

HUMAN SECURITY IN PRACTICE: SECURING PEOPLE FROM THE THREAT OF EPIDEMIC — WHAT CAN WE LEARN FROM THE ECOWAS RESPONSE TO EBOLA?

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1. Introduction

A recent case count of the Ebola outbreak in West Africa published by the Centres for Disease Control and Prevention (CDC) put the total number of deaths at 9 194 (CDC, 12 February 2015). Still counting, these figures will not be the last as the people of Liberia, Guinea and Sierra Leone continue to battle the Ebola virus day by day. Until a community or a country spends 42 days (double the 21-day incubation period of the Ebola virus) without a new case and the last patient in isolation becomes laboratory negative, that country or community will not be declared Ebola-free (CDC 2015). Attaining this status has been the goal of many communities affected by Ebola in West Africa today. There are many stakeholders who share this goal and are working to help the communities. The focus of this commentary is, however, on the role played by the Economic Community of West African States (ECOWAS) in tackling Ebola. The Ebola epidemic is, in the first instance, a regional concern for ECOWAS, affecting three of its member states and threatening the others. Although ECOWAS has played an important role in the fight against Ebola, the narratives of other more resourced stakeholders, such as the World Health Organisation (WHO) and the United Nations (UN) agencies, have largely overshadowed this effort. This commentary therefore, examines the ECOWAS response by answering the following questions: how did ECOWAS respond to

the Ebola virus? What lessons can be learned from the response? Using a timeline analysis, it argues that ECOWAS played a leading role in tackling the disease. However, the response of ECOWAS was hampered by its initial approach of over-reliance on the member states and their institutions, most of which lack adequate capacity, to control and contain the virus, and then by the slow process of adapting the response to regional interventionism.

2. Ebola: A threat to human security?

More than violence, deadly, communicable diseases such as HIV/AIDS and Ebola threaten humanity in an unprecedented way. On Ebola, the head of WHO, Margaret Chan, said:

I have never seen a health event threaten the very survival of societies and governments in already very poor countries, I have never seen an infectious disease contribute so strongly to potential state failure (The BBC, 13 October 2014).

This statement underscores the human security implication of deadly diseases, and rightly supports an expanded conceptualisation of security. Ebola not only threatens the lives of the people, but also the survival of the state. Without a healthy, productive population, state survival is imperilled.

The Ebola virus disease (EVD), also known as Ebola haemorrhagic fever, is a severe, often fatal illness in humans (WHO 2014). The origin of Ebola virus has been traced to wild animals, which transmits the virus to people, and then unleashes a chain of human-to-human transmission. The fatality rate is as high as 90 per cent in the recent outbreaks (WHO 2014). It has been proven that with early supportive care with rehydration and symptomatic treatment, a victim's chance of survival improves, even though no licensed treatment has been established yet (WHO 2014). EVD is not a new phenomenon. Its history dates back to 1976, when it first appeared simultaneously in Sudan and the Democratic Republic of Congo (DRC) (WHO 2014). The name Ebola came from a river in DRC where the case was recorded. Early detection, control and management are key in fighting the disease. Therefore, community engagement is key to successfully controlling Ebola (WHO 2014). When Ebola broke out in West Africa in December 2013, most of the affected communities did not know what it

was, and thus, resorted to superstition. Some people attributed it to a mysterious snake, while others believed it was witchcraft (Estrada 2014). Many of these people then turned to traditional healers for help (Mueller 2014). However, since the information on the virus became available in March 2014, global efforts have been on to tackle it.

Ebola poses a threat to human security. It is categorised as a complex health emergency that negatively impacts the socio-cultural and economic lives of the people (UN 2014). Ebola's impact in West Africa has been devastating. It has destroyed families, communities and livelihoods. Survivors not only return to their homes bereaved, but also they return to nothing as their belongings are destroyed in the process of controlling the disease. More so, fear and stigma loom in the communities, and survivors are often not welcome in their communities (Diallo 2014). The impact on the affected states is huge. The International Monetary Fund (IMF) and World Bank estimate that the short-term fiscal impacts of the disease for the three countries are US\$113 million (5.1 per cent of GDP) for Liberia, US\$95 million (2.1 per cent of GDP) for Sierra Leone, and US\$120 million (1.8 per cent) for Guinea, (UN 2014). This economic impact further weakens the states' capacity to combat the disease. ECOWAS, along with other stakeholders, have had to come in to assist these countries.

3. ECOWAS: sub-regional response to the EVD

ECOWAS has the mandate to intervene in the Ebola crisis. Article 61, sub-section 2(d) of the 1993 *ECOWAS Revised Treaty* contains an undertaking on the part of the member states to encourage and strengthen cooperation amongst themselves in health matters (ECOWAS 1993). Before then, in 1987, the ECOWAS member states established the West African Health Organisation (WAHO), as a means for the effective mobilisation of all human, material and financial resources available within the sub-region for solving health problems (ECOWAS 1987: 1). They realised that diseases know no boundaries, and unequal development in different countries in the promotion of health and control of disease pose a common problem (ECOWAS 1987). Hence, when the Ebola outbreak became public in March 2014, ECOWAS was in hand to begin a series of actions against the disease.

