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COMMENTARY

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The Ebola crisis dominated Western media in late summer 2014, even though the first case was reported six months earlier. Sensational news coverage contributed to fears of Africa as a disease-ridden continent and to the dehumanization of Africans navigating the epidemic (Dionne & Seay 2015). International responses to the health crisis in West Africa have been slow in coming and not always particularly effective, despite the efforts of local health workers and nongovernmental organizations including Médecins Sans Frontières and Samaritan’s Purse. Western governments’ designation of the Ebola crisis as a crisis of security for the West also seemed to put Africans who were ill and dying in the same category as politically motivated terrorists.

Analysts attribute the outbreak’s severity to slow response by domestic and international decision makers and to the persistent poor health care conditions in Guinea, Liberia, and Sierra Leone. In this commentary, we demonstrate how these conditions are shaped by historical and contemporary contexts of international political economy. After providing a brief
background on the epidemic and then setting the scene that led to the emergence of Ebola in West Africa in 2014, we document the response by domestic and international decision makers to the outbreak, identifying critical junctures in which domestic and international responses—in the forms of action and inaction—produced the current and rapidly evolving situation. We conclude by discussing policy implications of this response and potential directions for future research.

Background

The 2014 West African Ebola outbreak was the first recorded in the region, and the largest on record.¹ Researchers estimate it began in Guinea in December 2013 in Méliandou Village, Guéckédou District (Baize et al. 2014). It was not until March 21, 2014, however, that Guinea’s Ministère de la Santé et de l’Hygiène Publique (Ministry of Health and Public Hygiene) reported its first suspected Ebola cases to the World Health Organization (Dixon & Schafer 2014). By the end of March, Liberia reported Ebola cases in Foya District, located near Liberia’s border with Guinea. By late May Ebola cases were reported in Sierra Leone in Kailahun District, which borders both Foya District in Liberia and Guéckédou District in Guinea. Ebola has since spread within these countries and beyond.

The outbreak is ongoing, and by the end of 2014 20,206 people had been infected. Of those, 7,905 died (WHO 2014a). Previous Ebola outbreaks often occurred in remote locations and were contained in a single country. This outbreak, in contrast, has been regional in scale, spreading into densely populated urban areas and across multiple international borders. More than 99 percent of recorded infections have been in Guinea, Liberia, and in Sierra Leone. Cases linked to this outbreak were also reported in Mali, Nigeria, Senegal, Spain, the United States, and the United Kingdom (see map below).

Historical and Contemporary Political Economy in Ebola-Affected Countries

Initial international media coverage of the 2014 Ebola outbreak focused largely on the cultural practices that heightened risk for contracting and transmitting the disease (e.g., Fox 2014; Thompson 2014; see also McGovern 2014). However, analysis of earlier epidemics demonstrates that an emphasis on individual behavior or “exotic cultural practices” often obscures the larger political economic context shaping the likelihood of a major disease outbreak and the ability of relevant actors to respond. In this commentary we follow the advice of Schoepf (1991), who, writing about HIV/AIDS in the 1990s, urged analytical approaches to epidemics that use a social lens and consider a dynamic relationship between political economy and culture, rather than viewing them as a function of institutional failures, cultural practices, or individual behaviors. We focus in particular on international political economy—what has been described elsewhere as “geographically
broad and historically deep” analysis (Farmer 2006:xiii)—and how it has shaped the conditions that spurred and intensified the spread of Ebola in the region. Following chronological order, we examine the continued relevance of (1) the trans-Atlantic slave trade, (2) colonialism, (3) structural adjustment policies, (4) civil wars at the turn of the millennium, and (5) postwar foreign aid dependency.

