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Governing Ebola: between Global Health and Medical Humanitarianism

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Biography

Sophie Harman is a Reader in International Politics at Queen Mary University of London where she teaches and conducts research into global health, African international politics, and feminist methods. She has published six books in these areas, most notably *Global Health Governance* and *The World Bank and HIV/AIDS*. She is the co-editor of the *Review of International Studies*, co-founder of the British International Studies Association Global Health working group, and is the Chair of the International Studies Association Global Health book prize. She is Visiting Professor at HEARD, University of Kwa-Zulu Natal and founding trustee of the Tanzanian-based NGO *Trans Tanz*. Her first feature film - *Pili* - premiered in competition at the Dinard British Film Festival in 2017 where it was awarded the Hitchcock Public Award. Sophie's previous work on Ebola has focused on gender and women, and civil-military relations.

Clare Wenham is an Assistant Professor in Global health Policy at LSE. Her work for the most part falls in the cross over between global health and international relations, focusing on global health governance, health security, surveillance and infectious disease control. Her recent work has focused on Zika, Ebola, pandemic influenza, and more broadly on the governance structures of the global health landscape and global disease control. Her work has appeared The Lancet, BMJ, Third World Quarterly, Phil Trans B, and Global Health Governance. She previously worked in the Department of Infectious Disease Epidemiology at the London School of Hygiene and Tropical Medicine, working on projects relating to surveillance and transmission of infectious disease. Prior to this she undertook at PhD at the Centre for Health and International Relations at the Centre for Health and International Relations, Aberystwyth University examining the tensions between global disease governance and individual state sovereignty. During this she did a fellowship at the Parliamentary Office of Science and Technology and consulted for the Asian Development Bank. Before her academic career, Clare worked in public health policy roles at the Faculty of Public Health and for an NHS trust.

Abstract

Medical humanitarianism and global health are two distinct but co-dependent spheres of global health security. Global health and medical humanitarian organisations differ in their units of analysis, understanding of neutrality, and organisational capacities. While health underpins some of the hard and soft normative principles of humanitarian action, humanitarian ideas, and notably medical humanitarian organisations, are absent from global health security planning. This article develops the work of Lakoff (2010), clearly outlining the distinction between these two groups of actors and how this distinction had stark consequences in the 2014/15 Ebola outbreak in Guinea, Liberia and Sierra Leone. The Ebola outbreak was framed as a problem of global health but rapidly became a humanitarian crisis. Such a frame excluded medical humanitarian organisations from the initial global strategy and resulted in the creation of a new organisation (UNMEER) and the involvement of militaries to bridge the health-humanitarian divide. The article argues that reconciling the distinct but co-dependent relationship between medical humanitarianism and global health is fundamental to the effective delivery of global health security and pandemic preparedness. The lessons of Ebola can only be met through reconciliation of organizations from these two spheres of global health security.

Key words: global health, Ebola, humanitarianism, medical humanitarian, global health security

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Governing Ebola: between Global Health and Medical Humanitarianism

The 2014-5 outbreak of Ebola in Guinea, Liberia and Sierra Leone brought stark attention to failing emergency response systems, weak and under-funded domestic health infrastructure, and the lack of global political will to act in a timely and effective manner to address the epidemic. Failure to fully respond to the outbreak and prevent the direct death toll rising to 11,325 (CDC, 2016) was for some a consequence of a 'perfect storm' of weak health systems, government corruption, and lack of community engagement (Piot, 2014; Piot Muyembe & Edmunds, 2014; Anderson & Beresford, 2015; Kieny & Doulo, 2015), for others a failed test of pandemic preparedness and global health emergency response mechanisms (Baden et al, 2014; Gostin, Lucey & Phelan, 2014; Martin-Moreno, Ricciardi, Bjegovic-Mikanovic, Maguire & McKee, 2014; Mullan, 2014; The Lancet Infectious Diseases, 2014; The Lancet, 2014), and for Redfield (2015) an example of global health hubris. At the global level, the World Health Organisation (WHO) rapidly became the fall organization for the 'crisis' (McInnes, 2016) that emerged from these failings, receiving criticism for being too slow to act and hesitant in declaring the outbreak a Public Health Emergency of International Concern (PHEIC) (Youde, 2015; Kamradt-Scott, 2016). Several subsequent reports and institutional reflections on 'lessons learned' from Ebola have reviewed preparedness, community engagement, relations between civilian and military actors, finance, scientific research, and the need to invest in health systems of low and middle income countries (Kamradt-Scott, Harman, Wenham & Smith, 2015; WHO, 2015a; Moon et al, 2015; WHO Ebola Team 2016). While such findings will inform new ways of thinking about pandemic preparedness and provision in the short term, we argue that the response to Ebola reveals a more structural tension in the governance of global health security: that between medical humanitarianism and global health, echoing the divide between these two spheres of governance encapsulated in the WHO interim panel on Ebola (2015b).

