

Photo: Moses Sawasawa Associated Press

# THE FIGHT AGAINST *EBOLA*

Presented by Astrid, Maria, Maël, Mogne Emma, Nour and Violette

# INTRODUCTION



A critically ill patient is transferred to and admitted to the MSF-run Ebola treatment centre at Mongbwalu General Hospital.

## JULY 2026

Democratic Republic of Congo : the third-largest outbreak ever recorded according to MSF.

The organization is therefore calling on the Congolese health authorities and humanitarian actors to quickly strengthen the resources dedicated to fighting the virus. This includes community engagement, surveillance, screening and diagnosis, patient care, and the management of deceased patients.

MEDECINS SANS FRONTIERES

# WHAT IS EBOLA ?

- Ebola is a virus that causes high fever and severe bleeding, which can often be fatal (average death rate around 50%)
- The Ebola virus was discovered in 1976
- Transmission can occur through direct contact with infected animals
- Even after death, a person can remain contagious for several days, which creates a risk of transmission during funeral rituals
- Preventive vaccines are now available, but only against two strains of the virus

# GEOGRAPHY AND CHRONOLOGY

**First observed in 1976**

Several periods of resurgence:

- **1995:** 315 cases, including 250 deaths, in the Democratic Republic of Congo.
- **2000:** 425 cases, including 224 deaths, in Uganda.
- **2007:** 187 deaths in the Democratic Republic of Congo.

From **2013 to 2016,** in Guinea, Liberia, and Sierra Leone, around 29,000 cases, including at least 11,300 deaths, were reported.




Extension of the epidemic - November 2, 2014

# THE FOCUS ON THE *2013–2016* CRISIS

**Ebola received proportionally more funding to contain the crisis than other health crises.** ***Why ?***

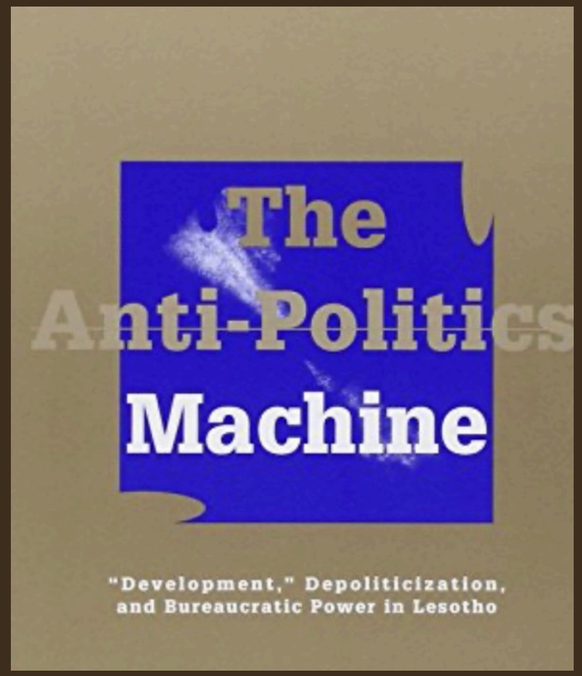
- risk of transmission to Western countries
- vertical approach : during the 2013–2016 outbreak in West Africa, financial aid for Ebola increased from 662 million dollars in 2014 to 1.12 billion dollars in 2015 (70.7% of all international health aid in the region that year)
- The WHO was late in declaring a Public Health Emergency of International Concern, or PHEIC.  This created a “shock effect”: the acute, highly visible and heavily mediatized nature of Ebola encouraged donors to make massive financial commitments very quickly.



# THE HUMANITARIAN IDEAL

## *AN INSTITUTION BUILT ON NEUTRALITY*

- 4 principles of **humanitarianism** : humanity, neutrality, impartiality and independence (UN General Assembly Resolution 58/114)
- Definition : “a humanitarian action is one which aims to preserve life while respecting dignity, to restore their capacity to choose to those who have been deprived of it by circumstances. The action is **carried out pacifically and without discrimination by organisms acting, to the exclusion of all other considerations**”(Rony Brauman, Humanitarian aid)




# THE CLAIM OF NEUTRALITY IS *POLITICAL*

- Ferguson and the **“Anti-politic machine”** :  It frames crises like diseases as technical problems that experts can fix, which hides their political causes
- the tension exists **within** the sector itself : orthodox VS solidarity-based



Source : The Boston Globe

# WHY FOCUS ON *AID WORKERS ?*

**1) Between aid workers and the affected population**

**“Politics of Life” (D.Fassin)** as ranking lives unequally, risking other lives and selecting which existences can be saved

**Depoliticisation (P.Fawcett M.Wood) :** “removing or displacing the potential for choice, collective agency and deliberation"

**2) Within the workers themselves : a stratified labour market**

**UNSAID** in 2024 : international NGOs in the DRC paid salaries that were, on average, 3.7 times higher than local ones

# HOW DOES EXAMINING THE AID APPARATUS AGAINST EBOLA AND THE RISKS FACED BY AID WORKERS HELP US UNDERSTAND THE *POWER DYNAMICS* INHERENT TO HUMANITARIAN AID ?

