

REPORT

High-Level Roundtable on Governance Issues in the Multi-Stakeholder Response to the Ebola Virus Disease (EVD) in West Africa



4 April 2016

African Union Commission Headquarters

Addis Ababa, Ethiopia



AFRICAN UNION



INSTITUTE FOR PEACE AND SECURITY STUDIES
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“Governance issues were to some extent at the root of the inability of the three most affected countries (and even the international community) to timely mobilize prompt and effective responses.”

- H.E. Dr. Mustapha Sidiki Kaloko, Commissioner for Social Affairs, African Union

I. Introduction

The African Union Commission (AUC) and a consortium of four partners, namely the Institute for Peace and Security Studies (IPSS) at Addis Ababa University, the African Peacebuilding Network (APN) programme of the Social Science Research Council (SSRC), the Oxfam Delegation to the AU, and the UNDP Regional Service Centre for Africa, jointly hosted a one-day High-Level Roundtable on the topic of “Governance Issues in the Multi-Stakeholder Responses to the Ebola Virus Disease (EVD) in West Africa”. Held at the African Union Commission (AUC) headquarters in Addis Ababa, Ethiopia, on 4 April 2016, the event brought together stakeholders to reflect, for the first time, on their experiences since the worst phase of the spread of Ebola ended. The Roundtable afforded participants an opportunity to exchange lessons learnt from the multi-stakeholder response to the epidemic, as well as reflect on what should be done differently and qualitatively to respond to future health-related emergencies.

Participants were drawn from national agencies and leading inter-governmental and non-governmental bodies that undertook the fight against EVD in West Africa. In order to harvest and exchange critical lessons from the experiences of other countries that tackled the disease, the Roundtable also received participants from the Democratic Republic of the Congo (DRC), Sudan, and Uganda. The event was unique in that it attracted some of the key actors who, in their individual and official capacities, played major on-the-ground roles in the most affected West African countries as well as their peers from other parts of the continent (See attendance list in Appendix I).



Figure 1: Roundtable participants

The Roundtable was held against the backdrop that after many months of heightened concern, the worst seemed to be over - even if partially - in arresting the spread of the disease in West Africa. It was recalled that after the initial outbreak in Guinea in December 2013, the disease quickly spread to several other parts of the region: into Liberia, Sierra Leone, and to a lesser degree, Nigeria. In comparative terms, however, the outbreak of the disease in West Africa represented by far the largest, longest, most complex, and most daunting occurrence in the nearly four-decade history of the disease's mutations across Africa. The spread, no

doubt, caught everyone unawares, from public health practitioners and governments to citizens of the affected countries and the international community. It occurred, quite instructively, in the context of collapsed health systems in the most affected countries that had been ravaged by many years of civil war as much as by decades of negligence and/or abysmal investment in critical health and social infrastructures.

With the benefit of hindsight, it is not surprising that it took four months, from December 2013 when the first incidences occurred in Guinea, until March 2014 when laboratory confirmation arrived, before the most affected countries and the international community began to fully grasp the profoundly alarming public health implications of the outbreak; and soon after, its multiplier effects on social, cultural, economic, and political issues. In the week leading up to the Roundtable, the World Health Organisation’s (WHO) International Health Regulations Emergency Committee regarding EVD in West Africa declared the end of the public health emergency. However, the declaration did not indicate that the disease had been fully arrested, as a few isolated cases continued to resurface. Data released by WHO indicated that by the first week of March 2016, a total of 28,646 confirmed, probable, and suspected cases resulting in 11,323 deaths had been recorded in the three most impacted countries: Guinea, Liberia, and Sierra Leone.

