s least developed, resource-deprived countries, many also having experienced in recent years upheavals of civic society, including civil wars. Not surprisingly, the healthcare infrastructure in these impoverished countries is severely under-resourced and needs strengthening at all levels.

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369 informal dialogue with high-level humanitarian worker, December 2014.
The Role of the Media

The relevant role played by the media in the construction of humanitarian crisis was discussed in Chapter 1. Cohen argues that in some cases, the media select, filter and frame the issues they decide constitute “news”, and set the political agenda and consequently, the operational priorities. They “do not tell us what to think, they do tell us what to think about.” The origin and confinement of EVD to the “marginal” rural areas in central Africa, and the way it affected the lives of the nobodies, or the “Others” generated mystery and intrigue in Western societies. Still, the world took only passing note of the disease when small outbreaks occurred after the first one in 1976. This exotic and deadly disease with no cure had almost no media coverage prior to the first arrival of the virus to US territory in 1989. The virus was detected in a shipment of macaque monkeys to a laboratory in Reston, Virginia. Although it was lethal for the monkeys, the Reston serotype of EVD has proven harmless for humans. Yet, this attracted media attention, and triggered fear of the virus that only grew with time (ibid). Non-fiction thrillers like The Hot Zone and Hollywood films like Outbreak (1995) incited public fears about Ebola creating potential scenarios for the disease to be spread in US territory. According to Western narratives, the mobility of the virus represents a threat to Western societies. There is also fear regarding its possible use by terrorist groups as a bioweapon, or its probable mutation and consequent sparking of a pandemic. Media interest and their approach to events play a decisive role in the construction of the EVD epidemic. Farmer explains this process,

Modern communications, including print and broadcast media, have been crucial in the construction of Ebola—a minor player, statistically speaking, in Zaire’s long list of fatal infections—as an emerging infectious disease… journalists and novelists wrote best-selling books about small but horrific plagues, which in turn became profitable cinema. Thus, symbolically and proverbially, Ebola spread like wildfire—as a danger potentially without limit. It emerged.
Since late December 2013 the virus has been spreading throughout West Africa at an alarming pace, killing thousands of Africans.\footnote{http://www.who.int/csr/disease/ebola/situation-reports/archive/en/, last accessed 5 February 2015.} Notwithstanding efforts to curb the epidemic, there were no clear signs of a decrease in the number of cases until late January 2015.\footnote{http://www.doctorswithoutborders.org/article/encouraging-decline-ebola-cases-critical-gaps-remain, last accessed 7 February 2015.} Despite the epidemiological trends and the suffering it inflicted in the lives of millions of West African citizens, the outbreak did not garner international media interest. An analysis of data from Google Trends in Fig. 2.3 shows how the attention paid to the crisis fluctuates according to particular events that marked the course of the epidemic.\footnote{Numbers assigned to the graph reflect how many searches have been done for a particular term, relative to the total number of searches done on Google over time. They don’t represent absolute search volume numbers, because the data is normalised and presented on a scale from 0-100. Each point on the graph is divided by the highest point and multiplied by 100. When we don't have enough data, 0 is shown.} The role the local media from the affected countries played will be discussed later in the document, as part of the analysis of the home construction and response to the epidemic.

**FIG. 2.3. EVD IN THE INTERNATIONAL MEDIA HEADLINES**

Point “G” in the chart –between 3 and 9 August 2014- coincides with the repatriation of two EVD sick US aid workers (Dr. Kent Brantly and Nancy Writebol) from Liberia to Atlanta and the WHO declaration of the EVD outbreak as a “global public health emergency”. After this moment, the attention decreases. The raising trend starts by 21 September 2014 when Brother Manuel García Viejo, a Spanish citizen who was medical director at the San Juan de Dios Hospital in Lunsar (Sierra Leone), had been evacuated to Madrid after being infected with the virus. His death was announced on 25 September 2014. Shortly after, on 30 September 2014 the first confirmed EVD case was imported into the US. A Liberian man, Thomas Duncan, travelled carrying the virus from Monrovia to Dallas. The upward trend continued as on 6 October 2014, a nursing assistant, Teresa Romero, who had cared for the Spanish priest became unwell and on 6 October tested...
positive for Ebola. The nurse is said to be the first person in the current outbreak known to have contracted Ebola outside Africa. The unfolding of events leads us to point “D” in the chart, the highest peak in the graphic. It was on 12 October 2014 when the CDC reported, “A healthcare worker at Texas Presbyterian Hospital, Nina Pham, who provided care for the index patient has tested positive for Ebola according to preliminary tests by the Texas Department of State Health Services’ laboratory.” The graph evidences a Western ethnocentric tendency, as high peaks of interest occurred only when events that are directly related to Western interests took place.

This picture by Lisboan cartoonist Andre Carrilho (Fig. 2.4) illustrates how Western media addresses Ebola.

FIG. 2.4 ARTIST DEPICTION OF WORLD MEDIA COVERAGE OF EVD OUTBREAK IN WEST AFRICA

Source: Andre Carrilho

There are three aspects the picture highlights. Firstly, international media coverage reports in a West vs. the rest perspective. The disproportion in the comparison of the number of Africans affected by the EVD with the number of non-Africans is absurd. Nevertheless, as Fig. 2.3 demonstrates, the world pays attention to the outbreak when non-African people contracted the disease or when patients were treated in Western countries. It is “us”

versus “them” for Carrilho\textsuperscript{389}, “the nature of the Western media hysteria over Ebola underscores a more pernicious trend in how the West views the rest of the world. More than any other event in recent memory, the Ebola epidemic has brought to light America's lingering and simmering fear of "the other." Western media portrays EVD as a disease of the “other” – of black Africans in this case, the risk lies in the fact that “they” can bring it to “us”\textsuperscript{390}. The way US media reported on Duncan’s story, as Kleeman\textsuperscript{391} writes, “the Dallas patient was a foreigner, which made him far more suspect than missionaries Nancy Writebol and Kent Brantly, who were lily-white, born and bred Americans.” Different news media\textsuperscript{392} report on Duncan as a virus-bearer to be vilified, as they suggest he knew he was sick before leaving Liberia. His story was the subject of fear mongering, not of compassion. This approach reinforces the divide as it fuels racist and xenophobic\textsuperscript{393} reactions. Politicians\textsuperscript{394} warning against migrants in the US stimulated anti-immigration groups\textsuperscript{395} and levels of discrimination against immigrants were reported on the rise in Dallas\textsuperscript{396}. Meanwhile, in Europe, the Italian anti-immigration group Catena Umana (Human Chain) posted in their webpage: “Stop all arrivals, close all borders or keep [the migrants] in quarantine on the sea. Do you want to give the citizenship to Ebola as well?”\textsuperscript{397} There were travel bans imposed from EVD affected countries into the US and other African countries. The borders of the affected countries were sealed. At the same time, international European and US airline companies cancelled their flight routes to the three most affected countries (Guinea, Liberia and Sierra Leona).\textsuperscript{398} The WHO\textsuperscript{399} reacted to the imposition of these measures. In a statement, they remark how the isolation of EVD-affected countries results in detrimental economic consequences at the same time as it hinders relief and response efforts, risking further international spread of the disease.
Second, media reports are scaremongers and misleading. For instance, when Duncan’s case was reported in Dallas, as happened in 1989 with the Reston EVD, the hysteria of a possible outbreak in the US glimmered. Analysts criticise the media –mainly US media– for spreading misinformation about EVD. They explain how, led by the adage “if it bleeds, it leads”, journalists push the fear button, with a sensationalist coverage of events (ibid). Journalists from main media companies –i.e. Fox News, CNN– politised the issue, creating narratives of blame that gave life to conspiracy theories. They also talk about the possibility of EVD to become airborne. In Spain –a country with one infected person, Teresa Romero– fear was spread among the football community due to the presence of African players in the national league. Football-specialised media explained how “some clubs demanded their players return from friendly matches being played in Africa to avoid the epidemic. African countries are most affected by the virus and the clubs that have players of those nationalities are on alert.” They refer to Guinean, Ghanaian and Congolese players. A subject of great interest to the press –not only local Spanish media, but international as well– was Teresa’s dog, Excalibur. The government decided to execute the dog after he was in contact with Teresa while she developed symptoms. Pictures of the dog could be seen in printed journals, the Internet and social media, under the title “sacrificed”. A petition with almost one hundred thousand signatures was sent to the Spanish health minister to cancel the order to kill the dog. In an interview given to CNN, Teresa explains how she found out she was positive while she was isolated in the hospital waiting for the results of the EVD tests. “Nobody told me anything, and there I saw my picture with Excalibur on the front page of the newspaper, it was surreal…they tell you nothing, then they put you inside in a bubble and they take you away.” She is going

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through a legal process to get compensation for the killing of her dog, Excalibur. The media spent hours, and pages, focusing on matters like Excalibur while at the same time – this was in October 2014– the EVD epidemic was escalating in West Africa, already killing 3,857 of the 8,011 affected. This is a clear example of Cohen’s argument about the manipulation of the information by the media, telling the audience what to think about.

Thirdly, international media creates a parallel representation of EVD in West Africa and in Western countries. On one side, they tell the personal stories of every non-African person infected with EVD. All cases that either were transferred to or occurred in Western countries were singularised. As shown in the preceding paragraphs, patients are called by their names and their ordeal is described with empathy. On the other hand, the Africans affected by EVD–The Nobodies in Galeano’s terms– do not have names but numbers. Carrilho explains,

People in the African continent are more regarded as an abstract statistic than a patient in the U.S. or Europe…How many individual stories do we know about any African patients? None. They are treated as an indistinguishable crowd.

A crowd whose graphic representation has no limitations. An article on the New York Times entitled A Hospital from Hell, In a City Swamped by Ebola includes a set of eight photographs taken by Samuel Aranda. Nossiter describes the first picture: “a 4-year-old girl lay on the floor in urine, motionless, bleeding from her mouth, her eyes open. A corpse lay in the corner – a young woman, legs akimbo, who had died overnight…” This image contrasts with the ones from white EVD patients as the suffering of nameless patients apocalyptically dying in stinking pools of contaminated fluids is exceptionally visible. Edwards comments,

Pernicious undertones lurk in these parallel representations of Ebola, metaphors that encode histories of nationalism and narratives of disease. African illness is represented as a suffering child, debased in its own disease-ridden waste; like the continent, it is infantile, dirty and primitive. Yet when the same disease is graphed onto the bodies of Americans and Europeans, it morphs into a heroic narrative: one of bold doctors and priests struck down, of experimental serums, of hazmat suits and the mastery of modern technology over contaminating, foreign disease. These

parallel representations work on a series of simple, historic dualisms: black and white, good and evil, clean and unclean.

Images from the handling of Western patients show respect and dignity. Patients and their carers are hidden behind protective equipment. Edwards interprets that the images imply invisible pain and no sense of dirtiness and stench produced by the secretion of body fluids the sickness provokes.