We make this argument by first outlining what we mean by global health security and the difference between medical humanitarianism and global health. Second, we then explore how the division between medical humanitarianism and global health was evident in the 2014/15 Ebola outbreak response and lessons learned. Third, we draw together the main findings of the paper and articulate how such a distinction helps us understand the Ebola outbreak, global health security and the role of medical humanitarian and global health actors within this. The findings of the paper are drawn from a literature review on Ebola from 2014 – August 2017, policy analysis of WHO and Medécins Sans Frontières (MSF) reports, and semi-structured interviews

with key government, United Nations (UN), military and Non-Governmental Organisation (NGO) representatives involved in the Ebola response in Liberia and Sierra Leone in 2015.

Medical Humanitarianism and Global Health: co-dependency in global health security

Tension within global health security is not new. This paper argues that global health security can be conceived as a governance apparatus conjoining actors, objects, statements and technical devices in a network of expertise in both proactive and reactive activities to minimise vulnerability to acute public health events (WHO, 2007; Weir 2015). Inherent in such an understanding is tension over who provides security, what is deemed a security threat or risk (McInnes & Roemer-Mahler 2017), who is to be protected, and how to manage both proactive and reactive security activity (King, 2002; Fidler, 2005; Hoffman, 2010; Rushton, 2011; Deloffre, 2016). We witnessed these tensions during the Ebola outbreak with regard to the role of security actors, including the military, the use of quarantine and travel restrictions of citizens of the affected states, and who was given what treatment and where. Moreover, after the outbreak the focus has remained on strengthening pandemic preparedness and emergency response rather than investing in health systems and infrastructure.

The prominence of such tension in global health over the role of global health security has led Lakoff (2010, p. 59; 2017, p. 67) to suggest there is a divide in global health between humanitarian biomedicine and global health security. For Lakoff, humanitarian biomedicine is concerned with providing universal access to health for all individuals, prioritising a common humanity, and aims towards 'apolitics' by developing links with non-state actors. The actors Lakoff locates in this space are NGOs and philanthropic organisations such as the Bill and Melinda Gates Foundation (BMGF). In contrast, his vision of global health security is concerned with preparedness and surveillance of infectious diseases, with state-based institutions leading this health activity. His analysis concludes that because of the state centric nature of the global health security framework, the normative underpinnings of health security are inherently focused on self-protection of high income states (Lakoff, 2010, p. 64) in contrast to humanitarian biomedicine where the focus remains on the individual. Whilst this Western bias in global health is not new (Aldis, 2008; Rushton, 2011), during the Ebola outbreak, Lakoff (2015; 2017) argues, the problem shifted from a humanitarian issue to one of global health security, notably when the outbreak first reached Nigeria as a new infected region, and in so doing became a politicised emergency. We agree with Lakoff that there is an inherent tension around global health security and humanitarian biomedicine, and that this played out in the Ebola response. However we differ to Lakoff on where the fault-line between two regimes lies. We see the tension as

occurring *within* the broader framework of global health security between global health and medical humanitarian actors and consider this division as problematic.