## I. EBOLA : THE CONSTRUCTION OF A CRISIS

A. Constructing a "sanitary security" problem to justify intervention
B. UNMEER : the UN's EFFORT at a centralised and cooperative non-coercive mission
C. Financing the Ebola Response: *who paid?*
D. After the mission : claims of success

## II. THE RESHAPING OF THE "GLOBAL HEALTH SECURITY" FRAMEWORK BY THE GROUND : A STRUCTURAL YET INTERACTIONIST ANALYSIS OF THE EPIDEMIC

A. Anchoring the sociological understanding of the epidemic management in history and politics
B. Understanding the "figuration" of Ebola through a sociology of risk
C. From friction to innovation : when social interactions reshape the ebola responses

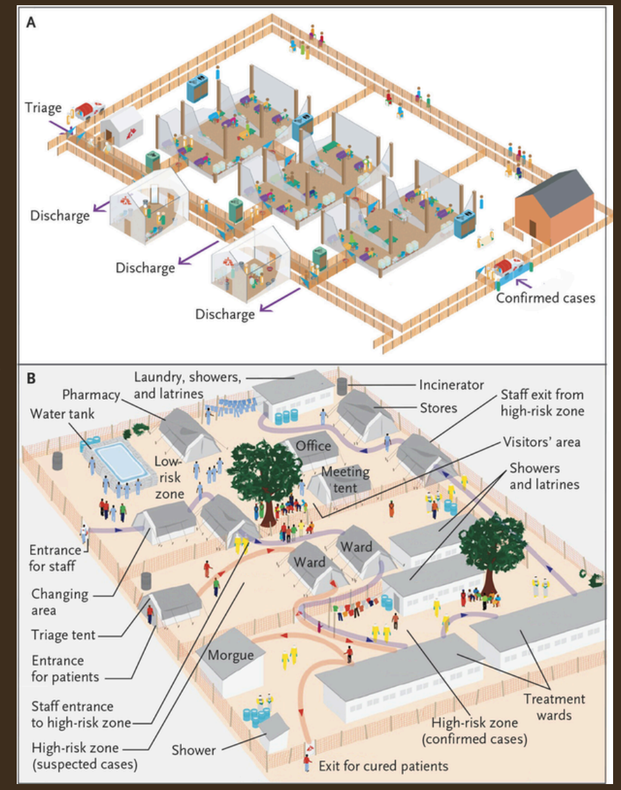


Source : Le Monde, may 2026

# I. EBOLA : THE CONSTRUCTION OF A CRISIS

# INITIAL INTERNATIONAL INACTION

- **First alert on March 21st 2014**
  - EU mobile lab alerted by WHO > Guinea deployment
  - But most work concentrated in the first field laboratory in the Ebola Treatment Center (ETC) managed by **Médecins Sans Frontières**
- **Small NGOs overwhelmed & exhausted**
  - MSF criticises lack of international aid from the **“coalition of inaction”**
- **After months of pressure, WHO declares a “global emergency”(08/2014)**
  - UN Security Council Meeting
  - **Resolution 2177 declaring a public health crisis** (18/09/2014)
  - **United Nations Mission for Ebola Emergency Response mission** leading all aid + centralising funding




Chertow, D. S., Kleine, C., Edwards, J. K., Scaini, R., Giuliani, R., & Sprecher, A. (2014). Ebola virus disease in West Africa — clinical manifestations and management. New England Journal of Medicine, 371(22), 2054–2057.

