

# EBOLA: DEMANDING ACCOUNTA- BILITY AND MOBILISING SOCIETIES TO AVOID A DEADLY RELAPSE

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One year into history's largest and deadliest Ebola outbreak, the failures and fatal inadequacies of the current arrangements for response to global health crisis have been brutally exposed. The toll of the epidemic has been huge: more than 26,000 people were infected and more than 11,000 left dead. The people of West Africa and the world deserve better, and civil society movements need to step up.

The enduring Ebola epidemic has taught the world some hard lessons over the last 12 months, which we must take to heart. Despite early warnings, and the extraordinary efforts of local healthcare workers and private medical humanitarian organisations, the epidemic has exposed the institutional failures that saw the Ebola outbreak spiral far out of control, with tragic and avoidable consequences.

In particular, we should reflect on the role civil society must play in response, and how it can spur on mandated international bodies to shake off their paralysis and act decisively during crises, instead of leaving it to private organisations, such as MSF, to respond.

In March 2015, the downward trend of admissions in Ebola treatment centres, was cause for optimism, not least in Monrovia, Liberia, previously the epicentre of the emergency during September 2014, at the height of the epidemic. But as we have seen before, the epidemic remains unpredictable, and new Ebola cases were diagnosed again, proving the necessity to match vigilance with improved contact-tracing (see box two) and efforts to rebuild trust in health services, to ensure that all new Ebola cases are identified and their contacts traced and monitored.

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## MSF Ebola response

- o MSF operated eight Ebola case management centres, providing 650 beds in isolation, and one transit centre until March 2015.
- o In March 2015 the organisation employed 4,475 staff (local and international) in Guinea, Liberia and Sierra Leone.
  - Of these 25 have been southern African medics.
- o At the height of the epidemic, from August to November 2014, MSF operated 22 Ebola case management centres, including the world's biggest centre: the ELWA 3 centre in Monrovia, which had a 250 bed capacity.
- o Since the beginning of the outbreak up until May 2015, MSF has:
  - admitted 9,446 patients
  - confirmed 5,168 patients as having Ebola
  - discharged over 2,449 patients as Ebola survivors.
- o To date, MSF has trained 800 of its own staff and 250 people from other CSOs, the UN and government agencies in Ebola response.

epidemic certainly was not over. It is no time to slow down, especially since new cases of Ebola were being recorded in neighbouring Guinea and Sierra Leone, meaning that the outbreak is not over yet. There is now a need to improve cross-border surveillance to prevent Ebola re-emerging in Liberia.

What we have learned so far is that stopping the epidemic depends on all the different pillars of the response being in place, and having experienced responders who are well-resourced and able to adapt. To take control of the epidemic, the people of West Africa need an active public health surveillance system at the core of a fully mobilised, agile and flexible crisis response that has the trust of communities. The continued reluctance of some communities in Guinea to engage, coupled with sporadic attacks against healthcare workers, pose a threat to bringing the outbreak under control.

## WHY EBOLA FLOURISHED

Convenient explanations emphasise the Ebola epidemic as a perfect storm of a cross-border outbreak in countries with weak public health systems that had never seen Ebola before.

While the outbreak did thrive on the pre-existing weaknesses of the public health system in Guinea, Liberia and Sierra Leone, it was international inaction and institutional failures that precipitated an avoidable tragedy.

It was not only the legacy of civil war in Liberia and Sierra Leone that played a role, but also the corrosion

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On 9 May 2015 the World Health Organisation (WHO) officially declared Liberia Ebola-free, after 42 days of no new infections. This was a great milestone, but the

wrought by efforts to rebuild these societies. The International Monetary Fund (IMF) programmes that bankrolled redevelopment placed priority on debt and interest payments, rather than social welfare and health spending. These conditions attached to IMF and World Bank loans forced Guinea, Liberia and Sierra Leone to cap the number of health workers they employed and what they could be paid, according to an article in *The Lancet* medical journal.<sup>1</sup>

The impact was detrimental. Even before the Ebola outbreak, the health systems in Liberia and Sierra Leone had less than one doctor per 10,000 people, and less than three nurses and midwives per 10,000 people. Women in Liberia and Sierra Leone were left especially vulnerable; they are more at risk of dying during childbirth than almost anywhere else in the world.<sup>2</sup>

