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Global Response to Local Problems:The Global Health Community Response to the Ebola Outbreak of 2014

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GLOBAL RESPONSE TO LOCAL PROBLEMS:

THE GLOBAL HEALTH COMMUNITY RESPONSE TO THE EBOLA OUTBREAK OF 2014

By

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ABSTRACT

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Health crises are often met with much support from the global health aid communities, who strive to contain the current health crisis and improve the conditions of the affected society. The recent Ebola outbreak of 2014 is no exception. Driven by public panic and media coverage, the global health community responded in force, dispatching aid organizations, monetary help, and military assistance to both assist those affected with the disease and prevent it from spreading. The World Health Organization, along with Doctors without Borders and many other global organizations, swept in to provide aid to the affected areas. This project examines how these organizations responded to this particular outbreak as well as examining how the global health community responds to health crises in general. It will look at the possible negative impacts of unhindered foreign aid, specifically how the presence of so many possibly conflicting aid organizations in one area attempting to solve a health problem can inhibit local aid work, damage local infrastructure, and insult local culture and practices. The project will examine the importance of empowering and retaining the autonomy of local communities and working with them to create a framework that will sustain itself, address future potential problems, and rely on local organizations and resources. Using a combination of news articles, books, social studies of the area and of providing health aid in general, and interviews with Michele Sare (a nurse, author, and advocate for local autonomy in developing countries) and George Risi (a doctor who responded to the Ebola epidemic), this project will use the crisis of Ebola in Africa as a study in how the global health community should aim to respond to health crises.

Global Response to Local Problems:
The Global Health Community Response to the Ebola Outbreak of 2014

Health crises are often met with much support from global health aid communities, which strive to contain the current health crisis and improve the conditions of the affected society. The recent Ebola outbreak of 2014 is no exception. Driven by public panic and media coverage, the global health community responded in force, dispatching aid organizations, monetary help, and military assistance to both assist those affected with the disease and prevent it from spreading. The World Health Organization, along with Doctors without Borders and many other global organizations, swept in to provide aid to the affected areas. This project examines how these organizations responded to this particular outbreak as well as how the global health community responds to health crises in general. It will look at the possible negative impacts of unhindered foreign medical aid, specifically how the presence of so many possibly conflicting aid organizations working in one area can inhibit local aid work, damage local infrastructure, and insult local culture and practices. The project will examine the importance of empowering and retaining the autonomy of local communities and working with them to create a framework that will sustain itself, address future potential problems, and rely on local organizations and resources. It will explore the question of how the international global health community can better respond to and prevent global health crises in developing countries. For health challenges to be mitigated, a greater emphasis must be placed on maintaining autonomy and cultural integrity of the local community and empowering those communities to confront and ultimately prevent future crises themselves, thus promoting sustainability. This project will use the crisis of Ebola in Africa as a study in how the global health community should aim to respond to health crises.

The Ebola outbreak began in Guinea on December 6th, 2013 with a two-year-old boy, who contracted the virus by playing around a bat roost. He passed the disease on to members of his family, and when people came from surrounding countries to assist in the burials, they too were infected (Risi, "Ebola Hemorrhagic Fever"). The disease spread very quickly, leading the WHO to declare the epidemic a "Public Health Emergency of International Concern" on August 8th, 2014 (Chippaux). Médecins Sans Frontières (MSF, or Doctors Without Borders) was the

first to respond in March, and the UN and the US soon deployed supplies and personnel, forming outposts and recruiting health workers (Butler; MSF, "Guinea").

As the largest Ebola outbreak in history, the panic was widespread, and the global attention was vast (CDC, 2014). Responding to this epidemic was not simple, and conflict with local culture and customs was common (Risi, "Ebola Hemorrhagic Fever"). With the intent of preventing the spread of the disease, the Western culture took charge, attempting to change long-held customs and impose a better form of health management. The Ebola outbreak showcases the deficiencies that exist in the current global response plan.

