TOPIC: INTERNATIONAL HUMANITARIAN INTERVENTION AND AFRICAN PANDEMICS: A CASE OF THE WORLD HEALTH ORGANISATION (WHO)’S RESPONSE TO THE 2014 EBOLA OUTBREAK IN WEST AFRICA.

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A thesis submitted in partial fulfilment of the requirements for the degree of Master of Science in International Relations (MSc. I.R) of the Bindura University of Science Education, Faculty of Social Sciences and Humanities.

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DEDICATION

I dedicate this study to all those who contributed towards the fight against Ebola in West Africa; whom without their efforts the sole objective of ‘humanitarian intervention’ would not have been achieved.
ACKNOWLEDGEMENTS

To all the respondents, who participated in this research study and enabled me to complete the research, to which without whose cooperation, this work could not have been fruitful. Special recognition goes to Dr. Wesley Mwatwara for his insightful scholarly perspectives and constructive criticism of this study; and to Mr. Yaya Sanyang, for sharing his personal experiences, challenges and exploits of his sojourn in Sierra Leone, Guinea and Liberia as part of the W.H.O personnel who volunteered to contribute to the fight to pacify the spread of Ebola in West Africa.
ABSTRACT

The outbreak of the 2014 Ebola Virus Disease (EVD) in West Africa caught the region by surprise considering the fact that West Africa was inadequately prepared to deal with an epidemic of such magnitude. Due to its unprecedented impact to the three most affected countries of the Mano River region – Guinea, Sierra Leone and Liberia, the Ebola virus was unique as characterised by the severity of its transmission, size and rapidity of spread to urban areas which was further exacerbated by the multi-country outbreaks occurring simultaneously. To this end, this study explores the international community response to the EVD outbreak in West Africa; in particular W.H.O’s response which had the mandate and authority to lead and coordinate a global health emergency response to the Ebola outbreak of 2014 in West Africa. This study utilised various data collection tools including documentary review of submissions on speeches and a plethora of W.H.O Situational Reports that were produced in the initial phases of the Ebola outbreak. These were complemented by carrying out key informant interviews with academic experts in the public health field and W.H.O personnel from Zimbabwe who were involved in containing the outbreak of the Ebola virus. The research established that lack of timely international response, lack of emergency response models in limited resource countries, mistrust and resistance by the affected population, traditional beliefs and cultural attitudes towards health-seeking behaviour, poor governance and the legacy of protracted civil strife in the Ebola hard-hit countries which all complicated international humanitarian efforts to contain the outbreak. As a way of recommendation, this study posits that the international community should rethink humanitarian intervention approaches to disease outbreaks in low income developing countries like Liberia, Guinea and Sierra Leone, where significant public health knowledge gaps exists which impede effective international humanitarian relief and epidemic control efforts.
TABLE OF CONTENTS

Declaration Form........................................................................................................i
Approval Form...........................................................................................................ii
Release Form............................................................................................................iii
Dedication................................................................................................................iv
Acknowledgements..................................................................................................v
Abstract....................................................................................................................vi
Table of Contents......................................................................................................vii
Abbreviations...........................................................................................................xii

CHAPTER 1: INTRODUCTION

1.1 Background of the Study.......................................................................................1
1.2 Statement of the Problem......................................................................................2
1.3 Purpose of the Study............................................................................................3
1.4 Research Objectives............................................................................................3
1.5 Research Questions...............................................................................................3
1.6 Assumptions.........................................................................................................3
1.7 Significance of the Study.....................................................................................4
1.8 Limitations of the Study.....................................................................................4
1.9 Delimitations of the Study..................................................................................5
1.10 Definition of Key Terms....................................................................................5
1.11 Chapter Outline..................................................................................................6
1.12 Chapter Summary...............................................................................................6
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction..................................................................................................................7

2.1.1 Theoretical Framework............................................................................................7

2.1.2 Conceptual Framework............................................................................................8

2.2 State Sovereignty; Responsibility To Protect and the Changing Nature of Humanitarian Intervention.................................................................9

2.2.1 Responsibility To Protect and Humanitarian Intervention.................................10

2.2.2 State Sovereignty and Humanitarian Intervention..............................................11

2.3 Situating Global Health; Human Security and Humanitarian Intervention to the Ebola Virus Outbreak Response in West Africa.........................................................12

2.4 Ebola Virus Disease Trajectory in West Africa..........................................................14

2.4.1 What is Ebola Virus...............................................................................................14

2.4.2 History and Origins of Ebola................................................................................15

2.5 Country Specific Ebola Virus case studies in West Africa.........................................15

2.5.1 Guinea....................................................................................................................16

2.5.2 Liberia...................................................................................................................17

2.5.3 Sierra Leone........................................................................................................17

2.5.4 Nigeria..................................................................................................................18

2.6 Chapter Summary........................................................................................................19
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction ................................................................. 21
3.2 Research Paradigm ......................................................... 21
3.3 Research Design ............................................................ 21
3.4 Research Methodology ..................................................... 22
3.5 Population ................................................................. 23
3.6 Sampling ................................................................. 23
   3.6.1 Sampling Methods ..................................................... 24
   3.6.2 Snowball Sampling ..................................................... 24
   3.6.3 Expert Purposive Sampling .......................................... 24
3.7 Data Collection Methods ................................................. 25
   3.7.1 Documentary Review .................................................. 26
   3.7.2 Interviews ............................................................ 26
3.8 Validity and Reliability .................................................... 26
3.9 Ethical Considerations ..................................................... 27
3.10 Data Presentation and Analysis Procedures ......................... 28
   3.10.1 Qualitative Data Analysis .......................................... 28
   3.10.2 Thematic Analysis .................................................... 28
3.11 Chapter Summary ........................................................ 29
CHAPTER 4: DATA PRESENTATION; ANALYSIS AND DISCUSSION

4.1 Introduction..................................................................................................................30
4.2 Pitfalls to WHO’s response to the 2014 Ebola Virus Outbreak in West Africa..........30
   4.2.1 Bureaucratic Pitfalls...............................................................................................31
   4.2.2 Delay in pronouncing a Public Health Emergency of International Concern....31
   4.2.3 Absence of an Emergency Health Workforce.........................................................32
   4.2.4 Lack of Adherence to the International Health Regulations...............................33
   4.2.5 Lack of Funding.....................................................................................................34
   4.2.6 Lack of an Emergency Contingency Fund...............................................................34
   4.2.7 Lack of commitment by Member states .................................................................34
4.3 Impact of the 2014 Ebola Virus Outbreak to West Africa........................................35
4.4 Chapter Summary .........................................................................................................38

CHAPTER 5: SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction..................................................................................................................39
5.2 Summary of Findings..................................................................................................39
5.3 Conclusion....................................................................................................................39
5.4 Recommendations......................................................................................................40
5.5 Areas for Further Research........................................................................................43
References.......................................................................................................................44
Appendix 1: Introductory Letter.......................................................................................48
Appendix 2: Key Informant Interview Guide.................................................................49
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
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<td>ETC</td>
<td>Ebola Treatment Centers</td>
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<td>EVD</td>
<td>Ebola Virus Disease</td>
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<td>HTC</td>
<td>High Transmission Countries</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>MSF</td>
<td>Médecins Sans Frontières (Doctors Without Borders)</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MRU</td>
<td>Mano River Union</td>
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<tr>
<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
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<tr>
<td>R2P</td>
<td>Responsibility To Protect</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Emergency Children’s Fund</td>
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<td>UNMEER</td>
<td>United Nations Mission for Ebola Emergency Response</td>
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<tr>
<td>UNOCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>W.H.O</td>
<td>World Health Organization</td>
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CHAPTER 1: INTRODUCTION

1.1 Background of the Study

The World Health Organization (W.H.O) was founded in 1948 as a United Nations (U.N) specialised agency responsible for directing and coordinating global public health policy and interventions. Since its inception in 1948, W.H.O has been at the forefront of coordinating intervention mechanisms to public health crises in the field of epidemiology and eradicating communicable diseases including malaria, tuberculosis, H1N1 virus and most notably, the elimination of Smallpox in 1979. Except for Security Council Resolutions 1308 on HIV/AIDS, the Ebola 2014 outbreak in West Africa constitutes only a second time that the United Nations Security Council has intervened to directly deal with a public health emergency as noted by the subsequent establishment of the U.N Mission for Ebola Emergency Response (UNMEER).

The 2014 Ebola Virus outbreak in West Africa has been the largest and most complex in the 40-year-old history of the virus detection in Africa, with the majority of infections and deaths cases occurring in East and Central Africa particularly Guinea, Liberia, and Sierra Leone. It was publicly declared a global health epidemic on 8 August 2014 by the World Health Organization (W.H.O) and by that time, the calamity statistics had reached 3 707 of reported cases and 1 808 reported deaths.

It took several months for W.H.O to designate the West African Ebola Virus outbreak a Public Health Emergency of International Concern (PHEIC); which was only a third time that such classification had been invoked since the creation of the International Health Regulations in 2007; and this was after Médecins Sans Frontières (MSF) had urged for such a declaration in March 2014. MSF President, Joanne Liu warned the United Nations against losing the battle against the Ebola epidemic in West Africa, calling the international community laissez faire efforts ‘a coalition of inaction’ (UNSC, 2014). It was until 18 September 2014, that the United Nations Security Council (UNSC) had its first emergency meeting on the Ebola crisis and adopted UNSC Resolution 2177 of 2014; and the subsequent establishment of the U.N Mission for Ebola Emergency Response (UNMEER).

Since the outbreak of the Ebola virus in West Africa, the international community and political leaders in West Africa were presented with a challenge of lack of an emergency response strategy to public health emergencies in low-resource income countries like Liberia,
Sierra Leone and Guinea. As such, this research seeks to explore the W.H.O’s reasons for the delay of an ‘emergency response’ to the outbreak of Ebola in West Africa and to demonstrate why humanitarian intervention continues to be a controversial topic not only for the United Nations but also for the international humanitarian organisations like W.H.O and other international non-governmental organisations at large.

This research acknowledges that the W.H.O was a crucial player in the fight against the Ebola epidemic of 2014 in West Africa. However, the slow response by W.H.O in declaring the 2014 Ebola virus in West Africa ‘a Public Health Emergency of International Concern (PHEIC)’ and the delayed intervention casts doubt on the effectiveness of international humanitarian intervention mechanisms.

1.2 Statement of the Problem

The Ebola virus disease outbreak presents a major public health concern to Africa and the world. However, the Ebola virus was mistakenly thought by the international community, W.H.O in particular to be endemic to Central and East Africa. The outbreak and duration of the 2014 West African Ebola virus epidemic created a global public health crisis so severe that the then W.H.O Director-General Margaret Chan in a presentation at the UNSC called it ‘the greatest peacetime challenge that the United Nations and its agencies have ever faced,’ (WHO | WHO Director-General address to the UN Security Council on Ebola). The W.H.O has been widely criticised by various public health academics and international relations scholars for its slow and delayed intervention to the crucial early stages of the detection of the Ebola Virus in West Africa. Chan argued that the international community including W.H.O, ‘was ill prepared to deal with an epidemic of such magnitude’ making the 2014 Ebola outbreak several times larger than all previous Ebola outbreaks combined. An initial alert was issued to the W.H.O in March 2014 by the Ministry of Health of Guinea, and W.H.O dismissed the call as a mere ‘alarmist’ call and it was only until 8 August 2014, that the W.H.O declared the Ebola outbreak in West Africa a Public Health Emergency of International Concern (PHEIC); and was framed a humanitarian emergency of extraordinary severity with 3707 confirmed Ebola reported cases with 1808 deaths, in Guinea, Liberia, and Sierra Leone (www.who.int/ebola). As such, this raises questions as to why the W.H.O failed to deal with such emergency health crisis; particularly in West Africa, and this has cast doubt on W.H.O humanitarian intervention efforts.
1.3 Purpose/ Aim of the Study

Though utilising the 2014 West African Ebola outbreak as a case study, this study explores the phenomenon of humanitarian intervention by the international community, examining the shortcomings, challenges and inadequacies of W.H.O’s humanitarian intervention mechanisms and response to public health emergencies as a human security phenomenon.