Until now the discussion was around representation through images, but what about sound? Whose voices are the ones telling how events unfold in the affected villages and neighbourhoods of Western Africa cities? Courageous and exhausted Western citizens are provided the space to express how they feel about EVD, as well as their impression on the crisis. They can share with the world how they heroically collaborate in the contention of the epidemic working endless hours under an enormous pressure. On occasions, they also speak for the Others, in order to transmit their impressions on the crisis. This situation is an example of what Cohen, Boltanski, Moeller, Fassin, and Veena Das argue about the relation between media and humanitarian action in Chapter 1. The voice of the Others is not heard. Most accounts of how EVD affected the life of Western Africans come from humanitarian workers. EVD-positive Western workers who survived the disease (84% of the infected ones) tell their story to the world. Some of them take advantage of the attention they attracted “for the plight of West Africa in the midst of this epidemic” using the language of humanitarian reason, of suffering and aid. Experimental drugs and treatments were part of the supportive care these patients received. At the time of writing this document, there is no certified preventive or curative treatment for EVD. Despite the lack of scientific evidence, experts think these treatments, as part of the comprehensive care provided to patients played a role in their recovery.

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Drugs and vaccines for EVD

As previously detailed, Dr. Sprecher in his argument mentions experimental treatments as one of the possible contributing factors in the survival of EVD patients treated outside West Africa. The current large epidemic triggered the testing of new treatments and vaccines. In early August 2014, the WHO convened a panel of medical ethicists to explore the use of experimental treatments in the EVD outbreak. The conclusion of the meeting states

They concluded unanimously that it would be acceptable on both ethical and evidential grounds to use as potential treatments or for prevention unregistered interventions that have shown promising results in the laboratory and in animal models but have not yet been evaluated for safety and efficacy in humans, provided that certain conditions are met. In reaching these conclusions, the panel members were mindful that this is a departure from the well-established, historically evolved system of regulation and governance of therapies and interventions.

According to WHO experts and practitioners on the ground two factors seem to justify this decision. First, the large numbers of people affected, and second the high CFR. If we review epidemiological data, since the first detected outbreak of EVD in 1976, excluding the present one, a total of 2,401 people were confirmed positive of the virus and 1,607 have died of the disease. For the ongoing epidemic, a total of 8,981 deaths and 22,495 confirmed cases have been registered until 4 February 2015. It is true that compared with previous EVD outbreaks there is a remarkable increase in the number of people affected. However, these totals in correlation with the statistics of other main diseases affecting poor people in poor countries put things in perspective. Diseases like malaria, TB, and HIV-AIDS are some of the main killers of deprived people. Furthermore, the CDC explains Neglected Tropical Diseases (NTDs),

are a group of parasitic and bacterial diseases that cause substantial illness for more than one billion people globally. Affecting the world's poorest people, NTDs impair physical and cognitive development, contribute to mother and child illness and death, make it difficult to farm or earn a living, and limit productivity in the workplace. As a result, NTDs trap the poor in a cycle of poverty and disease…They are called neglected because they have been largely wiped out in the

429 http://www.cdc.gov/globalhealth/ntd/
more developed parts of the world and persist only in the poorest, most marginalised communities and conflict areas.

According to the CDC\textsuperscript{430}, an estimated 534,000 people are killed yearly by NTDs. Some of these diseases have known preventive measures or acute medical treatments which are available in the developed world but which are not universally available in poorer areas. In some cases, the treatments are relatively inexpensive. Treatment cost for most NTD mass drug administration programmes is estimated at less than fifty US cents per person per year.

Fig. 2.5 and 2.6 show the total number of people killed and affected by Malaria in 2012, and TB and HIV-AIDS in 2013 (WHO Global Health Observatory data 2012, 2013\textsuperscript{431432433}). EVD total corresponds to all deaths registered in all known outbreaks since 1976 (total includes all registered cases up to 4 February 2015). NTDs total is estimated yearly according to the CDC.

\textbf{FIG. 2.5. COMPARISON OF TOTAL DEATHS OF NTDs, MALARIA, HIV-AIDS, TB AND EVD}

\begin{center}
\begin{tabular}{l|c}
\hline
NTDs & 554,000 \\
Malaria & 627,000 \\
HIV-AIDS & 1,500,000 \\
TB & 1,460,000 \\
EVD & 10,586 \\
\hline
\end{tabular}
\end{center}


\textbf{FIG. 2.6. COMPARISON OF TOTAL NUMBER OF PEOPLE AFFECTED BY NTDs, MALARIA, HIV-AIDS, TB AND EVD}

\begin{center}
\begin{tabular}{l|c}
\hline
NTDs & 2,000,000,000 \\
Malaria & 207,000,000 \\
HIV-AIDS & 35,000,000 \\
TB & 9,000,000 \\
EVD & 24,896 \\
\hline
\end{tabular}
\end{center}


Despite the dramatic increase in the incidence in this last outbreak, the enormous differences between the numbers of people affected and killed by EVD, and people

\begin{footnotes}
\footnote{430 http://www.cdc.gov/globalhealth/ntd/fastfacts.html}
\footnote{431 http://www.who.int/gho/hiv/en/}
\footnote{432 http://www.who.int/gho/malaria/en/}
\footnote{433 http://www.who.int/gho/tb/epidemic/cases_deaths/en/}
\end{footnotes}
suffering any of the other diseases portrayed in Figs. 2.5 and 2.6 shows that the concern about poor people appears to be at odds with the health threats they face. Such high numbers of human loss—*the nobodies*—seem to fit Agamben’s definition of “bare life”, where powerful international actors decide over the life and death of entire societies. As Jones (2014) explains in his article, global structural forces condition the emergence and spread of diseases. Disease distribution is linked to inequalities. This inequity is nourished by international policies, donors’ decisions about the kind and location of aid and the international financial institutions’ impositions regarding national economies. For instance, the development by a pharmaceutical company of treatments and vaccines requires big investment. Surowiecki\(^\text{434}\) writes in his *Ebolanomics* column in The New Yorker,

Diseases that mostly affect poor people in poor countries aren’t a research priority, because it’s unlikely that those markets will ever provide a decent return. So diseases like malaria and tuberculosis, which together kill two million people a year, have received less attention from pharmaceutical companies than high cholesterol.

Chandran and Dye\(^\text{435}\) put in plain words the position of the industry in relation to EVD until the present outbreak,

Pharmaceutical companies are understandably unwilling to invest the considerable resources needed to develop drugs against a disease that currently infects only a few thousand people every few years in resource-poor countries, especially when there is little chance they will recoup their investment, let alone turn a profit.

One could argue that it is not only about pharmaceutical companies; as the media section showed above; the world in general was not paying attention to what was happening in West Africa. The construction of the epidemic, and the way the response is assembled by the international community can be presented through the historical analysis of events that shaped it. The first declaration of the outbreak on March 2014 saw the response of a handful of organisations on the ground. Despite alarming epidemiological trends in West Africa, there was no reaction from the international community. The occurrence of affairs changed when on 8 August 2014\(^\text{436}\) the WHO declared the current EVD outbreak a “global public health emergency”. Even so, according to MSF—one of the few responders to the outbreak until that moment—the situation on the ground was far from being controlled.\(^\text{437}\)


\(^{435}\) http://www.huffingtonpost.com/kartik-chandran/ebola-virus-drugs_b_5572084.html

\(^{436}\) http://www.reuters.com/article/2014/08/08/us-health-ebola-emergency-idUSKBN0G80M620140808

MSF’s president, Dr. Joan Liu, addressed the UN in two occasions, on 2 September and 16 September 2014, calling for an urgent global response through the deployment of civil and military teams. On 18 September 2015, the UN Security Council, in the first emergency meeting called on a health crisis, proclaimed the EVD epidemic a “threat to international peace and security”. Around this period, the virus travelled from West Africa to Europe and the US. Media coverage started to bloom. The fact that a handful of European and US citizens got infected and brought the disease to their countries of origin certainly had an influence in these declarations. The EVD that kills a few thousand – mostly poor people in Africa was put on the spot. Direct consequence of this was the appointment by Secretary General Ban Ki-moon of a UN Mission for Ebola Emergency Response (UNMEER) to control the epidemic. Another outcome was the availability of funds from different governments, foundations and individuals. There was a surge in financial support for EVD research to identify clinical and public health interventions with a potential benefit in the epidemic from Welcome Trust and the Innovative Medicine Initiative.

As the facts are presented, this is an example of Duffield’s argument about the superiority of the Western identity, where their sovereign power decides over the life of people. The unfolding of events as explained in this study, shows two fundamental reasons that explain the international community reaction as Western interests were at stake. First, their own kind, US and European volunteers working in West Africa, got infected with the virus and brought it closer to the West, to “us”. Secondly, the possibility of terrorist groups using EVD as a bioweapon was in the discourse of the US and UK government way before this outbreak. Nevertheless, there is reasoning provided by experts that counteract this possibility. Antoni Fauci, the director of the National Institute of Allergy and Infectious Diseases in the US explains that there are historical accounts of states, like the Soviet Union, and cult groups like the Japanese Aum Shinriyo who tried – and failed – to tap the

439 http://www.msf.ca/en/node/43781
442 http://en.wikipedia.org/wiki/Responses_to_the_Ebola_virus_epidemic_in_West_Africa
443 http://www.wellcome.ac.uk/funding/international/wtp057179.htm
444 http://www.imi.europa.eu/content/ebola-project-launch
448 http://www.scientificamerican.com/article/weaponized-ebola-is-it-really-a-bioterror-threat/
virus for bioterror. However, the US government maintains the interest in EVD, as Amy Derrick-Frost, spokeswoman for the US Department of Defence interviewed by the Washington Post clarifies,

The Department of Defence maintains research interests both for protection against intentional use and natural exposure to many diseases that can impact the health of its personnel around the world, and that concern extends to viruses, such as Ebola.

On the same logic, Jennifer Cole, a senior research fellow at the Royal United Services Institute for Defence and Security Studies in the UK, interviewed by the Guardian, commented

The US and UK military have been carrying out research for some time into infectious diseases. The fact that vaccines are so far along in development is because of concerns that the US has had about the virus being weaponised.

The development of EVD vaccines was not linked to the interest in alleviating the burden of the disease before this outbreak. In comparison with malaria, HIV-AIDS or TB, the number of people affected by it is relatively small. Pharmaceutical companies are reluctant to invest in research for drugs and vaccines for diseases that affect poor people in poor countries, even if they kill millions every year. Except when high-level decisions are made and funds are made rapidly available. The WHO explains on its website

Pharmaceutical companies developing the vaccines have committed to ramp up production capacity for millions of doses to be available in 2015, with several hundred thousand ready before the end of the first half of the year. This could be the fastest vaccine rollout in history.

