Ebola Virus Disease Outbreaks in West Africa 2014 – 15: Multi-stakeholder responses to a complex crisis

David Nabarro, 4SD Strategic Director – June 2, 2025

Introduction

During 2014, the numbers of people diagnosed with Ebola Virus Disease in West Africa was doubling every three weeks. The Presidents of the most affected nations (Guinea, Liberia and Sierra Leone) sought international support for combating the outbreaks, and the United Nations (UN) system was asked to help.

Early 2014

The 2014 – 15 outbreak of Ebola Virus Disease in West Africa started in the interior of Guinea, West Africa, in December 2013 probably as a result of contacts between a child and a bat. The virus is contagious, spread through contact with people's body fluids. But the outbreak was relatively localised for several months. In May 2014 the President of Guinea visited the World Health Assembly in Geneva. He assessed that relatively few cases had been reported in his country and that the outbreak was under control.

The international NGO Médecins sans Frontières (MSF) was raising the alarm about the outbreak in Guinea in April 2014. It was concerned that local representatives of the World Health Organisation (WHO) were not taking its reports seriously. MSF leaders wondered whether WHO's representatives in the region were influenced by the positions of the national governments who were understandably anxious that this outbreak might have severe economic consequences for their countries.

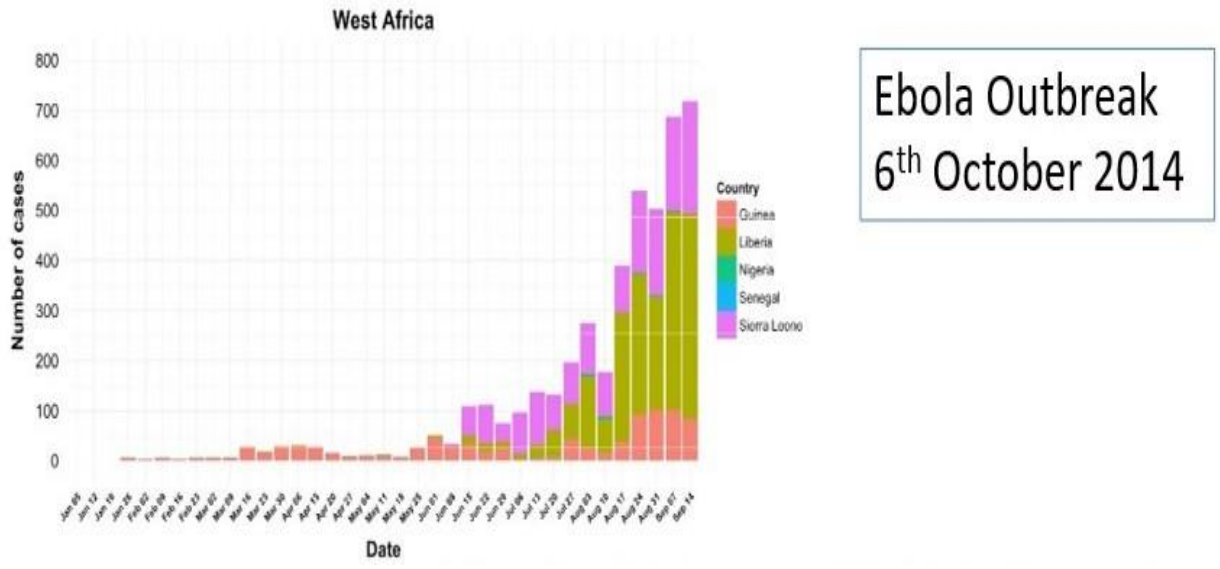

Figure 1: Numbers of people confirmed with Ebola virus disease in 2014 each week, in the different affected countries, up to early October 2014