1.4 Research Objectives

The research proposes the following objectives:

1. To evaluate whether the 2014 Ebola Virus outbreak in West Africa received enough international response from international community.
2. To examine the criticism levelled against W.H.O on its delayed response to the outbreak of the Ebola Virus is justifiable.
3. To investigate challenges that made it difficult for W.H.O to contain the 2014 Ebola outbreak in West Africa.
4. To discuss the implications of the outbreak of the Ebola virus on Africa and future W.H.O humanitarian response mechanisms to future public health emergencies in Africa.

1.5 Research Questions

The international response to the 2014 Ebola outbreak through humanitarian intervention raises a number of questions to this study.

1. Did the Ebola Virus outbreak in West Africa receive adequate response and intervention from the international community?
2. Is the critique of an inadequate and delayed humanitarian response and intervention to the Ebola virus outbreak directed at W.H.O justified?
3. Why was it so difficult to contain the outbreak of the Ebola Virus?
4. What implications does the outbreak of the Ebola epidemic have on Africa and future W.H.O’s humanitarian intervention mechanisms to future public health emergencies in Africa?
1.6 Assumptions
This research shall be based on the following assumptions:-

- That the W.H.O has a mandate to respond quickly and effectively to cases of emergency health crises; in this case the outbreak of the Ebola virus in West Africa, since it has the mandate and authority to lead a global response to health epidemics of international security concern.
- That humanitarian intervention in essence should benefit the intended target group without the interference of ‘states self-interests’ or other motives not humanitarian.

1.7 Significance of the Study
This research shall demonstrate and contribute significantly to a plethora of research findings on shortcomings of international humanitarian interventions; as such this research shall be regarded as a point of reference for further research while simultaneously adding to the knowledge gaps overlooked by previous research studies on the same subject. A limited number of research studies on Ebola have been pursued within the field of social sciences and most research on Ebola have been relatively limited to the field of medicine. The epidemiological aspects of Ebola, such as contamination and transmission dynamics have been some of the focal research areas in the medical field. According to Gray (2007) research inculcates scientific and inductive thinking and it promotes the development of logical habits of thinking and organisation. As such, this study shall proffer recommendations for adoption to assist policy makers in government, international non-governmental organizations, decision-makers in the international community and W.H.O in particular on how the international community can improve on effective humanitarian intervention mechanisms to public health emergencies like the Ebola Virus outbreak.

1.8 Limitations of the Study
The case study design of this research study shall limit the generalisability of findings to the subject scope of W.H.O’s response in tackling the outbreak of the Ebola Virus in West Africa. The study shall also juxtapose the role played by other international organisations like Red Cross and MSF who timeously responded to the Ebola Virus epidemic; against W.H.O’s delayed response to the outbreak. It shall be difficult to engage in participatory fieldwork due to financial constraints to visit the Ebola Virus hit countries; this shall however have adverse implications on the empirical depth of the research. It may also be difficult to conduct face to face interviews with the target respondents who are the victims of the Ebola Virus pandemic.
in West Africa. But the researcher shall overcome this obstacle by carrying out key informant interviews with academic experts in the public health field and W.H.O personnel from Zimbabwe who were directly involved in the outbreak of the Ebola virus in West Africa.

1.9 Delimitations of the Study

It should be taken into consideration that this study dwelt on a specific timeframe with regard to the ‘initial’ phase of the Ebola outbreak which was between December 2013 to August 2014 when the outbreak was at its peak until it was declared a ‘Public Health Emergency of International Concern’ (PHEIC) in August 2014. The subsequent adoption of a United Nations Security Council Resolution 2177 triggered the setting up of the United Nations Mission for Ebola Emergency Response; that heralded an effective reaction from the international community to contain the outbreak.

1.10 Definition of Key Terms

**Global health security:** - involves the universal promotion and enhancement in ‘health for all’ policy. The global health security aspect is emphasised, to include epidemics that transcend national boundaries which are known as borderless diseases. These epidemics become global as several countries are affected, which is the case during epidemic infectious diseases (e.g. HIV, SARS, H1N1, Zika Virus or Ebola Virus). Global health security has been the underlying motive for the 2014 Ebola intervention (W.H.O: 2014).

**Humanitarian Intervention:** - Humanitarian intervention in the context of this paper should be understood as the ‘rapid assistance that is given to individuals or communities by individuals, groups, organisations and or governments to alleviate human suffering after a disaster that is natural or manmade’ according to Scheffer (1992). In the context of the Ebola pandemic, these interventions included provision of adequate relief medical and sheltering material; food aid to the hard-hit and the hard-to-reach communities in rural West Africa, and encouraging adherence to emergence guidelines to stop the further transmission of Ebola.

**Neo-Liberal institutionalism:** - this theory propounds that states are key actors in the international system; but not the only significant actors due to the existence of international institutions. As such, states will seek to maximize absolute gains at the expense of relative gains, and pursue interests through cooperation with institutions as they are seen as mutually beneficial according to Keohane and Martin (1995).
1.11 Chapter Outline

The study is organized into five chapters; with Chapter 1 focusing on revealing the weaknesses of the international community in effecting a global response to emergency health crises in developing countries; and to expose the W.H.O for the delay in declaring the Ebola outbreak a ‘public health emergency of international concern’. Chapter 2 underlines the theoretical (neo-liberal institutionalism) and conceptual frameworks that informs this research study and situates the Ebola virus trajectory in West Africa within the concept of humanitarian intervention; global health and human security discourses and the impact of the epidemic on West Africa economically, socially and politically. Chapter 3 locates the data collection methods used for this study which include, documentary review and key informant interviews. Research findings and analysis of data is presented in Chapter 4 which revealed several reasons that could have contributed to the escalation of the West Africa Ebola crisis which include lack of an emergency contingency fund, lack of an emergency workforce, W.H.O bureaucratic pitfalls and budgetary constraints. It is the recommendation of this research study; as presented in Chapter 5 that the international community should rethink humanitarian intervention approaches to disease emergence situations in low-income countries.

1.12 Chapter Summary

This chapter focused on the introduction to the research study, Background of the study and Purpose of the study highlighting on the advent and spread of Ebola in West Africa; whereas the Statement of the Problem revealed the undesirable element which the study seeks to address, which is the delay in response by W.H.O to the outbreak of the 2014 Ebola virus in West Africa. The international response to the 2014 Ebola outbreak or lack of; did raise a number of Research Questions presented in this chapter which generated Research Objectives and Assumptions for this study. Limitations and Delimitations to the study were also presented in Chapter 1.
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The chapter presents an overview of various scholarly contributions and related literature on the response by the international community to combat the Ebola outbreak in West Africa. The Ebola crisis triggered various debates about the interdependencies of relations between the Global North and the Global South that manifest through neoliberal institutionalism as the theoretical framework that informs this study. Humanitarian intervention as such, the researcher presents a critique of various scholarly debates on the concepts of state sovereignty, responsibility to protect doctrine as they are the contending driving forces behind the concept of humanitarian intervention as an important component of neo-liberalism school of thought.

Despite the predominantly epidemiological research focus in this field, this paper shall present an overview of previous research on Ebola virus disease origin, history, outbreak and spread in the African context. This chapter will also cover the theoretical and conceptual frameworks that will guide this research with a view to elaborate on the rationale of W.H.O’s humanitarian intervention to the Ebola virus outbreak in West Africa.

2.1.1 Theoretical Framework

This research is theoretically guided by Neo-liberal Institutionalism as a theory of international relations. Neo-liberal institutionalism is a political philosophy that has its roots in the broader neo-liberalism school of thought originating from the Wilsonian Doctrine. Neo-liberal institutionalism emphasise that global governance should be the mandate of international organisations in a given international system. The central issues that the theory seeks to address are the various setbacks that hinder the interaction of states and institutions as non-state actors on issues of human security. Neo-liberal institutionalism further places emphasis on the belief that nation-states are concerned first and foremost with absolute gains (economic and strategic), rather than relative gains (social and humanitarian) to other nation-states (Keohane and Martin, 1995).

Neo-liberal institutionalism is interested in institutions which can pursue and maintain a balance of power as well as regularize cooperation between states. Intergovernmental organizations like W.H.O are premised on these tenets of neo-liberal institutionalism. Keohane and Nye (2001) as major proponents of the neo-liberal institutionalism school of
thought, argue that institutions and states are the dominant actors in international relations; and this mutual interdependence between states and intergovernmental institutions positively affects behavioural patterns and changes in the way states cooperate (Keohane and Nye, 2001).

Neo-liberal institutionalists see institutions as the mediator and the means to achieve cooperation in the international system. Keohane and Martin (2005) agree that regimes and institutions govern a competitive and anarchic international system and they encourage multilateralism and cooperation for securing national interests. They focus on the creation and maintenance of institutions associated with managing the globalization process. Neo liberal thinkers like Nye and Keohane (2001) propound that the neo-liberal institutionalism school of thought is premised on the idea of complex interdependence and as such international institutions should regularize the interaction of states. To which in essence to the subject of this study; the W.H.O as an international agency is mandated to respond to emergency situations that threaten human security. Hence, this makes the neoliberal institutionalism argument very relevant to this study as it allows intergovernmental organisations (non-state actors) and states to interact in the international system through mechanisms like humanitarian intervention.

However, tenets of neo-liberal institutionalism shall be implored to critique humanitarian intervention based on the argument by neo–realists that; states will always remain selfish but can employ moral tactics like humanitarian intervention to pursue their selfish interests. As such neo-realists like Mearscheimer (2012) assert that humanitarian intervention would continue to be determined based on national interests of great powers. Neo-realists argue that neo-liberals exaggerate the impacts of institutions and regimes on states. Neo realists like Mearscheimer (2012) is of the opinion that international institutions and regimes cannot mitigate the constraining effect of anarchy on cooperation.

Mearscheimer (2012) argues that neo-realism continues to enjoy greater explanatory power for humanitarian intervention than institutionalism. The abuse of the humanitarian intervention mandate by international organisations has made developing states suspicious about the motivations of intervening states as noted by Smith (1998). This will inevitably prevent humanitarian intervention from developing as an influential norm, and the future of humanitarian interventions in humanitarian crises like Ebola will be contested. Hence,
Humanitarian intervention has become more firmly connected to the issues of high politics as a form of political strategy used by powerful states according to Mearscheimer (2012).

Mearscheimer (2012) argues that it follows that states will never act for primarily humanitarian motives. Which is why most of the cases regarded as examples of ‘humanitarian intervention’ involve mixed motives; that is they are cases in which humanitarian objectives and self-interest coincide, and both serve to prove a point according to Teson (1996). Lar (2014) points out that critics of the doctrine of humanitarian intervention have failed to distinguish between intention and motive. Hence, humanitarian intervention is often described as the ‘externalisation of neo-realist and neo-liberalist norms and values of self-interest versus morality merged together’. Using W.H.O’s intervention to the Ebola crisis in Guinea, Liberia and Sierra Leone as case studies, this paper will argue that humanitarian intervention though with major challenges has emerged as a major phenomenon in shaping the behaviour of states in the international system.

