

EBOLA RESPONSE: WHERE ARE WE NOW?
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INTRODUCTION

In early September 2014, MSF urged states with biological disaster response capacity to intervene in West Africa, where an outbreak of Ebola has already taken more than 5,900 lives. Without the help of foreign governments, the organisation said, nongovernmental groups and the United Nations had no hope of effectively implementing WHO Global Roadmap against Ebola.

In particular, MSF called for states to urgently intervene in Guinea, Sierra Leone and Liberia to dispatch trained personnel in their numbers, to create mobile laboratories to improve diagnostics and to set up Ebola case management facilities. The organisation also called for these states to establish dedicated air bridges with which to move personnel and equipment to and within West Africa; to create a regional network of field hospitals to treat medical personnel; and to address the collapse of state infrastructure, which has left people in many parts of West Africa without access to basic healthcare.

Three months later, the Ebola response is rolling out in the worst-affected countries, and local people and authorities, international NGOs and foreign governments are now involved to varying degrees. There have been positive steps forward: for example, a number of bodies have been established to improve coordination at the national and regional levels; a handful of field hospitals for healthcare workers have been set up in the region; and governments – with some support from the international community – are now leading on efforts against Ebola in all three countries.

On the whole, however, the response to this rapidly-changing epidemic has so far been inadequate. Instead of the well-coordinated, comprehensive and expertly-staffed intervention MSF called for ninety days ago, actual efforts have been sluggish and patchy, falling dangerously short of expectations. In particular:

- ***The international response to Ebola in West Africa has been slow, encumbered by serious bottlenecks in terms of staffing.*** Though all three of the worst-hit countries have received some assistance from foreign governments, these actors have focused primarily on financing and/or building Ebola case management facilities, leaving staffing them up to NGOs and local healthcare staff who do not have the expertise to do so. Training people to safely operate Ebola case management facilities and carry out other necessary activities takes weeks of theoretical and hands-on training. Though a number of organisations including MSF have been offering training, this bottleneck has created major delays.
- ***In all three of the worst-affected countries, there are still not adequate facilities in which to diagnose and care for patients, and there are major gaps in all other elements of the response¹.*** In Liberia, most of the operational beds are concentrated in the capital Monrovia, while remote rural areas are benefitting from little international support. In Sierra Leone, there are still not enough additional case management facilities for the increasing number of infections across the country: most patients currently in MSF's case management centres

¹ MSF's strategy to control Ebola is organised into six elements: isolation and supportive medical care for cases, including laboratory capacity to confirm infection; safe burial activities in case management facilities and in communities; awareness-raising; alert and surveillance in the community; contact tracing; and access to healthcare for non-Ebola patients, including protection of health facilities and health workers. These activities are interdependent and all must be in place to contain the epidemic.

(CMCs)² in Bo and Kailahun come from other districts. In Guinea, there are only a handful of CMCs open and running, eight months after the epidemic was declared. Across the region, there are major gaps in all other elements of the response. Only a small number of international actors are carrying out these activities and not all of the affected areas are covered.

- ***We must avoid a “double failure” situation whereby the response is slow in the first instance and ill-adapted later on.*** Many international actors seem unable to adapt quickly enough to a rapidly-changing situation. The result of this is that resources are being allocated to activities that are no longer appropriate to the situation. In Monrovia, Liberia, for example, more case management facilities are being built despite adequate isolation capacities and a drop in cases in the capital. All actors involved in the response – MSF included – must take a flexible approach and allocate resources according to the most pressing needs at any given time and place.

Today, Guinea, Sierra Leone, Liberia and now Mali are all in different phases of the outbreak and the hotspots are constantly moving. Across West Africa, MSF is providing assistance in all six of the essential elements of an Ebola response: isolation and supportive medical care for cases; safe burials; awareness-raising; alert and surveillance in the community; contact tracing; and the provision of general healthcare. More flexible support is urgently required in all of these areas until the outbreak is over – in other words, until the very last contact has been followed up and is found to be Ebola-free.