**The Trans-Atlantic Slave Trade**

Social, political, and economic organization in the region has been shaped, in part, by the legacy of centuries of trans-Atlantic slave trade. As scholars of the region have noted, frequent and small-scale warfare, particularly from the eighteenth through the early twentieth centuries, was driven by the desire...
to gain power through capturing land and selling and trading slaves. Avoiding enslavement required alliances with powerful families, kingdoms, or other political entities, and constant shifting of ethnic and political identifications and allegiances (Bledsoe 1980; McGovern 2012). Unstable, uncertain conditions cultivated through this enduring history of enslavement, warfare, and shifting loyalties produced enormous capacity for adaptation to crises, mistrust of various kinds of outsiders, and discretion in the face of extreme danger. The legacy of the trans-Atlantic slave trade continues to shape the contemporary attitudes of ordinary citizens, particularly in terms of their trust or distrust in others, including the government (Nunn & Wantchekon 2011). Levels of trust, as we discuss later, matter for how individuals and communities react to government and international interventions against Ebola.

Colonialism

The outbreak’s epicenter has a well-documented colonial history of interconnected epidemics—sleeping sickness, smallpox, and Spanish influenza—suggesting not only an enduring relationship among pathogens, local ecologies, and migration patterns, but also the persistence of cross-border collaborative responses (Lachenal 2014). During the smallpox and flu outbreaks of World War I—both of which were attributed to international wartime commerce—colonial governments levied fines for hiding sick people, and village authorities initiated quarantines and led active house-to-house surveillance, case detection, and isolation. Such interventions deepened already tense relations tied to inflated food prices and rising colonial taxes on households. These early epidemics also triggered sluggish responses, furthering mistrust and antagonism between colonial governments and their subjects (Killingray 2003; Tomkins 1994). The extent to which these events and political practices linger in local memory and history has been little explored, but may prove instructive in the continuing analysis of the outbreak (see Rashid 2011; Tomkins 1994; Cole 2006; Lachenal 2014). Of course, Guinea, Sierra Leone, and Liberia had different colonial experiences, with Guinea having been colonized by the French, Sierra Leone by the British, and Liberia by U.S. corporate interests. 2

Structural Adjustment Policies

Structural adjustment policies (SAPs), instituted in the 1980s by international financial institutions such as the International Monetary Fund (IMF) to support economic development in low-income countries, had enduring negative consequences for health care provision (Rowden 2009; Pfeiffer & Chapman 2010). IMF loan conditionalities restricted government spending on social services, including public health and health care. They also placed a limit on public sector wages, including for health care workers, and decentralized health care in a way that has served as a barrier to “mobilizing coordinated, centralized responses to outbreaks” (Kentikelenis et al. 2015).
Protracted conflicts in the Mano River region arose in the wake of these World Bank and IMF policies and in response to a political elite unaccountable to citizens after decolonization (Conteh-Morgan 2006).

**Civil Wars**

Outbreaks of the scale of the current Ebola epidemic are most likely to occur in places where long civil conflicts and continued marginalization within a global economy have led to deteriorated health systems and economic conditions (Bausch & Schwarz 2014). The epicenter of the outbreak was also ground zero for a decade of civil wars spanning the 1990s and early 2000s. In Liberia and Sierra Leone, tens of thousands were killed, and millions were displaced internally and to other countries in the region. Health facilities in Liberia and Sierra Leone were among the institutions destroyed or left to deteriorate during the war (Kruk et al. 2010; Hodges et al. 2011). Training for health workers, along with much tertiary-level education, was suspended or severely limited in the most affected areas (Challoner & Forget 2011), and the most well-trained health workers fled as the war intensified and to take advantage of employment opportunities abroad (Clemens & Pettersson 2008). Guinea, while never officially engulfed in civil war, experienced skirmishes in towns and villages at the border with Sierra Leone, and at great national expense (and benefit), it provided refuge for people fleeing wars in Sierra Leone and Liberia (Jacobsen 2002; Van Damme 1999).

