The Real Versus the Ideal in NGO Governance: Enacting the Right to Mental Healthcare in Liberia During the 2014-2016 Ebola Epidemic

Hunter Keys, Bonnie Kaiser, André den Exter[*]

Abstract

Increasingly, transnational Non-Governmental Organizations (NGOs) figure heavily among the institutions and actors that constitute humanitarian governance during disease outbreaks. However, while NGOs may "self-task" in their work to provide healthcare, they are not the original subjects of international legal frameworks on the right to health. One argument to strengthen accountability of NGOs is to evaluate their operational activities against the rubric of consensus guidelines for humanitarian non-state actors. Examining on-the-ground, contextual pressures felt by NGOs alongside principles charted out in guidelines exposes unresolved challenges in relying on an "ideal" framework to evaluate "real-world" dilemmas. This contribution begins by discussing the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Humanitarian Settings, which contain core principles for NGOs and others to follow. After tracing the development of the IASC Guidelines back to right-to-health norms found in international legal instruments, the discussion considers the Liberian context by reviewing the country's history and health policies, with attention focused on the National Mental Health Policy. This section draws on findings from interviews with key informants at an NGO that assisted the Liberian Ministry of Health to develop and implement the policy. This is followed by a case study of the contextual challenges faced

---

* *Hunter Keys* is a PhD candidate in anthropology at the University of Amsterdam, the Netherlands and is supported by the Netherlands Organization for Scientific Research. *Bonnie Kaiser* is a postdoctoral researcher at Duke University, Durham, USA. *André den Exter* is lecturer in health law at Erasmus University, Rotterdam, the Netherlands. The authors thank the key informants for their time in granting interviews to share their experiences and perspectives on mental health in Liberia as well as offer feedback on earlier versions of this contribution. The authors also thank the editors for their time in reviewing this contribution as well. All websites last accessed January 14, 2017.

by an NGO in Liberia during the 2014-2016 West Africa Ebola epidemic. This vignette provides a springboard for arguing that the IASC Guidelines, while extremely useful in their operationalization of ideals and rights norms, only go so far when applied in practice. Given that NGOs must bend and adapt to contextual pressures, accountability approaches must recognize the need for flexibility in addition to a grounding in rights norms.

I Introduction

Governance, the traditional province of states, has been partly reconfigured by non-states, the NGOs whom nobody elects but through whom lives are saved.[1] The entry of NGOs into the "humanitarian space" has sharpened the moral and political contours of providing aid and to whom: moral in the sense of "doing good" and political by way of delivering care to a hierarchy of victims.[2] Even as NGOs have helped carve out the moral and political dimensions of humanitarian governance, their relationship – as non-state actors – to legal frameworks on the right to health has remained largely undefined.

In fact, this murky relationship between humanitarian NGOs and international legal frameworks points to a core dilemma within the legal analysis of global authority structures and their publics: within the realm of global

1 Barnett, M, "Humanitarian governance" (2013), 16 *Annual Review of Political Science*, 379 (379). In reference to the term "global governance", this contribution draws chiefly on the ideas proposed by *Barnett*, in that the "international humanitarian order, [or] the self-conscious effort by the global community to relieve the suffering of distant strangers" (380) has to a large degree become "legitimated and organized in and around international institutions, norms, and laws, and undertaken in the name of compassion, care, and responsibility" (380). In this contribution, this conceptual framing of governance is limited to the interactions of NGOs (non-state actors), state institutions such as Ministries of Health, and individuals, including expatriate humanitarian aid workers and local community members on-the-ground during both an "inter-crisis" or rehabilitation period, as well as amidst the Ebola outbreak. Of interest in this contribution are the power dynamics among these various actors and the discrepancies that arise between ideal norms as envisaged by guidelines or rights frameworks and complex real-world dilemmas that embroil and implicate such a governance structure.

2 Fassin, D, *Humanitarian Reason: a Moral History of the Present*, 2012; see also Ticktin, M, "Transnational humanitarianism" (2014), 43 *Annual Review of Anthropology*, 273.

governance, what acts, and by whom, should be the focus of *legal* discourse? How may such acts acquire legitimacy? Global health governance in particular involves complex linkages among states, the private sector, and hybrid bodies such as International Organizations like the World Bank[3] – in sum, a constellation of actors and institutions that "escape the grasp of established legal concepts".[4] Legal scholars have recently developed the analytical concept of *the exercise of international public authority* to circumscribe the activities of any institution, administration, state, or non-state actor that *determines* others, that "unilaterally shape[s] their legal or factual situation"[5] in regards to a *public interest*.[6] In this vein, humanitarian NGOs qualify as international public authorities through, first, their engagement in civil society writ large,[7] but also through such programmatic activities as generating and disseminating information about a given crisis through reports, media profiles, and statistics; fundraising and delivery of material goods and human resources; or producing standardized guidelines and instruments for decision-making – all in the public interest of curbing the toll of disease, delivering aid, or promoting human rights.

Qualified as international public authorities, NGOs serve the interests of broad publics: "on-the-ground" beneficiaries as well as donors, political stakeholders, and policymakers. The expertise that underlies these activities further bolsters their "self-legitimacy"[8] on the international scene, yet no international legal framework formally contains them.[9] Indeed, international legal instruments[10] and dozens of national constitutional

---

3 Hein, W & Kohlmorgen, L, "Global health governance" (2008), 8 *Global Social Policy*, 80.

4 Bogdandy, A von, Dann, P & Goldmann, M, "Developing the Publicness of Public International Law: Towards a Legal Framework for Global Governance Activities" in Bogdandy, A von, Wolfrum, R & Bernstorff, J von et al. (eds.), *The Exercise of Public Authority by International Institutions*, 2010, 7.

5 Ibid., 11.

6 Bogdandy, A von, Goldmann, M & Venzke, I, "From Public International to International Public Law: Translating World Public Opinion into International Public Authority", *European Journal of International Law* (in press).

7 Ryfman, P, "Non-governmental organizations: an indispensable player of humanitarian aid" (2007), 89 *International Review of the Red Cross*, 21.

8 Ibid., 34.

9 Ibid.

10 International Covenant on Economic, Social, and Cultural Rights (ICESCR), 1976, available at http://bit.ly/J1E1V3. This article is devoted almost exclusively on a specific set of guidelines intended for humanitarian NGOs and foregoes in-depth discussion of the legal basis for the right to health. For further reading on

measures[11] stipulating the right to health all pertain to responsibilities of states – and even then, the "soft law" of these legal instruments is essentially unenforceable through any institutionalized process.[12]

Nonetheless, despite the lack of specific international legal frameworks to address the role of NGOs in emergencies, what have emerged in recent decades are consensus guidelines, which are often rooted in right-to-health norms that arose in response to health disparities and unequal access to care. In effect, non-binding standards[13] like operational guidelines can further buttress the exercise of international public authorities like NGOs, since "the benefits of observing them outweighs the disadvantages of ignoring them".[14] In the absence of formal legal frameworks, consensus guidelines for NGOs may serve as a critical link between ideal principles and real-world contexts, perhaps going further to function as an accountability mechanism.