The example of this “fast track” process that allowed ethical considerations to be bent, funds to be immediately deployed and drugs and vaccines to be shortly available for large numbers of people shows the power and capacity of the international community. Decisions are taken according to the interest of Western actors. They choose valid life and by default, bare life. In this case it was the chance of the few thousand EVD patients over more than 2 billion people suffering from malaria, HIV-AIDS, TB and NTDs, trapped in a cycle of poverty and disease. In the eyes of Dr. James Orbinski, president of the MSF International Council, this is injustice. He expressed the organisation’s opinion in his acceptance speech of the Nobel Peace prize awarded to MSF in 1999,

449 http://www.scientificamerican.com/article/weaponized-ebola-is-it-really-a-bioterror-threat/
Some of the reasons that people die from diseases like AIDS, TB, sleeping sickness and other tropical diseases is that life-saving essential medicines are either too expensive, are not available because they are not seen as financially viable, or because there is virtually no new research and development for priority tropical diseases. This market failure is our next challenge. The challenge, however, is not ours alone. It is also for governments, international government institutions, the pharmaceutical industry and other NGOs to confront this injustice. What we as a civil society movement demand is change, not charity.\textsuperscript{452}

Everybody should receive proper medical attention, even if born in the marginal zones (Shields 1991). Even with the “fast track” procedures, it was not until December 2014 when the first African patient was offered the possibility of an experimental treatment.\textsuperscript{453} Western patients treated outside Africa were offered the chance to try these drugs when they started getting sick, back in July 2014. In this particular point, decision-makers opt not to create an exception to allow access to proper treatment to everyone who requires it. Not even for African front line health workers fighting the disease. The case of a VHF specialist, Dr. Sheik Umar Khan, in Sierra Leone sparked the debate.\textsuperscript{454} He was the head of the Lassa fever programme at the Kenema hospital, 300 km east of Freetown. He was part of the EVD response in the country. In July 2014, he was admitted in the Kailahun ETC run by MSF as an EVD-positive patient. There was a chance to give him a complete treatment of ZMapp that was available in a nearby laboratory, being tested for heat resistance.\textsuperscript{455} MSF doctors made the difficult decision not to treat him with experimental drugs. The arguments were that the effects of the drug were unknown and there was not a supply guaranteed to treat everybody who might need it; therefore it would be unfair to give Dr. Khan privileged care. The contradiction is that, at the very same time MSF was justifying this action; the doses travelled to Liberia and were administered to two EVD positive Western health workers.\textsuperscript{456} MSF expats who became infected with EVD were also provided with new treatments when they were being cared for in their respective US or European hospitals. This situation generated heated debate, both outside and inside MSF as well. Dr. Jean-Hervé Bradol from the Paris-based Centre for the Reflection on

\textsuperscript{452} http://www.msfaccess.org/the-access-campaign, last accessed 24 February 2015.
\textsuperscript{456} http://www.reuters.com/article/2014/11/14/us-health-ebola-msf-idUSKCN0JY0CT20141114, last accessed 16 February 2015.
Humanitarian Action (CRASH) commented, “if you argue the drugs are not safe because they are experimental but you give them to the expatriates, it makes no sense.”

At the time of writing this report –February 2015– no conclusive results are yet obtained to certify any of the treatments or vaccines being tested as a cure for or prevention of EVD. As a consequence of the significant drop in the number of EVD cases in the last weeks of January, the trial of one of the two drugs that were being tested –the antiviral Brincidofovir– was suspended in Monrovia. The other one, an antiviral called Favipiravir is still ongoing in Guinea but still far from the critical mass needed to jump to conclusions on efficacy or safety. A convalescent plasma (CP) trial seems to be ready to start, with a delay of 2 and half months. ZMapp, a cocktail of monoclonal antibodies is on the horizon as a promising candidate for trials. Clinical tests are finished for two vaccines –Chimpanzee adenovirus serotype 3 (ChAD3-ZEBOV) and Recombinant vesicular stomatitis virus (rVSV-ZEBOV)– with positive outcomes. Vaccination of frontline workers –i.e. health staff, burial teams, and hygienists in the ETCs– and close contacts of people proven to be infected with the virus will soon start in the affected countries. Being able to conclude these trials depends on the epidemiological situation. The disheartening WHO roadmap situation report for the first week of February shows an increase in the incidence and continued community resistance. The scientific community and practitioners are hoping to finalise the research and collect significant data “to ensure that when Ebola virus appears again –as it will somewhere– we are in a position to prevent a devastating outbreak such as the one we have been watching over most of the last year.”

**Detection of EVD Outbreaks**

There are certain elements that trigger the alert of a possible EVD outbreak, especially when there are records of previous outbreaks in the same area. These include the unexpected increase in mortality in members of a same family or a particular village, and

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461 http://apps.who.int/iris/bitstream/10665/151311/1/roadmapsitrep_4Feb15_eng.pdf?ua=1&ua=1, last accessed 14 February 2015.
in health staff working in a clinic or hospital in the region. At the same time, there might be rumours of people dying with haemorrhagic symptoms and of sudden death of non-human primates. For instance, the emergence of the current EVD outbreak in West Africa is traced back to an 18-month-old boy – Emile Ouamuno, in the town of Meliandou, located in Guinée Forestière, on the border with Sierra Leone and Liberia. The village, with 31 households, is located in a heavily human-modified landscape, surrounded by oil palm cultivations, foreign mining and timber operations. This forest loss, experts suggest, brought potentially infected wild animals, which normally stay within the forest ecosystem, into closer contact with human settlements.\textsuperscript{463} The research team in Meliandou searched for clues to understand how Emile may have contracted the EVD. There was an anthropologist in the team who conducted focus group discussions and individual interviews during the eight days the team investigated in the village. The information collected points at Emile playing near a hollow tree home of thousands of bats before the onset of symptoms. The tree was found burnt at the time the researchers arrived to the village. A report mentions that the burning of the tree was either by coincidence or as a result of the Guinean public health authorities halt to the consumption of any bush meat, including bats.\textsuperscript{464} There is no information in the report or in other sources regarding the villagers’ reasons for the burning of the tree. The researcher’s conclusions miss the interpretation of the facts and the consequent reaction in the logic of the people affected. How do the villagers explain the outbreak? What explanation did they give to the sudden deaths of its members? The cultural models section of this document examines these issues later on.

According to studies conducted, Emile developed an illness characterised by fever, black stools and vomiting on 26 December 2013.\textsuperscript{465} By mid-January, his three-year-old sister Philomene, their pregnant mother Sia and their grandmother Koumba had developed a similar illness and died. The village midwife also got infected –it seems after attending the funeral of Emile’s grandmother– and passed the disease to her family members. She was treated in Gueckedou hospital. One of her relatives travelled to the village of Dandou where six more people died. This took place in the month of February 2014. Someone sick from Gueckedou was treated in a hospital in Macenta, a village a hundred kilometres west of Meliandou. Another one went to Nzerekoré. By March 2014, a doctor who took care of

\textsuperscript{463} http://www.who.int/csr/disease/ebola/one-year-report/virus-origin/en/
\textsuperscript{464} http://www.nature.com/news/new-clues-to-where-the-ebola-epidemic-started-1.16651#/b1
\textsuperscript{465} http://www.who.int/csr/disease/ebola/one-year-report/introduction/en/
the patient in Macenta contracted the disease and passed it on to his brothers in the town of Kissidougo, one hundred and fifty kilometres north of Macenta. Figure 2.7 shows the early transmission chains of the outbreak. Meliandou presents the combination of favourable conditions that Pigott et al. conclude are needed for an outbreak to take place: a larger, mobile human population invading the spaces where the virus naturally exists, getting in closer contact with their viral hosts and transporting the virus to other places. Guéckédou is a major regional trading centre and by the end of March 2014, EVD had crossed the border into Liberia. In May the same year, it was confirmed in Sierra Leone, two months later Nigeria had its first case and Senegal reported its first case of EVD in August 2014.

**Fig. 2.7 Transmission chains in the emergence of the EVD outbreak in Guinea**

The first alert was raised on 24 January, when the person responsible for the Meliandou health post informed district health officials of five cases of severe diarrhoea and rapid death. Two teams were sent to the area to investigate – local health officers plus MSF. Given the bacteria showed in the microscopic examination of samples, and the symptoms

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presented by the patients, the teams thought the unknown disease was cholera.\textsuperscript{468} Diagnosis of EVD can be difficult initially. First, because the symptoms can be confused with those of common diseases in the region, such as malaria, cholera, typhoid fever, bacterial meningitis, or Lassa fever. Second, there is a need for special tests to be performed in security level 4 labs to be able to confirm the presence of filovirus in patient samples, and normally those are not available in remote regions in Africa.\textsuperscript{469}

When the MoH issued the first alert on 13 March, the disease had already spread to four prefectures and other villages and cities, including the capital, Conakry. A major exploratory mission –with MoH, WHO Regional Office for Africa (AFRO) and MSF– was sent to Guinée Forestière. Epidemiological links were found in the investigation and on 21 March, the Institut Pasteur in Lyon, France, confirmed the causative agent was the Zaire strain of EVD.\textsuperscript{470} On 23 March, with 49 cases and 29 deaths officially reported, the MoH and the WHO declared the EVD outbreak in the region. The virus was transmitted for three months before the outbreak became apparent, allowing many transmission chains and an elevated number of EVD cases, even across the border with Liberia.

**Outbreak intervention**

Generally, national governments, mainly through their MoH, and a small number of international organisations with expertise in EVD –i.e. MSF, the WHO and the CDC– are responsible for the response to these outbreaks. Until now, outbreaks were sporadic, limited in number, and took place in remote isolated areas in Central Africa. Despite the characteristics of the disease, a limited number of people were affected and total control of the epidemic was achieved within four or five months. Even if the ongoing West Africa outbreak is changing the way the response to EVD is conducted, the core procedures remain more or less the same. There are many critiques of the response that until February 2015 seems unable to stop the outbreak. These accounts will be presented later in the document.

Once the outbreak is declared, and international organisations are called to assist, a response team is organised and travels to the area for an initial assessment to implement the response. The evaluation team will identify priority areas for intervention according to

\textsuperscript{468} http://www.who.int/csr/disease/ebola/one-year-report/virus-origin/en/
\textsuperscript{470} http://www.who.int/csr/disease/ebola/one-year-report/virus-origin/en/
epidemiological patterns, logistics possibilities, security, and availability of resources and local capacity of response. As the outbreak is already declared and there are suspect and confirmed cases, it is very important to note that at the same time the investigation is ongoing, a place is created to properly isolate suspect patients. This part of the work was, until the current epidemic, the exclusive responsibility of MSF as implementer on the ground. Actually, in the current West Africa epidemic, for six months since the outbreak was declared, MSF was the only stakeholder running Ebola Treatment Centres (ETCs) in the affected countries.

