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1. Ebola’s history

Prior to 2013, 24 naturally occurring outbreaks of Ebola virus disease affecting humans had been reported. All but one of these outbreaks were confined to four central African countries: Democratic Republic of the Congo (DRC, formerly Zaire), South Sudan (formerly Sudan), Gabon and Uganda. In total, approximately 2300 people were known to have contracted the infection, around 1500 of whom died. The only reported human infection in West Africa was a single case of Tai Forest Ebola virus infection in Côte d’Ivoire in 1994.

Ebola was first discovered following an outbreak near the Ebola River in Zaire in 1976. Analysis of this first reported outbreak identified two key modes of transmission: (i) healthcare workers and family members were becoming infected after close contact with a patient, and (ii) patient-to-patient transmission was occurring through reuse of contaminated needles for injections at the local hospital. This outbreak was rapidly controlled as quarantine measures were instigated by village leaders, and nosocomial transmission was eliminated when the hospital was forced to close after most healthcare workers were infected. The absence of sustained transmission and the small number of individuals infected did not pose a wider public health threat outside the affected communities. Ebola, therefore, did not hit the headlines. However, it did generate some scientific interest concerning vaccine development and pathogenesis, triggered primarily as a result of biosecurity concerns due to the high case fatality risk.

2. Awareness of Ebola

Before the 2013-2016 epidemic, public knowledge of Ebola was heavily influenced by the descriptions in popular fiction and Hollywood blockbusters, largely inspired by the media attention triggered by the 1995 Ebola outbreak in Kikwit, DRC. These depictions generally portrayed a catastrophic, worst case scenario, highlighting the potential apocalyptic qualities of Ebola—in these fictional scenarios, not only could it spread virulently, destroying communities, regions and continents, but it also held significant potential as a bioterrorism weapon. However, outside central Africa, Ebola was considered more of a fascination than a genuine risk; although dangerous, it was limited to central Africa and to the most rural and poorest regions. That view was soon to change.


In December 2013, in Gueckedou prefecture in the Forestière region of Guinea, near the tripoint of Guinea, Sierra Leone and Liberia, a 2-year old boy would later be identified as the index case of this outbreak. During the following
28 months, there was sustained transmission across Guinea, Liberia and Sierra Leone, as well as spillover cases and connected outbreaks in a further three West African countries, three European countries and the USA. There was a sense of shock, not least because none of these ten affected countries had previously experienced an Ebola case (except for one laboratory worker accidentally infected in the UK in the 1970s). This outbreak heralded a new era for Ebola—a multi-country epidemic of global significance. It was the result of a perfect storm created by the intersection of a slow response, the legacy of civil war and corrupt dictatorships, poorly functional health and governmental systems commanding little public trust, and highly mobile populations. In its wake the epidemic has left us with a list, albeit incomplete, of what went wrong in our attempts to control the disaster, and of what the lessons are for future outbreaks of Ebola and other lethal pathogens.

4. What have we learned?

After it became clear that much of the devastation could have been prevented, four different panels were formed to review the international response—the World Health Organization (WHO) Ebola Interim Assessment Panel, the Harvard University and the London School of Hygiene and Tropical Medicine’s (LSHTM) Independent Panel on the Global Response to Ebola, the US National Academy of Medicine’s Commission on a Global Health Risk Framework for the Future and the United Nations High-Level Panel on the Global Response to Health Crises. These panels aimed to identify the reasons that contributed to poor outbreak control and to provide recommendations on how to strengthen future responses. They were unanimous in implicating the WHO in failing to avert the disaster. The WHO has since responded by restructuring its approach to epidemic response. This restructuring can, in principle, tackle several recommendations by the Harvard/LSHTM Panel which state the need for the WHO to scale back its broad remit and instead refocus on: providing technical assistance to nations to strengthen their public health system capacity and epidemic preparedness and response; providing emergency response and declarations; establishing best-practice guidance; and coordinating the global health response. Other organizations have reacted to separate Panel recommendations: most notably, the World Bank has launched a pandemic financing facility to underpin national response initiatives, and the Coalition for Epidemic Preparedness Innovation (CEPI) has been launched to incentivise vaccine development for pathogens where there is epidemic potential but little interest from the pharmaceutical industry. A priority for CEPI is to complete full testing and registration of at least two Ebola vaccines so that they can be used in future Ebola virus outbreaks, and to protect healthcare workers and other vulnerable populations. Despite some improvement in global epidemic preparedness, implementation of most recommendations is still patchy and will require continued strong leadership at political, scientific and public health levels.

