
# The African Union and its Behaviour During the Ebola Outbreak 2014-2016: Steps Towards Understanding Actorness and Effectiveness

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## Abstract

The following thesis seeks to test Brattberg and Rhinard's hypothesized correlation between actorness and behaviour (assumed to facilitate effectiveness) during disasters. Its goal is to test it on the African Union during the Ebola outbreak and thereby investigate if there is a positive relation between degrees of actorness and behaviour. The test shows, broadly speaking, a positive result, but it does suggest that certain expectancies in behaviour need to be conceived in broader terms.

Key word: actorness, behaviour, effectiveness, African Union

# 1. Introduction

An often shared sentiment among scholars is that the international security environment is becoming increasingly complex. This complexity have been marked by the rise of regional organizations, through which states have attempted to integrate their efforts in addressing common interests. In the wake of this development, scholars have debated whether or not regional organizations themselves are effective actors. Commonly, these debates rest on the basic assumption that "more actorness equals more effectiveness". Yet, as observed by Arne Niemann and Charlotte Bretherton, in what way actorness impacts effectiveness is under-theorized.[1] To begin with, actorness itself is a contested concept. While the concept usually pertains to an entity's ability to act deliberately in relation to other international actors, other relational objects have been acknowledged as well, such as disasters.[2] Against this backdrop, consider the Ebola outbreak in West Africa and the involvement of the African Union (AU).

The outbreak started in 2013 and would result in 11,310 deaths across primarily Guinea, Liberia and Sierra Leone.[3] As it was escalating, the World Health Organization (WHO) declared the outbreak to be a public health emergency and in dire need of an international response. Moreover, the UN Security Council stressed that it was a threat to international peace and security.[4] Although the AU, along with the rest of the international community, were initially criticized for being complacent, the Union would become involved with funding, and contributed about a third of the international personnel in the WHO-lead response.[5] In combination with international and local efforts the outbreak was finally under control by 2016, and though occasional flare-ups have since been reported it is no longer considered an emergency.[6]

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[1] Arne Niemann and Charlotte Bretherton 'EU external policy at the crossroads: The challenge of actorness and effectiveness', *International Relations*, vol. 27, no. 3 (2013): 261-2.
[2] Ibid., 265; Erik Brattberg and Mark Rhinard, 'The EU and US as International Actors in Disaster Relief', *Bruges Political Research Papers*, no. 22 (2012), 3-4.
[3] WHO, 'Situation Report: Ebola Virus Disease 10 June 2016', *Ebola outbreak 2014-2015*, Website the World Health Organization, 2016-06-10 (Accessed 2017-04-06).
[4] WHO, *Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa*, Website the World Health Organization, 2014-08-08 (Accessed 2017-04-06); UNSC, Res 2177 (18 September 2014), UN Doc S/RES/2177, 1.
[5] Nana Yaa Boadu, *At the epicenter of the Ebola crisis: Africa's response – good, bad, not nearly enough or still too early to tell?*, Website International Health Politics, 2014-12-17 (Accessed 2017-03-06); WHO, *WHO Strategic Response Plan: West Africa Ebola Outbreak* (WHO, 2015), 7.
[6] WHO, 'Situation Report: Ebola Virus Disease 10 June 2016'.

Herein emerges the question of how actorness impacts effectiveness. Actorness is commonly considered issue-specific.[7] Although there has not been any studies that have evaluated the AU's actorness in epidemics disaster management, there are reasons for concern. First and foremost, there is little literature that actually considers the AU to be a proper actor. When investigating the issue, Bjørn Møller found that the Union repeatedly have failed to live up to the notion of a (traditional) security actor as it often has lacked unity. [8] Moreover, Simon Hollis, while not investigating epidemic management capabilities specifically, notes that the AU somewhat lacked disaster management capabilities in general.[9] Lacking capabilities constitute damaging evidence, since capabilities are often considered an important feature of actorness. For example, in Gunnar Sjöstedt's seminal work on actorness, capabilities are intimately tied to effectiveness. High capabilities allow for the distinction between strong and weak actors, while also allowing for purposive action. Taken together, these characteristics make the difference between an international actor and an *effective* international actor.[10] Given the indication that AU lacks high actorness in dealing with both traditional and non-traditional threats in general, one might thus hypothesize that the AU also lacked high actorness in specifically epidemic disaster management during the Ebola outbreak. Based on the aforementioned literature, this would also lead one to expect that the AU was ineffective. Effectiveness is, however, notoriously difficult to assess, not least because what is considered effective can change depending on the perspective. Christopher Hill, for example, approached it as an actor's ability to live up to expectations, whereas Roy Ginsberg instead focused on the outcomes of any given action.[11] The latter perspective has, however, informed much of the literature that investigate how actorness impacts effectiveness. Thus effectiveness has been measured as "goal attainment", meaning whether or not an actor achieves its objectives.[12] But in the case of the Ebola outbreak, the AU collaborated with international partners in an effort that eventually turned out successful.

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[7] Niemann and Bretherton 'EU external policy at the crossroads', 268.
[8] Bjørn Møller, *The African Union as Security Actor: African Solutions to African Problems?* (Copenhagen: Danish Institute for International Studies, 2009), 15-6.
[9] Simon Hollis, *The Role of Regional Organizations in Disaster Risk Management: A Strategy for Global Resilience* (Basingstoke: Palgrave Macmillan, 2015), 19-22.
[10] Gunnar Sjöstedt, *The External Role of the European Community* (Farnborough: Saxon House, 1977), 15-6.
[11] Christopher Hill, 'The Capability-Expectations Gap, or Conceptualizing Europe's International Role', *Journal of Common Market Studies*, vol. 31, no. 3 (1993), 306; Roy Ginsberg, *The European Union in International Relations: Baptism by Fire* (Lanham: Rowman & Littlefield, 2001), 15.
[12] Niemann and Bretherton 'EU external policy at the crossroads', 267.

Hence, numerous actors were involved and together working for the same or similar goals. If the AU's own degree of actorness affected the achievement of common goals is therefore difficult to causally distinguish. The AU's involvement in the Ebola outbreak thus reveals the difficulty in understanding how actorness (or lack thereof) translates into effectiveness (or ineffectiveness).

With this complication in mind, Erik Brattberg and Mark Rhinard's approach to actorness and effectiveness is therefore well worth pointing out. They have recently attempted to address the shortage of theory by suggesting a number of hypothetical connections between actorness and behaviour during disasters. While they do not assume that actorness is the sole cause of behaviour, their hypotheses address predictions in how they correlate.[13] Moreover, though these behaviors (such as smooth cooperation and sufficient resource mobilization) do not inherently translate into goal attainment, they are assumed to facilitate effectiveness.[14] The benefit compared to other approaches is thus that the outcome (behaviour) can be distinguished from other actors involvement, contrary to a focus on only goal attainment. As such, their hypotheses are a step in the right direction to better understand how actorness translates into effectiveness. While there is a degree of correlation in their own test of the hypotheses, it is still not entirely conclusive. For example, the correlation between actorness and coordination was not clear. They thus argue that further research is required to strengthen if actorness has any added value in terms of outcomes in behaviour.[15] The intentions of this thesis is therefore to examine if the AU's degree of actorness during the Ebola outbreak, correlated with expectations in behaviour, as defined by Brattberg and Rhinard.

## 1.1 Research objective

The principle objective of this thesis is to test Brattberg and Rhinard's hypotheses on actorness and behaviour in order to further establish their validity. The primary contribution by this thesis should be seen in relation to the cases in Brattberg and Rhinard's own test, which were the EU and the US. Though both the EU and the US were found to be lacking in

[13] Erik Brattberg and Mark Rhinard, 'Actorness and effectiveness in international disaster relief: The European Union and United States in comparative perspective', *International Relations*, vol. 27, no. 3 (2013), 359-60.
[14] Ibid., 360.
[15] Ibid., 368-9.

certain areas of actorness, both exhibited significant degrees of actorness in general.[16] The AU thus makes for an interesting case, since it is hypothesized to exhibit low actorness overall. The thesis therefore has the potential to examine if the hypothesized relationship between actorness and behaviour necessarily is positive. Once the AU's actorness in epidemic disaster management and its behaviour during the Ebola outbreak have been analysed, the thesis stands to make a number of assessments of Brattberg and Rhinard's hypotheses. Should the AU exhibit low actorness but still behave as an entity with high actorness, the hypotheses are weakened since a positive relationship between the degree of actorness and expected behaviour is not present. The hypotheses are conversely strengthen, should the AU not behave as an entity with high actorness. In the event that the AU exhibit surprisingly high actorness, the thesis stands to contribute on the generalisability of the correlation between high actorness and behaviour. But it will not be able to assess if the correlation is stronger among entities with high actorness than low actorness.

With regards to Brattberg and Rhinard's own study, certain limitations of this thesis' goal should also be acknowledged. In their study they also attempted to address how the behaviour of the EU and the US affected their goal attainment.[17] But as argued before, analysing individual actors' own goals attainment in collaborative disaster responses are difficult. Due to this, the goal of the thesis only concerns testing the correlation between actorness and behaviour.

Having laid out the research objective, it is necessary to assess the contribution by the thesis' test from the perspective of whether the case of the AU and its behaviour during the Ebola outbreak constitute a most- or least-likely case. Most-likely cases are cases that conform to the intended application of theories, which therefore makes the theories likely to predict the outcome in the cases. Least-likely cases are consequently the reverse. When testing a theory, most-likely cases are usually considered less beneficial if a theory is well established. In these instances least-likely cases are instead preferred since they can investigate the boundaries of the theory.[18] The intended application of Brattberg and Rhinard's hypotheses concerns the actorness of entities in the international system and their behaviour during international disasters. The fact that the outbreak occurred on the AU's

[16] Brattberg and Rhinard, 'The EU and US as International Actors in Disaster Relief', 28
[17] Brattberg and Rhinard, 'Actorness and effectiveness in international disaster relief', 368-69.
[18] Alexander George and Andrew Bennett, *Case Studies and Theory Development in the Social Sciences* (Cambridge: MIT Press, 2005), 121.

home turf might seem to contradict the last part of Brattberg and Rhinard's intentions. But it should be emphasized that WHO was the leading organization in an international response, which included the AU, to a disaster considered to be of international concern. The case of the AU during the Ebola outbreak therefore conform to Brattberg and Rhinard's intended application and thus constitute a most-likely case. But given that Brattberg and Rhinard's original test was not entirely conclusive, and that the hypotheses are in their infancy in terms of leading to concrete theory development, more research on a most-likely case is therefore still warranted.

### 1.2 Research questions

To guide this thesis' research objective, the following research questions are asked:

- What was the degree of the AU's actorness in epidemic disaster management at the time of the Ebola outbreak?
- What behaviour, as listed by Brattberg and Rhinard, was exhibited by the AU in its response to the Ebola outbreak?

### 1.3 Disposition

Key to the thesis is the AU and epidemic disaster management, hence the thesis will start by introducing a short description of the AU as an entity and what constitute epidemic disaster management. Next, the thesis will consider the strengths and weakness of Brattberg and Rhinard's writings on actorness and behaviour in relation to previous literature, thereby situating the thesis' contribution clearly. From there, the thesis will turn to its conceptual framework, drawn from Brattberg and Rhinard. Thereafter the method underpinning the thesis will be discussed and described, followed by the analysis itself. Finally, conclusions and considerations for future research will be presented.

