and 1·7 nurses per 10 000 people in Sierra Leone (compared with 93 in France).[2] It is unrealistic to think that high-income countries can supply the hundreds of caregivers needed to run the treatment centres being built when Médecins Sans Frontières is having trouble finding recruits and is questioning their model (supply of treatment centres), which needs enormous amounts of money and human resources.

Furthermore, foreign caregivers—unfamiliar to local cultures, thought by some local individuals to be importing the disease, equipped with infection control suits, and the first, or even only, to receive the few experimental treatments—are perhaps not the best choice of people to curtail the spread of the disease in communities upstream of treatment centres, where the epidemic continues unabated. Other models are needed that are better adapted to local realities, and, most importantly, that arm and reassure local health-care personnel—ie, those who know the environment and can still be mobilised, despite their small number and heavy losses.

For more on **resolution 1265** see http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N99/267/94/PDF/N9926794.pdf

For the **ESTHER European Initative** see http://www.esther.eu

Indeed, not far from the treatment centres that have been expensively equipped by the international community, public health structures (referral centres, district hospitals, and primary health centres, which are the referral structures in the communities) remain dangerously under-equipped, with inadequately trained and ill equipped staff.

Most of the solution is to help the remaining health-care personnel to work, under the responsibility of national managers; to supply them with the personal protective equipment that is absent or in short supply; to offer them the training and the supervision they need to feel safe; and to work with them and community organisations to help in the effort of raising community awareness and ensuring early treatment via a task shifting system. National health stakeholders are the cornerstones of outbreak response.

Capacity-building at all levels of health care is key. Although such groundwork must occur in addition to emergency interventions, it is essential to change the situation where the virus is being spread—ie, in the primary health-care facilities and the community.[3] Treatment of confirmed cases in treatment centres with specialised staff is necessary at the height of the epidemic; but upstream actions in community and national health-care facilities, with local workers who have been given the methods they need, is indispensable, before, during, and after the peak of the outbreak.

Health-care workers from high-income countries could help their colleagues in Africa in a capacity development strategy. Many are accustomed to participating in such capacity-building programmes (eg, the ESTHER European initiative), through existing hospital partnership cooperation networks, international programmes like the WHO's African Partnership for Patient Safety, partnerships and professional networks. Mobilisation of these workers and their professional networks would have unquestionable value, provided the mechanisms and policy initiatives existed to promote and support them. Such approaches have real potential if response to this epidemic looks towards the medium term and sustainably strengthening depleted health-care systems.

We declare no competing interests.

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Ebola and the UN's responsibility to protect

The Lancet Editorial (Oct 25, p 1477)[1] on the Ebola epidemic concluded that "the military seem set to play a greater part in global civilian health in the future". This is challenging and deserves comments.

Liberia has 0·1 physicians, and 1·7 nurses and midwives for every 10 000 people,[2] compared with 5·4 soldiers for every 10 000 people. Does Liberia need more soldiers or more health-care workers?

Since 1999, the UN has intervened in many countries to protect civilians from the effects of armed conflict—the responsibility to protect (resolution 1265). Should the Security Council now also be in charge of deployment of military personnel to fight health-care crises? Considering the likely incompetence of WHO, this move might be wise.[3]

On May 21, the Ministry of Health for Guinea reported 258 cases of Ebola, including 174 deaths (17 of health-care workers).[4] Without showing much concern, WHO held its annual meeting on May 19–24, at the Palais des Nations, Geneva, with more than 3500 participants.

It seems wiser to rely on the military—they cannot do worse than WHO.

I declare no competing interests.

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