# Governance Beyond the Law

# The Limits of the International Health Regulations: Ebola Governance, Regulatory Breach, and the Non-Negotiable Necessity of National Healthcare

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*Abstract*

If international regulation is the answer to epidemic disease containment, the 2014 Ebola outbreak in Sierra Leone would have come under control quickly. The health ministry, bi- and multi-lateral organizations, and Non-Governmental Organizations (NGOs) in Sierra Leone are rife with regulation, recommendation, and best-practice standards. The fragmentation of the health sector in many poor countries following economic liberalization, though, has led to what some anthropologists have qualified as "republics of NGOs"; each NGO has its own set of standards and regulatory affects, most often donor interest-driven. National and international law imposes another set of obligations. In Sierra Leone this has created healthcare service and response that is more of an ad hoc healthcare *assemblage* and *medicoscape* than a healthcare *system*. In many impoverished countries, the contemporary moment is one in which health regulations – the documents themselves – sometimes stand in as emergency response-ready mechanisms, not just for local administrators but also and even more so for members of the international community. That is, until there is an epidemic threat, when disease can and does move into realms of human experience beyond regulation and rule of law. This article focuses on one document, the International Health Regulations (IHR),[1] to show how despite good

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1 This article refers to the WHO, *International Health Regulations (2005), 3th edition*, 2016, available at http://bit.ly/2mhqVK8.

international intentions, the bureaucratic energies devoted to making and maintaining the document and its regulations are over-done and disproportionate compared to the dearth of international political moxie needed to support Sierra Leonean national healthcare system-building in an age of global zoonotic disease migrations. In sum, while the IHR are important to the global health community aspirationally, the larger on-the-ground problem is that, first, there must be a national healthcare to plug them in *to.* The IHR operate as important guidelines, but do not meet the measure of regulations.

## *I Method*

In March 2014 when news of Ebola infections first reached Sierra Leone,[2] the author was in-country leading an ethnographic research team in the capital city, Freetown. Although the author and her team were studying a different topic – the use of health data – the team was respectively embedded in and witnessed the local health sector's initial efforts to manage the Ebola outbreak. The research employed anthropological theory and method; fieldwork-informed ethnography is the disciplinary expertise of the author. The research team spent a combined total of 14 months in 2013 and 2014 in Sierra Leone collecting data, conducting over 75 interviews. In addition to the recently collected research data, the contribution is informed by nearly a decade of the author's professional experience working in Sierra Leone and Washington, DC, in the field of international development prior to becoming an academic.

In the last several decades, anthropologists and other social scientists have expanded their scholarly attentions from village and ritual life to everyday habits and practices. Fieldwork experiences are as likely to take place in global institutions as they are in rural outposts. Data collection is as likely

2 Although the Ebola outbreak primarily affected three West African countries – Sierra Leone, Liberia, and Guinea – the author has worked as an international development worker and more recently as a university researcher and anthropologist only in Sierra Leone. It is from that expert perspective that the article is written. Sierra Leone, Liberia, and Guinea have different historical, colonial, and contemporary trajectories and engagements in the world system, and this evidenced in the governance of the respective Ebola outbreaks. Although the IHR are intentionally universal in their design, the on-the-ground governance of Ebola was not universal and was shaped by former colonial engagements and particularist contemporary national healthcare configurations.

to include observations of bureaucrats and executives as it is ritual specialists. Data analyses, in the case of this article, incorporates a theoretical science and technology studies orientation that examines international artifacts of bureaucratic and political impact and control, thus making documents, regulations, standards, and laws subjects of scientific inquiry in their own right. As such, this article moves outside legal paradigms and employs the conventions of anthropological method and analysis for its conclusions.

## *II Introduction to the IHR*

This article contextualizes and explains the ways that IHR[3] are limited in some places in the world. In this author's observation, this is not because countries intentionally defy international regulations, but rather that the IHR are too far removed from on-the-ground public health realities of particular geographies. The disconnect had and continues to have serious consequences for disease governance. As witnessed in 2014-2015, the spread of Ebola was unregulatable,[4] simply beyond the rule of law.[5]

### 1 IHR as a Legally Binding Agreement, in Theory

The IHR is an international treaty among 196 States Parties, which voted and approved the document most recently at the 2005 World Health Assembly. The IHR have accomplished an important achievement in that they offer a cooperative template of measures to deter "naturally, accidentally, or deliberate [sic] released infections from spreading internationally".[6] The template imposes a "reciprocal responsibility – the obligation of all nations to detect, report, and contain public health threats, in order to

3 See above Fn. 1.

4 See also Wilkinson, A & Leach, M, "Briefing: Ebola – Myth, Realities, and Structural Violence" (2014), *African Affairs*, 1.

5 "Rule of law" is a term used throughout this article. This term refers to its customary legal interpretation as an international legal principle in which laws rather than arbitrary action govern the people of a nation-state. In this article, the notion of "rule of law" also refers to the contemporary need for uniform legal principles and their enforcements for state and non-state actors.