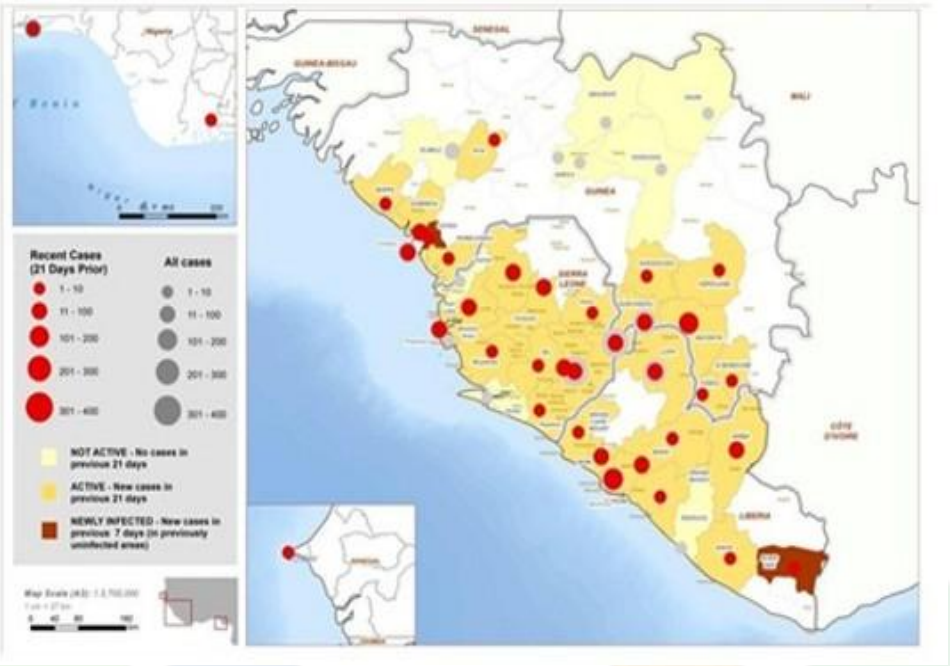

Figure 2: Location of people confirmed with Ebola virus disease in the 21 days up to October 6th, 2014 (red dots)

A worsening situation

During June 2014, reports started to come through that large numbers of people were becoming ill with Ebola in Liberia and Sierra Leone: many of these were health care professionals. Severe illness was spreading in urban areas of all three countries (Guinea, Sierra Leone and Liberia), with numbers of cases doubling in less than a month.

