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Photo: Einar Nilsen

If we (again) choose to believe that pathogenic viruses and bacteria can be isolated to distant lands and populations, we are burying our heads in the sand

Ebola – when will we learn?

«For those who say it's hopeless, this is an antidote – you can control Ebola,» Thomas Frieden, director of the US Centers for Disease Control and Prevention (CDC), told reporters in late September. Nigeria's minister of health had announced that the Ebola outbreak there appeared to be over. On 20 July, an acutely ill passenger had landed at the international airport in Lagos, a city of more than 20 million people. He had time to expose approximately 70 others at the airport and in the hospital before it became clear that he was infected. The Nigerian health authorities immediately established a central emergency centre. The index patient died on 25 July. Two months later, altogether 19 patients had been infected – eight of whom had died and eleven had been discharged. Close to 900 contacts had been identified and followed up. All of these had been declared risk-free. No new cases had been reported after 31 August (1).

On the day after the good news from Nigeria, the CDC reported the first case of Ebola in the United States (2). A man who had left Liberia with no symptoms had fallen ill four days after arriving in the USA. He went to a hospital and stated that he had just arrived from Liberia, but was sent home with some antibiotics because the health personnel did not link his symptoms to the place where he had recently been. After two days he fell seriously ill with vomiting and diarrhoea and was brought to hospital by ambulance. Contacts were identified, but several errors were committed. A curfew was imposed on the patient's partner and three others who had been in the apartment with him, and an armed guard took up position outside. However, nobody wanted to remove towels, bedclothes and mattresses that the patient had used while he was ill, and nobody wanted to clean the apartment! Only a few days later they were permitted to move to an apartment that had been placed at their disposal by a private individual. At the time of writing, the patient's condition is characterised as critical. So far, nobody else has developed any symptoms, but avoiding other cases of infection will be down to sheer luck.

In other words, this is not only a question of resources, but also about the organisation of resources. We are well aware of how an Ebola outbreak should be handled. In 2000–01 a total of 425 cases and 224 deaths linked to viral haemorrhagic fever were recorded in Uganda in what was then the largest Ebola outbreak in the world (3). Despite numerous difficulties, a coordinated effort by national and international authorities and organisations succeeded in bringing the outbreak under control. In 2007 and 2011 further Ebola outbreaks in Uganda were effectively halted (4).

«As the human immunodeficiency virus (HIV) disease pandemic surely should have taught us, in the context of infectious diseases, there is nowhere in the world from which we are remote and no one from whom we are disconnected.» A working group wrote this in the preface to the report *Emerging infections: microbial threats to health in the United States* in 1992 (5). They recognised that in the years before the emergence of the HIV pandemic, the potential of infectious diseases to become a serious medical problem had been

underestimated. It was believed that infections could be kept under control with the aid of antibiotics and vaccines, and traditional measures such as preventing the spread of infection and infection control were «forgotten». The HIV pandemic therefore – tragically – assumed quite unnecessarily large proportions.

The report entailed major consequences; for example in 1994, the WHO again started to concentrate on communicable diseases after having given low priority to these efforts since the 1970s (6). The medical journals also started to become involved. In January 1996, altogether 36 journals in 21 countries published 242 different articles on this topic (7), and in 2000 the WHO established the Global Outbreak Alert and Response Network (GOARN), which was charged with «providing an operational framework to link expertise and skill to keep the international community constantly alert to the threat of outbreaks and ready to respond» (8).

The outbreak of viral haemorrhagic fever in Uganda in 2000–01 was the first occasion on which the coordination was handled by this network, and successfully so (3). So what has happened since? Why did the WHO and the world in general fail to react to the Ebola outbreak in West Africa in 2013 at a time when it was still minor and could be dealt with? Aid organisations such as Médecins Sans Frontières for months attempted to sound the alarm, but it was not until missionaries and aid workers from Europe and the USA became infected that the alarm bells started ringing in earnest.

We are burying our heads in the sand if we (again) choose to believe that pathogenic viruses and bacteria can be isolated to distant lands and populations. In privileged Norway we are of course far better equipped than Liberia to deal with an epidemic. However, viruses and bacteria know no borders. Or as Onyebuchi Chukwu, Minister of Health in Nigeria, warned after the announcement of the good news that the Ebola outbreak in his home country had been brought under control: «Declaring a country Ebola-free is just theoretical. As long as a single case of Ebola is found in any part of the world, all countries remain exposed.»

References

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