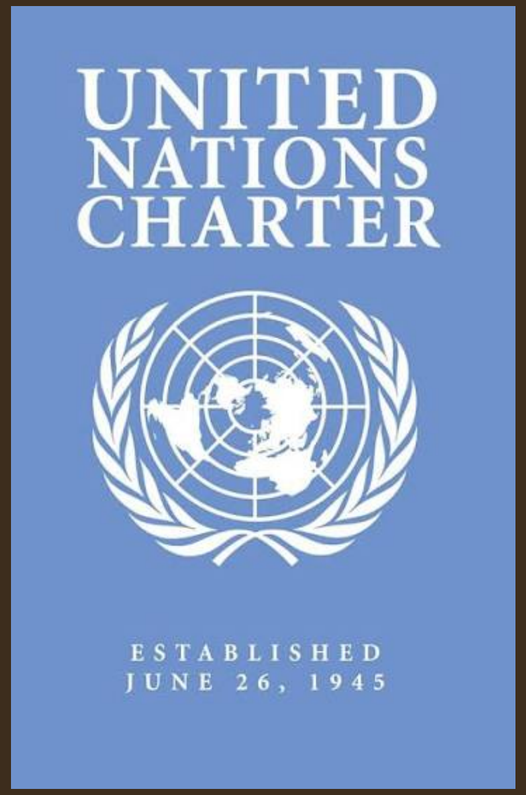
# A. CONSTRUCTING A "SANITARY SECURITY" PROBLEM TO JUSTIFY INTERVENTION

- Health on the agenda (WHO constitution; WHO 1995 resolution)
- **Scaling up by passing Article 39.**
- Article 39 makes health crisis ***a breach of peace***
  - A threat to human lives, to livelihoods, to peace and global security
  - Moving crisis from local to **global responsibility**
  - Global problem = **global solutions**

Kap. VII - Art. 39

**Article 39 UN-Charter**

The Security Council shall determine the existence of any **threat to the peace**, **breach of the peace**, or **act of aggression** and shall make recommendations, or decide what measures shall be taken in accordance with Articles 41 and 42, to maintain or restore international peace and security.




**Security *buzzword* : deployed as a means of justification for totalising and centralised foreign intervention.**

**2 kinds of security :**

- **Health security**
- **Militarised security** UN concerned about **Ebola's potential *"impacts on the fragile internal equilibrium of the affected countries, both at the socio-economic and political level"*** (Antonietta Elia 2015)
- Domino effect

# B. *UNMEER* : THE UN'S EFFORT AT A CENTRALISED AND COOPERATIVE NON-COERCIVE MISSION

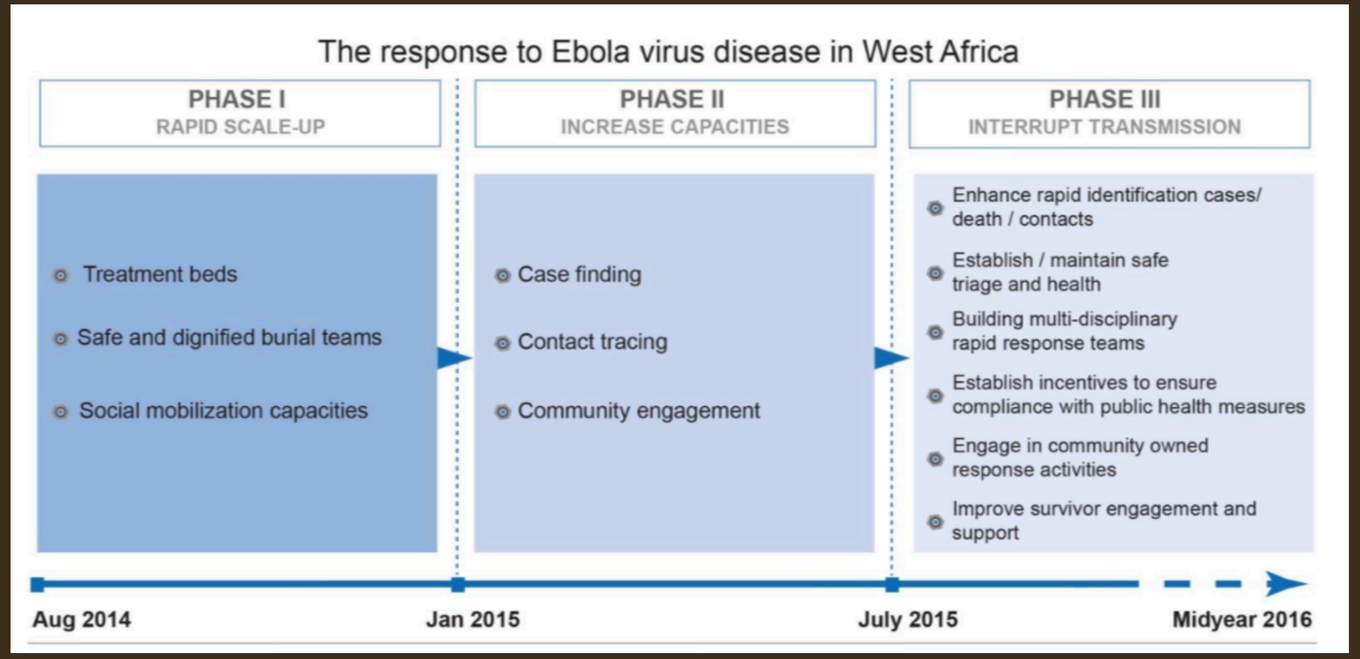
## UNMEER (19/09/2014 - 31/07/2015)