The main objectives of the MSF intervention are first to contain the spread of the disease by reducing the number of cases and deaths and, second, to reduce the suffering of patients and communities. In order to achieve these goals, the response is designed with four components: surveillance and epidemiology, case management, social mobilisation and laboratory. In the current epidemic, two components were added to the classic ones: access to healthcare for non-Ebola patients and protection of health facilities and health workers. These activities are interdependent and all must be in place to contain the epidemic. A local level coordination body dependent on a national one –set up by the MoH and the WHO– manages all activities and shares information regarding resources, needs and strategic orientations. Fig 2.8 is part of the MSF Guidelines for VHF outbreak response; it shows all components of the response in a comprehensive way.

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471 Epidemiological patterns: number of cases and deaths, epicentre of the epidemic.
472 Logistics possibilities: accessibility –air, road, and possibilities of cargo transport.
474 MSF, 2008.
The schema MSF designed shows where their analysis places people – nowhere in the diagram. The reasoning is centred in the response itself, the urgent actions and the actors performing them. The affected communities are not considered implementing actors in the response. This is a practical example of what Hilhorst and Jansen\(^{475}\) define as the bi-dimensional framework of the humanitarian space of aid givers and receivers. Givers and receivers are conceived within the dominant Western vision with a clear pre-existing power relation stemming from colonial times as Homi Bhabha\(^ {476}\) and Spivak\(^ {477}\) describe it. More often than not, humanitarians miss the interaction and interpretation of the encounter with patients as individuals in specific contexts and realities as argued by Malterud\(^ {478}\) and Helman.\(^ {479}\) The recurrent failures of the humanitarian system are not foreign to EVD responses.

MSF built expertise responding to EVD outbreaks driven by its identity as a medical humanitarian organisation and its financial independence. These two reasons allowed the

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\(^{476}\) Homi KB. *The location of culture*, Location of Culture, 1994.

\(^{477}\) Spivak G. *Can the subaltern speak?* 1988.

\(^{478}\) Malterud K. *The Legitimacy of Clinical Knowledge: Towards a Medical Epistemology Embracing the Art of Medicine*, Theoretical Medicine, 1995.

organisation to be the only one implementing the response at field level. The first encounter with EVD was in 1995 when MSF responded to an outbreak in Kikwit, in the Democratic Republic of Congo (DRC). Since that first intervention, MSF has responded to fourteen outbreaks both of EVD and MHF.\textsuperscript{480} After all these years of experience, the organisation is recognised worldwide for its capacity to respond to such outbreaks within days, bringing expertise in safe patient care and infection control. On one hand, the time factor is a very important aspect in an EVD response. Quickness in the deployment of activities is assured with the Ebola “kit”\textsuperscript{481} containing fifteen modules that include medicines, protective equipment, and logistic and sanitation materials to set up a treatment centre with 15 beds for three weeks.\textsuperscript{482} These “kits” are prepositioned and ready to be delivered within a very short timeframe through a well-established supply system.

On the other hand, the response protocol has been improved after years of responding to outbreaks in different parts of central Africa. There is a process that allows for interventions to be enhanced as lessons learned are incorporated into the procedures and applied in the subsequent response. Nevertheless, it is not a straightforward process as mistakes are often repeated response after response.\textsuperscript{483} But this situation is not unfamiliar to the functioning of the humanitarian system, as it was described in Chapter 1 of this document. For instance, there is one major change the response to the unprecedented current epidemic brought about to the approach MSF had to EVD operations. When Nigeria confirmed its first case of EVD in the country, the reaction from the government was immediate. Among other actions, they called MSF for help. At that moment, the organisation was already operating at full capacity, with interventions in the three countries with widespread and intense transmission (Guinea, Sierra Leone and Liberia). Therefore, a small experienced team in EVD was sent to evaluate the possibility for the organisation to contribute in the operations. As part of that team, I experienced a shift in the approach to the response and the repercussions of its application in the particular


\textsuperscript{481} As explained in Chapter 1 (page 35), kits are a consequence of the standardisation of humanitarian responses. Having all material ready ahead of the emergency speeds up the delivery of aid and facilitates and professionalises the work of humanitarians. For a definition of “kit” please see page 35.

\textsuperscript{482} MSF. Kit, Viral Haemorrhagic Fever, 15 days, 2013.

The Ebola Emergency Operations Centre (EOC) in Lagos was quickly activated after the confirmation of an Ebola case on 23 July 2014. Lagos is Africa’s largest city, with a population of 21 million people, of which a large number live in crowded and unsanitary conditions in many slums. This is a very busy metropolis with frequent traffic jams and thousands of people moving in and out every day. National and state authorities as well as the international community were extremely worried about the consequences of a possible urban outbreak of such magnitude. Even though there is an epidemiological link, this proved to be a different outbreak from the one taking place in neighbouring countries.

Patrick Sawyer, a Liberian-American diplomat arrived on a flight from Monrovia to Lagos. He was there to attend an ECOWAS (Economic Community of West Africa States) conference in Calabar, in the south-eastern part of Nigeria. At the airport, two protocol officers from the organisation picked him up. According to narratives, Sawyer was acutely ill on arrival at the airport, so he was taken to the private First Consultants Medical Centre in an exclusive area of Lagos. When queried about EVD at the hospital, he denied any possible contamination. After he did not respond to malaria treatment and his condition worsened, the doctors treating him requested an EVD test, which resulted positive on 23 July. EVD came in business class to Lagos. Before dying on the 25 July, Sawyer passed the disease on to nine health care workers at the hospital in Lagos. There is one particular characteristic of this first group of contaminated people: they belong to the well-educated class of Nigeria. EVD, the disease of the poor has contaminated the “us” in Nigerian society. Like with the expatriate Western volunteers who got infected and were repatriated for treatment, they were all called by their names. These Nigerian EVD patients were, as well, provided with the space to share their personal account of the facts in the media.

They had a direct relation with the responsible authorities implementing the response; they shared tribe, religion, professional background and social class. Going through the corridors of the EOC you could overhear conversations about them, like “did you go today

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486 http://therealnews.com/t2/index.php?option=com_content&task=view&id=31&Itemid=12572


to visit Stella? No, but I saw her mum and dad yesterday...how is Morris doing today? Much better, he does not have fever thank God."

The example of Nigeria is a successful one, as they managed to contain the outbreak in three months. On 20 October 2014, the country reached 42 days with no new cases (this period represents twice the maximum incubation period of EVD, 21 days), therefore it was declared Ebola-free. There were pivotal factors that contributed to this accomplishment. Namely, the country’s strong public health system and the participation of experienced staff in polio eradication, the fast and thorough tracing of all potential contacts and their monitoring, and the rapid isolation of sick contacts. The quick establishment of the EOC to coordinate the response is, according to analysts, largely credited with helping to contain the outbreak early.

The overall design of the response as well as the approval for all activities, work and resources rested with a senior strategy team composed of the Incident Manager (IM), Deputy Incident Manager and primary partner agencies: MSF, UNICEF, WHO and CDC. Six response teams were developed within the EOC, including: Epidemiology/Surveillance, Case Management/Infection Control, Social Mobilisation, Laboratory Services, Point of Entry, and Management/Coordination (see Fig. 2.9). Terms of reference and priority activities were developed by the strategy team to guide each operational team’s work; operational teams developed their own staffing, lists of material and financial needs, and a goal-oriented operational plan.

I would argue that the empathy generated at the early stages of the outbreak, when the first health workers got infected, also played an important role in terms of motivation and commitment of the people responsible for the response.

490 Personal informal observations collected during my work in the Nigeria EVD response in Lagos, July–August 2014.
The situation was challenging for MSF as quality resources were on the ground, both material and human. Where could the EVD “kit” for fifteen beds fit in this scenario? There was one element missing though, and it was knowledge on Ebola and expertise on how to implement the response. The MSF team in Lagos filled that gap. We were advisors for the EOC. Our team was composed of a general manager, an epidemiologist, a doctor, a water and sanitation engineer and an anthropologist. We were welcomed as part of the strategy team, clearly our leverage was the organisation’s recognised EVD management knowhow.

At the same time we were responsible for the construction and running of the ETC, as well as for the training of the MoH staff – doctors, nurses and hygienists – in case management and infection control. Participating at such high level provided the capacity to impact in all activities in cascade. This has never been part of the MSF strategy in any previous responses. Generally, MSF focuses on implementing activities on the ground and acts independently – while coordinately – from general management bodies. In the eyes of the organisation, these leadership groups are perceived as inoperative and detached from the daily reality of the outbreak. This position relates to the organisation’s identity, the
humanitarian impulse, what Rony Brauman defines as the compelling moral pressure to “do something”.\textsuperscript{494} The interventions in Senegal and Mali, where I also participated were set up in the same way. The three countries managed to contain the spreading of the disease in a few months from the index case. This is an example \textit{single-loop learning}, as explained by Argyris\textsuperscript{495} and Ramalingam’s model of organisation learning. The alteration to standard procedures that is taking place is highly dependent on the person doing the job, and it does not reflect change at the level of policies or norms. The challenge here is to incorporate this approach into the EVD response. There are historic precedents of such change in goals within the organisation. At the end of the 1990s, compelled by the difficult situation of HIV-AIDS patients, MSF decided to tackle the problem at different levels. On top of providing the medical treatment, they moved further into addressing the root of the problem. So they developed links with activist organisations (the Treatment Access Campaign in South Africa) and created the Campaign for Access to Essential Medicines to urge for treatment to be part of the response strategy. Dr. Jean Hervé Bradol from MSF thinktank CRASH, explains,

MSF was now represented at every link in the chain: at the patient’s bedside, at meetings in hospitals, in the office of the physician in charge of health at district or regional level, at the ministry, at the offices of international organisations, at scientific congresses, whenever and wherever international activists were organised (the G8 counter-summits, for example), but also in the offices of the heads of states’ sherpas, at the headquarters and factories of pharmaceutical companies, in the administrative departments responsible for importing medical products – and of course in the public debate.\textsuperscript{496}

There are obvious differences between the HIV-AIDS pandemic and EVD –i.e. in terms of numbers of people affected and the level of knowledge and expertise related to the disease and response strategies– but there are certain resemblances as well. Back in the 1990s, AIDS also posed a threat to public security and called the attention of the international community, as it is the case now with the West Africa EVD epidemic. Maybe this is an opportunity for change. For the time being, response strategies like the ones in Nigeria, Mali and Senegal continue to be exceptions to the standard.

Operating within the structure of the standard response as represented previously in Fig. 2.8 and in the Nigerian example of Fig. 2.9, the focus is placed on the isolation and management of cases, and on infection control. The algorithm in Fig. 2.10 describes the main areas of action, according to MSF in the VHF response guideline of the year 2000.

**FIG. 2.10 MSF OBJECTIVES OF EVD MANAGEMENT AS PER YEAR 2000 GUIDELINE**

![Algorithm Diagram]

Source: MSF 2000.

