Ebola Epidemic

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This article seeks to critically examine various dimensions of the impact of the 2014 Ebola epidemic in Guinea, Sierra Leone, and Liberia and on the international community. How did poverty and inequality exacerbate the epidemic? How did legacies of violence and civil war complicate efforts against Ebola? Critically examining the outbreak may trigger more questions than answers; nevertheless, it is instructive to draw lessons from such crises. What does history teach us?

The Greek war historian Thucydides was perhaps the first to detail the history of an infectious disease, which he called the "plague of Athens," an affliction that reduced its population by over one-third and contributed to that city-state's defeat in the Peloponnesian Wars. In what could fit a description of some Ebola-afflicted regions during the 2014 epidemic, Thucydides wrote, "The bodies of the dying were heaped one on top of the other, and half-dead creatures could be seen staggering about in the streets or flocking around the fountains in their desire for water. For the catastrophe was so overwhelming that men, not knowing what would next happen to them, became indifferent to every rule of religion or law."[1]

In a more recent example, 95 percent of American Indians were killed by diseases brought by European explorers to the New World between 1492 and the end of the seventeenth century. Francisco Pizarro defeated an Incan army of 80,000 soldiers with only 168 Spaniard soldiers because a smallpox epidemic

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killed large numbers of the Native Americans.[2] In the twentieth century, the morale of German forces was undermined by the 1918 influenza outbreak, contributing to an Allied victory. During World War II, disease claimed the lives of more soldiers than actual combat in many battle areas.[3]

Epidemics have been critically important throughout history in determining the fates of communities, armies, states, and entire civilizations. The 2014 Ebola epidemic threatened havoc in West Africa, undermining the recovery and well-being of the postconflict states of Guinea, Sierra Leone, and Liberia while also bringing attention to how the affluent world is not immune to diseases in the global South in the context of a worldwide economy.

Ebola and the Scope and Impact of the Epidemic

The Ebola virus was discovered in 1976 in what is now the Democratic Republic of Congo (DRC), formerly Zaire. Small-scale outbreaks have occurred in the DRC, Uganda, and Southern Sudan. There has been much public confusion about Ebola transmission. According to the *New York Times*,

> You are not likely to catch Ebola just by being in proximity to someone who has the virus. It is not spread through the air like the flu or respiratory viruses such as SARS [severe acute respiratory syndrome].
>
> Instead, Ebola spreads through direct contact with bodily fluids. If an infected person's blood or vomit gets in another person's eyes, nose or mouth, the infection may be transmitted. In the current outbreak, most new cases are occurring among people who have been taking care of sick relatives or who have prepared an infected body for burial.[4]

Ebola forced the swift isolation of victims, along with those not showing symptoms who were from the affected or even suspected areas. Furthermore, the symptoms of Ebola closely resemble those of other diseases such as influenza, causing confusion and increased panic. Different from prior Ebola outbreaks, the 2014 epidemic was far larger, encompassing many countries in West Africa and defying earlier strategies of containment. The most affected nations in Africa were Liberia, Guinea, and Sierra Leone. Nigeria also reported over a dozen deaths and many more infected. The World Health Organization (WHO) determined that the East African country of Kenya was at high risk for Ebola because it is a hub for air travel to many West African countries.[5] In a knee-jerk reaction and bowing to international pressure, Kenya's airlines stopped all flights to the affected countries.[6] South Africa followed suit by similarly banning flights.