## 2. The African Union and Epidemic Disaster Management

Due to the thesis' topic, a description of the AU as an entity at the time of the Ebola outbreak is needed, as well as a definition of epidemic disaster management. The Union was established in 2001 and formally came into effect in 2002, replacing its predecessor the Organization of African Unity (OAU). At the time of the Ebola outbreak the AU consisted of

53 member states, corresponding to every state on the African continent that was a member of the UN, with the exception of Morocco (which first became a member in January 2017) and the Central African Republic (its membership was suspended ahead of the outbreak in 2013).[19] Similar to many other regional organizations, the AU has a central institutional arrangement: the Assembly of the African Union which is the supreme decision-making organ, comprising all the Heads of States among member states; the Executive Council of the African Union which also deals with decision-making and is comprised of ministers from the member states; the Pan-African Parliament which serves as the legislative body of the Union; and lastly the Commission of the African Union functioning as the executive branch.[20] The distinguishing feature of the AU is its relationship with subregional organisations on the African continent. Many member states are not only members of the AU but also of regional economic communities (RECs). As their name imply, these organizations were mainly formed to enhance economic integration among their members, but they have over time also grown to deal with a wider number of issues, such as health and disaster management. A number of treaties have attempted to integrate the RECs more closely with the AU, and eight RECs are today formally recognized by the AU as subregional organizations. From the perspective of the AU, they are considered to be key "building-blocks" and can function as the implementation arm of the AU. But these RECs should not be confused with formal subregional AU institutions. They have formed largely on their own, and are still, legally speaking, separate entities. Given their distinctness, not every action by the RECs are connected to the AU and their relationship remain collaborative.[21] This thesis will therefore not included the RECs within the scope of the AU as an entity.

What epidemic disaster management is might be self-explanatory, but it should still be explicitly defined as to reduce any risk of confusion. It marks the intersection between disaster management and the health sector in combating the spread of disease.

## 3. Previous literature

In the introduction, an overview was provided on how Brattberg and Rhinard's contribution

[19] African Union, *Member States of the African Union*, Website the African Union (Accessed 2017-04-16).
[20] African Union, *AU in a Nutshell*, Website the African Union (Accessed 2017-04-16).
[21] South African History Online, *The African Union and Regional Economic Integration*, Website South African History Online, 2015-10-30 (Accessed 2017-04-16).

relates to the actorness and effectiveness debate. But this debate is not only a matter of how one should go about addressing effectiveness, but it also concerns actorness itself. Hence this thesis need to be situated within the literature on actorness as well, in order to examine if the thesis is testing relevant concepts.

Writings on actorness have largely descended from Sjöstedt's study from 1977. He broadly equated actorness with *actor capability* which he defined as a "[...] capacity to behave actively and deliberately in relation to other actors in the international system".[22] Aside from actor capability, he also emphasized an actor's *autonomy*, referring to its separateness from the external environment and its internal cohesion. While several scholars have since attempted to reconceptualize actorness, Sjöstedt's influence can still be felt. Among the prominent more recent concepts is one stipulated by Joseph Jupille and James Caporaso. Similar to Sjöstedt, they emphasize *autonomy* while also suggesting three additional concepts: the internal and external *recognition* of an actor; its level of legal *authority* to act; and lastly, whether or not there is internal *coherence* among values, policies and processes.[23] Several of these concepts have been invoked as especially important when dealing with effectiveness. Maurizio Carbone, for example, have suggested that *coherence* is the most important component of actorness, arguing that it is what ultimately permits actions and in turn effectiveness.[24] Daniel Thomas, following this line of reasoning, have suggest a hypothetical link between specifically the EU's coherence and the effectiveness of its foreign affairs.[25] On the other hand, when Geoffrey Edwards similarly investigated the EU's foreign affairs, he found the EU's lack of *autonomy* to be a significant detriment to its effectiveness.[26] Given the diverging conclusions among these authors, Lisanne Groen and Arne Niemann's attempt to strengthen the understanding of how actorness impacts effectiveness by emphasizing both *coherence* and *autonomy* may be seen as a relevant contribution.[27] That

[22] Sjöstedt, *The External Role of the European Community*, 15-6.
[23] Joseph Jupille and James Caporaso, 'States, Agency, and Rules: The European Union in Global Environmental Politics', in *The European Union in the World Community*, eds. Carolyn Rhodes (Boulder: Lynne Rienner Publishers, 1998), 216-8.
[24] Maurizio Carbone, 'Between EU actorness and aid effectiveness: The logics of EU aid to Sub-Saharan Africa', *International Relations*, vol. 27, no. 3 (2013): 343.
[25] Daniel Thomas, 'Still Punching below its Weight? Coherence and Effectiveness in EU Foreign Policy', *Journal of Common Market Studies*, vol. 50, no. 3 (2012): 457-8.
[26] Geoffrey Edwards, 'The EU's foreign policy and the search for effect', *International Relations*, vol. 27, no. 3 (2013): 276-8.
[27] Lisanne Groen and Arne Niemann, 'The European Union at the Copenhagen climate negotiations: A case of contested EU actorness and effectiveness', *International Relations*, vol. 27, no. 3 (2013): 308-10.

said, Bretherton and Niemann recognizes that due to the specific nature of actorness, the relevance of certain actorness concepts might very well vary between issues.[28] In particular when dealing with disaster management, examining actorness as autonomy (the distinctiveness of an entity) and coherence (common values, policies and processes) would be insufficient. As pointed out by Hollis, gaps between existing disaster management capabilities and what is formally expected of an entity will have a large impact on what an entity can achieve.[29] Thus, if the correlation between actorness, as autonomy and coherence, and effectiveness (or behaviour as is the case in this thesis) is studied, the correlation would be subject to heavy influence from external factors. This all circles back to lend support for Sjöstedt's initial argument, that *capabilities* are a non-neglectable part of actorness, not least when debating effectiveness. Brattberg and Rhinard's actorness concept does include both *coherence* and *capabilities*, and while *autonomy* is not explicitly measured they argue that their *coherence*-concept draws on Jupille and Caporaso's *autonomy*-concept.[30] In relation to the actorness and effectiveness literature, Brattberg and Rhinard thus include concepts recognized as important by that specific literature. But they also measure concepts that have an expected importance based on the broader actorness literature. It is therefore possible to argue that the contribution of this thesis is strengthened on the basis of testing relevant concepts.

Another point of concern, however, in the actorness (and effectiveness) literature is the referent object. Whereas Sjöstedt approached actorness as a plausible, but not necessary, characteristic of any international entity, later studies have developed actorness concepts specifically in relation to the EU.[31] This development have been based on the assumption that the EU is *sui generis*, a unique entity.[32] Ian Manners, who has informed much of the debate on the EU as a normative power, follows this line of reasoning as he states that the EU is one of a kind in the international system.[33] Similarly, Bretherton and John Vogler, while trying to move away from the EU as normative power, still argue that EU is markedly unique.[34] The

[28] Niemann and Bretherton, 'EU external policy at the crossroads', 268.
[29] Hollis, *The Role of Regional Organizations in Disaster Risk Management*, 138-40.
[30] Brattberg and Rhinard, 'The EU and US as International Actors in Disaster Relief', 8.
[31] Sjöstedt, *The External Role of the European Community*, 13; Niemann and Bretherton 'EU external policy at the crossroads', 262.
[32] Jens-Uwe Wunderlich, 'The EU an Actor Sui Generis? A Comparison of EU and ASEAN Actorness', *Journal of Common Market Studies*, vol. 50, no. 4 (2012): 654.
[33] Ian Manners, 'Normative Power Europe: A Contradiction in Terms?', *Journal of Common Market Studies*, vol. 40, no. 2 (2002): 238-9.
[34] Charlotte Bretherton and John Vogler, 'The European Union as a Protagonist to the United States

literature on actorness have thus largely been limited to the EU with little consideration for other international entities. Only in the last couple of years has there been a move, albeit limited, towards a less EU-centric approach to actorness. In doing so, Jens-Uwe Wunderlich highlights two methodological problems that underpin the broadening of the actorness concept to include other regional organizations. The first is the assumption that progress, or high actorness, necessarily must look like the institutional integration found in the EU. The second problem is drawn from the literature on regionalism, whereby he argues that there is little agreement on what constitute a "region" and how to conceive of its boundaries.[35] Both points are well worth consideration in relation to this thesis. The literature that has explored in detail the actorness and effectiveness correlation has so far been quite limited. Niemann and Bretherton, who introduced a special issue on the topic (in which Brattberg and Rhinard were included), noted that it was their intention to move away from the EU as *sui generis*.[36] Despite this, the EU was the only entity studied in the issue, with the exception of Brattberg and Rhinard who also added the US.[37] Moreover, in what has since followed, the EU has stayed in focus.[38] Hence the actorness and effectiveness literature appears still *de facto* rooted in an EU perspective on what actorness is. Given this thesis' goal of testing if the AU's degree of actorness in epidemic disaster management correlated with certain behaviours (or lack thereof) during the Ebola outbreak, the thesis stands to make a much needed assessment of the concept in relation to non-Western entities. Should, for example, the thesis find that the AU exhibit low actorness but a behaviour that match high actorness, there are reasons to consider alternative approaches to actorness. Irrespective of the thesis' findings, however, it contributes to a rather small literature on the actorness of other regional organization.[39]

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on Climate Change', *International Studies Perspectives*, vol. 7, no. 1 (2006): 4-5.

[35] Wunderlich, 'The EU an Actor Sui Generis?', 654.

[36] Niemann and Bretherton 'EU external policy at the crossroads', 262.

[37] Ibid., 261-71; Brattberg and Rhinard, 'Actorness and effectiveness in international disaster relief', 357.

[38] See: Louise van Schaik, *EU Effectiveness and Unity in Multilateral Negotiations: More Than the Sum of its Parts?* (Basingtoke: Palgrave Macmillan, 2016); Eugénia da Conceição-Heldt and Sophie Meunier, 'Speaking with a single voice: internal cohesiveness and external effectiveness of the EU in global governance', *Journal of European Public Policy*, vol. 21, no. 7 (2014); Lisanne Groen and Sebastian Oberthür, 'The Effectiveness Dimension of the EU's Performance in International Institutions: Toward a More Comprehensive Assessment Framework', *Journal of Common Market Studies*, vol. 53, no. 6 (2015).

[39] For an overview see: Wunderlich, 'The EU an Actor Sui Generis?', 654-5; Merran Hulse, 'Actorness beyond the European Union: Comparing the International Trade Actorness of SADC and ECOWAS', *Journal of Common Market Studies*, vol. 52, no. 3 (2014), 547-9.