**Foreign Aid**

During the wars and in the fragile postconflict period, humanitarian groups substituted for a receded public sector to provide health care in the three countries (Kruk et al. 2011). Some of these groups continue to operate today within a patchy network of health services, while others, in collaboration with government agencies, have slowly devolved responsibility for providing health services to international NGOs or the government. In each of the affected countries, health care expenditures are largely financed not by governments but by households and international donors. Because most households have severely limited income, serious illness can be a significant financial burden for families and communities. Since the introduction of SAPs, health aid has been redirected to international NGOs and away from governments (Pfeiffer & Chapman 2010). But unlike domestic governments, international NGOs lack the motivation and mandate to develop comprehensive health systems with robust public health surveillance or primary care. Instead, they often generate “vertical” programs designed to address specific target groups—for example, pregnant and lactating women or children under five—and diseases. Vertical programs have been fairly effective for eradicating diseases and improving key indicators like immunization rates; more recently, as in the case of HIV/AIDS treatment, increased financial support for vertical programs has been premised on the notion that
specific targeting will collaterally strengthen health systems (Benton 2015). But while targeted programs may improve progress along some key indicators, there is evidence that vertical programs can crowd out delivery of other health services, particularly in settings with few health care workers (Grépin 2012). Vertical programs have not improved public health capacity to respond to emerging infectious diseases like Ebola in these three countries.

**Responding to Ebola in 2014**

Early in the outbreak, ordinary people navigating the epidemic in their communities were—unsurprisingly—frightened and mistrustful. Ebola patients would leave treatment centers out of fear and suspicion of health workers dressed in head-to-toe protective gear (Fofana 2014a). Many of the region’s residents questioned whether Ebola was real (Fofana 2014b). In Liberia there were rumors that medical personnel treating the infected were spreading the disease on behalf of political leaders motivated to solicit foreign aid (Epstein 2014). In the forest region of southeastern Guinea, a group of young men attacked and killed members of a team of journalists and health educators (Tinti 2014). Regional observers understood these actions within a larger pattern rooted in deep-seated suspicion of earlier government interventions (McGovern 2012; American Anthropological Association 2014). Citizens have expressed dissatisfaction with their governments’ responses to the epidemic. In July 2014 a Liberian man set the country’s health ministry offices on fire to protest the government’s handling of Ebola, reportedly after losing a relative to the disease (Williams 2014). In November residents of the Guinean village where journalists and health educators were attacked launched a hunger strike in front of Parliament to protest military occupation of their community (BBC 2014). Given the historical context provided above, we should expect that ordinary people navigating an epidemic would be suspicious of the motives and directives not just of their governments, but also of local agents implementing health interventions on behalf of their governments. It should not be surprising that these suspicions could further antagonism toward governments.

Citizens’ fears of Ebola go beyond suspicion of government motives to rational assessments of the intersection of the poor health systems serving them and the deadly nature of Ebola itself. The fatality rate of Ebola can be as high as 90 percent when access to effective supportive therapies—replacement of electrolytes and fluids, blood transfusions, and other forms of intensive palliative care—is limited. The cumulative negative legacy of war and SAPs on health care provision was acute at the outset of the outbreak: there was too little expertise for managing Ebola cases, and there were too few hospital beds, supplies, and personnel to provide intensive care for the increasing number of seriously ill patients. In settings already experiencing a health worker shortage, the 2014 outbreak made a bad situation worse. By the end of 2014, six hundred and sixty health workers had been infected in Guinea, Liberia, and Sierra Leone, of whom three hundred and seventy-five died (WHO 2014a).
Early response to the Ebola outbreak relied largely on the heroic efforts of local health workers and burial teams, who were poorly supported by their governments. In Sierra Leone and Liberia, in fact, these workers went on strike when their employers failed to pay them or provide the appropriate gear and equipment (Fofana 2014c; Agence France-Presse 2014a).