The Ebola outbreak worsened their lot, as health facilities were closed, since healthcare workers abandoned their posts, fearing that they too would become infected, given that hundreds of health staff had already died while trying to help without the necessary protective gear and support. Obscured from view by Ebola is the over one million malaria cases reported in Liberia and Sierra Leone, and nearly 800,000 in Guinea.<sup>3</sup> But in the wake of Ebola, this deadly disease was not prioritised. So far MSF has managed to distribute antimalarial drugs to more than 650,000 people in Monrovia and 1.8 million people in Freetown, as well as opening a new maternity unit for pregnant women with Ebola in Sierra Leone.

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wildly, amid a dearth of leadership and the urgent action that was required.

The WHO is internationally mandated to lead on global health emergencies and possesses the know-how to bring Ebola under control, as does the US Centers for Disease Control (CDC), which has laboratory and epidemiological expertise. However, both WHO in the African Region (WHO AFRO), and its Geneva headquarters, did not identify early on the need for more staff to do the work on the ground, and nor did they mobilise additional human resources and invest early enough in training more personnel.

The initial response was left to private organisations such as MSF: an untenable situation that stretched our organisation and people to the limit to take on significant risks to try and save lives.

For MSF, our most significant limitation in the beginning was the lack of experienced staff to deal with an outbreak on this scale. At the onset of the outbreak our own staff complement who were experienced in Ebola work numbered only around 40 people, who had worked on much smaller isolated outbreaks during the last 20 years.

They had to simultaneously set up and run operations on the frontline, and coach inexperienced staff. MSF embarked on the most extensive knowledge transfer operations in its 44 year history. Trainings began in earnest at headquarters and in the field, with more than 1,000 people trained and more than 1,300 international staff and over 4,000 national staff deployed over 2014/2015.

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# CAN CIVIL SOCIETY HOLD GLOBAL ACTORS TO ACCOUNT?

The three countries hit hardest by the Ebola epidemic are characterised by a lack of strong traditions of organised local civil society. After the conflicts in Liberia and Sierra Leone in the early 2000s, the rebuilding of these societies and social services were hamstrung, leaving authorities with a tendency towards knee-jerk reactions when faced with crises. A hallmark of this was the use of repressive quarantine measures, which masked the paralysis of the state authorities while, with deadly irony, trapping Ebola inside communities. In Sierra Leone corruption thrived, as desperate people resorted to bribing officials to let them out of quarantine so they could go about their normal business, given that quarantine was a euphemism for imprisonment, often without adequate supplies for daily existence. But this was overshadowed by the alarm, framed by media reportage on the outbreak, in Western Europe and the United States as Ebola crossed the Atlantic. Some of the media coverage reached for sensationalism when reporting on the thousands of horrible, undignified deaths in West Africa, juxtaposed with one of two infections in the EU or US, which resulted in calls for isolation and flight cancellations to West Africa.

At the other end of the spectrum, little attention was focussed on the WHO - one of the world's

largest intergovernmental organisations - since it was out of touch with the reality on the ground and unable to shift quickly from technical advice to taking responsibility with hands-on deployment and coordination.

When the WHO was founded 60 years ago as a specialised UN agency, its primary charge, laid out in its constitution, was to ensure the “attainment by all peoples of the highest possible level of health.”

How then did the WHO fail to carry out its mandate in protecting the vulnerable people of West Africa?

## Six steps to stop Ebola

- 1. Isolation and care for patients:** Isolate patients in Ebola management centres staffed by trained personnel and provide supportive medical care and psychosocial support for patients and their families.
- 2. Safe burials:** Provide and encourage safe burial activities in communities.
- 3. Awareness-raising:** Conduct extensive awareness-raising activities to help communities understand the nature of the disease, how to protect themselves, and how to help stem its spread. This works best when efforts are made to understand the culture and traditions of local communities.
- 4. Disease surveillance:** Conduct and promote thorough disease surveillance in order to locate new cases, track likely pathways of transmission, and identify sites that require thorough disinfection.

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**5. Contact-tracing:** Conduct and promote thorough tracing of people who have been in contact with the Ebola-infected. If contacts are not mapped and followed up, it undermines all the other activities and the disease will continue to spread.

