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Ebola Outbreak in West Africa and CSOs Response

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ABSTRACT

This article highlight the roles civil society organizations (CSOs) played in response to the recent past Ebola disease epidemic in West Africa; despite the pros and cons associated with the outbreak. The article presents practical episodes of global health governance processes employing Ebola as case study. In Liberia, CSOs disseminate information, and other necessities to local communities; in Sierra Leone, CSOs conducted advocacy and sensitization activities; while in Guinea, CSOs conducted more than 20,000 information sessions. Funds diversion and human movement restrictions temporarily hampered CSOs operation during the outbreak. More disturbing was contracting of the disease by Health professionals while on duty; to protect healthcare givers at service delivery points against nasocomial infections, evidence base study that envisage workplace safety should be conducted.

Keywords: Outbreak, CSOs, response, Ebola, sensitization, healthcare

INTRODUCTION

This article brings to fore the roles civil society organizations (CSOs) played, as global health actors in response to the recent past Ebola disease epidemic in West Africa. Significant issues like shortage in clearly visible framework elements, challenges like legitimacy of multilateral agencies on certain issues and absent of transparent accountability processes of civil societies, characterized Global Health Governance (GHG) landscapes (Julio and Suerie, 2013). Moreover, financial diversion, restrictions of movement and activities of groups and individuals hindered smooth performance of the CSOs. Despite these hitches in theory, in practical CSOs response was tremendous and cardinal to the success of Ebola fight in West. Available secondary data

on the Ebola outbreak in West Africa within the broad spectrum of global health governance such as partnerships, informed actions, and experiences gained while curtailing Ebola disease were exploits.

The Disease Ebola

Ebola virus was first noted in an African village in the 1970s. It was rumored at first that Ebola virus transmitted to individuals through contact with wild animals, the claimed was debunked with scientific fact. Ebola disease derived its name from River Ebola in Congo republic where the case was first diagnosed (Jorge et al., 2004). Every epidemic of the Ebola disease within the past 30 years has induced phobia and crises in livelihood patterns at all levels, especially in African neighborhood (Sarathi et al., 2015). Several incidences of Ebola epidemics had occurred, in fact over 20 episodes were recorded since the 1970s (Gerardo and Nishiura, 2014). In August 2014, World Health Organization declared Ebola epidemic a global health emergency, which was the widest and most influential in four decades of the disease history (Jeremy and Peter, 2014). Almost 14,100 incidences and 5,200 deaths were recorded during the 2014 outbreak that last for months, with cumulative 37% mortality rates (PIH, 2015). Vaccine against the deadly disease was developed by Canadian Public Health Agency in 2015. A trial of the vaccine in humans conducted in Guinea was successful as reported in *The Lancet;* it was lead by World Health Organization, in collaboration with Ministry of Health, Guinea; Medicines Sans Frontiers; Norwegian Institute of Public Health and other international development partners (WHO 2016).

CSOs Roles during the Ebola Outbreak

In response to the epidemic, CSOs played a tremendous support in curtailing the menace. From September 2014 to June 2015, a CSO called Partners in Health (PIH) indulged in local communities' confidence building mission, with the sole aim of extinguishing the Ebola outbreak. PIH engaged and improved the capacity of approximately 200 expatriate

physicians, Registered Nurses and other health care experts to take care of Ebola victims. Roughly 2,000 community members that comprise disease survivors, non-health care workers, health professionals and orphans and welfare staff were employed by PIH. Also, at the peak of the incidence PIH supplied facilities to 21 healthcare delivery points (NDI, 2014).

Task force was formed in Liberia to oversee the activities of the disease transmission control and treatment. The task force has Natural Resource Management (NRM), the Southeastern Women Development Association (SEWODA), and WASH-Liberia in the taskforce (EPSMG, 2014); the taskforce and community leadership helped in preventing the epidemic from escalating. The taskforce built the capacity of the local community, organized the processes of developing community needs strategic plan; convinced the locals to lobby their legislators to ensure their proposals are added to national planning scheme. World Health Organization identified community engagement in which communities lead their course as the backbone of an effective response; in places where communities take charge during the outbreak, the disease was curtailed (EPSMG, 2014).

