Preventive Medicine Reports 20 (2020) 101206

Contents lists available at ScienceDirect

Preventive Medicine Reports

journal homepage: www.elsevier.com/locate/pmedr

Correspondence

Tackling the COVID-19 pandemic in West Africa: Have we learned from Ebola in Guinea?

The COVID-19 pandemic is rapidly spreading in Guinea. Of the three West African countries that experienced the Ebola epidemic in 2014–2016, Guinea is currently the most affected country, with 4841 confirmed cases, compared to 542 in Liberia and 1273 in Sierra Leone as of 19 June 2020 (Fig. 1) (World Health Organization. Coronavirus disease, 2019).

Although these countries were expected to have developed a solid and reactive disease surveillance system after Ebola (Monde, 2020), we are very concerned about the rapid increase in the incidence and spread of COVID-19 in Guinea. The situation points out several failures and deficiencies in the national control response to the pandemic that merit further attention.

First, the claim that Guinea is capitalizing on its Ebola experience might overstates country's self-confidence and be misleading because the response to COVID-19 requests different control mechanisms and the disease risk perception among the population might be different (Brewer et al., 2004). COVID-19 is more contagious than Ebola, can be transmitted by healthy carriers, and has a rather low mortality and severity compared to Ebola. For instance, patients with COVID-19 do not experience hemorrhage that are common in Ebola patients. Certainly, Ebola enabled Guinea, Sierra Leone and Liberia to strengthen their health systems (Delamou et al., 2017); however, the management strategies of the COVID-19 pandemic are not similar to that of Ebola due to the differences in the biological parameters of the two viruses with the very different transmission dynamics and different impact profiles. This includes the level and duration of containment and mitigation measures along with comparative health resources involved.

Second, the COVID-19 pandemic in Guinea is unfolding in a tense social and economic context which has resulted in the distrust of part of the population in the public authorities. Consequently, the rules of public hygiene and containment are disregarded. In contrast, in Liberia and Sierra Leone, better adherence of communities to public control measures seems to be slowing the spread of the disease. During Ebola, the reasons for mistrust and resistance were the non-involvement of community leaders/actors and the management of the response funds (Ebola business) (Thiam et al., 2015). However, for COVID-19, the major challenge in Guinea lies in the governance of the response mechanism, particularly the ambiguity in the roles of key stakeholders which seems not the case in Liberia and Sierra Leone. In Guinea, a presidential decree has designated the National Health Security Agency (ANSS) as the body coordinating the response (prevention and community mobilization, laboratory diagnosis, clinical care and disease surveillance) and managing all the funds (local and donors' funding) creating a feeling that the Ministry of Health (MoH) has become helpless bystander. In Liberia, the MoH and the National Public Health Institute (NPHIL) are coordinating the response with some collaboration challenges but the country is still achieving less cases than Guinea and even Sierra Leone where the national response is led by the Military and the MoH. Another reason might be the delay in the implementation of public health response measures in Guinea with the state of health emergency declared in country about three weeks after the first case of COVID-19 was confirmed. At that time, the community transmission had already started. There is a need to better explore the response strategies implemented in these countries in light of the Ebola legacy to improve the understanding of the situation.

Third, the contributions of development partners to the COVID-19 has been limited compared to that during Ebola. Development partners and their funding, including the required equipment and inputs, were mostly been directed towards donor countries where the pandemic was already wreaking havoc. Accordingly, West African authorities need to perceive this limitation and rapidly mobilize internal resources to contain the rapid increase and spread of the pandemic.

Fourth, the illusion of learning from Ebola might be resulting in neglect of the response. One might wonder whether countries such as Guinea have really learned from Ebola as compared to Liberia and Sierra Leone. This raises questions as to whether there were differences in the external support or health system strengthening between the three countries considering the different trajectory in COVID-19 cases. In Guinea, the major components of the Ebola response were managed thanks to the solidarity of development partners such as MSF/ALIMA (treatment), WHO/CDC (disease surveillance), and UNICEF (prevention). The question is whether national institutions took their prerogatives during that unprecedented public health emergency. It seems that Guinea did not achieve enough in retaining expertise post-Ebola, ensuring emergency preparedness and securing needed local resources for future outbreaks as might have done the two counterparts. This would have put the country in a better position to now tackle COVID-19. However, despite what has been said, one could argue that the number of confirmed cases and deaths is lower in Guinea and much more in Liberia and Sierra Leone than many European countries and the US which might suggests successful lessons were learned from the Ebola outbreak in relation to the speed of the border closures, quarantine measures and contact tracing.

Reversing the current COVID-19 trend in these countries, Guinea in particular, will require rethinking the governance of the response. Priority should be given to mobilizing internal resources and creating better synergy between national institutions to pool existing strengths and gain support from communities. To this end, national institutions responsible for each pillar of the response (Prevention, Community mobilization, Laboratory, Clinical care and Epidemiological surveillance) should be identified and provided the needed resources (eg. local budget lines) under the coordination of the MoH or the designated institution. This could lay the path for long-term capacity building of local actors with support from developing partners.

https://doi.org/10.1016/j.pmedr.2020.101206
Received 14 May 2020; Received in revised form 22 June 2020; Accepted 8 August 2020
Available online 16 September 2020