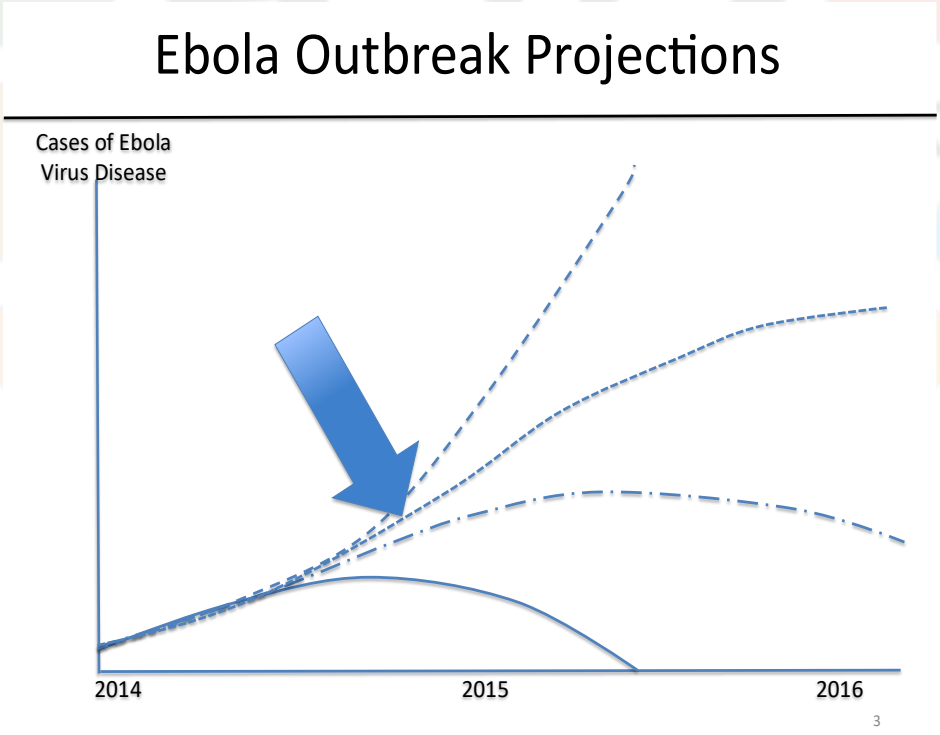

Figure 3: Several projections for the evolution of the outbreak were developed. They implied that it was likely to continue being active into 2015

In July 2014 the disease was being widely reported in all three countries and there was a growing recognition of a severe health care emergency in West Africa. WHO declared that the epidemic was a Global Public Health Emergency (PHEIC). In early August, the Presidents of the three countries concluded that the outbreak was more than a health emergency and had turned into a social, economic and political crisis: they needed much stronger support. They formally asked the UN Secretary-General (UN S-G) to help. After the UN S-G (Ban Ki-moon) had consulted with Margaret Chan, Director General of the WHO, he established a leadership structure which evolved into the UN Emergency Ebola Response. David Nabarro – a medically qualified senior UN official with experience in pandemic planning - was nominated as the UN Secretary-General's Special Envoy responsible for coordinating responses to the outbreaks of during August 2014. Some weeks later, Tony Banbury – who had previously led a UN response mission for the control of Syria's chemical weapons – was appointed to take charge of a special UN Mission for Emergency Ebola Response (UNMEER) that was established by the UN General Assembly to intensify the support provided for responses by national governments.

Responsibilities of the UN Special Envoy for Ebola

David Nabarro's first task was to assemble information about the extent of the challenges posed by the disease and then recommend optimal ways in which the Secretary-General's office could help. This involved making sense of the many different perspectives at the time on what was going on and what needed to be done. David sought efficient ways to listen to these perspectives and make sense of them. These emerged from visits to the affected countries, to WHO, other UN entities, the World Bank, the African Development Bank and African Union, as well as to Washington, Paris, London, Brussels, and (later) Nigeria and Mali. There were also frequent exchanges with country representatives in the UN General Assembly and Security Council. In the early weeks David sought to establish for himself an understanding of the pattern of the outbreak. At the same time, he wanted to be open to multiple points of view in a rapidly evolving situation. That meant moving quickly between having a detailed impression of specific needs and - at the same time - a meaningful big picture of the many outbreaks occurring throughout the region, often doing this several times a day.

Special Envoy's Initial Assessment

The thinking in August 2014 was that multiple outbreaks of Ebola Virus Disease were occurring in three countries with a population of nearly 22 million in an area of around 450,000 sq km (the size of Sweden). The scale of the outbreak was unprecedented with the disease spreading in **urban areas** and **no clarity on the chains of transmission** and **the origins of each person's infection**. Around half those who became ill went on to die: the hospitals and treatment centres in the three affected countries were overloaded and there was increasing concern among the local population that these were not safe places to be. The priority of the response in 2014 was to reduce the mortality rate and slow the rate of spread – ie to bend the outbreak curve – before getting into the more conventional approach to infectious disease control – finding cases, isolating them, tracing contacts and containing surges.

Specific requests from the countries

Access to Treatment: During David's August 2014 visit to the region there were requests from the Presidents for specially constructed Ebola Treatment Centres where the emphasis could be on saving lives, limiting the spread of the virus, and enabling health care workers to stay safe.

Behaviour change to reduce risks: Most importantly, the in-country view was that there should be sharing of up-to-date information, with the local populations, about actions **they** could take to reduce their risks

of being infected. This was a strong position taken by Ellen Sirleaf Johnson, Liberia's president, and she encouraged Members of Parliament from each county to take the initiative. In Liberia, the leader of a long-

term UN Peacekeeping Mission (Dr Karen Landgren) had, since early 2014, been working with the President, engaging at county level, encouraging local leaders to be confident in advocating behaviours that reduce spread of the disease.