Private companies as non-state actors ensured the safety of their staff, dependents and neighboring communities, and also helped in organizing and coordinating immediate large scale response strategies as soon as the outbreak was declared. These roles have shown how vital and relevant private companies are as critical partners to national governments, International organizations and civil societies at large in the fight against diseases of global health significance like Ebola (Edwin, 2014). Market base organizations contributed to the course by responding promptly, strongly and quickly in reaching the affected communities with resources. These gestures were particularly demonstrated by Private sector actors in the likes of Dangote Foundation, a Nigerian base organization.

In Nigeria two Ebola disease Emergency Operation Centers were instituted in Rivers state, and in the Central Public Health Laboratory, Yaba-Lagos. These centers were established in collaborations of Centre for Disease Control, Nigeria; WHO, UNICEF, Médecins Sans Frontières and the US Center for Disease Control and Prevention. This consortium organized and carried out several implementation services, advocacy roles, behavior change communication, evidence base information dissemination and remarkable contact tracing activities. Dangote Foundation donated about $1,000,000.00 to the Emergency Operation Centre in Lagos in support of its logistic cost (CIDRAP, 2014). Bill & Melinda Gates Foundation funded the first trial of convalescent therapy for Ebola in West Africa, conducted by Clinical RM in coordination with Liberian health authorities and the WHO (WHO, 2015).

In Sierra Leone ENCISS was one of the umbrella CSOs that supported government's efforts in responding to the threat of Ebola disease within the country. ENCISS organized, coordinate and engaged volunteers, disseminate information, shared logistics, and motivated health professionals in the affected communities. In Kailahun, a town in Sierra Leone; a locally based CSO called SEND formed a part of a project called 'Rapid Response', coordinated by Christian Aid and funded by ENCISS's 'Start Fund', handled by a consortium of charity foundations (ENCISS, 2015). Local leadership contributed to the fight against Ebola in Sierra Leone; traditional and religious heads understand the needs to adopt scientific means in preventing the disease, and shared it with their subjects.

Succinctly, significant to the success of the fight was the bond established at the grass root with the local and deep knowledge of community needs. Another factor was the partnership established between governments and CSOs, also the willingness from the local

communities helped in reducing the morbidity, fatality and general mortality rates of the disease (UNDG, 2015). Partnership and coordination between government agencies and CSOs in service delivery to the communities are cardinal to project sustainability, more especially in tackling epidemics, humanitarian emergencies etc. CSOs have indeed played several key roles during the outbreak, but these roles are not without challenges.

Challenges Faced by CSOs during Ebola Disease Outbreak

CSOs in the fight against Ebola disease during the epidemic faced various challenges, most of it avoidable. According to World Bank most telling challenge of the Ebola epidemic is its tragic effect in human lives, general sufferings, and retrogressive touch on developmental gains of the affected countries, and escalating level of already dwelling poverty. The World Bank on 17th April, 2015 released an economic data reflecting the economic cost of Ebola to Guinea, Liberia, and Sierra Leone to the tuned of not less than USD $2.2 billion of a lost in economic growth (World Bank, 2015). Other studies reported impact of Ebola epidemic in these countries to include unemployment due to retrenchment and downsizing, poor agricultural harvest, and looming food insecurity pointing famine (World Bank, 2015).

During the outbreak, risks of doing business in the affected countries skyrocketed to a level in the history of the disease. Flight movements were cut drastically, ports of the affected countries were avoided, health and life insurance prizes escalated and a times terminated, wooing of employees with experience becomes difficult for companies due to medical evacuation uncertainty. Working capital reduced and number of bank loans default increase considerably, thereby affecting the economic performance of small and medium enterprises, the life line of most local communities' negatively (Edwin, 2014).

Access to essential drug is a key factor in health care delivery process, in developing countries quarter of the medicines are considered fake or of

sub-quality. Therefore, global trade in counterfeit drugs threats the ability to timely nabbed Ebola disease, also declining trust of public in governments and international organizations ability is another factor (David et al., 2015).