Ebolavirus is a genus in the family Filoviridae with five distinct species, four of which infect humans and all of which cause hemorrhagic fever (Wit, Heinz, & Feldmann). It is endemic to Africa and the Philippines, but cases have been endemic to several other countries, including the United States (Wit, Heinz, & Feldmann). If a person is infected, they face an incubation period ranging from several days to three weeks, and then sudden onset of symptoms. The symptoms begin flu-like for approximately the first week, with the patients exhibiting nausea, vomiting, headache, malaise, and a characteristic rash. Through the next several days, the symptoms progress rapidly to widespread hemorrhaging through stool, in the vomit, under the skin, through the nose and gums, and around the eyes. Eventually, if the case is fatal, the patient will fall into a coma, go into shock, and die (Wit, Heinz, & Feldmann). This entire process can take only 10-12 days (Wit, Heinz, & Feldmann). The virus damages tissue, disrupts genetic expression, inhibits the immune system, and causes a massive inflammatory response that leads to further damage and edema (tissue swelling) (Wit, Heinz, & Feldmann). Mortality of the disease is often very high (Chippaux).

Ebola is not transmitted through proximity to an infected person. Rather, Ebola is transmitted by close contact with an infected person's bodily fluids (Chippaux). The most common transmissions are from caring for an infected person, preparing the deceased for a funeral (in parts of Africa it is a long, intimate process), hunting or consuming infected bush meat, or a nosocomial transmission through reuse of medical equipment that was formally used on an infected individual (Chippaux). Ebola is thought to originate in fruit bats and spread from there to monkeys and humans. A study in China found definitive evidence of this transmission by isolating the presence of Ebolavirus antibodies in bats (Yuan et al.). It is thought that primary

infection occurs by hunting or consuming bush meat (bats, monkeys, etc.), possibly fueled by the migration of fruit bats from the changing climate (Chippaux).

Currently, there is no effective vaccine against Ebolavirus, and although promising research is being conducted, it is hampered by limited commercial interests (Chippaux). Quarantine is the most utilized form of containment and, once a person has been exposed, monitoring them for the incubation period. Palliative treatments are often the only available forms of treatment in Africa. Patients are kept isolated and given rehydration solutions and, if available, drugs to treat pain, fever, nausea, diarrhea, and the anxiety of the patients in certain cases (Chippaux). Unfortunately, the first stage of the disease is difficult to differentiate from other diseases, since its symptoms apply to a wide range of pathogens, and secondary transmission can occur before the patient even knows they are infected.

In a study performed by Nishiura and Chowell, it was found that the infectiousness of the Ebolavirus is similar to that of influenza. The virus has a slightly lower likelihood of infection both over time and per amount contact with infected individuals (Nishiura & Chowell). That said, the virus remains infective for a period after death, and has a much higher mortality rate than the common influenza virus. This is one of the main reasons that the epidemic spread so quickly. In Western Africa when a family member, friend, or neighbor dies, people often travel to that location and prepare the individual's body for burial. This is a highly involved process consisting of washing the corpse, changing the corpse, going through the deceased's belongings, and spending nights in the same room (Chippaux). After being infected from a deceased relative, the family would then travel back to their villages and the cycle would start again. This is one of the main mechanisms through which Ebola was able to spread so quickly. The virus can be infective through "blood, saliva, feces, breast milk, tears and genital secretions" so post mortem transmission to family members caring for the infected individual was common (Chippaux). The lack of understanding about the disease and this deep-set cultural ritual made it extremely difficult to contain the outbreak. According to Dr. George Risi, (an interviewed physician that responded to the outbreak for several weeks) it was difficult to work with the local communities due to a severe lack of understanding an education in the local staff. In the interview, he stated, "…Burial practices have been the hardest thing to change and in many places still have not changed" (Risi, Personal Interview).