**6. Non-Ebola healthcare:** Ensure that medical care remains available for people with illnesses and conditions other than Ebola (e.g. malaria, chronic diseases and obstetric care).

The problem was a vacuum of leadership. I saw this first-hand when I worked in Sierra Leone during the peak of the epidemic in August and September 2014. I arrived in the capital, Freetown, a few weeks after the WHO eventually declared the outbreak a public health emergency of international concern on 8 August 2014, six months after Ebola was confirmed in Guinea. At the time of my arrival, the international response to this deadly outbreak left much to be desired, either because of fear, lack of expertise or political will.

During joint response coordination meetings, I sat through what was more like a round table discussion, while outside in the streets, people were dying horrible deaths without dignity, new infections soared and healthcare workers struggled to respond. The same could be said for top level meetings, where the WHO did not manage to take decisions on setting priorities, attributing roles and responsibilities, ensuring accountability for the quality of activities, or mobilising resources on the necessary scale. There was little sharing of information between affected countries. Only in July 2014 was a regional operations centre established in Conakry, Guinea to provide the much needed technical and operational support

critical for an unprecedented outbreak of this nature that traversed borders.

Epidemic response activities (see box) should have been coordinated inside and beyond the borders of the affected countries. The successful execution of these demanded a direct operational approach, which the WHO could not sufficiently provide.

This epidemic also showed the lack of vision and capacity to ensure that local community-based organisations, which traditionally have carried out infection control education for measles, Lassa Fever and other poverty related diseases, to play an instrumental role within communities to drive change in health behaviours to stop Ebola transmission.

From the outset the WHO was out of step with the reality experienced by terrified communities in Guinea, Liberia and Sierra Leone. The WHO's January 2015 report relates how a "mysterious" disease began silently spreading in a small village in Guinea on 26 December 2013, but was not identified as Ebola until March 2014. When MSF responded in March 2014 to the outbreak in Guinea, calling for international support because the spread of the outbreak was unprecedented, the WHO in April maintained that the outbreak was still "relatively small."

MSF's initial Ebola response focused on Guinea from March 2014, and another rapid response in Liberia during April 2014, where cases numbers quickly dwindled. By May 2014, MSF teams had started working in Sierra Leone, after being requested to intervene in late May.

By June 2014 MSF told the world that the outbreak was out of control, and that the response capacity

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was completely inadequate. We also announced that our teams had reached their operational response limits, necessitating massive deployment of resources from international governments.

In July the situation in Liberia reached alarming proportions, and MSF received impassioned phone calls from former Liberian staff, currently members of MSF's Association, who were active in civil society, pleading for an MSF response.

The existing pressures on MSF's Ebola teams in Guinea and Sierra Leone were massive, but we could not ignore the distress signal. With internal pressure strong, MSF had technical support teams on the ground in Liberia during July 2014, and by August we had built a massive isolation centre in Monrovia. At 250 beds, the ELWA 3 case management centre was the world's biggest Ebola centre, compared to the 40-60 bed facilities previously set up. But within days it was overwhelmed with the Ebola sick. In September and October, my colleagues there could only open the gates for 30 minutes a day, to allow new patients in to take the place of those who had died overnight.

In July 2014 these experiences and perspectives from working in all three countries pushed MSF teams to the limit, and we called on UN member states to launch an intervention, since CSO capacity was completely outstripped. The WHO eventually declared an Ebola Public Health Emergency in August, and only in September 2014 did a slow stream of foreign aid support start to trickle in, after MSF took the unusual step of calling for civil and military biohazard responses from UN member states.

## WHAT CIVIL SOCIETY'S HIV RESPONSE TAUGHT US

Unlike civil society movements, the WHO is not built on the principles of solidarity with people in crisis, and it does not respond to the inequalities in the world out of anger and outrage. In the late 1990s, at the epicentre of the HIV epidemic, the South African government was gripped by AIDS denialism, which paralysed its response to AIDS. At the time, the disease was killing 1,000 people daily, and in the absence of response, grassroots civil society organisation (CSO) the Treatment Action Campaign (TAC) stepped in.