This contribution uses the example of the 2014-2016 West Africa Ebola epidemic to contrast ideal principles enumerated in NGO guidelines with the real-world contexts in which they are implemented. Section II provides a concrete example of ideal principles by reviewing the Inter-Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Humanitarian Settings (hereafter, "the IASC Guidelines").[15] The IASC Guidelines (2007) were developed within the UN system by partnering NGOs and research institutions. On the one hand, they represent a tremendous political feat in outlining agreed-upon principles; on the other, they emanate from spheres of power and influence that can be far removed from the humanitarian contexts in which they are intended, leading to operational challenges and ethical tensions.

To illustrate these points, Section III reviews the historical context of Liberia, with attention on the role of both state and non-state actors working on the right to mental healthcare in the years before the epidemic. Drawing

---

the international legal basis for the right to health, see the contribution of *A. Katarina Weilert*, "The Right to Health in International Law – Normative Foundations and Doctrinal Flaws" in this volume.

11 Backman, G, Hunt, P & Khosla, R et al., "Health systems and the right to health: an assessment of 194 countries" (2008), 372 *Lancet*, 2047.

12 Hein & Kohlmorgen, "Global health governance", above Fn. 3.

13 Bogdandy, Dann & Goldmann, "Developing the Publicness of Public International Law", above Fn. 4, 12.

14 Ibid.

15 Inter-Agency Standing Committee (IASC), *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007.

on interview data obtained from two key informants at an NGO that assisted the Liberian Ministry of Health,[16] Section III recalls important Liberian health policy achievements, notably the National Mental Health Policy, and then moves into a case study of *Global Care* (pseudonym), an NGO that recruited and sent expatriate clinicians to Liberia during the Ebola response. The case study of Global Care is based on the experiences and observations of the lead author, a clinician who worked for Global Care in early 2015 to help strengthen mental health and psychosocial care services in a remote area of Liberia.[17] The case study provides a snapshot of challenges in applying ideal principles in a given context.

Bearing the case study in mind, Section IV reconsiders ideal principles as an accountability mechanism for real-world dilemmas. While guidelines can provide useful evaluative criteria for NGOs, the more fundamental question rests on whether such guidelines are even appropriate as an accountability mechanism, given the challenging and conflicting circumstances encountered on the ground. Section IV returns to the concept of NGOs as international public authorities, serving the health interests of a population but acting outside traditional right-to-health legal frameworks. While it is tempting to substitute guidelines in the place of those frameworks, it must be recalled that guidelines do not (or cannot) account for the dynamic, day-to-day realities of a given crisis, its geopolitical and cultural setting, and the constraints faced by NGOs and their publics. While praiseworthy for their efforts to steer NGOs towards an ethical praxis of the right

16 In 2016, the lead author conducted three semi-structured interviews by telephone, each lasting approximately one hour, with two key informants at a well-known NGO that assisted the Liberian Ministry of Health to develop and implement the National Mental Health Policy before and during the Ebola outbreak. In their various roles, these informants worked closely with high-level executives within the Liberian Ministry, served in country-level leadership positions, undertook community-level research and anti-stigma campaigns, and/or worked with community leaders, clinicians, and practitioners as they developed the policy and responded to the outbreak. Hereafter, citations from these interviews will reference each informant sequentially as "Key informant 1 [or 2], NGO, 2016."

17 There is a debate in the global mental health discipline concerning appropriate terminology. It is beyond the scope of this article to address these issues, but for this discussion, the general phrase "mental health and psychosocial care" will be used to reference the broad realm of human experience that considers mental health, interpersonal relationships, human functioning, and ability to cope with stress in a given social and cultural context. For further reading, see Patel, V, Minas, H & Cohen, A et al. (eds.), *Global Mental Health: Principles and Practice*, 2014.

to health, operational guidelines should not be held as a gold standard. In Section V, we describe how modes of accountability for NGOs must leave enough space for contextual bending but keep a firm grounding on right-to-health norms.

II IASC Guidelines and Mental Health in Humanitarian Emergencies

A useful starting point is to review how the humanitarian sector took up the goal of standardizing the psychosocial response to emergencies. Mental health effects of war and disasters had long been acknowledged among public health practitioners.[18] Interventions followed the premise that repairs to the "social fabric" were necessary for collective healing in the aftermath of disasters.[19] This trend reflects how human rights and mental health became increasingly inter-connected in spheres of NGO policy and practice. For example, in the aftermath of Liberia's devastating civil wars, the Carter Center, a non-profit NGO, partnered with the Liberian government to implement an access-to-justice program for war-affected communities and victims of atrocities.[20] The networks and institutional trust that emerged from this program contributed to the country's National Mental Health Policy. Additionally, the policy includes a sub-section on the rights of persons with mental illness and the need for consistency with international human rights norms.[21] Thus, the push for psychosocial and mental health care in contexts of widespread human rights violations became a means of restoring and strengthening a human rights platform in affected communities. Human rights and mental health became understood as fundamentally inextricable from each other: rights violations harm mental health, and mental health is requisite to enjoy other human rights.[22]

---

18 Mollica, R, Lopes Cardozo, B & Osofsky, H J et al., "Mental health in complex emergencies" (2004), 364 *Lancet*, 2058.

19 Abramowitz, S & Kleinman, A, "Humanitarian intervention and cultural translation: a review of the IASC guidelines on Mental Health and Psychosocial Support in Emergency Settings" (2008), 6 *Intervention*, 219 (220).

20 The Carter Center, *Where We Work: Liberia*, available at https://www.cartercenter.org/countries/liberia.html.

21 Republic of Liberia, *National Mental Health Policy*, 2009.

22 Gostin, L & Gable, L, "The human rights of persons with mental disabilities: a global perspective on the application of human rights principles to mental health" (2004), 63 *Maryland Law Review*, 20.

At the same time, while NGOs increasingly incorporated mental health and psychosocial care into their practices, often predicated on a rights framework, there had been no formal effort to standardize the response.[23] Such diversity among psychosocial actors reflected "fundamentally different theoretical perspectives on the nature of psychosocial issues and the causes of problems".[24] In the absence of consensus guidelines regarding humanitarian psychosocial response, there remained a greater risk of uncoordinated activities, duplicated efforts, and unintentional harm. The existence of competing "camps" – such as those taking a biomedical, trauma-focused approach and those taking a public health approach – led to fierce debate, competition for funding, and rarely cooperation.[25]

Efforts to develop a standardized framework for mental health and psychosocial support coincided with broader movements within the humanitarian system. Despite their occurrence in diverse geopolitical and historical contexts, humanitarian emergencies were eventually understood to share a set of universal characteristics, including complex political antecedents; massive population displacement and disruption of political, economic, sociocultural, and healthcare infrastructures beyond their capacity to cope; in settings of armed conflict, insecurity affecting those not engaged in fighting; and the emergence of "predatory social formations"[26] that threaten livelihoods.[27]

This macro-perspective in conceptualizing humanitarian emergencies helped prompt the standardization of certain "clusters", or sub-specialties within the humanitarian system itself, such as water and sanitation, health, and logistics. UN Resolution 46/182 (1991) provided a framework for

---

23 Wessells, M & Ommeren, M van, "Developing inter-agency guidelines on mental health and psychosocial support in emergency settings" (2008), 6 *Intervention*, 199.

24 Strang, A & Ager, A, "Psychosocial interventions: some key issues facing practitioners" (2003), 1 *Intervention*, 2 (2).