Changing burial practices is a challenge that is not relatable to many Western cultures, because our culture and education is so different than that of the global south. In developing countries such as Africa, many challenges arise that are not present in developed countries. A lack of education means a lack of a good network of local staff, lack of understanding of how diseases infect and are transmitted, and a smaller number of individuals that are literate. Dr. Risi named one of the major problems in response as "The majority of the locals were illiterate or at best poorly educated, so could function in only a few of the jobs that were needed" and "By the time we got there in August the outbreak had been going on for several months, many of the local staff were either dead or demoralized" (Risi, Personal Interview).

Poverty and isolation further contributed to a lack of understanding as well as a lack of resources. Risi names obtaining basic supplies as one of the most difficult obstacles they encountered. In developed countries, if a person is sick they simply go to a nearby local hospital and are met with a full team of extremely qualified medical professionals and plenty of supplies. In Liberia, Sierra Leone, Guinea, and other such developing countries, medical care is highly inaccessible and often unavailable. Further, even if an infected individual were to make it to a health post, it is probable there would be limited supplies and staff. According to the *New England Journal of Medicine*, "In the current outbreak, the number of patients has far exceeded local capacity, which has resulted in a vicious cycle in which more cases lead to overloading of facilities which leads to more cases" (Frieden et al.).

In the case of the Ebola epidemic, many people were so afraid of the disease they would distrust workers or refuse to aid in even many ways. For example, in the 2011 outbreak of Ebola in Uganda, distrust ran so deep that families directly ignored the advice of health workers:

> For a long time, the eldest son of the deceased head of the family refused to comply with the response team's advice to minimise contact within the family, and to of gathering around the central ones. The notion of infection and transmission was rejected, instead the son was convinced that the family had been poisoned as immigrants by its autochthonous neighbours, and advised the other family members accordingly (Borchert et al.).

The distrust of Ebola aid workers was so bad that in multiple cases workers were attacked and sometimes killed. Eight Ebola aid workers were killed in Guinea during the 2014 outbreak when villagers attacked the approaching group with rocks and forced them to separate and flee.

Several were able to escape to a nearby town, but of the nine that went the other way, only one was left alive after the massacre (Wilson). This was not an isolated experience during the response to the outbreak. An Ebola treatment center was forced to disband and flee in Liberia when it was attacked by armed assailants (Wilson). MSF was forced to leave Guinea for a period of time because the threat of violence and lack of cooperation became so severe that they could no longer conduct operations safely (Wilson).

The attacks and lack of cooperation were fueled by many different mechanisms, namely deep-set distrust of Westerners and lack of education and understanding. People were unaware of what caused Ebola, and were also unaware as to what would cure it. An external Western aid worker with unknown motives attempting to explain confusing topics such as viruses is much less likely to be trusted than a long-known member of the community. Another problem that the aid organizations dealt with was the prevalence of alternative cures to Ebola. The WHO reported that at least two people have died from drinking concentrated salt water in an attempt to avoid contracting Ebola (Jones & Elbagir). Further, many people would forego treatment in favor of false treatments such as onions, holy water, and turmeric (Jones & Elbagir). To a major extent, this was due to large cultural differences.

The response to the Ebola outbreak by the global community was delayed. To quote MSF, "On 8 August, far too late, the World Health Organization (WHO) declared the Ebola epidemic a public health emergency of international concern. However, it had been officially declared in West Africa since March 2014" (MSF, "Ebola"). Ebola was a new disease to West Africa; previously it had only been seen in central Africa and went initially unrecognized. The outbreak was originally mistaken for cholera. In March, by the time doctors realized what was occurring, the disease had already infected large portions of the population (Flynn & Nebehay). MSF immediately responded to the outbreak and urged others to follow example, but WHO did not respond for months. After prematurely declaring the swine flu outbreak a state of emergency, they were afraid of inducing an unjustified panic (Flynn & Nebehay). MSF representative Michel Poncin stated, "WHO kept saying it's not our role to do it, we just advise the health ministry. I've been really shocked by the WHO's level of amateurism in responding to this crisis" (Flynn & Nebehay). However, much of this delayed response was due to a large cut in the budget of WHO. As Dr. Risi put it, "Every Western nation over the years has cut back on

funding for organizations like WHO, it is a global scandal. The organizations did the best they could with extremely limited resources" (Risi, Personal Interview).