This algorithm was included in the briefing of international staff participating in VHF responses. Although the chart mentions the community under “minimising biohazards for staff, patients and community”, following the algorithm down, there is no description of an activity addressing community aspects. There is one reference to “cultural beliefs” under burial procedures as part of secondary containment of the infection. This mention expanded in Chapter 5 Burial Practices of the guideline reads:

All people have their own behaviour related to death, based on cultural beliefs (religion, traditions, politics, etc.), and local circumstances (climate, available

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material, family size, wealth, etc.). As corpses and body liquids are extremely infectious, some practices and rituals can introduce enormous risks for the people involved…To limit the risks, the ideal procedure is to bury: immediately after the patient has died, just outside of the VTC (e.g. on the hospital compound), without family intervening, with a specialised, full-time burial team…Due to family wishes, logistical problems and local community resentments often it will be difficult to follow the ideal procedure. Compromises have to be made, but must never result in risky practices, whatever pressure from family or community may exist.

Even though there is recognition of local culture, it seems to be seen as an obstacle to achieve the “ideal procedure” for safe burials. This perception of the affected people as part of the problem and not as part of the solution as well, persists until present times in the response to EVD outbreaks. 499 Local belief and practices are considered barriers to overcome and immediate behaviour change has to be achieved. Even if peoples’ role and capacities are not fully understood, there is no section in the MSF 2000 manual describing how to work with the communities to attain this change. The addendum to the guidelines, a briefing for EVD printed the following year, includes a very succinct section on “sensitisation, education and information” directed to the affected people. The document explains the importance of conducting these activities, it is

…an important issue in fighting an outbreak. Community awareness and accurate disease information can help to avoid possible infections linked to behaviour and traditional practices. It can also diminish many problems linked to stigmatisation 500…accurate information on the disease will be mainly done through: mobile teams, trained local leaders and community volunteers; information through mass media (radio, TV) and posters and leaflets; informing and educating through participatory meetings. 501

Interesting how the word “participatory” is placed within a statement that clearly denotes a unidirectional flow of communication still framed by pre-existing power relations. The “accurate disease information” will be disseminated from the international response actors (“givers”) to the community (“receivers”). This type of participation is what Arnstein considers as manipulation, where the real objective “is not to enable people to participate in planning or conducting programmes, but to enable power-holders to “educate” or “cure” the participants.” 503 This “non-participatory” approach has serious repercussions for the

504 Arnstein, 1969.
success of the total control of the epidemic. Transmission patterns of the disease turn society’s normal practices into dangerous acts that need to be modified to stop community transmission, like burial practices. Certainly, these adaptations have to be devised by the people themselves, empowered to take informed decisions and actively participate in the solution to their own problems.

Most of the response activities are planned with the isolation centre – called Ebola management centre (EMC) or treatment centre (ETC) – at the core of the intervention. The biomedical model considers the isolation of infected individuals as one of the most important actions to undertake in order to avoid contamination of other people. Additionally, this is the place where patients will be taken care of with the better-known available treatments\textsuperscript{505}, which increases the possibility of survival. ETCs are normally set up either using wards of an existing hospital or built as an extension in the hospital grounds.\textsuperscript{506} Given the size of the current epidemic, the centres are being constructed as well in school compounds.\textsuperscript{507} These structures are specially designed and put up to ensure proper infection control. Infection control measures require, among other things, the closing of the perimeter where the centre would operate, a thorough waste management circuit and disposal area incorporated in the structure. The example of an ETC in Fig. 2.11 shows the fencing of the perimeter, which limits the access points to the centre. The space is clearly divided between a “low risk zone” and a high risk zone”. All personnel in the “low risk” area should wear scrubs and boots, and the “high risk” area can only be accessed in full personal protective equipment (PPE), like the drawing of the person in Fig. 2.11.

\textsuperscript{505} For the debates regarding treatment of EVD patients please see EVD treatment and care section of this document.

\textsuperscript{506} MSF. Briefing Ebola Outbreak, 2001; MSF. Filovirus Haemorrhagic Fever Guideline, 2008.

Given the sense of urgency mentioned earlier plus the “non-participatory” approach of the international response, normally there are no consultations with the community regarding the place where the isolation unit is to be constructed. A common reaction to this imposition is a rejection of the foreign response and a refusal to go to the hospitals, even to be treated for other diseases than EVD. Dr. Tim O’Dempsey explains in an interview how the Kenema community reacted to the construction of the ETC,

The community were upset by the fact that the Ebola treatment centre had been established in their hospital…the adult, medical and surgical wards were abandoned, so the local community didn’t really have access to basic levels of medical care for conditions other than Ebola…in fact there was quite a lot of civil unrest as a result of that…on one occasion while I was working there, there was a riot and the team had to be evacuated from the hospital…

As clearly stated by Dr. O’Dempsey, excluding communities from participating in the national response has serious consequences, not only in terms of security, but also for the control of the epidemic. This segregation translates into mistrust in the strategy and the

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504 BMJ interview with Dr. Tim O’Dempsey, available at https://www.youtube.com/watch?v=luqH_zu8f1M&feature=youtu.be&list=PLiC5xP8bJUbjUq6D5LFwsz9Qxbbb3GHf, last accessed 21 February 2015.
people undertaking the responsibility, as well as in the proliferation of negative rumours. As we will see later, the production of rumours, its monitoring and elimination plays a crucial role in the development of the epidemic.

In terms of surveillance, a system is established to trace all contacts from confirmed cases. All contacts of an infected person need to be identified and closely monitored for 21 days –the length of the incubation period– from the last day of exposure. In case they develop symptoms, they must be taken to the treatment centre to be tested for the virus.509

The alert team –as part of the surveillance/epidemiology group– picks up possible cases and brings them in an ambulance to the triage point in the ETC. After evaluating the person, medical staff decides, according to clinical signs and case definition criteria510, if the person is admitted to the suspect area. Once in the suspect area, a blood sample is taken from the person and sent to a biosecurity laboratory level 4 to be tested for Ebola. This entry point to the ETC is one of the places where there is high risk of contamination of non-Ebola patients as they wait for the test result. Nevertheless, strict measures are taken for infection control and to avoid contact between patients while admitted, i.e. two-metre separation between beds in the ward and information sessions where people are explained safety procedures.

Establishing good communication channels with patients, their family members and the society in general is essential to curb the epidemic. For instance, the 21-day incubation period makes contact tracing a big challenge, how can authorities control people’s movements and monitor their health condition twice a day for 21 days? The way this extremely intrusive surveillance system is implemented is determinant for finishing with the epidemic. Under particular circumstances, like epidemics, states have legal power to restrict the liberty of individuals to protect public health. States have public health laws that empower authorities to impose control strategies in case of epidemics, i.e. quarantines. Quarantines are defined as the separation and restriction of movement of people who are not yet ill, but who have been exposed to a contagious disease.511 Despite its ancient

509 WHO. Contact Tracing During an Outbreak of Ebola Virus Disease, 2014.
510 The classification of cases relies on clinical, epidemiological, laboratory and high-risk exposure criteria, allowing the identification of persons required to be investigated for EVD and the differentiation of probable and confirmed cases for reporting. It needs to be contextualised according to transmission patterns, i.e. widespread or localised. See for instance, WHO, Case Definition Recommendations for Ebola or Marburg Virus Diseases, 2014; http://ecdc.europa.eu/en/healthtopics/ebola_marburg_fevers/EVDcasedefinition/Pages/default.aspx
origins—thirteenth-fourteenth centuries in Italy—and lack of technological sophistication, quarantine continues to be one of the only available public health measures to limit the spread of contagion.\textsuperscript{512} Incidents of non-compliance with police-imposed quarantines are common through history as those being asked to restrict their movement are asymptomatic, and most of them are not, and never will become, infected.\textsuperscript{513} This raises an ethical conflict of public health: individual vs. population rights and interests. Rothstein\textsuperscript{514}, in his article regarding the legal and ethical considerations for modern quarantine, argues that in order to obtain public support for the measure, four factors should be carefully addressed

(1) necessity, effectiveness, and scientific rationale; (2) proportionality and least infringement; (3) humane supportive services; and (4) public justification. Thoughtful incorporation of these considerations will increase the likelihood of a successful quarantine, thereby hastening the end of a deadly disease outbreak. Of equal importance, these considerations are essential to maintaining the social fabric of a society during the period of quarantine and thereafter.

Quarantine and \textit{cordone sanitaire}—limitation of movement in a geographic area where a contagious disease exists\textsuperscript{515}—were imposed in all West African countries. There were different positions and results, depending on the country and the stage of the outbreak they were at. For instance, in Nigeria and Mali the strategy was successful given that it was applied at a very early stage of the epidemic, with controlled transmission of the disease. On the contrary, in Liberia and Sierra Leone, countries with widespread transmission, the imposition of such measures had devastating effects, as Rothstein’s four factors were not addressed. NGOs like MSF and Oxfam were openly opposed to the imposition of the measure. They argue that, first, services where not reaching quarantined neighbourhoods as the number was rising exponentially and there was no capacity to plan and coordinate the support. Therefore, people were on the move in search of food, potentially spreading the disease if they had it.\textsuperscript{516} Second, the non-acceptance and non-compliance with the measures translated into clashes with authorities, where a teenager was killed. This reduced the trust in the government and politicised the response.\textsuperscript{517} Finally, quarantines increased the stigma and discrimination against the affected; they are identified as “Ebola


\textsuperscript{513} Rothstein, M., Talbott, M., 2007.

\textsuperscript{514} Rothstein M. \textit{From Sars to Ebola: Legal and Ethical Considerations for Modern Quarantine,} Indiana Health Law Review, 2015: 46.

\textsuperscript{515} Rothstein, M., 2015: 47


people” and are rejected and alienated by the rest of society.

Oxfam’s Sierra Leone country director explains:

This imposed restriction caused unnecessary hardship to families and communities who, in many cases, are already poor, marginalised, and vulnerable...The danger is that people will try and avoid quarantines, and there will be a knock-on effect with people under-reporting infections and deaths, or trying to care for Ebola victims at home, thereby furthering the spread of the killer disease. 518

Social burden of EVD outbreaks and responses

EVD outbreaks have the potential to have a huge social impact. As seen before, the measures taken by the authorities to control the epidemic and the way the response is carried out affect social dynamics. Furthermore, families are crippled, as several members often get infected and die when taking care of each other when getting sick. Infections can also occur when family members participate in burial practices that include washing and preparation of the corpse. 519 As the person’s condition worsens, the viral load increases creating general organ failure and death occurs. Consequently, the corpse of a patient who died of EVD is highly contagious. 520 For this reason, traditional burial practices that involve manipulation of the corpse are high amplifiers of the epidemic. Adaptation of this custom into safer behaviour is a must to control transmission in the community.