# 4. Conceptual Framework

## 4.1 Actorness

Since the goal of this thesis is to test Brattberg and Rhinard's hypotheses, their concepts need to be described. Starting with actorness, according to Brattberg and Rhinard it is comprised of four main concept: context, coherence, capabilities and consistency.[40] *Context* denotes the acceptance of an entity as an actor by the international system and member states. This concept is however dependent on three subconcepts. The first one is *recognition* of an entity as an actor, and it is divided between *de jure* and *de facto* recognition: the former relates to formal acceptance and the latter concerns perceptual (or informal) acceptance. The second subconcept is *opportunity*. It pertains to the external perception and expectation of an actor, and thus forms part of the structural circumstances of when an actor can act. The last subconcept is *authority*, and it refers to what level of mandat an entity has for action.[41]

*Coherence*, the second main concept, concerns whether an entity has common values, preferences, institutional procedures and policies, through which it can project influence. This concept is similarly broken down in a number of subconcepts, the first one being *value coherence*. It relates to whether or not there are shared commitments to overarching principles within an entity. The next subconcept is *preference coherence*, which instead focuses on whether there are shared interests within an entity. *Procedural coherence* is the third subconcept and it denotes to what extent there is agreement on rules and procedures in terms of policy-making. Finally there is *policy coherence,* and following from where the last subconcept left off, it asks whether an entity is able to formulate common policies and to what extent those policies determine a specific behaviour.[42]

The next main concept is *capability* and it refers to instruments, mechanisms and other resources that are available, and the ability to mobilise these towards policy goals. This definition thus contains the two subconcept: first, *existent capabilities* which range from diplomatic tools, to military resources, to trade agreement depending on the issue; and second, the *capacity to utilise*, which denotes the degree of ease or difficulty by which

[40] Brattberg and Rhinard, 'The EU and US as International Actors in Disaster Relief', 5.
[41] Ibid., 6-7.
[42] Ibid., 7-9.

capabilities are deployed.[43]

*Consistency* is the last main concept and relates to whether an entity can carry out agreed policies in practice, and it has two components. *Vertical consistency* concerns whether member states and regional institutions have implemented similar policies. *Horizontal consistency,* on the other hand, denotes whether similar policies at the member state level or the regional level have been implemented.[44]

## 4.2 Hypothetical link between actorness and behaviour

Based on their actorness concept, Brattberg and Rhinard's hypotheses predict certain behaviours during disaster management if an entity has high actorness. It should be emphasized here that the relationship between actorness and behaviour is assumed to be predictive, rather than deterministic, given that other factors than actorness can affect behaviour.[45] Brattberg and Rhinard hypotheses are as follows:

> "High levels of *context*-related actorness should lead to: An actor being (a) quickly accepted in situations requiring disaster relief, thus enabling (b) quick mobilisation, (c) smooth coordination and (d) strong normative influence."[46]

The first behaviour (behaviour a) refers to the expectancy that entities with high *context* will quickly be accepted by other actors involved in a disaster response. Since less energy is needed to convince other actors of its involvement, the entity can quickly mobilize resources for the response (behaviour b). As an accepted actor it is also more likely to enjoy functional coordination with its partners and local authorities (behaviour c), but it will also have a better position to influence how the response should be managed (behaviour d).[47]

> "High levels of *coherence*-related actorness should lead to: Lower transaction costs related to (a) coordination, both internally and in a host country during a disaster owing to clarity of purpose, (b) low inter-organisational competition and (c) uncontested leadership hierarchies."[48]

[43] Ibid., 9-10.
[44] Ibid., 10-11.
[45] Brattberg and Rhinard, 'Actorness and effectiveness in international disaster relief', 360.
[46] Ibid., 362.
[47] Ibid., 360.
[48] Ibid., 362.

Should an entity enjoy high *coherence* it will have clearer goals and objectives, thus enabling highly functional coordination internally, from the top level down to the field level. Apart from the internal coordination, *coherence* will also affect the external coordination, given that clear goals permit partners to adjust themselves (behaviour a). Similarly, high *coherence* will result in few competitions between an entity's agencies given that they share common values, preferences and policies (behaviour b). This will also strengthen the leadership hierarchies and minimizing the risk of them being contested (behaviour c).[49]

> "High levels of *capability*-related actorness should lead to: Ability to mobilise (a) a sufficient amount of resources (b) which are also relevant to a certain disaster, thus alleviating suffering in a swifter manner."[50]

High *capabilities* will increase the likelihood that an entity is able to mobilise an adequate amount of resources in a disaster situations (behaviour a), while also increasing the odds that the resources that have been mobilized are relevant (behaviour b). Both of these thereby clearly add to an entity's ability to quickly engage with victims. [51]

> "High levels of *consistency*-related actorness should lead to: (a) agencies working together smoothly (with fewer disputes) and (b) operating in areas of relative strength (rather than in competing over operational priorities)."[52]

High *consistency*, meaning similar policies have been implemented at different levels within an entity, is expected to facilitate smooth work between an entity's various agencies, rather than them being weighed down by disputes (behaviour a). This will also mean that they are likely to pursue common agendas, rather than competing over individual agendas. Moreover, by advancing a common agenda, agencies will be able to work in their area of expertise (behaviour b).[53]

[49] Ibid., 361.
[50] Ibid., 362.
[51] Ibid., 361.
[52] Ibid., 362.
[53] Ibid., 361.

# 5. Method

## 5.1 Research design

In order for this thesis to ensure high validity and reliability throughout its analysis and the conclusions thereafter, its overall research design must first be clearly established. Since its objective (testing) and case (the correlation between the AU's actorness and behaviour during the Ebola outbreak) have already been determined, the basics of the research design are set: a single-case study used for testing. Falling in line with the research objective, such a research design is devoted to either rejecting or confirming the validity of hypotheses and theories.[54] Naturally, the thesis is therefore not equipped to develop Brattberg and Rhinard's hypotheses. This point is well worth highlighting as even though the test may provide suggestions on how the hypotheses could be altered, the thesis is by design not able to explore the validity of these alterations in-depth.

In the section on the thesis' research objective, an argument was presented as to why the thesis stands to make a contribution as a most-likely case. However, as a single-case study its limitations and possible pitfalls need to be fully acknowledged. The principle rule concerning the generalisability of theories and hypotheses is that if they hold across a large number of cases they are strongly supported.[55] Given this thesis' test only involves a single case, it therefore has an inherently weak ability to generalize its result. That said, when testing a theory or hypothesis, the test is implicitly done in comparison with every other test of the same theory or hypothesis.[56] In that context, this thesis' contribution gains an increased significance, as it is done against the backdrop of Brattberg and Rhinard's own test.

## 5.2 Method of analysis

With the basics of the research design laid out, the next step is to address how the analysis will go about. In doing so, the first issue to deal with is whether it should be a qualitative or a quantitative analysis. While certain concepts could be assessed through a purely quantitative analysis (such as *existent capabilities*), not all concepts lend themselves well to it (such as

[54] Juliet Kaarbo and Ryan Beasley, 'A Practical Guide to the Comparative Case Study Method in Political Psychology', *Political Psychology*, vol. 20, no. 2 (1999), 386-7.
[55] George and Bennett, *Case Studies and Theory Development in the Social Sciences*, 110-1.
[56] Ibid., 69.

*opportunity* which deals with other actors' subjective expectations). A qualitative analysis thus provides a more suitable approach in analysing the hypotheses overall. That said, a qualitative approach can still deal with quantitative assessments.[57]

Qualitative analyses include a number of approaches and can broadly be categorised as: discourse analysis, text analysis and process-tracing.[58] Discourse analysis is predominantly tied to a post-positivistic orientation in terms of ontology and epistemology.[59] As that is not the case in this thesis, it is of little use. Process-tracing on the other hand is firmly rooted in positivism, and specifically deal with the causal relationship between variables.[60] But applying this method is also difficult. The benefit of Brattberg and Rhinard's focus on behaviour rather than effectiveness *per se* was that the behaviour of an actor could be distinguished in international disaster responses. But even so, their hypotheses only predict a correlation. When analysing through process-tracing it is imperative that the researcher identifies a mechanism of causality and possible intervening variables, otherwise a study may overestimate the causality between the variables.[61] Because it is not within this thesis' scope to address all the possible intervening variables in between actorness and behaviour, changing the hypotheses' focus from correlation to causality would therefore be highly problematic. But not using process-tracing does have a number of implications. Since no exact mechanism of causality between variables is analysed, this means that whether or not a specific actorness characteristic actually caused a specific behavioral outcome can not be determined. The analysis can only examine if they covariate.

With two of the qualitative approaches discarded, text-analysis is left in order to study the correlation. This type of method of analysis broadly denotes an investigation of written (and oral) data to establish the meaning of its content.[62] Concerning this thesis, using this method means that the analysis asks what the content of written data says about the concepts in Brattberg and Rhinard's hypotheses. To put it more clearly, the text-analysis will proceed

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[57] Peter Esaiasson, et al., *Metodpraktikan: Konsten att studera samhälle, individ och marknad* (Stockholm: Norstedt Juridik AB, 2012), 221-2.
[58] Ibid., 211-212.
[59] Donatella della Porta and Michael Keating, 'How many approaches in social science? An epistemological introduction', in *Approaches and Methodologies in the Social Sciences: A Pluralist Perspective,* eds. Donatella della Porta and Michael Keating (Cambridge: Cambridge University Press, 2008), 22-4.
[60] George and Bennett, *Case Studies and Theory Development in the Social Sciences*, 205-7.
[61] Derek Beach and Rasmus Brun Pedersen, *Process Tracing-Methods: Foundations and Guidelines* (Ann Arbor: University of Michigan Press, 2013), 89-91.
[62] Esaiasson, et al., *Metodpraktikan*, 210.

deductively. Deductive analysis are commonly used when testing hypotheses, and do so through a process of assessing the validity of pre-established concepts based on the collected data.[63] In practice the analysis will study the AU's actorness and its behaviour during the Ebola outbreak separately and then compare them in order for the correlation to be determined, thereby concluding the test. However, since Brattberg and Rhinard's hypotheses are predictive rather than deterministic, a single slip in the correlation between actorness and effective behaviour does not mean that their hypotheses can be all out rejected. There need to be consistent discrepancies in the correlation, in order to have strong evidence that the hypotheses are weak. To accomplish the deductive text-analysis requires the theoretical concepts to be adequately operationalized, the purpose of the next section.

## 5.3 Operationalization

### 5.3.1 Actorness

As stated in the aforementioned section, the concepts will require operationalization in order to ensure that theoretical concepts are properly used in assessing the data. Given that the four main concepts are all divided into subconcepts, it is the subconcepts that need to be operationalized as those are the ones that link the main concepts to the data. Furthermore, since actorness is a matter of degree, the operationalization of the subconcepts must both contain indicators of the concepts' presence and measurement.

The concept *context* has three subconcepts: recognition, authority and opportunity. First is *recognition*, which itself has two components: *de jure* (formal) and *de facto* (informal) recognition. *De jure* recognition will be operationalized as whether there are formal treaties and partnerships, and/or diplomatic visits that in effect recognized the AU as an actor in epidemic disaster management. The measurement entails whether or not the formal recognition concerns large parts of the international system and member states. *De facto* recognition, however, is a more complicated matter. Since it is meant to assess the perception of an entity as a legitimate actor among a broad set of actors, providing concrete evidence concerning all of them is difficult. Instead, this thesis will work with a simplified operationalization: cooperation. Brattberg and Rhinard argues that acceptance as an actor

[63] Adrienne Héritier, 'Causal explanation', in *Approaches and Methodologies in Social Science: A Pluralist Perspective*, eds. Donatella della Porta and Michael Keating (Cambridge: Cambridge University Press, 2008), 63.

underpins an entity´s ability to work with other actors.[64] Hence assessing if the AU frequently or infrequently cooperated on issues pertaining to disease disasters will be used to measure whether the AU was *de facto* recognized. But since *de facto* recognition is only indirectly assessed through this method of operationalization, the analysis can only provide an indication and not conclusive evidence. *Opportunity* is the next subconcept, which deals with the international perception and expectations of an entity as to whether it is an active international actor. This concept lends itself to very comprehensive studies depending on how it is approached. Some scholars have, for example, dedicated entire studies to *opportunity* alone.[65] Similar to *de facto* recognition, however, this thesis will work with a simplified approach, as to make an analysis of it feasible. *Opportunity* is therefore operationalized as whether the AU is expected to be active in external epidemic disaster management by external actors. Lastly there is *authority*. Operationalizing the degree of *authority* will be based on to what extent the AU Commission (the executive branch) can make decisions, or if a high degree of intergovernmental decision-making is required during epidemic disaster management.

The next concept is *coherence*. Brattberg and Rhinard do acknowledge that it is possible to focus on a specific set of subconcepts regarding *coherence* since they are linked.[66] But this means that the estimates of the other concepts can only be inferred, not examined. The first subconcept is *value coherence*, and it will be operationalized as to what extent the AU and its member states have implemented formally recognized principles and goals concerning epidemic disasters. This is not entirely suitable in terms of validity, given that formally recognized values do not necessarily include the full scope of the values at play. But it will provide an indication of the level of value coherence within the AU. Importantly, it provides an indication concerning values that should be common. *Preference coherence* is likewise difficult to assess since it concerns the interests of states. Consider for example the literature on international relations which often focus on interests, yet often remain divided as to what they are. That AU member states recognize common goals could indicate similar interest, but that would make the indicators for *value* and *preference coherence* indistinguishable.