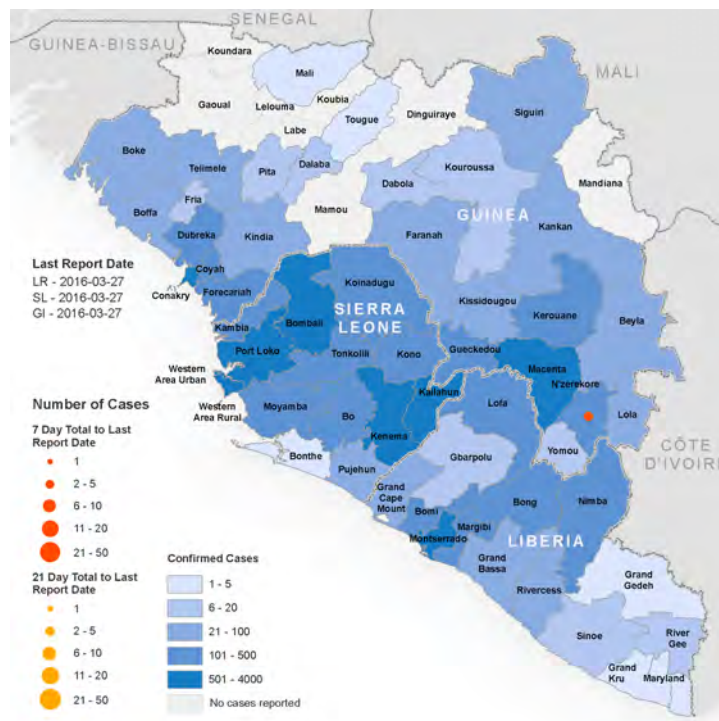


Figure 2: Geographical distribution of new and total confirmed cases in Guinea, Liberia, and Sierra Leone as of 30 March 2016

Between the discomfiting predictions made earlier by the UN Economic Commission for Africa to the effect that no one can predict the “epidemiological path” of the disease, and the more recent optimism that the probability of a relapse is dimmer, the Roundtable offered an opportunity to determine the requirements for maintaining the momentum in responsive action, as well as maintain continual vigilance against the disease and other health-related threats in the future.

II. Organisation of the roundtable

The Roundtable commenced with a welcome address by the Commissioner for Social Affairs of the AUC, H.E. Dr. Mustapha Sidiki Kaloko. Short opening remarks were then delivered by representatives from the consortium of organisers: the Director of the Africa Peace and Security Programme of IPSS; the Director of APN/SSRC; the Head of the Oxfam Delegation to the AU; and the Deputy Director of the UNDP Regional Service Centre for Africa. Following the introductory remarks, Professor Onyebuchi Uche, the former Minister of Health in Nigeria, presented the keynote address. Professor Uche played a pivotal role, not just in his country's decisive response to EVD but also in mobilising regional and continental responses aimed at arresting the epidemic. The welcome address, opening remarks, and keynote address reiterated the timeliness of the Roundtable as an opportunity to take stock of, and document lessons learned from multi-stakeholder responses to the epidemic, alongside the imperative to deepen reflections on what to do in the immediate and long-term periods.

The Roundtable sessions were conducted around five thematic pillars (Appendix II):

- 1) Local Response, Mobilisation and Accountability: Community Engagement and Accountability Issues in EVD-affected Communities;
- 2) 'Never Again' - Learning from the Ebola Crisis: Governance Issues in Building Resilient Health Systems and Emergency Preparedness;
- 3) From Local to Regional - Creating Value-Added Local Leadership with Regional and International Support;
- 4) Improving Governance in the Management of Health Epidemics - Preparing for the Future
- 5) Conclusions, Recommendations and Charting the Future

III. Bringing governance issues back

Occurring months after the unprecedented (and mostly unhelpful) media frenzy that followed the Ebola outbreak had subsided, the Roundtable afforded participants the opportunity to engage in level-headed stocktaking; placing emphasis on nuanced accounts of the complexity of national, regional, continental, and global responses to EVD. Rightly so, there was an acknowledgment that governance issues and dimensions that are at the heart of the intervention have not been sufficiently articulated and factored into critical discourse or debate on what worked, or failed. For participants, this gap significantly limits any attempt to systematically identify and integrate the myriad governance issues implicated, for good or bad, in efforts to combat the tragic disease. Further, the event responded to the urgent imperative to mobilise an array of forward-looking strategies that might help stem inevitable future tides; bearing in mind that governance deficits, in its myriad ramifications, tend to be at the epicentre of most health-related epidemics in the past and those that are likely to present themselves in the near future.

In light of the above, then, the Roundtable sought to go beyond the dominant fixation on only health issues, despite their importance, by soliciting a much broader understanding of more critical and complex governance issues and concerns. By emphasising critical and complex governance issues and concerns, the event solicited a much broader framework for better understanding and responding to health epidemics in the future. The need to recalibrate ongoing interrogations of the multi-stakeholder responses to EVD by

mainstreaming critical governance dimensions was clear to participants; and, in specific terms, to explain how governance issues were substantially responsible for the evident capacity gaps or limitations faced by governments in the affected countries. This would include, but not limited to, questions linked to transparency and accountability in the management of the limited resources earmarked for the response.

By focusing on governance issues, participants were keen to shed light on:

- Why - and how - the health systems in the affected countries failed to mobilise immediately and adequately against Ebola;
- How the public health emergencies triggered by the spread of the disease were directly or otherwise, linked to the paucity or outright absence, of effective health management systems;
- Wider systemic problems of governance and insecurity in the three affected West African countries.

