ABOVE: The executive board room of the World Health Organization.
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TWO STATES OF EMERGENCY

EBOLA 2014

Andrew Lakoff revisits the received wisdom that the WHO was slow to respond. Slow to respond to what exactly?

In the late summer and early fall of 2014, as the Ebola epidemic spun seemingly out of control in West Africa and threatened to spread globally, multiple observers began to weigh in on where the failure of response lay. The international response had been "slow and feeble," wrote two leaders of Médecins Sans Frontières (MSF). "It can equally be defined as irresponsible" (Nierle and Jochum 2014). World Bank President Jim Yong Kim noted multiple lapses: health care systems had not been put in place, monitoring was not conducted when the first cases appeared, and there was no organized response. "We were tested by Ebola and we failed," he concluded (Elliot 2014). The diagnosis of failure, of course, assumes a locus of responsibility. From this perspective, the disaster was neither unforeseen nor uncontrollable: the epidemic was not an unavoidable danger but a manageable risk, and therefore it demands a retrospective accounting.

The World Health Organization (WHO) received much of the criticism; the organization learned of the outbreak in March but did not declare an official emergency until August, and even then had difficulty galvanizing an intensive international response. The WHO "should be the global leader" in directing and coordinating international health efforts, argued two legal scholars, but the organization's institutional weakness and lack of control over its resources had made it unable to lead global health response: "Failures in leadership have allowed a preventable disease to spin out of control, with vast harms to social order and human dignity" (Gostin and Friedman 2014). Journalist Laurie Garrett was even more scathing: "The WHO's response has been abysmal. It's just shameful." In defense of its leaders, however, she also noted "WHO is just a shadow of its former financial self" because of the changing priorities of its member nations (Renwick 2014).[1]

Meanwhile, WHO was already engaged in critical self-scrutiny. In October, the Associated Press reported that an internal WHO investigation revealed that the agency had "missed chances to prevent Ebola from spreading soon after it was first diagnosed in Liberia, Sierra Leone and Guinea last spring, citing factors such as incompetent staff and a lack of information," but also the inappropriate application of response methods that had been successful in other settings to the region of the 2014 outbreak (Cheng and Geller 2014).[2]

In this essay I offer a somewhat different interpretation of the "failure." Rather than focusing on a lack of resources or organizational weakness, I suggest that the failure was one of administrative imagination: global health authorities did not conceptualize Ebola as the source of a potentially catastrophic global epidemic, but rather categorized it as a disease that could be managed via localized humanitarian care combined with straightforward public health techniques. I focus on a moment that looks, in retrospect, like one of lost opportunity: in late March and early April, when the outbreak was first reported to WHO. Why, a number of critics have asked, did the agency not immediately declare a global health emergency and seek to galvanize international response (see Fearnley, this issue)? Why did it wait until five months later to do so, and more than a month after MSF warned that the outbreak was "totally out of control"?

An initial way to pose the question might be: To what extent, as of spring 2014, did the Ebola outbreak present a global health emergency? It is useful to begin with a timeline of the early stages of international response. In mid-March, MSF discovered suspected Ebola cases near its malaria clinic in Guéckédou, Guinea. Within a week, MSF launched an emergency response: doctors, nurses, logisticians, and hygiene and sanitation experts were sent to Guinea; isolation units were set up in Guéckédou and elsewhere; and 33 tons of supplies (such as personal protective equipment and palliative medicines) were shipped to Guinea from warehouses in Belgium and France. This was an event for which MSF was well prepared. As Peter Redfield notes in this issue, MSF had lengthy experience with prior Ebola outbreaks and was the only organization with the personnel, equipment, and treatment protocols available for rapid response to this one.

On March 25, the Guinean Ministry of Health officially notified WHO of the outbreak, reporting 86 suspected cases and 60 deaths. Such notification pointed toward the potential declaration by the WHO Director-General of a "Public Health Emergency of International Concern" (PHEIC), an alert that puts into motion the administrative mechanism of emergency response that is at the heart of WHO's "global public health security" system (see Collier and Lakoff 2008).[3] This system, laid out in the revised International Health Regulations (IHR; WHO 2005), is designed to ensure continued state sovereignty over public health response to an outbreak while at the same time regulating state actions to minimize disruption of the global economy and ensuring that international health authorities can monitor and seek to minimize the

1 "The WHO's legislative body, the World Health Assembly, has consistently voted to downgrade the institution's capacity to deal with outbreaks and infectious disease in favor of increasing commitment to noncommunicable disease programs such as cancer and heart disease" (Renwick 2014).