[64] Brattberg and Rhinard, 'Actorness and effectiveness in international disaster relief', 360.
[65] See: Sonia Lucarelli and Lorenzo Fioramonti, 'Have You Heard of the EU? An Analysis of Global Images of the European Union', *GARNET Policy Brief*, no. 7 (2008); Lorenzo Fioramonti and Arlo Poletti, 'Facing the Giant: Southern Perspectives on the European Union', *Third World Policy*, vol. 29, no. 1 (2008).
[66] Brattberg and Rhinard, 'The EU and US as International Actors in Disaster Relief', 7-9.

*Preference coherence* will therefore be cut in order not to employ a too weakly operationalized concept, even though the thesis consequently lacks the capacity to examine it directly. The third subconcept, *procedural coherence*, is simpler to operationalize. It will be based on whether member states frequently partake in decision-making processes concerning epidemic disaster management since that requires a basic level of acceptance of procedural rules. It should be noted, however, that if states do *not* take part in decision-making processes, this fact does not conclusively establish that they disagree on procedural rules. There could be other reasons that caused them not to partake. Policy coherence is rather straight forward, and is operationalized as: if there are common policies on epidemic disaster management, and to what extent they determine a specific, rather than *ad hoc*, behaviour during epidemic disaster situations.

*Capabilities* is the third main concept with two subconcepts: *existent capabilities* and *capacity to utilise*. The first will be operationalized as whether member states and institutions have the resources required to deal with epidemic disasters. Concerning *capacity to utilise*, Brattberg and Rhinard suggest two ways of studying it: whether resources were easily deployed in specific cases or if they appear easily deployable in general.[67] This thesis will go with the former one and base its assessment on to what extent the AU have experienced smoothness or difficulties in deploying capabilities that are useable in epidemic disaster management.

The last concept, *consistency*, has two subconcepts: *vertical* and *horizontal consistency*. *Vertical consistency* is operationalized as whether the AU institutions on the regional level and member states had implemented similar policies regarding epidemics disasters. *Horizontal consistency* will instead be based on whether similar policies on epidemic disasters have been implemented among the member states themselves or if there is a high degree of individual solutions. *Horizontal consistency* also includes a measurement of the regional level, and it will be based on the extent to which the regional level had implemented its own policies on epidemic disasters.

### 5.3.2 Behaviour

Apart from the actorness concepts, behavioural concepts also require operationalization. Relating to the concept *context*, there are four behavioural outcomes. The first two are *quick*

[67] Ibid., 10.

*acceptance* and *quick mobilisation*. A non-surprising issue here is that there is no objective measurement in determining what is quick and what is slow. But concerning both concepts, the *quickness* can be measured comparatively to other international actors that were involved in the Ebola response. *Acceptance* itself will be measured by formal recognition, such as requests to partake in the international response and diplomatic meetings on the subject matter. But there is also the question of acceptance from whom. Given that WHO was the leading organization in coordinating the international response, its acceptance (and the UN at large) is important. An alternative is acceptance from the countries in which the Ebola outbreak mainly occurred. Regarding *quick mobilisation*, mobilisation will refer to resources that were ready for deployment. The latter two behavioural expectancies, *smooth coordination* and *strong normative influence*, are easier to operationalize. *Smooth coordination* is based on whether or not the AU experienced successful coordinations with external actors. *Strong normative influence* will be assessed in relation to whether the AU had a large impact on how the international response to the epidemic should be managed.

Next up, *coherence* is associated with the three behavioral outcomes. The first, *high coordination internally and in host countries due to clarity in purpose*, is similar two smooth coordination with a few difference: whether or not the AU experienced functional coordination, both internally and externally, due to clear goals. *Low inter-organisational competition* and *uncontested leadership hierarchies* are the other two behaviours. The first will be operationalized as whether there were recurring competitions between AU agencies. The second behaviour is operationalized as whether the leaderships structures remained unchallenged.

*Capability* is related to two behaviours. The first one, *that sufficient amount of resources have been mobilized*, can be difficult to assess. Simply seeing it as what was required to stop the outbreak is too imprecise, since the response was an international collaborative effort and not the AU's alone. Instead, the behaviour will be operationalized as whether or not the resources were enough for the AU to carry out its own response with few complications. The second behaviour, *deploying relevant resources*, is likewise difficult to assess, given that it is an qualified assessment. In order to measure the relevance, this thesis will base its indications on whether there were internal or external praise or complaints regarding the resources that either were or were not deployed.

Finally, there are the behaviours connected to *consistency*. The first, *agencies are*

*working together smoothly with few disputes*, will be based on whether or not disputes caused interruptions to the collaboration between AU agencies. The second behaviour is that *agencies operated in areas of relative strength instead of competing over operational priorities*. It is operationalized as whether the agencies worked in their area of expertise towards a common agenda, rather than pursuing their own agenda.

## 5.4 Method of data collection

The last methodological consideration that needs to be examined is the data collection itself. When collecting data for qualitative research there are a number of basic approaches: collect pre-existing material, conduct interviews or do site-intensive research.[68] As the last one requires a large on-site presence, it has (perhaps unsurprisingly) not been used. Interviews, were neither used. Due to the scale of the thesis' topic, a representative approach to interviews were out of the question. However, interviewing key personnel, especially concerning the AU's Ebola response, would have been both possible and beneficial. Nevertheless, only pre-existing material was used (with the exception of a single e-mail that contributed to fact-checking). The data collected through this method therefore need to be discussed in terms of reliability. The first principle guideline regarding reliability has been that the data must relate to the relevant entities, the AU and external entities as required by how the hypotheses were operationalized. The second guideline has been that the data must relate either to the specific actorness issue of epidemic disaster management (defined as the intersection between disaster management and the health sector) or to the AU's response during the Ebola outbreak. Consequently, the second guideline evokes that the data must pertain to certain time frames. Concerning the AU's actorness, this thesis seeks to study what it looked like at the time of the Ebola outbreak. Although actorness can vary over time, certain things (such as mandates and common policies) obviously existed long before the outbreak. The time frame for relevant data on the actorness therefore starts all the way back to when the AU was first established in 2001, though the data's relevance increases the closer to the outbreak it originated. As for the end of the actorness timeframe, the outbreak started in 2013 but its severity was not immediately known. Hence the start of the outbreak will instead be based on when WHO was formally informed on 23 March 2014. The time frame for data

[68] Diana Kapiszewski, Lauren M. Maclean and Benjamin L. Read, *Field Research in Political Science: Practices and Principles* (Cambridge: Cambridge University Press, 2015), 151, 190, 234-5.

on behaviour picks up right after the actorness timeframe ends, and it itself ends on 29 March 2016 when WHO terminated the outbreak's emergency status. With these principles established, the actual data that has been collected should be evaluated.

Of the data collected, not all suffer the same level of difficulty in establishing their reliability. Concepts such as *authority* and *policy coherence* are simply reliant on existent legal and policy documents at the AU level. Hence, such data do not need to be further discussed. But concerning data where the data itself is not the object of inquiry, it gets a bit more tricky. Concerning the AU's actorness, a lot of data have been drawn from evaluations done by either the AU or UN organizations. To begin with, data from the AU may be suspected of presenting skewed evidence due to political biases. The stakes are different for the UN, yet as it is politically invested in issues regarding health and disasters, one might all the same be suspicious of its bias. Additional data have also be drawn from studies done by other third parties, such as the Swedish Defence Research Agency (FOI) and the Organisation for Economic Co-operation and Development (OECD). While one might assume less political bias, these evaluations (similar to ones by the UN) are secondary sources, and therefore might have lacked relevant insights. Concerning the AU's behaviour during the Ebola outbreak, two documents made up the bulk of the data. One is an evaluation of the AU's military and civilian mission, AWESOWA (the core contribution by the AU), produced by AWESOWA itself. The second is an evaluation of the AU's response by an independent organization, EpiAFRIC. Apart from these sources, a few newspaper articles have to a lesser extent also been used. Similar to the data on actorness, the evaluation by AWESOWA might be expected to suffer from political bias, whereas the EpiAFRIC evaluation and news paper articles suffers in terms of being secondary sources. Taken together, one can therefore surmise that each individual source of data lacks maximum reliability. But by measuring various concepts through a combination of different sets of data, the overall reliability is strengthened through triangulation. That said, as pre-existing material, each source has a fixed amount of information.[69] Interviews could, for example, have benefitted the thesis by investigating if the pre-existing data left something out.

[69] Ibid., 170-1.

# 6. Analysis

## 6.1 The AU's Actorness in Epidemic Disaster Management

### 6.1.1 Context

Assessing the AU's actorness in epidemic disaster management requires assessing its *context*, whether the AU was an accepted actor by the international system and member states. At the first Ordinary Session of the Assembly in 2002, the statutes of the Commission was formally adopted by AU member states.[70] Article 3 of the statutes stipulates that the Commission should assume "control of pandemics; [and] disaster management".[71] While not explicitly mentioning epidemic disaster management, member states did formally accept, through the adoption of the statutes, that the AU had a role to play in matters of disease and disasters. Moreover, health ministers from various member states convened six times in the Executive Council between 2003 and 2013, debating infectious diseases among other topics.[72] The Commission also organized, in cooperation with the UN Office for Disaster Risk Reduction (UNISDR), ministerial conferences on disaster risk reduction (DRR). Two of these occurred before the outbreak, 2005 and 2010 respectively.[73] The operationalization of *de juro* recognition contained both formal treaties and diplomatic visits. The adoption of the Commission's statutes combined with the conferences (seen as diplomatic gatherings) therefore indicate that the AU was internally *de juro* recognized as an epidemic disaster manager. Concerning *de facto* recognition, it was operationalized as cooperation on epidemic disaster management. The most prevalent cooperation on diseases between member states and the AU has specifically concerned HIV/AIDS, malaria and tuberculosis. Cooperation on these diseases has been ongoing since the AU's inception.[74] However, concerning epidemic disaster management in general, the Commission has since 2006 been overseeing a process of integrating the African Regional Strategy on Disaster Risk Reduction (adopted in 2004)

[70] African Union, *AU in a Nutshell.*
[71] *The Statutes of the Commission of the African Union 2002*, AUC, art 3.
[72] Executive Council, *The Impact of Non-Communicable Diseases (NCDs) and Neglected Tropical Diseases (NTD) on Development in Africa* (Addis Ababa: Executive Council, 2013), 2.
[73] Executive Council, *Report of the Second Ministerial Conference on Disaster Risk Reduction* (Kampala: Executive Council, 2010), 1.
[74] During this time there has been a number of action plans for these specific diseases, such as the 2006 Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa (African Union Commission, *African Union Roadmap: Progress in the First Year* (Addis Ababa: African Union Commission, 2013), 2).

among member states.[75] Since the strategy also concerned disaster management, the implementation process indicates a level of cooperation on disaster management.[76] In the health sector, the Commission was similarly overseeing the implementation of the African Health Strategy to reduce the burden of diseases since 2007 (more on both of these strategies, below in the section on *coherence*).[77] Although both of these processes were ongoing at the time of the Ebola outbreak, progress was reportedly slow.[78] Nevertheless, the *occurrence* of progress does indicate a measure of cooperation, which in turn indicates a level of *de facto* recognition. However, the exact scope of the recognition is difficult to establish. For example, whether the slow progress was affected by varying degrees of *de facto* recognition is hard to determine since a lot of factors can affect implementation processes. Thus, while the analysis provides an indication that *de facto* recognition existed, it is not possible to assess whether *de fact* recognition (as cooperation) was at best moderate or in fact high.