The epidemic became a source of wide international attention when Americans began to become infected. Patrick Sawyer became the first US citizen to die after responding to the outbreak in Liberia on July 25, 2014. Realizing he was becoming sick, he boarded a plane to Nigeria with the hopes of receiving better healthcare and collapsed as soon as he deplaned (Christensen). Panic grew larger in October as Nina Pham and Amber Vinson became the first people infected in America after caring for Nigerian patient Thomas Eric Duncan in a Dallas hospital (Christensen). Vinson then boarded a public flight to Cleveland before she was diagnosed and sparked mass panic throughout the country. Although she infected nobody on the flight, Americans began fearmongering and conspiracy theories that became prevalent in Africa. This epidemic was driven by fear and misunderstanding.

On August 4th, 2014, President Obama held a large conference with many different African heads of state with the theme of "Investing in the Next Generation" (Christensen). The main topic of this conference focused on the pressing threat in Africa at that time: Ebola. From this conference, many of the major aid organizations began to respond and donate money and resources. USAID and the World Bank were among the first to respond and pledged money to the response efforts, setting the example. Later in the year, the US donated well over $100 million and the Gate Foundation pledged $50 million. On September 16th, 2014, the US deployed military personnel to build treatment centers, bring over treatment kits, and train 500 locals a week (Christensen). The response to the Ebola epidemic was global, and the attention that it received was exceptional. Perhaps if the response had been larger from the initial warning, the outcome might not have been so grim. The CDC reported on their Ebola Case Count page that there were 25,228 cases in countries with widespread transmission and 35 in previously affected countries. The death count was 10,477 (CDC, 2014).

The response to the Ebola epidemic had many problems that were difficult to circumvent; namely, the clash of cultures and mistrust of foreign medical personnel. These problems stem from similar issues, but have different implications and results. The isolation of developing countries and lack of education or corrupt education creates false perceptions of Westerners and a misunderstanding of science. Citizens and organizations of developing countries cannot be forced into trusting paternalistic and neocolonial aid workers of the Global North. That said, the

Global South does not have the resources to confront crises such as the Ebola outbreak by themselves. However, communities such as these deserve the autonomy to fully understand and confront crises as a community. Further, they deserve to build a sustainable means of confronting future crises. A different approach must be found to confront the crisis of Ebola, ideally with the intention of developing local communities and organizations to have the ability to addresses future disasters.

Currently, an attitude of neocolonialism and Western superiority permeates many current methods of aid administration to developing countries. One characteristic example of this that is rapidly growing in popularity is the concept of traveling on a vacation to developing countries with the side purpose of administering aid. This phenomenon has become to be known as "volunteer tourism" or "voluntourism" (McGehee). Volunteer tourism is something that began some time ago as a more integrated and legitimate way to experience travel than simply sightseeing. Volunteers travel to developing countries with the intention of helping the ailing locals and seeing the sights on the side. The intended benefits of volunteer tourism are the hope of instilling a sense of altruism into a younger generation and helping with self-improvement, international development, and cultural understanding (McGehee). However, this form of tourism has many downfalls. As McGehee states in her volunteer tourism article,

> [Voluntourism can cause] exploitation of host communities, volunteers, and the environment; dependency and continued neo-colonialism of at-risk populations; mismanagement of human, physical, social, and financial resources; poor project work conducted by volunteers; a reduction in employment for local people; and lack of communication among the various stakeholders (McGehee, 847-854).