Kenya Airways was singled out, but it is not the only major airline serving West Africa. Ethiopia, for example, is the headquarters for organizations like the

African Union, and Ethiopian Air Lines makes frequent flights to West Africa and many other African countries.[7] According to an Oxford study, Ethiopia was one of the African countries most at risk for developing Ebola outbreaks through animal-to-human transmission while Kenya was not, demonstrating the contradictory and incoherent nature of international responses to Ebola.[8]

In the United States, some people called for shutting down all air travel to the affected countries. As of August 2014, there were no commercial American airlines that had not already suspended flights to the region, and even this prohibition did not guarantee that infected persons wouldn't simply take a connecting flight from a non-American airline—witness the case of Ebola diagnosed in Texas, the victim having arrived in Dallas via Brussels. Additionally, it was vitally important to keep lines of travel open to assist the movement of supplies and health workers critical to the local containment of the disease in efforts to stop Ebola in its tracks. As Vauhini Vara of the *New Yorker* wrote, "There may be situations in which the U.S. could benefit from keeping out of other countries' affairs; this, public-health officials seem to agree, is not one of them."[9] Flight bans only served to further isolate and stigmatize countries that most needed incoming health workers, medical and emergency supplies, and international communication.

Local Responses to Ebola

Ebola exposed how dysfunctional the public health system in most of Africa truly was—in many cases almost nonexistent. However, some states are in a far better position than others. With all its imperfections, and despite President Goodluck Jonathan's mass firing of 16,000 resident doctors for striking in August 2014, Nigeria still had a far stronger public health infrastructure than any of the other affected countries in West Africa.[10] By the end of September 2014, President Jonathan told the United Nations (UN) that Nigeria is "Ebola-free."[11]

In what sounded encouraging, Ethiopia claimed to have established a special hospital for potential Ebola cases. Yet, the health care system in Ethiopia was and still is one of the worst in the world. In her 2014 trip to that country, Amy Walters of National Public Radio discovered that even its best hospital, Tikur Anbessa, had inadequate equipment, facilities, and medical personnel.[12] The doctor/patient ratio in the country has been suffering from a chronic brain drain to Western nations because of the exodus of doctors who complain about low salaries. Additionally, due to issues of class and accessibility, 85 percent of Ethiopians may never see doctors at all in their lifetimes.[13] In Liberia, where the Ebola epidemic was at

its worst, initially only 45 doctors nationally served a population of approximately 4.5 million. The picture remains more or less similar in most African countries.[14]

The fact that Ebola spread much faster than was generally acknowledged publicly was blamed on the porous nature of African borders. In response, governments strengthened them, but cordoning off the affected countries soon proved an ineffective approach. Ultimately, epidemiological surveillance and contact tracing (the tracking and diagnosing of all people who came in contact with an infected patient) were widely adopted as a proven method to track Ebola victims on the recommendation of Doctors Without Borders / Médecins Sans Frontières (MSF).[15]

The blanket quarantining of entire communities as a reaction to Ebola or any contagious disease resembles the scenario in Michel Foucault's *Discipline and Punish* of how plague-struck towns were treated in Europe in medieval times: "First, a strict spatial partitioning: the closing of the town and its outlying districts, a prohibition to leave the town on pain of death."[16] We saw in the 2014 epidemic a similar phenomenon happening to the inhabitants of Ebola-stricken areas. It was also evident in the international air travel bans and increased border security across the world. In an illustration of how quarantining is not effective, "a university student infected with Ebola evaded health surveillance for weeks as he slipped into Senegal, carrying the deadly virus to a fifth West African nation showing how quarantines, border closures, and flight bans have failed to contain the outbreak."[17]

West African Practices and Ebola

Not only is Ebola killing Africans, it also undermines dearly held social structures and values. Touching, washing, and arranging bodies for burial are rituals integral to most African communities. For example, secret societies of women perform burial rituals for women and girls, and men do so for men and boys. To be prevented from long-held traditions of burial practices and to have strangers wearing hazardous-material suits take away the bodies compounded the tragedy. The situation deteriorated to an extent that bodies were not even picked up at all. The trauma of being denied traditional closure was psychologically devastating to surviving relatives. On the Public Broadcasting Service's *Frontline* television program, a dying father practically crawls to an iPad provided by MSF staff members to see a video recording of his four children wishing him well shortly before he succumbs to Ebola.[18]