6 Fischer, E, Kornblet, S & Katz, R, "The International Health Regulations (2005): Surveillance and Response in an Era of Globalization" (2011), *White Paper, Stimon Center Washington, DC*, 3, available at http://bit.ly/2mRC5a1.

protect lives and livelihoods worldwide"[7] – on all 194 World Health Organization (WHO) member nations plus Liechtenstein and the Holy See.[8] Article 2 states:

> "The purpose and scope of these Regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[9]

## 2 The WHO as Principal Implementation Agent

The principal agent for assuring global health security is the WHO, a United Nations (UN) organization endowed by its Member States with the authority to respond to public health events requiring "immediate action".[10] Following the International Sanitary Regulations that emerged from a 1892 European conference, new international health regulations were revised by WHO member nations first in 1969, and then more recently in 2005. The WHO is the world body tasked with 1) regulating, 2) identifying and naming, and 3) possessing the emergency powers to ensure global health security when the world confronts a public health emergency.[11]

## 3 IHR as the Primary Document Governing Global Health Security

The IHR is inarguably necessary and important to achieving measures of global health security, and there is little doubt that the IHR – as a document – succeed in setting forth international bureaucratic standards for public health emergencies of international concern. Therein lies a problem: In many impoverished countries, the contemporary historical moment is one in which health regulations – quite literally, the documents themselves –

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7 Fischer, J & Katz, R, *International Health Regulations 101*, 2012, 4, available at http://bit.ly/2mhQIC0.

8 WHO, *International Health Regulations (2005)*, above Fn. 1, Appendix 1, 59.

9 Ibid., 10.

10 WHO Constitution, as cited in Kamradt-Scott, A, "WHO's to blame? The World Health Organization and the 2014 Ebola Outbreak in West Africa" (2016), 37 *Third World Quarterly*, 402. Kamradt-Scott is citing Articles 21 and 28 of the WHO Constitution.

11 Ibid., 402; WHO Constitution, Article 21, as cited in Acconci, P, "The Reaction to the Ebola Epidemic within the United Nations Framework: What Next for the World Health Organization?" in Lachenmann, F, Röder, T J & Wolfrum, R (eds.), *Max Planck Yearbook of United Nations Law*, 2014, 408.

sometimes stand in as response-ready mechanisms, not just for local administrators but also and even more so for members of the international community. That is, until a health emergency hits. The more difficult, necessary and fundamental task of global health security is the building of emergency clinical response capable of thwarting the spread of disease. Such an infrastructural-intensive remedy is sine qua non.

However, the research informing this contribution found that time and again, in offices in Freetown, documents and readiness checklists *stood in for* actual preparedness. These substitutions were not a product of malice or deception but rather of the contemporary ad hoc non-systems health governance structures described below. The "system-making of no system" has been taken up by various medical anthropologists, who have described the ad hoc assemblages of care in poor countries as "medicoscapes",[12] and "republic[s] of NGOs",[13] and the grand challenge of real health system building.[14] In the lead up to the 2014 Ebola outbreak and after, global governors have relied too much on these documents for governance.

## 4 Acknowledged and Unacknowledged Limits of the IHR

### a Issue of Enforcement

When people, including the Director-General of the WHO, talk about lessons learned from the West African Ebola outbreak, they frequently reference the IHR as authoritative and legally binding.[15] For an international regulation to be authoritative as a rule of law, there needs to be aa) a clear definition of a breach, ab) a clear explanation of what will happen should

12 Hörbst, V & Wolf, A, "Globalisierung der Heilkunde: Eine Einführung" in Hörbst, V & Wolf, A (eds.), *Medizin und Globalisierung: Universelle Ansprüche – lokale Antworten*, 2003, 3.

13 Schuller, M, *Killing with Kindness: Haiti, International Aid, and NGOs*, 2012.

14 Pfeiffer, J & Chapman, R, "The Art of Medicine: An Anthropology of Aid in Africa" (2015), 385 *The Lancet*, 2143 (2143-2144).

15 See for example "The IHR […] are the only internationally-agreed set of rules governing the timely and effective response to outbreaks of infectious diseases and other public health emergencies. If its legally-binding obligations on States Parties are not being met, change is urgently needed." In Chan, M, "WHO Director-General Addresses the Review Committee of the International Health Regulations Focused on the Ebola Response", August 24, 2015, available at http://www.who.int/dg/speeches/2015/review-committee-ihr-ebola/en/.

any party fail to fulfill their responsibilities, and ac) enforcement means in the case of a breach.[16] The IHR does not include such items.

Nation-states, according to the IHR, for example, are obliged to report infectious disease outbreaks to the WHO within 24 hours.

> "Each State Party shall assess events occurring within its territory by using the decision instrument in Annex 2 [decision tree]. Each State Party shall notify WHO, by the most efficient means of communication available, […] within 24 hours of assessment of public health information."[17]

### aa Definition of a Breach

The IHR does not define a breach of the obligations. Rather, it relies on "shall" language, leaving treaty ratifiers in question as to what constitutes "have not yet", "did not", or "will not".[18] Article 13 of the IHR, put in force with the 2005 ratification, specifies that there is a state obligation to "develop, strengthen and maintain" government capacity to respond to public health risks:

> "1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern […]."