Generally, health-seeking behaviour will lead sick people to indigenous healers that will contract the disease, act as amplifiers as they pass it on to other people they treat, and later die as well. According to Hewlett and Hewlett, 521 the politics of blame around healers is not justified in all cases. During the Uganda outbreak in 2000-2001, the government banned all healing practices as they were thought to be infecting patients with unhygienic methods of cutting the skin. Their research in the region showed that this was not the case. The reason why they were transmitting the disease was related to the fact that when they became ill, people cared for them. After they died, as they were prominent figures in the community, many people also participated in the burial ceremonies, propagating the disease. As healers are important gatekeepers in the community, their participation in the response is essential. Nevertheless, caution should be exercised as certain healers may

approach the situation in harmful ways. Hewlett and Hewlett\textsuperscript{522} describe the example of a man whose vision of epidemic control passed through the killing of the sources of sorcery. In cases like this one, an established partnership with the healers may reinforce detrimental cultural models.

Going to the nearest clinic poses a risk for people as well. Health staff working in these clinics are highly vulnerable as they are ill prepared to receive EVD patients. Symptoms of the disease resemble those from other common diseases, therefore are easily mistaken. At the same time they lack the necessary protective material to care for patients. Consequently, the infection rate and CFR among the health staff and of patients attending health facilities is extremely high. Those who come to the centre and do not have EVD have great chances of getting infected due to the lack of proper infection control measures. These events lead to a decreased confidence in the medical system and in the EVD response in general. Another direct consequence of this situation is the reduced access to the health system by the community in an outbreak area. This increases the possibilities of dying of non-Ebola curable diseases such as malaria or TB, as well as due to pregnancy complications as women do not carry on with their monthly controls and deliver at home.

People who contracted the disease and their family members have to face stigma and discrimination from their communities. As Dr. O’Dempsey explains,

\[\ldots\text{there are issues about stigma...for our nurses for example and other healthcare workers, including drivers even...if you are working with Ebola patients you may find that your landlord doesn’t want you to stay any longer, that your family are afraid of you, they don’t want you to go to work...there are all these other issues that the health workers have to deal with. From the point of view of the patients, people are very afraid of the disease and therefore not wanting to associate themselves with people that are symptomatic...also with people who may have recovered...so people who are not infectious, who have survived the illness and have been discharged are themselves going back to communities where they might be ostracised or victimised in some way...so there is a huge amount that needs to be done in creating public awareness to addressing the fears that exist within the community...}\]

\textsuperscript{523} BMJ interview with Dr. Tim O’Dempsey, available at https://www.youtube.com/watch?v=luqH_zu8f1M&feature=youtu.be&list=PLiC5xPiBbjjUqb0D5LFwsz9Qxbbb3GHF; last accessed 21 February 2015.
If the person survived the disease, she is cured of EVD and develops immunity to the same virus strain.\textsuperscript{524} One study shows the presence of Marburg virus in the semen of a patient two months after the onset of symptoms. According to the research, the man infected his wife through sexual intercourse. This is the only registered case of transmission of the virus from a cured patient.\textsuperscript{525} In the case of EVD, research conducted with survivors in Kikwit, DRC, showed that the virus was present for ninety-one days in the semen of EVD recovering patients.\textsuperscript{526} There might be no information reaching the communities explaining these facts, leaving space for the creation of rumours and misinformation. This is detrimental not only for the patients and their relatives, but also increasing the fear and anxiety in the community.

This section has presented the model powerful actors use to construct and respond to emergencies. The emergency management approach develops techniques for managing health emergencies that can work independently of political context and of socio-economic conditions. The evidence presented shows how previous EVD outbreaks were easily controlled with a vertical international intervention. The current West Africa outbreak exposed the weakness of this approach when facing a longer-term problem. In the particular case of MSF, the organisation is not equipped to deal with structural socio-economic inequalities, which are beyond the scope of the biomedical intervention. Redfield\textsuperscript{527} describes the example of the HIV-AIDS programmes of the organisation, where they struggle to provide treatment for a chronic disease amid matters of poverty and unemployment they are unable to address. For Lakoff and Collier\textsuperscript{528}

The fact that emergency-oriented measures do not take into account the social realities of the contexts in which they are applied often undermines the effectiveness of such measures.

In an ideal world, each country’s public health system should be able to provide medical care to their citizens, even in acute circumstances. But, maybe we have to accept the need of humanitarian assistance in a world in which powerful actors do not show interest to end

poverty and inequity. The argument of this study is that even within the biomedical model, there is a way for humanitarians to approach the concept of emergency and the way they respond to it that allows participation of the affected people. Commonly, the media, films and documentaries show how the Western biomedical high-tech “saviours” and “heroes” risk their lives to save strangers\(^{529}\) from themselves. People affected by these outbreaks are generally characterised as naïve and prone to panic and violence. Local culture and social practices are seen by the predominant narratives as barriers to overcome. For some authors\(^{530}\) the term “epidemic” itself erases the diversity of accounts related to the outbreak. Aiming to widening the analytical gaze toward a more comprehensive understanding of the problem, the next section explores answers to the question that needs to be asked: how do humans view, explain and respond to infectious diseases outbreaks?

**EVD Outbreaks construction and Response: Cultural Models**

Cultural models refer to people’s knowledge and feelings about a particular realm. The concept derives from cognitive theory in anthropology.\(^{531}\) This theory is based on the proposition that how people think and feel about something dramatically impacts their behaviour. Applied to diseases, it refers to people’s explanations and predictions regarding the disease.\(^{532}\) This is what Kleiman\(^{533}\) calls explanatory models (EM).

Until the current outbreak there have been but a few studies of human perceptions and responses to EVD. As previously explained in this chapter, since 1976 there has been a certain interest in the topic, with a proliferation of books and movies describing the horrible bloody deaths of Africans succumbing to EVD. It is difficult to find in the literature information on how these “other” affected people from those out-of-the-way places view, perceive and respond to these outbreaks. When references are found they portray people as ignorant, superstitious and savage, needing the Western biomedical knowledge and wisdom to save them from themselves.

This section starts by presenting local affected communities’ perceptions and responses to EVD. It discusses how certain factors determine this vision, such as previous experiences

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\(^{529}\) Please see The Why Factor, BBC at http://www.bbc.co.uk/programmes/p026j78c, last accessed 15 February 2015.


of EVD outbreaks, history and politics. It explores as well the encounter with the Western biomedical model, how do they interpret the international response?

The work of anthropologists Bonnie and Barry Hewlett\textsuperscript{534} and Alain Epelboin\textsuperscript{535} has greatly contributed to shed light on “indigenous sciences” and local knowledge around EVD. Barry Hewlett is the first anthropologist who was invited by the WHO to participate in an EVD outbreak. Before the EVD epidemic in Gulu, Uganda, in 2000 this position was not considered as part of the response team. On the side of anthropologists there was not much interest in the specific topic until the current West Africa EVD outbreak. The role and contribution of anthropology and anthropologists to EVD outbreak control will be detailed in the document.

On the other hand, in spite of much new knowledge generated and made widely available about local affected communities’ perceptions and coping mechanisms, there is still a missing link. How to systematically incorporate all this valuable information into the humanitarian EVD operation responding to the epidemic? Continuing the work of the Hewletts on cross-cultural analysis of epidemics and on the explanatory bio-cultural model, this research develops a possible strategy to systematise contextualisation and the incorporation of such knowledge in the strategies as well as frame the participation of affected communities.

**Explanatory Models for EVD**

If the outbreak takes place in an endemic EVD area, most probably people from the region may have experienced diverse epidemics throughout their history, and over the time have accumulated cultural knowledge about these illnesses. Kleinman\textsuperscript{536} defines explanatory models (EM) as “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process.” In terms of content, EMs aim to address five aspects of illness episodes, namely the aetiology or cause of the condition, the timing and mode of onset symptoms, the pathophysiological processes involved, the course of sickness -natural history and severity, and the appropriate treatment for the

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\textsuperscript{536} Kleinman A. *Patients And Healers In The Context Of Culture : An Exploration Of The Borderland Between Anthropology, Medicine, And Psychiatry*. Berkley and Los Angeles: University of California Press; 1980.
condition. According to Kleinman’s theory, sicknesses (diseases) are based on biological realities experienced by the body, but illnesses are also produced within social, cultural, historical, economic and environmental conditions, ones that determine how the disease is understood and treated. Peter Conrad and Kristin K. Barker argue

Illnesses have both biomedical and experiential dimensions. Although often unnoticed or taken for granted, certain illnesses have particular social or cultural meaning attributed to them. These meanings adhere to the illness and may have independent consequences on patients and healthcare.

Epidemics affect social structure and function, but there is as well a biological impact of social disruption. Social disruption resulting from the occurrence of epidemic disease increases the biological impact of the epidemic, as assessed by the disease incidence. First, there is a need to identify the specific behaviours that constitute social responses to disease. As Malterud argued in her study, the biomedical variables considered of universal application need to be adapted to environmental cues and integrate humanistic matters that reflect value issues. Tinnaluck affirms that

Modern, or Western sciences, and indigenous knowledge systems (IKS) represent different knowledge systems because of their respective backgrounds and values, organising principles, habits of mind, skills, procedures and – how the knowledge is used.

Authors agree there is a need for the diverse knowledge systems to find ways of working together – with mutual recognition and respect – in a pluralist and complementary manner, for the good of mankind. A difficult task considering that in general, Western medical professionals are sceptic about what they consider “unscientific, scientifically unproven and ‘faith-based’ treatments for medical and psychiatric disorders.” Medical anthropology has developed several research areas related to medical relief responses, such as ethno-medicine, comparative studies of medical systems, cross-cultural studies of populations, nutrition, comparative epidemiology, and a strong focus on clinical studies.

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540 Malterud K. The Legitimacy of Clinical Knowledge: Towards a Medical Epistemology Embracing the Art of Medicine. Theory of Medicine, 1995.
Kleinman\textsuperscript{544} affirms that anthropological research linked to clinical work contributes to new knowledge, where culture is related to medical work.

For instance, Green\textsuperscript{545} conducted ethno medical research in six African countries and found that when it comes to diseases that account for the greatest morbidity and mortality, those biomedical classified as infectious and contagious, the indigenous and biomedical etiologic models are not very different in fundamental and important ways. But, he argues, health professionals commonly reject African medicine and promote Western medicine as if Africa were a tabula rasa, where there is a vacuum in the conceptualisation of diseases and their aetiology. Green\textsuperscript{546} defines the framework of local health knowledge as indigenous contagious theory (ICT).\textsuperscript{547} This framework comprises three interrelated types of etiologic belief. First, the naturalistic infection, defined by Murdock,\textsuperscript{548} as an invasion of the victim’s body by microorganisms, described as worms or tiny insects rather than germs and second, the mystical contagion, called pollution. This is the belief that people become ill as a result of contact with a substance considered dangerous because it is unclean or impure. People considered to be in a polluted state are kept apart from other people. Third, the environmental dangers, based on the belief that elements in the physical environment can cause or spread illness. One expression of this is the idea that contagious illness can be carried in the air or wind.