Evaluations of domestic government responses to the epidemic have mostly been critical. To their credit, all three countries, early in the epidemic, activated their national emergency response committees, drafted Ebola response plans, and carried out needs assessments (WHO 2014b). However, action on those plans was sluggish or weak, largely due to the governments’ limited experience with the disease and subsequent underestimation of the epidemic’s potential (Fofana 2014b; Nossiter 2014). For example, by April 2014 Guinea President Alpha Condé claimed that the disease was under control and publicly criticized Médecins Sans Frontières (MSF, or Doctors Without Borders) for issuing dire warnings about the outbreak. It was not until August—at which point five hundred Guineans had been infected—that President Condé began attempts to tackle the problem in earnest (Nossiter 2014).

More aggressive domestic government responses were mostly inadequate and no more effective at curbing transmission of Ebola. In June, for example, Liberian President Ellen Johnson Sirleaf declared that her government would prosecute anyone “reported to be holding suspected Ebola cases in homes or prayer houses” (Sirleaf 2014), and Sierra Leone’s President Ernest Bai Koroma made a similar statement shortly thereafter (Fofana 2014b). But these threats of prosecution—echoing those used during epidemics in the colonial period—were largely ineffectual. Worse yet were actual uses of force. One of the best known failed domestic responses was the ten-day quarantine in West Point, a densely populated informal settlement in Liberia’s capital, Monrovia. During the quarantine, Liberian security forces clashed with neighborhood residents, injuring several and killing a teenager (Epstein 2014).

Some contend that other government-supported interventions were more effective. Sierra Leone implemented a three-day house-to-house outreach and lockdown in late September, during which more than twenty thousand field workers visited homes to identify new cases and provide health education. While many observers were initially skeptical of the initiative, the effort and scale of its reach were generally praised (O’Carroll 2014). Swiss scientists argued, however, that while the initiative may have helped to identify infected individuals, the stay-at-home period was too short to significantly interrupt transmission (Agence France Presse 2014b).

Another problem—and an enduring legacy of SAPs and their emphasis on health care provision by nongovernment actors—was the heavy reliance in the three countries on aid organizations to provide patient care, particularly early on in the outbreak. Most prominent was MSF, which quickly opened several isolation units and sent sixty health care workers to the area even before the initial reported cases were confirmed to be Ebola (Sack et al. 2014). However, by late June MSF officials reported that the outbreak was out
of control and that they had exhausted all their available resources. At that point they implored domestic governments and the international community to supply more resources (Doctors Without Borders 2014), but these early dire proclamations were generally dismissed by local governments and the World Health Organization (Fofana 2014a; Nossiter 2014; Youde 2015).

Yet another major challenge was the large number of actors responding to the outbreak and a lack of clarity in regard to who should lead the effort. The cross-border nature of the outbreak required coordination among multiple organizations, including the local ministries of health of Liberia, Guinea, and Sierra Leone, the World Health Organization, MSF, the U.S. Centers for Disease Control and Prevention (CDC), UNICEF, bilateral aid agencies, and other nongovernmental and aid organizations. The World Health Organization (WHO), the United Nations’ directing and coordinating authority for health, is responsible for providing leadership on global health, giving technical support to countries, and monitoring and assessing health trends. But though the WHO was the unquestioned leader in international health immediately after World War II, other organizations—intergovernmental bodies as well as private corporations, philanthropic organizations, and civil society groups—have expanded their mandates to cover global health issues, and new health organizations have emerged, severely restricting the WHO’s ability to be a leading voice (Brown, Cueto, & Fee 2006; Youde 2012). Nonetheless, many looked to the WHO to lead and coordinate the response to the outbreak.

Global health analysts have characterized the WHO response as “woefully inadequate” (Youde 2015) and plainly a “failure” (Busby & Grépin 2015). In an internal draft document in October 2014, the WHO blamed staff members in Africa for initially bungling the response to Ebola, describing many of them as “politically-motivated appointments” and noting numerous complaints about WHO officials in West Africa (Ahissou & Cheng 2014). But the organization’s slow and out-of-touch response was also the product of a much more basic logistical problem—the fact that a global health agency headquartered in Geneva, Switzerland, was tasked with leading the response to an epidemic in West Africa. A report in the Washington Post on the failure of the global response captured the essence of this dynamic: “Officials hold faraway strategy sessions about fighting emerging diseases and bioterrorism even as front-line doctors and nurses don’t have enough latex gloves, protective gowns, rehydrating fluid or workers to carry bodies to the morgue” (Sun et al. 2014). Even in the limited sphere of “coordination,” the WHO failed: the Africa regional office rebuffed collaboration with the CDC, and WHO officials disputed claims by MSF that the epidemic was out of control (Youde 2015).