2.1.2 Conceptual Framework

The conceptual framework for this paper shall be premised on the doctrine of ‘humanitarian intervention’ and the rationale the concept is viewed in light of the argument by neo-liberalists that states may not only have the right to intervene but also have the moral obligation to do so as shown by WHO’s intervention to the outbreak of the Ebola Virus in West Africa. Humanitarian intervention in the context of this paper should be understood as a gesture that encompasses non-forceful methods, undertaken with or without military force to alleviate mass human suffering within sovereign borders according to Scheffer (1992), in his book “Towards a Modern Doctrine of Humanitarian Intervention”. According to Teson (1996) he posits that the arguments that underlies the humanitarian intervention debate is the perceived tension between the values of ensuring respect for fundamental human rights and the primacy of the norms of sovereignty, non-intervention, which are considered essential factors in the maintenance of peace and international relations.

The crux of the debate on identifying the best option for the maintenance of international order through humanitarian intervention has been the clash between the principle of sovereignty and non-intervention versus the doctrine of Responsibility to Protect. International relations scholars like Walsh, Seay, Levi etal. (2015) have tried to address the debate on how to maintain state autonomy (sovereignty – neo-realist perspective) whilst guaranteeing the protection of individual human rights (R2P – neo-liberalist perspective).
Ayoob (2012) is of the view that humanitarian intervention reflects the interests of great powers shrouded in moral principles. As such, there remains a challenge to attain genuine humanitarian intervention if there is no moral and political will of the international community. Lar (2014) proposes that it is only when individual states, and the Security Council (UNSC) collectively, have the political will to enforce and monitor humanitarian intervention mechanisms will then humanitarian intervention achieve the ‘protection’ it is meant to.

2.2 STATE SOVEREIGNITY; RESPONSIBILITY TO PROTECT (R2P) AND THE CHANGING NATURE OF HUMANITARIAN INTERVENTION

The discourse of humanitarian intervention has generated one of the most heated debates in the study of international relations over the past decade, for both theorists and practitioners. At the heart of this debate is the alleged tension between the principle of state sovereignty and the evolving norms of the ‘responsibility to protect’ related to global human security.

2.2.1 Responsibility to Protect and Humanitarian Intervention

It is clear that the foundations of humanitarian intervention are the liberalist view of the world. Neo-liberals emphasise, human security protection as the core of R2P. Additionally, responsibility to protect calls for international cooperation to protect citizens if states fail to fulfil such responsibility (Chandler, 2004). Thus, R2P is a norm comprised of core assumptions and beliefs of liberalism. The responsibility to protect concept is also derived from natural law premised on the naturalist doctrine that human beings have certain moral duties to protect by virtue of their common humanity (ibid). Its basic precepts are discovered through reason and therefore available to anyone capable of rational thought. For natural law theorists, the common human nature generates common moral duties – including, a right to humanitarian intervention.

Neo-liberalism propounds that if states fail to protect citizens from diseases and epidemics, the international community will fulfil that responsibility through R2P. As the WHO clarified in its report (WHO Situational Report, 2014) only the UNSC Security Council can authorise humanitarian intervention. More specifically, the five permanent member states would determine whether the “international community” will act on humanitarian intervention based on their national interests. Thus, realists would conclude that international community responses to humanitarian crises in Africa will not change even after the adoption of the humanitarian intervention doctrine that calls for the international community’s moral
duty to save civilians from human security atrocities like the Ebola Virus outbreak (Ayoob, 2012). As such humanitarian intervention will always be based on national interests of great powers.

It is clear that the foundation of neoliberalism is the liberal view of the world. As liberals emphasise, human rights protection is the core of R2P. Additionally, R2P calls for the international cooperation through humanitarian intervention to protect citizens if states fail to fulfil their responsibility (Keohane and Nye, 2001). Moreover, the use of force as a last resort to halt human rights violations can be justified and resonates with the argument of contemporary neo-liberal internationalism. Thus, R2P is a norm comprised of core assumptions and beliefs of neo-liberalism.

2.2.2 State Sovereignty and Humanitarian Intervention

The traditional conception of international relations according to classical realism recognises the state as the sole repository of sovereignty. This is placed on the assumption that the international order can be best maintained if states respect each other's sovereignty by adhering to the norms of non-intervention. As such the concept of state sovereignty has long been the obstacle to intervention in pursuit of humanitarian objectives. Holzgrefe and Keohane (2008) highlights on sovereignty as the major political objection by states to humanitarian intervention. These scholars argue that because states will continue to act in their perceived national interest, they will intervene where it serves that interest. This selectivity means that target states and those states “wedded to the concept of sovereignty” will view the interventions with suspicion.

According to Murphy (1996), humanitarian intervention is often described as the ‘externalisation of a state’s self-interests embedded with values of morality as a smokescreen’. Another argument raised by Mearscheimer (2012) is that it follows that states will never act for primarily humanitarian motives. Which is why most of the cases regarded as examples of ‘humanitarian intervention’ involve mixed motives; that is they are cases in which humanitarian objectives and self-interest coincide, and both serve to prove a point according to Teson (2005). For instance, during an interview one respondent revealed that Russia only participated in the humanitarian efforts to the Ebola crisis after the intensified involvement of the United States and for fear of the latter exporting the same virus to Russia as part of a biological warfare scam.
The international community in particular W.H.O had a responsibility to spearhead humanitarian intervention mechanisms, and authorise member states to take all necessary measures to protect vulnerable populations in West Africa. Whitman (2012) notes that military humanitarian intervention, though it is the violation of a state’s sovereignty was necessary for the purpose of protecting human life since the Ebola humanitarian crisis in West Africa required the use of mixed conventional and non-conventional humanitarian and military emergency responses. In addition to conventional intervention approaches, the military was used to reinforce the rule of law to limit community resistance and hostility against health staff (ibid).

Smith (1998) offers an analysis of humanitarian intervention from both a ‘neo-liberal’ and ‘neo-realist’ perspective. A neo-liberalist view, according to Smith’s understanding of humanitarian intervention, is that it is driven by ‘a universalist conception of human rights in which sovereignty is a subsidiary and a conditional value’. Under such an understanding, humanitarian intervention would clearly reflect moral and legal principles. As such, Smith (1998) argues that states who commit egregious human rights abuses break nearly all known moral codes and forfeit, according to neo-liberals, their legitimacy and the right to govern their own states free from international intervention. Furthermore, Nardin (2006) suggests that the non-intervention principle as expounded inherently in the concept of sovereignty accounts for exceptions made to it: since a state exists to protect the rights of its citizens and if it violates those rights it loses its moral rationale and therefore its immunity from foreign interference as expressed in the doctrine of Responsibility to Protect.

Davies (2012) notes that while the international society continues to be essentially pluralist and the state will continue to be the unit structure of international relations, new challenges in a dynamic international society have led to the emergence of international solidarist norms like humanitarian intervention which in the context of this study when applied appropriately complements rather than contrasts state sovereignty.

2.3 SITUATING HUMANITARIAN INTERVENTION; GLOBAL HEALTH AND HUMAN SECURITY TO THE EBOLA OUTBREAK RESPONSE IN WEST AFRICA

Contemporary discourses linking global health and humanitarian intervention stem largely from the ‘human security’ development paradigm of the World Bank’s influential Human Development Index Report of 1993 which argued that improving public health in developing countries would spur economic growth and prosperity (H.D.I World Bank, 1993). Global
health has emerged as a discourse that unevenly incorporates the logics and concerns of humanitarianism and biosecurity, and is also inherently connected to the roles and responsibilities of states; their obligations to safeguard the health of their people, and their willingness and capacity to do so (Farmer, 2014). Thereby, in the context of this research it was imperative for the international community to react to the Ebola Virus outbreak as a ‘threat to international peace and security’ in line with the International Health Regulations (IHR) classification of contagious diseases.

Global health is inherently geopolitical as propounded by Cheng and Setter (2015) who describes humanitarian intervention as “politics of life,” in that it involves saving of individual lives-at-risk and the power to determine which lives are to be saved; which then takes the form of qualifying disease-specific interventions. This form of global health interventions, in this case W.H.O interventions frequently operates independently from state-led public health agencies in lowly-resourced countries, and are governed through decentralized humanitarian aid agencies which are a part of a larger process of the neo-institutionalization of humanitarian intervention (Nardin, 2006).

In 2014, the then W.H.O Director-General Margaret Chan called for a ‘return to Alma-Ata’ and the principles of universal health coverage and primary health care (WHO Situational Report | Return to Alma-Ata, 2014). The 1978 Declaration of Alma-Ata had established a goal of “Health for All by 2000,” especially emphasizing universal access to primary health care (PHC). However, few practical efforts attempted to implement the principles of Alma-Ata and, selective primary health care have been rendered to particular global disease outbreaks. Farmer (2014) argues that the unprecedented mobilization of resources that HIV/AIDS has provoked is the result of a ‘successful framing of AIDS as a public-health human development security crisis.’

Paul Farmer popularised the notion that an effective Ebola response would have required ‘experienced staff, stuff, space, and systems’ (Farmer, 2014). The “systems” that were needed included not only state-run public health systems, but also a more robust, equitable system of global health intervention at an international level fostered under W.H.O. The infrastructural and cultural influences that made the epidemic unprecedented are not isolated within the High Transmission Countries (HTC) only, but also encompasses shortcomings of an international system that prioritises problems of global health of a certain cost-benefit
analysis and return on investment, thereby assigning relative values to human security based on national interests.

One legacy of the 21st century history of new and re-emerging infections was the revision, of the International Health Regulations in 2007. Drafted in response to the SARS outbreak, the I.H.R were intended to create a global health response and reporting system to future disease outbreaks. One component of this was the responsibility of states to report on emergency disease outbreaks, which was perceived by some international scholars like (Davies, 2012) to pose a potential challenge to sovereignty of some states. Previously, W.H.O had only responded to ten Ebola virus cases out of twelve in a period ranging from ten years in between. As such Ebola outbreaks in Africa were never treated as acute human security crises of public health concern, in comparison with the ‘international response’ to diseases like HIV/AIDS or SARS; as such Ebola was not considered to be a threat on a larger scale.

2.4 EBOLA VIRUS DISEASE TRAJECTORY IN WEST AFRICA

2.4.1 What is Ebola Virus?

The Ebola Virus disease is classified as a viral haemorrhagic fever caused by a filo virus agent. The Ebola virus is zoonotic, i.e. it is transferable between humans and animals, such as the fruit bat, which is assumed to be the Ebola virus’ natural host, which is particularly relevant because ‘wild meat’ is a source of nourishment in most rural African areas. The virus is introduced into the human body through close direct contact with the blood, secretions, organs or other body fluids of infected animals or people and it spreads within the human population through human-to-human transmission. It is characterised by severe fever, haemorrhaging (bleeding), multiple organ failure and often death. If infected by Ebola, a person is incubated between two to twenty-one days. During this period the virus destroys the white blood cells that are vital for combating infections in the body (W.H.O Situational Report 2014) The initial symptoms of Ebola like high fever, pain and diarrhoea are similar to other common tropical diseases, such as malaria and cholera. Due to this similarity, it is difficult to diagnose the disease at its early stages (Boulton, 2014).

2.4.2 History and Origins of Ebola

The first Ebola cases were discovered in the Democratic Republic of Congo (DRC formerly Zaire) in 1976 and the virus was named after the river Ebola in DRC. Since then, new species
of Ebola were discovered and outbreaks have occurred in different regions of equatorial Africa, mostly restricted to rural African regions (Boulton, 2014). There are five subtypes of the Ebola Virus disease, each named after its country of origin e.g. Ebola Zaire, Ebola Tai Forest (Cote d’Ivoire), Ebola Sudan, Ebola Reston and Ebola Bundibugyo (Uganda). As such, the earlier cases of Ebola virus were diagnosed as other conditions more common to the area of origin hence in West Africa, the disease took long to be detected as the Ebola virus.