Caring for those who die: Facilities to care for people who died were overloaded– and the manner of burial, which involved relatives touching of the bodies of the dead - was quickly found to be a source of explosive increases in case numbers. Ways had to be found to safely dispose of those who died while at the same time respecting the need to say a proper goodbye to the departed soul. One approach, developed locally, involved having a see-through plastic window into each body bag through which the deceased person's face would be visible.

Urgent need to scale up efforts and impact

During August, David worked closely with public health experts from national governments, WHO, UNICEF, and many providers of assistance, together with logistical specialists who were generously made available by the World Food Programme. There was widespread appreciation of the need for a dramatic leap in response capacity throughout the most affected countries because of the exponential increase in the number of cases.

The emerging plan (see figure 4) identified five priorities:

a) Stop the outbreak (through identifying and tracing people with Ebola).
b) Care for people with Ebola and prevent them from infecting others.
c) Ensure the continued functioning of essential health (and other) services for the wider populations.
d) Preserve economic and social stability in the affected countries.
e) Prevent outbreaks from spreading to other countries.

There were 13 mission-critical actions identified through the conversations. These included:

- Identifying and tracing people with Ebola.
- Caring for those who are infected (and infection control).
- Ensuring safe and dignified burials.
- Enabling responders to access essential medical care.
- Ensuring people's food security and good nutrition.
- Enable all to access essential health care.
- Offering cash incentives to essential medical workers.
- Protecting economies and enhancing recovery.
- Ensuring supplies of material and equipment.
- Essential transportation and fuel.
- All-round social mobilization.
- Communication of key messages.
- Enhanced preparedness for future pandemics.