- Part of the **Global Ebola Response Coalition** (09/2014)
- Partnered with the **World Health Organisation**
  - surveillance,
  - technical coordination
  - strategic response plan : ***the Ebola Response Roadmap***
- **Goal : stop Ebola transmission within the next 6-9 months**
- **5 point strategy** (Stop the outbreak ; Treat the infected; Ensure essential services; Preserve stability; Prevent further outbreaks)
- **Framing UN aid as : multiscalar, cooperative and community based coalition.**
- ***A reality of lacking funding & organisation***
  - WHO's emergency response quickly over capacity
  - **WHO needs increased from $71 million to $600 million** in one month (August-September 2014)

## MULTI ACTOR COALITION

- **United Nations Development Programme:** supporting socio-economic resilience
- **World Food Programme**: logistics & **supply** transportation
- **Medical NGOS :** MSF ; ALIMA (medical care & clinical trials for treatment) ; Red Cross (burials, contacts)
- **National governments**
  - Ministries of Health in **Guinea**, **Liberia** and **Sierra Leone**: **national crisis response teams**
  - Neighbouring governments deployed doctors and volunteers
  - UK, France, Cuba, Russia and China : human & material ressources
  - USA : **USAID disaster specialised unit (DART**) & ***Operation United Assistance***
- **African Union mission :** *AU Support to Ebola Outbreak in West Africa*

# B. AID WORKERS : A KEY HUMAN RESOURCE




- Initial **lack of doctors and trained medical workers in West Africa**
  - Liberia : only one doctor for every 100,000 people ;
  - Sierra Leone : two/100,000 people
- Aid focused on **providing medical workers**
  - USA training 500 health care providers a week, deploying staff, protective equipment
  - $10 million funding for African Union mission
- **Aid within the continent left an institutional legacy**

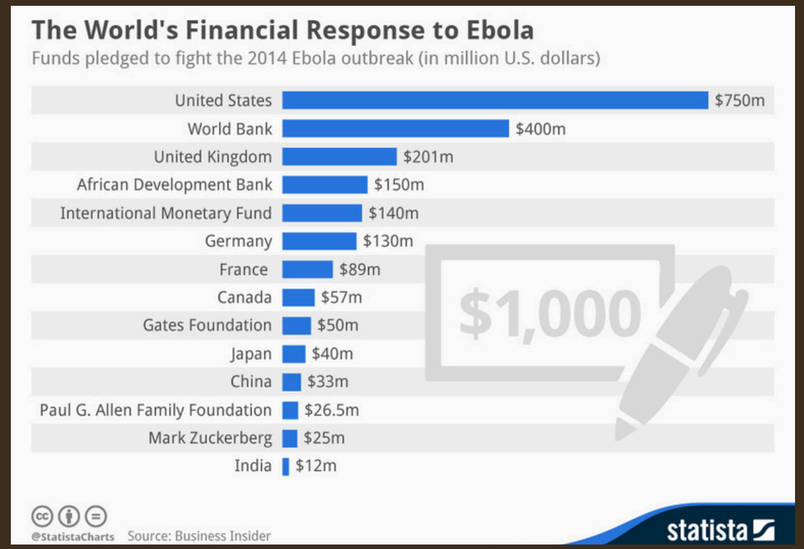
***Example : the African Union Support to Ebola Outbreak in West Africa mission** (ASEOWA)*

  - 20 member states providing 862 African professionals
  - Mission integrated into local systems
- Success :
  - **52% patient survival rate**
  - Restored routine health services to 88 care units
  - **49, 493 contacts traced**
  - **Zero volunteers contracted ebola** during deployment
  - **Institutional legacy :** launching the AU's **autonomous public health agency** (the Africa Centres for Disease Control and Prevention)

# C. FINANCING THE EBOLA RESPONSE : *WHO PAID ?*

APPROX. $5.92 BILLION

- **National governments:** United States, United Kingdom, Germany, Japan, France, China and others. **($3.96 billion)**
- **International financial institutions:** World Bank, African Development Bank and International Monetary Fund (IMF)**($1.09 billion)**
- **Regional organizations:** European Union and African Union.**($721.3 million)**
- **International organizations:** UN agencies, including WHO, UNDP, UNICEF and WFP, mainly as recipients and implementing organizations.
- **Private actors:** Philanthropic foundations, corporations and individual donors, crowdfunding. **($145.7 million)**