Lakoff's depiction of global health security rests on a narrow understanding of security: that it is purely the concern of state-based actors and their self-protection and ignores the wider role medical humanitarian actors have in delivering global health security. On the first point, global health security is more than states protecting their own self-interests. There is an ever growing range of approaches to understanding health security (McInnes & Lee, 2012), including global health security (Rushton, 2011), national health security (Price-Smith, 2001), biosecurity (Enemark, 2016) and human security (Paris, 2001; King & Murray, 2001). Each of these security conceptualisations has a different threat, referent object, securitising actor, and audience. Lakoff's vision of global health security solely portrays an understanding of national health security, and fails to consider other frames of reference contained within health security, such as an individual security concern, as highlighted by the World Health Report focused on security (WHO, 2007), the entrenchment of security from hunger, disease and repression (UNDP, 1994; Paris, 2001) or the shift to global solidarity (Frenk Gomez-Dantes & Moon, 2014). On the second point, actors that Lakoff locates in the area of global health security such as the WHO are prominent in humanitarian biomedicine response, and humanitarian biomedicine actors provide health services in multiple global health security contexts. The WHO has full membership of the UN Inter-Agency Standing Committee for co-ordination of humanitarian activities, and is the predominant health organization in humanitarian responses (IASC, 2015), currently undertaking operations in states currently designated as humanitarian emergencies by United Nations Office for the Coordination of Humanitarian Affairs (OCHA), such as Iraq Syria and Yemen (UNOCHA, 2017). WHO's previous humanitarian work has included safe access to firewood for displaced persons, gender and sexual based violence in camp settings, and concerns of communicable disease in displaced population settings (WHO, 2016a). The prominence of health clusters, is complemented by the presence of water, sanitation and hygiene (WASH) and nutrition clusters as standard elements of a humanitarian response further providing health provision to at-need populations. Not only do Lakoff's global health security actors work in humanitarian biomedicine, similarly humanitarian actors are increasingly active in pandemic preparedness, such as BMGF and Medécins Sans Frontières (MSF) which have had a prominent advocacy role in articulating the needs and calls for wider global health security provision through effective planning, prevention, and timely response (Gates, 2017; Hofman & Au, 2017).

We seek to elaborate on the tension within global health security, between global health referring to those actors working within public health governance, predominantly states and WHO, and

medical humanitarianism, namely NGOs such as MSF and International Committee of the Red Cross (ICRC). Similar to Lakoff's understanding, global (public) health is organised around the unit of the state and recognition of state sovereignty (Lee, 2009; Harman, 2012; Youde, 2012). This includes a state's role in providing health, strengthening health systems, investment in vaccines and research and the state as the object of the security threat posed by infectious disease. Where international-organisations, such as the WHO, are involved in global health they do so with respect to the Westphalian state system as paramount. This contrasts with medical humanitarians working within the wider framework of humanitarian governance including OCHA, the World Food Programme, MSF and ICRC. These actors prioritise the individual, rather than states, as the main unit of analysis (Bradol & Vidal, 2011; Fassin, 2012; Lakoff, 2010; Ticktin 2006), maintain the duty to interfere in states where people are suffering (Brauman, 2012; Fox, 1995), and are principally involved in emergency and crisis response with a specific focus on health delivery.

Actors in global health and medical humanitarianism stress their 'neutral' nature, however neutrality means different things to each sector. For medical humanitarians it means working beyond the conflict and political regimes to offer assistance for the universal individual. This has resulted in direct criticisms of governments for their failures to protect citizens, and even affecting the course of the crisis (Rostis, 2016, p. 70). For global health it means recognising the supreme sovereignty of states and equality between them, such as one-state one-vote at WHO (WHO 1948). The consequence of such positions is that apolitical recognition of sovereignty can restrict the ability of global health actors to respond when states are unable or unwilling to ensure global health security; and medical humanitarians can disrupt diplomacy mechanisms for maintaining health security.

However, such a distinction is not clear cut and both sectors are co-dependent. Global health actors need medical humanitarians to be overtly political and speak out about crises with health externalities, such as in Yemen and Syria, to highlight the scale of the problem, the effects on the population and to mount on the ground response to health and humanitarian concerns. Similarly, medical humanitarians need the WHO, as the 'directing and coordinating authority' in global health (WHO, 1948, p. 2) for technical guidance and diplomatic processes to negotiate aid routes and sources of funding. As such, there is a necessary co-dependency between health and humanitarian organizations in global health security: global health organizations need the on the ground capacity of the medical humanitarian sector to be able to deliver health assistance in times of emergency and humanitarian actors need the global level of state-based diplomacy enacted by global health organizations such as WHO.