Moreover, much of Africa is very sensorial. Not greeting people by shaking hands and in some cases by kissing on the cheek is considered rude. Embracing

people through hugging and touching is the norm. Therefore, Ebola struck at the heart of African customs and social structures: civility, liveliness, sense of community, respect for elders, and strength of the family unit. Traditional funeral practices involving contact with the corpse were forbidden. The initial resistance and respect for tradition, even at risk to one's life, were strong in the early days of the epidemic but eventually replaced by fear as people shifted into survival mode. Still, some individuals declared that they would "rather die of Ebola than stop hugging sick loved ones," desperately clinging to traditional norms and their humanity.[19]

Furthermore, religious obligations such as the Hajj pilgrimage, which millions of Muslims take to Mecca once in their lifetime, lost priority to fear of Ebola. As a precaution against the disease, Saudi Arabia turned down 7,400 visa applications from Liberian, Sierra Leonean, and Guinean pilgrims.[20] This denial of an important religious practice deepened the isolation and alienation caused by the disease.

Further straining the public health scenario, people who were ill with other deadly ailments like malaria refrained from seeking hospital care because of a perception that hospitals were transmitting agents for Ebola. Even worse, a quarantine center for suspected Ebola patients in the Liberian capital Monrovia was attacked and looted by protesters.[21] According to a government official, "The protesters were unhappy that patients were being brought in from other parts of the capital." In Guinea, health workers and journalists trying to raise awareness were attacked and later found dead.[22] Such outright mistrust and violence toward health workers again evoke Foucault's writing about those people who dealt with the sick and dead during a plague: "The 'crows,' who can be left to die . . . are 'people of little substance who carry the sick, bury the dead, clean and do many vile and abject offices.' "[23] According to Andrew T. Price-Smith, "Emotions and perceptual distortions . . . emerging as a result of a deadly disease outbreak . . . generate the construction of images of the 'other,' resulting in stigmatization, persecution of minorities, and even diffuse inter-ethnic or interclass violence."[24]

As people attempted to cope with the horrors of the epidemic in Albert Camus's *The Plague*, citizens blamed one another, resulting in violence. In the book, a doctor thoroughly chronicles an epidemic with scientific detachment in an attempt to make sense of human mortality and the circumstances beyond human control that isolate individuals.[25] Yet, the epidemic unites even the most personally and philosophically disparate within towns and villages. Camus's message is that there's no constant except that we are all in it together despite the panic, hysteria, and isolation. Despite the horrific conditions in West Africa, local and international cooperation offered a way out.

International Response

On 8 August 2014, Reuters reported that the WHO had declared Ebola an international public health emergency.[26] The designation required the agency to make recommendations for immediate international action and a ramped-up response. Concurrently, US health authorities acknowledged that Ebola's spread beyond West Africa was "inevitable," and MSF warned that the deadly virus was "out of control" with more than 60 outbreak hot spots.[27] MSF has been urging the WHO to provide stronger leadership in the fight against Ebola since it was the first group to realize the gravity of the situation.

The international community had been reluctant to respond constructively to the outbreak. Initially, the WHO participated only peripherally, supporting regional responses by groups such as the Economic Community of West African States, whose own reaction was considered slow and inadequate.[28] However, after months of relative inaction and receiving repeated calls for an international response from groups such as MSF, on 28 August 2014 the WHO finally launched a road map for controlling the international spread of Ebola in six to nine months.[29] As a specialized UN agency, the WHO is constrained by bureaucracy, donor interests, budget cuts, and interagency politics. For instance, the *New York Times* reported that "the W.H.O. would not send Twitter messages with links to the C.D.C.'s [Centers for Disease Control and Prevention] Ebola prevention information, part of a policy not to promote material from other agencies. Various offices within the W.H.O.'s balkanized hierarchy also jockeyed for position."[30]

This is an example of bureaucracy hampering efforts to address the crisis meaningfully. In particular, WHO Africa had been criticized for lacking competent leadership since many top jobs at the agency had been conspicuously given as political favors over the years. This practice had resulted in a culture of nepotism, confusion about the organization's mandate, political considerations trumping public health, and an agency lacking the skills and political will to deal with any serious public health emergency.[31] In contrast, MSF is an independent nongovernmental organization with a record of speaking out, often being the first in and the last to leave in many humanitarian interventions.