The first Ebola case was that of a two year old boy from a small village called Meliandou in the Guéckédou District of Guinea, which is some 400km from the borders of Sierra Leone and Liberia, who became infected, fell ill in December 2013 and died in January 2014 and this became an index case that heralded the advent of the Ebola virus in Guinea. (www.afro.who.int/en/dpc/ebola-outbreak-epidemic-alert-and-response/). By March 2014, the virus had spread to the neighbouring countries of Liberia and Sierra Leone as a rise in the numbers of suspected Ebola cases were confirmed in the Kenema and Kailahun districts of Sierra Leone and in May 2014, further cases were reported in Lofa district in Liberia which was followed by the discovery of more cases of transmission in the capital, Freetown (http://www.who.int/csr/don/2014 08 08 ebola/en/). These districts remained the focus of transmission in the border areas of the three countries.

According to W.H.O Situational Report (2014); July 2014 onward, there were sharp increases in confirmed Ebola cases in all the three countries, as the virus rapidly spread to the epicentre which were the capital cities of Conakry, Freetown, and Monrovia simultaneously. The Ebola epidemic took 9 months to reach peak incidence (August 2014), but cases were reported for an additional 18 months (until May 2016). Although the number of new cases had declined per week from December 2014 onward the outbreaks in each of the case study countries were not declared over until May 9 in Liberia, November 7 in Sierra Leone, and December 28 in Guinea. These dates were marked by a 21 day incubation period to ensure that no recurring cases of transmission could be detected.

2.5 COUNTRY SPECIFIC EBOLA VIRUS CASE STUDIES IN WEST AFRICA

The three most affected countries Guinea, Liberia, and Sierra Leone were at the receiving end of civil conflicts (in Liberia and Sierra Leone) and an inefficient government (in Guinea) for decades. The fact that the outbreak occurred in West Africa presents a relationship of weak economic and political systems with a lack of preparedness to face a devastating epidemic. This left these countries with debilitated infrastructures, health sector being no exception.
2.5.1 Guinea

Guinea was the first country to be affected by the Ebola virus and it illustrates many problems that compromised control efforts to the spread of the outbreak to other countries. The Ebola virus disease was detected in March 2014 in four districts of Guinea including Gueckedou, Nzerekore and Macenta which is some 200km from the Liberian border. From the beginning, reports from epidemiologists and public health experts working in Guinea failed to recognize that the true scale of the outbreak was underestimated, and the magnitude of underreported cases went undetected (http://www.afro.who.int/en/outbreak-news/4063-ebola-hemorrhagic-fever-in-guinea.html). The experts argued that the outbreak had most likely moved underground, because families would hide their sick ones in homes and buried bodies of the affected in secret ceremonies after dark. As such community resistance was a major barrier to Ebola virus control in all three countries but took on extreme dimensions in Guinea. http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html

Resistance to disease control efforts by health officials among the Guinean population remained greater than in Sierra Leone and Liberia, raising concerns over the effectiveness of foreign humanitarian intervention efforts to halt the epidemic. By mid-June, incidents of violence against response teams were being reported in communities across the country. The first recorded incident occurred on 4 April, when an angry mob attacked an MSF treatment facility in Macenta, claiming that the health staff had introduced the disease into the community (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html). Fear spread faster than the virus and in early June, an MSF emergency coordinator reported a resurgence of Ebola in West Africa, she attributed the rise in cases to community resistance and the challenges of conducting household contact tracing.

In mid-June a ‘health emergency’ was declared in Guinea and MSF reported a rise in cases with a total of 86 suspected cases, including 59 deaths which were believed to be due to funeral transmissions. By end of June 2014, it was reported that medical authorities in Guinea had quarantined more than 100 individuals who were considered at high-risk of contracting the fast spreading Ebola virus; the outbreak was being publicly described by staff in the Ministry of Health as ‘out of control’ and at that time Gueckedou was the epicentre of the outbreak, with Macenta recording a gradual rise in new cases (www.who.int/ebola)
2.5.2 Liberia

Fourteen of Liberia’s fifteen provinces confirmed Ebola cases and more than 11,300 people died from the Ebola virus outbreak in 2014. Liberia had the highest number of fatalities with 4,808 deaths. The first two Ebola cases in Liberia occurred in Nimba and Lofa districts near the border with Guinea in March 2014; when an infected traveller from Lofa passed through Monrovia, the country’s capital, but was undetected to have contracted the virus.

The Liberian Ambassador in Washington was reported as saying that he feared that his country may be "close to collapse" (W.H.O Situational Report: March 2014). On 6 August, President Sirleaf declared a three-month state of emergency and announced a string of new regulations, which included the closing of markets, curfews, and restrictions on the movement of patients which was to be enforced by the country’s military. She announced that Liberia would close its borders, with the exception of a few crossing points like the airport, where Ebola screening of travellers would be conducted. Schools and universities were closed and the worst-affected areas in the country were placed under quarantine. In August, Liberia made the cremation of people who died from Ebola mandatory in Monrovia.

By July 2014, all of the 15 Liberian districts had reported confirmed Ebola cases, and with only about fifty physicians in the entire country, Liberia was already in a healthcare crisis (W.H.O Bulletin, July 2014). Liberia was ill-prepared to cope with the onslaught of the Ebola infections that rapidly followed. Monrovia, the capital, was home to the country’s only large referral hospital, the John F Kennedy Medical Centre and that facility had been heavily damaged during the civil war and never fully repaired. Few medical staff had been trained in the basic principles of infection prevention and control hence several doctors became infected and died. By the end of August 2014, Liberia had the highest number of infections in health care workers with nearly 200 among the three affected countries.

2.5.3 Sierra Leone

In Sierra Leone, the outbreak of Ebola virus began slowly and silently, gradually building up to a burst of cases in early June. The country’s first Ebola case was of a woman who attended the first Ebola index case in Meliandou, Guinea. She contracted the disease and, she travelled back to her home in Sierra Leone and died there shortly after her return and her death was neither investigated nor reported at the time. The burst of new cases in early June was traced to a funeral of a respected traditional healer held in Kailahun district, near
the border with Guinea. The healer became infected while treating Ebola patients who crossed the border from Guinea. That funeral sparked a chain reaction of cases of multiple transmissions, deaths and funerals (Johnson: 2015). A state of emergency was declared in Kailahun, calling for the closing of schools, cinemas, places of gatherings and the screening of vehicles and travellers at checkpoints along the borders with Guinea and Liberia (www.who.int/ebola)

Freetown the capital of Sierra Leone became the epicentre of the disease and the first confirmed case was reported on 23 June. Ebola cases in Freetown rose significantly with patients transferred to Kenema for treatment. But the real surge in cases began in July as the virus gained a foothold in Freetown, Loko, Bombali, and Tonkolili districts, a situation described by W.H.O as ‘continuing to deteriorate’ (www.who.int/ebola). The biggest challenges in the densely populated capital were limited treatment and diagnostic facilities and the difficulty of undertaking contact tracing, increasing the risks of disease spread within households. Teams were soon struggling to bury as many as thirty bodies per day.

Kailahun and the larger city of Kenema, formed the early epicentre of the outbreak. In both Kailahun and Kenema, the greatest need was for more treatment facilities backed by greater and faster containment mechanisms. MSF opened an Ebola treatment centre in Kailahun in June (www.who.int/ebola). However, a shortage of experienced staff meant that containment efforts were not supervised in particular, the quality of contact tracing and the dynamics of transmission. Since people with high-risk exposure were missed; cases were not detected early and chains of transmission continued to multiply. W.H.O staff admitted that as an emergency response coordinator noted that, ‘we came too late when villages already had dozens of cases. And we don’t know where all chains of transmission are taking place.’ (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html). Throughout July and August, Kailahun and Kenema remained the districts with the most intense virus transmission, and cases there continued to escalate at an alarming rate.

In July, humanitarian partners working in Kenema and Kailahun agreed that intervention and containment to the fast spreading disease required an enormous and robust scaling up of the response capacity. As the situation rapidly worsened, South Africa deployed a mobile laboratory to Freetown and work began to construct Ebola treatment centres, as
Kenema’s treatment capacity was overwhelmed. On 6 August 2014, the President, Ernest Bai Koroma declared a national state of emergency, with an enforcement of quarantines by the military imposed in the hardest hit areas (www.who.int/ebola). In August 2014, the government also passed a law imposing a jail sentence of up to two years on anyone found to be hiding an Ebola patient. At the end of that month, the country reported a cumulative total of 1,026 cases, compared with 648 in Guinea and 1,378 in Liberia.

2.5.4 Nigeria (A Success Story)

The case of Nigeria is a good example of how local leadership, emergence response mechanisms and collaboration of national and international organizations helped to contain the Ebola virus. Nigeria is a very populated country and an escalation of the Ebola outbreak would have had a direct impact on the global community as there is a constant movement of people in and out of the country. The first case in Nigeria was a Liberian-American, who flew from Liberia to Lagos, Nigeria on 20 July 2014. On 6 August 2014, the nurse who attended to the Liberian also died of the disease and later more cases were detected and treated in isolation wards. According to the W.H.O website (www.who.int/ebola), 20 cases and 8 deaths were confirmed in Nigeria, including the imported case and other 4 cases of health workers who attended to the index case who also succumbed to the disease. Nigerian government ensured that there was contact screening at all its entry and exit points and extensive surveillance by public health workers. The W.H.O’s representative in Nigeria officially declared the country Ebola-free on 20 October 2014, after no new active cases were reported in the contact tracing follow ups (http://www.who.int/csr/don/2014 08 08 ebola/nigeria/). Nigeria was able to control and stem out the epidemic at the first signs of detection and it became the first African country to be declared Ebola free.

2.6 Chapter Summary

The chapter highlighted on the theoretical and conceptual frameworks that underlines the argument in this research study; that is the delay in emergency response to humanitarian crises such as the Ebola tsunami of 2014 which was felt, beyond the three major affected countries. The evolution of the Ebola crisis in West Africa as clearly illustrated in this chapter underscored a point that efficient health systems ensure resilience to outbreak of emergency epidemics like Ebola. Scholarly contributions acknowledged in this chapter revealed that the
failure to invest in fundamental health infrastructures left countries like Guinea, Liberia and Sierra Leone with no bedrock to stand on under the weight of the shock of the outbreak of the Ebola virus which left an unprecedented death toll, social strife, crippled economies and a weak health infrastructure. However, reference to other West African countries like Nigeria which managed to contain the spread of the virus as it was quickly detected was portrayed as a success story to the fight against the Ebola outbreak.
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter outlines the qualitative research methodology that was employed to generate data for this research. This research employed a descriptive research design whose major objective was to describe a phenomenon with a case study. Yin (2009) emphasizes that a case study inquiry takes a holistic, in-depth and comprehensive analysis of real life events, processes and phenomenon. The researcher used qualitative methods to gather data relevant for this study. The qualitative data collection tools employed for the study are secondary (documentary review) and primary (key informant interviews) respectively; highlighting on their strengths and limitations. The selected target population who responded to interviews were mostly W.H.O personnel who were part of the emergency response teams in the three most affected countries. Snowball sampling and expert purposive sampling were the sampling procedures employed for this study; and data presentation was in the form qualitative data analysis and thematic analysis and ethical considerations like anonymity, confidentiality and objectivity were upheld during the course of this study.

3.2 RESEARCH PARADIGM

A research paradigm refers to a set of philosophical assumptions and beliefs that directs research execution (McCraig, 2010). Gray (2007) defines a research paradigm as a collection of common beliefs and unanimous concurrence shared by social scientists about how problems should be understood and addressed. Powell (2009) echoes the same proposition by arguing that the qualitative research paradigm is designed to facilitate the understanding of social, economic, political and cultural phenomena. The research paradigm employed for this study is qualitative in nature as data gathered was analysed without complex statistical packages. Qualitative methods are according to Strauss and Corbin (1990) “any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification”.