What is notable is that where health actors are fully embedded in humanitarian practice, humanitarianism is absent from global health security structures and planning. The WHO's International Health Regulations 2005 (IHR), the global framework developed to prevent and control infectious disease, do not include reference to humanitarianism, clusters or OCHA. Moreover, the criteria for realising and designating a PHEIC, does not mention the broader humanitarian aspects of any particular outbreak (WHO, 2005). The PHEIC process involves the summoning of an emergency committee by the Director General of the WHO, comprised of public health professionals who specialise in the particular pathogen. However, given health underpins medical humanitarianism, and medical humanitarianism is central to the delivery of health security, we propose that Lakoff's division of global health security and humanitarian biomedicine are not two distinct regimes, but are part of the wider framework of global health security. As Nunes (2017) argues, actors such as MSF need to reconcile their self-perception as not involved with global health security with the reality that global health security frames the environment in which they operate. At the same time global health actors need to recognise the vital role medical humanitarians have in the delivery of emergency responses as part of ensuring global health security and to include them in governance structures. This fault-line in global health security between global health and medical humanitarianism is more than an academic argument, but as we show in the case of Ebola, has a direct impact on the response to disease outbreaks.

Ebola: from global health problem to humanitarian crisis

Ebola was a global health problem that became a humanitarian crisis. As this section demonstrates this was a core problem in the ensuing response. We argue that initially framing Ebola as a health problem led to an understanding that global health organizations such as the WHO and national health authorities would lead the response. However when it became clear that global health actors were overwhelmed by Ebola both in the scale and the challenges of working with systemic weakness in West Africa, this health frame limited the inclusion of humanitarian organizations in response planning and strategy. As a consequence whilst Ebola became a health-humanitarian crisis, the established practices for humanitarian activities were not triggered and the result was a fudged response through the creation of a new UN agency to manage the outbreak, the United Nations Mission for Ebola Emergency Response (UNMEER) and the deployment of international militaries.

As Calhoun (2015) and Mamdani (2007) argue, how a crisis is named has implications for how that crisis is responded to. For Calhoun (2015), the construction of a humanitarian issue as an

'emergency imaginary' facilitates moral imperative to act. The way in which the emergency is constructed as an exceptional issue dictates how that emergency is addressed. Calhoun's arguments have significant resonance with the response to Ebola. There have been more than twenty five outbreaks of Ebola in the last 50 years, and each has been effectively contained by rapid public health responses championed by global health. As such, an Ebola outbreak is seen as something that can be responded to quickly and effectively at the local level, using infection control protocols and by following guidance from the IHR (2005).

The first wave of the outbreak of Ebola in Guinea followed standard global health procedures, with the Health Ministry notifying WHO of an unusual health event (WHO, 2014c) and WHO deploying technical support to assist the national response. Similar to public health responses to SARS (2002-3), H1N1 (2009) and MERS-CoV (2012-3), WHO championed a response that focused on contact tracing, monitoring cases and global vigilance for new infection. Health authorities considered that the outbreak would behave with similar characteristics to previous Ebola health events and therefore could be readily controlled (Baden et al, 2014). Meanwhile, it was the medical humanitarian MSF, and later Save the Children, who were providing on the ground clinical support to domestic health systems in the initial response to the outbreak. This was not unusual, and nor does it negate the initial global health framing of the outbreak. MSF has a history of providing localised medical care in outbreaks of Ebola, due to its technical expertise, flexible financing, preparedness and capacity to respond to an outbreak rapidly which global health actors do not possess (Pagano & Poncin, 2016; MSF, 2015). Yet, medical humanitarians maintained no role in strategizing or coordinating the response at a national or international level, deferring this to national authorities and the WHO which continued to promote the global health framing of the outbreak (Pagano & Poncin, 2016, p. 42). Accordingly, from the outset the strategy for Ebola was positioned within the global health discourse, yet it was medical humanitarian organizations providing the majority of the direct response assistance to the affected populations.

The global health framework, beholden to states, overlooked several factors which contributed to the 'perfect storm' (Piot, 2014) and second wave of the Ebola outbreak. Despite the global health community's championing of pandemic preparedness, due to health sector mismanagement and years of political neglect in West Africa (Anderson & Beresford, 2016), it is estimated that it took at least three months for the Ebola outbreak to be detected by health authorities within Guinea (Baize et al., 2014). This was compounded by global health actors beginning to withdraw from the crisis in May 2014, examining declining numbers and remaining over confident in their standard global health procedures, negligent of the implications of

conducting epidemiological analysis amid weak health systems (Sack, Fink, Bullubk, Nossiter, 2014). These actors also failed to consider medical humanitarian experience of working in areas with poor attendance at medical facilities, poor data collection and logistical challenges of sharing timely information on disease cases and what this might mean for disease transmission.