25 Ventevogel, P, "From the editor: the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, from discussion to implementation" (2008), 6 *Intervention*, 193; see also Wessells & Ommeren, "Developing inter-agency guidelines", above Fn. 23.

26 Ventevogel, P, *Borderlands of Mental Health*, 2016, 21.

27 Toole, M & Waldman, R, "The public health aspects of complex emergencies and refugee situations" (1997), 18 *Ann Rev Public Health*, 283.

Member States and relevant organizations and agencies to coordinate humanitarian assistance.[28] The resolution also authorized the IASC to issue guidelines on humanitarian practice as well as improve coordination, knowledge-sharing, and delegation of responsibilities among humanitarian actors. The IASC Guidelines are therefore part of international administrative law and aim to coordinate humanitarian assistance among the UN, other multilaterals, and NGOs. Meanwhile, outside the UN system, the Sphere Project assembled an array of International Organizations and NGOs to publish the Humanitarian Charter and Handbook in 1997, detailing minimum standards for affected populations based on the core principles that people affected by disasters have a right to life with dignity and that all steps be taken to alleviate suffering.[29] The Sphere Project epitomizes the operationalization of human rights norms into humanitarian practice.[30]

Thus, IASC and the Sphere Project both grew out of this movement towards developing criteria for minimum response and improved coordination.[31] The approach taken by IASC is to include all stakeholders involved in humanitarian assistance, including both UN and other multilateral organizations, such as the World Health Organization (WHO), the United Nations International Children's Emergency Fund (UNICEF), the International Committee of the Red Cross, and the International Federation of Red Cross and Red Crescent Societies. Relevant NGOs can be invited to participate on an ad-hoc basis.[32] Various subsidiary bodies break off into different reference groups to support implementation of practice guidelines, among them early warning and preparedness, financing, protracted displacements, and – relevant here – mental health and psychosocial support.

Encouraged by the success of IASC HIV/AIDS guidelines and buoyed by the political support of the top-ranked WHO emergency official, a task

---

28 UN General Assembly Resolution 46/182, *Strengthening of the coordination of humanitarian assistance of the United Nations*, 1991; see also Office for the Coordination of Humanitarian Affairs, *What is General Assembly Resolution 46/182?*, available at https://docs.unocha.org/sites/dms/documents/120402_oom-46182_eng.pdf.

29 The Sphere Handbook, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, 2011, available at http://www.sphereproject.org/handbook/.

30 Hilhorst, D, "Being good at doing good? Quality and accountability of humanitarian NGOs" (2002), 26 *Disasters*, 193.

31 UN General Assembly Resolution 46/182, *Strengthening of the coordination*, above Fn. 28.

32 IASC, *IASC Membership*, 2016, available at https://interagencystandingcommittee.org/iasc/membership-and-structure.

force was formed to develop the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.[33] The Guidelines were released in 2007 following a lengthy consultative and participatory process among various NGOs and UN bodies,[34] with input from academic researchers. Despite some critiques that they fail to prioritize data-driven response efforts[35] or that the context in which they were developed (within the politically charged UN system) may compromise independent humanitarian action,[36] the Guidelines have been praised for being "field driven"[37] and are a major stride in responding to lack of consensus among aid agencies in providing psychosocial services in disaster settings.[38]

Referring directly to International Organizations, NGOs, donor agencies, and national governments, the Guidelines are intended for "all humanitarian actors […] operating in emergency settings at local, national, and international levels".[39] In the words of one figure instrumental in their development, the Guidelines have

> "contributed tremendously to the unity and spirit among policy makers, researchers, and practitioners alike […]. Moreover, the guidelines provide a framework, not only for action, but also for the systematic collection of empirical data on what works and what does not."[40]

They "are not just any guidelines"[41] but rather an authoritative document, a "political achievement".[42]

There are six core principles that underlie the IASC Guidelines: to (1) promote human rights of all affected persons and protect those at risk of

---

33 Wessells & Ommeren, "Developing inter-agency guidelines", above Fn. 23.
34 Ventevogel, "From the editor", above Fn. 25.
35 Lopes Cardozo, B, "Guidelines need a more evidence based approach: a commentary on the IASC guidelines on Mental Health and Psychosocial Support in Emergency Settings" (2008), 6 *Intervention*, 252; see also Miller, K & Fernando, G, "Epidemiological assessment in emergency settings: recommendations for enhancing a potentially useful tool" (2008), 6 *Intervention*, 255.
36 Jong, K de, Mills, C & Mackintosh, K, "Humanitarian issues beyond the technical tools: the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*" (2008), 6 *Intervention*, 334.
37 Ibid.
38 Wessells & Ommeren, "Developing inter-agency guidelines", above Fn. 23.
39 IASC, *IASC Guidelines on Mental Health*, above Fn. 15.
40 Ventevogel, "From the editor", above Fn. 25.
41 Ibid.
42 Ager, A, "Consensus and professional practice in psychosocial intervention: political achievement, core knowledge-base, and prompt for further enquiry" (2008), 6 *Intervention*, 261 (261).

rights violations; (2) maximize the participation of populations affected by an emergency; (3) do no harm; (4) build on available resources and capacities; (5) avoid stand-alone services and instead build integrated support systems; and (6) provide multi-layered supports, which take into account the different priorities of need (food, water, shelter). The Guidelines include "action sheets" for completing needs assessments, mobilizing communities, and linking psychosocial services to general healthcare structures. In the time since their development, the IASC Guidelines have had considerable impact on the delivery of psychosocial aid in humanitarian settings, serving as the key document for guiding minimum responses (as distinct from professional *standards*) in psychosocial aid.[43]

Indeed, the primary purpose of the Guidelines "is to enable humanitarian actors and communities to plan, establish and coordinate a set of *minimum* multi-sectoral responses to protect and improve people's mental health and well-being in the midst of an emergency"[44] (emphasis by authors). These minimum responses "are the first things that ought to be done", or in other words, the essential services done amid an emergency (acute, or relief phase) that lay the groundwork for comprehensive efforts undertaken in the (stable) rehabilitation phase.

Conceptually and practically, there is an enormous gap between minimum response, as envisaged by the IASC Guidelines, and the highest attainable standard of health, as promoted by key international legal frameworks. Nonetheless, a common thread still connects the IASC Guidelines to normative ideas found in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) as well as General Comment 14 (GC 14) (the formal legal interpretation of Article 12, ICESCR, which articulates the right to health)[45]: both stipulate responsibilities of actors responding to health disparities, or the disproportionate suffering borne by some more than others. Unfair social, political, and economic arrangements are increasingly implicated in contributing to poor health.[46] This understanding was

43 Meyer, S & Loughry, M, *Review of the Implementation of the IASC guidelines on Mental Health and Psychosocial Support in Emergency Settings: How Are We Doing?*, 2014; see also IASC, *IASC Guidelines on Mental Health*, above Fn. 15, 5.

44 IASC, ibid., 5.

45 Again, the reader is directed to the contribution of *A. Katarina Weilert*, "The Right to Health in International Law – Normative Foundations and Doctrinal Flaws" in this volume, for in-depth discussion of the ICESCR and GC 14.