3.3 RESEARCH DESIGN

The research design refers to the overall strategy that a researcher chooses to merge the different components of a research in a coherent and logical way according to (McCraig, 2010). Powell (2009) notes that research design is the overall plan of a research which sets guidelines for conducting the research. Descriptive research design is a scientific method
which involves observing and describing the behaviour of a subject without influencing it in any way (Yin 2009). Descriptive research designs help provide answers to the questions of who, what, when, where, and how associated with a particular research problem; a descriptive study cannot conclusively ascertain answers to why (Meena, 2011). As such, this study employed the descriptive research design to effectively address the research problem which is the reasons for the delay by the international community to respond to the Ebola virus outbreak in West Africa.

A descriptive research is used to obtain information concerning the current status of the phenomena, in this the Ebola outbreak of 2014 in West Africa. In addition, the descriptive research design employed for this study can be viewed as an overarching strategy for unearthing useful answers to a problem as preferred by Gray (2007). Yin (2009) describes a case study research as a practical in-depth investigation that examines, “a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not well defined”. Gray (2007) notes that, this type of research provides recommendations upon which decisions can be reached by policy makers; in this case, the study recommendation that W.H.O should rethink its emergency response mechanisms to address issues of bureaucratic pitfalls, budgetary constraints and funding.

3.4 RESEARCH METHODOLOGY

Research methodology is a science of studying how research is to be carried out. Its aim is to give the work plan of a research. The researcher is going to use qualitative methods to gather data relevant for this study in this case key informant interviews were carried out with W.H.O personnel and relevant public health experts who are well versed with the Ebola epidemiology to ascertain the role played by W.H.O to the outbreak of the Ebola Virus in West Africa and these were complemented by secondary data documentary review of various W.H.O Situational Reports on the Ebola outbreak. Qualitative data collection methods are according to Strauss and Corbin (1990) “any kind of research instruments that produces findings not arrived at by means of statistical procedures or other means of quantification”. Unlike in the case of quantitative methods, qualitative research methods are “sensitive to the context” as they allow the researcher to seek clarity to responses. This means that consideration of contexts provides the opportunity for questions to be answered to the best understanding of the respondents and according to their context. This provides an advantage over questionnaire that are administered without due consideration of cultural variations that may influence the responses that are given by respondents.
Gray (2007) defines qualitative methodology as “a systematic inquiry into meaning” and is empirical in that it is grounded on the world of experiences. Meena (2001) further notes that qualitative research involves interpretive and naturalist approaches. These scholars qualified this by agreeing that “qualitative researchers study things in their natural setting, attempting to make sense of or to interpret meaning”. Meena (2001) concluded that “quantitative methodologies cannot explain issues of perceptions” because perceptions are products of “social influences”. Since this study attempts to understand people’s perceptions on W.H.O response to the Ebola outbreak, qualitative research is thus the most ideal for this study because it is qualitative research that has the potential to unearth intangible factors such as social norms and perceptions in order to make conclusions on the topic under study.

3.5 POPULATION

A population can be defined as all people or items (unit of analysis) with the characteristics that one intends to study according to Gray (2007). According to Meena (2001) a study population consists of all the individuals and units satisfying the selection standard for a set to be studied and from which a representative sample is taken for an in-depth analysis. The target population for this research study consists of W.H.O personnel who were actively involved in the Ebola outbreak and were deployed in the most affected countries; and public health academic experts who are well versed with the Ebola epidemiology; early detection; warning signs and emergency response to humanitarian emergencies that characterised the Ebola outbreak in West Africa in 2014.

3.6 SAMPLING

Sampling is the process of selecting a sample of a population of interest for purposes of making observations and statistical inferences about that population. This representative portion of a population is called a sample. (Gray: 2007) notes that sampling is the process of selecting a group of subjects for a study in such a way that the individuals represent the larger group from which they are selected. McCraig (2010) asserts that sampling depicts a “parameter that is characteristic of the entire population that is estimated from a sample”. As such, the sampling frame employed for this research includes W.H.O personnel who directly participated in the Ebola outbreak and were deployed in the most affected countries of Sierra Leone, Guinea and Liberia.
3.6.1 Sampling Methods

According to Kumar (2011) sampling methods are broadly classified into probability sampling and non-probability sampling. In probability sampling, every unit in the population has a known non-zero probability of being sampled, meaning the sampling procedure involves random selection of units of the population selected by chance whereas; in contrast non-probability sampling entails the selection of sample elements based on the personal judgement of the researcher as noted by Gray (2007). This research shall employ the snowball sampling and expert purposive sampling techniques.

3.6.2 Snowball Sampling

The researcher used snowball sampling technique or chain referral approach which provides referral of participants from one participant to the other and is very is ideal for conducting Key Informant Interviews. Schumacher (1997) notes that, “snowball sampling”, also known as ancestry or recommendation, involves contacting a member of the target population being studied and asking them if they know anyone else with the required characteristics. The nominated individuals will be interviewed in turn and asked to further identify sample members. Snowball sampling has the advantage of clearly communicating about the researcher's intentions as noted by Gray (2007). An added advantage of snowball sampling is that it reveals a network of contacts that could be studied. However, Gray (2007) acknowledges that the main problem of the technique is that it only samples those within the connected network of respondents which can be a source of bias.

3.6.3 Expert Purposive Sampling

Expert purposive sampling is a type of purposive sampling technique that is used when the research needs to glean knowledge from individuals that have particular expertise in a specific area (Meena, 2001). In light of this study, the particular expertise that was being investigated formed the basis of the research, focusing on individuals on public health experts with expertise in Ebola epidemiology; as well as W.H.O personnel from Zimbabwe who were directly involved in the fight against Ebola in 2014. Gray (2007) notes that expert sampling is particularly useful where there is a lack of empirical evidence in an area of study as well as situations where it may take long for findings from research to be uncovered. Therefore, expert purposive sampling became a cornerstone of this study’s research methodology through the carrying out of key informant interviews.
3.6.4 Study Sample

Mc Craig (2010) describes a study sample as “a small set of cases a researcher selects from to represent and generalize the opinion of the larger population”. The study sample for this research comprised of respondents who were interviewed after a selection of respondents had been done in proportional representation of all three case study countries under review representing a larger population. Sampling allows the researcher to estimate the representativeness of the selected sample, thereby increasing the degree of confidence in the research findings drawn as noted by Yin (2001). In light of this, ten key informants were selected for the key informant interviews and were a true representation of the target population.

3.7 DATA COLLECTION METHODS

The collection of data constitutes an integral element of the research process. Data collection refers to the systematic gathering of opinions and views needed to answer a research problem of interest, in a systematic form that enables one to answer stated research questions, test hypotheses, and evaluate outcomes as noted by Mc Craig (2010). In order to address the research objectives, it is important to select suitable data collection tools that enhance the quality of research findings Schumacher (1997). In an attempt to answer the research questions this study utilized key informant interviews to collect primary data. Secondary data collection was conducted through a detailed documentary review of W.H.O paraphernalia.

3.7.1 Documentary Review

Documentary review made the fundamental data collection tool for this research study; it entails the critical appreciation and evaluation of reports on findings of various authors on an area of particular interest (Gray, 2007) and the researcher employed review of secondary documentary sources, particularly W.H.O Situational Reports which gleaned some insights on the progress of the outbreak, response, spread and transmission of the Ebola virus. Mc Craig (2010) suggests that a secondary source is a report that summarises the findings of the primary sources, and though it is not as authoritative as the primary source, it often provides a broad background of information and readily improves research findings depth through the data collected. Therefore, the researcher used available W.H.O material from the organisation’s website, Situational Reports and articles gathered on the outbreak of the Ebola Virus to complement primary data gathered from key informant interviews; and information
gathered from these sources punctuates the larger part of the research findings and interpretation of data.

3.7.2 Interviews

Interviews are undoubtedly the most common source of data collection in qualitative studies. Interviews are a far more personal form of research than questionnaires according to McCraig (2010). For the most part interviews are more open ended and less structured (Merriam, 2001). Interviews range from the highly structured style, in which questions are determined before the interview, to the open-ended, conversational format. The researcher carried out key informant interviews, whereby the interviewer had face to face direct contact with respondents in order collect an on the ground account of the Ebola outbreak and W.H.O’s response. Key informant interviews were seen as the appropriate data collection method to gain insights into the perceptions of the target respondents who were largely W.H.O personnel who participated in the Ebola Virus outbreak in West Africa.

Unlike with mail/ online questionnaires, with face to face interviews, the interviewer has the opportunity to probe or ask follow-up questions. And, interviews are generally easier for the respondent, especially when the researcher seeks opinions or impressions according to Yin (2001). However, it should be noted that, interviews can be very time consuming and they are resource intensive. And the face to face format is the most prevalent, but occasionally group interviews and focus groups are conducted. In this research, the structured interview format was used primarily to gather socio-economic impact of the outbreak of the Ebola virus in West Africa. In context of this study, the interviewer asked the same questions to all the participants, but the order of the questions would vary considerably depending on the role that was played by each individual in a particular affected country.

3.8 VALIDITY AND RELIABILITY

Validity and reliability are the most important aspects to be considered when evaluating a particular data collection instrument. Validity can be defined as the correctness or credibility of an account, explanation or interpretation that a researcher may come up with. It is also “concerned with the integrity of the conclusions that are generated from a piece of research” (McCraig, 2010). Reliability implies that “repeated observations of the same phenomena should yield similar results, and different observations following the same research methodology or procedures should arrive at the same conclusions.” Reliability of the research instruments used for this research was achieved because the documentary reviews carried out
yielded consistent results similar to those obtained from key informant interview respondents. Through careful expert purposive sampling for key informants who represented the W.H.O personnel who witnessed first-hand the outbreak of Ebola ensured that this researcher was able to achieve reliability through their responses as part of the research findings.

3.9 ETHICAL CONSIDERATIONS

The research sought informed consent from the target participants who participate in the key informant interviews; this was specifically achieved through prior interview debriefs that were carried out with the intended respondents as well as a written formal letter from BUSE requesting the target organisation to assist the researcher in carrying out her research. Confidentiality and anonymity of respondents who participated in this research was ensured, through largely not disclosing the identities of the W.H.O personnel who participated in responding to the key informant interviews. The use of offensive, discriminatory, or other unacceptable language was avoided in the formulation of the interview questions guide. The researcher guarded against the pitfalls of academic fraud and plagiarism through acknowledging the works of other scholars who have conducted research on Ebola; this was also achieved through proper referencing and citing their names throughout the course of this research study particularly in relation to documentary review of W.H.O website articles and W.H.O Spokesperson speeches presented at various international fora.

The researcher also maintained the highest levels of objectivity in discussion of findings through presentation of direct quotations of responses as gleaned from the selected key informant respondents. This study used multiple data collection sources such as documentary analysis and key informant interviews to confirm authenticity and accuracy of the research findings. According to Eisner (2016) this is called data corroboration which suggests the usage of multiple data sources to support or contradict the research interpretations. And overall, this research was done with transparency as objectives and purpose of this research were well articulated before the commencement of each interview. Also honesty was upheld in the conduct of this research as the researcher committed to use all the collected information for academic purposes only.

3.10 DATA PRESENTATION AND ANALYSIS PROCEDURES
Kothari (2005) describes data analysis as the process of making meaning out of data collected through editing, collating, and verification of research findings to make interpretations and analysis; and according to Yin (2009), data analysis entails the examination and revaluation of evidence to address the initial propositions of a research study. This study used the qualitative data analysis techniques, namely thematic and qualitative data analysis for the research analysis procedures. Qualitative data analysis is mainly concerned with summarizing data which is obtained after careful consideration of the objectives of this study. Also, the researcher analysed research findings from both secondary and primary data collection sources through thematic content analysis.

3.10.1 Qualitative Data Analysis

Qualitative data analysis has been qualified by Creswell (2009) as a technique of dialectical interpretation of textual data through systematic coding of major themes, categories and or cases in an endeavour to extract in depth meaning and patterns within a research study. In this study, data gathered on the outbreak of the Ebola virus; spread; trends and variations in transmission was grouped into themes by the researcher so as to come-up with a well-informed qualitative analysis on pitfalls to W.H.O’s response to the Ebola outbreak in West Africa. This then enabled the researcher to come up with critical scholarly conclusions and recommendations for the research.