Organizations often market programs such as these as "fulfilling" "cross-cultural" and "beneficial to the community" (Mostafanezhad, "Locating the Tourist"). In fact, most organizations do not even use the term "tourist" in the description. In an interview, many volunteer tourists were offended to hear the term used and instead preferred being called simply "volunteers" (Mostafanezhad, "Locating the Tourist"). This is an inherently paternalistic endeavor. In her article "'Getting in Touch with your Inner Angelina': celebrity humanitarianism and the cultural politics of gendered generosity in volunteer tourism", Mary Mostafanezhad points out that the majority of volunteer tourists are traveling abroad are females going to take care of children, often taking inspiration from Angelina Jolie or Madonna. This act

is often for self-promotion at its core, as volunteer tourists are hailed as "altruistic" and receive more attention from their peers, particularly on social media. Mostafanezhad points out the all-too-common pictures on social media presenting young white females with darker-skinned children, attracting "localized fame." She argues that pictures and trips like this are displaying inequality and dependence by placing the emphasis on children, demonstrating how much developing countries must need Westerners (Mostafanezhad, "Getting in touch").

Volunteer tourism has benefits of creating an awareness of international development in young, privileged Westerners, but how much benefit does it actually have in the destination developing country? To an extent, it depends on the organization, but it more so than not promotes the concept of Western superiority and paternalism. What lasting effect can an underqualified 20-year-old have on one room full of children for one week? While volunteer tourism may have a positive effect on the individual, there can be effects in the community that are too adverse to ignore. Volunteer tourists can damage an economy and create a false perception of Westerners. By promoting the idea that the locals in the community are helpless and need western influence to solve problems, it is creating a distinct lack of autonomy in the local communities. Further, it is promoting the idea that Western living is the only way to live productive, fulfilling lives. As summed up by Michele Sare, "Is $5000 per trip to Haiti…per person per week - who gets the $5000 benefit - Haiti or the person going and gaining an 'enriched life'?" (Sare, Personal Interview). The way in which we approach service in developing countries should be less of "I use my help to you to help myself" and more of "how may I help you help yourselves."

A framework on which to base global health responses is very well-illustrated by Michele Sare, a registered nurse that traveled to Haiti to teach a nursing course on January 12, 2010 (Mazzolini). Forty-five minutes after she arrived to the city of Leogane, it became the epicenter of a massive earthquake that devastated the country and pitched her into the middle of one of the biggest health crises of our time. She became part of a treatment team frantically treating victim after victim of the earthquake and witnessed firsthand how the global health community responded to a crisis from start to finish. Sare described Haiti as a "Republic of NGOs" that was unable to operate independently because of all of the aid organizations conflicting with each other and with the government (Sare, "15 in this Minute"). Before the earthquake, she had been one of very few people traveling to Haiti to administer developmental aid, and after the

earthquake, she reported seeing a huge influx of people doing "aid" work. She said that many people not necessarily traveling for the direct benefit of the community—they simply wanted to be involved in the event. Most notably, Sare said the second time she traveled to Haiti, she met a group of college-aged women that were traveling to the community to "hold babies" (Sare, "15 in this Minute").

The effect of these people disrupted the local economy of Haiti in ways unrealized. With their more privileged backgrounds, they were able to afford food, land, and other amenities at a price that many Haitians could not. Their mere presence raised the costs of different items until locals were "priced out" and could no longer afford to live. Sare describes it as a "non-alignment with local customs and economy...I can afford a $2 papaya or a $10,000 piece of land - and [with] both - I just created a false economy" (Sare, Personal Interview). Ironically, the volunteers who were attempting to alleviate the poverty and suffering of the locals and were in fact making it worse.

Collaboration with local organizations and governments should be one of the centermost endeavors of any aid work in developing countries. Above all else is the idea that, as outsiders, aid workers are merely guests in another country. This means that external organizations have neither the right nor the capacity to operate better than locals. On an ethical basis, the community belongs to the locals in it. Outsiders do not have the right to instill or impose anything that they think might make that community better—regardless of how good their intentions are. Local organizations understand local culture and custom, and are able to provide aid in a way that is respectful of the community. This correlates with the idea of cultural alignment. Simply put, improving a community must come from within, and it is not a job that outsiders are capable of. As stated by Sare, "The antithesis of empowerment is to take and maintain locus of control" (Sare, Personal Interview).