46 Marmot, M, "Social determinants of health" (2005), 365 *Lancet*, 1099.

even explicit in GC 14, which affirmed that the right to health was a right "closely related to and dependent upon the realization of other human rights".[47] The right to health went beyond access to health*care* to include rights to specific conditions that underlie health, such as food, housing, human dignity, non-discrimination, and freedoms of association and movement, among many others.[48] This broader conceptualization of health as envisaged by the ICESCR and GC 14 is especially relevant to international humanitarian law (IHL), which legally obligates state and non-state actors to deliver the so-called "second-generation rights" of the ICESCR (food, clothing, housing, water) during emergencies.[49] In essence, the approach to harmonize the delivery of mental health and psychosocial care during emergencies is integral to a broader conceptualization of health, understood as interdependent on many other rights, and essential to a life with dignity.

The ideals of "minimum response" and "highest attainable standard" thus represent poles on a spectrum of progressive realization: both state and non-state actors, whether implementing minimum response during an emergency or strengthening health systems per the ideals of the ICESCR and GC 14, must fulfill their obligations in an ethical and consistent way.

III Liberia: Historical Overview, Healthcare Structure, and Mental Health Policy

In the early 19th century, the American Colonization Society, an organization seeking to resolve the growing political tension posed by increasing numbers of free blacks in the United States, launched a policy of repatriation to Africa. Liberia's subsequent founding was, in a way, a premonition of the over-sized role that external, civil society organizations would have in its governance. The "Americo-Liberians" understood little of the sixteen different indigenous ethnic groups already living in the territory of what would become Liberia. The small, American-descended elite held the levers of political power until 1980, when *Samuel Doe*, a member of the Krahn

47 Committee on Economic, Social, and Cultural Rights (CESCR), *General Comment 14: the Right to the Highest Attainable Standard of Health*, 2000, para. 3.

48 Toebes, B, "Health and humanitarian assistance: towards an integrated norm under international law" (2013), 18 *Tilburg Law Review*, 133.

49 Ibid.

ethnic group, overthrew President *Tolbert, Jr* in a military coup, unleashing decades of domestic strife and back-and-forth attempts to assert authority.

The Liberian civil wars began in 1989, when *Charles Taylor* led an insurrection against *Doe*. After gaining victory, *Taylor*'s rebel force split off into factions, leading to a period of horrific violence. Lacking any ideological foundation, the conflict became notorious for war crimes.[50] Over 14 years of conflict, nearly 10 % of the population was killed and nearly everyone at one point displaced.[51] A fragile peace was brokered in 2003, overseen by the United Nations Mission in Liberia.[52] A long process of reconstruction began, including processing and dealing with the widespread psychosocial consequences of the wars.[53]

This backdrop provides perspective on the state of mental health in post-conflict Liberia. Liberia ranks 177th of 188 countries on the United Nations Human Development Index.[54] 64 % of the population lives below the poverty line. After the wars, healthcare infrastructure was almost non-existent, while what remains is overwhelmingly dependent on donor assistance,[55] a lingering consequence of not only civil war but externally imposed macroeconomic policies that restructured public sector spending.[56] The state of Liberia's public health sector is evident in a staggering statistic: before Ebola, around 50 doctors were available for a population of 4 million; the

50 Abramowitz, S, "Trauma and humanitarian translation in Liberia: the tale of Open Mole" (2010), 34 *Culture, Medicine, and Psychiatry*, 353.

51 Ibid.

52 United Nations Mission in Liberia, *UNMIL Background*, available at http://www.un.org/en/peacekeeping/missions/unmil/background.shtml.

53 Abramowitz, "Trauma and humanitarian translation", above Fn. 50.

54 United Nations Development Program (UNDP), *Human development reports*, 2014, available at http://bit.ly/1wPFLUk.

55 Kruk, M, Rockers, P C & Williams, E H et al., "Availability of essential health services in post-conflict Liberia" (2010), 88 *Bulletin of the World Health Organization*, 527.

56 Kieh, Jr. G, *The First Liberian Civil War: the Crises of Underdevelopment*, 2008; for more description of the impact of international financial institutions and structural adjustment programs (SAPs) on the health sector in this region, see the contribution of *Susan L. Erikson*, "The Limits of the International Health Regulations: Ebola Governance, Regulatory Breach, and the Non-Negotiable Necessity of National Healthcare" in this volume.

virus eventually claimed the lives of 8 % of the country's healthcare workforce.[57]

During and immediately after the civil wars, biomedical[58] healthcare remained largely under the purview of humanitarian governance, provided almost exclusively by international NGOs. The proliferation of NGOs across the landscape of post-conflict Liberia led to a formal National Policy on NGOs (2008), which, in a moving passage, remarks on the phenomenon of non-state NGOs "filling in" for weak states like Liberia:

> "The war years (1989-2003) shattered the governance structure and systems, the rule of law disappeared and a humanitarian crisis arose that needed immediate attention which no national authority could address. The international community had to take the lead in ensuring not only the provision of humanitarian assistance, but also the protection of life and property and eventual return to peace. Non-Governmental Organizations (NGOs) became the main instrument through which such support could be provided."[59]

In effect, the policy conferred ultimate authority to the Liberian State regarding regulation and accountability of NGOs.[60] For example, health-related NGOs must agree to oversight by the Ministry of Health and Social Welfare (MOHSW) to ensure that their activities are in line with national priorities.[61]

Despite the near-total destruction of its civil infrastructure and limited health budget, Liberia ratified the ICESCR,[62] in 2004. The Covenant's right to health was implicitly accepted in the 1984 national Constitution under "the right of enjoying and defending life".[63] As good health is inherent to

---

57 Evans, D, Goldstein, M & Popova, A, "Healthcare worker mortality and the legacy of the Ebola epidemic" (2015), 3 *Lancet Global Health*, e439; WHO, *World health statistics 2011*, 2011, available at http://www.who.int/whosis/whostat/2011/en/.

58 The authors acknowledge that healthcare is provided by a variety of figures and institutions (including neighbors, so-called "traditional" healers, religious leaders and congregations, etc.) and admit this discussion does not elaborate on their place in Liberian society. This is due to limited published data on these "informal" care providers, but their contribution deserves recognition and more scholarly attention.

59 Republic of Liberia, *National Policy on Non-Governmental Organizations in Liberia*, 2008, 5.

60 Griffiths, C, "Liberia" (2010), 12 *International Journal of Not-for-Profit Law*, 39.

61 Ibid.

62 ICESCR, see above Fn. 10.

63 Republic of Liberia, *Constitution of the Republic of Liberia, Article 11(a)*, 1984, available at http://onliberia.org/con_1984_1.htm.

"enjoying and defending life", Article 11 of the Liberian Constitution creates health obligations on the part of the State.