However, if a state cannot build capacity in five years (from 2005), extensions are possible:

> "2. […] a State Party may report to WHO on the basis of a justified need and an implementation plan and, in so doing, obtain an extension of two years in which to fulfil the obligation […].
>
> […] the State Party may request a further extension not exceeding two years from the Director-General […]."

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16 The argument here is a grassroots on-the-ground common sense argument, which may cause consternation for legal technicians. For regulations to be binding, there must be a consequence in a breach. Otherwise the regulations are not binding. This is well understood in the everyday praxes of international affairs. Common sense should not be ignored as a prevailing logic system. It is well circulated on-the-ground and more pervasive than legal systems – local and global – and one that requires far less formal training and precedent dependency for participation.

17 WHO, *International Health Regulations (2005)*, above Fn. 1, Article 6, Notification, 12.

18 Appendix 2 includes Reservations, Understandings, and Declarations qualifying the IHR ratifications of seven countries, none of which are the three countries primarily affected by Ebola.

This is an example of the IHR document out of sync with the on-the-ground realities of WHO member nations. An article in *The Lancet* summarized the magnitude of disconnect between the obligations set forth in the IHR and *most* member countries' inability to build infrastructural capacity:

> "[U]nder the International Health Regulations (2005), the 2012 deadline [was] extended for some countries to 2014, then 2019 after Ebola struck [...] *as of 2014, two-thirds of countries had not met their core capacity requirements and 48 countries had not responded to WHO queries regarding their readiness […]*."

The IHR did not include binding obligations for donors to provide support to poorer countries to meet these obligations, nor to fund WHO to fulfill its mandate to provide technical assistance. These shortcomings did not attract serious action or funding until the Ebola outbreak.[19]

### ab Setting Forth What Happens If Parties Breach Delegated Responsibilities

The IHR does not explicate what the WHO will do in the case of a breach, nor does it take up the various natures of breaches such as were seen during the recent Ebola outbreak. What happens if State Parties do not notify? Or what if they *do* notify the WHO and the Director-General does not act, as was the cause of the April to August 2014 delay in declaring Ebola in West Africa a public health emergency of international concern?[20] Further, what of countries, like Australia and Canada, that introduced epidemiologically groundless and unnecessary travel bans, thus defying the IHR's mandate against "unnecessary interference with international traffic and trade"?[21]

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19 Moon, S, Sridhar, D & Pate, M A et al., "Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola" (2015), 386 *The Lancet*, 2204 (2207 et seq.). Emphasis mine.

20 Kamradt-Scott, "WHO´s to blame?", above Fn. 10, 404-407.

21 "Australia Suspends Visas for People Travelling from Ebola-hit Countries" (October 27, 2014), *BBC*, available at http://bbc.in/2mB0a4g; Branswell, H, "Ebola: Canada Suspending Visas for Residents of Outbreak Countries" (October 31, 2014), *CBC*, available at http://bit.ly/10be51A; see also WHO, *Report of the Ebola Interim Assessment Panel*, 2015, 5, available at http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf: "[…] in violation of the Regulations, nearly a quarter of WHO's Member States instituted travel bans and other additional measures not called for by WHO, which significantly interfered with international travel, causing negative political, economic and social consequences for the affected countries."

What of quasi-state owned airlines like Air France that suspended travel to Sierra Leone?[22] What of non-state actors standing in for states – in this post-privatizing era there are many providing services in an Ebola outbreak – who fail to report disease outbreaks and/or interfere with traffic and trade?[23] What about non-affected countries whose companies bought up Ebola supplies – such as the medical hazmat suits knowns as PPEs (Personal Protection Equipment) – thus shorting the distribution in West Africa where they were critically needed?[24]

Within the IHR document, language concerning a breach in responsibilities is brief, unspecific, and dependent mostly on legal mechanisms operating outside the purview of the WHO. In Article 56, in seeking the settlement of disputes *between* Member States, states are advised:

> "1. […] to settle the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation or conciliation […]."[25]
>
> "4. [States may] resort to the dispute settlement mechanisms of other intergovernmental organizations or established under any international agreement."[26]

With regard to disputes between the WHO and its Member States, there is an internal process mechanism. Its language and procedural instructions, however, are tautological. The tranche below translates, in effect, to "In the event of a dispute between the WHO and others, the matter will be submitted to the WHO."

> "5. In the event of a dispute between WHO and one or more States Parties concerning the interpretation or application of these Regulations, the matter shall be submitted to the Health Assembly."[27]

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22 Gordon, S, "Air France Suspends Flights to Ebola-hit Sierra Leone at Request of French Government" (August 27, 2014), *Daily Mail,* available at http://dailym.ai/2mhWR11.

23 McKay, B, "Peace Corps, Aid Groups Evacuate Personnel From Ebola-Hit West Africa" (July 31, 2014), *Wall Street Journal,* available at http://on.wsj.com/2mSzHjm; Neate, R, "Mining Company at Centre of Fight against Ebola in Sierra Leone Goes Bust" (October 16, 2014), *The Guardian,* available at http://bit.ly/2lYy6nG.