2 "Its own experts failed to grasp that traditional infectious disease containment methods wouldn't work in a region with porous borders and broken health systems, the report found" (Cheng and Geller 2014).

3 A "Public Health Emergency of International Concern" is defined in the 2005 IHR as an "extraordinary event which is determined...(i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response" (WHO 2005).

circulation of the disease. Thus, within the IHR framework, the declaration of a PHEIC points toward a WHO role of coordination and collaboration with presumably functioning national public health systems, and toward an intensive effort to mobilize international assistance.[4]

However, unlike the outbreak of a novel strain of influenza in 2009, the detection of Ebola in the spring of 2014 did not automatically provoke such a declaration. In the prior two decades, Ebola had undergone a conceptual mutation: it was no longer the novel and fearsome virus that helped spark attention and resources to the phenomenon of "emerging infectious disease" in the late 1980s and early 1990s (see King, this issue). By 2014, global health authorities approached its detection with relative confidence. Its pattern of transmission was understood; methods of containment had been developed and standardized. In more than a dozen outbreaks since its initial discovery in 1976, the disease had never killed more than a few hundred people.

However, there were early indications that this event might be different. At the end of March, MSF described the outbreak as one of "unprecedented" magnitude in Guinea, with cases also reported in Liberia. MSF Director Bruno Jochum reported that the disease "had spread to several places and to a large city," making it "an exceptional event for an Ebola outbreak up until today" (Samb 2014). Despite these worrisome signs, Jochum lamented, the international response had so far been "minimal." In contrast, a WHO spokesman sought to assuage public concern, emphasizing that the event should not be considered an "epidemic" but was rather a "relatively small" outbreak in comparison with previous outbreaks (Samb 2014).[5]

Like MSF, WHO was quickly on the ground in Guinea. After its laboratories confirmed the reported cases, the agency deployed teams to the field "to strengthen surveillance, sensitize and educate the public, manage cases and implement appropriate infection prevention and control measures in health facilities and communities affected" (WHO 2014a). An internal situation report from April 2014 (WHO 2014c) describes a WHO "surge" in West Africa of more than 50 staff members as well as members of the Global Outbreak Alert and Response Network (GOARN) "in accordance with the grading of the outbreak as a grade 2 emergency under the WHO Emergency Response Framework."[6] On the response framework's scale of 1 to 3, a grade 2 emergency indicated an "event with moderate public health consequences," requiring a moderate response from health authorities (WHO 2013:19). The framework is a form of technocratic triage: In a world suffused with emergencies, decision-makers must have a means for deciding how to allocate scarce resources.[7]

At an April 8 press briefing, WHO Assistant Director-General for Health Security Keiji Fukuda provided an evaluation of the situation. On the one hand, he acknowledged this was "one of the most challenging Ebola outbreaks that we have ever faced," both because of the wide geographic distribution of cases and the level of fear and anxiety the outbreak had provoked (WHO 2014b). On the other hand, he expressed confidence that it would be controlled, given experts' familiarity with the disease: "We know very well how this virus is transmitted, we know the kinds of steps that can be taken to stop the transmission of the virus" (WHO 2014b). It was a straightforward matter of identifying the sick, tracing their contacts, and then taking careful prevention and control measures.[8]

By early May, it seemed that Fukuda's confidence had been warranted: few new cases had been reported in either Guinea or Liberia, though MSF "remain[ed] vigilant," and on May 14, WHO reported that "the outbreak seems to be slowing down" (MSF 2014). A U.S. Centers for Disease Control (CDC) epidemiologist on the scene would later recall: "For most of May, we had no new cases showing up at the treatment centers in Guinea or Liberia, and it was possible to think it might have run its course" (Wieners and Kitamura 2014). In retrospect, however, it is clear that over the next month a second wave of the disease was emerging beyond the view of health authorities. On June 20, an MSF director of operations appealed for help from international health organizations, reporting that the outbreak was "totally out of control" (Gander 2014). On July 11, MSF declared that it was in a "race against time" to stop the spread of the disease in Sierra Leone. And yet the international response remained tepid

4 IHR (WHO 2005) states: "If WHO…declares that a public health emergency of international concern is occurring, it may offer… further assistance to the State Party, including an assessment of the severity of the international risk and the adequacy of control measures. Such collaboration may include the offer to mobilize international assistance in order to support the national authorities in conducting and coordinating on-site assessments." The IHR acknowledged that many states lacked the capability for effective emergency health response, but instructed the treaty's signatories to "develop, strengthen, and maintain" such a capacity within five years of the adoption of the regulations—though no funding was allocated for poor countries to do so.