Developed under the leadership of President *Ellen Johnson-Sirleaf* and then-Minister of Health Dr. *Walter Gwenigale*, the National Health Plan (2007) contains statutory obligations by establishing public health infrastructure and formulating major public health responsibilities. Wishing "to serve as a model of post-conflict recovery"[64] and "committed to efficient use of its resources in order to achieve maximal health outcomes at the lowest possible cost",[65] the Plan explicitly sought to decentralize health services by outlining the Basic Package of Health Services, provided free of charge at the community and county levels, where "primary health care shall be the foundation of the health system".[66]

In 2009, Liberian health policy planners observed that "[m]ental health care is virtually non-existent in the country".[67] The only psychiatric hospital in the country, the Catherine Mills Rehabilitation Center outside Monrovia, was completely destroyed during the civil wars, while the one built in its place, the 75-bed Grant Hospital in Monrovia, was finally turned over from an international NGO to the Liberian Ministry of Health in 2010.[68] Prior to the 2009 National Mental Health Policy (discussed in detail below), only one NGO had an established network of mental health and psychosocial care services outside the capital; traditional healers, family members, and religious leaders were thought to provide most care.[69] The few psychiatric medicines on the Ministry's Essential List of Drugs were unavailable or too costly for most.[70] There were scarce opportunities for clinical training in psychiatry for both nurses and physicians or any standard curriculum or accreditation process.[71] Epidemiologic studies suggested a staggering burden of unmet mental health needs. For example, in 2008, a survey indicated nearly 40 % of the population lived with symptoms indicative of depression

64 Ministry of Health and Social Welfare (MOHSW), *National Health Plan: 2007-2011*, 2007, available at http://apps.who.int/medicinedocs/documents/s18363en/s18363en.pdf, 5.
65 Ibid.
66 Ibid., 10.
67 Republic of Liberia, *National Mental Health Policy*, above Fn. 21, 16.
68 Ibid.
69 Abramowitz, "Trauma and humanitarian translation", above Fn. 50.
70 Republic of Liberia, *National Mental Health Policy*, above Fn. 21.
71 Ibid.

and 44 % with some degree of post-traumatic stress disorder.[72] Admittedly, statistics such as these rely on preconceived notions of how mental disorders and forms of care should be measured[73] and likely miss informal systems of care,[74] such as among family members, community leaders, and healers. Nonetheless, as Liberia began taking steps to rebuild its health system, there was widespread agreement among government planners and external actors alike that the country needed to take an institutional-level response to mental health and psychosocial needs.[75]

1 Liberia's National Mental Health Policy

Liberia's response to mental health needs reflected broader trends in research, policy, and funding. Recognition of the toll of mental, neurological, and substance use disorders, especially in low-income countries, combined with publications like a special issue of the *Lancet,* led to the launch of a Movement for Global Mental Health[76] and the WHO-released Mental Health Gap Action Program (*mhGAP*), which provides health planners, policymakers, and donors with a set of clear and coherent recommendations and programs for scaling up care.[77]

These important frameworks helped to guide policymakers to include mental healthcare services within Liberia's nascent primary healthcare system. Both state and non-state actors, including the Liberian Ministry of Health and a variety of outside experts and funders[78] worked on developing a policy consistent with the premise of decentralized care articulated in the

72 Johnson, K, Asher, J & Rosborough, S et al., "Association of combatant status and sexual violence with health and mental health outcomes in postconflict Liberia" (2008), 300 *Journal of the American Medical Association*, 676.

73 Bass, J, Bolton, P A & Murray, L K et al., "Do not forget culture when studying mental health" (2007), 370 *Lancet*, 918.

74 Key informant 2, NGO, 2016; for explanation behind the interview data, see above Fn. 16.

75 Ibid.

76 Lancet Global Mental Health Group (LGMHG), "Scale up services for mental disorders: a call for action" (2007), 370 *Lancet*, 1241; see also Prince, M, Patel, V & Saxena, S et al., "No health without mental health" (2007), 370 *Lancet*, 859.

77 WHO, *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*, 2010, available at http://bit.ly/2a2IuoO.

78 Republic of Liberia, *National Mental Health Policy*, above Fn. 21.

National Health Policy.[79] The task was not to build a parallel system, but to integrate mental health services into the primary healthcare model, notably through County Mental Health teams and Wellness Units.[80] One leading global mental health scholar, who was heavily involved in assisting the Liberian Ministry of Health and an NGO on the ground in Liberia at the time, echoed the importance of building into the primary healthcare system:

> "In health systems throughout the world, the referral between primary care and mental health services is a chasm. A referral means that the patient and his/her family need to make a second visit to a healthcare provider. That involves much more transportation costs and time. Specialists are typically much further away – if you are in rural Liberia, a mental health specialist can mean 2-3 days' travel. […] In contrast, through primary care integration, there is no extra step […]. If you want to do successful mental illness prevention, by nature it must be a primary care and community-based process."[81]

Crucial to the success of a decentralized model was fostering a sense of trust between official institutions, tasked with implementing the policy, and local communities, where most care would be provided.[82]

While integration into the primary healthcare system was a defining aspect of the policy, a potential consequence was the demoralization of already over-burdened care providers. In places like rural Liberia, providers can feel incapable of addressing all of a patient's needs.[83] For these providers, the impetus to change may be perceived as top-down, whereby frameworks for developing mental healthcare services such as WHO's *mhGAP* originate in high-resource countries and amid powerful institutions, with the expectation that they be implemented in low-resource settings.[84] Such critiques of global health as a postcolonial project[85] bear relevance in Liberia, not only due to its own history as a state founded by colonizers but in light

79 Ibid.
80 Ibid.
81 The lead author communicated by email with a global mental health specialist who had first-hand experience consulting for an NGO in Liberia. Hereafter, citation provided as: Global mental health specialist, personal communication, 2016.
82 Key informant 1, NGO, 2016.
83 Merlin, *Mental Health in Liberia: Mapping, Overview, and Recommendations*, 2010, internal report obtained by authors.
84 Kohrt, B & Griffith, J, "Global mental health: perspectives from cultural psychiatry on research and intervention" in Kirmayer, L, Lemelson, R & Cummings, C A (eds.), *Re-Visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health*, 2015.
85 Anderson, W, "Making global health history: the postcolonial worldliness of biomedicine" (2014), 27 *Social History of Medicine*, 372.

of a startling discovery made during the epidemic itself. A scientific article published in 1982 was unearthed in April 2015, detailing how some blood samples taken in the late 1970s from a sample of Liberians working on a corporate rubber plantation had in fact tested positive for Ebola antibodies, indicating a potentially longstanding, latent presence of the virus in the region.[86] The fact that this alarming finding was never shared with Liberian healthcare workers or policymakers only underscored the political-economic arrangements that structure not only heightened disease risk but the lopsided allocations of knowledge-sharing, resources, and technologies.[87]

Ebola was first confirmed in Liberia on March 30, 2014.[88] As described by key informants at an NGO that worked closely with the Liberian Ministry of Health, an emergency policy issued by the Liberian government effectively closed all non-essential operations, affecting some core programs of the National Mental Health Policy.[89] And yet, as the outbreak unfolded, much of the work that the policy had already put in place proved crucial to the response, especially in terms of a human network between communities and health institutions. For example, there was an urgent need to address fear-based behavior, such as when family members hid sick relatives from health teams, patients escaped from Ebola Treatment Units (ETUs), or people spread false rumors about the disease, which all contributed to Ebola's spread.[90] Misunderstandings only deepened as outside actors, rather than trying to contextualize such behavior as part of a legacy of deep suspicion and mistrust towards authorities, began casting Liberians as ignorant or superstitious.[91]

As a counterweight, existing networks among county-level health teams and local healers and figureheads, which had grown in the years up to and since the adoption of the Mental Health Policy, facilitated clear and effective health messages.[92] Finally, in the years preceding the epidemic, the National Mental Health Policy's focus on graduating trained mental health

86 Dahn, B, Mussah, V & Nutt, C, "Yes, We Warned About Ebola" (April 7, 2015), *New York Times Opinion Pages*, available at http://www.nytimes.com/2015/04/08/opinion/yes-we-were-warned-about-ebola.html.