National governments further championed the global health framing of the response, relying solely on WHO reports of case numbers and condemning the medical humanitarian field as scaremongering about the potential magnitude and ongoing transmission of the disease (Pagano & Poncin, 2016, p. 39; MSF, 2015). This arguably created further distance between the global health and medical humanitarian actors and delayed detection of the second wave of the outbreak, meaning that standard public health responses were on the back-foot and soon overwhelmed by the scale of the problem. By June 2014, MSF declared the outbreak to be 'out of control' (MSF, 2014) and repeated their requests for the WHO to do more and to take the lead in the response (WHO, 2015). The WHO upgraded the concern posed by Ebola to a Grade 3 Emergency, but it took two additional months for the organisation to declare a PHEIC on 8th August 2014 (WHO, 2014b). By the end of September 2014 the scale of the outbreak had reached an acute crisis point, with 1,711 cases and 932 deaths making it the largest Ebola outbreak ever recorded (WHO, 2014b).

The humanitarian considerations of the outbreak were first publicly stated by MSF's President Joanne Liu's special briefing to the UN Security Council on 2nd September 2014, raising wider concerns of crumbling health systems, transnational crisis with social, economic and security implications at the African and global levels (MSF, 2014b). Liu's speech attracted worldwide attention for stressing the humanitarian crisis that was unfolding, moving the dialogue on from a health frame, and, controversially given MSF's historical opposition to military collaboration, calling for Western military resources in the fight against the disease. The notion that desperate times required desperate measures highlighted that Ebola was no longer just a health issue to be managed by health organisations but had developed into a humanitarian crisis that required a broader, more comprehensive response including humanitarian organisations and militaries.

The framing of Ebola as a global health crisis had three important consequences for the response. First, the health frame created a narrow path dependency in which the central decision makers of the response would be health organizations – the WHO at the global level and health ministries at the domestic level – the latter with limited experience of managing outbreaks and humanitarian crises. Further, the health frame meant the emergency would only be labelled as such once global health actors declared it to be so, through the declaration of a PHEIC. The

result of which was each health actor could deflect blame to the at-best overwhelmed and at-worse delayed and ill-functioning health sectors (Wenham, 2016). It also provided justification for some humanitarian actors to remove operations from the affected countries altogether, suggesting they lacked sufficiently trained staff to work in response to a haemorrhagic fever and as a health crisis, this went beyond their usual sphere of humanitarian work (Kamradt-Scott et al, 2015, p. 8). Moreover, those humanitarian actors which were still in the region struggled to get staff to deploy to the Ebola response 'we had people lining up to get shot at in Syria, but we couldn't get anyone to come to West Africa' (Interview A, 2015).

The second consequence of the health label was that even when it became apparent that the health sector was overwhelmed both domestically and internationally, the global health frame perpetuated and did not trigger established systems of humanitarian crisis management such as the global health cluster previously seen in a variety of natural disasters (such as the 2005 earthquake in Pakistan) and concurrently to the Ebola outbreak in the OCHA labelled humanitarian crises in Syria, Iraq, South Sudan and Yemen (2016). Instead, it became apparent that global health is organised around the premise of surveillance and prevention of an outbreak, and lacks the necessary *response* mechanisms for a large scale outbreak. The international community multilaterally sought to bridge the gap between the global health and medical humanitarian sectors through the formation of a new, Ebola-specific mechanism, UNMEER, led by the United Nations Security Council Resolution 2177 that expressly considered the humanitarian concerns of the outbreak and response (UNSC, 2014), and bilaterally through the deployment of foreign militaries.

The establishment of UNMEER on 19th September 2014 was the first time that there had been a UN body dedicated to a public health emergency. UNMEER's mandate was to co-ordinate the UN response to Ebola and its strategy followed the global health trajectory of framing Ebola as a health concern (Deloffre, 2016) with added humanitarian elements. UNMEER's 30-60-90 day strategy for containing the outbreak highlighted the public health approach through a 4-pillar framework revolving around: a) case management and case finding, b) laboratory and contact tracing, c) safe and dignified burials, and d) community engagement and social mobilisation (UNMEER, 2014).

