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THE return of the Ebola Virus Disease to the Democratic Republic of Congo, DRC, soon after the devastating West African Ebola epidemic has raised fears about the possibility of another disaster in the making.

In this piece, Dr. Terence Gibson, a Consultant Physician at Guys and St Thomas NHS Foundation Trust, London who was a Consultant Physician at Connaught Hospital in Freetown, Sierra Leone between 2014-16 writes about the issues surrounding the Ebola response, and why a stronger

leadership of the World Health Organisation is required to translate policy across continents.



Terry Gibson

With a new outbreak of Ebola cases being announced last week in the Democratic Republic of Congo, I am reminded of early 2014 when I took up a position as a consultant physician in the largest hospital in Freetown. I was a volunteer member of the Kings Sierra Leone Partnership, dedicated to supporting the development of clinical services and both undergraduate and postgraduate education.

In a country of just over six million people, there was an acute shortage of health workers and just 150 doctors nationally. For two months the pattern of my professional life was familiar; a mix of daily ward rounds, teaching and organizing seminars for house officers. The diagnostic facilities were

poor and treatment options limited by availability and patients' ability to pay.

Shadow cast: In neighboring Guinea, an outbreak of Ebola erupted in March and cast a shadow over Sierra Leone. Ebola had never been seen in the region and the country and health infrastructure was not prepared for the seismic shock that was about to come.

Public posters did appear in May advocating that those with blood stained vomiting or diarrhea report to a hospital. These symptoms were amongst the least likely early symptoms of Ebola.

Denial

As cases trickled into the East of the country, to many in Freetown it seemed too distant to cause an immediate worry. Denial of the disease led to inaction. Amongst the first practical moves of preparedness in Freetown, the Kings Partnership, in collaboration with the hospital authority, converted a surgical observation area into an isolation unit, a step emulated throughout the city and neighboring districts much later.

By summer, denial was overtaken by panic as deaths mounted. NGOs packed up and left, schools and colleges were closed, airlines withdrew services. There was a shock when the national clinical lead against Ebola died of the disease, followed soon by one of my two physician colleagues. Health workers around the country began dying in disproportionate numbers despite increasing availability of protective garments.

The house officers at my hospital went on strike and many deserted. For the next several months the local medical workforce continued to decline until bolstered by clinicians from elsewhere. Ebola treatment centres began to appear run by international volunteers and supported by outside agencies and governments. But it was too late to avoid the spectacle of corpses lying outside and within the hospital as remaining staff bravely maintained an inpatient service for all the other diseases.

Separating and isolating suspected Ebola from the main body of patients was a risky priority and more doctors and nurses were to die while performing their duty. The isolation unit at the hospital where I worked was staffed by volunteer Sierra Leone nurses and health workers from the UK and elsewhere, sponsored by the Kings Sierra Leone Partnership.

When cases were confirmed they were transferred to treatment centres of which there was only one in the first few months and that was a five-hour drive from Freetown.

Plateau of cases

By the end of 2014 the number of Ebola cases appeared to be reaching a plateau at the same time as isolation and treatment centres were expanding. As the number of beds grew so did the admission of suspects who proved not to have Ebola.

Throughout the epidemic, the many diseases sharing characteristics of Ebola such as fever, delirium or diarrhea were denied best treatment until cleared of Ebola. Many of those that died are not included in the official statistics, because they were hidden cases that involved secret burials.

Weak leadership and fear of offending the national pride of the Sierra Leone government may or may not have accounted for the invisibility of the WHO on the ground during this period. As a clinician who was there at the beginning and at the end, I was puzzled by the slow response of the WHO.

Personal interaction: My only personal interaction with the organization was as the disease frequency was in decline and the number of WHO officials was increasing. A policy of quarantining all those who had contact with initially unsuspected positive cases unless wearing full personal protective clothing was introduced by WHO and enforced by the suddenly numerous and zealous officers on site.

Those of us who had been exposed inadvertently on several occasions survived because of simple infection control precautions and the monitoring of body temperature. We wished that they had been present six months earlier when the disease was running rampant. Then, strict quarantine and monitoring would have been sensible but now the measures were seen as too late to make any real impact.

For those of us involved in clinical care during this period, the role of WHO in leading the effort to contain and manage Ebola seemed chaotic from start to finish.

Systemic failure: Ebola exposed a systemic failure at the highest level of the organization. Now that there is going to be a fresh head of the organization, there is an opportunity to ensure that such dilatory and inept behavior are not repeated should similar circumstances such as the Ebola pandemic recur.