87 Biehl, J, "Theorizing global health" (2016), 3 *Medicine Anthropology Theory*, 127.

88 WHO, *Liberia: a country – and its capital – are overwhelmed with Ebola cases*, 2015, available at http://bit.ly/2mgGlw3.

89 Key informant 1, NGO, 2016.

90 Key informant 2, NGO, 2016.

91 Ibid.

92 Ibid.

clinicians helped provide manpower to not only staff ETUs as psychosocial care providers but to assist survivors to reintegrate into their communities and care for fellow healthcare workers and others exposed to high levels of traumatizing experiences, such as burial teams.[93]

In sum, the National Mental Health Policy incorporates guiding principles for scaling up mental health services in low-resource, post-conflict settings. The policy itself emerged out of a governance structure composed of various state and non-state actors, including government ministries and policy advocates as well as research centers, funders, and NGOs primarily based in the Global North. Still, as one key informant explained, it was ultimately a collective effort on the ground that led to the policy's realization.[94] This informant's perspective is insightful because it speaks to the commitment of Liberian State institutions in taking a leading role in developing the National Mental Health Policy and National Health Plan. The implementation of rights norms (including the right to health) often occurs "in societies where the legitimacy of the state is low or even completely lacking, at least in the eyes of some groups in the society";[95] such contexts can fuel the "self-legitimacy" that NGOs may assume for themselves as they go about their work. The following case study scrutinizes in further detail the role of NGOs working within and alongside Liberian institutions by recalling the experiences and observations of the lead author, who worked in Liberia during the outbreak with an NGO.

2 Where the Ideal Meets the Real: The Case of Global Care

In late 2014, as the Ebola epidemic spiraled out of control, more NGOs, many never having worked in West Africa, poured into the region to provide aid. One was Global Care (pseudonym), an international health and human rights NGO committed to provision of equitable healthcare and invested in rebuilding Liberia's healthcare infrastructure. Global Care's entry into the Ebola response came after invitation by the Liberian Ministry of Health, a point that underscores Global Care's operating ethos of working within existing health systems, rather than parallel to them. As a short-term clinical volunteer, the lead author gained first-hand experience with Global

93 Ibid.
94 Key informant 1, NGO, 2016.
95 Hilhorst, "Being good at doing good?", above Fn. 30, 195.

Care in Liberia; as such, the findings below derive from the ethnographic process of *participant observation*,[96] wherein the line between observer and active participant is intentionally blurred to facilitate more reflexivity and understanding of on-the-ground realities. To enrich the discussion of NGO governance and accountability, the case study is shared to reveal ethical conflicts and "micro-challenges" that arose in a specific context where Global Care staff tried bridging the figurative space between ideals and local realities.

The strain on healthcare workforces across the three Ebola-affected countries led to a worldwide call among many international NGOs for expatriate clinicians to help provide care in Ebola Treatment Units (ETUs). Global Care was one such NGO that began dispatching expatriate clinicians to work in public health facilities throughout the country. For these clinicians, the focus was not to staff ETUs but to work alongside Liberian clinicians in existing health facilities, with the well-intentioned but vague mission of "health systems strengthening". In early 2015, the lead author, a clinically licensed healthcare provider, joined these efforts.

Given a short, six-week assignment, the small cadre of expatriate doctors and nurses arrived by UN helicopter to one of Liberia's remote counties, where Global Care had begun its work. Throughout the entirety of the epidemic, the county had only one case: a man who had been infected in Monrovia and who voluntarily admitted himself to an ETU before he could infect anyone. The region's remoteness, combined with the deplorable state of Liberia's roads, had limited transmission. In humanitarian parlance, the focus would be on health systems strengthening. But what exactly did that look like in practice? Without clear direction from Global Care's country-level leadership, the expatriate team took it upon themselves to flesh out its operational activities, first by meeting Liberian clinicians at the nearby public hospital, a facility that lacked electricity most hours of the day, had no running water, and went without the most basic supplies.

It is crucial to underscore that Global Care did not delegate specific operational objectives or responsibilities to its expatriate team once in-country, nor was it clear how and under what circumstances Global Care had already contacted local Liberian clinical and public health figures there. In retrospect, the shifting political (and financial) currents of the Ebola response at the time likely contributed to an "adhocracy" within Global Care

96 DeWalt, K & DeWalt, B, *Participant Observation: A Guide for Fieldworkers*, 2011.

and its frenetic relationship towards its expatriate staff.[97] This was compounded by the fact that this was Global Care's first venture into West Africa, let alone during the worst Ebola outbreak on record. These conflicts point to a deeper distinction as well: by all measures, Global Care operates and prides itself as a *development* organization, one committed to long-term engagement with communities. But if the goal was not to staff ETUs anyway, was not Global Care well positioned to assist with rebuilding Liberia's health system?

Ultimately acting under a short timeframe and without clear objectives, the expatriate team members worked closely with a Liberian clinician to contact the County Mental Health Team and other psychosocial staff at the nearby public hospital. These meetings eventually led to a training workshop for care providers throughout the area who sought improved communication strategies among clinical, community, and administrative health staff. The workshop was animated, beginning with participants citing core communication barriers with other providers outside their respective disciplines. The second half of the workshop was devoted to formulating strategies for overcoming those challenges. Afterwards, participants expressed their interest in additional collaborative sessions.

Towards the end of the team's assignment, Global Care's country-level leadership informed the team that the only two psychosocial workers at the hospital would be diverted to a larger project run by a different NGO for an unknown amount of time. At a later site visit, the country director, an expatriate, extolled the important work Global Care was doing in Liberia, from building a new teaching hospital, to developing medical school curricula, to what was envisioned for the county where the team was sent: a staff of more than 60 people; a team of building experts to "re-vamp" the hospital; and ranking needs by priority, divided between short- and long-term.

However, at the in-person meeting, the official alluded to the bind in which Global Care found itself. Through different channels, the team became aware that much of the money supporting Global Care's activities was strictly ear-marked for Ebola-related programs, such as ETU management and Ebola surveillance. A Global Care official later explained that the nature of Global Care's funding, which had been granted through the US

97 Dunn, E, "The chaos of humanitarian aid: adhocracy in the Republic of Georgia" (2012), 3 *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, 1.

Office of Foreign Disaster Assistance, constrained its long-term interest in health systems strengthening.[98] If, for example, the team wanted to train Liberian staff to provide psychosocial services *at an ETU*, or focus exclusively on Ebola-related stigma, higher-level approval and funding would have been expedited. But challenges such as scaling up psychosocial services throughout the county or supporting providers struggling to respond to chronic psychosocial issues in the community could not easily be justified at that point in time. The expatriate team left Liberia without any clear indication that their work would be carried forward. Later, some caught word that Global Care's presence had been drastically scaled back in the remote county to focus on needs elsewhere in Liberia.