24 Hinshaw, D & Bunge, J, "U.S. Buys Up Ebola Gear, Leaving Little for Africa: Manufacturers Strain to Meet Demand Amid Rising Anxiety" (November 24, 2014), *Wall Street Journal,* available at http://on.wsj.com/2mSwQqk.

25 Ibid.; WHO, *International Health Regulations (2005)*, above Fn. 1.

26 WHO, ibid.

27 WHO, ibid.

### ac Enforcement in the Case of a Breach

Years before the Ebola outbreak, there was already an understanding that the IHR contained unenforceable regulations. Summary Conclusion 1 of the 2011 Report of the Implementation of the International Health Regulations report that:

> "24. The most important structural shortcoming of the IHR is the lack of enforceable sanctions. For example, if a country fails to explain why it has adopted more restrictive traffic and trade measures than those recommended by WHO, no legal consequences follow."[28]

Yet during the 2014 Ebola outbreak WHO Director-General *Margaret Chan* and others continued to insist that the IHRs are legally binding. When the immediate threat of epidemic Ebola eased, *Al Jazeera*[29] and *Reuters*[30] reported that the WHO explored sanctioning country violators of the IHR, including not only those which "mishandled epidemics", but also those countries which inappropriately banned travel.[31] World Trade Organization-like sanctions were discussed as a reprimand model, but were rejected as not fit for purpose.[32] Ultimately, violations of the IHR – including failures on the part of the WHO – were noted but not censured. *Acconci* parses further by distinguishing that "under the IHR, the WHO has the power to control and lead the conduct of its Member States in case of an epidemic, [but] lacks the power to adopt measures enforceable as law", thus qualifying the IHR as binding, but not enforceable as law.[33]

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28 WHO, *Implementation of the International Health Regulations (2005) – Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009*, 2011, 13, available at http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf.

29 Bode, L De, "WHO Wants Sanctions Against Countries for Mishandling Epidemics" (October 22, 2015), *Al Jazeera*, available at http://bit.ly/2mhZnEm.

30 Miles, T, "States Could Be Sanctioned for Public Health Failings: WHO Boss" (October 20, 2015), available at http://reut.rs/2meWAu9.

31 Fidler, D P, "Ebola Report Misses Mark on International Health Regulations" (2015), *Chatham House Expert Comment*, available at http://bit.ly/2lSS2Yk.

32 Ibid.

33 Acconci, P, "The Reaction to the Ebola Epidemic within the United Nations Framework", above Fn. 11, 423.

### b Issue of Post-Westphalian Global Governance: WHO's State Problem

The fundamental organizational unit of the WHO is the nation-state. In the 21st century, this is a fairly antiquated organizational model, one with some remaining but clearly diminished utility. WHO global health governance, though, "does not operate in a post-Westphalian environment",[34] a point elaborated on below for Sierra Leone. The contemporary governance moment is one that is both organized by the nation-state and non-state actors.[35] In many poor countries – which are often post-colonial, sometimes postwar, usually marked by earlier decades of heavy economic lender intervention – healthcare happens, but in a decentralized, ad hoc way. The austerity conditionalities of the 1980s and 1990s promoted by the World Bank and International Monetary Fund (IMF) paved the way for privatization of healthcare services. Those conditionalities required state pullback, as private sector, market-driven healthcare was expected to remedy the healthcare needs of poor countries. Results were mixed, but largely negative for the world's poorest countries.[36]

In the case of Ebola governance, those very states whose governments were required to downsize have been widely criticized for their inadequate government healthcare oversight and administration. Yet the size and functionalities of those government were not chosen by Sierra Leoneans, but rather imposed by the global banking community. WHO's state problem is rooted in the contradiction that while much is expected of nation-states, and even as the IHR obligations continued to make states central to its regulatory structures, in many of the poorest countries in the world nation-state health governance functions have been gutted *by design* at the hands of global financial institutions.[37]

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34 Katz, R & Fischer, J, "The Revised International Health Regulations: A Framework for Global Pandemic Response" (2010), 3 *Global Health Governance*, 14.

35 See for example, Sharma, A & Gupta, A, *The Anthropology of the State: A Reader*, 2006; Ferguson, J, *Global Shadows: African in the Neoliberal World Order*, 2007; Mbembe, A, *On the Postcolony*, 2001; Roitman, J, *Anti-Crisis*, 2014.

36 Pfeiffer, J, & Chapman, R, "Anthropological Perspectives on Structural Adjustment and Public Health" (2010), 39 *Annual Review of Anthropology*, 149.

37 Benton, A & Dionne, K Y, "International Political Economy and the 2014 West African Ebola Outbreak" (2015), 58 *African Studies Review*, 223.

