PATTERNS IN OUR PROBLEMS:
U.S. RESPONSE TO HEALTH CRISES

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The ongoing Ebola virus disease (EVD) outbreak in West Africa affords an unfortunate opportunity to think about the larger context in which the Department of Defense (DoD) responds to health crises and patterns in the problems we encounter in these health crises. This commentary, briefly and simplistically due to space constraints, outlines a few aspects of that context and points to some of the challenges we face, moving from the abstract to the practical. The topics will be painfully familiar to anyone who has worked directly with a health crisis, but may be less familiar to other readers.

Epidemiological Transitions

We are living in interesting times in terms of the broad context of relationships among human biology, culture, and disease. These relationships have formed different patterns, sometimes referred to as epidemiological transitions, over time and in different places. For example, as many human groups shifted from small, mobile bands to more densely packed and fixed agricultural settlement patterns, infectious diseases were able to get more of a foothold. Later, as vaccines and treatments were developed, populations with access to these interventions were less affected by infectious diseases and chronic diseases, such as heart disease and asthma, became a more significant concern. Populations with less access to this type of care continued to struggle with the individual and social burdens associated with high rates of infectious disease.

Starting in the early 1990s, there was a proliferation of publications in the infectious disease and international health literatures pointing to how changing cultural trends were altering our relationship with infectious diseases. Global trends, including the potential for rapid travel, development of new areas, population density changes resulting from urbanization and basic population growth, are combining with patterns of inequality and conflict to create a new landscape for our interaction with infectious disease. These trends have combined with other issues, such as increased antimicrobial resistance, as pathogens adapted to our cultural responses (e.g. use of antimicrobial treatments and prophylaxes), and changing patterns of support for public health infrastructure and research.

It's easy to underestimate the changes currently underway, since medical care in wealthy areas has made it possible to successfully treat individual cases of previously lethal diseases, such as EVD. Yet, transitions on such a macro-level scale are unlikely to be changed by treating individual cases in wealthy communities. We find ourselves in a context where cultural changes, both broad and small, have created the potential for infectious diseases to move more quickly and further, infect more people, and be met with fewer cultural adaptations that can inhibit spread. If an infectious disease is in one place, it's often possible it can be everywhere at the pace of international travel and shipping.

Most people have at least a hazy sense that things are changing, but we don't yet fully understand what it means for us and the other places in the world. We have not yet really adjusted to changes in our relationships with disease. Each of the challenges I point to below is made more urgent by this context.

Outbreaks as part of a broader spectrum

Although we do invest some attention and resources in building health infrastructure and disease surveillance capability at home and abroad, the U.S. still tends to approach disease outbreaks as discrete events. In reality, an

outbreak is just an attention-grabbing moment in the course of much longer processes. Before an outbreak gets attention, a disease is fostered or inhibited by the cultural contexts – everything from infrastructure to beliefs about disease - in which it emerges. Those contexts are created over long periods of time by decisions of people in a community and others who affect them. The course of an outbreak, response, and the aftermath likewise are affected by contexts, as are which aspects of community life are resilient and which are disrupted in more enduring ways. The way the crisis plays out and people's perceptions of response in turn become part of the context of recovery and also the context in which the next health crisis does or does not emerge.

There are community and partner actions that can make a great deal of difference at all points on the spectrum, especially if well coordinated. However, the U.S. government in general and DoD in particular are not structured in ways that would make it easy to think about and address health in a more realistic way. Each organization has its lanes and its constraints. There is some sense in this structure, but it creates challenges in developing effective long-term approaches. It also can hamper the spread of useful information among organizations involved.

Our structural problems can't be solved easily. However, they do need to be considered when we think about how to build systems, programs, and responses that are resilient in the face of our flaws. Our orientations and organizations are part of the socio-cultural context of a response and should be addressed as such.

PLANNING FOR SOCIO-CULTURAL REALITIES

A related challenge is that, in the U.S., government and non-government organizations are much better at planning for biological realities than socio-cultural realities, domestically and abroad. There are volumes that have been and could be written about this issue. For now, it will suffice to say that, collectively, we do not always do a good job of anticipating how our responses, whether guidelines, treatment center designs, or personnel training, will intersect with real world contexts.