Governance issues were also at the root of the inability of the most affected countries (and even the international community), even with the best of intentions, to quickly mobilise the requisite resources for early action in a prompt, robust, and effective manner. Without exception, it was not surprising that all stakeholders (local, national, and global) were not only caught unawares but evidently demonstrated a lack of capacity to act on time; not even on basic issues, such as adequately informing the public and rapidly putting in place containment protocols.



Figure 3: Panellists at the roundtable

Other governance-related social, economic, and political issues also featured prominently in the multi-stakeholder responses to EVD. These include the dearth of effective consultation; erosion of trust and social contracts between government and citizens; participation and engagement of citizens in public affairs; access to and effective delivery of public services; legitimacy and credibility of governance institutions, and public leadership. Others were linked to the shrinking writ of the government beyond the capital and major urban centres; decentralisation of authority and infrastructure; and the gap (or disconnect) between rural and urban areas, in terms of availability of infrastructure and access to subsidised socio-economic opportunities, to name a few. The Roundtable therefore recognised that governance issues are, to a large degree, critical to understanding a number of issues or challenges associated with the fight against EVD.

IV. Lessons learnt from the deliberations

A. The multi-dimensionality of issues and responses

Participants recognised that EVD was much more than a medical emergency but also linked to psychological, humanitarian, social, cultural, security, and governance issues that require vertical as well as horizontal collaborations between and among different agencies in the deployment of human and

material resources. It also required identifying and mobilising local capacities, stronger coordination between stakeholders, and matching commitments with action. Unfortunately, the initial inability of a broad spectrum of stakeholders to appreciate the multi-dimensional imperative that should have driven the response from the beginning, led to the slow initial setbacks. For instance, it was acknowledged that had the inescapable linkages between and among different constituencies been recognised and quickly maximised, a more creative and complimentary ecosystem of partnerships (not one that is competitive, antagonistic, and at cross-purposes) would have evolved to ensure that stakeholders worked better and more efficiently.

The outbreak revealed Africa's inability to deal with an epidemic of such great magnitude; even though the cumulative experiences of other countries like the DRC, Sudan, and Uganda that have experienced equally tragic outbreaks in the past could have helped.

The Ugandan experience for instance, could have served as a veritable wake-up call on how best to mobilise and ensure better coordination. In that case, the Ministry of Health took the lead in creating a robust inter-ministerial response within the ministry and across the country; implementing a high-impact and rapid public health education programme for health workers as well as the public; setting up nationwide toll-free numbers for Ebola alerts; and vigorously pursuing strict adherence to protocol on case reporting, to name a few. Given the close similarities in the post-war experiences of Guinea, Sierra Leone, and Liberia, a large number of lessons in coping with health-related adversities in Uganda could have come in handy regarding early warning and early action in managing the spread of Ebola in West Africa.

A further lesson learned from the outbreak in West Africa was the fact that there were too many unknowns about the disease. With little or no crosscutting lessons-learned from other African countries (and regions) that had experienced Ebola, the management of the outbreak of the disease in West Africa meant that the affected countries literally had to learn everything from scratch; from how to trace actual and potential patients to the basic protocols on how to safely isolate them for examination. This partly explains the preliminary finding in a report on Health Workers Ebola Infections in Guinea, Liberia and Sierra Leone that depending on their occupation in the health services, health workers were between 21 and 32 times more likely to be infected with Ebola than people in the general adult population (WHO, 21 May 2015).

Apart from the broader imperative to put in place robust public health plans and strategies for emergency responses, the need to also routinely test the efficacy of such plans in real life simulations was widely acknowledged by participants. In the end, much could be learned regarding how critical early action plans were (or could have been) mainstreamed in health systems as in governance, peace, and security initiatives.

B. Closing resource gaps versus delays in deployment

Participants were concerned that much more than anticipated, the epidemic took a heavy toll on the affected countries not necessarily because the will to act fast did not exist but because badly needed human and material resources could not be mobilised and delivered quickly and adequately where and when they were needed. Whilst this gap could be linked to poor health systems in the affected states; a lack of accountability in the conduct of routine state affairs; the erosion of trust and the social contract between citizens and government; issues linked to lack of transparency and accountability in doing government business; minuscule or outright absences of seamless consultation mechanisms between and

among stakeholders involved in the response; and the failure of the global health governance system in the face of the spread; all contributed in no small way to the initial setbacks and several missed opportunities to tackle the disease headfirst.