### c Issue of Mission Creep and Confusion

Mission creep is a term that has been used to categorize an expansion in an organization's purpose, such as has been found for some military interventions[38] and international financial institutions.[39] But the WHO is guilty of that too; the IHR is an exemplar of a regulatory mechanism that takes up the right to this expansion uncritically. As cited earlier, IHR's purpose and scope includes the dictum to "avoid unnecessary interference with international traffic and trade"; the 2005 reforms of the IHR specifically added these two maxims on traffic and trade. Yet, the control of international traffic and trade are beyond the regulatory authority of IHR, not only in a pragmatic sense, but also in a bureaucratic one. The safeguarding of aviation falls to a UN specialized agency, the International Civil Aviation Organization, which is tasked with cooperative international regulation; the safeguarding of shipping falls to the International Maritime Organization, a separate UN agency. Trade falls within the jurisdiction of the World Trade Organization, an organization outside the UN family. As such, the IHR are a set of regulations designed to fail; neither the document nor the originating UN agency, the WHO, have jurisdiction over the domains of the document's own purpose and scope.

## *III A brief Background to Sierra Leone's Contemporary Political Economy of Health*

### 1 European Occupation and Colonial History

Prior to first recorded contact between indigenous upper west coast Africans and European (Portuguese) explorers in the 15th century, the region now called Sierra Leone was home to multiple politically independent ethnic groups. Coastal regions of Sierra Leone, including the area now known as Freetown, were occupied by the British as early as 1695.[40] By 1787 the British staked claim to the region, and in 1808, Sierra Leone became a

38 Cushman, J H, "Mission in Somalia is to Secure City" (October 10, 1993), *New York Times*, 2.
39 Einhorn, J, "The World Bank's Mission Creep" (2001), 80 *Foreign Affairs*, 22.
40 Griffith, T R, *Sierra Leone: Past, Present and Future*, 1881, vol. 13:82, 58.

British crown colony, with an administrative system of British colonials appointed by British King *George III*. By 1880, colonial control extended only about 50 miles inland, with several up-country outposts. Notable fights for local sovereignty include 1790[41] and 1898[42] conflicts with British authority. The divide-and-conquer administrative strategy of the British – setting ethnic groups against one another during the slave trade and colonial eras – set the stage for political rivalries at independence in 1961 which are still evident in contemporary Sierra Leonean politics.

## 2 Independence and Postcolonial History

Sierra Leone is among those countries that since its 1961 independence from its colonial ruler has experienced brief stretches of indigenous democratic governance, with longer lengths of time at the hands of one-party rulers. Immediate post-independence commitments to democratic governance gave way to indebted, donor-dependent administrative fragmentation. As the country struggled to find its political feet as a democracy during the 1960s and into the 1970s, across the Atlantic in Washington, DC, the World Bank and IMF were establishing the habit of making development moneys available to poor countries (via Structural Adjustment Programs – SAPS) with conditionalities that encouraged privatization.[43] Into the 1970s, 80s, and 90s, Sierra Leone was among those countries with rulers who were quick to accept loan conditions that devalued local currency and incentivized privatization of public services. Long-term commitments and the investments required to build a healthcare system from the bottom up were not incentivized, and were in fact actively discouraged by international development bank lenders.[44]

41 Ibid., 59.
42 Abraham, A, "Bureh, The British, and the Hut Tax War" (1974), 7 *The International Journal of African Historical Studies*, 99.
43 Pfeiffer & Chapman, "Anthropological Perspectives", above Fn. 36, 149-165.
44 For an overview, see also Kentikelenis, A, King, L & McKee, M et al., "The International Monetary Fund and the Ebola Outbreak" (2015), 3 *The Lancet Global Health*, e69.

## 3 War

In the years leading up to the 1991-2002 war, the privatization of previously state-owned infrastructures in Sierra Leone ensued. It was at this stage that an NGO-ification of Sierra Leonean healthcare began to establish – that is, health care services when available were increasingly offered by an uncoordinated hodge-podge of mostly foreign donor-driven NGOs. Sierra Leonean government and some NGOs tried to keep programs and facilities going, but everyday life during the war was too precarious for the kind of sustained efforts that build a healthcare system capable of serving most of the people most of the time. The war was horrific and devastating. Prior to the Ebola outbreak, the war was "the most destructive event in modern Sierra Leonean history";[45] in general conversations, Sierra Leoneans commonly marked time "before the war" and "after the war". Now conversations are temporally designated before, during, and after both the war and Ebola.

## 4 Postwar Sierra Leone

The immediate postwar years were marked by severed hardship in Sierra Leone: inflation, continuing and intermittent school and hospital closures, and food shortages. It was a time of isolation from the global community. By January 2014, however, conversations with all kinds of Sierra Leoneans, from health administrators to people on the street were peppered with newfound hope. In 2013 *Forbes* had named Sierra Leone the second Best Investment country in the world. President *Koroma* was fond of saying that: "Sierra Leone will be a middle-income country by 2035." And then Ebola hit. Major industries shut down or left. Wealthy diaspora Sierra Leoneans who had returned after the war again dispatched themselves and their families to Europe and North America.

45 O'Kane, D, "Towards 'Audit Culture' in Sierra Leone? Understanding 'Quality Assurance' and the University of Makeni" (2014), 155 *Max Plank Institute for Social Anthropology Working Paper*, 7.

