This transcript is on part of a joint interview conducted on April 17 2019. The interview was originally conducted in Dutch.

Interviewer (Emma den Brok) in plain text

**Interviewee in bold**

You were deployed with UNDAC?

**Yes, that’s a pool of about 200, 300 people worldwide who have been trained in assisting in the coordination of major disasters and incidents. And who’s in this pool – that’s roughly two types of people: Emergency managers like myself, people experienced in disaster management. And humanitarians. Both terms are very general – there isn’t something like *the* humanitarian or *the* disaster manager. But the distinction is important, because on the one hand you have people from international NGOs and UN-organisations who are involved with humanitarian operations on a daily basis. On the other hand you have people who are involved with emergency planning, risk management, disaster management. As far as I know, UNDAC is one of the rare and unique platforms in the world where these two skillsets are combined. Consciously so. As in, having a policy in combining both skills, and when a team is sent out you always see that – apart from the various team roles – there is always a mix between emergency managers and humanitarians.**

Yes, and when you say the team assists in the coordination, which level should I have in mind?

**That was on a national level. We were deployed in Monrovia with the explicit mission of assisting the coordination of the government. UNDAC can be deployed in two different ways. The first is that a country can ask the UN for help in coordination via UN OCHA. They will decide whether they will send a UNDAC-team, or a OCHA search capacity, or respond in a different way – they have several solutions around that. The other way is that the resident coordinator, the highest UN official in the country, can say: I ask for reinforcement from a UNDAC-team for the coordination of the international organisations, and in particular the UN. To support his role as resident coordinator. And sometimes it happens that a country says, look, we want assistance in the form of tents or water cleaning units, but we do not ask for assistance in coordination. Then the resident coordinator can say, and of course the country has to agree to this, in order to do my work as a UN coordinator properly I will ask for extra capacity from UNDAC.**

What was the case for you?

**In our case we were deployed on the request of the resident coordinator. Now, it was a really atypical mission. What was atypical, was that UNDAC was deployed in a non-acute setting. While it is made for acute disasters. And an outbreak is never, or rarely acute. It usually sees a really slow evolution and that was the case here. Ebola only became a health issue of international concern in the fall of 2014, or in the summer. While it had been going on since February or March. It had been underestimated for a really long time, the problem, to the frustration of MSF for example, who had been warning that they wouldn’t be able to keep it under control, that it required many more resources than were available. And eventually the UN decided, against normal practice to send an outbreak management team from the WHO, who were already there of course, to sent in a group of disaster managers from UNDAC, to do nothing but coordination.**

Was the coordination team also involved in decisions on the placement of ETCs?

**No, that fell within the responsibility of the health cluster. And then you have two sides, the national ETCs and those from the international community. And of cours,e in a health cluster – are you familiar with the cluster system?**

Yes, I am

**So you have the health cluster, lead by the WHO and the Ministry of Health. And that’s were the decisions were made in terms of, where are we going to open what ETCs. While we were deployed, there was always a representative of our group with them. We had a nurse and a doctor who had been added as field experts, but who were also UNDAC-members. We insisted on having them, because we work with a certain methodology. There was a shortage on health workers, but we needed someone with health expertise who could apply the UNDAC-methodology. So we had a doctor and a nurse in the team, who followed a lot of those meetings. In those terms we were involved in a couple of those decisions, but we couldn’t sway a decision. That’s easier in acute settings, or it can happen because UNDAC then takes on a more steering and coordinating role, which had not happened here.**

**This had several reasons. First, there was a Pleiad of agencies and NGOs active before we arrived. Which is also atypical -usually we try to be there in the first wave, or otherwise shortly after. The outbreak had been active for months before we arrived. Second, how will I put this, it had to do with the structure – or traits – of the country itself. There are countries in which working is easy, and there are those where it is hard. In Liberia it was difficult. It is one of the poorest countries in the world. That also translates to the abilities of the government. And another thing – I cannot prove this, but we had the feeling there was a lot of distrust from government and local populations towards the western organisations, the UN, or westerners. Liberia is a country founded by freed slaves from the States, and which has known civil war for years, so societal trust is low. And then there is the added suspicion toward the west or whites, which makes it very complex. That also has the effect that as a result of the internal struggles within government structures, someone has a job title which is completely out of line with their level of power.**

**Two examples. We had the explicit mission to help build up and assist the work of the civil protection agency in Liberia. As it turned out, although formally they had everything to do with disaster management, they had no power at all. Not over ETCs, logistics, not over the coordination, nothing. That was all embedded in the Ministry of Health, and the presidential services. As a result, the partner we had been assigned was side-lined, and we also had to look for different partners, to figure out how things were structured here. Another example: On the card of one of the most powerful advisors, it said he was the chair of the youth commission. During an outbreak, that doesn’t seem like the function you need to take on in order to influence policy makers. But it had to do with internal politics and clan lines et cetera. During deployment in a country like that we’re very aware that we have to look at what’s behind certain façades. But when you have to do that while an outbreak has been going for several months, and in which the government has been changing its own crisis management structure, it is extra difficult.**

**If you’re talking about uncertainty, and chaos, then that’s definitely as a result of the setting of a country which is so underdeveloped, with so little road infrastructure, so little communication infrastructure, very little health care infrastructure. But next to that there’s the factor of chaos and uncertainty in the position of the government and the way in which the government works.**

So that whole network of actors is essentially also a large uncertain factor.