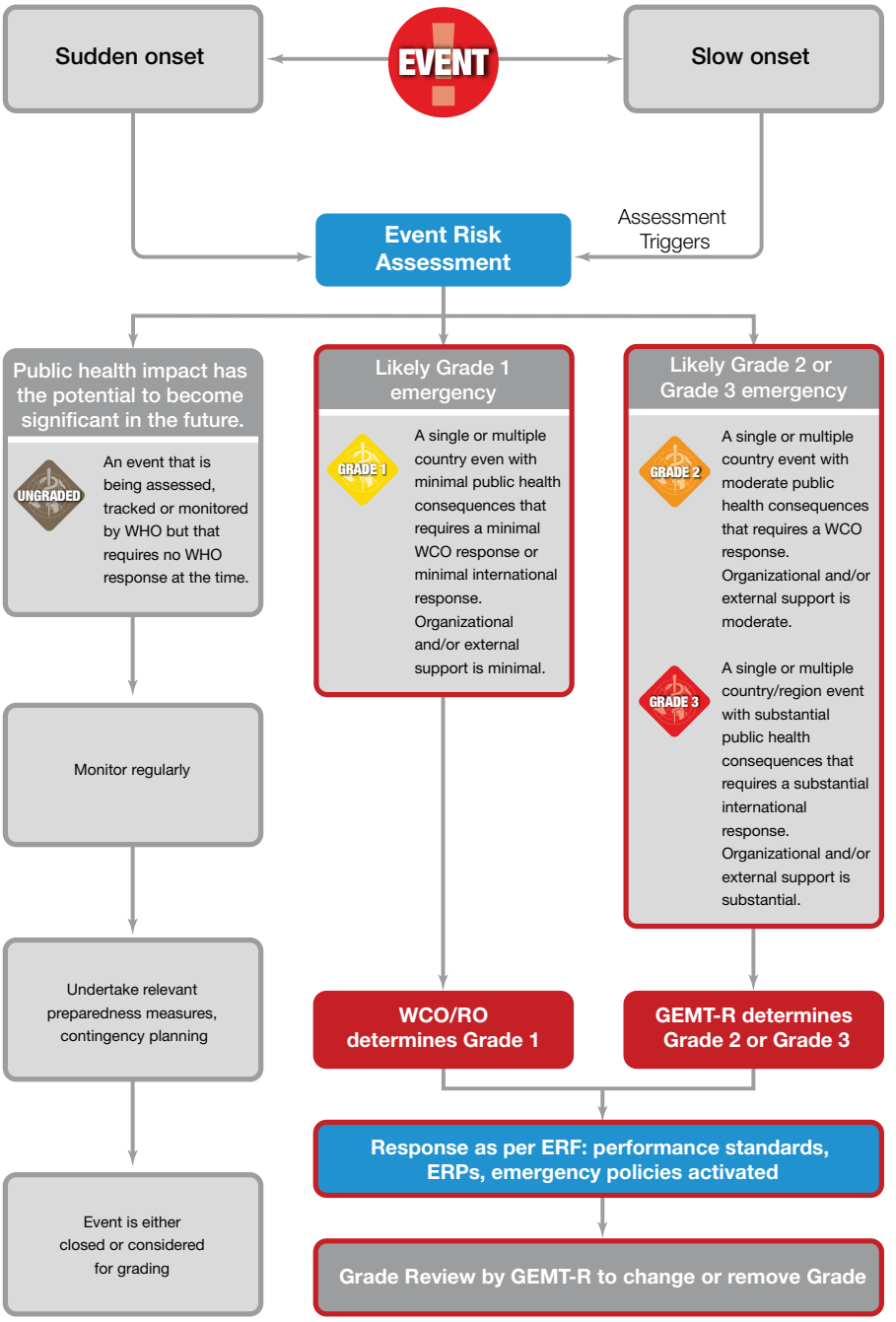
5 Gregory Hartl, the WHO spokesman, was concerned not to overstate the severity of the outbreak: "Ebola already causes enough concern and we need to be very careful about how we characterize something which is up until now an outbreak with sporadic cases" (Samb 2014).

6 Deployments included 52 WHO staff and 22 experts from among its global outbreak and response network (GOARN) partners (WHO 2014c).

7 "Over the decade 2001–2010, an average of more than 700 natural and technological emergencies occurred globally every year, affecting approximately 270 million people and causing over 130 000 deaths annually." Notably, the Emergency Response Framework was adopted (following the U.S. system of incident management) by WHO in 2013, not long after the agency was accused of massive over-reaction to the detection of a different pathogenic threat, A/H1N1 (swine flu), in 2009. See note 10.