3.1 Early response stage

ECOWAS's initial response on 25 March 2014 was to declare Ebola "a serious threat to regional security". The securitisation of the disease set the stage for ECOWAS to mobilise stakeholders and resources against the epidemic. It appealed to the international community for assistance (allAfrica, 28 March 2014). During these early days, ECOWAS response strategy was on strengthening the national health institutions. The health agency of the organisation, the WAHO, led the action on the response by requesting a sum of US\$250 thousand from the ECOWAS Commission to strengthen epidemiological surveillance and response along the borders of the affected states, namely Liberia, Sierra Leone and Guinea. It also dispatched letters containing recommendations on actions to mitigate the impact of the epidemic to all ECOWAS Ministers of Health (Egbeleye 2015). These include:

- a) strengthening epidemiological surveillance and notifying WAHO of cases in order to facilitate regional coordination,
- b) identification of diagnostic laboratories in West African region and elsewhere including taking measures to prepare for an eventual dispatch of biological specimens to the identified laboratories
- c) training and sensitisation of health workers
- d) provision of information to the population including sensitisation via educational messages targeting reduction of risk (WAHO 2014).

In addition, WAHO immediately organised a two-day technical workshop on Regional Disease Surveillance Capacity Strengthening Project (WARDS), with an eye on enhancing the regional epidemiological surveillance and response capacity in the face of the Ebola threats (WAHO 2014). The Director General of WAHO, Dr Xavier Crespin, continued the mobilisation effort by visiting the Ambassadors of China and France in Liberia. While soliciting for their support, Dr Xavier stressed the importance of epidemiological vigilance and strengthening of health systems as key to early detection and containment of the disease (WAHO 2014). The Chinese Ambassador expressed his willingness to support another health facility project along the Liberia-Cote d'Ivoire border, in addition to the funding provided for a similar facility along the Liberia-Guinea border (WAHO 2014). On his part, the French Ambassador said that France had donated US\$5 million to Liberia and was providing further bilateral support to both Liberia and Guinea in the form of

making available public health experts to train health workers in the two countries, leveraging additional funds via the European Community Humanitarian Office (WAHO 2014). This diplomatic effort of the WAHO was aimed at drawing support of development partners of the sub-region in tackling the menace.

In April 2014, at the Meeting of ECOWAS Assembly of Health Ministers in Monrovia, discussions on the Ebola outbreak dominated the theme of the meeting, thereby raising additional awareness and concern at the policy level of the member states. The ministers adopted the *Monrovia Declaration on the Management of Epidemics* in the ECOWAS region (ECOWAS, 2014). The meeting therefore enabled a regional mobilisation of member states' governments for vigilance and action against the EVD. It also sought the support of development partners in containing the disease. This effort started yielding fruit when the African Development Bank (AfDB) supported a tripartite agreement involving it, the WHO and WAHO with a sum of US\$2 million (WHO 2014). The money, which was given to WAHO, was used to support Guinea, Sierra Leone, Liberia, Gambia, Guinea Bissau, Cote d'Ivoire, Mali and Senegal (WAHO 2014). It is noteworthy that consideration was given to countries that were not affected by the virus to help them strengthen their epidemiological capacity.

3.2 Emergency response stage

Despite these efforts, the virus spread to Sierra Leone in May (Associated Press, 16 September 2014), thereafter spiralling out of control. On 17 and 18 May, WAHO met with the WHO Inter-Country Team in Burkina Faso to discuss a joint interventions programme. It also disbursed the US\$250 thousand approved by the ECOWAS Commission to Liberia (US\$66 120), Sierra Leone (US\$78 403), and Guinea (US\$105 444). Despite these efforts, by 12 June, the government of Sierra Leone had announced a state of emergency in the Kailahun district, banning public gatherings and closing schools; in Liberia, Ebola had reached the capital, with a health official saying seven people had died there (Associated Press, 16 September 2014). A senior official for Doctors Without Borders said the disease was "totally out of control" and that the medical group was stretched to the limit in responding to it (Associated Press, 16 September 2014). Furthermore, doctors and health workers were also infected and dying.