## 5 An Ad Hoc Health Assemblage in a Time of Ebola

By the time Ebola hit Sierra Leone in March 2014, the NGO-ification of healthcare was long established. The state drawback required by the IMF as a condition of receiving development loans had been on-going for almost two full decades.[46] People still looked to "Papa Govment" for healthcare, but the everyday reality was that healthcare in Sierra Leone was by 2014 more of an ad hoc healthcare assemblage than a healthcare system. The effects for rural Sierra Leoneans can involve "long, uncomfortable, and expensive journeys, navigating Kafka-esque bureaucracies".[47]

Assemblage[48] is a term that aims to capture "the actual configurations" of technological, scientific, political, and economic forms that come together in a particular place. Its markers include regulations and bureaucratic interventions like the IHR, targeted to shape human action and behavior. Sierra Leone's healthcare assemblage is a product of intermittent care that resulted from post-independence governance and foreign aid conditionalities.

The NGO-ification of the health sector means that each NGO imposes its own set of standards and regulatory affects. Whether or not these affects actively create, maintain, or disrupt successful, health governance depends on how well or poorly matched the regulatory standards are to purpose. It matters who writes the documents. Do they know the country? Do they understand village life? Do they source and eat local food? Have they traveled using public transportation? Have they gone through the paces of receiving health care in country? Do they understand the complexities of the very political vernaculars being negotiated in the governance of zoonotic disease? There is a vast range of scientific rigor and biomedical knowledge in the documents coming into Sierra Leone from the outside. In addition, it is common to find political and systems ignorance about Sierra Leone written into documented standards to which Sierra Leoneans are held.

At times of great stress to any given assemblage, as in the case of a disease outbreak, the global political economy of the on-the-ground health failures in impoverished countries is revealed. In the case of Sierra Leone, that

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46 Kentikelenis, King & McKee et al., "The International Monetary Fund and the Ebola Outbreak", above Fn. 44, e69.

47 Ferme, M, "Hospital Diaries: Experiences with Public Health in Sierra Leone" (2014), *Cultural Anthropology,* available at http://bit.ly/2lYrOoq.

48 Collier, S J & Ong, A (eds.), *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, 2005.

political economy implicates non-West African nationals and international institutions.[49] For example, IMF structural adjustment programs have "required reductions in government spending, [prioritized debt repayment] […] absorbing funds that could be directed to meeting pressing health challenges".[50] The IMF placed wage caps on government jobs, while NGOs offered salaries far exceeding those caps.[51] This contributed to "internal brain drain", with public health practitioners opting for employment in the private rather than public sector. Additionally, the IMF advocated decentralized healthcare in Sierra Leone,[52] which complicated coordinated responses during the Ebola outbreak. "The IMF and organizations like it have played an important role in creating a political environment in which the epidemic could emerge."[53] Consequentially, documents play a major role in this environment, a topic to which attention is now turned.

## *IV The Non-Negotiable Necessity of Health Sovereignty*

Health sovereignty is the inalienable right of a nation-state, no matter how impoverished, *to decide* how it will manage available resources to fight disease outbreaks within its territorial boundaries. Health sovereignty is the idea that nation-states possess in the first instance the supreme political authority to protect the health of its people, not external agency, donors, or philanthropies. The WHO agrees to this in theory, and references such sentiments in documents:

> "Health is considered the sovereign responsibility of countries, however, the means to fulfil this responsibility are increasingly global. The International Health Regulations (2005) constitute the essential vehicle for this action."[54]

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49 Benton & Dione, "International Political Economy and the 2014 West African Ebola Outbreak", above Fn. 37, 223-236.

50 Kentikelenis, King & McKee et al., "The International Monetary Fund and the Ebola Outbreak", above Fn. 44, e69.

51 Ibid.

52 International Development Association and the International Monetary Fund, *Sierra Leone: Enhanced Heavily Indebted Poor Countries (HIPC) Initiative Decision Point Document*, 2002, 13, available at https://www.imf.org/external/np/hipc/2002/sle/sledp.pdf.

53 Benton, A & Dione, K, "5 Things You Should Read Before Saying the IMF is Blameless in the 2014 Ebola Outbreak" (January 5, 2015), *Washington Post*, available at http://wapo.st/2mBd1n2.

54 WHO, *Report of the Ebola Interim Assessment Panel*, above Fn. 21, 5.

As with other international documents that aim to universalize action, the IHR draw on Westphalian notions of the state, which originate in territorialities. "The state" in this imaginary is able to govern people and implement policies, programs, and laws. Further, in this envisioning, state agency and authority are relatively unchallenged, and each state is assumed capable and unhindered in its pursuits of disease management.[55] This conceptualization is the ideal; the real is far more diverse and complex. The limits of ideal state forms have been realized as the weight of old political forms have become strained by internal contradictions and external hypocrisies.

No one cared more about ending Ebola in Sierra Leone more than Sierra Leoneans. Despite media representations to the contrary, "[o]ver 80 % of the personnel on the ground fighting [Ebola] in the country [were] Sierra Leonean".[56] An anthropologist with over 45 years of experience working in Sierra Leone noted that "Ebola is a fearsome disease, but learning how West Africans have coped with it is an antidote to fear and confusion".[57] Similarly, our research team witnessed that as early as March 2014 Sierra Leonean health ministry officials *knew what to do.* They recommended Ebola management through hot spot intervention, border management, contact tracing, and limited quarantine,[58] all of the classic public health interventions that, it must be noted, eventually did draw down the number of outbreaks.