Internationally speaking, the AU appeared to be accepted by several states, regional organization and international organizations. One indication is once again the ministerial conferences on health and DRR, which were attended by several third states (ranging from Canada to China) and organizations, such as the EU, WHO and UNISDR. The broad attendance at the ministerial conferences provides an indication that the AU was highly *de juro* recognized as an epidemic disaster manager. The AU also had ten principle partnerships that formalized their cooperation with international actors. Three of these, the China-Africa Cooperation Beijing Action Plan (2013-2015), the Joint Africa-EU Strategy 2007, and Framework of Cooperation for Africa-Turkey Partnership, covered cooperation on combating infectious diseases among other things. A fourth one with the US, the Assistance Agreement, dealt with health issues more broadly.[79] Concerning the UN, UNISDR has had a long history of collaborating with the AU on disaster management.[80] The AU's partnerships on how to cooperate with external actors and work with the UN thereby indicate a measure of *de facto*

[75] UNISDR, *Disaster Risk Reduction in Africa: Status Report on Implementation of Africa Regional Strategy and Hyogo Framework for Action* (UNISDR, 2014), 2.
[76] African Union Commission, *African Regional Strategy on Disaster Risk Reduction* (Addis Ababa: African Union Commission, 2004), 13.
[77] Department of Social Affairs, *Assessment Report of the African Health Strategy 2007-2015* (Addis Ababa: Department of Social Affairs, 2013), 5.
[78] Ibid., 36; UNISDR, *Disaster Risk Reduction in Africa: Status Report on Implementation of Africa Regional Strategy and Hyogo Framework for Action,* 79.
[79] African Union, *Partnerships*, Website the African Union (Accessed 2017-04-30).
[80] UNISDR, *Our partners*, Website the United Nations Office for Disaster Risk Reduction (Accessed 2017-04-04).

recognition. However, there is evidence to suggest that it was moderate at best. A study from OECD noted that the Sub-Saharan African countries received 49% of the global aid in the health sector between 2008 and 2009 (though African countries north of Sahara only received 1%). Of this, 41% of the aid was specifically for HIV/AIDS, while 19% was meant for combating other infectious diseases.[81] Hence, external actors appear to find disease to be an important issue in Africa. But as mentioned before, the AU only had three partnerships that defined cooperation with external actors. Given the apparent importance placed on combating diseases by external actors, the number of partnerships would appear comparatively low, or infrequent. Taken as a whole, this indicates that the AU was not generally considered as the most important actor to cooperate with on combating diseases, lowering its external *de facto* recognition in epidemic disaster management.

Aside from *recognition* concerning the AU's *context* there is also *opportunity,* which was operationalized as whether the AU was expected to be active in external epidemic disaster management by external actors. When examining the EU, Brattberg and Rhinard note that the EU is a leading actor on disaster relief, being able to both respond and support the international system with large donations. This has in turn created high international expectations that the EU should act during disasters.[82] There is little evidence to support that there is a similar relationship between the AU and the international system. Since AU member states generally only provides a fraction of the humanitarian aid worldwide (in 2015 estimated as less than 0,03%), this might suggest that such a relationship does in fact not exist.[83] However, there is evidence of other types of expectations. The AU had, as mentioned before, a number of partnerships which formalized its international relationships. In the China–Africa Cooperation Forum (FOCAC), where the Commission is represented, a final meeting before the Ebola outbreak was held in 2012. The Beijing Action Plan (2013-2015), a result of this meeting, noted that both sides (Africa and China) would continue to cooperate in preventing major diseases.[84] But only China was expected to take specific actions in relation to the other:

[81] OECD-DAC, 'Aid to Health', *Aid to Health*, Website the Organisation for Economic Co-operation and Development, 2011 (Accessed 2017-04-30).
[82] Brattberg and Mark Rhinard, 'The EU and US as International Actors in Disaster Relief',12-13.
[83] European Parliament, 'At a glance: The African Union's humanitarian policy', *Latest published documents*, Website European Parliament: Think Tank, 2016-05-17 (Accessed 2017-04-05).
[84] FOCAC, *The Fifth Ministerial Conference of the Forum on China-Africa Cooperation Beijing Action Plan (2013-2015)*, Website Forum on China-Africa Cooperation, 2012-07-23 (Accessed 2017-05-02).

> "China will continue to provide support to the medical facilities it has built in Africa [...] China will continue to train doctors, nurses, public health workers and administrative personnel for African countries. [...] China will continue to send medical teams to Africa."[85]

Similar role-expectations can be found in the other partnership agreements. From the Istanbul Summit in 2008 the Framework of Cooperation for Africa-Turkey Partnership came about.[86] Concerning disease it reads:

> "We have taken cognizance of Turkey's initiatives in supporting Africa in the area of health and related issues as well as its willingness to further provide assistance and expertise in this sector, and in this regard, we agree to: 1. Intensify efforts aimed at overcoming malnutrition and communicable and epidemic diseases; [...]"[87]

Once again a third state is expected to aid the AU and its member states with disease issues within Africa without corresponding expectations regarding the AU's external role.

The AU's relationship to the EU is formalized through the Joint Africa-EU Strategy 2007. It is a bit more ambivalent on role expectations as it states that both parties should jointly "address global challenges and common concerns such as [...] HIV/AIDS, malaria, tuberculosis and other pandemics".[88] Still, among its key objectives is "to ensure that all the Millennium Development Goals (MDGs) are met in all African countries by the year of 2015".[89] The importance of this is linked to the expected outcome of "[i]ncreased risk-awareness on emerging and re-emerging diseases, medical emergencies and epidemics".[90] The partnership therefore does not seem to wholly disregard that the AU could play an international role, but its objective emphasizes expectations that the EU should be engaged in Africa.

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[85] The Beijing Action Plan (2013-2015) (adopted 23 July 2012), art 5.5(5.5.4-7).
[86] African Union, *Partnerships*.
[87] Framework of Cooperation for Africa-Turkey Partnership (adopted 19 August 2008), art 4.
[88] The Africa-EU Strategic Partnership: A Joint Africa-EU Strategy (adopted 9 December 2007), 3.
[89] Ibid., 3.
[90] Ibid., 56.

A last formal partnership was the Assistance Agreement which was signed with the US in 2010. This partnership does not explicitly mention epidemics or disasters, but rather touch on health more broadly. The agreement concerns cooperation and funding for the AU in order to aid the Union to combat health issues in Africa.[91] All of these partnerships emphasize (to different degrees) a one-way direction on disease and health cooperation: a third party is expected to aid the AU with disease problems in Africa. By extension, the partnerships indicate that the AU is primarily expected to act within the confines of Africa. Hence the AU's *opportunity* was low, as it was not expected to be active in external epidemic disaster management. Only referring to these partnerships might obviously be problematic in terms of reliability when attempting to cover the expectations of the international system. But taken together with the absence of evidence on a larger international role in disease disasters, the significance of the partnerships' expectations becomes greater. Circling back to *de facto* recognition, by way of consequence, low expectations of the AU as an active actor outside of Africa results in lower *de facto* recognition in areas of epidemic disasters management outside of Africa.

A final ingredient of an actor's *context* is its *authority*. A basic function of the Commission, according to its statutes, is to "implement the decisions taken by other organs".[92] But as mentioned before, the statutes also gave the Commission a measure of power in dealing with diseases. However, it was not unlimited as the statutes reads:

> "The Commission shall: [...] take action in the domains of responsibility as may be delegated by the Assembly and the Executive Council. The domains shall include the following: i) control of pandemics; ii) disaster management; [...]"[93]

The Commission is thus reliant on the delegation of power by member states in order to take action in managing epidemic disasters. The degree of authority was operationalized as whether the Commission could make a lot of decision on its own (high authority), or if it was reliant on inter-governmental decision-making (low authority). Pertaining to epidemic

[91] USAID, *USAID and African Union Sign Assistance Agreement*, Website USAID, 2010-08-03 (Accessed 2017-04-15).
[92] *The Statutes of the Commission of the African Union 2002*, AUC, art 2(c).
[93] Ibid., art 3.

disasters, the legal texts makes it clear that the Commission can make decisions (or "take action"), but only when member states permit it. The AU thus appear to hit the middle ground concerning *authority*, neither non-existent nor high.

Summing up the *context* of the AU on epidemic disaster management at the time of the Ebola outbreak, it is difficult to assess its exact score. The AU appeared to be highly *de juro* recognized as an actor, both internationally and internally. At the same time, the extent to which it was internally *de facto* recognized was not entirely conclusive, while its external *de facto* recognition appeared to be lower (especially outside of Africa) than its *de juro* recognition. Furthermore, the AU's *opportunity* appeared low, as expectations regarding the AU as an active actor in international epidemic disasters appeared limited. Finally, AU was found to have a moderate amount of *authority*. Combining the three main subconcepts, *recognition*, *opportunity* and *authority*, the AU's acceptance in general as a epidemic disaster manager appears somewhat weak. But specifically within Africa the AU benefited from higher expectations as an actor. Thus, in relation to the Ebola outbreak, the AU should be seen as benefiting from at least a moderate score on *context*.

### 6.1.2 Coherence

Continuing with the next main concept of actorness, *coherence*, an assessment is needed of whether the AU had common values, agreed on procedures and had policies that defined its behaviour and through which it could exert influence. Starting with the latter two, procedural and policy coherence, up until the outbreak, the AU member states had agreed on a number of common policies and strategies. A few development strategies had specifically been adopted concerning HIV/AIDS, malaria and tuberculosis.[94] But since they only dealt with development issues regarding particular diseases, they did not provide guidelines for epidemic disasters in general. More broadly concerning health, two development strategies were adopted at the health minister conferences in the Executive Council in 2003 and 2007 respectively. At the first conference, the New Partnership for Africa's Development (NEPAD) agency was created and the NEPAD Health Strategy adopted. Although the AU facilitated the creation of NEPAD, the agency operated independently from the AU for a time. Only in 2010, it was formally integrated into the AU.[95] Nevertheless, the strategy

[94] Department of Social Affairs, *Assessment Report of the African Health Strategy 2007-2015*, 9-12.
[95] NEPAD, *About NEPAD*, Website the New Partnership for Africa's Development (Accessed 2017-04-05).

underpinning the agency's work set out guidelines for the development of the health sector among AU member states.[96] At a later conference, the African Health Strategy was adopted and this one applied directly to the AU.[97] The NEPAD Health Strategy´s principle goal was "to dramatically reduce the burden of disease, especially for the poorest people in Africa".[98] The African Health Strategy had a similar vision of "an integrated and prosperous Africa free of its heavy burden of disease, disability and premature death".[99] Thus in both instances, policies were created with a directly link to disease. But as development strategies, they provided few management guidelines in disaster situations. The NEPAD Health Strategy stated, for example, that "Ministries of Health need to enhance the effectiveness of interventions in the public, private and not-for-profit sectors, appropriately using all the tools potentially at their disposable".[100] Furthermore, the African Health Strategy stated, for example, that "[t]here should be committed intersectoral action for health involving other ministries and levels of government".[101] In both cases, the strategies provided structural guidelines which the AU could benefit from when responding to epidemic disaster. But they did not deal with the specific decisions during such situations.

On disaster management, the African Regional Strategy on Disaster Risk Reduction was adopted in 2004. Its goal was "to contribute to the attainment of sustainable development and poverty eradication by facilitating the integration of disaster risk reduction into development".[102] While disease was not explicitly mentioned in its goal, the strategy states: "[o]n an individual hazard basis, epidemics are the major cause of disasters".[103] Hence, diseases and epidemics were natural parts of what was considered a disaster in the strategy. But since this was development strategy, the guidelines for behaviour was mainly about how to achieve DRR-structures among member states.[104] It did make a single recommendation for disaster management: "emergency assistance, together with post-disaster rehabilitation and reconstruction, is necessary [...]".[105] Thus it added some general behavioral guidelines for

[96] NEPAD, *New Partnership for Africa's Development (NEPAD) Health Strategy* (NEPAD, 2003), 2.
[97] African Union Commission, *African Health Strategy: 2007-2015* (Addis Ababa: African Union Commission, 2007)*, 1.*
[98] NEPAD, *New Partnership for Africa's Development (NEPAD) Health Strategy*, 14.
[99] African Union Commission, *African Health Strategy,* 5.
[100] NEPAD, *New Partnership for Africa's Development (NEPAD) Health Strategy*, 17
[101] African Union Commission, *African Health Strategy*, 7.
[102] African Union Commission, *African Regional Strategy on Disaster Risk Reduction*, 9.
[103] Ibid., 9.
[104] Ibid., 2.
[105] Ibid., 13.

disaster management, albeit limited compared to its overall content.