Objectives and Critical Actions

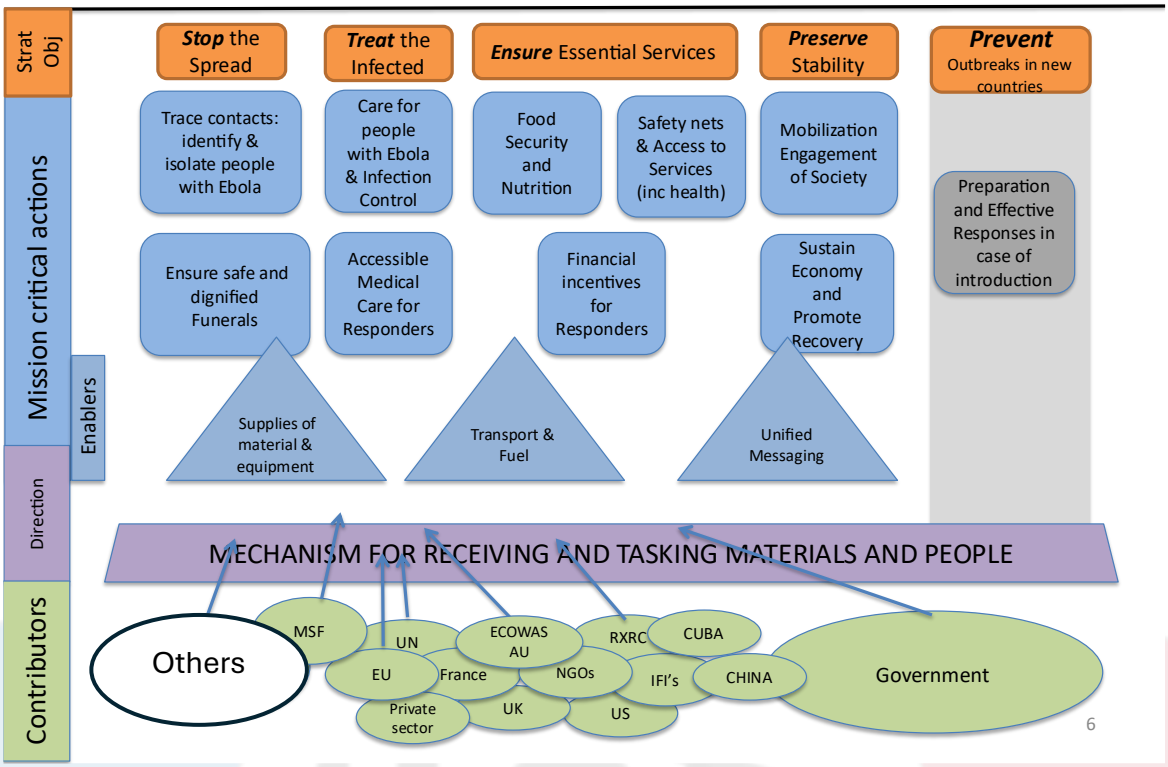

Figure 4: The emerging response plan

To ensure there was adequate response capacity in Ebola-affected countries, attention was given to building in-country platforms to support responses. These platforms were needed to prioritize and facilitate more ambitious action for behaviour change, to increase the number of accessible beds for patient care, and to encourage safe and dignified burials in the event of death.

The emphasis on **behaviour change** called for implementation of massive sensitisation campaigns about the extremely infectious nature of Ebola disease and the benefits of adopting behaviours that reduce intensity of transmission, including the immediate isolation of people who are suspected of having the disease.

More **beds** were needed, so the Presidents requested help with establishing new 50-person Ebola Treatment Centres to be located close to where people lived. In August 2014, the expectation was that to have adequate capacity, at least 20 new Treatment Centres would be needed.

And a programme was established for the safe and dignified **burial** of those who died had to be instituted.

So, the strategy for the early months was focused on **3B's: Beds, Burials and Behaviour change.**

Leaders felt they had been forgotten

The leaders of the three most affected countries contacted the UN S-G seeking support at the end of July 2014. When David Nabarro met with them in August, they all conveyed a sense that their needs had been neglected by the rest of the world. They noted that passenger and freight traffic to the region had greatly reduced (Royal Air Morocco was an exception), personnel from diplomatic missions were seeking to leave, and businesses were scaling back on their ambitions.

From the perspectives of the national leaders, David's main role was to help them access help and make the best use of whatever was available. Several different groups offered to provide support to the Ebola response. These included national governments - the United States of America (USA) stepping up in Liberia, United Kingdom (UK) in Sierra Leone and France in Guinea -, Chinese and Cuban medical teams, teams from the African Union, the Global Outbreak Alert, Action and Response Network (GOARN) and many Non-Governmental Organisations (NGOs) and missionary groups.

Because of the economic impact, the World Bank was involved. The President at the time, Dr Jim Kim, was an infectious disease specialist who became engaged in the effort to accelerate the response. There was strong support from philanthropic groups including the Bill and Melinda Gates Foundation.

The working environment was difficult and stressful. There were reports of response teams being attacked as they sought ways to bring help to some interior villages. From the UN side, the World Food Programme (WFP) provided logistics support for platforms in the form of transportation, construction, warehousing and land- and air-corridors (operating rotary and wing aircraft) between and within countries. The World Food Programme's air transport linking the three countries often encountered challenges: its planes could not land in Senegal until the outbreak appeared to be coming under control.

Aligning all efforts –national Emergency Response cells, local government coordination and UNMEER

In September 2014, the UN General Assembly appreciated the need for a major scale up in the response and established the UN Mission for Emergency Ebola Response (UNMEER) as the first ever *UN-authorised Public Health Mission*. UNMEER offered leadership, high-level coordination, response platforms and senior response officers in each of the affected countries. UNMEER was led by Tony Banbury, Special Representative of the UN S-G, from a base in Accra. The UNMEER strategy was to align the national governments' and UN system's responses to Ebola, to establish national emergency response centres in each country and to increase response capacity in local government areas (Districts in Sierra Leone, Counties in Liberia and Prefectures in Guinea). This form of networked multi-level leadership enabled responders to collaborate and quickly adapt to a shift in the pattern of emerging cases.