IV IASC Guidelines: Reconsidering Global Care

The case study of Global Care provides an example of the way principles and normative guidelines encounter serious challenges by way of shifting political winds, unclear objectives, and communication breakdowns, and the tensions that arise when sending short-term clinicians to initiate long-term work. A case in point is the emphasis on power relations between outside agencies and emergency-affected people under the core principle of *do no harm* (IASC principle #3). "During emergencies", read the Guidelines,

> "large numbers of people rely on humanitarian actors to meet basic needs. This reliance, together with disrupted or destroyed protection systems (e.g. family networks), contributes to inherently unequal power relationships between those delivering services and those receiving them."[99]

How did power relations shape up in practice? First, the deployment of a small group of expatriate clinicians to a remote corner of the country – and their quick exit – recalls what anthropologist *Peter Redfield* has termed "the easy passage of the privileged",[100] or the ease with which expatriate aid workers come in and out of crisis zones. The power to be present (and leave) figured heavily into how the expatriate team interacted with Liberian colleagues and surrounding community. Foremost, the decision to devote time and human resources to an exploratory study of psychosocial care in the area was made at the field level, between a few expatriate staff and local

98 Country-level official of Global Care, personal communication, 2015.
99 IASC, *IASC Guidelines on Mental Health*, above Fn. 15, 76.
100 Redfield, P, "The unbearable lightness of ex-pats: double binds of humanitarian mobility" (2012), 27 *Cultural Anthropology*, 358 (358).

contacts with professional training. This course of action illustrates how "every organization has to find a justification for being there"[101] and more fundamentally the "self-legitimacy" a NGO can grant itself at even the local level. As representatives of a well-known NGO with mixed degrees of experience and little oversight, the expatriate team had the power to interpret health systems strengthening for themselves and how to go about it. While reaching out and involving Liberian psychosocial workers at the nearby hospital and from the community was in keeping with the principle of building on available resources and integrating support systems (IASC principle #4), what to make of the way in which the team left, with little hand-off or continuity? Was this not an "unintended consequence" that the guidelines warn can result from a lack of understanding power relations?[102]

A more helpful approach to these questions comes from extending the analysis of power relations to the country-level leadership of Global Care and the pressures placed on it by the various publics to whom the NGO was held. By outward appearances, the recruitment, deployment, and extrication of field staff presents Global Care as an unfettered "do-gooder" that effortlessly moves from scene to scene based on need. Yet based on the experiences recounted here, such a (mis)characterization would incorrectly project too much agency onto Global Care and its decision-making capacity. For example, the decision to reassign psychosocial workers undergoing training came at the behest of a much more established, politically connected NGO; while frustrating to those on the ground, the need to re-allocate limited resources sprang from relationships between Global Care and other NGOs at the national level.

Furthermore, it is unsurprising that the needs of the psychosocial team were not prioritized considering that Global Care had not explicitly prioritized psychosocial care at the outset. Despite encouraging messages regarding the team's initial work, other needs forced Global Care to refocus elsewhere. Global Care seemed caught in that gray zone of transition between a humanitarian mode of governance and a vague, "development-oriented" phase that sought to work within the remaining Liberian infrastructure left in Ebola's wake – as though Global Care was trapped between the ideal of "minimum response" and its desire to work towards "the highest attainable standard" via health systems strengthening. In this regard, power relations between expatriate staff and local partners, as well as between field staff

101 Fritsche, G, "Controlling humanitarian aid cowboys in Afghanistan" (2001), 358 *Lancet* 2002.

102 IASC, *IASC Guidelines on Mental Health*, above Fn. 15, 76.

and executive-level leadership, reflect deeper tensions and conflicts at play, challenging the implementation of such a bedrock principle as *do no harm*.

V Conclusion: Principles, Practice, Accountability

Accountability is rooted in the principles of good governance and the fundamental values of a democratic society, including transparency, access to information, the use of explicit standards for the delivery of mental health services and their quality ensured through regular scrutiny, inspection and accreditation,[103] as well as public participation, civil society engagement, and corporate compliance. For non-state actors such as NGOs, which were not the original subjects of international legal instruments on the right to health, can consensus guidelines serve as an effective accountability mechanism for these international public authorities that "escape the grasp of established legal concepts?"[104]

Consider the IASC Guidelines, part of the broader human rights tradition, as a potential accountability mechanism for NGOs like Global Care. In practical terms, this could rely on indicator surveys, health benchmarks, and human rights assessments that glean quantitative information on the impact of an NGO's activities. As one informant explained:

> "One of the challenges has been clearly documenting how much mental health work is done when you use an integrated framework. How do we best count how much time a primary care provider spends on mental health after they get training? […] Then there is the impact on the community through religious leaders, pharmacists, police, and other stakeholders training in mental health now. Although there is very likely widespread impact through the health system and community, it can be challenging to capture that in numbers salient to domestic and international policymakers."[105]

Tracking practices among both international NGOs and state infrastructures like the public health system can be useful for assessing compliance with norms and standards and informing policy development for the future. Such

---

103 Chichevalieva, S, *Developing a framework for public health law in Europe*, WHO Regional Office for Europe, 2011, 32 et seq.

104 Bogdandy, Dann & Goldmann, "Developing the Publicness of Public International Law", above Fn. 4, 7.

105 Global mental health specialist, personal communication, 2016.

an "audit culture"[106] has also been met with its fair share of critique, however. For example, overreliance on numerical data can obscure local complexities, or worse, slip into a regressive pattern of counting and itemizing reminiscent of a colonial era, when counting was done to control.[107]

It must be recalled, of course, that accountability for compliance with the right to health, as stipulated in legal frameworks like the ICESCR and constitutional measures such as those in Liberia, lies squarely with states. The example of Liberia's mental health policy, before and during Ebola, demonstrates how states may adapt and bend along the continuum from "minimum response" to "highest attainable standard". First, in the aftermath of civil wars, Liberia's National Mental Health Policy corresponds to the "comprehensive responses" that the IASC Guidelines suggest should be undertaken in the post-emergency or "stabilized phase". These comprehensive responses include integrating psychosocial and mental healthcare into national policy; ensuring monitoring and evaluation mechanisms; strengthening human rights monitoring and accountability; and scaling up training of psychosocial care providers and clinicians.[108] At the same time, the way in which the policy adapted to the Ebola outbreak demonstrates how priorities shift in times of emergency. Rapid transitioning of resources away from "routine activities" such as general training to Ebola-specific needs (for example ETU staffing, collaborating with local healers, and developing appropriate Ebola-related health messages) are all examples of how the policy adapted to meet "minimum responses" as laid out in the IASC Guidelines.[109] Still, even four years *before* the epidemic, an exploratory mission report on the state of Liberian mental healthcare services concluded bleakly that the National Mental Health Policy "describes an 'ideal world' which will never be achieved in any African country and certainly not Liberia",[110] a dire assessment based on the dearth of available resources at the community/primary healthcare level, poor coordination between NGOs and the Ministry of Health, and lack of professional staff. Nonetheless, for

106 Strathern, M (ed.), *Audit Cultures: Anthropological Studies in Accountability, Ethics, and the Academy*, 2000.
107 Adams, V (ed.), *Metrics: What Counts in Global Health*, 2016.
108 IASC, *IASC Guidelines on Mental Health*, above Fn. 15, 21-29.
109 Ibid., 21.
110 Dealing with Disasters Conference, *From Mental Health Policy to the Provision of Care: Challenges for INGOs in Liberia*, 2010.

a country wracked by civil conflict, entrenched poverty, and Ebola, the policy is a laudable achievement incorporating right-to-health norms from various legal (ICESCR, GC 14) and guiding (IASC, *mhGAP*) frameworks.