3.10.2 Thematic Analysis

Thematic analysis is one of the most common forms of analysis in qualitative research. It emphasizes pinpointing and examining themes obtained from data collection. These themes are patterns across data sets that are significant to the description of a phenomenon and are associated with specific research question. To Yin (2009) thematic analysis is about identifying themes through careful re-evaluation of the collected data. The technique involves examining and recording patterns of emerging themes from the data collected. The recurring themes form the basis of categories of analysis (Yin, 2009). In respect of this study, the data collected through key informant interviews was thematically analysed through a system of coding or indexing of data with similar characteristics and then analysed on case-by-case basis. In this respect, reasons for W.H.O failure to respond to the Ebola virus outbreak in time before the epidemic claimed thousands was categorised into clusters of lack of funding, budgetary constraints, lack of an emergency workforce and bureaucratic pitfalls within the W.H.O.
3.11 Chapter Summary

The purpose of this chapter was to outline the qualitative research methodology that was used in obtaining data for this research. A description of the case study research design was also laid out in this chapter. The study population, sampling techniques and data gathering tools employed in conducting this research study were also laid out. Data presentation and analysis procedures which include qualitative and thematic data analysis employed in the foregoing research were also discussed; which therefore laid the foundation for the next chapter on data presentation, analysis and discussion of findings.
CHAPTER 4: DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Introduction

The chapter presents the data collection findings, a discussion of the research findings and conclusions drawn. The data was collected and then analysed in response to the research problems posed in Chapter 1 of this thesis. The fundamental goal which drove the collection of the data and the subsequent data analysis was to determine the shortcomings, challenges and inadequacies of W.H.O’s response to the Ebola outbreak of 2014 in West Africa and to further determine whether the international community can improve on effective humanitarian intervention mechanisms to future public health emergencies such as the Ebola Virus outbreak. It is of importance to note that the arguments advanced in this chapter are guided by the evidence generated from an array of data collection methods including Key Informant Interview (KII) and documentary reviews of mostly W.H.O Situational Reports as a form of secondary data collection method. These were thematically and qualitatively analysed to demonstrate the pitfalls and shortcomings that resulted in W.H.O’s delayed response to the Ebola virus outbreak in West Africa and the impact that this action posed to achieving an effective global health response in an effort to contain the unprecedented effects of the Ebola tsunami that hit West Africa in 2014.

4.2 PITFALLS TO W.H.O’s RESPONSE TO THE 2014 EBOLA VIRUS OUTBREAK IN WEST AFRICA

Themes emerging from the research findings presented here reveal that the West Africa Ebola virus outbreak exposed W.H.O’s deeper structural and administrative flaws which include inter alia, the absence of a standby global health emergency workforce, absence of an emergency contingency fund, lack of adherence to the International Health Regulations (IHR) and flaws in its structural reform, bureaucratic pitfalls and governance, W.H.O’s inadequate capacity of to carry out its own Ebola emergency response plans and lack of funding. As such insufficient international response to the outbreak reignited the debate on whether W.H.O should function primarily as a global health advisory body or maintain some form of operational capacity. This study focused on W.H.O’s response to the Ebola outbreak of 2014 which shall be proven by these research findings as a failed attempt to curb the spread of the Ebola virus in West Africa due to various reasons.
4.2.1 Bureaucratic Pitfalls (W.H.O Structural Reform)

The Ebola Virus epidemic in West Africa required a multi-sectoral response approach, to which W.H.O as the sole global organization responsible for the coordination of a global response to public health crises, fell short of its mandate and responsibility. Research findings obtained from a key informant interview involved with W.H.O personnel from the W.H.O Country Office in Zimbabwe suggests that; W.H.O delayed response to the outbreak of Ebola in West Africa could have been attributed to issues of bureaucracy; whereby, W.H.O structural leadership systems in place discouraged an open debate on public health issues that required an emergency declaration and early warning alert systems to be put in place. Various international relations scholars like (Gostin, 2014; and Farmer, 2015) have criticised W.H.O’s leadership attitude over the Ebola crisis response, they concur that there were a lot of diplomatic and bureaucratic shortcomings that arose in regards to the W.H.O’s response to the Ebola crisis that they are criticised for. The then W.H.O Director General Margaret Chan admitted that;

‘we did not work effectively enough in coordination with other partners to respond to the Ebola outbreak and there was confusion of who had which responsibilities and which roles’. http://www.who.int/csr/don/20140808ebola/en/

Public health critics like Cheng and Satter (2015) contended that W.H.O’s response to the Ebola crisis was stymied by bureaucratic issues. The President of Liberia, Ellen Johnson-Sirleaf, at a meeting in Monrovia with a visiting United Nations High Level Panel (HLP) on the Global Response to Health Crises spoke about what she termed the ‘introspection of the UNSC’ regarding the question of UNSC structural reform which she blamed to be hindering flexibility of other U.N structures like W.H.O to execute their mandate resulting in overburdened bureaucracies. President Ellen Johnson Sirleaf told the delegation ‘the international community response to the Ebola outbreak in Liberia was late and fragmented and that the international community’s role in the outbreak came late at a time when the virus was at its peak’ (http://www.who.int/csr/don/20140808ebola/en/); a situation that could have attributed to the escalation of the Ebola tsunami in West Africa in 2014.

4.2.2 Delay in pronouncing a Public Health Emergency of International Concern

The research findings gleaned from various documentary sources produced by Gostin (2014); Friedman (2015) and Lar (2014) have proved that, the W.H.O was heavily criticised for delays in declaring the Ebola outbreak a Public Health Emergency of International Concern
(PHEIC) under the International Health Regulations (IHR). One respondent to a key informant interview, a W.H.O Emergency Risk Management Officer revealed that W.H.O’s hesitation to declare Ebola a public health emergency of international concern (PHEIC) could have been because W.H.O was criticised for creating a panic in declaring a PHEIC to the relatively mild H1N1 pandemic of 2009 in its initial stages. In August 2014, the W.H.O admitted to very serious failings in handling the Ebola crisis and W.H.O Director General, Margaret Chan admitted that ‘we did not work effectively in coordination with other international partners, there were shortcomings in communication and there was confusion in roles and responsibilities’ (W.H.O Director Speech| UNSC Meeting). Coupled to that, Gostin (2014) noted that the W.H.O Director General was too politically influenced by powerful member states to make the bold decision to declare the 2014 Ebola outbreak a Public Health Emergency of International Concern (PHEIC). Under the provisions of the IHR, W.H.O had to use the Emergency Response Framework’s grading system to categorise and declare the Ebola outbreak a Public Health Emergency of International Concern.

According to an article on the W.H.O website where it was revealed that even though official personnel on the ground in the affected countries kept insisting that the Ebola epidemic was out of control and that additional assistance was needed. The W.H.O delayed declaring the epidemic a global health risk through the framing of the Public Health Emergency of International Concern which could have ignited mobilization of international support and humanitarian aid faster according to Davies (2012). The W.H.O acknowledged their shortcomings as was stated by its Director General, Margaret Chan who admitted that;

‘the W.H.O’s initial response to the epidemic was slow and insufficient and W.H.O was not aggressive enough in informing the world about the severity of the Ebola situation in West Africa on time’. http://www.who.int/csr/don/2014-08-08-ebola/en/

Relatedly, one respondent from the W.H.O Country office in Zimbabwe, confided that the release of the emergency contingency fund to kick start an emergency response was tied to a PHEIC declaration. According to an article on W.H.O website, the Guinean President, Alpha Condé also blamed the W.H.O of lacking the capacity to mount an effective response to the Ebola outbreak and was quoted to have had said

“the World Health Organisation was too slow in its response, by creating significant and unjustifiable delays in declaring a Public Health Emergency of International (PHEIC) which was of importance to Guinea to attract international humanitarian actors’” (http://www.who.int/csr/disease/ebola/evd-sitrep1-20140828.pdf.)
which albeit belatedly declared the Public Health Emergency of International Concern (PHEIC) was the turning point of the response to the Ebola outbreak as it heralded the international response to the Ebola epidemic in full force.

4.2.3 Absence of an Emergency Health Workforce

The absence of a robust emergency international health workforce represented a significant failure of W.H.O’s response to the Ebola outbreak in West Africa according to a respondent from W.H.O Country Office in Zimbabwe who was part of the W.H.O personnel that was dispatched to fight the Ebola virus in West Africa. Consistent with its constitutional mandate spelled out in Article 2(d) to furnish aid in emergencies, W.H.O had a mandate to launch a global health emergency workforce by January 2015 as noted by one respondent in an interview. Friedman (2015) asserts that an effective response to a public health emergency requires a range of human resources; doctors; public health professionals; and experts in communicable diseases. However, W.H.O faced major barriers to deploying an effective emergency workforce and these included expediting visas for foreign workers, granting permits for workers who contracted the Ebola virus (W.H.O Situational Report, 2014). Hence, as noted by one W.H.O administrative officer that it was hard to conceive how such a complex operation could be conducted without a major injection of a capable well trained emergency workforce.

4.2.4 Lack of Adherence to the International Health Regulations (IHR)

The International Health Regulations (IHR) is the key international legal instrument for governing global health emergencies as noted by one W.H.O Policy and Coordination Officer. Yet, the Ebola epidemic revealed W.H.O’s deeper structural flaws in IHR compliance and adherence as noted by one respondent. Despite, the gravity of the Ebola outbreak in West Africa the W.H.O made no immediate decision to allocate resources to the Ebola epidemic (W.H.O Situational Report: 2014). The W.H.O Director General, Margaret Chan did not declare a PHEIC until 6 months after the first international outcry about the outbreak and spread of Ebola and months after Médecins Sans Frontières (MSF) had urged for such a declaration (Gostin, 2014). As such, the W.H.O Policy and Coordination Officer interviewed concurred with the view by various W.H.O critiques that indeed W.H.O’s inability to adhere to the dictates of the IHR as stipulated in the global health response to emergencies clause, portrayed W.H.O in bad light globally.

45
4.2.5 Lack of Funding (Budgetary Constraints)

Moreover, W.H.O had a critical shortage of funding and did not control the majority of its budget. Yet, with the outbreak of the Ebola virus in West Africa; as contended by one respondent, W.H.O Deputy Country Representative for Zimbabwe that the budgetary cuts that began under W.H.O’s structural reform efforts made the Organization less effective and made its capacity limited to contain the Ebola outbreak. Lar (2014) posits that the 2014/2015 W.H.O budget was $4,385 billion, a 10.3% decrease from the previous budgets. The 2014-2015 W.H.O budget called for a 51% reduction in outbreak and crisis response activities from prior budgets of 2012-2013. As revealed by one respondent, the 2014/2015 W.H.O budget was not commensurate with W.H.O’s worldwide mandate, and was lower than the budget of many major hospitals in the United States. Gostin (2014) noted that voluntary contributions by member states and large donors like the Gates Foundation, the Global Fund and UNAIDS accounted for about 79% of the W.H.O’s budget, which was not adequate to meet the W.H.O’s global health demands. Coupled to that as noted by W.H.O Deputy Country Representative for Zimbabwe was the revelation that the Director General controls only 21% of the budget; as such this exposed the W.H.O administrative flaws that external donors dictate the organization’s emergency response priorities. Many key informant interview respondents from W.H.O Country Office concurred that these budget cuts crippled the W.H.O by reducing the much needed financial flows hence, undermining the organization’s operational capacity.