On a practical level, any affective and positive change cannot be sustained by outsiders. If an international aid organization begins and spearheads an aid initiative without contribution of local organizations, then that initiative is only viable for the period that the aid organization is actively involved. This means that if a program is to have any real effect, the external organization would never be able to leave and move on to something else; this is the core makes the program unsustainable. If local organizations are involved from the beginning, then they can take over the program and further develop it themselves after a period of time.

One of the biggest reasons that the fight against Ebola was so difficult was that there was an inherent sense of distrust against the foreigners attempting to administer aid and a widespread misunderstanding of the disease itself. Locals did not understand *why* they needed to change their sacred burial practices, they believed that aid workers were carrying the disease or even poisoning them, and they were vastly uneducated as to what caused and worsened the disease and how to best combat it. This could have been addressed more efficiently with better integration of international aid workers and local organizations. Rather than an unfamiliar white foreigner explaining through a translator that a loved one who died of a mysterious disease could not be traditionally buried and taking away members of the community that fell ill wearing the equivalent of a hazmat suit, it would be vastly more effective to have local workers that understood the culture, the language, and the customs explain it in terms that they would understand and appreciate. Further, education could have continued after the aid workers had left. This outbreak was an African problem, and the spearheading of the fight against it should have been run and facilitated by Africans.

There are many challenges associated with working with and establishing local organizations in a health crisis. It is idealistic to assume that local organizations would seamlessly fuse with international organizations and work flawlessly towards the same goal. Firstly, local organizations may not exist in the first place. It may have to be part of the initiative of the international aid organizations to find and establish local organizations once the aid plan is underway. This brings on many other problems such as, how does one form a local organization, how does one develop it without being paternalistic and how does one motivate people to join and form this local organization once it is founded? Although there may not be many established aid organizations, there is usually a system of government with the best interest of the country in mind. From there, international organizations can collaborate with these to create an aid organization, training locals interested in impacting their communities for the better. This falls in with the idea that any aid initiative is going to take more time than several months. To effectively establish organizations such as this and create a lasting impact on the community, it would take years to recruit and educate locals and establish an organization.

In the cases that local organizations exist prior to the international aid initiative, there may be challenges with the existing organizations. Unfortunately, there are instances in which organizations could be corrupt, self-serving, or have goals that do not have the best interest of the

community at core. This is a particularly challenging circumstance, because to change these organizations inherently adopts a paternalistic nature. An international aid organization attempting to manipulate an existing local aid organization so that its goals are more in alignment with that international organization's goals means that, to some extent, local ideals would be oppressed. In cases such as this, reorganization could not be headed by international organizations. They would need to find an existing local organization to support that did have the best interest of the community at heart, or they would need to adopt the practices of the previous concept and help to establish one. After this is done, the local organization would head the initiative to work with the corrupted aid organization to create a common goal. This is not a simple process, and each framework would be very situationally dependent. However, the bottom line is that, even if it is more challenging to work with local organizations than it would be to independently spearhead an approach, it is crucial to create partnerships that lend to the sustainability of the program.

Local collaboration is crucial in a successful aid initiative, but aid is hard-pressed to be affective with the shifting of attentions placed on health crises or disasters currently. Before the earthquake, Sare remembers seeing almost nobody traveling to Haiti on her flight. The second time she went, the terminal was crowded with people that were traveling to provide aid. Then, as soon as the earthquake was out of the news, the influx died down again (Sare, "15 in this Minute"). People arrived to provide temporary disaster relief, then, as soon as it was no longer pressing, they left. This is not a sustainable form of help. This type of aid can be categorized as the "Zoo Model of Charity" (established by Jesse Conn). As described by Sare,

> The zoo visitors (the aid organizations come & go) - come see those trapped-in their unfavorable life conditions and then leave - to be replaced by other 'observers' - each in their own colorful tee-shirt and each compassionate and dedicated to the well-being of those trapped in their respective life … this creates that parallel 'universe' that exists in so many disparate areas between outside aid and day-to-day life in a community (Sare, Personal Interview).