Focusing disease hotspot intervention in the Eastern Province of Sierra Leone was among the most logical recommendations from Sierra Leoneans. The first Ebola outbreak occurred over 400 km from Freetown, the capital city of Sierra Leone. This is where Doctors without Borders (MSF) set up its first Ebola Treatment Center. Calls by some Ministry officials for government and NGO reinforcements to support hotspot intervention began in March 2014. These calls went unheeded and unrecognized not only federally as business owners and government officials in other Sierra Leonean sectors anticipated losses to the economy, but also of course internationally up to and after the World Health Organization's August 8, 2014 announcement of Ebola as a public health emergency of international concern.

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55 For thoughtful analyses of the limits of the state imaginary, see also Das, V & Poole, D, *Anthropology in the Margins of the State*, 2004.

56 Koroma, E B, "Interview: President of Sierra Leone on the Ebola Crisis" (Dezember 10, 2014), *World Economic Forum*, available at http://bit.ly/2mxh57y.

57 Richards, P, *Ebola: How a People's Science Helped End an Epidemic*, 2016, 9.

58 Limited quarantine was imposed on people with known Ebola exposure. Individuals and geographies (rural villages), for example, were placed under quarantine for 21 days, the duration of Ebola incubation.

From March 2014 until August 2014, Ebola raged in Sierra Leone virtually unmanaged and uncontained. More significantly and to the incredulity of Sierra Leonean citizens on the street, Ebola progressed westward, toward Freetown, the most densely populated area because that is where most donors – again with the exception of MSF – were willing to headquarter their early outbreak containment efforts. Ebola victims were brought to Connaught Hospital in the center of Freetown for definitive care. A treatment center was set up at a former tuberculosis sanitarium on the far western region of Freetown, which required that sick patients travel from east to west Freetown through the most impoverished and densely populated parts. Doctors, public health officials, and citizens alike argued vociferously that contagious patients should not be brought to urban centers. Yet that was where the donors wanted them. The on-the-ground realities of health sovereignty are complicated. Empirical evidence from our study shows that in the Ebola outbreak stages, Sierra Leoneans did not make, did not take, and were not empowered to make sovereign decisions about health within their borders. Sierra Leoneans, including the president, attempted to declare the Ebola outbreak as a public health emergency several months before the August 8, 2014 WHO announcement.[59]

Still, in the WHO's 2015 assessment report of the Ebola spread, the emphasis remains on the IHR *document.* Even as the report acknowledges global collective action, they cite the IHR as "an essential vehicle for this action", as below:

> "9. Whereas health is considered the sovereign responsibility of countries, the means to fulfil this responsibility are increasingly global, and require international collective action and effective and efficient governance of the global health system. The International Health Regulations (2005) constitute an essential vehicle for this action. The legal responsibilities contained in the Regulations extend beyond ministries of health, and must be recognized as obligations at the highest levels of Member States' governments."[60]

Further, the report continues to declaratively promote "shared sovereignty", a notion unlikely to be promoted for the containment of diseases in affected Member States like the United States, Germany, or Japan. As such, shared sovereignty is a notion selectively promoted as a remedy.

> "10. This Panel suggests that in the interest of protecting global health, countries must have a notion of "shared sovereignty". Through the International Health

59 Koroma, "Interview: President of Sierra Leone on the Ebola Crisis", above Fn. 56; Richards, *Ebola: How a People's Science Helped End an Epidemic*, above Fn. 57.

60 WHO, *Report of the Ebola Interim Assessment Panel*, above Fn. 21, 10.

> Regulations (2005), Member States recognized that there are limits to national sovereignty when health crises reach across borders […]."[61]

Most remarkably, however, is that para. 10 continues with an emphasis still on the IHR document, rather than on the larger structural mechanisms that would empower poor countries.

> "[…] In the Ebola crisis, there were failings on the part of the Secretariat and of Member States in upholding the Regulations. Unfortunately, a great opportunity to strengthen the Regulations was lost when the 2011 recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 were not fully implemented […]. The Ebola outbreak might have looked very different had the same political will and resources been applied in order to support implementation of the International Health Regulations (2005) over the past five years."[62]

Most unfortunately, emphasis on the document obscures the fact that Sierra Leoneans knew how to curb the March 2014 outbreak through public health measures like contact tracing and targeted quarantine. But Sierra Leoneans – not health ministry officials, doctors, nurses, nor citizens – did not have the sovereign power and authority to catalyze the emergency response necessary and implement hot spot interventions prudently.