4.2.6 Lack of an Emergency Contingency Fund

As a result of the outbreak of the Ebola epidemic, the W.H.O made plans to launch a ‘specific, replenishable emergency contingency fund’ with a target capitalization of $100 million as per the provisions of Article 58 of W.H.O's constitution which stipulates that a special fund be established to meet unforeseen public health emergencies (W.H.O, 2016). Gostin (2015) notes that the fund was to be financed through voluntary contributions by member states. However, the W.H.O Deputy Country Representative in a key informant interview argued that considering the billions of dollars poured into other global health related epidemics like the outbreak of H1N1 virus, HIV/AIDS, malaria control and tuberculosis, $100 million seemed incommensurate with the Ebola crisis at hand and it was too late to begin resource mobilization for a rapidly spreading infectious disease like the Ebola virus. As such, research findings revealed that the lack of a contingency fund adversely crippled the W.H.O’s capacity to respond effectively to the Ebola outbreak of 2014.
4.2.7 Lack of Commitment by member states

The initial outbreak and spread of Ebola Virus disease was at the confluence of the three affected Mano River Union member states, and it rapidly evolved into a sub-regional phenomenon. The epidemic exposed the limited capacity of national and sub-regional (Africa Union and ECOWAS) systems to deal with an emergency outbreak of such magnitude in West Africa as noted by one respondent, a public health expert with the Department of Health Science, University of Zimbabwe. Coupled to that was the failure by African states to honour the endorsed Abuja Declaration where African Union countries met in Abuja, Nigeria in 2014 and pledged to set a target of allocating and investing at least 15% of their national Gross Domestic Products (GDP) into public health. (Farmer, Kim, Klein…etal, 2015) noted ‘that on the ground’ local response and leadership were important to complement the international aid that was being provided. One respondent agreed that affected counties could not work in isolation to contain the epidemic; it had to be a collaborative effort of all ECOWAS and Africa Union member states and the international community at large. Maintaining zero Ebola virus infections required member states commitment and the intervention of joint action to build resilience to future emergencies and ensure that emerging diseases preventative and control measures are effectively put in place so as to promote sustainable humanitarian interventions.

4.3 IMPACT OF THE 2014 EBOLA VIRUS OUTBREAK TO WEST AFRICA

The bio-security threat posed by the Ebola Virus Disease in West Africa in 2014 arguably was the most challenging global health challenge of all times. This human security threat was amplified by the magnitude, longevity and speed of transmission of the disease. Research findings gleaned from both primary and secondary data collection sources have revealed that; explanations for the rapid spread and persistence of the Ebola virus outbreak in West Africa include widespread poverty, corruption, underdeveloped health care systems, poor health infrastructure, limited qualified health personnel, weak governance and funding for the health sector, political instability, a significant cross-border population mobility and lack of proper education and unwillingness to accept the existence of the disease itself coupled with socio-cultural behaviours and attitudes misaligned with infection control measures, were a major hindrance in checking the spread of the disease in these West African countries. As such, what began as an insignificant health crisis snowballed into a humanitarian, social, economic and human security crisis whose consequences were felt globally.
(Lar, 2014) noted that the Ebola outbreak in West Africa brought to the fore the significance of strong health systems which can withstand disease outbreaks. One respondent narrated that; the Mano River Union region of West Africa had no previous history and experiences with the Ebola virus disease and their fragile health systems as a result of protracted years of civil conflict were completely overwhelmed by the impact of the epidemic. The three afflicted countries Guinea, Liberia, and Sierra Leone has the world's lowest health worker-to-patient ratios (accessed at http://dx.doi.org/10.15620/cdc.24900). And having only recently emerged from years of civil war and unrest, accordingly these countries’ were characterized by low human development, inadequate health infrastructure and weak health systems with less than one to two doctors per one thousand patient population as noted by some respondents.

Liberian Health Minister Dr. Bernice Dahn admitted that ‘our health infrastructure was not designed to cope with an epidemic of such magnitude and unprecedented impact’. These three countries remain high on the list of fragile states with Liberia ranking 176th, Guinea 179th, and Sierra Leone 183rd of the 187 African countries according to their Human Development Index (HDI) assessed by United Nations Development Programme (UNDP: 2014). Gostin (2014) asserts that countries with weak health systems cannot withstand sudden shocks of an emergency epidemic like the Ebola Virus. Hence under the weight of the Ebola crisis, health systems in Guinea, Liberia and Sierra Leone collapsed.

Findings from the key informant interviews carried out by the researcher revealed that, traditional practices in Ebola affected West African countries like the bathing of corpses by hands before burial, was regarded to be a health hazard which proved instrumental in perpetuating the outbreak and spread of the Ebola virus. Boulton (2014) study on the contamination and transmission dynamics of Ebola virus disease argued that African traditional local practices and beliefs were perceived to have escalated the spread of Ebola. The challenge of disease prevention and control due to socio-cultural practices such as burials was emphasized by Boulton (2014), when he noted that socio-cultural factors hampered the prevention and control of the spread of Ebola since community burials and traditional funeral practices obscured the implementation of effective preventive measures to the spread of the Ebola virus.

The various respondents interviewed concurred that the Ebola virus outbreak had a significant impact on the country economies of the Mano River region. The outbreak severely curtailed business and trade activities. Due to the severity of the spread of the disease, and
compounded by fear within and beyond borders of the affected countries, schools, markets, businesses, airlines and shipping and trading routes were closed down, and neighbouring countries like Ivory Coast, Senegal and Mali completely closed their borders for any trade as noted by Friedman (2015). To compound matters, as noted by one respondent who witnessed first-hand the outbreak of the epidemic revealed that sending supplies and additional medical staff to the affected communities became more difficult due to flight cancellations and border closures which was aimed at averting the increasing spread of the Ebola infection to the region and preventing a global pandemic with much far reaching effects.

Africa’s challenges and limitations in implementation of appropriate conventional disease outbreak, control and containment measures were compounded by lack of a regional bloc early emergency response warning systems and absence of contingency plans to emergency situations as gleaned from the several respondents interviewed. Coupled to this was the failure by African states to honour the endorsed Abuja Declaration of 2014, where African Union Head of States had met in Abuja Nigeria in 2014 and pledged to set a target of allocating and investing at least 15% of their national Gross Domestic Products (GDP) into public health emergencies that constantly plague Africa as reported by Ayoob (2012).

The Ebola virus outbreak in West Africa also demonstrated the different social challenges faced in rural and urban areas. One public health expert with the Health Studies Office, Ministry of Health in Zimbabwe revealed that:

‘whereas health services are more accessible in cities, contact tracing is difficult in the remote areas and require more staff and given the contagious nature of the Ebola virus, there were numerous opportunities for close contact and spread of the virus to occur’.

As such in the three West African countries rural affected areas, the two biggest problems were community resistance to safe burials and refusal to cooperate with contact tracing teams as revealed by one respondent from W.H.O who spearheaded the trainings on safe burial practices in all the three affected countries. As the emergency response teams learned, contact tracing was impeded by public interpretations of contact lists as “death” lists indicating who would be dying next (http://www.who.int/csr/don/2014-08-04 ebola/en/).

Poverty has been regarded as a major factor that fuelled the unbridled nature of the Ebola virus outbreak in West Africa. Ayoob (2012) noted that poverty is deep-rooted and resources are limited in these low income earning countries. UNICEF declared that the Ebola epidemic
orphaned over 22,000 children in West Africa (UNICEF Report, 2015). One key informant interview respondent noted that, Ebola reduced agriculture and fishing activities which were the mainstays of the rural communities in West Africa thereby increasing food insecurity. It is believed that human activities resulting in the disruption of the forest ecosystem and climate change driven by population expansion and poverty also triggered the Ebola outbreak. Ebola being a zoonotic disease and owing to poverty, the people of West Africa had developed a greater reliance on animal products, predominantly bush meat a host to the Ebola virus (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html).

The research findings gleaned from both documentary reviews and key informant interviews have proved that ill-implemented Ebola virus control strategies and insufficient communication strategies with the affected communities led to a public suspicion of the ‘Ebola business’ that created mistrust between the health care workers and the affected communities. This resulted in people stopping receiving or seeking health care for Ebola symptoms and avoidance of health facilities. Subsequently, what then unfolded was an Ebola virus tsunami of unprecedented magnitude that left crippled economies and defunct health infrastructures.

4.4 Chapter Summary

This chapter presented the research findings carried out to ascertain the shortcomings that led to the delay in response to the outbreak of the Ebola Virus in West Africa. Interpretation and analysis of findings was presented through thematic and qualitative analysis techniques. Research findings gleaned from respondents of the key informant interviews carried out and a plethora of documentary reviews provided the much needed answers to the problem statement of this study; that is the reasons for W.H.O’s delay to proffer emergency response to the outbreak of Ebola in West Africa. Reasons gleaned from the various sources employed for the study revealed that bureaucratic issues within the W.H.O curtailed an effective emergency response, budgetary constraints, lack of an emergency contingency fund, lack of an emergency workforce and lack of commitment by regional blocs’ member states all contributed to the delay in effecting a global response to the human security threatening emergency of the Ebola outbreak. As such given the above research findings, the international community presented with these realities, it was imperative to embark on an effective and immediate response to the Ebola outbreak but a delayed response resulted in the disastrous public health misfortune that hogged West Africa in 2014.
CHAPTER 5: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter is a summary of the whole research project, highlighting the key research findings, recommendations from research findings and conclusions drawn after assessing the shortcomings of W.H.O’s response to the outbreak of the Ebola virus in West Africa in 2014. This was done to satisfy the demands of the research questions and objectives articulated in Chapter 1. This chapter further presented recommendations for W.H.O’s response to future global health pandemics guided by the research findings discussed in Chapter 4. The chapter also identified research gaps in knowledge and areas for further research in response to the lessons learnt during the 2014 West Africa Ebola Virus outbreak.

5.2 SUMMARY OF FINDINGS

Africa is a changing landscape, and international humanitarian intervention approaches subsequently have to address the complexities and challenges of the region and its people’s livelihoods. Many factors could have contributed to the outbreak of Ebola in countries of the Mano River Union, i.e. Liberia, Sierra Leone and Guinea, which face the challenges of, an increasing population size, social unrest, and poverty which could have undoubtedly influenced both the explosive and uncontained nature of this epidemic. Due to the lack of Ebola outbreak early warning alert systems, preparedness, surveillance and response systems, the most deadly, complex and largest ever seen Ebola war destroyed West African communities in 2014. This thesis examined the multiple contested criticisms to W.H.O’s response to the outbreak that have emerged in response to the epidemic.

Various reasons have been cited to have contributed to the escalation of the West Africa Ebola crisis such as: lack of timely international community response, uncoordinated humanitarian organisations response, lack of emergency response models in limited resource countries, mistrust and resistance by the affected population, traditional beliefs and cultural attitudes towards health-seeking behaviour, inexistent country specific and regional epidemic preparedness mechanisms, poor governance and corruption in most African government systems. Due to these reasons, the affected countries were unable to stem out the outbreak before it claimed thousands of victims leaving behind a trail of unprecedented destruction. Hence, the outbreak turned out to be an insidious threat to the public health systems of West Africa and by extension to global health security.
To amplify matters, the three most affected countries which are Guinea, Sierra Leone and Liberia are among the poorest in the world, characterised by weak healthcare systems, high mortality rate, a history of civil wars and the advent of the Ebola virus accelerated the crippling of the socio-economic and health systems of these countries and their governments (Friedman, 2015). All of these are factors that contributed to the alarming numbers of fatalities from the Ebola virus outbreak of 2014, which is said to have claimed more lives than all the other previous Ebola outbreaks combined.