Despite these efforts, calls for a far more aggressive campaign were made to address an efficient system of transporting volunteer doctors and health care professionals to affected areas with the necessary preventive equipment and improvements in access to diagnostic technologies. The few health care workers who treated these underserved populations, including the top chief medical officer in Liberia, were consistently exposed to danger since they were overstretched and had inadequate access to protective gear.[32] Even when hazardous-material suits

were available, some gallant doctors and nurses had already paid the ultimate price—witness the tragic death of Dr. Victor Willoughby in Sierra Leone just hours before experimental drugs arrived from Canada to treat him.[33] Furthermore, travel bans had an adverse effect on the movement of health care workers, stranding nurses and doctors in transit centers far from where they were needed.

On 25 January 2015, the WHO finally acknowledged its shortcomings in handling Ebola, after much rationalization and denial in the preceding months: "For many years we've been able to manage medium, small-sized outbreaks . . . [b]ut the Ebola outbreak was a mega-crisis, and it overwhelmed the capacity of WHO. The world is not as well prepared for epidemics as they are for war." The agency pledged to establish a reserve force of about 1,500 health care workers for similar crises in the future, along with a new fund with seed money totaling $100 million for emergency response.[34] Mindful of past criticisms, WHO Africa selected a new regional director, Dr. Matshidiso Moeti, from Botswana, who "during the selection process . . . was not pressured to promise jobs to anyone in return for any country's vote, which is known to have happened in the past."[35]

Ebola and International Travel

According to the WHO, air travel is low risk for transmitting the disease.[36] Yet, we continued to witness extreme hysteria, as when the United Arab Emirates and British Airways suspended flights to affected countries. Germany asked its nationals to leave the region. Korean Airlines suspended flights to Kenya, Liberia, Sierra Leone, and Guinea. The International Olympic Committee ruled that young athletes from those countries would not be allowed to compete in combat sports or in the pool during games in Nanjing, China.[37] Brazilian executives canceled a visit to Namibia over fears about Ebola despite the fact that that country has never seen a single case and is almost 3,000 miles away from the center of the outbreak.[38]

Some details of various international responses to this epidemic raise questions of how differently the outbreak would have been treated if it had occurred within Western states among more affluent populations. An article in the *Guardian* noted that "from Austria to Ireland, Spain to Germany, there have been at least a dozen cases of West Africans with mild flu symptoms being isolated until it was established that they were not suffering from Ebola."[39] Journalist Barbie Latza Nadeau wrote on 20 August 2014 that "a Berlin building [was] locked down after an African woman faints. An African man with a nosebleed [was] removed from a mall in Brussels. With Ebola panic spreading, racial profiling could be next."[40] As it turned out, the woman Nadeau refers to was from Kenya,

thousands of miles from any of the affected areas. She goes on to describe other events in Italy, where schoolchildren of African descent had been required to present health certificates before returning to school, a demand that did not apply to European children even when they had recently visited Africa.[41]

Similar reactions have been reported in the United States, where, among other instances of discrimination, a Georgia school district barred enrollment of Liberian students.[42] Even the elites of Africa were not immune from suspicion of infection: African political leaders attending the US-Africa Leaders' Summit in Washington, DC, had to be screened before being allowed to set foot in the United States.[43] The reality of how Western countries with sophisticated health care systems are able to handle Ebola doesn't support the hysteria of targeting people of African descent, which may have more to do with typical patterns of "othering" Africans:

> The consensus among scientists is that the Ebola virus does not pose any risk to the general public in Western countries with well-resourced public health care systems. However, African refugees living in foreign countries are often impacted by disease outbreaks such as the recent Ebola eruption. . . . In fact, research shows that outbreaks of diseases such as measles, rubella and hepatitis A have disrupted the resettlement of African refugees.[44]