## *V The IHR are Beyond the Rule of Law in Some Countries*

> "The Review Committee considers the IHR themselves to be the *best insurance policy*."[63]
>
> "The failures in the Ebola response did not result from failings of the *IHR themselves*, but rather from a lack of implementation of the IHR."[64]

These statements are part of a 2016 WHO review of the role of the IHR in the 2014 Ebola outbreak and response. Therein lies a telling problem: that global health governance experts in good faith proffer a robust defense of the IHR "themselves", thus re-sanctioning a document that erases global historical and structural inequities and holds rich and poor countries to the same account. Bureaucratic energies devoted to making and maintaining

61 Ibid.
62 Ibid.
63 WHO, *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of International Health Regulations (2005) in the Ebola Outbreak and Response, A69/21*, 2016, 79, available at http://bit.ly/2lY-Iax4. Emphasis mine.
64 Ibid., 9. Italics mine.

regulatory documents are disproportionate to the political energy and exertions necessary for national healthcare system-making in an age of global zoonotic disease migrations.

The IHR ignores harmful caps, limitations, and austerities on health care building in Sierra Leone. In the 68 years since the inception of the WHO and the 55 years since Sierra Leone's independence from Britain, the hard, complex work of domestic health governance has yet to be accomplished. This is a profound problem with accountabilities both within and beyond Sierra Leone federal governance. The IHR will not remedy this problem.

Invigorating political moxie[65] for poor countries to establish healthcare *systems* – rather than continuing to sustain and invest in the current ad hoc assemblages of intermittent care – is the smart upstream anticipatory remedy to increase global health security. Most health policymakers who have not worked in West Africa seem to have a hard time imagining the absurdity of imposing IHR obligations in places without strong-enough healthcare systems. But for those of us who work there and have witnessed the fortitude of Sierra Leonean healthcare practitioners, even as global policies continue to *structure* local salary caps and equipment shortages, we know that they know that the IHR are but window dressing to global structural violence.[66] International health regulations and universal standards for global health security – if they are to work in the future – depend of "how standards manage the tension[s] involved in transforming work practices, while simultaneously being grounded in those practices".[67] Standards and regulations require local reappropriation. In West Africa, global histories and habits have hindered the development of local comprehensive health care systems; non-West African nationals are deeply implicated. To this day, the work of documents like the IHR obfuscate and stand in for the more important, more difficult, more fundamental work that needs to be done of building a comprehensive healthcare system first and foremost.

The IHR depends on there being a healthcare *system* – not an assemblage or medicoscape – to plug the regulations in *to.* Building on the local successes of Ebola governance to create healthcare sovereignty in Sierra Leone

65 Erikson, S, "Getting Political: Fighting for Global Health" (2008), 371 *The Lancet*, 1229 (1229-1230).

66 Farmer, P, "On Suffering and Structural Violence: A View from Below" (1996), 125 *Daedalus*, 261.

67 Timmermans, S & Berg, M, "Standardization in Action: Achieving Local Universality through Medical Protocols" (1997), 27 *Social Studies of Science*, 273.

is "next generation" work. Global health partisans[68] are most useful to Sierra Leonean overall well-being when they work on the global scale to reduce and bring more balance to the impositions placed on small countries by international development and humanitarian industry conditionalities.

## *VI Conclusion: When Regulations are Actually Guidelines*

Documents like IHR work well as entry points for better understanding the strengths, weaknesses, and limitations of prevailing global health governance instruments. But continuing attention and refinement of the IHR cannot be a primary act of health security for impoverished areas of the world.[69] Long before the 2014 Ebola outbreak, the global community was distracted from digging in and taking up its own systemic failures of health governance at global structural levels. One of those failures has been the inability to be realistic about sovereign unevenness of states it aims to regulate. One on-the-ground effect of this failure in Sierra Leone in 2014 was that the IHR were largely irrelevant to early Ebola containment governance. Before, during, and after the height of the Ebola outbreak, health governance in Sierra Leone has been shown to be beyond the rule of law, the international umbrella under which the IHR as a treaty resides.

This article is critical of the IHR. However, the author supports their continuance as guidelines but not as regulations. After decades of working in Sierra Leone, the author concludes that both Sierra Leone and the global community need the IHR as a helpful conceptual yardstick for disease governance throughout the world. High aims and expectations for ideal disease management are essential to the further public health work that needs to be done. The world needs such guidelines and policy windows are now open for officially changing the International Health Regulations to International Health Guidelines. The global infrastructures for emergency preparedness as well as the WHO leadership are in flux. New remedies to global health governance ailments are in play. The WHO's Health Emergencies Programme (HEP), for example, may prove to be "a comprehensive way

68 Erikson, "Getting Political: Fighting for Global Health", above Fn. 65, 1230.

69 Gostin, L, DeBartolo, M & Friedman, E, "The International Health Regulations 10 Years On: The Governing Framework for Global Health Security" (2015), 386 *The Lancet,* 2222.

[to successfully manage epidemics] 'through the establishment of one single Programme, with one workforce, one budget, one set of rules and processes and one clear line of authority'".[70] HEP needs good guidelines; the IHR are good guidelines. Practical optimists acknowledge on-the-ground limitations of the IHR. Make the IHR guidelines instead of pretending they operate as regulations and get on with the harder, more intractable concerns of global health governance.

70 WHO, *Health Emergencies Programme*, 2015, available at http://bit.ly/25dvmaA.