Preventing Ebola's Spread

By Jim Bever, retired Senior Foreign Service Officer, U.S. Agency for International Development

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By early October 2014, Ebola had already devastated Liberia, Guinea and Sierra Leone. Like a wildfire, it leapt across national boundaries, spreading via infected people traveling into Senegal, Mali, The Gambia and Nigeria. The deadly disease, first identified near the Ebola River in 1976, in what is now the Democratic Republic of the Congo, almost made it into Ghana, where I was posted as USAID mission director. A couple of months earlier, in July, an infected Liberian American citizen had spent time in the Accra Airport transit lounge before flying on to Nigeria, where he spread the disease before dying.

U.S. Ambassador to Ghana (and Senior FSO) Gene Cretz and others on our country team at the embassy gathered to plan for a potential outbreak. We knew it was highly likely that Ebola could not be stopped at the border. The virus is transmitted through direct contact with blood or other bodily fluid from an infected person, and the illness raged only a few hundred miles to our west. Yet we believed it incumbent on us to do our utmost to help the government of Ghana contain and defeat Ebola's spread should it get past the doorstep.

This conviction reflected both humanitarian and political considerations. The human suffering was horrible to see, but we also knew the disease had the potential to destabilize this key politically and economically progressive democratic country located in a region not known for either. The task was even more urgent because Ghana, unlike the other three most seriously affected countries, hosts more than one million visitors a year, many of whom fly back and forth from the United States.

The Ghanaian Government's Initiatives

As the disease spread in surrounding countries, the government of Ghana tracked down and checked those citizens who were exposed to the Liberian-American in the Accra Airport's transit lounge. Government officials set up rudimentary screening and temperature testing at airports and official border crossings, and procured 10,000 protective clothing suits for medical personnel to be used if needed. Ghanaian personnel built an Ebola isolation center just outside the capital, and two more around the country were under construction. Ghana's President John Dramani Mahama, who was also the head of the Economic Community of West African States at the time, immediately agreed to the United Nations proposal to set up its regional response logistical base at the airport in Accra. This would allow U.N. experts to quickly service the three most-affected countries without burdening those countries' absorptive capacities at their time of extremis. A few months earlier, Ghana had, with U.S. and others' help, developed a "National Preparedness and Response Plan for Prevention and Control of Ebola," which included establishing a Cabinet-level interministerial coordination committee.

Yet the pace of the plan's implementation was slow. We were concerned that two or three levels down, the government of Ghana did not seem to share our sense of urgency or that of its official donor group (which USAID chaired). The people's knowledge about Ebola and about the

cultural and behavioral changes that would be needed to contain a possible outbreak was still minimal. The press was full of outbreak rumors.

It was unclear whether the government's security agencies would be prepared for possible massive investigations, quarantining and riot control (already underway in Liberia). There was little confidence that anyone had the authority to direct
daily operational command and control in case of an out - break, and it was unknown whether health workers would stay on the job to battle the disease. We and our fellow assistance donors, along with international security and health experts, judged that, so far, the preparedness actions Ghana had taken were necessary but not yet sufficient for its own protection.

Embassy Strategy to Assist Ghana
FSOs at USAID teamed up with experienced professionals from the Centers for Disease Control and Prevention (CDC), one of whom was on detail to USAID for malaria work and one of whom was on the country team for HIV/AIDS work. We were joined by a small specialized team from CDC, its International Task Force for Unaffected and Less-Affected Countries. With the political leadership of our ambassador, we came up with a strategy for helping Ghana move to a higher and more reassuring level of preparedness. Our strategy was based on what we had learned so far from the three most affected countries—and especially from Nigeria's success at containing its own outbreak.

We knew that having a robust health sector capability would not, by itself, be enough. Ghanaian citizens had to understand what would happen in case of a disease outbreak: there would be quarantines. Security services and police would have to assertively investigate and detain people for health observation, and treatment if infected—using force, if needed, while respect - ing citizens' rights. Normal sick patient visitation and long - standing cultural and religious burial practices by relatives and religious authorities would have to be dramatically altered, if not curtailed altogether, because any contact with the corpse of an infected person would further spread the disease. Normal transit of people and goods might be stopped; shortages and hoarding were likely. Accurate public information would be at a premium, both to inform and to reassure the people.

