The Ebola crisis: Ethical challenges in the African context

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The current outbreak of Ebola virus disease (EVD) in West Africa is proving particularly challenging to contain. At the time of preparing this editorial, over 2 500 lives have already been lost since the index case, which involved a 2-year-old child who died in December 2013. This outbreak was officially reported by the World Health Organization (WHO) towards the end of March this year. The Ebola virus is a filovirus that is believed to be harboured by specific bat species in the affected regions. Transmission is from bat to bat and spill-over occurs into other animal species, in particular antelope and primates. Spill-over to humans is through contact with infected animals or direct contact with infected bats. Once a person is infected, mortality is reported to be between 60% and 90%, and the disease spreads quickly through contact with infected tissues and body fluids of affected persons. It is therefore not surprising that EVD is now one of the most feared diseases of the globalised world.[1]

EVD has given rise to several ethical challenges, ranging from concerns regarding measures to contain the disease, to how decisions are made in terms of who to treat in the face of limited treatments, to the planning and conducting of clinical trials in this context.[2,3] Moreover, the age-old concerns regarding lack of access to healthcare in Africa have resurfaced. It is this lack of access that clearly interferes with the achievement of the Millennium Development Goals (MDGs) on the continent, and while progress has been achieved globally in making people healthier since 1990, this progress is not equally distributed. Dr Margaret Mungherera, President of the World Medical Association (WMA), recently stated that in Africa there has been very little progress – the disease burden continues to be disproportionate to the population. Africa has 11% of the world's population but 49% of the maternal deaths, 50% of the under-5 deaths and 62% of the burden of HIV/AIDS globally. She pointed out that three countries have achieved only one MDG so far, e.g. Ethiopia has achieved MDG 4, and by 2015, no African country will have attained all the MDGs. The reality is that with the current status quo, most African countries will attain the MDGs 35 years or more after 2015. This is because of problems of natural disasters, political instability, wars, poor political governance, inadequate health financing, inattention to the social determinants of health, and weak health systems.

The six building blocks for an effective national health system are:

- Health workforce
- Health service delivery
- Health information systems
- Medical products, vaccines and technologies
- Health financing
- Leadership, governance and management.

All six need strengthening in African countries.[4] It is therefore not surprising that the regions affected with EVD, with their fragmented and under-resourced health infrastructure where strict infection control and quarantine are difficult to achieve, are struggling to contain the disease. Infection control as a preventive measure ought to be routine practice in health facilities throughout the globe, including Africa.

EVD was first described in 1976 and has been recorded in several central African countries including the Democratic Republic of Congo, Sudan, Gabon and Uganda, with cases having been imported into South Africa. In the past, cases have also been imported into the Netherlands, Italy and the USA.[1] However, EVD has been seen as mainly an African disease, and it is perhaps because of this that market-driven drug development has not found it necessary to invest in research and development in this arena. This is not unexpected, given Big Pharma's slow response to other infectious diseases in the developing world. This is also a stark reminder of the 90/10 disequilibrium that was frequently raised in ethical discourse on global distributive justice in research during the past decade, where 90% of research conducted globally was aimed at 10% of the world's privileged populations. It has been stated that treatments and a vaccine would probably have been available today if the prevalence of EVD was, in the main, a problem of high-income countries.[5] In this context, research and development would no doubt be financially attractive to drug companies.

The reality of the current outbreak is that health workers now confront several problems – problems they did not face when dealing with EVD in Africa in the past. Health systems in the three affected countries are extremely weak. This, coupled with insufficient staff, equipment and facilities, makes disease surveillance, isolation and supportive care almost impossible without assistance from well-resourced regions. In addition, fear of the disease and mistrust of health professionals have resulted in patients being removed from hospitals and being concealed, together with others that are sick in the communities. Moreover, cross-border movement between the three affected countries in West Africa has facilitated spread across a vast stretch. Effective contact tracing, which is critical for containment of the disease, has therefore become increasingly challenging, especially in remote rural areas.[2]

Because no cure or vaccine exists for the disease, the WHO convened a special consultation on 11 August to assess the ethical implications of the use of unregistered interventions which existed in the laboratory in small quantities at that time. A day later a statement was released that in the face of the EVD threat, it was ethical to offer unproven interventions with as yet unknown efficacy

and adverse effects as potential treatment or prevention. The ethical criteria to guide the provision of such interventions should include transparency regarding all aspects of care, ensuring freedom of choice and informed consent, respecting confidentiality, human dignity and involving the community.[6]

The WHO decision is in line with the WMA's Declaration of Helsinki (section 37) on 'Unproven Interventions in Clinical Practice', which states: 'In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorised representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available.'[7]

The WHO followed with a statement on 5 September which highlighted four critical elements that are required for treatment and research in this context:

- Appropriate protocols for informed consent and safe use must be rapidly developed.
- Mechanisms for evaluating pre-clinical data need to be established in order to recommend which interventions are to be evaluated as a first priority.
- A platform needs to be set up for transparent and real-time collection and sharing of data.
- A safety monitoring board must be established so that data from all interventions can be evaluated.[8]

The incidence of EVD continues to spiral, and external sources have now come forward to assist the affected countries. However, for as long as governments in these countries do not commit to strengthen their healthcare systems and improve the underlying social determinants of health attempts at combating the Ebola crisis and other crises following in the future could end up being ineffective.

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