LIBERIA

Progress being made, adapted response still required

In terms of the number of cases, Liberia has been the worst hit by this outbreak, and Monrovia and the capital region the most gravely affected area of the country. Case numbers have begun to drop in Monrovia, and the four case management centres (CMCs) in the capital currently have spare bed capacity. However, elsewhere in the country, such as in Bong, Margibi, Gbarpolu, Grand Cape Mount and River Cess counties, new cases are appearing. The outbreak is far from over, as a single case can start a localised epidemic.

Case management facilities with large bed capacities are now being built by foreign governments and NGOs. Beds for Ebola patients are currently concentrated in the capital, and 16 more CMCs are to be built across the country. However, the staffing of these planned case management facilities will fall largely to “implementing partners”, such as local healthcare workers and NGOs. A number of actors are providing training to these implementing partners; but it will take some weeks before these individuals are trained up and ready to safely care for patients.

Striving to deliver on what was promised two months ago, many international actors seem unable to adapt to the rapidly-changing situation in Liberia. The result of this is that resources are being allocated to activities that are no longer appropriate to the situation. For example, the Chinese government has just built another 100-bed CMC in Monrovia – where there were already 580 operational beds in four existing CMCs – while there are only 178 operational beds in CMCs in the rest of the country. Two more CMCs are planned to open in the same neighbourhood.

² A case management centre (CMC) is a centralised facility where people can be screened and receive supportive medical care for Ebola in large numbers (50+ beds); by centralising patients a high standard of infection control can be assured. Sometimes referred to as ‘Ebola treatment centres’. Not to be confused with transit centres, which are facilities where suspected cases can be safely isolated and receive care until transfer to a CMC; or community care centres (CCCs), which are small (eight to ten bed) facilities where suspected patients from a smaller catchment area are isolated within their communities and are administered basic care, medications, safe water and sanitation, and food supplies.

Though seemingly sufficient in Monrovia for the moment, isolation and supportive medical care for patients are still urgently needed in rural parts of the country. In some cases, such as in River Cess county, patients must travel for up to 12 hours by road in order to reach a functioning laboratory and a CMC. Getting care to patients in rural, hard-to-reach areas poses major challenges in terms of logistics and transport.

In many places, personnel at regular healthcare facilities have not received training on infection control and how to manage Ebola patients, should one walk through the door; nor have they received medical equipment required to protect themselves. Healthcare facilities are fast becoming sites of Ebola transmission and many have closed as a result: in Monrovia, for example, most healthcare facilities have shut their doors. To allow them to safely reopen, triage points must be set up in these structures, and activities to restore trust in healthcare facilities must be carried out.

There are still active chains of transmission in almost every part of the country, demonstrating the need for further awareness-raising and community engagement. MSF teams are still finding that misconceptions about Ebola are widespread and stigma is intense, leading some to avoid seeking treatment or report cases. On a recent exploratory mission to Bong county, for example, MSF found that people who had been in contact with the sick were fleeing into the bush so as not to be traced as a contact or taken to a case management facility, fearful of what may happen.

Other activities that require urgent support – especially in remote, rural parts of the country – are laboratory services (with transport if necessary for quick turnaround), safe burials, alert and surveillance systems, ambulance services and contact tracing. Though Ministry of Health (MOH) teams have been dispatched to all counties to carry out these activities, they sometimes lack the basic equipment necessary to do it and are not paid for their work. On an exploratory mission to Margibi county two weeks ago, MSF found that contact tracing and active case finding teams lacked essentials like vehicles and SIM cards for their mobile phones. Support from foreign actors is starting to appear in some affected rural counties; but there are others where this is not the case.

MSF has seen that a comprehensive response to Ebola that includes all of the necessary elements can help to reduce transmission. In Foya, Lofa county, where the full complement of Ebola response activities has been carried out and the local community has been very engaged, there has not been a single confirmed case for more than four weeks. In this fluid and rapidly-changing outbreak, all actors involved in the response to it must take a flexible approach and allocate resources to activities when and where they are most needed.