# WHERE DID THE MONEY GO?

- 42% UN agencies
- 19% NGOs
- 11.5% to the governments of the three countries

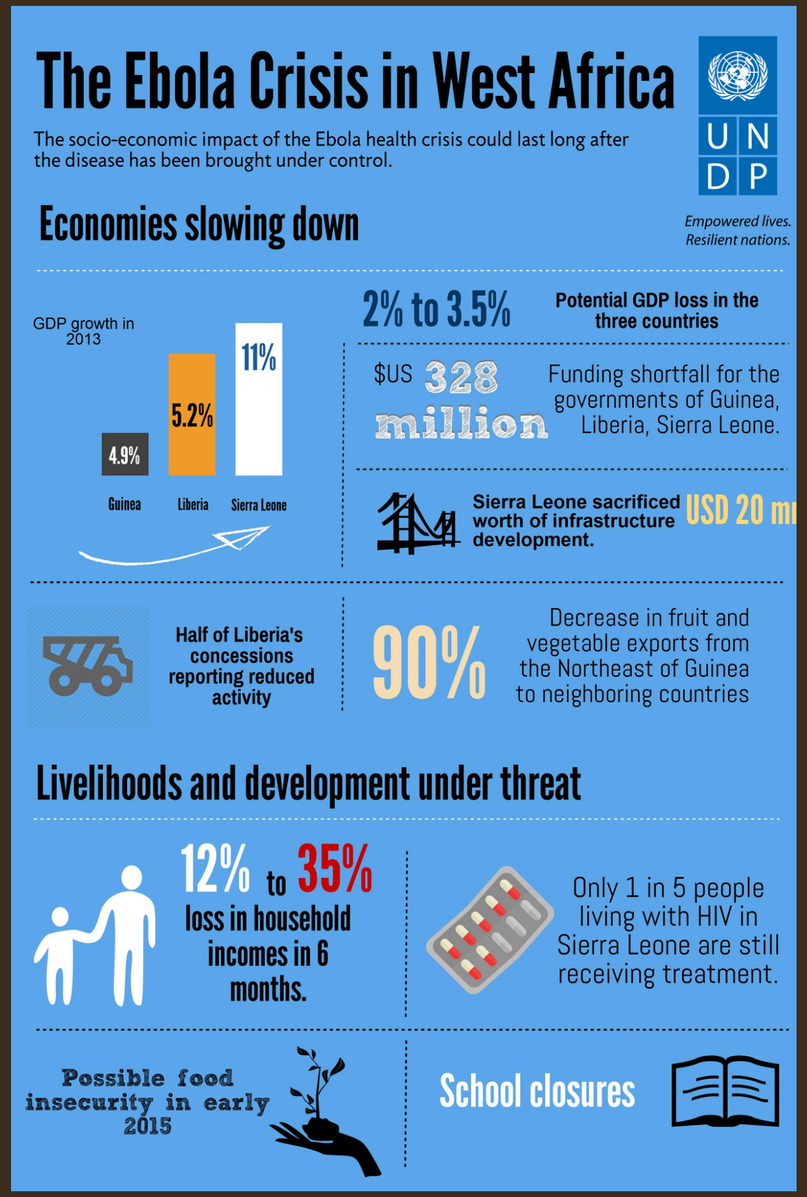
→ the official language was **“national ownership”** yet the financial structure was largely run from outside

**UNDP Payments Programme for Ebola Response Workers**

- About 49,250 workers, roughly 70% of the response workforce
- Regular salary and hazard payments
- Innovative digitised payment systems
- 75% salary bonus for health workers entering high-risk “Red Zones”
- Aim: end delayed pay, which had caused strikes and tension

- Billions of dollars were mobilized, but late
- Most of the money was administered by international organizations, not by the affected states
- The people who risked the most depended on systems they did not control

# TO SUM UP



# D. AFTER THE MISSION : CLAIMS OF SUCCESS

## Affirmations of success

- Ending mission after less than a year
- UN success ?
  - **“scaling up the response of the group”**
  - **“establishing unity of purpose among responders”**
- **“Health-making”** (Millet-Devalle 2016) **with no coercion**

## Versus a more nuanced reality

Associated Press revelations (10/2014) :
WHO internal document admitting to flaws in aid response

- **Postponed alert** for economic fears
- **Justifying ‘inadequate’ international cooperation** (Houssin 2014) by reference to **inequalities in conforming to International Health Regulations (WHO 2005)**
  - Scapegoating poorer, less developed countries
  - Mael & Nour examining power dynamics shaping this