Dunn\textsuperscript{549}, physician and anthropologist, developed a framework for integrating anthropologic work into disease control efforts. This framework emphasises identifying both health-enhancing and health-lowering beliefs and practices of all present actors in a medical humanitarian response. An anthropological approach addresses political, structural, psychological, and cultural factors along with biomedical protocols not only as problematic to achieving medical objectives, but also as opportunities for collaboration. Understanding people, the community, their culture and social practices as co-participants rather than as vessels of disease could go a long way toward re-perceiving the varied encounters that lead to transmission.

\textsuperscript{544} Kleinman, A., 1980.
\textsuperscript{545} Green E. \textit{Indigenous Theories of Contagious Disease}. Walnut Creek: Altamira Press; 1999.
\textsuperscript{546} Green, E., 1999.
\textsuperscript{547} One of the critics to this model is the inadequate consideration of political and economic factors that also may affect the disease process (Singer, 1996).
Hewlett and Amola\textsuperscript{550} applied this framework to the 2000-2001 EVD outbreak in Gulu, Uganda. The results provided essential information about local views, explanatory models and responses to the outbreak. Their study was the first systematic socio-cultural analysis of EVD, and despite it being performed after the end of the outbreak—a limitation in the words of the authors—it provided useful data for control efforts as it showed how relevant it is to consider, and even more, to negotiate with the different explanatory models of an illness. According to their findings, the Acholi identified three primary EMs. In the early phases of the outbreak, many people thought about malaria or a bacterial infection, seeking biomedical treatment in the hospital (treated with chloroquine and tetracycline). As people continued dying, in certain areas, the chiefs asked the healers to look for poisons (yat) that may be causing the illness. By the time the biomedical model of EVD was introduced by the Ugandan Ministry of Health, the two other models were already in use by the local people. After, the illness has been identified as a killer epidemic (gemo). When this happened, a native protocol with epidemic control measures was applied. These measures implemented were consistent with the biomedical protocols being promoted by health workers. This study opened the path for the inclusion of socio-anthropological work as part of the response protocol for viral haemorrhagic fevers. In order to achieve total control of the epidemic it is essential to understand and include other knowledge systems, discourses, and practices into the relief operation.

When I worked in Bundybugyo, Uganda in the 2006 EVD outbreak, I researched the Babwesi, Bankonzo, Bayiras and Bambaas EMs for EVD and the international response. The shifting patterns of cultural models resembled those identified by the Hewletts in Gulu. According to the information provided, at the first stage of the outbreak, before the international intervention, there was a lot of fear and panic among the population, especially in Kykyo, the area where the first cases appeared. In this remote place, up in the mountains, two families lost 5 and 6 members respectively. One of the first affected families is Bakonzo and the other one is Baamba/Babwese. These early cases were explained through sorcery or other cultural beliefs, such as the cannibals had bewitched the people to take them away; the Baambas/Babwesi had poisoned the Bakonzo with spoiled palm oil; the Bakonzo brought and used the power “befalu” against the Baambas/Babwesi; Emirimu came. Emirimu are the spirits created and associated with forests, water, trees,

caves and other lonely places. In certain cases, such spirits were believed to be at work when there were epidemics. According to Magesi et al.,\textsuperscript{551} travellers used to sleep in caves in the bamboo-forested part of the mountain. When inside, they would hear voices saying: “let us close the door before we rest.” Those taking shelter in the cave would immediately leave or else a big stone would close the entrance. It is interesting how there is a link as well with the scientific knowledge regarding the possible reservoir of the EVD, the bats. Bats are found in caves; in fact, most MHF outbreaks known were linked to mines and people working in them.

As the outbreak continued, and people from both tribes contracted the disease and died, the EM turned into a known illness, the “akasenene.” This disease has traditional protocols, which were put in place to some extent. At the declaration of the outbreak and consequent arrival of the international teams and introduction of the biomedical model in the community, the deaths and cases continued. The community now started to create other stories for the epidemic, related to politics, the government and the intervention of the “white people” in the outbreak. Rumours started proliferating, such as if you go into the isolation ward, you will die; the government wants to kill all infected people so they will stop the epidemic; the whites are injecting water to the people, like they did in Gulu, to kill the sick ones and finish with the epidemic.

As soon as the intervention started, the biomedical model was introduced in the community through a multidimensional health education programme: brochures, radio, theatre, and songs. A burial team formed by an anthropologist, a psychologist, a health promoter and a water and sanitation technician was responsible to ensure safe adapted burials to avoid contamination and ensure families’ and communities’ wishes were taken into account. Many health workers were affected and both the health post in Kykyo and the hospital in Bundibugyo were transmission amplification points, so people were afraid to go to be treated. At the same time, health workers refused to go back to work without proper protection. In general, discharged patients were accepted back in the community. The family was the first one welcoming the person. The health promotion and the psychosocial support teams worked with both the family and the community. The community in general welcomed the teams and appreciated the work done.

Rumours

Rumours, especially in the critical early phases of a crisis, can determine the outcome of the crisis. In 1951, Peterson and Gist\textsuperscript{552} published a paper in which they describe different types of rumours. Among them, they focus on the ones that appear spontaneously, under conditions of social unrest. They claim that this kind of rumour can be considered the product of collective efforts to interpret a problematic situation, when the public views the situation affectively and when authoritative information is lacking...A social setting conducive to rumour occurs when a public is interested and concerned about a past or anticipated event...and when social controls relevant to the situation are external to most members of the public.\textsuperscript{553}

The evidence of this definition can be clearly seen in the case of the ongoing West Africa outbreak. Rumour exists in the absence of secure standards of evidence –in the form of scientific knowledge– on the lack of authoritative explanation, and when foreign solutions to the problem are applied. Until the current outbreak studies related to EVD were scanty, as explained in previous sections of this document. Consequences of this are limitations in the understanding of the virus and its behaviour, as well as the inexistence of specific drugs for treating or preventing the disease. This uncertain basic knowledge, plus the lack of experience in dealing with an EVD outbreak, constitute the substance of information campaigns and communication strategies. The matter of the “official” information spread during the current outbreak was a major issue in all affected countries. Real-time research on Ebola communication in Guinea conducted by Johns Hopkins University in September 2014\textsuperscript{554} revealed, among other aspects, that the content of the messages linked to a lack of understanding of the functioning of the ETCs and mistrust in the foreign intervention impacted directly in the way people responded to the outbreak and the response. Messages addressed to the public were stating that there is no treatment or cure for EVD, ant that 90% of sick people will die. They then prompted people to go to the hospitals if they develop symptoms. One woman from Conakry\textsuperscript{555} told me in an informal conversation, once you go inside the hospital [ETC], you will come out in a black plastic bag to be thrown into a pit somewhere...nobody else gets to see your face again once you go in... why go to the hospital, if I am going to die, I’ll die at home with my family...

\textsuperscript{553} Peterson, W., Ginst, N., 1951: 159.
\textsuperscript{554} Coordination National Ebola, Note Conceptuelle Pour La Mise En Oeuvre Des Comites De Veille En Reponse A L'epidemie A Virus Ebola En Republique De Guinee, 17 Novembre 2014.
\textsuperscript{555} Personal informal conversation with a woman from Conakry in the market, November 2014.
In Sierra Leone, the situation was similar, as an account from Dr. Tim O’Dempsey, working in the UK government-run Kenema ETC explains,

There were lots of rumours flying around about what was happening on the wards, and I think it’s very understandable…if you think about people being admitted to wards that their relatives have no access to, and the people wondering around these wards, the healthcare providers wearing these very weird looking suits…it is a very frightening experience for people in the community…added to that the knowledge that many people who are admitted into that environment are going to die…I think is entirely understandable that people would have a reluctance to bring their loved ones to be cared for in that environment.556

The messages were also misleading, as they told people to go to the hospitals or health facilities, in general. As was mentioned in the previous section of this chapter, the health system of these West African countries is ill prepared to deal with the outbreak. Health structures lack the resources to safely receive possible EVD sick people. It is a risk both for the public and for the health workers who either get contaminated or refuse to see patients in order to protect themselves. This concatenation of events, resulting from a combination of structural problems and a major lapse in the devising of the communication campaign, feeds the proliferation of rumours, the mistrust in the authorities and the search for alternative solutions to the problem. All of which contribute to the propagation of the disease.

**The Role of Anthropologists: Minding the Gap**

Barry Hewlett has been working with health workers throughout the Ebola outbreak in an effort to find culturally appropriate forms of treatment and containment for the virus that don’t alienate West African communities or undermine important cultural practices. Yet, according to his narrative, it was not an easy task to be deployed the first time with the WHO in Gulu, Uganda in the year 2000. When he heard of the outbreak, given his expertise in the anthropology of infectious diseases, he had the initiative to call the CDC and the WHO and offer to collaborate in the EVD response. Only a month later the WHO got in touch with him, when the number of cases was on the rise and the teams were experiencing “problems” with the local people.557 My personal account resembles very much that of Hewlett. When I was called to participate in the Uganda 2007 Bundibugyo outbreak they told me I was going as a logistics coordinator. Once I reached Kampala, the

556 BMJ interview with Dr. Tim O’Dempsey, available at https://www.youtube.com/watch?v=luqH_zu8f1M&feature=youtu.be&list=PLtC5xPiBtjUq0D5LFwsz9Qxbbb3GHF, last accessed 21 February 2015.
medical coordinator asked me if I would be able to work as an anthropologist in the project because it seems there are some issues with the community. He openly told me that he had no idea what my job would be like, but the field said that maybe an anthropologist could help to solve the situation. Whether the WHO, the CDC or MSF, it seems that everyone shared the same position regarding anthropologists working on EVD outbreaks. There was not a clear understanding of how the discipline’s tools and anthropologists could play a part in outbreak control efforts.

Yet, it seems like the story repeats outbreak after outbreak. International responders do not include anthropologists in their teams until complications in the field arise. For instance, during the 2005 MHF outbreak in Uige, Angola, anthropologists were not part of the initial response team. The response was based on the biomedical protocol. No communication channels were established with local communities and all efforts were placed on isolating the cases, tracing the contacts, burying the dead and burning their belongings as infection control measures. After facing serious difficulties to implement the biomedical protocol due to the mistrust and reluctance of the community to collaborate, organisations on the ground changed their perspective and opened up to the inclusion of anthropologists to address the issues. Their contribution had a positive impact. A published article that evaluates the MSF response from the community perspective concluded the containment of the MHF epidemic depended on the collaboration of the affected community. Actively involving all stakeholders from the start of the outbreak response is crucial.