UNMEER's health-focused 4 pillar approach created confusion among the international response. It ignored a number of wider socio-economic consequences of the outbreak, such as the impact on food security, emergency shelter, education, women and protection for survivors which would have been expected in an OCHA cluster approach from previous humanitarian

activities (Kahn, 2015). Concerns were even raised regarding the failure of the health framed UNMEER pillars to address public health consequences of the outbreak, for example the shifting of resources away from other prescient concerns such as maternal and newborn healthcare (Menendez, Lucas, Munguambe & Langer., 2015; Sochas, Channon, & Nam 2017). Practically, the 4 pillar approach was also at odds with the 6 pillar medical humanitarianism approach adopted by MSF in previous Ebola outbreaks, and the OCHA-led cluster approach (Vetter et al, 2016). As was observed by those involved in the response, these pillars created considerable confusion amongst the actors implicated (Interview B, 2015).

The UNMEER debacle and quagmire between the pillar and cluster approaches demonstrates how the health framing of Ebola impacted on how the response was addressed even after the humanitarian impacts of the epidemic were voiced. Yet, a representative of UNMEER (Interview C, 2015) suggested that the cluster approach could not have been used in the Ebola response, as UN protocol dictates that such a system be initiated in states with poor to no infrastructure. Ironically, it was the poor to no infrastructure in the region which fooled the global health responders to consider the dwindling case numbers during the first wave of Ebola in April 2014 as representative of the end of the outbreak (Sack et al., 2014), and thus these clusters could have been justifiably implemented. Nevertheless, for many involved in the response, the pillar approach was representative of wider issues with UNMEER and the sense that the severity and humanitarian aspects of Ebola had not been acknowledged thus far and a more scaled up and experienced response from OCHA was required, rather than creating a parallel agency (Interview D, 2015). However, as this outbreak was framed as a global health emergency, the decision to mobilise OCHA was realised too late.

The third consequence of framing Ebola as a global health issue and the inability to draw on the strengths of both sectors within the UN system led to the international community and affected states to draw on alternative crisis responders: the military. Foreign militaries came from the African Union, China, France, Germany, the United States (Operation United Assistance, Liberia), United Kingdom, Canada and Ireland (Operation Gritrock, Sierra Leone) (Benton, 2017). This suggests that these states had already understood that the health centred response to this outbreak was insufficient. In Sierra Leone, Operation Gritrock operated alongside the Republic of Sierra Leone Armed Forces (RSLAF) who had taken over leadership of the domestic response to the crisis after several failings in the Ministry of Health and Sanitation. The involvement of the military has been controversial for some, and a much-needed game changer in the response for others (Kamradt-Scott et al., 2015). What is notable here is how the military's intervention was framed. Many on the ground expected the military, as a state institution, to

perpetuate the global health framing of the outbreak, and to launch the medical corps and biohazard teams in an effort to bring direct clinical assistance to the response as a public health emergency (Heller-Perache, 2015). However, in many respects the military responded to Ebola based on a humanitarian model of logistics, command and control, and engineering. For example, the UK operation did not provide direct patient care to the infected communities as expected (but specifically to healthcare workers and international staff (UK Government, 2014)), but assisted more broadly with the building of Ebola Treatment Units, logistical capacity for quarantine and supporting infection control. Of concern, these foreign militaries were in many ways risk averse, evidenced by being confined to barracks, the US military's refusal to airlift Ebola patients and the alleged 'no touch care' policy of the UK military. Indeed, there was a mis-match in what was expected – health assistance to match the established global health frame - and what was delivered – technical support and coordination for humanitarian assistance (Kamradt-Scott et al., 2015; Benton, 2017).

However, instead of this health-caused humanitarian crisis provoking a need to rethink the relationship between these spheres of governance, the Ebola outbreak has widened the gap, as the medical humanitarian field became acutely aware of the failings of global health organizations. MSF were particularly critical of the WHO as the lead institution, through its delay and inactivity when the outbreak could have been contained (Heller-Perache, 2015). From the global health side, the WHO has continued to not engage humanitarian organisations in the subsequent PHEIC - Zika-related microcephaly - despite the apparent linkages between poverty and the incidence of the virus and its associated neonatal complications (Yamin, 2016). If anything, the gap has widened between the global health and medical humanitarian fields, with some in the humanitarian community conceptualising global health as a failed governance structure, in need of significant reform (MSF, 2015).