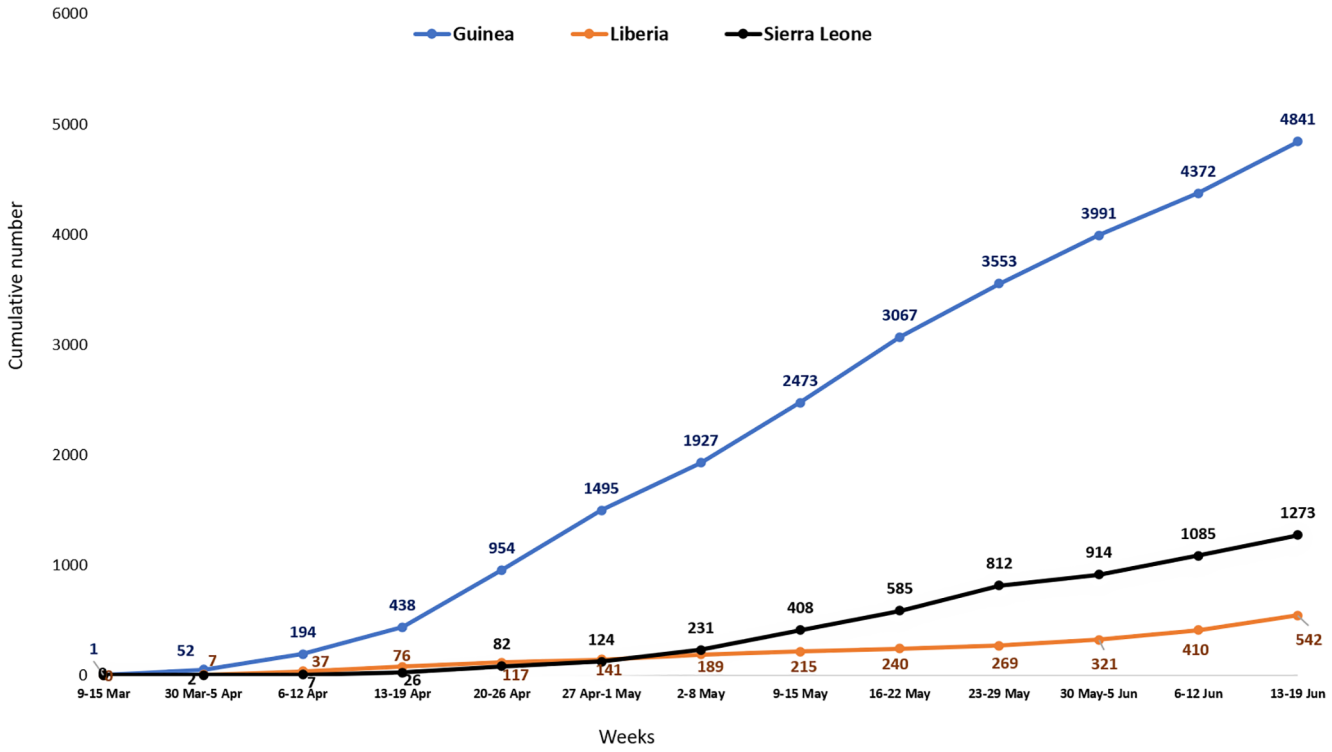

Fig. 1. COVID-19 epidemic curves in Guinea, Liberia, and Sierra Leone as of 19 June 2020.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

World Health Organization. Coronavirus disease 2019 (COVID-19); Situation Report – 151 (19 June 2020). 2020 [cited 20 June 2020]; Available from: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200619-covid-19-sitrep-151.pdf?sfvrsn=8b23b56e_2.

Le Monde. Coronavirus: la Guinée capitalise sur son expérience de l'épidémie d'Ebola (17 mars 2020). 2020 [cited 25 April 2020]; Available from: https://www.lemonde.fr/afrique/article/2020/03/17/coronavirus-la-guinee-capitalise-sur-son-experience-de-l-epidemie-d-ebola_6033432_3212.html.

Delamou, A., Delvaux, T., El Ayadi, A.M., Beavogui, A.H., Okumura, J., Van Damme, W., et al., 2017. Public health impact of the 2014–2015 Ebola outbreak in West Africa: seizing opportunities for the future. BMJ Glob Health 2 (2), e000202.

Brewer, N.T., Weinstein, N.D., Cuite, C.L., Herrington Jr., J.E., 2004. Risk perceptions and their relation to risk behavior. Ann. Behav. Med. 27 (2), 125–130.

Thiam, S., Delamou, A., Camara, S., Carter, J., Lama, E.K., Ndiaye, B., et al., 2015. Challenges in controlling the Ebola outbreak in two prefectures in Guinea: why did communities continue to resist? Pan. Afr. Med. J. 22 (Suppl 1), 22.

Alexandre Delamou[a,b,*], Sidikiba Sidibé[a], Alioune Camara[a,c], Mohamed Sahar Traoré[a], Abdoulaye Touré[a,d], Wim Van Damme[e]

[a] *Africa Centre of Excellence for Prevention and Control of Transmissible Diseases (CEA-PCMT), University Gamal Abdel Nasser, Conakry, Guinea*

[b] *Maferinyah National Centre for Training and Research in Rural Health (CNFRSR), Forécariah, Guinea*

[c] *National Malaria Control Program, Ministry of Health, Conakry, Guinea*

[d] *National Institute of Public Health, Ministry of Health, Conakry, Guinea*

[e] *Institute of Tropical Medicine, Anvers, Belgium*

E-mail address: adelamou@cea-pcmt.org (A. Delamou).

[*] Corresponding author at: Africa Centre of Excellence for Prevention and Control of Transmissible Diseases (CEA-PCMT), University Gamal Abdel Nasser, PoBox 1017, BP: 4099, Conakry, Guinea