Xenophobic agendas have used infectious disease to great effect in setting public attitudes against immigrants and refugees.[45] In fact, there is plenty of evidence that "from the trans-Atlantic slave trade of the 15th–19th centuries to the diseases, epidemics and wars of present time, the West has consciously, consistently and systematically pursued policies designed to control, reduce and eliminate altogether Africa's population" in an effort to secure land and resources.[46] Following this legacy, some Westerners see the Ebola epidemic or any other infectious disease in poorer countries as a necessary evil to control population growth. The view that the death of Africans from Ebola and other epidemics helps such control has been voiced by popular individuals such as Chris Brown and smacks of social Darwinism.[47]

Reinforcing this predisposition to social Darwinism, the affluent world's priority is to invest in diseases of the "rich" (diabetes, heart ailments, etc.), whereas Ebola, tuberculosis, cholera, malaria, and so forth, may be tacitly seen as nature's way of balancing the global population. Writing for the *New Yorke*r, James Surowiecki declares that

> [pharmaceutical companies] have an incentive to target diseases that affect wealthier people (above all, people in the developed world), who can afford to pay a lot. . . .

> This system does a reasonable job of getting Westerners the drugs they want. . . . But it also leads to enormous underinvestment in certain kinds of diseases. . . . Diseases that mostly affect poor people in poor countries aren't a research priority, because it's unlikely that those markets will ever provide a decent return.[48]

This exact scenario has played out with Ebola. For nearly a decade, a 100 percent effective vaccine against both Ebola and the Marburg virus in monkeys has been shelved due to the low profitability of a vaccine benefiting primarily poor Africans. Now, these same companies that deemed developing the vaccine too costly are eagerly switching positions as wealthy donors become increasingly willing to finance any possible cure because Ebola has begun to threaten and infiltrate the affluent world.[49] This approach to public health is so profit driven that WHO director-general Dr. Margaret Chan "castigated the pharmaceutical industry for failing to develop a vaccine for Ebola over the some 40 years that the virus has threatened West Africa."[50]

Similar to reactions to HIV, panic about the unknown and unseen contagion can do as much damage as the disease itself. Unlike HIV, Ebola is spread by clearly symptomatic people. That said, the virus mutates over time and may eventually develop strains that can be transmitted by people with few or no obvious symptoms. This eventuality concerns the international community and has been framed as a national security threat by President Barack Obama.[51] This proclamation by the president echoed a National Intelligence Estimate from the year 2000 concerning the US response to tuberculosis and HIV/AIDS: "In June 1996, President Clinton issued a Presidential Decision Directive calling for a more focused US policy on infectious diseases. . . . [An] unprecedented UN Security Council session devoted exclusively to the threat to Africa from HIV/AIDS in January 2000 [was] a measure of the international community's concern about the infectious disease threat."[52]

National security has often been invoked in politics to gain support, and President Obama has certainly been no exception, but other approaches to international relations such as "human security" may pave the way to more effective, humane responses to Ebola and other infectious diseases. Examining human security and global health, Lincoln Chen and Vasant Narasimhan write that "human security attempts to broaden security thinking from 'national security' and the military defense of political boundaries to a 'people-centered' approach of anticipating and coping with the multiple threats faced by ordinary people in an increasingly globalizing world."[53] Human security could have provided a compelling alternative lens by focusing on the victims of Ebola and their plight, in contrast to the dominant national security narrative that news media and politicians

repeatedly used to characterize Ebola as lethal, contagious, and out of control, thus hampering timely intervention.