UNMEER drew on the WHO 3 Bs strategy for immediate actions to reduce the intensity of the Ebola outbreaks in the affected communities to a stage where chains of transmission could be understood and the disease could be fully contained.

Sharing experience amongst responders: the Global Ebola Response Coalition

Space was needed for dialogue, sharing experiences and encouraging alignment of approach among national government Ebola emergency response teams, government staff, in-country partners, non-governmental organizations, religious groups, businesses, and leaders and teams from UNMEER, WHO and across the UN system. In September 2014, the Special Envoy established a Global Ebola Response Coalition (GERC) designed to enable strategic updates to be shared, and tactical priorities to be discussed. More than 100 responder groups were working in the region: the GERC contributed to their coordination in the face of an outbreak that was advancing in ways that were hard to predict.

The GERC welcomed any responder organization, including those who were not comfortable with the UN's approach. The GERC meetings took place every week (Fridays) with participants speaking in English and French. The utility of the GERC depended on the strong strategic engagement leadership of WHO, UNMEER, UNICEF, WFP, other UN system actors, and the constant engagement of Medecins Sans Frontieres, the Red Cross movement and many other national, regional and international NGOs.

Each meeting started with an update on epidemiology from WHO and concluded with an overview of priorities from David Nabarro as special envoy and the UNMEER leadership. A written note would be circulated within days of the meeting.

The GERC, the national emergency management offices and the coordination capacities at district or county levels, **equipped responders to anticipate and adapt to changes in the pattern of spread.**

Towards the end of 2014, the focus of the response shifted from emergency efforts to take the steam out of the outbreak to a steadier state where there was the capacity to detect new cases, identify contacts, work out chains of transmission and keep a lookout for new surges (as took place in Western Sierra Leone in 2015). Both UNMEER and the GERC focused on coordinating development assistance agencies, philanthropies, and pooled funds were all called on to support different phases of the response. The GERC also offered a space where responder organizations could come together and consider whether they were getting the upper hand in detecting and responding rapidly to new Ebola outbreaks as they appeared. There was plenty of space for national actors whose participation was greatly appreciated: they were valued sources of realism.

Meeting people where they are

It became clear during 2014 that there were high levels of public concern in West Africa about the dangers of Ebola for individuals and societies, and the challenges of ensuring a collaborative response. There were questions in the GERC about how best to do this. UNMEER engaged anthropologists from the region and tasked them to provide advice on optimal ways to engage with local communities. They suggested that personnel should not go to the villages wearing jackets adorned with the logos of different responder organizations and accompanied by military escorts. This meant they were more likely to be targeted. Instead, the connection should be low-key, with a small gift to the local chief and a respectful exchange emphasising that the disease is caused by a pathogen and that the pathogen, not the people themselves, is the problem. In the first encounter, the role of people as partners in the response would be emphasised, and leaders would be invited to suggest how their key role could be enhanced. The role of people as partners in the response was championed by the President of Liberia in August 2014: she requested that any efforts to control quarantined populations should not be accompanied use of lethal force.

A strategic shift from 3 B's to 3 C's

As the outbreaks continued into 2015, and the disease was confined to, and still active in, a smaller number of areas. In other areas the outbreak was quieter but there was still the potential for resurgence. This meant that the strategic focus shifted to **finding Cases** - identifying and acting promptly in case people are suspected of being newly infected, as well as on **tracing Contacts** of anyone who might be newly infected and encouraging greater **Community engagement** in all aspects of prevention, surveillance and response (3 Cs).

The strategic shift was from reducing the intensity and "bending the curve" towards the steps needed to "get to zero", or from the "three B's" to the "three C's".