# II. THE RESHAPING OF THE "GLOBAL HEALTH SECURITY" FRAMEWORK BY THE GROUND :

## A STRUCTURAL YET INTERACTIONIST ANALYSIS OF THE EPIDEMIC



source : MSF volunteers work during the Ebola outbreak in August (AFP/Getty Images)

# NOTIONS

Michael Lipsky



**“Street-level bureaucrats”**

Norbert Elias



**“Figuration”**

J.P. Olivier de Sardan



**“Revenge of contexts” : “practical norms” and “social engeeniring”**

# A. ANCHORING THE SOCIOLOGICAL UNDERSTANDING OF THE EPIDEMIC MANAGEMENT IN HISTORY AND POLITICS




“Whilst bacteria and viruses may arise ‘spontaneously in nature’, there is, on the other hand, ‘nothing natural or spontaneous’ about an epidemic “

# Unequal power dynamics between *Western organisations*, *local elite* and *local communities*

## Lack of sovereignty over the medical process :

**Over reliance on Western health institutions**
- exemple of Pasteur institute in Lyon

**Epidemic Management throught stigmatised views of the field**
- Concept of “blazing epidemic”
- Congolization

**Exception of MSF**



**Countries prioritize themselves**

Low contribution to WHO budget in a context of post-2008 crisis austerity

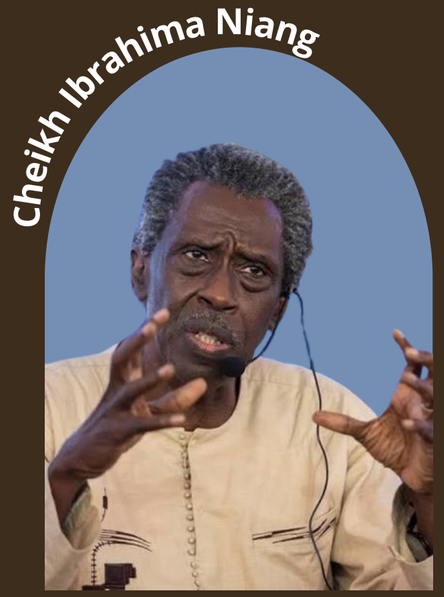
**WHO: constrained by the wishes of its member states**

Fear that a Public Health Emergency declaration would slow trade

**Heavy Bureaucracy inside the WHO**

Slow communication and internal disputes

# A CONTEXT OF "POSTCOLONIAL EPIDEMIC"




**1st characteristic** as *deep social inequalities and extreme poverty* : the poor state of health infrastructures in Liberia and Sierra Leone

**2nd characteristic** as *weak trust between local communities, state and foreign NGOs*

- *Exemple of Sierra Leone*: Private British companies ruling the country at the end of the 18th century

**3rd characteristic** as *heritage of violence* : Civil war legacy

# B. UNDERSTANDING THE "FIGURATION" OF EBOLA THROUGH A SOCIOLOGY OF RISK

| | 2018 | 2017 | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2000 | 1999 | 1998 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of incidents | 244 | 180 | 179 | 168 | 197 | 265 | 173 | 154 | 135 | 42 | 33 | 26 | 35 |
| Total aid workers affected | 488 | 387 | 320 | 317 | 358 | 474 | 291 | 322 | 255 | 92 | 69 | 68 | 75 |
| Total detained* | 27 | 48 | 11 | 13 | 16 | 1 | 14 | 13 | 2 | 1 | 1 | 0 | 0 |
| Total killed | 131 | 141 | 113 | 111 | 130 | 159 | 71 | 86 | 74 | 57 | 33 | 35 | 39 |
| Total injured | 147 | 103 | 99 | 110 | 90 | 179 | 115 | 127 | 85 | 23 | 15 | 15 | 6 |
| Total kidnapped | 183 | 95 | 97 | 83 | 122 | 135 | 91 | 96 | 94 | 11 | 20 | 18 | 30 |
| International victims | 44 | 40 | 46 | 30 | 34 | 60 | 50 | 30 | 42 | 21 | 26 | 22 | 30 |
| National victims | 444 | 347 | 274 | 287 | 324 | 414 | 241 | 292 | 213 | 71 | 43 | 46 | 45 |
| UN staff | 71 | 55 | 74 | 50 | 72 | 115 | 48 | 92 | 45 | 31 | 17 | 21 | 23 |
| International NGO staff | 256 | 154 | 167 | 179 | 153 | 142 | 111 | 148 | 154 | 46 | 31 | 11 | 32 |
| ICRC staff | 5 | 14 | 13 | 3 | 16 | 14 | 3 | 5 | 10 | 9 | 7 | 26 | 9 |
| NRCS and IFRC staff | 23 | 65 | 12 | 30 | 35 | 44 | 24 | 10 | 1 | 0 | 7 | 7 | 10 |
| NNGO staff | 133 | 99 | 52 | 52 | 79 | 145 | 92 | 67 | 45 | 5 | 7 | 3 | 0 |