Prior Ebola cases occurred in geographically limited areas or isolated villages. The 2014 epidemic included cities and population centers, distinguishing it from earlier outbreaks in the DRC, Uganda, and South Sudan. Such dramatic spread increased the fear of the virus potentially mutating, becoming infectious in new ways, and extending its reach globally. As of 26 September 2014, the CDC projected that without adequate containment, 1.4 million cases of Ebola would occur by 20 January 2015.[54] Increased intervention and change in behavior, however, resulted in far fewer total infections over the course of the epidemic: 28,601 by the end of December 2015.[55]

Every aspect of responding to Ebola involved staggering costs. As of 3 September 2014, few states had seriously committed resources to fighting Ebola. The WHO estimated that efforts to contain Ebola would require at least $490 million; the UN a few days later updated the estimate to $600 million, and the figures kept growing.[56] In response to a White House request for $88 million from Congress to fight Ebola, House Republicans argued for less than half before eventually submitting to the whole amount.[57] Meanwhile, the nonprofit Bill and Melinda Gates Foundation pledged $50 million, quickly releasing funds to UN and other agencies to fight the crisis.[58] Cuba took the lead in responding proactively by initially committing 165 health care workers to affected areas, and by 21 October 2014, it had helped fill the critical need for medical personnel with 276 total workers.[59] As of 16 October 2014, Colombia was the first and only country to contribute to a UN request for a billion dollars to fight Ebola, giving $100,000 in cash deposits.[60] Eventually, more countries did come through in a variety of ways, including many more donations to the UN fund and a $6.2 billion request by the Obama administration from Congress, of which $5.4 billion was approved in December 2014.[61]

After the WHO's belated call for international intervention in the spread of Ebola, the response suddenly picked up momentum. The UN talked about a global response coalition. President Obama announced on 16 September 2014 that "[the United States] will send 3,000 troops to help tackle the Ebola outbreak as part of a ramped-up plan, including a major deployment in Liberia, the country where the epidemic is spiraling fastest out of control . . . [and] plans to build 17 treatment centers, train thousands of healthcare workers and establish a military control center for coordination."[62] Even with these efforts, escalation of the disease was so rapid that no one knew when it would be contained. It was uncharted territory. Peter Piot, who helped identify Ebola 40 years prior, worried that through this outbreak Ebola would become endemic in humans.[63]

An acute need exists for innovation to combat Ebola. Experimental drugs should be available and delivered in a timely manner. In an unprecedented move, the WHO determined that under the circumstances, it was ethical to use "unregistered interventions"—drugs such as Zmapp—with patient consent.[64] Japan also offered Avigan, a drug used to treat new and reemerging influenza viruses, as a possible treatment for Ebola.[65] Granted, these drugs were merely experimental and no clinical trials had been conducted, but lives could have been saved if they had been made available at an expedited pace. One potential treatment was the transfusion of blood serum from Ebola survivors. This treatment might have been accessible more quickly than drugs like Zmapp, which weren't scheduled for even small-scale use until January 2015.[66] Several European countries, Russia, and China provided mobile labs to help with diagnosis. Later, US Navy researchers staffed two mobile labs, reducing the time to determine if a patient had Ebola from days to hours.[67]

Postconflict Challenges

The severely affected countries of Liberia, Guinea, and Sierra Leone are still emerging from prolonged and debilitating internal conflict and civil war fueled by competition for mineral resources. Sierra Leone, for instance, was the locus of the Hollywood film *Blood Diamond*, depicting the crippling violence and corruption of the illicit diamond trade. Tourism has been critical in the region's attempts to recover economically. The hospitality industry in Sierra Leone was disabled by Ebola, leaving businesses bankrupt and abandoned.[68] The economies of these countries were all greatly affected; the World Bank predicted on 8 October 2014 that if the outbreak spread significantly to neighboring countries, costs in the region would reach US $32.6 billion by the end of 2015.[69] The *Wall Street Journal* reported that, outside the affected region, although no flight bans had taken place in Ethiopia, Ethiopian Airlines was losing about $8 million a month in sales as travelers avoided the area.[70]

Fragile postconflict states are vulnerable to epidemics such as Ebola because of weak public health infrastructure and lack of confidence in public officials. An effective response to Ebola and other public health issues is therefore closely linked to economic development, improvements in governance, peacetime, and the rule of law. The history of Liberia exemplifies how tumultuous and protracted civil conflict leaves countries too weak to respond to epidemics and natural disasters.

