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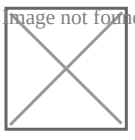
NO EFFECTIVE RESPONSE TO COVID-19 IN AFRICA WITHOUT THE INVOLVEMENT OF CIVIL SOCIETY ORGANISATIONS

When we think of the recent epidemics in Africa, it is of course Ebola that comes to mind. Its virulent nature, its initial lack of a vaccine and treatment, but also its shocking nature for the populations of the affected countries, has left its mark on people's minds. If there is one thing that we have learned from this episode, it is the indispensability of the multi-disciplinary nature of the actors who have joined forces to combat the epidemic. As microbiology researcher Professor Philippe Sansonetti explains, "This is probably the first disease where field interventions have involved doctors, epidemiologists as well as sociologists and anthropologists. This made it possible to identify very precisely the areas and sources of contamination. In particular the funeral events, the situations of traditional groupings which, perhaps, would have gone unnoticed in other circumstances".

Cumulative confirmed cases of COVID-19 on 31 March 2020



Source: WHO Africa Dashboard

As the African continent is now affected by the COVID-19 pandemic, which has already infected more than 4,000 people and caused the death of some 100 across the continent, it is striking that the lessons learned from the Ebola crisis do not seem to guide most of the discussions in ministries and among

donors, who seem mainly focused on the medical response. The challenges to the health system are obvious: it is reasonable to assume that capacity for emergency management, coordination of intensive care, numbers of health workers, and equipment is insufficient. This capacity has been shown to be inadequate in some countries that have, seemingly, the best-performing health systems.

But beyond the challenge for health systems, which we know will not be able to respond adequately if COVID-19 spreads, the lessons of Ebola also teach us important lessons about priority subjects such as the protection of health workers, the limits of biomedical approaches, which often create great social tension between populations and health-care services, the role of the media and the difficulty of communicating in an appropriate and effective way, and relative confidence in the health system. Added to all this are issues related to the continuity of care for chronic patients, who are known to be the first victims of these epidemic phenomena.

Protection of medical staff

In Europe, healthcare workers are paying a heavy price in the fight against COVID-19: in Italy, 4824 professionals have been infected as of March 24, 5400 in Spain (representing 14% of that country's total infections), and in France, the Minister of health announced 600 new infections among health professionals last week. This is due to the virulence of the transmission of this particular coronavirus, but also to the inadequacy of the protective measures available: too few masks, which have to be recycled, no more double protection, the unavailability of face shields, and so on. Many health workers have denounced this situation and testified they were working unprotected, with fear of being contaminated.

During the last Ebola epidemic in West Africa between 2014 and 2016, 891 healthcare workers died from the virus out of the 10,000 people who died, i.e. 9% of the total. One remembers the long and important disputes about the outfits and protections used to care for the sick. Without going into this long debate, it is clear that the protection of the carers, who are few in number to begin with, as well as the protection of the community actors who will be involved in the activities we will describe below, is essential. These community actors were systematically forgotten in the response to Ebola, denying their important role in awareness and prevention activities, and denying their needs, in terms of protection, and psychological and social support.

We do not know whether today, in the needs assessments made by the Ministries of Health of countries that have submitted plans to the Global Fund for additional funding, these needs have been fully taken into account, and whether the staff of community-based organizations can count on the protections that will be put in place for health workers.

Bio-secure approaches and their limitations

Countries that have been able to respond rapidly and relatively effectively to the COVID-19 epidemic have all applied the same strategies: systematic and large-scale population testing with very rapid isolation of positive cases, and containment measures such as quarantine and self-isolation. The difficulty of the French, Italians or Americans to respect the prevention instructions as soon as they were put in place (social distancing, and later on containment) was obvious. And all this while sources of information on modes of transmission, recognition of symptoms, actions to take, etc. were widely accessible and understandable by all.

The socio-anthropological work carried out at the time of the Ebola crisis clearly showed to what extent bio-security approaches, based on medical knowledge, and the dissemination of information through traditional channels, were not effective. The local reinterpretation of national decisions and international WHO guidelines thwarted these plans, to the extent that interventions by health workers and community agents met with strong resistance from the population and in some cases their refusal to be treated. Among the most unpopular measures: the isolation of patients, some of whom were not seen alive again after being placed in isolation, the evacuation of bodies and the impossibility of organizing funerals, authoritarian modes of disinfection and, in front of the whole neighbourhood, the disinfection of the homes of infected people, and compulsory screening linked to the study of the chain of transmission, all of which caused misunderstanding, fear and stigma among some communities.

Alice Desclaux describes well how anthropologists were then, belatedly, asked to deploy, and "to understand the perceptions and attitudes of the populations, to identify opinion leaders and 'allies' for communication, to suggest appropriate messages, and to support the constitution of local Ebola control committees in order to facilitate the deployment of health interventions and to promote community participation in the response (…). This work, which is specific to local micro-social settings, requires rapid response – before social tensions escalate into conflict, which is important in view of the large number of sites involved."

Isn't it also the role of community-based organizations (CBOs) to raise needs, to adapt the discourse imported from the medical environment so that communities can better understand it, and to support local-ownership approaches?

Confidence in the health-care system

Another key factor in the fight against COVID-19 will come from the confidence that the population places in its health system, and in the instructions given by the political authorities. What is at stake goes well beyond the simple framework of the epidemic, and refers to many other subjects, among which are the following:

- The memory of how other crises of any kind – health, security or natural disaster – have been managed, and how the government of the day has dealt with them. Were they transparent and honest? Did they take into account the real needs of the population and protect them? Did they put in place the necessary mechanism

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