While Liberian institutions have come far by way of policy development, many chief implementers remain non-state NGOs. Administrative and judicial capacity are therefore essential for states to regulate the activities of NGOs and ensure that their practices comply with rights norms. Liberia's official NGO policy delegates specific oversight roles to certain Ministries, implicating the responsibility of the state to monitor NGOs in the country.[111] In post-conflict states, where stability and institutional capacity may be present, mechanisms could be developed that are transparent, participatory, and independent to review progress, measure core indicators, and recommend corrective measures to realize the right to health.[112] These governmental and administrative accountability mechanisms function in addition to judicial means of accountability, referring to the ability to claim a remedy before an independent and impartial body when a violation of a (human) right has occurred ("justiciability"). On several occasions, domestic and regional courts held claims on healthcare access justiciable, providing an effective remedy to enforce its realization.[113]

Of course, what NGOs have once "in the field" are guidelines, which may share common norms with legal instruments but are not in themselves enforceable. But perhaps they should not be. Guidelines are intended to do exactly that: to guide the operational role of NGOs and other agencies. Although guidelines reflect best practices on paper, they are not magic bullets in practice; indeed, a major critique of the IASC Guidelines is a lack of evidence base or strong call for collecting evidence at local levels (although they do emphasize the importance of culture and local adaptation of interventions). As the West Africa Ebola outbreak attests, each humanitarian emergency occurs in context, in a specific historical and geopolitical time and place and among socially differentiated groups of people. Not only that,

111 Republic of Liberia, *National policy*, above Fn. 59.

112 Friedman, E A, "An Independent Review and Accountability Mechanism for the Sustainable Development Goals: The Possibilities of a Framework Convention on Global Health" (2016), 18 *Health and Human Rights Journal*, 1

113 For an interesting overview see Flood, C & Gross, A (eds.), *The Right to Health at the Public/Private Divide: A Global Comparative Study*, 2014, describing national experiences on litigating healthcare access such as: *Minister of Health v. Treatment Action Campaign* (TAC) 2002 5 SA 721 (CC) South Africa; Colombian Constitutional Court ruling T-760/08, July 31, 2008, etc.

guidelines themselves may be taken as "cultural artifacts" produced in a specific culture of moral humanitarianism, where the power to produce and disseminate knowledge can be too easily taken for granted.[114] Finally, an NGO itself has its own ethos, operating culture, levels of expertise, and relationships with the communities they try to serve.

Clearly, in times of emergency, many other competing forces besides medical needs push and prod along the track hollowed out by guidelines like IASC. In front of such a broad array of contingencies, surely some "room to maneuver" must be left open based on the intricacies of context and the micro-scaled setting where highly mobile expatriate (and sometimes inexperienced) staff bump up against local realities.[115]

In the end, the point resurfaces: as an international public authority, the NGO is accountable to multiple publics, from donors and executive boards, to most importantly, their supposed beneficiaries. The Liberian people whom Global Care's staff encountered and worked with, for example, did not have a say in how and in what form aid would come to them, nor were their voices heard when Global Care left. Nor could Global Care, supported financially by ear-marked money, justify its deployment of resources, however short-term, to a remote corner of Liberia left relatively unscathed by Ebola but still in dire need of health systems strengthening. Core principles of IASC, especially that of *do no harm*, can be insightful for NGO representatives as they try to go about implementing the right to health on the ground. Arguably, by this measure, Global Care's work in this corner of Liberia was left unfinished and only exposed the fault lines of power coursing through regimes of global health governance.

At the same time, working relationships among local clinical staff were indeed fostered in this area of Liberia, however short-lived, and Global Care has maintained a fruitful relationship with the Liberian Ministry of Health while re-focusing its attention to other areas of the country thought to be in higher need and where its impact might be stronger. These realities point to ways in which hierarchies of need materialize along the course of the humanitarian timeline, marked by phases such as emergency, post-emergency, or rehabilitation, with each demanding different operational paradigms among NGOs and states as well as different guidelines to follow. Once on the ground, these conceptual phases become even harder to differentiate.

---

114 Kohrt, B & Jallah, B, "People, praxis, and power in global mental health: anthropology and the experience gap" in Kohrt, B & Mendenhall, E (eds.), *Global Mental Health: Anthropological Perspectives*, 2015.

115 Hilhorst, "Being good at doing good?", above Fn. 30.

A lesson of the Global Care experience is that context can be a powerful determinant of whether certain ideals get translated into practice. Context in this sense refers to the historical legacy of external, non-state actors "filling in" for a weak, war-torn, and ultimately post-conflict state, but one that has also honored deep commitments to realizing the right to health through policy achievements and was, to some degree, equipped to mount a psychosocial response to the Ebola outbreak through its existing health system.

However, context also refers to upstream actors and institutional sites of power, such as host country Ministries of Health, the WHO, the US Office of Foreign Disaster Assistance, and the IASC itself, whose decisions bear consequences in the smaller-scaled, local settings where they are intended to have a positive effect. Simply consider how the International Health Regulations (2005), which enabled the WHO to declare the outbreak a "public health emergency of international concern" and thereby set in motion the large-scale international response,[116] only revealed the fundamentally *reactive* nature of the humanitarian system: "The world sought to 'respond' to Ebola – when it should have responded to deep-seated problems that gave rise to it."[117] Perhaps one of the greatest sources of power within this governance structure is the way in which international legal frameworks, regulations, and NGO guidelines "are so obviously rationally and inclusively framed, [that] their users are assumed also to act rationally and inclusively",[118] an assumption called into question by the case study above.

The activities of NGOs like Global Care should not be separated from this larger web of relations, and as such accountability mechanisms cannot rely exclusively on "ideal principles" that pertain mostly to the interactions between an NGO and the local population. Such principles serve their purpose, but only to a point. Humanitarian NGOs often find themselves in a bind; accountability approaches must remain flexible to this reality while also tending to macro-level political decisions made in distant sites of power. A helpful way forward may be found by strengthening the normative links between operational guidelines like those of IASC and the primary legal frameworks on the right to health, the ICESCR and GC 14. Clarifying

116 WHO, *International Health Regulations*, 2007, available at http://www.who.int/topics/international_health_regulations/en/.

117 Nunes, J, "Doctors Against Borders: Médecins sans Frontières and Global Health Security" in Hofman, M & Au, S (eds.), *The Politics of Fear: Médecins sans Frontières and the West Africa Ebola Epidemic*, 2017, 8.

118 Martínez, S & Kiper, J, "Perpetrators, responders, and the construction of moral distance in human rights", forthcoming, 31.

these links in turn enriches the perspectives at both standpoints: it encourages NGOs to remind themselves of rights principles that form the basis for much of their work in fragile or weak states, while for policy, legal, and academic circles, case studies from the field can reveal points of tension and breakdown in applying those principles, and as such suggest areas for improvement. Scholarship that untangles the convergence of principles, policy, and practice can shed additional light on the gap between the ideal and the real.

International and Regional Organizations and the Securitization of Health