Many of the recommendations made by the panels centred around global governance and leadership, with little attention to the role of the individual nations. However, for infectious disease outbreaks, acting effectively is often synonymous with acting rapidly. Without strengthening local core capacity to rapidly detect and respond to outbreaks, weeks will be lost prior to international mobilization of resources occurring. With the number of cases increasing exponentially, a delay of even a few weeks can be the difference between effective outbreak control and a public health emergency.

5. Was the response different to that during previous epidemics?

This outbreak was unlike all previous outbreaks in many respects: it was unique in terms of its magnitude—being over 90 times larger than any previous outbreak; in terms of its timespan—with transmission continuing for more than 2 years; in terms of its geography—occurring in West Africa where no human-to-human Ebola transmission had been reported previously; and in terms of its spatial distribution—with intense transmission spanning three entire countries, coupled with significant urban spread. This is in contrast to previous outbreaks that were localized to specific rural areas or geographically isolated small towns. In previous outbreaks control efforts (usually led by Médecins Sans Frontieres (MSF), The Centers for Disease Control (CDC) and WHO, alongside national authorities) were implemented prior to early cases seeding transmission in new areas. This was again displayed by the rapid control of an Ebola outbreak in Boende, DRC in 2014, led mostly by Congolese experts, local government, health services and MSF.

In comparison with historical outbreaks, the 2013-2016 West African outbreak at times seemed ‘out of control’ and evolved into a major humanitarian crisis, resulting in an unprecedented global health response. It is the first time key players in an Ebola response have included international military and governmental organizations from the UK, USA, China, France, Cuba and the African Union, along with many other countries. Public health strategies were complemented by military and military-style coordination and logistics that helped implement preventative interventions and enforced curfews to try to limit further transmission.

Media coverage significantly affects how a disease is perceived. The 1995 Kikwit outbreak was the first epidemic to generate global media coverage, largely due to technological advancements making it possible to broadcast and send images in real time. This media attention played a major role in mobilizing public engagement, which in turn led to increased resources during the epidemic and generated the development of several documentaries, books and films, producing a new global wave of public information about Ebola. Worldwide media attention exploded during the 2013-2016 epidemic, and oscillated between helpful public information to almost hysterical fear-mongering.

6. Ebola as a game-changer

The unprecedented size and duration of the West African Ebola epidemic tested the limits of medical knowledge, health system infrastructure and capacity, and the international global health response. The epidemic uncovered fatal weaknesses in these systems that set back the Ebola response, and if left unchanged, will hamper future disease control across all emergent diseases. With Western, Middle and Central Africa increasingly hosting dangerous ecological
risk factors for zoonotic spillover events, this recent Ebola epidemic must be a game-changer for how we, as a global community, deal with this ever-present health threat. Great leaps forward have sometimes followed great tragedy, as was the case with the ongoing HIV/AIDS epidemic. Achieving a political and social movement, AIDS activism allowed health to be placed on the top of global agendas. New health priorities allowed access to pharmaceuticals under patent to low income countries, and the field of ‘global health’ emerged with its own research agenda.

This Ebola epidemic highlighted the inadequacy of scientific and medical advancements in preventing global spread of emerging infections. Making progress will rely on higher-level governance to improve economic incentives in pharmaceutical development and timely financial decisions. In addition, there is a great need for innovation—from diagnostics to vaccines, better data collection and management, improved detection and surveillance protocols, and sober consideration of the socio-economic drivers of many ecological risk factors for disease spillover.