**Correct.**

I was also wondering, if you look at specific information, for example on the number of potential patiens within a region, how people travelled between regions, how the disease would evolve, was there clear information on that or was the feeling that there was a lot of uncertainty on that?

**There was very little data on that. While we were there, a whole data collection protocol had been drawn up. There were several problems: one was due to the extensiveness of the country, before you knew a person had Ebola, that person had to have been at an ETC, a blood sample had to have been taken and tested in an external lab. It took some time before you knew that person x in centrum y had Ebola. That information came in very late. For example, a person died of Ebola at home, that was told to family. They would drive for half a day on a moped, cross a river, ride on a bus for half a day, get to a slightly bigger city, and from there call to the district health officer to alert them. He puts it on paper, and two day later that piece of paper arrives in Monrovia, in the capital. There that data will be parsed. It’s very difficult to guarantee data is correct in such a fragile chain. That person x died on that particular date. A person in such a day can think they have the date on which a person has died, but that might only be the date on which that information became available. And in epidemiology data is everything, it’s extremely important to be able to determine the transmission pattern. That was very hard.**

So what you’re saying, even if the data that is being passed on is correct, there is a delay of several days.

**Yes, depending on what region it was. You had regions which were much more remote, and you had regions which were easier to reach. So yes, depending on where it occurred the speed of information transmission was also different.**

**We started making maps to plot where the hotspots were occurring. For this, we used the humanitarian data set, of geographical data of the provinces, districts, regions, etc. combined with population data from Liberia. We arrive there and the national institute for geology and cartography says, look, we have much better data. But their computer system had a bug which meant that if you requested a specific region, on the digital map, two regions, which were not next to each other, were selected. So that took days, we had experts with us from map action, and they spent days trying to figure out how they could get the correct dataset with geographical information, and then we had to negotiate for weeks before we could release the maps.**

**This is an example of the combination of lack of capacity, lack of trust, and lack of institutional power. If that all comes together things get very difficult.**

Indeed. What I’m also wondering about, the interaction you get when you put a treatment centre somewhere and through that you get more information from the region. As you indicated there is a delay on that, because the data has to be collected and sent. Can you say something about how that works if in a particular region there is no field hospital or something similar? How do people obtain information about what is going on in that region?

**In principle that’s the responsibility of the district health officers. You try to make maximum use out of their regular channels. You can’t show up and build a whole new system. So that would move through the district health officers. So the scenario I just described was – there are also regions where it’s a lot easier and a district health officer would get information from different health posts (not ETCs), but it varies a lot. So the difficult thing was that there was very little communication infrastructure. Eventually it was decided, after we were deployed there (September – October 2014), that I think NetHope, along with other providers would try to set up satellite connections throughout the country so that data transmission would become easier. Because forms would literally get picked up with a helicopter.**

Okay, I have asked you all my questions. Are there things that you think are relevant that we haven’t discussed yet?

**I already briefly mentioned it, local culture plays an incredibly big role. So I just spoke about** [note: this was discussed in the other part of the joint interviewed and not transcribed here] **the cultural practices with death, burial rituals, which unfortunately were very problematic in the affected countries. With a strong belief in shamanism and such, people have died because someone said that a person could cure Ebola patients with hand touches, and like that transferred infections. If you just had a fever and no Ebola, you would still get it that way. So local culture plays a role, not only in those types of aspects, but also in the way you can do your work. It was being said that westerners would spread Ebola, health care workers where murdered, they went to do a screening in a village in Sierra Leone, and they were murdered by the local population because they were suspected of bringing Ebola to the village. That’s a factor that, according to me, for many people has played a much stronger role than we would have thought beforehand. It means community engagement becomes much more difficult, because as a westerner you are not believed. So what I believe played a role in the end, is that we managed to stop the burial rituals, by saying, Look, it’s the local Red Cross, the international Red Cross that’s occupying themselves with safe burials, that the local government and local Red Cross worked on awareness. It’s really difficult because as a responder you just weren’t believed.**

**I’m not sure if that came across enough in what we talked about. But if you ask me, what a factor would be, that would have been the biggest eye-opener for me.**