TAC built a powerful movement of patients who organised themselves as a force to be reckoned with in South Africa and to be admired internationally, inspiring a new wave in the global HIV solidarity movement. TAC was able to empower people living with HIV with knowledge of their disease, and mobilised them to demand anti-retroviral treatment and accountability, and to fight HIV stigma.

This kind of social activism grew against the backdrop of ineffective global health leadership. Despite the evidence of treatment success in 1996, international bodies such as the UN and WHO took five more years to produce treatment protocols for resource-poor countries. In the midst of the raging pandemic, there was little recognition of the gravity of HIV's social and security impact until 2000.

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But unlike the virus that causes AIDS, the Ebola virus and its transmission puts people without effective available treatment at immediate high risk of dying from the disease. The usual methods of mobilisation familiar to activists are not possible for people living in West Africa. Instead, what is needed is a global movement in solidarity with the plight of the people of West Africa that keeps the WHO, as well as wealthy countries that have an obligation to meet their mandates, accountable to people in desperate need.

## LEARNING THE LESSONS

Over the last 20 years reforms have gradually reduced the direct operational capacities in the UN system. For example, the restructuring of the WHO in Geneva has led to the closure of its viral haemorrhagic fever unit. UN member states should be held accountable for an unceasing reduction of response capacity.

In the face of a lack of international action, desperation in communities drove people to develop their own imperfect offering. Volunteer Ebola fighters, donning improvised protective gear to treat sick family members, and volunteer burial teams, were willing to endure stigma and social exclusion.

A destructive spiral materialised, leading to the catastrophic situation in West Africa, characterised by lack of leadership, deficient coordination and, last but not least, a striking absence of operational capacity. This was compounded by the fact that the international community simply doesn't feel responsible for responding to what is happening in regions that are not perceived as politically or

economically significant. It is left to fragile health systems in the affected countries to manage international health crises, as well as to private organisations that have, by their nature, limited capacities to respond to major outbreaks.

While the WHO Executive Board wants to enact reforms for epidemic response and address internal incoherence, it seems unlikely that radical reform will happen overnight, and there is little interest from UN member states in empowering an epidemic response body with the power that could potentially challenge their own sovereignty.

Without the power of mobilised societies, change will not happen. Millions of West Africans have lost confidence in the health system, and patients suffering from life-threatening health conditions not related to Ebola, such as birth complications or malaria, still cannot receive appropriate care. Coupled with fear, this deepens people's distrust of health services and authorities, as in Guinea. It is urgent that access to healthcare is restored as a first step to rebuilding healthcare systems in the region that are able to face the difficult, uncertain future.

There was a powerful defining feature of the response from MSF, aside from the establishment of case management centres and effective contact tracing: it was the fact that this movement is based on an association of humanitarian fieldworkers, international and national staff members, who volunteered to work in the fight against Ebola, feeling compelled to act. Many returned two and three times over the course of months because of the enduring dire need. This speaks to their humanitarian spirit of solidarity with the people of West Africa. The WHO is now talking about building a global workforce in

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preparation for other similar outbreaks, but what marked the volunteers' motivation and efforts was their visceral refusal to accept the status quo, and their drive to provide access to healthcare to meet the needs of people caught in crisis, based on what they witnessed.

Today, we know that huge efforts are needed for large-scale community mobilisation and health promotion, and information sharing, much as was the case with HIV. But this process will demand significant financial and human resource investments. It's here where CSOs in Guinea, Liberia and Sierra Leone must find a meaningful role to play in the mobilisation effort, while international civil society should demand transparency and accountability from international bodies such as the WHO. Without it we are doomed to repeat history.

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1 Alexander Kentikelenis, Lawrence King, Martin McKee and David Stuckler, 'The International Monetary Fund and the Ebola outbreak', *The Lancet Global Health*, February 2015, Vol. 3, No. 2, [http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(14\)70377-8/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70377-8/fulltext).

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<http://www.doctorswithoutborders.org/sites/usa/files/MSF%20Safe%20Delivery%20ENG.pdf>.

3 WHO, *World Malaria Report 2014*, [http://www.who.int/malaria/publications/world\\_malaria\\_report\\_2014/en](http://www.who.int/malaria/publications/world_malaria_report_2014/en).

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