The WHO response was also terribly slow. It was not until July 2 that the organization convened a meeting to bring together local ministries of health and other partners to discuss a collective response (WHO 2014c), and a subregional outbreak coordinating center was not established until mid July (in Conakry) (Youde 2014). It was not until August that the WHO declared the 2014 Ebola outbreak a Public Health Emergency of International
Concern (WHO 2014d); this was five months after the first cases were reported to the WHO, and by this time 1,779 people had become infected, 961 had died (WHO 2014e), the outbreak had spread to Nigeria, and two American aid workers infected in Liberia had been evacuated to the United States (see timeline). In November an election was held to change the leadership in the WHO Africa regional office, but by then the U.N. had already taken more direct charge of the control efforts (Ahissou & Cheng 2014).

In September U.N. Secretary General Ban Ki-Moon announced during an emergency meeting of the U.N. Security Council the creation of the U.N.’s first-ever emergency health mission, the United Nations Mission for Ebola Emergency Response (UNMEER). In his remarks, the secretary general stated that the WHO had the necessary “strategic perspective” but lacked “a very strong logistics and operational capacity” (U.N. Security Council 2014a). Rather than increasing the capacity of the WHO to respond effectively, U.N. officials insisted upon this parallel effort. Particularly interesting was the rhetoric supporting UNMEER’s creation, which invoked international security concerns above other motivations; the resolution adopted at the end of the emergency meeting stated that “the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security” (U.N. Security Council 2014b). The security paradigm—and particularly one in which threats from West Africa were spreading to the West—therefore colored U.S. and European responses to the crisis. 7

Colonial legacies are obvious in the organization of Ebola response. While general assistance in each of the countries has been multinational, military assistance has been delivered along old colonial lines, with the United States sending aid to Liberia and the United Kingdom assisting Sierra Leone. A fraught decolonizing relationship between Guinea and France, by comparison, appears to have limited France’s response to the outbreak in Guinea; a visit to the affected region by French President François Hollande did not take place until late November 2014 and by the end of 2014 the French government had only begun to sketch a coordinated response.

Conclusions

Clearly more research is needed to provide an in-depth investigation of the issues we raise in brief here. For example, anthropologists and political scientists could explore the institutional cultures and political-economic factors that influence health systems and that might strengthen health initiatives. Historians could examine the role played by the colonial legacy and its influence in the outbreak and the ability of governments to respond. For example, Ebola’s disregard of national borders has yielded a natural experiment in the differential impact of French and Anglo colonial legacies. We suspect that there are even more relevant questions. As Guillaume Lachenal (2014) asked, “What histories does the Ebola epidemic ask for?”

For all of the devastation it has caused, Ebola has also afforded the opportunity for serious conversations about building health systems with robust public
Timeline of West African 2014 Ebola Outbreak