Assuredly, communities need more help when in direct crisis, but temporary treatment of isolated factors does not facilitate a long-term solution. Sare stressed in her lecture that when Westerners provide aid in a developing country, they are guests that are privileged to be there, not rescuers of the unfortunate. There is an "us vs. them" mentality that lends to rescue and

saving paradigms rooted in superiority (Sare, Personal Interview). The focus should be on empowering the citizens of the country so that they may help themselves in the future. In a lecture to the MSU nursing program, Sare stated "See the solution, don't just see the tragedy. Don't let it go away. Don't let it go away when the news reports do" (Mazzolini).

Sare stresses that for a response in a developing community to work, responders must be willing to commit in the long term.

> Think - deeply - look at all of the evidence - and create a proposal for what you can and are committed to do - not just this or next year - but for a minimum of 5 years...no one should engage unless they are 'in-it' for at least 5 years (have a long process to create sound relationships and build trust) (Sare, Personal Interview).

Following that, responders should listen and learn, be willing to form partnerships with existing communities, and build with them. The plan should be presented to local governance and stakeholders with all of the necessary permissions and licenses obtained before beginning. All of the ethical, legal, and cultural considerations should be taken. Other organizations, both local and international, should be collaborated with. A prevalent idea that needs to be disbanded is the mentality of ownership surrounding developmental aid. "It isn't about 'your project' - nor is it about competing for funds or that you have the only or best ideas how to 'help'" (Sare, Personal Interview). A truly sustainable aid response to a health crisis involves an ultimate transfer of responsibility to local organizations entirely and addressing factors that contributed to the crisis in the first place.

In regards to the Ebola crisis, a greater emphasis should have been placed on working with local organizations, as Sare would put it, "Always with, never to and rarely for" (Sare, Personal Interview). In Western Africa, a place that experiences many hardships outside of the Ebola epidemic, there are many local aid organizations already in place. These work for a variety of causes, many of them health-related (Aid for Africa). Before responding to the Ebola outbreak, it should have been analyzed as to exactly where these organizations needed help and the responders should have contacted them to work on developing a response plan together. Then, throughout the process, the team should have been working together to recruit, train, and develop local communities to help respond to this epidemic as well as future epidemics in the region.

After the outbreaks had died down, the organizations should have committed more time to staying in the communities to aid with long-term development. As Sare asserted, multiple years are needed to actually instill a lasting impact on a community. Before organizations such as MSF and WHO removed their teams from the crisis area, they should have devoted much more time to collaborating with the local organizations and evaluating what could be changed to better prepare for future epidemics and what could be improved with dealing with the past one. Ultimately, the local organizations would take over this initiative with continued support and guidance from the international aid organizations. This is not to say that the international response community did not collaborate with local communities at all and that they were not attempting to address future problems. However, the key points in the response to the outbreak were not centered on these ideas. In order to better respond to epidemics such as this and other health crises, organizations should enter the epidemic with the specific intentions of collaborating with and working alongside local organizations and with the long-term effect of their response in mind.

In Peter Koehn's theory on Upstream, Midstream, and Downstream influences, it is explained that the downstream effects are continually being influenced by upstream and midstream factors (Koehn, "Global Health Challenges"). Downstream factors are what are usually thought of when addressing of a problem affecting a particular area. These include problems that crisis response organizations usually attempt to solve, such as the prevalence of a disease, natural disasters or famine. However, these problems are not isolated incidents, and are continually influenced by midstream factors such as socioeconomic status, education, and agricultural stability. These are in turn influenced by upstream factors such as the global economy and conflict (Koehn, "Global Health Challenges").