There was also the adoption of the Kampala Convention regarding the management of internally displaced people. As such it was not specifically meant for epidemic disasters, but it did concern natural disasters.[106] Compared to the aforementioned strategies, this convention provided more specific behavioural guidelines, such as: "[e]nsure assistance to internally displaced people by meeting their basic needs as well as allowing and facilitating rapid and unimpeded access by humanitarian organizations and personnel".[107] But with its focus on internally displaced people, it did not provide any overall behaviour guidelines for managing epidemic disasters. Finally, there was the African Union Humanitarian Policy Framework which was presented as a draft in 2010. But it would only come into effect after it was adopted in its final form in 2015, well into the Ebola outbreak.[108]

The NEPAD strategy, the African Health Strategy, and the African Regional Strategy on DRR all touched on disease or disaster management, and were adopted at meetings with near full attendance.[109] Hence, their mere existence indicates a relatively high level of *procedural coherence*, given that by adopting the strategies the member states implicitly also accepted the rules by which the policies were accepted. Concerning *policy coherence,* however, it gets a bit more tricky, since it does not only depend on the existence of policies but also on how high the determinacy in behaviour was. While three strategies and one convention were found to exist that related to epidemics generally, they were not specifically concerned with disaster *management*. This also meant that there were few behavioural guidelines for epidemic disaster management, which would require a lot of *ad hoc* decision-making. Thus, if these aspects of *policy coherence* are added up, the overall estimates appear to be weak *policy coherence*.

Besides *procedural* and *policy coherence*, some assessments can also be made regarding *value coherence*. Because it was operationalized as the extent to which formally accepted goals and principles have been implemented, both health strategies become relevant. In

[106] African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (adopted 23 October 2009) (entered into force 6 December 2012), 1.
[107] Ibid., art 3(1(f)).
[108] European Parliament, 'At a glance: The African Union's humanitarian policy'.
[109] WHO, *The OAU/AU Conference of African Ministers of Health - April 2003*, Website the World Health Organization, 2003 (Accessed 2017-05-05); Executive Council, *Report of the Third Ordinary Session of the African Union Conference of Ministers of Health* (Addis Ababa: Executive Council, 2007), 1; Executive Council, *Report of the Second Ministerial Conference on Disaster Risk Reduction*, 1.

addition to the previously mentioned goals, regarding lessening the burden of disease, the NEPAD Health Strategy covered four basic principles:

> "Health and access to quality affordable health care is a human right
> Health is a developmental issue requiring a multi-sectoral response
> Equity in health and health care is beneficial to countries as well as individuals
> Evidence should be the basis of public health practice; effectiveness, efficiency and quality its product."[110]

Furthermore, the African Health Strategy added a number of principles directly relating to disease: "Prevention is the most cost-effective way to reduce the burden of disease; [...] Diseases know no borders and cross border cooperation in disease management and control is required".[111] In both cases member states had adopted strategies with goals and principles, which in turn suggest a measure of coherence among values. At the same time, African Health Strategy (a successor to the NEPAD Health Strategy) was noted in 2013 to only have been implemented in a limited capacity.[112] Hence the evidence that exist does not support that the AU enjoy a high degree of value coherence. To summarize the AU's *coherence* in epidemic disaster management, only *procedural coherence* was indicated as high, whereas both *policy* and *value coherence* were estimated as low. The scale thus appears to tip towards the AU's overall *coherence* (its ability, through common values, procedures and policies, to project influences) being low at the time of the Ebola outbreak.

### 6.1.3 Capabilities

Instruments, mechanisms and other resources that are available and can be mobilised mark the *capabilities* within an actor. At the AU level, the Commission (which was tasked to deal with disasters) was supported by a number of subordinate institutions. Two of its main institutions, the Peace and Security Council (PSC) and the Department of Social Affairs, had links to disease and disaster management. PSC was a decision-making body for the purpose of security and stability and its core mission concerned "prevention, management and

[110] NEPAD, *New Partnership for Africa's Development (NEPAD) Health Strategy,* 15.
[111] African Union Commission, *African Health Strategy,* 5.
[112] Department of Social Affairs, *Assessment Report of the African Health Strategy 2007-2015*, 5.

resolution of conflicts".[113] As such, its instruments (the continental- early-warning-system (CEWS) for example) were therefore not dedicated to non-traditional threats like diseases, but specifically to violent conflicts.[114] But PSC was also meant to be the main body overseeing the African Peace and Security Architecture (APSA), a comprehensive agenda on creating security in Africa that was formed in 2002. Although APSA did not explicitly mention epidemic disaster, it did list "humanitarian action and disaster management" as a prime concern.[115] However by 2010, criticism was leveled at APSA for not being comprehensive enough, noting its lacking disaster management.[116] Hence, neither PSC nor the broader APSA appear to have provided the AU with credible and existent epidemic disaster management capabilities. The Department of Social Affairs, on the other hand, had a clear link to diseases through its Division of HIV/AIDS, Malaria and Tuberculosis and Other Related Diseases. But this division functioned within the department's overall goal of "promoting and intensifying collective efforts for accelerated and sustained development of social services in Africa".[117] Thus, while having a division concerned with diseases, the division's ability to deal with diseases appears limited to development, calling into question its ability to function as an epidemic *disaster manager*.

By 2010, two specialised agencies with links to diseases and disasters became part of the AU. Firstly, the African Risk Capacity was formed in order to better coordinate the Commission's disaster management capacity.[118] But at the time of the Ebola outbreak, it had yet to develop a department dealing with epidemic outbreaks and was therefore not directly involved in managing the outbreak.[119] Secondly, NEPAD, which was formed in 2003 in order to deal with health issues in Africa, became integrated into the AU. The agency´s activities did not include epidemic disaster management, however.[120]

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[113] African Union, *Peace and Security Council (PSC)*, Website the African Union (Accessed 2017-05-01).
[114] Ibid.
[115] Peace and Security Council, 'African Peace and Security Architecture', *African Peace and Security Architecture (APSA)*, Website Peace and Security Council (Accessed 2017-05-01).
[116] Louis Matshenyego Fisher et al., *African Peace And Security Architecture (APSA): 2010 Assessment Study* (Addis Ababa: Peace and Security Council, 2010), 9.
[117] Centre for Citizens' participation on the African Union, *The African Union Commission: Departments and Officials* (Centre for Citizens' participation on the African Union, 2011), 20.
[118] African Risk Capacity, *Vision and Mission*, Website the African Risk Capacity (Accessed 2017-04-02).
[119] Annie Kyanna, Executive Assistant at African Risk Capacity (Contact 2017-04-03).
[120] NEPAD, *About NEPAD*, Website the New Partnership for Africa's Development (Accessed 2017-04-05).

Finally, concerning the regional level, it should be noted that the AU had a number of specialized funds, for example the Emergency Assistance Fund for Drought and Famine. But at the time of the Ebola outbreak, no such fund existed for epidemic disasters.[121] Assessing *existent capabilities* on the regional level was based on the operationalization of whether institutions had the resources required to deal with epidemic disasters. Though the Commission was tasked with dealing with disasters, the assessment above indicates that the regional institutional arrangement was not adequately developed to deal with epidemic disasters. Hence *existent capabilities* at the regional level was low.

Concerning the national level, 40 countries in Africa had formed national platforms or something similar in order to deal with disasters as of March 2013. However, a UN report noted that the overall capacity of these platforms were generally quite low.[122] A particular concern for epidemic disaster management was that the report criticized the low integration of DRR into the health sector due to an overall shortage of budgetary commitment.[123] A report from 2012 studied capacities concerning health disaster preparedness and responses (DPR) in Africa. One of the highest activities observed was the establishment of early warning system on communicable diseases, which had been done by 40 member states. Other activities dropped in the level of execution. 28 member states had trained personnel in public health pre-deployment and in health emergencies in large populations.[124] The report went on to further criticize what the personnel in the 28 member states in reality amounted to, noting that:

> "The critical mass of trained persons needed to support countries in DPR is not yet in place. Eighteen countries lack human resources with even the basic training to manage emergency responses. In countries where trained persons exist, they are limited in number ranging between 1 and 5".[125]

Only three countries were the exception, which had benefitted from training by the Red

[121] WHO, *The African Union Commission Pledges One Million to Ebola Response*, Website the World Health Organization, 2014-08-13 (Accessed 2017-05-10).
[122] UNISDR, *Disaster Risk Reduction in Africa*, 34.
[123] Ibid., 38.
[124] Kalula Kalambay and Usman Abdulmumini, *Disaster Preparedness and Response in the African Region: Current Situation and Forward* (World Health Organization, 2012), 31.
[125] Ibid., 32.

Cross. A related issue was that fifteen countries did not have functional emergency units. Among the ones that existed, they were generally under-staffed and under-resourced.[126] A final problem, highlighted by the report, was that national emergency funds had only been established by 19 countries.[127] Though capabilities regarding epidemic disasters existed, the description above indicates they did not measure up to the member states being overall adequately able to deal with epidemic disasters. Thus similar to the regional level, *existent capabilities* were low on the national level.

An actor's *capabilities* were also determined by its *capacity to utilise,* operationalized as to what extent the AU have experienced smoothness or difficulties in deploying capabilities that are useable in epidemic disaster management. It should be noted that the AU's undertaking during the Ebola outbreak was unique, meaning no exact comparison exists.[128] But since the *existent capacities* at both the regional and national level were estimated as low, this would suggest low capacity to deploy, simply due to the shortage of resources. Moreover, the AU has a less than optimal track record in other situations. Regarding the AU's military mission, AMISOM, in Somalia, a report by FOI states: "[...] the mission's ability to perform the tasks outlined in its mandate was hampered by a number of factors such as a lack of resources and its insufficient logistical ability to supply its own troops".[129] In order to meet logistical demand, the UN had to put together a support mission which provided AMISOM with "health and sanitation, [and] medical support".[130] The AU had similar experience during its military mission in Darfur. When AMIS was deployed "[...] the logistics system was severely strained" and altogether lacked medical evacuation.[131] While these were military operations in conflict zones, they indicate a low capacity to deploy medical resources. Consequently, these experiences suggest that the AU has a low *capacity to utilise*. With both *existent capabilities* and *capacity to utilise* measured as low, the overall *capabilities* of the AU in epidemic disaster management can be identified as low.

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[126] Ibid., 32
[127] Ibid., 31.
[128] ASEOWA, *ASEOWA Final Exit Report: December 2015* (Department of Social Affairs, 2015), 2.
[129] Cecilia Hull Wiklund, *The Role of the African Union Mission in Somalia: AMISOM - Peacekeeping Success or Peacekeeping in Regress?* (Stockholm: FOI, 2013), 18.
[130] Ibid., 30.
[131] Arvid Ekengren, *The African Union Mission in SUDAN (AMIS): Experiences and Lessons Learned* (Stockholm: FOI, 2008), 18; Seth Appiah-Mensah, 'AU's Critical Assignment in Darfur', *African Security Review*, vol. 14, no. 2 (2005): 18.