Health-related epidemics can only thrive when and where windows of opportunity to respond to them promptly and decisively are foreclosed for whatever reasons.

By way of example, even though the importance of coordination and the adequacy of logistical support were recognised very early, it took several weeks after the arrival of the African Union Support to the Ebola Outbreak in West Africa (ASEOWA) volunteers before they could be deployed in the most affected countries. In other words, whereas expert volunteers were identified and readily available in a number of African countries, concluding the necessary paperwork and travel plans constituted critical bureaucratic bottlenecks in the first few weeks/months into the outbreak.

Further, although public awareness and sensitisation were recognised as essential and expedient to preventing the outbreak of epidemics and to stemming their spread, this was unfortunately not carefully designed and executed in a systematic, culturally nuanced, and gender sensitive manner. Where they were conducted, public sensitisation was mostly ad-hoc, short-term and therefore limited in scope and coverage. For instance, almost as soon as the nationwide hand-washing campaign was reportedly stopped in Liberia, the population simply returned to the status quo of unsanitary habits that created another unwarranted spike in the spread of cholera. A robust and well-nuanced public awareness and sensitisation campaign would have put government and stakeholders on the same page, and allowed them to gain the confidence of citizens. Such campaigns would not have missed communicating the imperative to change certain cultural practices - especially relating to caring for the sick or burying deceased relatives. It was also a costly mistake to have ignored the pivotal role of local gatekeepers who are recognised for exercising traditional power and authority.

C. Mobilising local communities and other constituencies

Community mobilisation, building trust, and participation were identified as critical linchpins in taming the epidemic. Very little could have been achieved without gaining, and retaining, the trust of local communities directly affected by the epidemic. Perhaps, the first and most immediate step would have been to put in place hybrid top-down and bottom-up mechanisms, including one that could facilitate the seamless exchange of information from stakeholders to communities, and vice versa. Unfortunately, the spread of the disease in remote villages and towns, locations where the writ of the state in terms of lean or non-existent communication infrastructure is scanty, constituted a big challenge.

The one-way messaging systems adopted by governments and international partners was also counterproductive since people still relied on, and needed, information from other trusted sources such as traditional and community leaders that were initially side-lined or discountenanced.

Stakeholders missed the opportunities to act faster due to non-engagement with traditional healers. In tackling the epidemic, a bottom-up and community-focused strategy would have produced a different (positive) result than was the case during the early months of the epidemic. For one, it would have fast-tracked public confidence in, as well as triggered, greater community participation required to galvanise the

response. A corollary to these would have been the scaling-up of the pivotal role of civil society organisations (CSOs) vis-à-vis local communities in building critical community trust.

The role of the media (both new and traditional media) was also raised as an issue that both facilitated and constrained the multi-stakeholder response. Innovative public awareness and mobilisation strategies were recognised; including the creative use of religious and community leaders, media executives, community radio, local newspapers, television, entertainment industry as well as call centres and the social media, to name a few. Different stakeholders deployed the media in markedly different ways to pass information on prevention, contact tracing, treatment of victims, etc. The use of slogans or jingles, such as “Ebola must not escape”, was effective for mobilisation even though the same media platforms were also creatively used to peddle rumours and falsehoods about the epidemic.

Perhaps with the benefit of hindsight, from a communications perspective, attention should have been given to content, context, and culture when approaching communities or addressing sensitive issues involving key local stakeholders. Generally, participants insisted that some of the initial attempts to engage impacted communities either failed to gain traction or backfired because they raised serious ethical and moral concerns or simply because they were not in tune with the cultural practices and belief systems of the people; especially on sensitive issues such as the collection of blood samples, caregiving, isolation of victims and burial, etc. It is instructive that to date, no one can account for what happened to the numerous blood samples collected from community members, those infected or otherwise.

After the initial error of trying to bypass traditional authorities to engage directly with communities, ASEOWA was therefore in a better position to avoid the same costly mistakes that agitated local authorities by the time the contingent arrived. Although the number of volunteers (including those deployed by ECOWAS) as of January 10, 2015 stood at 835, short of the 1,000 personnel anticipated, ASEOWA’s success was not far from the fact that its mission and mandate came at a time when some of the initial rough hedges in community engagement had been cleared and substantial improvements made in the provision of routine health services, not in spite of them. The abrupt exit of ASEOWA, well before the worst phase of the epidemic was over, generally drew the disappointment of participants as it left many loose ends unattended. It was further observed that the effectiveness of multi-stakeholder responses to Ebola would have been better managed if there were tangible local human and financial resources as well as basic local infrastructure (road networks, ambulances services). The absence of these resources and infrastructure that should have been the responsibility of governments to provide, according to participants, made the response particularly tortuous.

