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What can be learnt from Ebola about the dangers of the global health security approach?

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Introduction

The current outbreak of Ebola that has been raging out of control for over 1 y in the Democratic Republic of Congo (DRC) has brought back painful memories from West Africa about the dangers of the global health security approach. Drawing on the author's personal experience of working as a medic in both outbreaks, this article reflects on the challenges of responding to the disease inside a global health security framework. Insights and recommendations are made as to how the global health community can contribute towards gaining better control of Ebola both now and in the future.

Discussion

The global health security approach to the West African Ebola outbreak has received a large amount of criticism, which includes the delay in international support that only came after a perceived threat to Western countries.[1] Sadly, we see the same mistakes being made in the current outbreak, where the international focus on Ebola as a global health security threat has heightened local concerns about a Western security agenda. People's perception that our presence will only be short term and not address other locally important causes of morbidity and mortality has broken down our therapeutic relationship with patients and communities, which continues to frustrate efforts to gain control of the disease. Criticisms leveraged at the international response echo those we have heard previously—'You're not here because we're sick, you're here because we're infectious'—and have been compounded by a political and media focus on people as biosecurity threats rather than as human beings.

Internationally, the framing of Ebola as a global health security threat has led to the closure of borders, despite warnings from WHO about the negative impacts this has on both the response and on the livelihoods of people in the region. In the 2014 West African outbreak this involved the closure of multiple international borders. Attempts were made to close the border between DRC and Rwanda during the current outbreak, although these measures were reversed later the same day. Paradoxically, these measures only serve to increase the risk of the virus spreading as it forces people to travel through unofficial border crossings where monitoring systems and health support services are not readily available. Even when formal crossings are being used, the presence of intimidating border patrol officials are discouraging people from coming forward to disclose their symptoms. Adding to this growing sense of fear and mistrust, we continue to see the army escort burial teams and vaccination campaigns and suspected contacts being chased down by local police. It should come as no surprise then that frightened patients 'escape' from quarantine and cross international borders into neighbouring countries, as demonstrated in Uganda earlier this year. The security approach has also worsened issues around stigma, which deters people from presenting for help until they are too sick for our medicines to be effective. It also results in a reluctance to disclose contacts, which prevents us from being able to provide ring vaccination, a crucial element of achieving effective control.

Fear has also been compounded by a lack of understanding about what is happening to friends and family members behind the intimidating and opaque barriers of our Ebola Treatment Centres. In the West African outbreak this led to rumours that we were harvesting body organs and today we hear similar concerns are delaying people from seeking medical attention. In order to combat these rumours, we need to ensure the services we provide are delivered with transparency and accountability. The development of see-through tents and an increased focus on the development of honest and trusting relationships with patients and their families will go a long way here. However, in order to truly gain people's trust, we also need to ensure that we are providing them with the highest standard of care, that which we would each hope to receive for ourselves and our family members if we were in a similar situation. The huge difference in the case fatality rate between Western compared with African patients is not only unethical but also worsens the perceived divide between 'them and us'.[2] Breaking this divide down requires us to discard the use of a security rhetoric so that we can focus on treating people as individuals instead of public health risks and

with the dignity and respect we all deserve. Encouraging efforts have already been demonstrated in the DRC where the level of care has been increased to an ITU standard.[2] This, in combination with the successful campaign to gain access to experimental drugs, has helped to reduce case fatality rates. However, there is also a need to attend to patients' other health concerns besides from Ebola, both in order to gain their trust but also to fulfil our humanitarian duties. Medecins Sans Frontieres (MSF) has experienced positive feedback after developing isolation centres that focus on providing holistic care by attending to people's other healthcare needs. Social scientists are also doing work that provides valuable insights into how the local community can be more meaningfully integrated into the Ebola response. This still requires a shift in perceptions, from one that views people and their traditions as barriers to be overcome, to a more meaningful and respectful engagement with their perspectives.

Our responsibilities at an international level are to maintain open borders that can facilitate the delivery of much needed aid but also to acknowledge the damaging consequences of the global health security approach. This narrow focus on reducing international spread has led to the absorption of precious resources from already under-resourced systems, which has fractured fragile public health services and damaged wider humanitarian and public health goals. The indirect health consequences of transferring local staff and resources into the 2014 West African Ebola response are believed to have claimed more lives that the virus itself.[3] We are seeing evidence of this again in the DRC, where the neglect of essential health services such as vaccination programmes has led to outbreaks of measles, which have infected more people than Ebola.[4] This highlights the need for a response that is integrated with existing health services and addresses other health needs of a local priority. It also requires us to widen the scope of our approach to address the structural factors that contribute to these disease outbreaks such as poverty and weak healthcare systems.

Conclusion

There is an urgent need to re-evaluate the global health security approach to infectious disease outbreaks such as Ebola. Instead of focusing on a technical response that frames these issues as a global health security threat, we need to address the wider socioeconomic and political determinants so that we can increase the quality of the global response and prevent further outbreaks in the future. This will involve a serious reanalysis of the concept of global health security in view of the damaging effects it has had in both the DRC and West African outbreaks. It will also require us to reconcile the conflicting priorities between those pursuing the health security agenda versus more humanitarian public health goals in view of their common interests. *The Lancet* has begun this process by establishing a commission for understanding how the fragmentation between these different approaches can be overcome.[5] It warns that if these tensions are not addressed to realise a coherence in global health, opportunities will be lost in terms of lives saved and quality of life. Whilst these conflicts are being resolved we must focus on the human beings at the centre of the current Ebola crisis in the DRC so that a more effective and compassionate response can be generated.

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Ethical approval **Author's biography** Dr Samantha Roper is a UK-based Paediatric Doctor currently training as a Public Health Speciality Registrar. She worked with MSF in the 2014–2016 West African Ebola outbreak and returned recently from a second mission in the DRC Ebola outbreak on the Ugandan side of the DRC-Ugandan border. She completed her Masters in Public Health for Development at the London School of Tropical Medicine and Hygiene this year and received two diplomas in Tropical Medicine and Hygiene and in Conflict and Catastrophe Medicine prior to this. She has worked with a variety of other non-governmental organisations responding to humanitarian emergencies and continues to mentor on the NHS *Improving Global Health through Leadership Development* programme.

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