SIERRA LEONE

Isolation capacity still inadequate, local healthcare workers struggling to cope

The fight against Ebola in Sierra Leone is being outpaced by the increasing number of infections. Despite efforts by the national authorities and support from international actors, the situation is far from under control. Every district in Sierra Leone is affected by the epidemic, and the number of infections has increased alarmingly. The Western area (Freetown and suburbs) and Port Loko, Bombali and Tonkolili remain zones with high case loads and ongoing transmission.

Foreign governments – mainly the UK and China – have sent teams to construct new centres in different locations around the country, including Port Loko, Freetown and Makeni. In September, the UK announced that it would construct and provide material resources for 700 additional beds (it would be up to implementing partners to staff them). As of 27 November, only 11 of these beds were operational, and only 28 patients had been treated. While the remaining centres are under construction and scheduled to open soon, they will not be running at full capacity until well into the New Year. Training is now being carried out by a number of actors, which is a welcome development.

Despite large pledges of assistance from the international community, the bulk of the hands-on work with patients and communities is still being carried out by local people, the Sierra Leonean authorities and NGOs. At the moment, in the Western area – one of the most affected – the vast majority of the available beds for Ebola patients are operated by the Ministry of Health (MOH), with some support from international agencies and governments like the UK, China and Cuba. About 50 per cent of the available beds in all of Sierra Leone are operated by the MOH and the Sierra Leonean armed forces, and another 40 per cent are run by MSF.

Isolation and supportive medical care for patients remains a critical issue: there are still not enough operational beds for the increasing number of infections across the country. In MSF's case management centres (CMCs) in both Bo and Kailahun, the majority of patients are now coming from other districts as there are insufficient case management capacities further afield. There is an acute lack of bed capacity in Freetown and the Western region: this weekend, the MSF CMC in Kailahun admitted 10 patients who had come from Freetown as there were no free beds closer to the capital. Freetown is nine hours away by road.

In the absence of adequate facilities to isolate, diagnose and manage Ebola cases, Sierra Leonean healthcare workers are struggling with the needs and are forced to face the epidemic with whatever support they can get. MSF is deeply concerned about contamination of uninfected patients and healthcare workers in existing healthcare facilities, where staff are not necessarily trained to manage Ebola patients and where infection control measures cannot be assured.

GUINEA

Long overlooked by international efforts, response in Guinea painfully slow

Guinea was the first country affected by Ebola in West Africa, but initially the country benefited from little international support. As the epidemic expanded to neighbouring countries, the largest international commitments to help respond went largely to Liberia and Sierra Leone; since September, however, local and international commitments have been trickling in.

The situation in Guinea is alarming. Since August, case numbers in Guinea have been on the rise, and in November the caseload was about 25 per cent higher than it was in October. The outbreak has also been spreading geographically: new areas are reporting infections and 17 of Guinea's 33 prefectures have reported cases in the past three weeks.

The national task force for the coordination of the Ebola response is improving; but at the same time, at the prefecture level there are still gaps that must be filled with urgency. Deployment and reinforcement of the different activities required to control the outbreak – and support from international partners to the Ministry of Health (MOH) to implement them – is urgently required in most of the areas affected.

At present, there are only four case management facilities receiving Ebola patients. In mid-November, the French Red Cross (FRC) took over the MSF-built case management centre (CMC) in Macenta, and the French government now fully finances the structure and the attached laboratory – a positive development. But the FRC and MSF are two of only a handful of international organisations running case management facilities in the country. Two other CMCs are being built by the World Food Programme (WFP); but for the moment, only one international organisation has been identified to run one of the supplementary facilities.