From 2-3 July 2014, the WHO convened an emergency ministerial meeting on Ebola in Accra, Ghana. The meeting adopted a series of national measures to be taken by the affected states, while urging the ECOWAS leadership to mobilise resources to assist the affected communities and countries (Kosolo Francis 2014). Consequently, on 10 July 2014, the ECOWAS summit adopted a regional approach towards containing and managing the Ebola outbreak (ECOWAS Press Release 2014). The Summit also decided to establish a solidarity fund, where Nigeria immediately contributed US\$3.5 million (ECOWAS Press Release 2014). Meanwhile on 23 July 2014, the virus reached Nigeria when a Liberian man flew into the country and eventually infected health staff of a clinic where he was being treated (AP, 16 September 2014). On 8 August, the WHO, belatedly, declared the Ebola outbreak an international public health emergency. The head of the organisation, Margaret Chan, said that the countries affected did not have the capacity to manage the outbreak and thus urged the international community to provide urgent support (The Guardian, 8 August 2014). Around the world panic measures were being taken. Airlines cancelled their flight schedules to West Africa and some ECOWAS member states closed their borders (Mark Anderson 22 August 2014). Meanwhile, the death figures were increasing, reaching 700, as the disease was moving faster than efforts to control it (AP, 16 September 2014). The effort of the governments and the international community was suddenly overwhelmed by the chaos that set in.

ECOWAS continued with its efforts at combatting the epidemic. On 11 August 2014, the WAHO organised a three-day workshop on synchronising cross-border interventions to contain Ebola. The workshop brought together 30 participants from the three affected countries,¹⁾ including health officials, civilian administrators, community leaders in border districts, and national disease control officials, as well as implementation partners such as *Fondation Merieux* and the International Federation of the Red Cross (IFRC) (WAHO 2014).

Furthermore, a major adaptation of the ECOWAS response came at a meeting of its Health Ministers on 28 August 2014. The ministers adopted a wide-range of measures to assist the affected countries, which included the provision of health personnel. The decision to send health personnel, rather than providing money and materials, was to help the long overwhelmed health workers in the affected states. On 26 September 2014, the Ministerial Coordination

Group, established to implement the new regional action, approved the immediate deployment of health delegations to the affected countries. On 3 December 2014, the first batch of 150 trained volunteer health workers, coordinated by WAHO on behalf of the African Union (AU) and ECOWAS, were deployed (WAHO 2014).

Thus far, Ebola infection has been on the decline. It would not have been possible without the external deployment of volunteer health workers by ECOWAS and other stakeholders. To review the progress so far and harmonise the activities of the different stakeholder, the ECOWAS Commission organised a high-level coordination meeting with partners on the EVD on 15 January 2015 (WAHO 2015). Part of the discussions in the meeting was about preparing for post-Ebola reconstruction.

4. ECOWAS response: A brief evaluation and lessons learned

From the timeline analysis above, it can be seen that ECOWAS was proactive in confronting Ebola from the beginning, declaring it a threat to human security. ECOWAS also followed up on this response with actions aimed at tackling the virus: providing information, financial, material resources, and health personnel to assist the member states contain the EVD. However, at both the early and the emergency stages of the response, ECOWAS relied so much on weak and inadequate health institutions in the affected member states. That proved to be insufficient as the virus spread unnoticed without adequate surveillance provisions by the national governments. Moreover, there was failure on the part of ECOWAS leadership to acknowledge that the health personnel in the affected countries were being overstretched, and therefore needed additional hands rather than just money and materials. Consequently, when the leaders acknowledged that and adapted the response by starting to deploy health personnel from the sub-region, over 7 000 people had lost their lives to the EVD. It was a little late. Moreover, the deployment was slow. It took three months for the first batch of 150 personnel to be deployed.

The slow response is, in part, due to the absence of an ECOWAS health emergency response mechanism. This is the first time the organisation was confronted by such a health emergency.

Although ECOWAS has an early warning system to detect and track security challenges across the sub-region, including health security threats, the early response is still a work in progress. The inter-governmental decision-making process is usually too long for an effective and timely response to emergency. More often than not, a high-level meeting will be convened, either a ministerial meeting or a summit of heads of state and governments, before directives are issued to the regional institutions to proceed with working out modalities for the response. These modalities, which often take time to be prepared, are then submitted for approval to the ministers or heads of state, before resources are mobilised. It takes about three months before any real action is seen. Moreover, the focus of the early warning and response has so far been on military response to conflicts under the African Standby Force.

The lessons learned from the Ebola epidemic are clear. An improvement of the regional response strategy is a *sine qua non*. There is a clear need to accelerate decision-making, and make it more proactive. This will entail the states yielding some powers to the technical institutions, such as the WAHO, and providing them with adequate funding. The lengthy process of organising meetings of the member states, and securing the modalities of regional response to crisis, and then mobilising resources, allows much room and time for crises to escalate. In the end, the cost of slow responses will be higher than early intervention. There is also the need to focus more on non-military threats to human security in the sub-region. Health security is a threat to the regional economy and survival of the states. A robust regional response to human security threats such as Ebola, in the future, would have to rely on an effective standby health emergency response mechanism. Building this mechanism should form part of the ECOWAS post-Ebola reconstruction. For a start, the ECOWAS Solidarity Fund for Ebola should be transformed into an Emergency Solidarity Fund.

Endnotes

1. Participants from Liberia were unable to attend due to last minute flight cancellation. This shows the difficult context of the regional response.

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