D. Accountability and other crosscutting issues

Issues of funding, especially in terms of how much was received and/or spent within the framework of transparency and accountability, were also raised. Despite complaints that international responses were high on promises but abysmally low on actual commitments, millions of dollars were raised from a variety of governmental and non-governmental sources to help in the fight against the disease. After an initial lull, the funds that eventually arrived significantly fell short of the actual amounts committed. This was also the case with regard to the post-Ebola Action Plan that has so far attracted only a fraction (estimated at 20%) of the total amount pledged. The huge gap, in both instances, raised serious institutional apprehensions that current and future mitigation efforts might be hampered.

A further, and more overarching, concern directly linked to funding related to how the amount raised was spent. Taking this issue up in the context of accountability and transparency, the Roundtable not only highlighted the difficulty - or outright impossibility - of making resources available to stakeholders at the frontlines as and when needed. As mentioned by several participants, there was also the substantive - but mostly unresolved - issue over how money received was actually spent; often without any form of diligent adherence to financial regulations in an environment where the prevailing public financial management system is lax. To quote the Chair of Transparency International, José Ugaz, on this concern:

“Weak public financial management systems coupled with high levels of corruption in these three countries create many opportunities for the abuse of power, bribery and unethical actions that limit the ability of donations to be used effectively to stop the Ebola outbreak. When so much money floods into the region in such a short period of time, accountability for those funds should shoot to the top of any list of priorities.”

Several other national and global accountability institutions represented at the Roundtable such as Accountability Lab (based in Liberia) and Oxfam International raised specific issues around undocumented expenses, over-invoicing, duplication of expenses, unauthorised charges as well as wider concerns as to whether or not there was real (tangible) value in the money spent to rebuild collapsed health infrastructures or virtually non-existent health systems in the most affected countries. It was acknowledged, with some justification, that rebuilding health systems and infrastructures is expensive but that doing so represents a crucial step towards tackling further health-related emergencies in the Ebola affected countries, in particular, and in other African countries, in general.

Beyond unsettled questions around transparency and accountability are pockets of other crosscutting issues that were raised at the Roundtable, but are presented here in no particular order of importance. The first had to do with the argument that the EVD response in West Africa, or elsewhere in other parts of Africa, did not fully embrace and mainstream gender issues and sensitivities, and in most cases, that the responses actually eroded - or at best undermined - gender and human security in the already fragile states. Participants did not miss the fact that a disproportionate number of women, estimated at 75%, were either direct victims or indirectly affected by the EVD. For the most part, this was due to the manner in which dominant patriarchy-prescribed roles left women with riskier chores in the fight against Ebola; be it as caregivers or as health workers.

The second crosscutting issue, which also settled well within the framework of governance, related to the contrasting roles the security sector played, for good or bad, at different phases of the outbreak and spread of Ebola. While a strand of opinion at the Roundtable pointed to a number of positive roles that security agencies played in mainstreaming law and order during the most difficulties phases of the outbreak, others insisted on not ignoring the many ways in which they routinely trampled on the human rights and human security of victims, their families, and impacted communities.

The third crosscutting issue which has been missing so far in on-going debates and narratives, is that linked to the roles of: (1) African Diaspora, especially professionals in the health and social sectors; (2) small local businesses and the private sector in mobilising seed funding for small-scale complementary activities; and (3) youth-led organisations serving as vigilantes or generally supporting different constituencies, including helping to trace the victims and incidences of Ebola.

Of essence, none of the crosscutting issues would have been decisive enough without taking cognisance of the pivotal - and coordinating - roles that families, and traditional and modern leaders from the community level upwards, played in rallying support against the disease.

Following the spread of the disease, enormous pressure piled on leadership at all levels to fully take charge; be it in terms of helping to galvanise collective local and national action but also in terms of the mobilisation of resources or simply just showing purposeful leadership in the face of grave danger. For participants, however, the jury is still out as to how leadership at different tiers performed, or should be appraised. What cannot be disputed, in the interim, would be the enormity of pressing issues that called for the attention and decisive statesmanship by leaders at all levels. With the benefit of hindsight, perhaps the point to concede is that without leadership at different levels rising to the task, the affected countries might still be in the woods trying to grapple with the disease and its broader ramifications.

E. The contrasting roles of external actors

A wide range of external actors (state and non-state) were actively involved in the multi-stakeholder responses to the EVD crisis in West Africa. They played a variety of complimentary - but sometimes, also competitive - roles; from the deployment of human and material resources to the setting up of requisite facilities such laboratories, isolation wards, incidence management systems, monitoring and operations centres, etc.