A 2014 *Frontline* documentary entitled "Firestone and the Warlord" illustrates how a private American business, Firestone, embedded itself deeply in the

Liberian economy. Indeed, it became crucial to financing and providing a strategic stronghold for Charles Taylor, the brutal warlord who has since been convicted by the International Criminal Court for war crimes during the Sierra Leone civil war and is serving a 50-year sentence in Britain. In post-Taylor Liberia, Firestone's rubber plantation had successfully contained Ebola in its area where the government had not.[71] With significant resources and power, the company supported the people who operated the rubber plantation and protected its financial interest. In contrast, the Liberian government was ill equipped to respond to this crisis for many reasons: corruption, an inherited legacy of conflict, and a lack of timely aid from the international community. Firestone is one example of how foreign entities typically interact with poor countries. They protect their limited interests while propping up whatever dictatorial government might exist in the process, benefiting from low operational costs, cheap resources, and lax regulation provided by kleptocracies desperate for foreign exchange.

Regardless, the areas surrounding Firestone's plantation profited from the company's investment in terms of Ebola, but it is clear that "ground zero" for this improved care was precisely the place where the company stood to protect its earnings. If the Liberian government had been in service of the people rather than pandering to multinational corporations and enriching corrupt officials, there probably would have been more infrastructure, confidence in government, and generally better preparation for any disaster—public health or otherwise.

Fighting corruption is critical to effective public health in postconflict states. A well-known case of corruption in West Africa occurred in Nigeria, where the northern part of the country is effectively outside government control. Boko Haram militants freely kidnap girls and wreak havoc on civil and state institutions, making governability difficult at best. Nigeria, the second-largest economy in sub-Saharan Africa, has lost more than $380 billion to graft since independence in 1960.[72] Further, Equatorial Guinea—which has the longest-standing dictatorship in Africa fueled by oil wealth—offers a classic example of the "resource curse." In search of international attention and legitimacy, that country leveraged fears of Ebola and volunteered to host the African Cup of Nations when Morocco asked the Fédération Internationale de Football Association to delay the tournament because of the Ebola outbreak.[73]

Ebola severely limited the ability of governments in affected countries to provide for their populaces, which in turn undermined legitimacy. Citizens dissatisfied with their governments protested and rioted, which caused and exacerbated violent internal conflict. Distrust in government had been cited as a major driver of the Ebola outbreak in Liberia. Helen Epstein wrote in the *New York Review of Books* about how Ebola was exacerbated by rumors and economic cor-

ruption, such as the misuse of aid money. According to Epstein, poor health care infrastructure was only a partial explanation; rather, the root cause for the spread of Ebola was political. She compared equally weak infrastructures in Southern Sudan and DRC, where the disease was contained relatively easily. She argued that Liberians felt so estranged from their government that they disbelieved official warnings, convinced that President Ellen Johnson Sirleaf had concocted Ebola to kill the people and draw foreign aid since Sirleaf has a history of diverting aid money toward family and for patronage. Moreover, Liberians perceived nurses and medical workers as messengers to poison the people and accomplish this goal.[74]

The long history of Liberia feeds into such cynicism. Freed slaves, known as Americo Liberians, settled in the country, oppressing indigenous Liberians and creating a system akin to apartheid for nearly 200 years. William Tolbert, a reformist president, was murdered in 1980, resulting in civil war and mayhem for over two decades. Current president Sirleaf was internationally recognized with a Nobel peace prize, presumably for what she might do: end the cycle of violence in Liberia. The reality has been far less peaceful. She has been accused of nepotism, benefiting from government contracts with foreign firms, and involvement with Charles Taylor. The fact that there is little in Liberia's history to instill faith in government among the people contributes adversely to an epidemic like Ebola.