Health teams manning health posts in some counties in Liberia were found to be not well trained, which was a challenge during the response, more so are difficult transportation system and poor communications connectivity hindered the successful efforts of curtailing Ebola in distant rural settings(VOA, 2014). At the time of rainfall medical staff could not access roads which were an impediment to getting specimens or ill victims in time to the Ebola designated treatment centre in Monrovia. Moreover, many locations lack communication network availability which subjected health workers to difficulties in communicating with appropriates channels, new cases, suspect diagnoses or prompt transfer of lab specimens for evaluation. For instance, in River-Cress, health staff took about six hours round trip to access internet to report surveillance findings to Ministry of Health, while in Sinoe County, the medical staff experienced 3 days elapsed before receiving a confirmatory lab outcome (VOA, 2014).

It was reported by Red Cross Society of Liberia that infected death bodies were not received for cremating due to non availability of space. In the outskirts cities of Monrovia infected cases have no alternative than to remain indoors, because they are not proximal to Ebola care centers, and in turn posed a risk of transmitting the disease to their families. Not payment of hazard allowances and increment of wages to medical staff resulted in repeated work boycotts in Liberia and Sierra Leone. Medical staff had staged a walkout protest in the lone treatment centre at Bo town located in southern Sierra Leone over increment in wages and hazard allowance payment (Katie, 2016).
Inaccessibility to government's health institutions create heavens for herbalist to exploit the victims of Ebola, and also quacks and patent

medicine vendors had a field day during the outbreak. These non scientific options were preference to many locals for socio-economic reason and ignorance. Several incidences were linked to herbalist, quack, and traditional healers or at a funeral (Katie, 2016).

Other challenges are those raised from patronizing prostitutes, over populated public arenas, lack of protective clothing, stigmatization, discrimination of survivors and their dependents, overstretched health facilities, inadequate staff, phobia and anxiety induced chaos, boundary closure, reduction of flight and ships movement, and shortage of food supplies (VOA, 2014).

Further Research Areas

Advices were given to men recuperating from Ebola for a minimum of 12 weeks abstinence prior to indulging in non-protective conjugation. A review study conducted in Columbia on recuperated Ebola men victims within the range of 30 years from 1977 to 2007; it revealed on average that the virus persisted for 70 days, and 91 days on a single victim. These authors recommended larger studies on clinical, social and serological aspects of Ebola disease, to fill in the gap, created by them (VOA, 2014); the study was not yet conducted.

No informed or tangible finding or opinion is available on the ability of Ebola virus to lives corporeally under a specific physical condition (Jonathan et al., 2004); it is recommended for a study that will provide better perception and shaped the understanding of why some victims experienced more severity in clinical syndromes, while others don't (Jennifer, 2015).

At the peak of the outbreak healthcare professionals contracted Ebola while on duty at both sides of the globe, the issue highlights protective gaps in the healthcare settings (WHO, 2015). To build health workforces' confidence in the near future, a research investigating the

best protective means for health personnel while handling infectious cases of similar multitude need to be conducted.

CONCLUSION

The recent past devastating Ebola outbreak stimulates a prompt response from across the global health actors, not only that, it has exposed the laxity of the affected government preparations in time of public health emergencies. The epidemic has really tested the response expected during a global health case of such promiscuity. Hither skater efforts employed during the outbreaks had institutes a makeshift system that produces great outcome, though not on the platter of gold, but a progress has been made. Multi-various stakeholders from multi-discipline background comprising of healthcare professionals, administrators, producers, foundations, researchers, volunteers, expatriates, journalist, foreign aids and several others have diligently responded in the prevention and control of the deadly epidemic. Quarantine regulation should be adhered to at point of entry for passengers from Ebola infected countries, likewise, Ebola victims should be monitored for 21 days by health departments from the date of their departure from affected countries, and also, Ebola Treatment and Research Group should be given a mandate to carry out an extensive research into the Ebola virus patterns. Therefore, in the near future global health family should not left any stone unturned, every principle of protection while handling infectious diseases cases should be well taken care up.

Advocacy, lobbying, partnership, collaborations, consortium, and involvement of local communities to lead their affairs in times of need have all proven effective during the Ebola outbreak in West Africa, the largest in its history.

REFERENCES

CIDRAP, C. F. I. D. R. A. P. (2014). CDC Assessment Cites Rural Gaps in Liberia's battle with Ebola [Online]. Available: http://www.cidrap.umn.edu/news-perspective/2014/12/cdc-assessment-cites-rural-gaps-liberias-battle-ebola.