The variation in the intensity of disease transmission between localities meant that the shift in strategy was advanced locality by locality, with decisions made based on information – sometimes unverified - from multiple sources. Hence experience sharing and coordination were vital.

Different information sharing mechanisms were used to help groups stay aligned and to appreciate whether there was a need for greater emphasis on the C's rather than the B's. The Global Ebola Response Coalition helped all involved to be sure that they were aligned.

There was an upsurge of cases in Western Sierra Leone early in 2015. The GERC enabled the many different responders, each with their own mandates, to coordinate themselves without sensing that they were having to give up power and authority to others.

The outbreaks of disease were concentrated in Guinea, Liberia and Sierra Leone: by the time the Public Health Emergency was declared over in June 2016, more than 28 600 people had been infected, and 11 325 people had died. It had spread to 7 additional countries: Italy, Mali, Nigeria, Senegal, Spain, the United Kingdom, and the United States of America (USA), though did not become established in any of them.

The spread and damage could have been so much worse had there not been a decision to use systems leadership approaches for directing, coordinating and organizing responses to the outbreak.

There were at least five reviews of action and impact after the Ebola outbreaks had subsided in 2016. The initial learning was situation specific though some entities contributed to more generic lesson-learning.

Some reflections

An emphasis on coordination

Because a large number of entities were involved in the response, and these reported to different governments and international organizations, a voluntary co-ordination approach was used. It was light touch. In this situation, co-ordination was provided by the UN system, and it was made possible through David Nabarro and Tony Banbury being given authority to do so the UN Secretary-General. This arrangement for adaptable strategic coordination continued into 2015.

Special envoy's analysis

David Nabarro says: "At the start of this complex assignment I did not know where it would end so I wanted to be sure that however it evolved, we were putting in place ways of working that would be strong enough to last for the duration of the crisis and contribute to an effective response. One of the starting challenges was that different entities, and individuals working for these entities, had very different perceptions of what was going on at any particular point in time, and of what was needed to contain things. Our challenge was to establish conditions in which there was sufficient trust between different entities to encourage them to navigate the differences and sustain the alliance. This meant finding alignment in a rapidly evolving, unstable and undefined environment – it was as much a political as a medical act".

The vital requirements in this response were a **regularly updated strategic direction** that reflected the stage of the outbreak, a **well-understood organizing framework** (the concentration on managing the response in national emergency centres and in local government hubs), and **a "big tent" for enabling all concerned to meet at intervals** – the GERC.

Strategic Direction

For establishing the direction of the response, a meaningful narrative was vital. At the beginning the focus was on reducing the overall load of infection to a point where it was possible to know how each person with Ebola became infected. Then it would be possible to move to the next stage where different chains of transmission were contained, and the outbreak curve could be bent to zero.

Organizing Framework

For the response system, the organizing framework consisted of a) the high-level presence in UNMEER, b) the National emergency response teams – strongly focused on coordination – in each national capital, with a senior officer from UNMEER alongside the national government's incident manager, and c) the local authority-based coordination at District-level. The US was the primary contributor to Liberia; UK was the primary contributor in Sierra Leone and France was the primary contributor in Guinea.

The big tent

The big tent was the GERC which offered opportunities for networked leadership and for encouraging alignment despite the large numbers of entities involved in the response.

It is helpful to establish the equivalent of a big tent in which all are welcome. This is often not done because of a sense that a system for expert command and control is key. The problem then is that whoever establishes the tent likes to limit participation to make the proceedings more manageable.

A big tent helps one work in highly politicised environments and enables one to establish systems for networked leadership and coordination.

Acronyms

GERC	Global Ebola Response Coalition
GOARN	Global Outbreak Alert, Action and Response Network
NGO	Non-Governmental Organization
UK	United Kingdom
UN	United Nations
UN S-G	United Nations Secretary General
UNICEF	United Nations Children's Fund
UNMEER	UN Mission for Emergency Ebola Response
USA	United States of America
WHO	World Health Organization
WFP	World Food Program

References

https://ebolaresponse.un.org/

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