In collaboration with the visiting CDC team and with the help of USAID/Nigeria, we decided to try to find a way to expose the very top of the Ghanaian government to Nigeria's experience battling the disease. We wanted to show them what Nigeria, the most populous country on the continent, had done to keep the disease from becoming a catastrophe of unthinkable proportions—not just for Africa, but for the world, which relies heavily on Nigeria's oil exports and global maritime and aviation systems.

We invited Nigeria's most experienced epidemiologists to come to a gathering in Accra of regional officials, who were coming from as far away as The Gambia, to share lessons learned about Ebola. They would be joined by both CDC's team and by one of our top experts from USAID headquarters.

Stars Align for Straight Talk

Sometimes in life, the stars align: the timing was perfect for a serious, straight-talking briefing with key Ghanaian presidential and Cabinet players. Our USAID health director, an FSO who had diligently led her team on the Ebola issue, worked her magic with the deputy minister of health to support such a briefing, while Ambassador Cretz reached out to the president's chief of staff to convene it.

On Oct. 9, 2014, the combined U.S. embassy team (Ambassador Cretz, USAID, CDC and the Defense Department's defense cooperation officer) and the Nigerian epidemiological team entered the Cabinet Secretariat of the Ghanaian president. President Mahama's chief of staff presided, joined by the minister of health, the minister of the interior, the minister of communications and Ghana's minister of defense. First, Ambassador Cretz laid out America's interest in helping Ghana, and then the Ghanaian officials shared their progress in preparedness. The officers from CDC, USAID and DOD gave their observations and recommendations, offering to continue to assist Ghana and to further marshal the country's official donors group.

Then it was the Nigerians' turn. We held our breath as Dr. Akin Oyemakinde, chief consultant epidemiologist to Nigeria's Federal Ministry of Health, proceeded quietly but with deep conviction to share his country's experience fighting the reemergence of yet another insidious disease—polio—just one year earlier, followed by the frighteningly lethal Ebola virus that had arrived in Nigeria just 80 days before this meeting. He humbly and gravely laid out his assessment of the most decisive actions taken in Nigeria, those that made all the difference in containing both diseases' spread—especially that of Ebola in densely populated Lagos and Port Harcourt.

"The government must be seen to be in control of the situation at all times, with political commitment across the board backed by funding," Oyemakinde emphasized, to make things happen quickly. He concluded by noting that it "engenders citizens' confidence that the government is out to protect their lives and removes suspicion and creates compliance with directives. A state of chaos or fear must not exist." Ghana's press later picked up these thoughts. The government officials thanked us soberly, and our discussion adjourned.

Our Impact

The Ghanaians' discussion, however, did not end there. A normally scheduled full Cabinet meeting was starting immediately after our meeting ended. The Ghanaian officials with whom we had talked were so seized with the briefing and the gravitas of the Nigerian experience that President Mahama agreed to change the agenda so that his officials could brief attendees about what had just transpired.

The next morning we learned in the Ghanaian press the extent of the impact we'd had. President Mahama and his Cabinet had agreed to establish an Inter-Ministerial Task Force on Ebola to streamline the chain of command and control. They also appointed the highly revered deputy minister of health as incident commander for Ebola. In addition, they activated a life insurance package for health workers to motivate them to stay on the job battling the disease in case of an outbreak, knowing that their families would be taken care of if they died due to their service. All of these critically important decisions had been pending for months.

Finally, we knew that Ghana was as prepared as it could possibly be. And we could all sleep a bit easier that night. Perseverance, political astuteness and creative diplomacy in reaching out to the Nigerians; our embassy's timely access to and credibility with the top of Ghana's government; and successful U.S. government interagency teamwork with CDC's outstanding experts made a real difference for Ghana—and, ultimately, for our own country as well.