“MSF made a big mistake.” Not a small admission from Claudia Evers, MSF’s Emergency Coordinator in Guinea. Think how much more effective international aid might be if more aid organizations publicized rather than buried such opinion. But that is another blog.

The issue is basic. In its early stages and as the Ebola outbreak mounted, MSF placed almost all its apples in the treatment basket. Fueled by the twinning of high transmission levels and the sloth-paced scaling up of treatment (MSF aside), the virus far outpaced the intervention. Evers concludes: “Instead of asking for more beds we should have been asking for more sensitization activities.”

But did MSF make a mistake? Or is this more of a design flaw in the system? Treatment is what MSF does. Treatment is what MSF is designed to do. When it comes to outbreaks like cholera, or diseases like malaria, or even ‘epidemics’ in some places like maternal mortality, MSF is a hammer of treatment. Nobody, and not even MSF, should be surprised that it sees a world of nails – people who first and foremost need treatment.

To simplify: A good buddy of mine is a cardiologist. His brother is a cardiac surgeon. They disagree bitterly on how best to deal with their aging mother’s heart problems. The former wants to manage it through drugs, diet and exercise. The latter wants to cut. The lesson is that identity determines perception.

So the problem was not MSF calling for a massive, rapid increase in beds and treatment capacity. The problem was that MSF the hammer’s voice stood virtually alone. The problem, in other words, was the absence of other tools in the kit. Where were the wrenches, NGOs that specialize in grassroots mobilization, and who would have seen its potential and pressed for it? Where were the screwdrivers who would have championed decentralized models of care? Where was the diversity of discourse?

Even as sensitization activities scaled up, local communities seem to have been viewed more
as targets than as actors. One concern is that the authorities (foreign and international) installed centralized structures for the dissemination of information, rather than capitalizing on local capacities. Another claim is that messages were too simplistic: being told what not to do with a sick child does not provide an actionable solution for a mother with no access to a treatment center. What should she do?

It seems there is an emerging consensus that local communities in Sierra Leone, Liberia and Guinea were sidelined in the rush to contain Ebola, treated more as an obstacle due to their distrust and ‘primitive’ behavior (see, e.g., here). Treated then as a vector for the disease, to be contained rather than sought out as a potential partner in defeating it; not understood to be necessary to generating solutions and disseminating the word. In the end, it seems providential that they did not remain contained, and many communities took the fight against transmission into their own hands (see, e.g., here).

To recap: the Ebola outbreak response reduced communities to a combination of victim, vector, and potential security threat. Otherwise, the aid response and media coverage of it rendered these communities invisible. That invisibility comes because the entire international community – the Western governmental and NGO aid response – is deeply, messianically self-referential. That is the hammer of being a savior, and it blinds us to anything but the nail of victimhood; to the reality that many people, given the shortcomings of international aid, need to know how to save themselves. That is the hammer of being largely Western/foreign, and seeing the nail of disarray, primitivity and ignorance.

One step further: consider this piece from Oxfam CEO Mark Goldring on his recent encounters in Liberia and Sierra Leone. In a few simple paragraphs he conveys the “suffering, bravery and stoicism” of the people. Yet such narratives always fall short. Be it Syrian refugees or civilians in Central African republic or the survivors of Ebola, the sheer scale of grief, social/livelihood devastation and grinding anxiety over life itself evade our comprehension. For all our efforts, this tremendous suffering remains beyond our ability to fathom with clarity. And it lies beyond our ability to mend. As humanitarian organizations, we find it much easier to be the hammer of crisis response, seeing the nail as the problem called hunger or shelterlessness or, in this case, outbreak. As important as it is to contain and defeat this outbreak, I wonder if we are preconditioned to see the virus, sick people to be mended, and not the millions of people who need something altogether different than the hammers of Western pity, charity, or aid.
3 THOUGHTS ON “THE HAMMERS AND NAILS OF EBOLA”

Christina Bennett  
FEBRUARY 7, 2015 AT 12:11
Do humanitarians only have hammers because we prefer blunt instruments and are neither skilled nor inclined to use other, more specialised tools? Or do we need another toolbox altogether? Or maybe a chef’s kitchen: engineered for creativity and adaptable to every type of dish.

JMCcooper2010  
FEBRUARY 9, 2015 AT 14:44
This article captures the essence of what is wrong with humanitarian aid in today’s world. As a citizen of Liberia and a 25-year veteran humanitarian worker, I was not aware how far our frontline actions have strayed away from the real need and even the impact that could really save lives. It is hard to explain the sheer helplessness people faced despite that billions of dollars of ‘charity’ and so-called aid pouring in. Simple answers would have saved countless lives and turned this situation around, maybe even before it got started. Thank you for this analysis.

★ marc  
FEBRUARY 12, 2015 AT 08:11
Thanks for adding this comment. So much of this blog is essentially the view from far off, meaning there is a major risk of getting wrong. Always good to hear that the view from the ground chimes with the view from London.