Controlling VHF outbreaks requires not only medical expertise but also adhesion to control measures by the concerned populations. The acceptance of control measures, essential element of response operations, remains the fruit of an intense social mobilisation. The inclusion of anthropological work in the VHF control efforts can improve the quality of the response, to make it more “human-friendly”, and therefore gain faster acceptance in the community. After the year 2000, the contributions of the work of anthropologists progressively translated into policy change. At the present time, in-force policies and guidelines from key EVD response actors contain a section on anthropological

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aspects, health promotion and community engagement.\textsuperscript{560} Nevertheless, this does not ensure systematic application in the field. As discussed earlier in the study, the idiosyncrasy of the humanitarian system is to devise very comprehensive policies that are never put into practice. The current West Africa outbreak is the living proof of this argument. Rather than instruction manuals and guidelines, measures adapted to each context must be devised for each situation to thoroughly manage coercive needs and mesological constraints relating to the specific indigenous, ecological, economic, political, cultural, psychological, historic and religious characteristics of the region.\textsuperscript{561} The issue is how to systematise this approach and include it in the standard humanitarian response.

It is relevant to remark as well that there has not been, until the West Africa outbreak, a massive interest on the side of anthropologists to contribute in EVD outbreak responses. There were just a few anthropologists specialised in infectious diseases who spearhead the way to the inclusion of the discipline in field operations\textsuperscript{562} It must be said that this could be an extremely challenging job to undertake for an anthropologist. Security constraints may impede them from working in the usual way, i.e. staying for longer periods with the people they are researching. They may have issues adapting to the pace of relief operations as they adapt to the changing context. It could be difficult for researchers to grasp the dynamics of the international response, as well as their protocols. There is an adaptation specific to humanitarian aid that needs to take place; both in the mind and in the tools and methods anthropologists will apply in the field of humanitarian assistance.

As part of the initiatives taken by scholars, a global Ebola Emergency Anthropology Network has emerged, drawing from experts from the US, UK, Canada, France, Netherlands, Belgium, Germany, Senegal, Liberia, Sierra Leone and Guinea. This network operates across multilingual online platforms.\textsuperscript{563} Valuable information from experts in the region is made rapidly available to practitioners. The initiative has great value and is certainly appreciated. Nevertheless, there is a critique that has to be made. There is a gap between the production of academic knowledge and the practice of humanitarian aid.

\textsuperscript{562} As previously mentioned, Barry and Bonnie Hewlett and Alain Epelboin.
There is a need to devise modes of cooperation between both disciplines. This EVD outbreak is providing an incredible window of opportunity to develop this collaboration. I was invited to an Emergency Ebola Response workshop organised by the American Anthropological Association (AAA) in November 2014 and to the AAA Annual Meeting, in December 2014, both in Washington D.C. Academics organised the panel discussions including practitioners in the field of anthropology and EVD. Very fruitful discussions with practical consequences took place during those meetings. The findings of one of the roundtables where I participated, “Averting chronically acute crises: Bringing anthropology to and from the global Ebola response”, were published in the journal Anthropology Today. While working in Freetown, Sierra Leone, I met with Prof. Susan Shepler, one of the AAA Ebola network steering committee members. She came to visit the Kissy ETC with Prof. Nina Yamanis and I explained to them the work I was doing, focusing on details regarding the operationalisation of anthropological knowledge. They were positively impressed with the way the anthropological approach was applied in practical terms in the EVD outbreak response. They published a report of the visit in their blog, Sierra Leone’s Invisible War.

Another area where the contribution of anthropologists has been highly requested is in the clinical trials that are currently taking place in the affected West Africa countries. Both the WHO and UNMEER contracted anthropologists to conduct assessments before the vaccines trials start in Guinea. I am a member of the MSF Ebola Experimental Products Investigation Platform. This platform interacts with the Consortium at WHO level as implementing partner for the trials. As an anthropologist, I have conducted research in Guinea before the Favipiravir and convalescent plasma trials started. Some of the outcomes of my work were published together with the work of other anthropologists in one article that discusses the social meaning of blood.

From the position I currently occupy in MSF, together with colleagues working in similar positions in other sections of the organisation we are working towards the normalisation of the relation between anthropology and humanitarian aid. If we manage to take advantage of the momentum this EVD outbreak is providing, this may be the beginning of a

collaboration path between the two disciplines. I believe we are at a stage where both are listening to each other with interest, leaving pre-judgements aside. We are beginning to pave the way; hopefully we will make it easy to transit for the benefit of the people humanitarian aid aims to assist.
Conclusion

I make many claims in this study. My primary argument is that the roots and original values that gave birth to Western humanitarianism, as recognised today, are still embedded in its discursive and practical forms. Despite being considered to be universal, the grandiloquent ethical humanitarian discourse has historically proved to be a one-sided discourse, stemming from European ideals and interests. Rooted in nineteenth century Christian charitable ethics, humanitarianism was aimed to help victims of conflict in European territories. An enterprise created by Westerners, based on Western values to aid Western citizens. As it starts expanding its frontiers, it carries along what Benthall calls an “unconscious ethnocentrism”, or, in the words of Prof. Taithe, a “fully assumed sense of superiority” in the way assistance is provided. The continuous expansion and growth of the humanitarian system brought along an increased focus in the quality of humanitarian assistance. Evaluations carried out were looking at the performance of a system, in a navel-gazing exercise. These revision processes gave birth to major changes in the structure and internal functioning of the system. They were centred as well around the standardisation and professionalisation of aid delivery, aiming at faster deployments to save more lives. Surely, the ongoing response to the EVD epidemic in West Africa will be followed by an evaluation. WHO director-general Dr. Margaret Chan addressed the Special Session of the Executive Board on Ebola in Geneva stating the need for urgent change in three main areas:

To rebuild and strengthen national and international emergency preparedness and response, to address the way new medical products are brought to market, and to strengthen the way the WHO operates during emergencies. The Ebola outbreak had revealed “some inadequacies and shortcomings” in the WHO’s administrative, managerial, and technical infrastructures, including the need for “a dedicated contingency fund” to support rapid responses to outbreaks and emergencies; “streamlined recruitment procedures” in order to increase the agency’s personnel base; the application of a “one WHO” approach in which all levels of the agency use “the same standard operating procedures, tools, and frameworks for risk assessment, monitoring, and accountability during emergencies” and need to enhance crisis management and field experience during emergencies in WHO country offices.

The question to pose is, would this be another navel-gazing exercise leading to yet another internal restructure in Agyris’ single- or even double-loop learning? The root of the

568 Prof. Bertrand Tahite, suggested the change in the term used. 16 February 2015.
problem is structural: poverty. Applying the structural violence approach, it can be argued that West Africans suffer this EVD epidemic because of global and national political-economic inequalities, histories of exploitation, corruption, and poverty.\textsuperscript{570} Certainly these measures do not address these issues, far more complex to solve. More than complexity is the lack of will or interest from the international community in changing the world order. Better create yet another “dedicated contingency fund” to support rapid responses to outbreaks. Dr. Chang neither referred to changes in the humanitarian approach, on the contrary, she stressed more the standardisation of procedures and tools at all levels of operations. There is a need to make participation and empowerment of affected peoples a reality, to re-think the hegemonic accounting of time (history) and the spatial distribution of knowledge (power) that constructs emergencies and humanitarian aid.

The history of the humanitarian system shows its limitations to incorporate the complexity and diversity of global realities. On the one hand because it was purposely used to attain other goals, so there was no real intention to achieve humanitarians’ objectives. Humanitarian operations’ raison d’être is to assist people caught in crisis. Not placing the people undergoing those circumstances at the centre of analysis undermines the humanitarian mission. Locating other elements as priorities –like politics, economics, organisational mandates, or personal aspirations– has consequences in all facets and at all levels of the humanitarian mission. On the other hand, I suggest that the idiosyncrasy of Western humanitarian aid is greatly responsible for the lack of success of aid delivery. For the purpose of the study I proposed to particularly focus on three aspects of evaluations to the responses to the genocide in Rwanda in 1994, the Indian Ocean tsunami in 2005 and the earthquake in 2010 in Haiti. These reports repeatedly mention as causes of failure the lack of understanding of local contexts and cultures, the inability to establish communication channels with the affected communities and finally the failing to recognise local capacities as a starting point to develop ownership of humanitarian responses.

For instance, analysing the successful response to the EVD outbreak in Nigeria in juxtaposition with the three recurrent reasons for failure of humanitarian aid provides important information for the objective of this research. Firstly, the decision-makers’ group, and most members of the EOC were by large a majority Nigerians, mostly Lagos residents. This fact was pivotal in the understanding of the context, the society and the

\textsuperscript{570} Farmer, P., 2005.
humanitarian arena. This knowledge was embedded in the construction of the strategy.

Secondly, communication channels with the society were established from the very beginning of the outbreak and the response. A strong emphasis was placed on the strategy to ensure the creation of bi-directional channels of communication. The society had ways to be heard, the connection was established and there was fluid dialogue between the general public and those responsible for the response. Finally, highly committed and motivated leaders mobilised people to participate in the response at all levels in the society. The common citizen felt the responsibility to contribute to the success of their control programme.

Three particular aspects of the response to EVD outbreaks are relevant for this study. Firstly, MHF and EVD outbreaks show the limitations of science to solve these health problems given the failure to produce a cure or a preventive vaccine to the diseases. Treatment for EVD is limited to supportive symptomatic therapy as there is no specific treatment to cure or prevent the disease developed at the time of writing this document. Secondly, in the response there is recognition of the key role that societal determinants and lifestyle play in infectious maladies affecting both their dissemination and control – i.e. burial practices, health-seeking behaviour and explanatory models for the disease. Finally, even though this key role is acknowledged and addressed in policy, there is no systematic inclusion of actions and resources to address these social determinants in the actual response. Moreover, people affected by the disease are rarely considered agents to contain transmission.

Each EVD outbreak is unique, and community understanding of diseases and their spread is complex, context dependent, and culturally-mediated. Therefore, a one-size-fits-all response is not sufficient. Understanding and addressing local views and responses to EVD is crucial to help control outbreaks. Beliefs and behaviours that are health lowering and therefore favour the spreading of the disease should be targeted for change. At the same time, beliefs and behaviours that are health enhancing and contribute to the control of the infection should be identified and encouraged. Involving the community in the response to the outbreak from early stages is key to developing a comprehensive and successful response. Despite the repeated lessons learned in different outbreak responses where this
approach was not applied, it is still neglected by powerful actors who lead outbreak control operations. The development and application of an anthropological approach to EVD plays an important role in the outbreak response as it deals with the three failures and frames the analysis of the situation in an inclusive manner, putting together both socio-cultural aspects and biomedical response protocols. Nevertheless, the anthropological tools and methodologies need to be adapted to the humanitarian reality. A tailored humanitarian anthropology should be developed that could be applied in any relief project in any context. Work towards this goal has started.
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