Recently in the U.S., a fair amount of confusion arose when the general public tried to make sense out of EVD-related guidelines, emerging scientific reports, and journalistic accounts, which sometimes seemed to contradict each other. This is not the first time this pattern of information flow and confusion has occurred. We saw it in the 2004 influenza vaccine shortage and in many other cases. Turning to global health, the classic example involves infection control guidelines that emphasize hand washing. In areas where water is scarce, wash water may be shared and put to other uses once the washing is complete, undermining the intended purpose. Likewise, no matter how effective it would be, expecting personnel to change protective gear every two or three hours may not be realistic in places where supplies are critically low and where there are insufficient personnel. Each of these issues is not especially hard to anticipate, but it does take time, and finding solutions often requires creative thinking with information from different vantage points.

People who work in health crises usually are aware of and able to anticipate the impact of context. Likewise, social scientists often have useful information. However, in part because of the structural issues described above, people with information sometimes do not know it is needed or how to get it to the right recipients. One of the solutions, as is so often the case with complex, multi-organizational activities, lies in the informal

information sharing relationships that cross cut geography, organizations, and sectors. In my experience, these relationships work when they are established in advance, but are hard to form on the fly. However, recently individual anthropologists and the American Anthropological Association established a network for developing and pushing information to organizations involved in the current EVD response in West Africa. The network's products were well received and, as of this writing, they are still answering requests for information from responding organizations. The way this network formed and its effectiveness gives me some hope that we need not rely entirely on a dichotomy of formal processes and informal relationships. Other means of information sharing across sectors and organizations are emerging.

THE DANGER OF EXOTICISING

One fairly common cultural pattern in the U.S. is a tendency to see cultural influence in a crisis and subtly shift to talking as though this makes the situation intractable. We do this with conflicts, which get simplified as "centuries old tribal tensions." We do it with human rights issues. As the old critique of development work goes, "when men can't vote, it's a human rights violation, when women can't, it's culture." We also do it with cultural aspects of health crises. A lot of early media coverage and briefings on the EVD outbreak in West Africa fell into this trap. We heard that local funerary practices were the primary reason for the spread of disease. While those practices do play a role, saying that they are a primary reason for the outbreak is simply unfounded. The scale of this outbreak had far more to do with travel capacity, infrastructure, and other issues. Additionally, I saw relatively less attention paid to the way communities adapted, changing customary greetings and making what must have been deeply painful concessions in how they cared for the sick and the dead.

There also is more routine exoticising that occurs in mass media and social media and can easily paint a picture that is out of sync with reality, subtlety influencing our planning. Simply stated, stories about exotic cultural traditions, riots, and strange rumors are more likely to get published and shared than stories about things going relatively smoothly. The challenge here lies in two areas. First, the need to balance attentiveness to real cross-cultural challenges with recognition of how our own prevalent cultural discourses can affect what information is made available to us and how we interpret it. Second, ensuring that in our own desire to make a compelling case or an interesting paper, we don't communicate in ways that feed lines of discourse that make it easy for the public and policy-makers to dismiss the situation as intractable.

PREPARING PERSONNEL FOR DIFFERENT CONTEXTS

My last point involves the very practical business of preparing people for the cross-cultural aspects of supporting health crises in a variety of different roles. Personnel going to staging areas will need help navigating the cross-cultural and language complexity of a multi-national, multi-organizational response, but probably need only basic language and culture information specifically related to the outbreak. Those building facilities will need some of the same preparation, but also more information on local governance challenges and opportunities, etc. Personnel working in health care facilities or on teams traveling to provide care need other kinds of culture and language preparation.

Watching different responses, domestically and abroad, I have noticed that we seem to get stuck

on either trying to develop a "one size fits all" approach to preparation that ends up not serving any deploying personnel as well as it could or waiting to find out what specific personnel are going to do. However, in advance of a crisis, we can develop processes and perhaps even design some training and supportive products based on the broad categories of work personnel do in health crises. We may not be able to anticipate every piece of detail that needs to go into preparation for an endless range of possible crises. We certainly can develop the frameworks, processes, and information sharing relationships that would allow us to create materials more rapidly as a crisis emerges. This is one problem where a big part of the solution lies in the individual working relationships that each of us can affect.

CONCLUSION

This commentary has moved rapidly from the abstract context of the human relationship with disease to practical matters of preparing personnel to respond to health crises. Many of the complications we face, whether our own discursive habits or the way international responders will be received by a community, can be anticipated. People who regularly deal with health crises and social scientists who study them are good at thinking through the this complexity. The structural impediments to sharing and, perhaps more importantly, using their knowledge are significant. Yet, informal working relationships among government officials, social scientists, and international health professionals do work, especially if established and maintained in advance of an outbreak. These relationships are likely to become increasingly important given the changing disease landscape and enduring organizational challenges. Those of us working in DoD should do all we can to support them.

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