Just as the humanitarian sector had Darfur and the Asian Tsunami to act as catalysts for change (culminating in the Humanitarian Response Review), Ebola may provide the defining moment for global health organizations to address weaknesses and reform governance structures. In response to the criticisms made by medical humanitarian actors (and others), global health actors have responded with new mechanisms such as the WHO's Health Emergencies Programme (HEP) (WHO, 2016c) and the global public-private partnership Coalition for Epidemic Preparedness (CEP1, 2017). However, instead of focusing on coordinating or strengthening the actors which already exist, or a concerted effort to improve deployable response mechanisms, or increased engagement with the medical humanitarian sector, these responses have create more global health framed structures. For example, the aim of the HEP is to streamline WHO's

response to infectious disease outbreaks through 'one workforce, one budget, one set of rules and processes and one clear line of authority' (WHO, 2016c). Whilst WHO should be commended for listening to the criticisms it faced during Ebola and seeking to address its failures, much of what is proposed in this new programme exists already within Global Outbreak Alert and Response Network (GOARN) and the broader WHO framework. The creation of the HEP further reflects the tendency of global health to create new actors that replicate the mandate and work of other institutions (for example UNAIDS and the WHO, IAVI and GAVI) (Harman, 2012), rather than directly addressing institutional limitations or organisational problems.

Further, the language used to develop this new programme continues to focus on the global health framing. Although this programme notionally puts together health emergencies (Ebola, Zika, Yellow Fever) and emergencies with health concerns (Haiti, South Sudan, Yemen, Syria), there appears little connection between the two conceptually different emergencies, or WHO's response to each. One area in this programme where convergence between the two governance structures may appear is through WHO's commitment to 'a fundamental change' offering 'new operational capacities' alongside the technical and preparedness (WHO 2016d), a significant departure for a normative and technical organisation (McInnes, 2015). However the WHO has been clear to state that this will focus on 'early recovery', echoing Lakoff's suggestion of global health's focus on prevention and surveillance, rather than sustainable response mechanisms of the medical humanitarian sector, and therefore does not represent a change from the current global health mechanism which failed to ensure global health security during Ebola (WHO, 2016d). Some consideration has been given to the role that OCHA could play in integrating response mechanisms for large scale infectious crises (WHO, 2016c), but to date this has not been manifest, and the continuation of the single health frame has perpetuated. As such, the creation of HEP adds another layer of confusion to the governance of infectious disease and further fails to address the fundamental divide which exists between global health and medical humanitarian organizations.

Countering the global health-medical humanitarian divide

The framing of the Ebola outbreak as a global health issue created a problematic trajectory that placed responsibility to respond in the hands of overwhelmed and possibly negligent national and global health authorities too focused on preparedness and prevention and simultaneously unable to enact formal humanitarian protocols for crisis management. Ebola fell between the cracks of a crisis labelled and strategized as a health emergency that required the type of action

seen in standard humanitarian response mechanisms. The inability to fully address Ebola as a health-related humanitarian crisis resulted in confused structures of co-ordination, a mis-match between expectations and delivery, an ill-equipped ad hoc institutional solution (UNMEER), and the deployment of actors of last resort – the military. What is particularly curious about the response to Ebola is how the global health label excluded medical humanitarianism, despite these actors being on the ground providing direct patient care from the very start of the known outbreak.

It is important to note three potential counter-factual arguments to what we outline here. The first is that the 2014/15 Ebola outbreak was an exceptional result of a 'perfect storm' of factors and had the outbreak behaved as expected, there would never have been a humanitarian crisis, hence the need for inclusion of humanitarian organisations may be over-stated (Piot, 2014). Ebola outbreaks are not rare, but crises are. However, what is not rare is the role of medical humanitarian organisations working in states where Ebola outbreaks happen or their involvement in responding to such outbreaks. As global health organisations do not have the same deployment capacity as humanitarian responders, it is imperative that the pre-existing or potential role of medical humanitarian organisations are not overlooked by global health governance structures should disease outbreaks develop.