Like in Sierra Leone and Liberia, the absence of implementing partners willing and able to manage CMCs and a lack of trained staff have been a bottleneck and the source of large delays. MSF has taken a key role in training staff from other organisations: so far around 120 national and international non-MSF staff have been trained in MSF's two CMCs. However, training these individuals to safely staff the new CMCs takes time, on the order of weeks; meanwhile case numbers continue to mount.

There is insufficient capacity for isolating and providing supportive medical care to patients in Guinea. As of the middle of November, MSF's Guéckédou CMC was full to capacity, with the majority of patients coming from far away areas.

Other activities such as alert, surveillance and patient referral to case management facilities are slowly starting to receive the support required in terms of expertise, human resources, training, supervision and logistics; however, they are still fragile and insufficient. Ambulance services require urgent improvement, for instance: in Macenta and other areas, confirmed and suspected patients are transported in the same vehicle for long periods, potentially causing individuals who are not already sick to become infected.

Awareness-raising, a key activity to help communities to adapt behaviour and reduce transmission, remains very weak for an intervention that began eight months ago. These activities are unevenly supported throughout the country and there is still a great deal of resistance towards the Ebola response. Around Conakry, for example, there are still areas where MSF teams are not welcome. Again, training for both local and international staff in safely leading these activities remains a major constraint.

NOTES TO EDITORS

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In Liberia, MSF is running a 240-bed Ebola case management centre (CMC) known as ELWA 3 in Monrovia and is scaling down its CMC in Foya, in the east, as there have been no new cases since 30 October. In Monrovia, MSF has restarted a campaign for community health promoters to go door to door, raising awareness about how to avoid infection. Beyond case management, the organisation has distributed approximately 63,000 home protection and disinfection kits; are running a 10-bed transit centre on the site of Redemption hospital to do triage and refer Ebola patients onwards to a CMC; and have distributed anti-malarial medications to 551,971 people in densely populated areas of Monrovia. This is to stem contamination of patients with fever (but not Ebola) in CMCs as well as to reduce the incidence of fever related to malaria and mortality in children under five.

In Sierra Leone, MSF is operating approximately 160 beds for patients ill with Ebola: a 104-bed Ebola CMC in Kailahun in the east of the country, and a 60-bed CMC in Bo. Because of the acute lack of bed capacity in the country, MSF will soon be opening two more: one in Magburaka and another in Freetown. At both existing sites, MSF is offering case management training for the Ministry of Health (MOH) and other health actors looking to open case management facilities. It is also providing social mobilisation and sensitisation training in communities and has trained over 750 health workers to spread health promotion messages since July. Distributions of anti-malaria medication to 1.4 million people and home protection and disinfection kits will begin in the coming days.

MSF is running two CMCs in Guinea: an 85-bed facility in the capital, Conakry, at Donka hospital and a 99-bed facility in Guéckédou in the Forest region of Guinea. At both of these sites, the organisation is training MOH medical staff so they can be deployed to transit facilities in other parts of the country. MSF has also constructed a new transit centre in Forécariah for the MOH and a new CMC in Macenta for the French Red Cross (FRC), which was officially handed over on 14 November. MSF staff will continue to work with FRC colleagues until December to facilitate transfer of competencies and investigation and health promotion activities in the area.

The organisation started an intervention in Mali on 24 October, just after the first case of Ebola was confirmed in Kayes, in the north of the country. Later, when a new case was detected in Bamako on 11 November, MSF reinforced its team there and expanded activities to help stop the disease from spreading further. MSF is now running a case management facility in collaboration with CNAM (Mali's national disease centre). The organisation is also training Malian staff from CNAM and the MOH in the management of Ebola patients, while overseeing the organisation of an ambulance system and safe burials.

MSF provided technical support to the Nigerian and Senegalese health authorities in areas including isolation, contact tracing, training and public education. Both countries have since been declared free of Ebola.

As an exceptional measure, the organisation will work with three research institutes to host trials of three experimental treatments for Ebola in three of its CMCs in West Africa. These trials are planned to begin as early as December.