As an example, in times of famine, MSF has a practice of administering ready-to-use foods (RUFs) that are a high-caloric, high-nutrient nut-based paste that can sustain a person for a period of time (MSF, "How is Malnutrition"). This is directly addressing a downstream factor without regard to other factors. This RUF may save a person from starvation and malnutrition while they have it, but it does not solve the problem as to why they did not have food in the first place. Clearly, addressing this downstream factor is very necessary—without it the person would die—but it is not a sustainable form of treatment. Rather than respond to the crisis of malnutrition until it is lessened, midstream factors such as growing more food, improving access

to food, and improving food storage should be addressed to increase sustainability. On broader terms still, a conflict that keeps people from receiving food or a deficit in seed trade to the global community should be addressed on a multi-national scale. The United Nations report by the Economic and Social Council discussed this issue directly, stating that developmental aid should focus on stimulating the economic growth of developing countries through regional integration and free trade (UN News Centre).

There were midstream and upstream factors that contributed to the spread of Ebola in Africa that do not exist in the global North. Much of Africa was uneducated and had limited access to sanitation. A main contributor to this is mass poverty, which will be very complicated to address, but many of these factors are able to be focused on. It is not enough to treat the problem of Ebola and move on. Africa is vastly understaffed in medical professionals and vastly uneducated in basic subjects such as biology or literacy. If Ebola is contained and these problems are not solved, another uncontrolled outbreak of a disease is likely—almost inevitable. This problem needs to be addressed so that Africans can not only be more involved contributors to addressing future epidemics, but also be advocates of safe and sanitary methods of containing disease. As the crisis response teams are being phased out and the epidemic is being contained, developmental aid crews need to be working with them directly to attempt to find and address some of the major problems faced in confronting the Ebola epidemic. Ultimately, the goal would be to work with and establish local organizations that can continue this work on their own and utilize help from the global North as they require and ask for.

An example that embodies this idea is one established by Sare after her response to the Haitian earthquake. After the hype had died down, she helped to establish Santé-Konbit-Fondwa. This is a Haitian-created and Haitian-run health community that focuses on teaching and establishing relief in their own country. This organization embodies everything that Sare was trying to achieve in her time in Haiti. She honors the Haitians as a proud, determined people that deserve to run and care for their own country. On speaking of her most affecting experience in Haiti, she stated,

> [It was] witnessing strength, dignity, courage, profound generosity, compassion and the very best that humanity has to give...amidst ridiculous odds - unimaginable suffering...It was NOT outside international aid or white heroes that

> saved Haiti - it was Haitians...Haiti has her own most powerful heroes and heroines. (Sare, Personal Interview).

Something that was lacking in the response to the Ebola epidemic was respect for the local cultures and communities. The response was driven with a paternalistic mindset of changing culture to better assimilate to Western ideals. It brought on fear and, in some cases, violence. If the international response teams had been able to see the African people the way that Sare was able to see the Haitian people, the response could have been based more on collaboration, respect, and the improvement of the community.

The Ebola outbreak of 2014 was a challenging crisis to address filled with widespread fear, misunderstanding, and cultural clashing. However, rather than view this as a failure of the global health community, it should instead be viewed as an opportunity to expand and enrich the responses to epidemics and other global crises in developing communities. The international aid communities needed to have more of a focus on local development and collaboration. To truly change and affect a community, the change needed to come from within the community. Local collaboration would have helped with mitigating the distrust of the aid workers, addressing the difficulties in cultural clashes (such as burial practices), and could have ultimately made the entire process more efficient since locals of a community truly understand how best that community functions. After the initial epidemic was contained, a shift towards developmental aid should have been emphasized. The developmental teams could have worked closely with response teams, replacing them to isolate and address issues that made the epidemic worse. These developmental teams could have then worked with the local organizations to address the downstream, midstream, and upstream factors that worsened the epidemic. The international response to the Ebola epidemic was performed with the best of intentions in mind. However, future responses should have a larger focus on improving the overall community and preventing future crises, creating a local, sustainable framework that would withstand other challenges.

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