*Data on detentions/arrests is limited before 2025

The Aid Worker Security Database (AWSD) records major incidents against aid workers, with incident reports from 1997 through the present since 2005.
https://www.aidworkersecurity.org/incidents/report

# WHY WOULD THE POPULATION OPPOSE HUMANITARIAN AID?

Merging of the afformentioned **weak trust** towards government and foreing organisation and the **importance of the body** because of the **coercive bio-security measures:**

- **Confrontation with local beliefs** :In *mendé* and *kissi* culture ( in Guinea, Sierra Leone and Liberia), there is a strong idea of a life after death which is the base for ancestry and rituals attached to the deceased person

# RESISTANCE FROM COMMUNITIES

**Passive resistance**

- Mistrust and rumors
  - exemple of Kenema (Sierra Leone)
- hiding or not declaring contaminated corpse
- Denial: consumption of bush meat, tradition burial,
- Escaping village quarantine

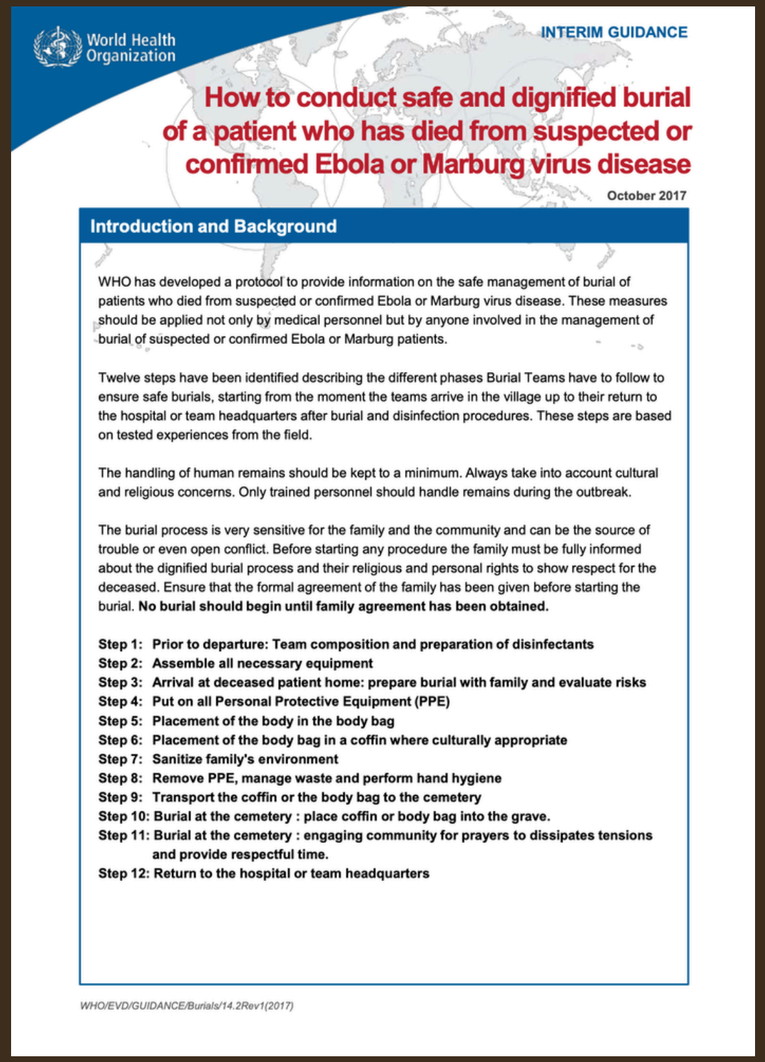
**Active resistance**

- Womey massacre in septembre 2014 (8 aid workers were killed)
- Refusal to let patient transported to medical centers
- NGOs ambulance set on fire by locals

# C. FROM FRICTION TO *INNOVATION* : WHEN INTERACTIONS RESHAPE THE EBOLA RESPONSES

The institutions calling their practices into question : WHO's new protocols

"New WHO safe and dignified burial protocol - key to reducing Ebola transmission"



World Health Organization

INTERIM GUIDANCE

**How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola or Marburg virus disease**

October 2017

**Introduction and Background**

WHO has developed a protocol to provide information on the safe management of burial of patients who died from suspected or confirmed Ebola or Marburg virus disease. These measures should be applied not only by medical personnel but by anyone involved in the management of burial of suspected or confirmed Ebola or Marburg patients.