Though much of the media attention given to W.H.O and the rest of the international community concentrates on its humanitarian intervention role in controlling and managing infectious diseases; W.H.O’s mandate to intervene in West Africa was far broader than that and in this particular case study was not adequately fulfilled. W.H.O’s mandate entails timely intervention to international public health epidemics worldwide. However, critics have said that W.H.O was slow to mobilize resources for immediate response, had difficulties with coordination of emergency intervention and ran into significant problems of resistance and public mistrust in the affected countries. As such, W.H.O only declared the Ebola virus outbreak a ‘threat to international peace and security’ in August 2014; several months after the initial alert of the fast-spreading pandemic had been made (W.H.O Situational Report, 2014). Since then this unparalleled Ebola tsunami has prompted interrogations into, and uncertainties about, the efficiency of national, regional and international community’s responses using conventional humanitarian interventions mechanisms, containment and response to public health emergency epidemics in Africa.

5.3 CONCLUSION

The conclusion that can be drawn from the research findings discussed in this study presents a notion that the World Health Organization’s delayed emergency response to the Ebola Virus outbreak has raised several questions regarding global health governance and international commitment to strengthening health systems and emergency response capacities for low income countries. Ever since the outbreak of the Ebola Virus became a global health issue, it drew the attention of key international players like W.H.O to West Africa in response to minimise the effects of the epidemic. This study acknowledged that, since its formation W.H.O has taken the lead in the fight against many global public health epidemics including the subject of this thesis, Ebola virus disease (EVD).
The outbreak of the Ebola virus in the Mano River Union region was unique in the sense that; it was the largest most persistent Ebola outbreak ever since its detection in Africa and it represented the first time the virus spread to West Africa. Moreover, it was the first time that the virus spread to urban setups in addition to rural areas posing difficulties for effecting disease control efforts. And various public health experts and international relations scholars have criticized the international community’s response to the Ebola outbreak of 2014 in West Africa; bemoaning the pace and scale of assistance that was rendered until the Ebola crisis was declared a Public Health Emergency of International Concern (PHEIC). An analysis of the various scholarly submissions presented in Chapter 2 of this study have proved that for successful reduction and containment efforts for an emergency epidemic, necessary international support and humanitarian intervention mechanisms should be provided to resource constrained affected countries in order to curb a global spread.

In conclusion it should be pointed out that the legacy of the 2014 Ebola virus outbreak in West Africa should not only be considered from a negative perspective, since the epidemic also brought several opportunities to West Africa by improving health infrastructure, improving health standards, health seeking behaviour and developing local public health research and training capacities in the affected countries. And while efforts are needed to mitigate the impact of the Ebola outbreak to West Africa; this study recommends that an emphasis should also be put on the need for preparedness of West African countries affected by the Ebola virus to face future epidemics of such magnitude.

5.4 RECOMMENDATIONS

- Recommendations of this study are that governments in developing countries like Sierra Leone, Guinea and Liberia must show more commitment to better health care planning and financing as the provision of quality, affordable health is a fundamental human right. Key research findings from this study revealed that the outbreak of the Ebola virus in 2014 exposed the health systems in the affected countries as weak and this affected their ability to contain the outbreak. Hence, all the building blocks of the health systems should be strengthened; including health infrastructure, staff and provision of vaccines as this improves the capacity to deal effectively with any disease outbreak of the near future.

- Furthermore, Ebola research relevant to the African context should be intensified through funding from both corporate international organizations and governments. Paradoxically, the majority of research into Ebola vaccine and drugs development is mainly undertaken in the US, Italy and Canada, while little is known about the research efforts from Africa.
despite the fact that the brunt of the scourge of Ebola was felt across the continent. African governments need to demonstrate sufficient political will to reverse the abysmal level of research into drug and vaccine development, especially for (tropical) emerging or re-emerging diseases like Ebola. Enabling laws can be promulgated to facilitate corporate international organizations including multinational companies to commit a certain percentage of their profits into public health research, specifically drug and vaccine development research.

- The use of multiple contemporary digital approaches to raise educational awareness such as e-health to send relevant health information and use of social media can be quite effective in severe public health emergencies. During the Ebola virus outbreak, awareness was widened through use of SMSes with dedicated toll free mobile lines.

- Increased disease outbreak emergency preparedness is of paramount importance in an emergence disease outbreak. Public health alertness mechanisms like screening at airports, sensitization of airport personnel and training in handling emergency situations, sensitization of traditional; religious leaders, faith based organizations leaders, screening at markets and other public meeting places can all go a long way in arresting the spread of contagious diseases like the Ebola virus. All these innovative practices were conducted in Nigeria, and they contributed immensely to the country’s success story of effective containment efforts of the outbreak.

- There is need for emergency disease outbreak response preparedness for West African countries mostly affected by the diseases to face future epidemics of such nature. Preparedness would entail an improvement in the post-Ebola health care strategies for the three most affected countries and subsequent improvements of the health standards and sustained health systems strengthening across the continent.

- In order to prevent disease outbreaks from turning into a global catastrophe, there is need for competent governance in the African continent, and this demands strong political leadership and political will in order to provide the necessary support to strengthen member country capacities essential to responding to public health epidemics like the Ebola virus.

- Institute policies, actions and programmes to correct weaknesses at the sub-regional level and international level that were revealed by the Ebola outbreak and strengthen the resilience of the sub-region i.e. Mano River Region to future Ebola-like threats.

- Prioritise post-Ebola recovery initiatives within the Mano River Union that could buttress and strengthen epidemic preparedness and response measures to future epidemic outbreaks.
5.5 AREAS FOR FURTHER RESEARCH

Areas for further study would be to focus on research that would stimulate debate on W.H.O structural reform and possible existence of the agency as an independent body. It can be argued that if W.H.O is to fulfil its constitutional mandate to lead and coordinate a global response to health emergencies, it has to provide necessary adequate emergency humanitarian intervention. As such, scholarly research on whether W.H.O should have such humanitarian intervention capacity and or should remain in a global health supervisory role can be the focus of such research; and also exploring the reasons why the W.H.O reform rhetoric is always a topical discussion at the centre of many international debates at international fora, yet it lacks implementation.
REFERENCES

Books


**Journals and Articles**


**Electronic Internet Sources**


www.who.int/ebola
INTRODUCTORY LETTER

TO WHOM IT MAY CONCERN

My name is Amandla Wadzingaire, a Masters’ in International Relations (MSc. I.R) student from the Bindura University of Science Education (BUSE) carrying out an academic research study titled, 'International humanitarian intervention and African pandemics: A case of the World Health Organisation (WHO)’s response to the 2014 Ebola Virus Disease outbreak in West Africa'. May you please assist me in responding to this Key Informant Interview Guide which requires you to offer your views and recommendations on WHO’s response to the 2014 Ebola Virus Disease outbreak in West Africa. Confidentiality shall be upheld and information provided shall be used solely for the purposes of this research.

Yours Faithfully

…………………

Wadzingaire Amandla.
Appendix II

PERSONAL DETAILS

Please put a tick (√) in the appropriate box below:

1. Please indicate your gender?
   (a) Male  (b) Female

2. Please indicate your age group?
   (a) 18-30+ Years  (b) 31-40+ Years  (c) 41-50+ Years

3. How long have you been with your organization?
   (a) 0-5 Years  (b) 6-10 Years  (c) 11-20 Years

KEY INFORMANT INTERVIEW GUIDE

1. How was your organisation/ ministry and or you as an individual specifically involved in the Ebola outbreak of 2014 in West Africa?

2. How do you view W.H.O’s emergency response to the 2014 Ebola outbreak in West Africa?

3. Do you think the Ebola virus outbreak of 2014 in West Africa received adequate response from the international community at large; and specifically W.H.O.? Explain your answer;

4. What do you think were the major reasons for W.H.O’s delay in response to the Ebola Virus outbreak in West Africa?

5. What lessons can be learnt from the W.H.O’s response to the 2014 Ebola virus outbreak in West Africa regarding international and regional emergency health preparedness to fast spreading epidemics like the Ebola virus disease?

6. What measures do you recommend W.H.O should adopt in response to future outbreaks of fast spreading epidemics like the Ebola virus disease

61
CHAPTER 1: INTRODUCTION

1.1 Background of the Study.................................................1

1.2 Statement of the Problem...............................................2

1.3 Purpose of the Study.....................................................3

1.4 Research Objectives.....................................................3

1.5 Research Questions....................................................3

1.6 Assumptions.............................................................3

1.7 Significance of the Study.............................................4
CHAPTER 2: LITERATURE REVIEW

2.2 Introduction...........................................................................................................7

2.1.1 Theoretical Framework......................................................................................7

2.1.2 Conceptual Framework......................................................................................8

2.2 State Sovereignty; Responsibility To Protect and the Changing Nature of Humanitarian Intervention.....................................................9

2.2.1 Responsibility To Protect and Humanitarian Intervention..........................10

2.2.2 State Sovereignty and Humanitarian Intervention........................................11

2.3 Situating Global Health; Human Security and Humanitarian Intervention to the Ebola Virus Outbreak Response in West Africa.........................................................12
2.4 Ebola Virus Disease Trajectory in West Africa

2.4.1 What is Ebola Virus

2.4.2 History and Origins of Ebola

2.5 Country Specific Ebola Virus case studies in West Africa

2.5.1 Guinea

2.5.2 Liberia

2.5.3 Sierra Leone

2.5.4 Nigeria

2.6 Chapter Summary

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.2 Introduction

3.2 Research Paradigm
3.3 Research Design ........................................................................ 21

3.4 Research Methodology ................................................................ 22

3.5 Population .................................................................................. 23

3.6 Sampling ..................................................................................... 23

3.6.1 Sampling Methods .................................................................. 24

3.6.2 Snowball Sampling ................................................................ 24

3.6.3 Expert Purposive Sampling ...................................................... 24

3.7 Data Collection Methods ............................................................. 25

3.7.1 Documentary Review ............................................................... 26

3.7.2 Interviews .............................................................................. 26

3.8 Validity and Reliability ................................................................. 26

3.9 Ethical Considerations ................................................................. 27

3.10 Data Presentation and Analysis Procedures ................................. 28

3.10.1 Qualitative Data Analysis ....................................................... 28
CHAPTER 4: DATA PRESENTATION; ANALYSIS AND DISCUSSION

4.1
Introduction........................................................................................................................................30

4.2 Pitfalls to WHO’s response to the 2014 Ebola Virus Outbreak in West Africa..................30

   4.2.1 Bureaucratic Pitfalls.................................................................................................................31

   4.2.2 Delay in pronouncing a Public Health Emergency of International Concern...........31

   4.2.3 Absence of an Emergency Health Workforce.................................................................32

   4.2.4 Lack of Adherence to the International Health Regulations.................................33

   4.2.5 Lack of Funding......................................................................................................................34

   4.2.6 Lack of an Emergency Contingency Fund.....................................................................34

   4.2.7 Lack of commitment by Member states...........................................................................34

4.3 Impact of the 2014 Ebola Virus Outbreak to West Africa.............................................35
CHAPTER 5: SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction ............................................................................................................39

5.2 Summary of Findings ...........................................................................................39

5.3 Conclusion ............................................................................................................39

5.4 Recommendations ...............................................................................................40

5.5 Areas for Further Research ................................................................................43

References ..................................................................................................................44

Appendix 1: Introductory Letter .................................................................................48

Appendix 2: Key Informant Interview Guide ...............................................................49

ABBREVIATIONS

CDC  Centers for Disease Control
ETC  Ebola Treatment Centers
EVD  Ebola Virus Disease
HTC  High Transmission Countries
IHR  International Health Regulations
MSF       Médecins Sans Frontières (Doctors Without Borders)
MoH       Ministry of Health
MRU       Mano River Union
PHEIC     Public Health Emergency of International Concern
R2P       Responsibility To Protect
UNICEF    United Nations Emergency Children’s Fund
UNMEER    United Nations Mission for Ebola Emergency Response
UNOCHA    United Nations Office for the Coordination of Humanitarian Affairs
USAID     United States Agency for International Development
W.H.O     World Health Organization

END OF QUESTIONS....THANK YOU FOR YOUR TIME!!!