David, L. H., Thomas, R. F. & Ravi, P. R. E. (2015). Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic. *Lancet,* 385, p1884–1901.

Edwin, I. (2014). Case Study: How Nigeria Contained the Ebola Outbreak.Available from: https://www.one.org/us/2014/10/29/case-study-how-nigeria-contained-the-ebola-outbreak/.

Enciss, E. I. B. C. A. T. S. I. S. L. (201)5. *CSOs in Ebola Response* [Online].Available: http://programme.christianaid.org.uk/programme-policy-practice/programmes/enciss [Accessed].

EPSMG, E. P. S. M. G. (2014). Observations of Role of the Private Sector Contribution in Fighting Ebola and Promoting Recovery [Online]. Available: https://www.epsmg.com/media/6217/the-ebola-private-sector-mobilization-group-dec-10-11-statement-final-.pdf.

Gerardo, C. & Nishiura, H. (2014). Transmission Dynamics and Control of Ebolavirus Disease (EVD. *BMC Med,* 12.

Jennifer, M. (2015). Focus on Research: Ebola Crisis Highlights Gap in Health Care Worker Safety.: Centre Daily Times.

Jeremy, J. F. & Peter, P. (2014). The Ebola Emergency — Immediate Action, Ongoing Strategy. *N Engl J Med,* 1545-1546.

Jonathan, S. T., Pierre, E. R., Daniel, G. B., Anthony, S., SHARON, M. C., Martin, V., William, F. L., Christina, F. S., Thomas, G. K., Mathew, L., Felix, K., Robert, D. & Stuart, T. N. (2004). Rapid Diagnosis of Ebola Hemorrhagic Fever by Reverse Transcription-PCR in an Outbreak Setting and Assessment of Patient Viral Load as a Predictor of Outcome. *J Virol;,* 78, 4330–41.

Jorge, E. P., James, M. W., Compton, J. T., Ray, A., Peter, B. J. & Pierre, F. (2004). Trigger Events: Enviroclimatic Coupling of Ebola Hemorrhagic Fever Outbreaks. *Am. .J Trop. Med;* , 664–74.

Julio, F. & Suerie, M. (2013). Governance Challenges in Global Health. *N Engl J Med* 936-42.

Katie, M. (2016). No One Is coming to save us [Online]. Marc Maxmeister Ebola Available: http://ebolastories.wordpress.com

Ndi, N. D. I. (2014). Task Force to Spearhead Community Response to Ebola in Liberia [Online]. Available: http://www.ndi.org/liberia-ebola-cso-community-response [Accessed].

Pih, P. I. H. (2015). Ebola: We work with partners in Liberia and Sierra Leone to treat people affected by the Ebola virus. [Online]. Available: http://www.pih.org/blog/partners-in-health-ebolsa-response.

Sarathi , K., Dhanashree, K., Sagar, C. G., Thomas, J. P., Stanislaw, P. S., Bonnie, A., Brian, A. H., Richard, P. S., Donna, S. & Jeffrey, A. J. (2015). The Emergence of Ebola as a Global Health Security Threat: From 'Lessons Learned' to Coordinated Multilateral Containment Efforts. *J Glob Infect Dis,* 6, 164–177

Undg, U. N. D. G. (2015). Socio-Economic Impact of Ebola Virus Disease in West African Countries [Online]. Available:

http://reliefweb.int/report/sierra-leone/socio-economic-impact-ebola-virus-disease-west-african-countries

VOA (2014). WHO: $1 Billion Needed to Contain Ebola Outbreak.

WHO (2015). *Ebola Response in Action* [Online]. Available: http://www.who.int/csr/disease/ebola/en

WHO (2016). Media Centre' Final Results Confirm Ebola Vaccine Provides High Protection Against Disease. http://www.who.int/mediacentre/news/releases/2016/ebola-vaccine-result/en/

WORLD BANK (2015). World Bank Group Ebola Response Fact Sheet [Online]. Available: http://www.worldbank.org/en/topic/health/brief/world-bank-group-ebola-fact-sheet [Accessed].