The Way Forward

The first months of the epidemic saw inadequate international attention, but when Ebola arrived on American and European shores, the international discourse and sense of urgency shifted dramatically. Although it was unlikely that Ebola would kill many people in more affluent countries, fear reached a new level, dominating 24-hour news cycles and public discourse. Former UN secretary-general Kofi Annan, himself a Ghana native, released a public statement on 16 October 2014: "I am bitterly disappointed by the response. . . . I am disappointed in the international community for not moving faster. . . . If the crisis had hit some other region it probably would have been handled very differently. In fact when you look at the evolution of the crisis, the international community really woke up when the disease got to America and Europe."[75]

Rather than fearful rhetoric, travel bans, and stigmatization, these countries needed effective international responses and support in a clear demonstration of shared humanity. A reasoned, compassionate approach was desperately needed. According to Laurie Garrett, a Pulitzer prize winner for her writings on Ebola,

> As terrifying as Ebola is, the virus has been controlled in the past, and can be again. The current crisis, which threatens an 11-nation region of Africa that includes the continent's giant, Nigeria, is not a biological or medical one so much as it is political. The three nations in Ebola's thrall need technical support from outsiders but will not succeed in stopping the virus until each nation's leaders embrace effective governance.[76]

Garrett was urging a political mobilization transcending borders on a massive scale to stop the epidemic. She did not believe that airport screenings were effective, urging nations to exert a focused political will to deal with Ebola with high levels of coordination at the regional and international levels. Otherwise, Garrett warned that we could be looking at this epidemic graduating into a pandemic catastrophe.

Education and informed awareness are of key importance. Superstition exacerbated the epidemic, reflected by the fact that some victims were afraid to seek medical treatment since they believed sorcerers created the disease.[77] To make matters worse, conspiracy theories and misinformation added to the confusion and distrust of both humanitarian intervention and domestic health workers.[78] In May, several well-intentioned Liberian musicians collaborated to warn people about Ebola, but some of their lyrics wrongly implied that asymptomatic people were highly contagious and shouldn't be touched.[79] Radio and cellular technology, school programs, traditional leaders, and music by popular artists could have been more effectively used to raise awareness and improve community responsiveness to this public health emergency.[80]

Internationally, campaigns to educate and raise funds for Ebola and Africa in general would have proved more effective if Africa had been represented in its many facets and as many countries rather than as a perpetual single victim. On 1 November 2014, musician Bob Geldof, founder of the original Band Aid fundraiser in 1984 that addressed famine in Ethiopia, proposed a new Band Aid single to raise money for Ebola. However, both musicians and critics expressed concern about the effort projecting a negative image of Africa with far-reaching, long-term implications. Fuse ODG, an English musician of Ghanaian descent, declined to participate in the new single, saying that "though shock tactics and negative images may raise money in the short term, the long-term damage will take far longer to heal."[81] Even so, the Band Aid single came out later in November, raising over $2 million within five minutes of release. Jack Lundie of British Oxfam responded to critics, supporting "the Band Aid single as a 'mainstream charitable initiative' that would 'bring in people who wouldn't normally engage.'"[82]

As a lesson, humanitarians—musicians, educators, nongovernmental organizations, and policy makers—need to invest in health care infrastructure and re-

search on tropical pathogens in Africa. Ebola has been known since 1976. What does it take for the wealthy world to invest in vaccines that predominantly affect the global South? It is clear that up to this point, vaccines for diseases such as Ebola have not been lucrative for pharmaceutical companies to develop. How can a class-neutral public health system thrive globally when profit dictates what diseases to research and which people are worth curing?

Increased funding for research and finding a cure or vaccine not only is about altruism but also is a matter of enlightened self-interest. Investing in the health care of Africans is cheaper than the inevitable disruption to lives, trade, and transportation in a globalized world.[83] It is myopic to assume that a disease like Ebola or any tropical pathogen can be contained in Africa for long. In medicine, as in many aspects of life, the "us versus them" mentality is pervasive. It is important to note that Ebola eventually did make it to the United States—likely part of the reason that an outcome of this epidemic has been accelerated research into the development of an Ebola vaccine.[84] This virus does not discriminate. The lesson has been that rather than isolating and alienating communities, countries, or regions to try to contain an epidemic, let us recognize the humanity of every victim, regardless of race, class, or country, and fight the disease itself.

Notes

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