European Commission

EBOLA IN WEST AFRICA

Fernando Fernández
DG ECHO Ebola Response - Freetown

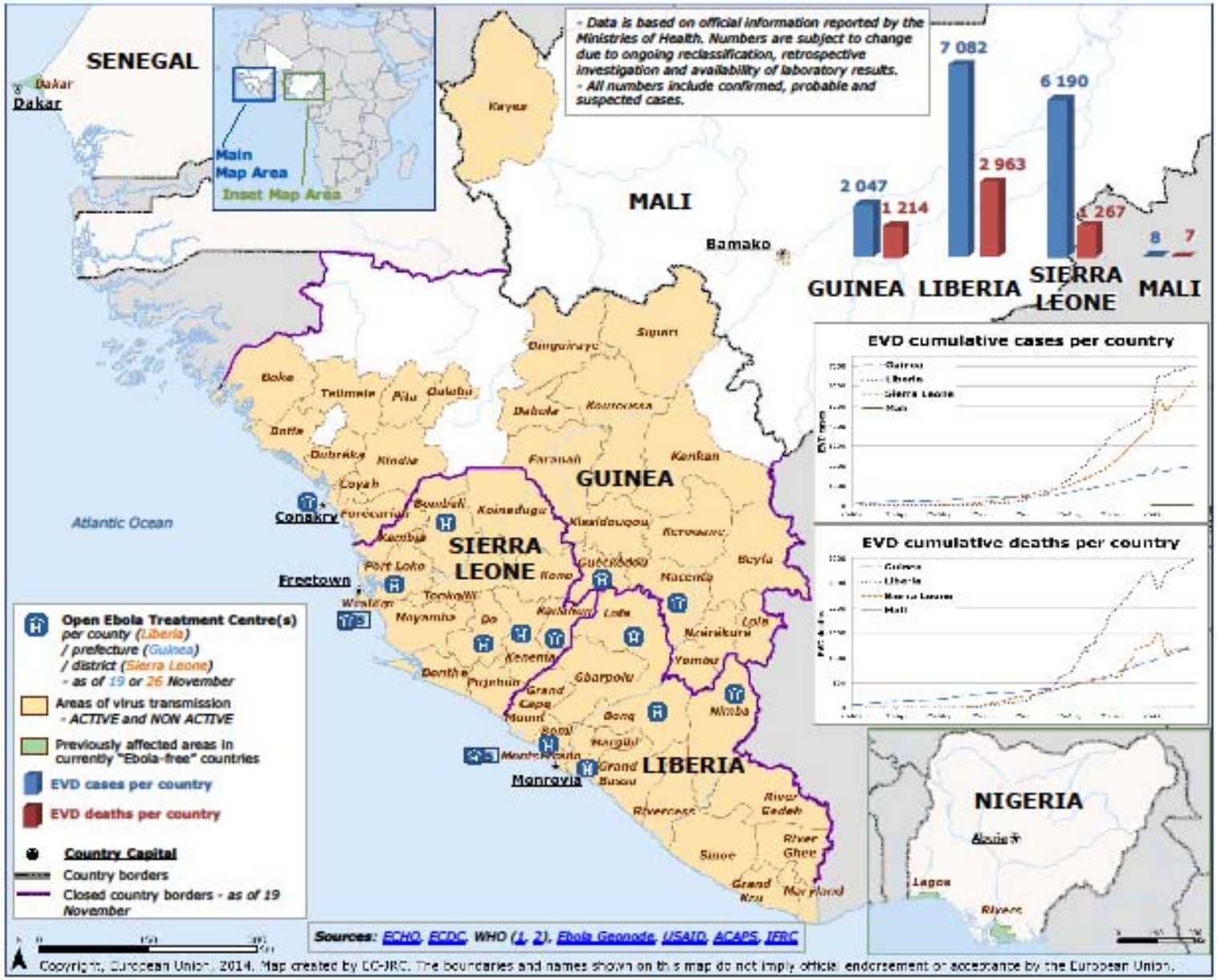
Humanitarian Aid Civil Protection

History of the outbreak

- December 2013. Index case in Guinea.
- “Cholera” outbreak declared in “zone forestière” in Guinea.
- March 22nd: First ebola case confirmed in Guinea.
- April. First ebola case confirmed in Liberia.
- May 26th, first ebola case confirmed in Sierra Leone.
- Outbreak in Nigeria and exported case in Senegal.
- October. First infections in Spain and US.
- November. Mali. First imported case. Second outbreak in Bamako