### 6.1.4 Consistency

The final aspect of the AU's actorness that needs to be assessed is its *consistency*, meaning whether it could carry out its agreed policies in practice. As noted regarding *policy coherence*, there was an overall lack of common policies that directly applied to epidemic disaster management. Regardless, one important feature of *consistency* was *vertical consistency*, operationalized as whether the AU institutions and member states had implemented similar policies regarding epidemics disasters. The African Humanitarian Policy Framework was meant to address the fact that "[...] Africa still lacks a comprehensive and overarching humanitarian policy framework".[132] In doing so, the policy would provide member states with an AU-wide disaster management policy.[133] When drafted, the policy was meant to "[...] synchronize with the Commission's mitigation policy on Disaster Management".[134] But in its final form, the Commission was to be provided with new disaster management guidelines.[135] However, since the policy was not adopted until 2015 it had not been implemented at the time of the Ebola outbreak. The need for the African Humanitarian Policy Framework in and of itself suggests that there were differences in implemented policies concerning disaster management at the regional level and member state level. This is furthermore reinforced by a UN report. It found, when investigating DRR in Africa in relation to hazards such as diseases, that nearly all AU member states had implemented preparedness or emergency plans "[...] although the scope and resourcing of these vary considerably".[136] By way of consequence, it is implausible that the Commission's mitigation policy on Disaster Management was similar to all the member states' different preparedness or emergency plans. To sum up, though the evidence does not explicitly state that were considerable differences in implemented policies regarding epidemics disaster management, the evidence does support this interpretation. Hence the AU's *vertical consistency* can be estimated as low.

*Horizontal consistency* was, concerning the member state level, operationalized as

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[132] Humanitarian Affairs, Refugees and Displaced Persons Division, *African Union Humanitarian Policy Framework* (Addis Ababa: Department of Political Affairs, 2015), 3
[133] Ibid., 15.
[134] Humanitarian Affairs, Refugees and Displaced Persons Division, *African Union Humanitarian Policy Framework: Initial Draft* (Addis Ababa: Department of Political Affairs, 2010), 7.
[135] Humanitarian Affairs, Refugees and Displaced Persons Division, *African Union Humanitarian Policy Framework*, 15.
[136] UNISDR, *Disaster Risk Reduction in Africa*, 108.

whether similar policies on epidemic disasters have been implemented among the member states themselves or if there was a high degree of individual solutions. As already stated, there were considerable differences regarding what preparedness or emergency plans member states had implemented. But there are more indications of differences among member states. The NEPAD Health Strategy, the African Health Strategy and the regional strategy on DRR were all meant to guide member states in implementing structures that could benefit the AU in epidemic disaster management. In 2014 an assessment of the African Health Strategy (and indirectly the NEPAD Health Strategy) was produced. The assessment report states that the implementation of the African Health Strategy was low among member states in general. On average, member states' own health plans reflected 39% of the strategy's guidelines.[137] Regarding the regional strategy on DRR, a report from UNISDR in 2014 noted that "[t]here is some commitment and capacities to achieving DRR but progress is not substantial".[138] Finally, besides the development strategies, member states had also adopted the Kampala Convention on internally displaced people in 2009 which entered into force in 2012. At the time of writing, it has so far been ratified by only 25 member states, meaning less than half of the member states have officially committed to implementing it.[139] Since member states had only weakly implemented common standards on structuring the health sector and DRR, and there were apparent commitment shortages concerning the Kampala Convention, this suggests that there were also differences in what member states had implemented in these areas. Concerning the regional level, *horizontal consistency* was operationalized as the extent to which the regional agencies had implemented policies on epidemic disasters. As noted in the prior section on *capabilities*, PSC (through APSA) and the African Risk Capacity were the institutions within the Commission tasked with disaster management. But the African Risk Capacity had not created its department on epidemics yet, and PSC had been criticized for not adequately dealing with disaster management. Hence, the Commission's internal disaster management policy appears to not have been adequately implemented. The member states level and the regional level taken as a whole thereby indicate low *horizontal consistency* overall. Given that *vertical consistency* was also found to be low, the AU's general *consistency*, its ability to carry out agreed policies in practice, is measured as low.

[137] Department of Social Affairs, *Assessment Report of the African Health Strategy 2007-2015*, 35-6
[138] UNISDR, *Disaster Risk Reduction in Africa*, 76, 79.
[139] African Union, 'List of Countries which has Signed, Ratified/Acceded to the Kampala Convention', *Treaties*, Website the African Union (Accessed 2017-05-02).

## 6.2 Behaviour

### 6.2.1 Context related behaviour

An entity that scores high on *context* is hypothesized to be quickly accepted in situations that require disaster relief, followed by quick mobilisation, smooth coordination and a strong normative influence. To begin with, between 14th and 17th of April 2014 (22 days after WHO had formerly been notified of the Ebola outbreak) the AU and WHO held their first joint meeting for African health ministers.[140] At the meeting a solidarity motion regarding the Ebola outbreak was adopted which requested of "[...] African countries to take the measures required in accordance with the International Health Regulations (2005)".[141] *Quick acceptance* was operationalized along three lines: *quick* compared to others; *acceptance* as formal requests to partake in the international response and diplomatic meetings on the subject matter; and acceptance *from* relevant actors. The meeting in April in itself signified diplomatic meeting on the subject matter, whereas the solidarity motion signified that the AU was requested to engage through its member states. Since WHO would also become the leading agency for the international response, it qualifies as acceptance from a relevant actor. Furthermore, it can be estimated as a *quick* acceptance given that the meeting was held before WHO's conference on 2 and 3 July 2014 where the need for collective international response was discussed.[142]

However, quick acceptance did not lead to quick mobilisation. The AU managed to produced its first donations of 1 million dollars to the affected countries in West Africa in August 2014. The AU's core contribution, the African Union Support to Ebola Outbreak in West Africa (ASEOWA), which comprised of civilian and military volunteers, was later approved on 8 September 2014 by the Executive Council.[143] The first set of volunteers were mobilised and ready for the deployment in September, though deployment would continue until February 2015.[144] But before the AU had managed to produce its donations and mobilize

[140] WHO, *First meeting of African Ministers of Health jointly convened by the AUC and WHO: Volume 1: Ministerial meeting* (WHO, 2014), 1-2.
[141] Ibid., 27.
[142] WHO, *Ebola virus disease, West Africa – update 3 July 2014*, Website the World Health Organization, 2014-07-03 (Accessed 2017-04-29).
[143] African Union, 'Fact Sheet: African Union Response to the Ebola Epidemic in West Africa', *Documents,* Website the African Union, 2015 (Accessed 2017-04-02).
[144] Final mission report, 2.

ASEOWA, it had been criticized for being too complacent in engaging with the Ebola outbreak compared to the international community.[145] The EU's response serves as a comparison. It donated 500.000 euros on 28 March 2014, and by July the donations had steadily increased to a total of 3.9 million euros. Apart from donations, the EU had also aided its member states in coordinating the mobilisation and deployment of humanitarian resources to West Africa during the summer.[146] *Quick mobilisation* was operationalized as the comparative speed by which resources were made ready for deployment. Judging by both the general criticism and the specific comparison to EU, there are ample indications that the AU was not quick to mobilise.

*Smooth coordination* was operationalized as coordination with few complications with external actors. Though there are evidence relating to the AU's external coordination, there are, however, difficulties in determining its exact state. In ASEOWA's final report, it was noted that weak coordination posed a challenge since "[w]eak harmonization of planning and intervention leading to the duplication of activities amongst partners".[147] But at the same time, an independent analysis by EpiAFRIC also highlighted positive aspects of the coordination, stating that "ASEOWA integrated well into the local structures and strengthened the coordination and collaboration between different partners".[148] In between these two positions can an observation by Kim Yi Dionne, writing for the Washington Post, be found. Although recognizing complications in the external coordination by African countries, she also acknowledged that complications often occur in large international responses due to the high number of actors.[149] Exactly how weak or strong the AU's external coordination was is therefore difficult to determine based on these sources. A feasible interpretation is that the AU did experience challenges in its external coordination to the detriment of its mission. But these coordination challenges were not *exceptionally* high from a comparative perspective, which could explain the more positive outlook by EpiAFRIC. Based on this interpretation, the external coordination, while not exceptionally weak, does

[145] African Union, 'Fact Sheet'; Nana Yaa Boadu, *At the epicenter of the Ebola crisis: Africa's response – good, bad, not nearly enough or still too early to tell?*, Website International Health Politics, 2014-12-17 (Accessed 2017-03-06).
[146] European Commission, *The EU's response to the Ebola outbreak in West Africa*, Website the European Commission, 2014 (Accessed 2017-04-02).
[147] ASEOWA, *ASEOWA Final Exit Report*, 12.
[148] Chikwe Ihekweazu et. al., *An Evaluation of the African Union's Response to the Ebola Virus Disease (EVD) Outbreak in West Africa* (EpiAFRIC, 2015), 43.
[149] Kim Yi Dionne, *Why West African governments are struggling in response to Ebola*, Website the Washington Post, 2014-07-15 (Accessed 2017-05-10).

not match *smooth coordination*.

The last expectancy regarding entities that score high on *context* is that it has a *strong normative influence*, operationalized as whether the AU had a large impact on how the international response to the epidemic should be managed. Both the report from ASEOWA and EpiAFRIC states that the AU mission had a positive impact overall on curbing the spread of Ebola.[150] That said, there is little evidence to suggest that the AU had a large impact on how to manage the international response. First of all, even though the outbreak occurred in Africa, it was WHO which was assigned the leading role. This could in and of itself be interpreted as meaning that external actors did not think that the AU should determine how the response should be managed. Furthermore, aside from personnel contributions, WHO's own reports and assessments concerning the international response make little mention of the AU.[151] However, the absence of evidence concerning the AU having had a large impact on how the international response should be managed, does not conclusively determine that the opposite must be true. It can, however, be taken as an indication of the AU not having had an impact that amounted to *strong normative influence*.

### 6.2.2 Coherence related behaviour

Functional responses as results of *strong coordination due to clarity of purpose*, *low inter-organisational competition* and *uncontested leadership* are hypothetical expectancies of entities with high degrees of *coherence*. As noted in the prior section, the AU experienced challenges in coordinating with external partners. Similar evidence is available concerning the internal coordination. A basic challenge to the mission, reported by ASEOWA, was that "[t]he AU system as it is today does not have adequate capacity to coordinate and manage a complex humanitarian operation like ASEOWA".[152] EpiAFRIC furthermore report that:

> "At the beginning of the mission, there [was] no evidence of an operational plan for the mission with a budget attached to it. [...] In the early months of the outbreak, the entire AU mission was made up of volunteers. There was no one from the AU secretariat in [the] country; this led to lack of knowledge on many

[150] ASEOWA, *ASEOWA Final Exit Report*, 2; Chikwe Ihekweazu et. al., *An Evaluation of the African Union's Response to the Ebola Virus Disease (EVD) Outbreak in West Africa,* 4.
[151] See: WHO, *Report of the Ebola Interim Assessment Panel* (WHO, 2015); WHO, *WHO Strategic Response Plan*.
[152] ASEOWA, *ASEOWA Final Exit Report*, 30.

AU processes."[153]

Given the lack of an operational plan and guidance from the AU level (in the beginning), the complications in the AU's internal and external coordination could be surmised as (at least partly) being the result of unclear goals and purposes. Besides the response on the ground, there were also complications in the management between the AU and its member states. In the early month of the outbreak, a number of member states closed their borders and placed travel restrictions in order to maintain national security.[154] The AU secretariat stated that this was in conflict with recommendations for an effective response provided by international partners.[155] However, it would take until 2016 for some of the member states to reopen their borders.[156] This would thus indicate that internal coordination was suffering since the AU and some of its member states had conflicting goals.