INDEX CASE DIES IN GUECKEDOU, GUINEA

LIBERIA REPORTS TWO CASES

FIRST WHO REPORT: 49 CASES IN GUINEA

MSF SAYS ITS RESOURCES ARE EXHAUSTED

WHO DECLARES INTERNATIONAL HEALTH EMERGENCY

US PRESIDENT PROMISES $6 BILLION

FIRST CASE IN US

FIRST CASE IN MALI

UNMEER ESTABLISHED

FIRST CASE IN NIGERIA

FIRST CASE IN SENEGAL

FIRST CASE IN SPAIN

FIRST CASE IN UK

EBOLA CASE COUNT PASSES 1,000

EBOLA CASE COUNT PASSES 10,000

EBOLA CASE COUNT PASSES 20,000

US COMMITS $175 MILLION

FIRST AMERICAN INFECTED
health capacity to detect and respond to outbreaks (Ahissou & Cheng 2014). The poor response by the WHO demonstrates that in its current structure, it is incapable of responding to cross-border public health emergencies (Youde 2015; Busby & Grépin 2015). The Ebola outbreak and the failures in responding to it highlight the need for public health scholars and policymakers to reevaluate a number of factors, including bilateral agreements for providing health care; the adequacy of the health workforce; infrastructural, financial, and institutional barriers to building functioning public health systems; and the diverse needs of the populations living in the most affected countries.

References


Commentary: The 2014 West African Ebola Outbreak


Notes

1. Ebola is an infectious virus that often results in death. Ebola transmission requires close contact with someone who is sick, and thus the most at-risk populations are family members or health care workers caring for the infected. Any time between two and twenty-one days after infection, a patient’s early symptoms will include fever, weakness, muscle pain, headaches, and a sore throat. The disease progresses to vomiting, diarrhea, impaired organ function, and in some cases, bleeding. There is no vaccine to protect against Ebola, and there are no specific treatments beyond managing symptoms of those infected.

Evidence suggests there was at least one earlier, unrecorded outbreak in Sierra Leone, some time before 2008 (Schoepp et al. 2014) and possible outbreaks in Liberia as early as the late 1970s (Knobloch et al. 1982; Van Der Waals et al. 1986). In August and September 2014 there was also an unrelated Ebola outbreak in the Democratic Republic of the Congo (DRC) that culminated in sixty-six cases, of which forty-nine people died; on November 24, 2014, the World Health Organization reported no new cases had emerged in the preceding forty-two days, meaning the 2014 DRC Ebola outbreak was over (Centers for Disease Control and Prevention 2014).

2. Liberia is often referred to as one of two African countries that was never colonized (the other being Ethiopia). While it is technically true that Liberia was never formally declared a colony of a major power, Padmore (1931) notes that U.S. officials referred to Liberia as a “protectorate” and that the American company Firestone “enslave[dl] millions.” See also Schecter (2012).

3. The humanitarian NGO Médecins Sans Frontières, for example, has operated in each of the three countries for decades now, providing wartime emergency services and supplementing and supporting government health initiatives in the postconflict period. The organization, which initially led the Ebola response in the region, operated in Liberia for more than twenty years until 2012, when the “emergency phase” came to an end, and it returned in 2014 after the Ebola outbreak (see www.msf.org.uk/country-region/liberia). It has worked in Sierra Leone since 1986 (see www.doctorswithoutborders.org/country-region/sierra-leone) and in Guinea since 1984 (see www.doctorswithoutborders.org/country-region/guinea), providing training and support to government health facilities and health workers and for disease-specific community-based surveillance and treatment.

4. For example, in Sierra Leone in 2012, 87% of health care funding came from abroad; households cover 76% of the costs of payment for health care services while government carries 17% of the costs (World Health Organization 2012).

5. Governments were not alone in miscalculating a premature departure of Ebola. After seeing no new cases for a month in Liberia in early May, MSF withdrew and ceased its operations; word from the government, while cautious, was optimistic that the outbreak was nearing its conclusion (UNICEF-Liberia 2014; Sack et al. 2014).

6. After a surge in cases in Sierra Leone’s diamond-rich Kono District, a second lockdown was declared in December 2014. Large holiday gatherings were forbidden, causing international news outlets to proclaim dramatically that Christmas had been canceled (Moore 2014).

7. Indeed, a substantial pledge of financial and military support from the U.S. government to Liberia for the Ebola response followed the first two American cases of Ebola in August (White House 2014a), which was further increased after the first Ebola case was diagnosed on American soil in late October (White House 2014b).