Although significant and pivotal, the critical roles of external actors raised a number of disturbing governance-related contradictions. Participants, first and foremost, acknowledged the fact that the presence of a large number of external actors, sometimes pursuing divergent interests, made desirable and seamless coordination prove difficult to achieve. Second, decision-making in terms of who does what, when, and how was a recurrent concern that bogged down operations while it lasted. As multiple stakeholders applied themselves to the dire situation at hand, there were difficulties in coordination and ensuring that resources were deployed to key areas of need. One way to tackle this problem was to put in place a centralised system to oversee the coordination and effective deployment of resources. This, for instance, was the case in Nigeria where the creation of robust Incidence Management Systems (IMS) and Ebola Operations Centres (EOCs) were effective in ensuring timely responses. It is instructive, as participants highlighted, how very quickly the structure already in place to fight polio was creatively used for EVD contact tracing.

The third point was that the different agencies involved in the EVD response were locked routinely in contestations for visibility and relevance thereby creating duplication and the attendant waste of scarce resources. Fourth, while the presence of a multiplicity of external actors meant that the governments in the most affected countries had to dissipate time, energy, and meagre resources in trying to relate or engage with them. Finally, just as the entire spectrum of multi-stakeholder responses to EVD have now been called to question in terms of whether or not resources actually located were judiciously used, similar issues around transparency and accountability have also been raised with respect to external actors.

Over all, then, criticisms that resonated throughout the roundtable also related to the unanticipated risk or cost of the involvement of the international community in the EVD response in West Africa; including those related to the closure of borders, stricter visa regimes, the cancellation of international flights to the affected

countries that slowed medical supplies and other forms of assistance, heightened premium on shipping and freight insurance to the affected states, and how negative media reportage hampered the response on the ground. There was, in short, an absence of any robust and forward-looking risk governance mechanism to mediate some of the adverse dimensions of the international response to EVD in West Africa.

V. Key Recommendations

Giving the multi-dimensionality associated with the spread of Ebola and the multi-stakeholder responses to the epidemic, some of the recommendations made by participants at the Roundtable are understandably linked to governance issues relating to health systems, partnerships, research, civil society, and development, to name a few. Although by no means exhaustive, the key recommendations were as follows:

(i.) Participants acknowledged the need to bring urgency to the task of developing effective risk governance systems to mitigate some of the critical - but unintended and often negative - effects of isolating affected communities and countries from the rest of the world; the same places where urgently needed assistance should be going to.

(ii.) Participants proposed that on the back of the investments and innovations that attended the multi-stakeholder responses to Ebola in West Africa, there is need to continue and expand on-going initiatives to build stronger and volunteer-based community networks using the innovative governance institutions developed in the course of the EVD response. Specific examples of such innovative institutions include the National Ebola Response structures, ASEOWA, and the Office of the UN Special Envoy on Ebola, to name a few. Functioning health care institutions, and communications and transport infrastructures are also required. In this regard, breaking the barrier of unequal access to healthcare should be the focus of stakeholders. There is also a need to improve healthcare and universal health insurance coverage.

(iii.) Participants proposed the development of a robust coordination framework for health emergency and epidemic response, making sure that CSOs form part of such frameworks for the purposes of transparency and accountability in the allocation and utilisation of funding to fight epidemics. In this regard, adequate international standard auditing and accountability mechanisms should be implemented within the framework of the International Health Regulations (IHR) to ensure that funds collected to provide health disaster relief to target communities reach them at the end of the day.

(iv.) Participants were keen that African CSOs should be mobilised and strengthened to play proactive advocacy and watchdog roles that are pivotal in the future, as against the disjointed and negative ones that slowed the EVD response. The fledgling efforts to better organise and support African-led CSOs to create specific platforms capable of tackling the continent's myriad humanitarian challenges should be encouraged and flexible enough to accommodate health emergencies. It was in this regard, for instance, that a Continental Rapid Response Corps (CRRC) was adopted by the African Field Epidemiological Network (AFENET) to include CSOs as part of the first-line of rapid response team. Such an initiative needs to be fully supported by governments, and regional and international organisations. This would also include the mobilisation and

coordination of CSOs with experiences in other health issues (such as HIV/AIDS, tuberculosis, and polio) whose vast experience in managing complex health challenges can be leveraged as and when required. By also building the research and advocacy capacities of African CSOs, they would be in a better position to generate, produce, document, and exchange new knowledge and competencies required for future EVD (and other health) responses. These networks and platforms would have the experience and expertise required to respond to health emergencies similar to EVD with minimum delays.