8 The April 17 situation report (WHO 2014b) evinced a somewhat more nuanced view of the unfolding situation, pointing to the ways in which this event was in fact unlike prior Ebola outbreaks: it was unfolding in a major city, a number of health workers had been infected, and there had been cross-border transmission of the virus.

How the World Health Organization grades emergencies: The Emergency Response Framework



FROM *WORLD HEALTH ORGANIZATION, EMERGENCY RESPONSE FRAMEWORK* (2013), P. 50

until late July, when two U.S. humanitarian workers came down with the virus and Nigeria announced its first case.[9]

On August 8, 2014, WHO officially declared a PHEIC and established an emergency committee. "The outbreak is moving faster than we can control it," acknowledged Director-General Chan. The declaration of a global health emergency, she said, "will galvanize the attention of leaders of countries at the top level" (WHO 2014d). Replying to the question of what had finally sparked the official declaration, Fukuda pointed to "the identification of the travel-related case, in Nigeria": Ebola was now threatening to spread outside of the immediate region via air travel.

The PHEIC declaration did not by itself direct an infusion of medical care for afflicted populations: rather, WHO recommended that affected states should activate their emergency management mechanisms, engage in risk communication to improve citizens' awareness of the disease, establish secure pipelines of protective medical equipment, and screen travelers for signs of the disease. An ethics committee approved the emergency use of experimental medication (insofar as any such medication could be procured). The emergency declaration did not suspend normal constitutional order (even as individual states did so), nor did it recognize a "stateless" place of complex humanitarian emergency; rather, it was a technocratic classification that activated a system of anticipatory monitoring and response that hopefully would staunch the disease's spread along the circuits of global interconnection.

At its press briefing following the official declaration of emergency, a reporter questioned Director-General Chan about the WHO's belated response. She attributed it to the agency's "stretched" resources:

> **Q:** [G]iven that the first cases I think were reported in Guinea in March, I'm wondering if the response from WHO and others was insufficient at the beginning. Did we not pay enough attention to this? Did we somehow fall down on the job?
>
> **A:** Let's be very frank. WHO is, at this point in time, or actually, for the last few months, dealing with four Level Three humanitarian crises; they are the biggest, meaning the highest level of crisis, and these are Central African Republic, South Sudan and Syria, and of course, at the same time, we are dealing with three outbreaks, Ebola, MERS-CoVirus, and H7N9, and we have actually mobilized all assets in WHO, and as I said, we are extremely stretched... (WHO 2014d).

And yet, as we have seen, WHO was closely monitoring the outbreak in West Africa in the spring, and had the capacity at that time to coordinate a broader response, or at the very least to galvanize international attention.[10] As significant as the number of emergencies WHO was faced with at the time is its decision—noted above—to initially grade the Ebola outbreak as a "grade 2" emergency.

In conclusion, let us return to the question posed above: Was the outbreak a global health emergency as of April 2014? Is WHO to blame for not responding more aggressively? Perhaps the better question is not whether the initial outbreak should have been considered an emergency, but rather: What kind of emergency was it? If at the time of the outbreak Ebola was best understood as a "neglected disease" that afflicted marginal populations in settings characterized by the absence of state-based health infrastructure, it called for a response from humanitarian biomedicine, concerned with the compassionate alleviation of human suffering regardless of national borders and political conflict. If, alternatively, Ebola was an "emerging disease" that threatened global catastrophe, then it demanded the intensive, coordinated response of international and national health agencies. We can say that some time during the late summer of 2014, Ebola shifted from one state of emergency to another.

Accompanying this shift was a change in the conceptualization of the disease. What changed was not its biological but rather its techno-political meaning. If in the decades prior to the 2014 outbreak Ebola had stabilized as a dangerous but fairly manageable virus, the public health understanding of the disease now had to take other elements into consideration: in particular, the extent to which its virulence and transmissibility—its capacity to provoke a global health emergency—depended on the condition of the local public health infrastructure in which it appeared. ■

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9 At this point, WHO increased its Emergency Response Framework Grade to level 3.

10 Another reason why WHO may have been hesitant to immediately declare a PHEIC is that in 2009 the agency was accused of rashly declaring an emergency very soon after the appearance of H1N1 (swine flu). European critics charged experts on the WHO Emergency Committee with a conflict of interest for encouraging the mass purchase of vaccines that had been developed by companies with whom they had paid consulting relationships. See Lakoff (2013).

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