Twelve steps have been identified describing the different phases Burial Teams have to follow to ensure safe burials, starting from the moment the teams arrive in the village up to their return to the hospital or team headquarters after burial and disinfection procedures. These steps are based on tested experiences from the field.

The handling of human remains should be kept to a minimum. Always take into account cultural and religious concerns. Only trained personnel should handle remains during the outbreak.

The burial process is very sensitive for the family and the community and can be the source of trouble or even open conflict. Before starting any procedure the family must be fully informed about the dignified burial process and their religious and personal rights to show respect for the deceased. Ensure that the formal agreement of the family has been given before starting the burial. **No burial should begin until family agreement has been obtained.**

**Step 1: Prior to departure: Team composition and preparation of disinfectants**
**Step 2: Assemble all necessary equipment**
**Step 3: Arrival at deceased patient home: prepare burial with family and evaluate risks**
**Step 4: Put on all Personal Protective Equipment (PPE)**
**Step 5: Placement of the body in the body bag**
**Step 6: Placement of the body bag in a coffin where culturally appropriate**
**Step 7: Sanitize family's environment**
**Step 8: Remove PPE, manage waste and perform hand hygiene**
**Step 9: Transport the coffin or the body bag to the cemetery**
**Step 10: Burial at the cemetery : place coffin or body bag into the grave.**
**Step 11: Burial at the cemetery : engaging community for prayers to dissipates tensions and provide respectful time.**
**Step 12: Return to the hospital or team headquarters**

*WHO/EVD/GUIDANCE/Burials/14.2Rev1(2017)*





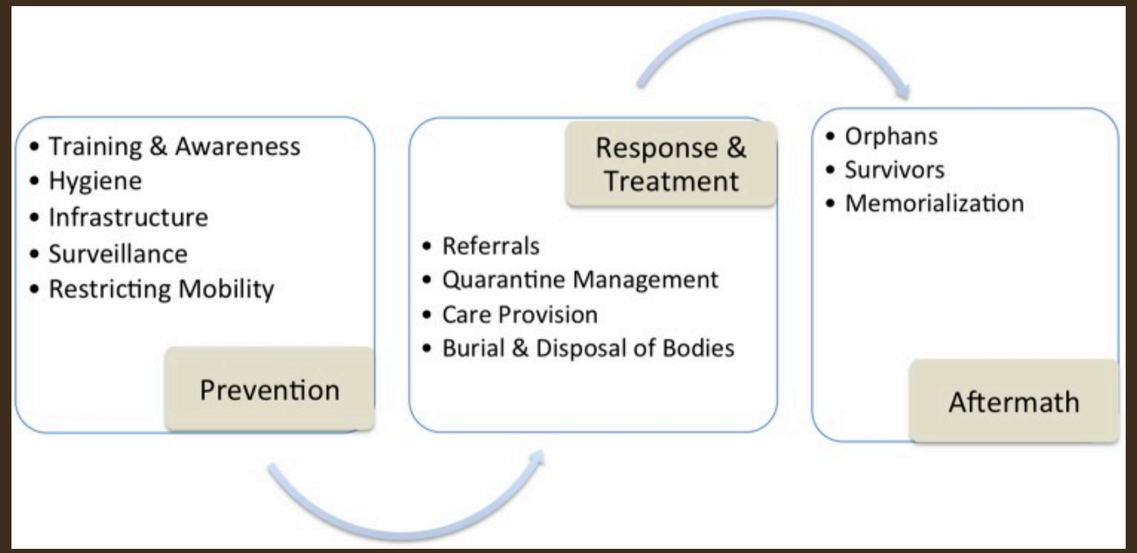


**A traditionnal healer attended in the Health center of the Prefectural Health Directorate of Gueckedou after been beaten by villagers**

Anoko J.N. (2014), Communication with rebellious communities during an outbreak of Ebola Virus Disease in Guinea : an anthropological approach. Ebola Response Anthropology Platform.

# Community-based responses to the failures of state and international institutions

– Fig 1. Monrovia community leaders' representation of optimal community-based care, August—September 2014.




– Abramowitz, S. A., McLean, K. E., McKune, S. L., Bardosh, K. L., Fallah, M., Monger, J., Tehoungue, K., & Omidian, P. A. (2015). "Community-centered responses to Ebola in urban Liberia: the view from below". *PLOS Neglected Tropical Diseases*

– Fig 2. Monrovia community leaders' detail of optimal community-based Ebola surveillance, August—September 2014.




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# CONCLUSION