(v.) Participants pushed for full-fledged and sustainable funding windows or mechanisms capable of meeting the resource requirements for health emergency responses of the type provoked by Ebola. The place to start is for national governments to considerably scale-up budgetary allocations to the health sector, by working towards achieving minimum budget commitments for national health financing as contained in regional and international agreements. On the back of the huge investments into the EVD response, it is difficult to contemplate anything short of a medium- and long-term horizon funding arrangement that prioritises the health sector in Africa. The Abuja Declaration (2001) that proposed a 15% annual national budgetary allocation to the health sector as endorsed by member states of the Economic Community of West Africa States (ECOWAS) is a milestone benchmark.

(vi.) Participants recognised the modest - yet critical - roles that the African private sector, small and big, played in the countries most affected by Ebola, and the need to be amplify rather than ignore them in mainstream narratives on state and non-state responses. However, a patient-centred and public good, as against a private interest-driven approach, should be adopted. When it comes to the issue of research and development (R&D) initiatives in the health sector, the private sector is however not a monolithic entity. There is, for instance, a strand of that sector that transcended private commercial interests to support the Ebola cause, notably the Dangote Foundation. One key lesson, then, is that faced with serious health-related epidemic (or broader humanitarian) challenges, developing countries have to be creative in mobilising resources from within rather than having to rely solely on external resources who sometimes bring a misaligned agenda or interest.

(vii.) Participants were acutely aware that a corresponding improvement in global health governance would be critical in putting up a better, more robust, and strategic response to EVD and other epidemics in the future. In this regard, and in the light of divergent realities across the world, there is also a need to develop regional, continental, and transnational response components that would automatically trigger the global health governance systems to respond to emergencies. It is important that global health governance infrastructures are adequate and responsive at different levels of governance; including in terms of creating better access to and sharing of information, as well as flexible mechanisms for coordination between and among different stakeholders and partners. Further, and as a matter of urgency, global health governance systems need to review and bring about new regulatory mechanisms, rules, and institutions that would complement what is in existence and fill the gap in existing structures.

(viii.) Participants were enthusiastic that several constituencies (e.g. the African Diaspora and youth) represent major class and demographic categories whose resources, creativity, and innovation could easily be mobilised and leveraged to implement an Africa-wide health

emergencies programme. It is important to recognise and address the root cause of brain drain in the health sector, especially among qualified youth, in many African countries. This can be done, amongst several other ways, by mainstreaming health policies and programmes at the local, national, regional, continental, and global levels.

(ix.) Participants proposed that as a matter of priority, **national disaster management and coordination structures should be flexible and proactive enough with adequate decentralisation mechanisms in place for nationwide coverage.** In many countries, such structures are mostly located in national capitals and a few urban centres – with virtually nothing located in rural areas where a majority of Africans still reside without the most basic health and social amenities. The Ebola outbreak in West Africa revealed the density and intricacies of rural-urban networks, and how epidemics starting from rural areas can quickly spread and prove fatal given the desolate state of infrastructure in such places. The focus of health emergencies and other forms should be on disaster and development systems, not merely bringing palliatives, just as the requisite infrastructure to achieve this should be widely available in a fairly balanced way to make containment easier and quicker.

(x.) Participants were clear that **effective and efficient responses should involve all strategic partners coming under one umbrella to take part in decision-making, approving and disbursing funds, and monitoring the implementation of key activities, to name a few.** This was the role EOCs played in bringing the Ebola response under control simply by improving collaboration and the collective sense of ownership. Doing so effectively solved the initial deficit of coordination that created inertia and waste. Whereas some centralisation is required to respond to health emergencies, additional safeguards would definitely have worked better than having uncoordinated, decentralised, or compartmentalised “silos” responses.

(xi.) Participants highlighted **the need to accelerate as well as deepen support for the full establishment of the African Centre for Disease Control (CDC).** It was gratifying that about the same time the Roundtable was taking place, the Africa-CDC was already shaping up, with the nucleus of personnel arriving for the inaugural workshop in Addis Ababa. Participants called for full support to the Centre, starting with substantial buy-in from African governments even before development partners begin to provide complimentary assistance. It was clear that the full operationalisation of the Centre would substantially contribute to closing up the capacity gaps that initially hindered the EVD response.