Second, a further problem with the Ebola response was the world getting the lead global health actor (WHO) that it pays for (Clift, 2016). As a membership organisation, the WHO can only act on behalf of its member states. As such, political decisions such as the socio-economic impact of announcing a PHEIC, were taken into account by the global health frame (Cheng & Satter, 2015), rather than necessary simply considering the 'best' public health response. Furthermore, the WHO is reliant on its member states (and others) for financing its work, and has suffered significant budget reductions to emergency activities in recent years. The budget for responding to outbreaks was reduced from $469M in 2012-3 to $228 in 2014-5 (The Lancet, 2014). It can be hardly surprising that the global health frame, led by an under-resourced and politically compromised actor, was unable to achieve what the global community expected of it in time of crisis.

The third counter-argument is what the response would have looked like had medical humanitarian actors been considered at global levels of decision-making from the start. Without the global health frame and protocols such as the IHR (2005) in place, detection of the outbreak may have been even further delayed with states having no obligation to tell the global community about the disease, risking trade disruption. If a medical humanitarian frame had been

employed entirely, states may have relied on the provision of healthcare of these humanitarian actors, and not have taken agency in the response themselves. Aid dependency continues to be a problem in the health sector in West-Africa (Benton & Dionne, 2015), and this outbreak may have proved no exception, furthering the reliance upon non-state actors in health. As suggested, the medical humanitarianism community needs the global health system for diplomatic efforts and to generate resources for interventions. In contrast to other humanitarian crises in 2014/15, the health frame potentially provided the opportunity to capture the world's 'emergency imaginary' (Calhoun, 2015) in a different, and subsequently, urgent way. Without this high level conceptualisation of the outbreak as an 'emergency', it is possible that the medical humanitarian community would not have received the same public and financial support to manage the outbreak.

Only a joined up approach incorporating both health and humanitarian organizations presents the best chance of success for future pandemic planning and response. Lack of funding to the WHO as a lead organization in global health should be a reason for *further* integration and collaboration with the medical humanitarian sector not justification for extra funds to replicate the work of the humanitarian sector. Failure to acknowledge the co-dependence of such governance structures resulted in problematic, fudged response to a disease outbreak through the creation of new organisations (UNMEER) and actors of last resort (militaries).

Conclusion

The 2014/15 Ebola outbreak exemplified the wider dysfunction in the provision of global health security: delayed response, lack of clear accountability, and a myriad of actors with no clear role or leadership. This has resulted in initiatives to bring better functionality into global health security such as the HEP. However, in many respects the actors involved in the Ebola response functioned as per their mandate. This article has developed Lakoff's division of two regimes of global health to show that a substantive problem with the response to Ebola was the co-dependent but distinct relationship between medical humanitarianism and global health actors within the shared field of global health security. In so doing, the article offers three central points in conclusion. First, global health security is not just about pandemic preparedness and planning located within WHO. Global health security is concerned with both prevention and delivery. Medical humanitarian actors do not operate outside of this field, but as the Ebola response demonstrates, are deeply embedded in the delivery of global health security. In addition global health actors should be more aware of their reliance upon the core functions medical humanitarians provide during crises. Global health security is political and both global health and

medical humanitarian actors are political agents within this discourse, albeit with differing capabilities and interests. Such differing political agency and the role of such agency should be recognised by the actors themselves to deliver more effectively on global health security. While the Ebola response shows a distinction between these two fields, recognition that both sectors are united in the provision of global health security is crucial to future planning and ensuring global health security. Second, and relatedly, medical humanitarian and global health actors are distinct but co-dependent but this distinction is not fixed. Individuals working in global health organisations may have personal values that align with medical humanitarian ideals and want their institution to draw more on medical humanitarian practices and vice versa, but recognise the institutional limitations in which they work. Such shared ideas of individuals within these sectors are an opportunity for narrowing the gap between the two, particularly around the common intent of providing global health security. Moreover, events such as the Ebola outbreak can be seen as points of rupture in each sector's institutional development and offer space for reflection on institutional values and mandate. Finally, the Ebola response exposes the functionalities of global health and medical humanitarianism rather than the dysfunction of global health security alone. It is without question that clear mistakes were made at multiple levels of governance leading to the devastating events of 2014/15. However future preparedness and response will not be met by creating another mechanism for the provision of global health security. This will just add further division between global health and medical humanitarianism and ultimately undermine the common space of global health security in which these actors operate.

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