26 November 2014: West Africa - Ebola Virus Disease (EVD) Outbreak

European Commission



SITUATION

- The transmission of the EVD continues in the four West African countries, with over 1 000 cases reported between 11 and 16 November. All administrative divisions in Liberia and Sierra Leone have reported at least one case since the beginning of the epidemic. However, case reporting remains problematic and attacks on health workers and Ebola awareness teams are not uncommon.
- The health systems of Guinea, Sierra Leone and Liberia have collapsed due to the uncontained EVD outbreak, rendering it impossible to treat other patients effectively. Furthermore, the food security situation is worsening and displacement of people for fear of contracting the disease occurs despite the imposed quarantines.
- The European Union is using all available resources to help fight the epidemic, including deploying humanitarian experts in the region and mobilising medical evacuation capacities for humanitarian workers.

EVD OUTBREAK STATISTICS

Numbers correct as of 17 November (Liberia), 18 November (Guinea, Sierra Leone), 25 November (Mali)

Country	EVD cases	EVD deaths
LIBERIA	7 082	2 963
SIERRA LEONE	6 190	1 267
GUINEA	2 047	1 214
MALI	8	7
NIGERIA	20	8
SENEGAL	1	0
USA	4	1
SPAIN	1	0
TOTAL	15 353	5 460

Strategy against EVD

- *Early detection and isolation of cases.*
- *Contact tracing and follow-up.*
- *Safe management of dead bodies*
- *Community engagement and behavioural change.*

Initial response

- *MSF led, establishing Ebola Treatment Units.*
- *WHO and GOARN.*
- *Red Cross and others in supporting role.*

The first response failed…

Despite initial signs, epidemic continued upward trends.
Second wave in Liberia end of May.

Contributing factors:

- Deficient health systems
- Traditions in handling of dead bodies

Possible differences with previous outbreaks:

- Delay in early response
- Lack of recognition and technical knowledge
- Population density
- Population movement
- Urban áreas affected early
- Health seeking behaviour in big cities

… A new strategy launched

Declaration of Public Health Emergency of International Concern in August 8th.

Call for more actors to response directly (other NGOs, direct involvement of foreign governments (i.e. Special session during 69th UN GA in September 18th).

- USA co-led in Liberia, UK co-led in Sierra Leone.
- United Nations Mission for Ebola Emergency Response (UNMEER)
- Planning based on worst case scenario of 10,000 cases per week.
- Need for many isolation beds; building up of ETUs, setting up Community Care Centers (CCC).

Situation as of today

- Pattern change in Liberia. Less cases in Bomi and Montserrado.
- Cases still increasing in Sierra Leone mainly due to Freetown area. No cases in Kailahun and 1 in last 24 days in Kenema.
- “Guerrilla tactics” in Guinea
- Second outbreak in Mali

Need for a more flexible and quick response

Response would need to be

More decentralised and context-adapted

Importance of protection of health staff

Preparedness in surrounding countries

Challenges encountered (I)

- *Medical care*
  - **Ebola patients by others than MSF**
  - **Non-ebola cases (triage, lab confirmation, IPC)**
- *Training of staff:*
  - **Health staff, hygienists, burial teams**
  - **Cold, Hot and Red zone training**
- *Contact tracing in huge numbers*
  - **Closer supervision needed**
- *Quick expansion of epidemiological surveillance*
- *Alert and referral systems*
  - **Decentralization and Coordination centers at district levels**
  - **Long and difficult roads**
  - **Response teams fleet managements**

Challenges encountered (II)

- *Community education and mobilization. Behavioural change.*
- *Changing pattern of the disease. Epidemic modelling.*
- *Lack of cross-border coordination.*
- *Few actors with some experience. Difficulties attracting new partners.*
- *High turnover of staff and difficulties by partners to attract enough numbers.*
- *Bottlenecks: FMTs and labs. Require external support.*
- *Political environment in each country (sovereignity, other interest influencing decissions)*

Research & innovation

- *Vaccines (2 in advanced Phase I clinical trials)*
  - **ethical and fast-track considerations for vaccine development.**
- *Treatment*
- *Rapid diagnostic tests (RT-PCR vs antibodies)*
- *Drones (transport of lab specimens)*
- *Quick set up of small treatment facilities.*
- *e-health (pilots in Guinee to use smartphone technology for contact tracing)*

SANCO

- *Support to EU medical evacuation system, such as hospital identification*
- *Information exchange medical expertise between Sanco/ECDC and ECHO.*

LRRD / Post-humanitarian crises

Timely engagement of development actors to re-activate and strengthen the health care systems.