(xii.) Participants recognised that at the time Ebola broke out and spread in West Africa, the three heavily impacted countries were also emerging from decades of civil war, with virtually every sector in ruins. Despite the slow pace of post-war reconstruction and reconciliation, local communities still played heroic roles in the fight against EVD that have so far being downplayed. Apart from bringing those to the fore as part of lessons-learned, there was also consensus that such **myriad and innovative local responses should be catalogued and disseminated widely.** Further, participants expressed hope that victims support initiatives or similar initiatives to assist Ebola survivors and their families return to normal life should be vigorously pursued and remain devoid of social stigma, while allowing them to rebuild their homes and restore their livelihoods.

(xiii.) Participants recognised the need for empirically informed and sustainable research in the broad fields of medical sciences but also in the humanities and social sciences in view of the complexity of the social, cultural, economic and even political dimensions associated with Ebola. It was specifically noted that African scholars and researchers across various disciplines play important roles before, during, and after the outbreak of epidemics, just as mainstream medical sciences like epidemiology should be at the forefront of responding to the ever-changing trajectory of diseases. Invariably, the importance of research, training, and capacity building on the basis of multi-disciplinary engagements on health issues was emphasised.

(xiv.) Participants, finally, recognised that adequate preparations for future epidemics should include up-to-date country risk assessments that deliberately enable empirical data to speak to policy issues in early detection and responses at the grassroots level, and by strengthening good neighbourliness at the bilateral and multilateral levels for joint action; including under the aegis of regional bodies such as the West African Health Organisation (WAHO).

V. Conclusion

The Roundtable concluded, for all intents and purposes, that West Africa's Ebola crisis should be taken as a litmus test to allow stakeholders to re-think, revamp, fine-tune, and scale-up national, regional, continental, and global health governance systems and responses. There was also an acute recognition, more than ever, that health-related issues require multi-stakeholder interventions and responsibility but also flexibility to strike a balance between centralisation and devolution of responsibilities and coordination so as to enhance quick response and reduce waste. The Ebola epidemic was no doubt as much as a health issue as it was broadly also about security, economics, governance, and administrative issues, to mention but a few.

Finally, the Roundtable drew critical attention to the governance-security-development nexus in the response; especially that in which critical health, economic, social, and cultural resources and infrastructure are crucial in mobilising assistance to communities facing complex emergencies. Invariably, since health-related epidemics are too important to be left alone, participants recognised the urgent and concerted effort by a broad spectrum of stakeholders: CSOs, NGOs, the private sector, the Diaspora community, affected communities, youth organisations, national governments, and inter-governmental multilateral institutions as critical partners in managing and tackling health emergencies. Mobilising local and contiguous resources in moments of acute health emergencies in Africa, well before help arrives from the outside, is the most viable and sustainable way of fighting epidemics in the future. The Roundtable participants agreed to follow up the discussions through future platforms to ensure maximum sharing and implementation of proposed recommendations.



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Appendix I

PARTICIPATING ORGANISATIONS

1. Africa Against Ebola Solidarity Trust
2. Africa Humanitarian Action (AHA)
3. African Field Epidemiology Network (AFENET), Uganda
4. African Peacebuilding Network (APN), Social Science Research Council (SSRC)
5. African Union Support to Ebola Outbreak in West Africa (ASEOWA)
6. AIDS Accountability International
7. Budget Accountability Network of Sierra Leone
8. Department of History, Makerere University
9. Department of Peace and Conflict Studies, Fowiah Bay College, University of Sierra Leone
10. Department of Social Affairs, African Union Commission
11. Department of Social Development, University of Cape Town
12. Department of Sociology and Social Anthropology, University of Khartoum, Sudan
13. Ebola Emergency Operations Centre
14. Embassy of Cote d'Ivoire
15. Embassy of Guinea
16. Embassy of Japan
17. Embassy of Kenya
18. Embassy of Liberia
19. Embassy of Niger
20. Embassy of Nigeria
21. Embassy of Sierra Leone
22. Embassy of South Africa
23. Embassy of Zimbabwe
24. European Commission Humanitarian Aid Office (ECHO)
25. European Union (EU) Delegation to the African Union (AU)
26. Institute for Peace and Security Studies (IPSS), Addis Ababa University
27. International Committee of the Red Cross (ICRC)
28. International Federation of Red Cross and Red Crescent Societies (IFRC), Dakar, Senegal
29. Ministry of Foreign Affairs, Liberia
30. Nigeria Centre for Disease Control
31. Oxfam International AU Liaison Office
32. United Nations Development Programme (UNDP)
33. United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA)
34. United States Centers for Disease Control and Prevention (CDC)
35. World Food Programme (WFP)
36. World Health Organization (WHO)