The absences of an operational plan and lack of guidance from the AU secretariat furthermore indicate a lack of top-down leadership from the Department of Social Affairs, which was the agency at the AU secretariat in charge of the mission.[157] Concerning leadership on the ground, EpiAFRIC moreover notes that "[t]he chain of command was not clear and the team members often felt that they did not get sufficient feedback for their reports and sufficient guidance on what to do about the issues raised".[158] This unclarity in leadership would consequently affect the mission negatively by causing frustrations among the personnel.[159] *Uncontested leadership hierarchies* was operationalized as whether the leaderships structures remained unchallenged. The AU's leadership, spanning from the regional level to the operational level, does not seem to have been challenged as much as it was *unclear* or altogether *non-existent* (for a period of time). Similarly, there is little indication of specifically *inter-organizational competition*, operationalized as competitions

[153] Chikwe Ihekweazu et. al., *An Evaluation of the African Union's Response to the Ebola Virus Disease (EVD) Outbreak in West Africa*, 7.
[154] Jacque Wilson, *Borders closing over Ebola fears*, Website CNN, 2014-08-22 (Accessed 2017-05-20).
[155] African Union, 'African Union's Executive Council Urges Lifting of Travel Restrictions Related to Ebola Outbreak', *Press release*, Website the African Union, 2014-09-8 (Accessed 2017-05-20).
[156] Health News, *Ivory Coast re-opens western borders closed during Ebola epidemic*, Website Reuters, 2016-09-09 (Accessed 2017-05-20).
[157] ASEOWA, *ASEOWA Final Exit Report*, 2.
[158] Chikwe Ihekweazu et. al., *An Evaluation of the African Union's Response to the Ebola Virus Disease (EVD) Outbreak in West Africa*, 7-8.
[159] Ibid., 7-8.

between AU agencies which complicated the AU's response. Adding the weak internal coordination to the unclear leadership from the regional to field level instead paint a picture of inter-organizational *disconnect*. Concerning both *uncontested leadership hierarchies* and *inter-organizational competition,* the specifics of Brattberg and Rhinard's expectations do not quite fit.

### 6.2.3 Capability related behaviour

Behaviour derived from high *capabilities* is hypothesized to be an *ability to mobilise sufficient resources* that are *relevant to a disaster* and thereby alleviates suffering swifty. Mobilising a sufficient amount of resources was operationalized as whether or not the resources were enough for the AU to carry out its work. The final report on ASEOWA states that "inadequate national human resources, insufficient supplies (including personal protective equipment; or PPE), inadequate safe water and sanitation facilities" caused challenges to the mission.[160] Insufficient resources therefore appear to have complicated the AU's ability to carry out its work in the field. Apart from the direct involvement of ASEOWA during the mission, the Commission, as mentioned before, also produced donations. At the end, these donations comprised 1.2 million dollars.[161] This was markedly lower than the EU's donations. The EU Commission alone had donated 414 million euros by the end.[162] But to infer from this that the AU's donations were insufficient is no simple matter, given that the Ebola response was a collaborative effort. Nor is there any indications that the (lower) amount of donations directly complicated the AU's work. It should be noted, however, that the ability to mobilize sufficient resources also is qualified against the backdrop of alliviating suffering in a *swift* manner. The comparative lateness of both the mission and the donations (as elaborated in the section of *context*-related behaviour) provides an indication that the AU's resources did not add up to *swiftly* alleviating human suffering. Finally, on the donations, it should be noted that the donations were drawn from the Emergency Assistance Fund for Drought and Famine and staff members.[163] Thus these resources were *ad hoc* collected and not a natural part of the AU's epidemic disaster management capacity.

[160] ASEOWA, *ASEOWA Final Exit Report*, 12.
[161] African Union, 'Fact Sheet'.
[162] International Cooperation and Development, *EU response to the Ebola outbreak*, Website the European Commission (Accessed 2017-05-06).
[163] African Union, 'Fact Sheet'.

The AU's ability to mobilize *relevant resources* was operationalized as internal or external praises or complaints regarding the resources that either was or was not mobilized. On that note, EpiAFRIC reported that international partners had "[...] misgiving about the level of preparedness of some of the volunteers for the task at hand".[164] These complaints would suggest that the human resources mobilized by the AU to some extent were not as relevant or needed as they could have been. That said, the fact that ASEOWA's overall contribution to the international response was positively received indicates that the resources which were mobilized for the most part were relevant.[165] The main problem appears instead to have been that there were not enough relevant resources.

### 6.2.4 Consistency related behaviour

*Agencies working together smoothly (with few disputes)* and *operating in areas of relative strength instead of competing over operational priorities* are hypothesized behaviors by entities with high *consistency*. It has already been elaborated that a number of member states had closed their borders, irrespective of the AU's wishes. This would indicate that some national agencies were having disputes with the regional secretariat, to the detriment of their cooperation. As has also been mentioned, there were frustrations over the lack of coordination and leadership from the regional level down to ASEOWA's operational level, especially in the early months of the mission. Brattberg and Rhinard's first behavioral characteristic regarding *consistency* creates an expectation that entities with low actorness are expected to have disputes among its agencies, which *cause* their collaborative efforts to suffer. Hence it was operationalized as whether or not disputes caused interruptions to the collaboration between AU agencies. In the case of ASEOWA and the secretariat, however, the opposite appears to be present. Rather than being the cause, disputes (or frustrations strictly speaking) appear to be the *outcome* of agencies not working together. Hence, Brattberg and Rhinard's behavioral concept therefore does not always match.

There are similar conceptual problems regarding agencies operating in areas of relative strength. First of all, it was previously mentioned that the AU was criticized for not being fully equipped to manage a mission such as ASEOWA. This suggests that responsible agencies were not working in their area of expertise in general. Moreover, EpiAFRIC

[164] Chikwe Ihekweazu et. al., *An Evaluation of the African Union's Response to the Ebola Virus Disease (EVD) Outbreak in West Africa*, 43.
[165] Ibid., 43; ASEOWA, *ASEOWA Final Exit Report*, 31.

specifically pointed out that "[a]ll the support functions such as logistics, finance, communication etc were left in the hands of volunteers who did not have the requisite insights into AU procedures".[166] This furthermore highlights that the work distribution was not always done according to expertise. But the full operationalization of Brattberg and Rhinard's hypothesized behaviour was whether agencies worked in their area of expertise towards a common agenda, rather than pursuing their own agenda. In the specific case mentioned above, the weak work distribution appears not to have been caused by competition over agendas. Instead it appears to have been due to a lack of resources, since "[o]n arrival, there was inadequate organisational capacity in terms of HR, administration, logistics support".[167] Furthermore, when national agencies closed their borders despite the AU's wishes to the contrary, it could be seen as disputes over individual or common agendas. But the data that has been collected does not support that this necessarily resulted in workloads (among and within the agencies) not being distributed according to expertise. Thus, Brattberg and Rhinard's behavioural concept once again does not quite fit with the actual outcome.

# 7. Conclusion

## 7.1 Discussion

Deriving from the debate on actorness and effectiveness, the goal of this thesis was to test Brattberg and Rhinard's hypothesized relationship between actorness and behaviour during disasters. Brattberg and Rhinard have previously tested their hypotheses on the EU and the US, both exhibiting high actorness. By contrast, this thesis tested the hypotheses on the AU, itself hypothesized to exhibit low actorness, in order to better investigate if relationship between degrees of actorness and behavioral characteristics are positive. To do so, the thesis studied if the AU's degree of actorness correlated with expectations in behaviour, as defined by Brattberg and Rhinard, during the Ebola outbreak. To guide the thesis in accomplishing its goal, two research questions were asked. The first was: what was the degree of the AU's actorness in epidemic disaster management at the time of the Ebola outbreak? The analysis of the first actorness-concept, *context*, appeared not entirely conclusive as to the AU's exact score. This was in part due to that the AU's *de facto* recognition could not be firmly

[166] Chikwe Ihekweazu et. al., *An Evaluation of the African Union's Response to the Ebola Virus Disease (EVD) Outbreak in West Africa*, 37.
[167] Ibid., 38.

established, and in part because *de facto* recognition and *opportunity* were operationalized through simplified approaches. However, combined with the other components of *context*, the AU appear to have been at least moderately accepted as an epidemic disaster manager by member states and the international system at the time of the Ebola outbreak. Concerning *coherence*, although there was evidence of high *procedural coherence*, both *value* and *policy coherence* were measured low. Hence, the AU's *coherence* overall was considered low. That said, as clarified in the section on method, the subconcept *preference coherence* was not analysed. Though it is linked with other concepts (according to Brattberg and Rhinard) its exact state cannot be determined here. The analysis of *coherence* thus suffer slightly in its scope. Regarding *capabilities*, it was also measured as low, given the AU's lack of sufficient resources and troubled experiences of actually deploying health logistics. However, in the analysis of the AU's behaviour it was found that it made use of resources otherwise not meant for epidemic disaster management (the fund for drought and famine). This does raise a problem regarding how one is to define the concept of *capabilities*, given that *ad hoc* solutions can circumvent resource shortages in specific issue-areas. Finally, both the AU's *vertical* and *horizontal consistency* were considered low, adding up to an overall low *consistency*. To sum up, the AU's *context* was the only actorness concept that fitted badly with the AU's hypothesized low actorness, meaning the hypothesis was overall, but not completely, supported.

The second research question was: what behaviour, as listed by Brattberg and Rhinard, was exhibited by the AU's in its response to the Ebola outbreak? In relation to all four actorness concepts, the AU's behaviour did to some extent match that of an entity with low actorness. Only concerning *context*-related behaviour was there any clear indications that the AU also exhibited behaviour expected from an entity with high actorness, and only regarding *quick acceptanc*e. There are, however, some interpretive challenges regarding behaviour related to *coherence* and *consistency*. For example, the weaknesses in AU's leadership does not appear to have been due to it being challenged, nor does reported issues in distributing workloads based on expertise appear to have been due to competition over individual agendas. Hence, even though these behavioural characteristics were detrimental to the AU's efforts, they apply only in part to behaviours that Brattberg and Rhinard would expect of an entity with low actorness.

Taken together, the thesis supports in broad terms that Brattberg and Rhinard's

hypothesized relationship between actorness and behaviour in fact is positive. In doing so, the thesis also lends a measure of support for the application of Brattberg and Rhinard's hypotheses (and actorness concepts) on non-western entities. The AU's low *coherence, capabilities* and *consistency* in epidemic disaster management correlated with certain specific behaviours that are expected by entities with low actorness during the Ebola outbreak. But there is also some unclarity in the correlation. The AU's *context* related behaviour corresponded to expectations of entities with both high and low actorness. This could of course be related to the fact that the AU's *context* was measured as moderate, meaning that what one might expect in terms of behaviour is somewhat ambivalent. Regarding behaviour derived from *capabilities*, there is the fact that the AU used resources from its draught and famine fund. As stated before, these fund were not estimated as part of the AU's natural epidemic disaster management resources, meaning that the relationship between the AU's actorness and its actual behaviour is not altogether clear here. However, the primary problem for Brattberg and Rhinard's hypotheses was that they could not fully account for all behavioural outcomes, meaning that the specific correlation predicted by Brattberg and Rhinard could not always be supported. Given that their hypotheses are predictive and not deterministic, the hypotheses should be considered to have an inherently weak ability to predict too specific behavioural outcomes. Due to the testing design of this thesis, it is not for this thesis to state how the hypotheses should be specifically modified. But the analysis does support that the behavioural outcomes should be kept broad, to accommodate for variations that other theories and hypotheses better can explain.

## 7.2 Future research

With regards to future research on actorness and behaviour, the thesis supports that Brattberg and Rhinard's hypotheses should be further investigated. Based on the prior discussion, future research should develop and test the usefulness of broader behavioural expectations. With regards to Brattberg and Rhinard's problem of determining the relationship between actorness and coordination, the result of this thesis may be interpreted as facing a similar problem with regards to external coordination. As stated in the analysis, the AU's weak external coordination was not necessarily *exceptional*, which could be interpreted as correlating well with its moderate score on *context*. At the same time, the issue of relating actorness to external coordination might be considered problematic for the same reasons that

assessing individual goal attainment is problematic in collective disaster management. Since external coordination involves more than one entity, the outcome in coordination is dependent on more than the entity under investigation. Hence, the fall out of the AU external coordination may be considered circumstantial. To make a more comprehensive test on this topic, it would require more in-depth analysis of the external coordination based on a broader set of cases.

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