Demonstrating solidarity in Africa

The mandate of the African Union Support to Ebola in West Africa (ASEOWA) ends on the 31st December 2015. Dr Olawale Maiyegun, Director of the Department of Social Affairs of the African Union Commission, on experiences gained, lessons learnt and strategies needed.

Dr Olawale Maiyegun, *Director of the African Union Commission's Department of Social Affairs, chairing an ASEOWA meeting.*
Photo: ASEOWA

Rural 21: ***Dr Maiyegun, the African Union has played a key role in Ebola response right from the start. What are the most important experiences from this period – also with a view to future crisis management?***

Dr Olawale Maiyegun: A speedy response and deployment for the urgently needed human resources for health was paramount. The African Union Support to Ebola Outbreak in West Africa (ASEOWA) was established following the Peace & Security Mandate of August 19th 2015 and deployed to Liberia by September 15th. By October, ASEOWA had been deployed to all three affected countries. This is unprecedented. Once a surge was decided in November 2014 to increase the number of ASEOWA volunteers from the initial 100, it took less than a month to have close to 855 volunteers working in all three affected countries. The African Union Commission (AUC) moved rapidly from Lagos through Addis Ababa, Kinshasa and Nairobi to mobilise health workers, all within a month, to recruit and deploy volunteers from Nigeria, Ethiopia, Democratic Republic of the Congo and Kenya. In addition, ASEOWA recruited hundreds of local volunteers within the three affected countries.

What was the role of the volunteers?

The volunteers came from a very wide range of areas. They included doctors, nurses, epidemiologists, data managers, lab scientists and technicians, public health officers, social workers, psycho-social experts, community mobilisers, communications workers and survivors of Ebola. They came from 18 African countries with different backgrounds and cultures. Within a very short time, ASEOWA was able to blend them to work and deliver as a team. The mission was flexible enough to deploy its teams to where they were needed the most, and to support the people's priorities. For example, it worked with national authorities to restore critical Maternal Newborn and Child Health (MNCH) care and other medical services in vital health care centres. ASEOWA also co-operated with local organisations to help revitalise hospitals and support strained medical capacities in an infection free environment. All this cost only a fraction of spending on other aid interventions.

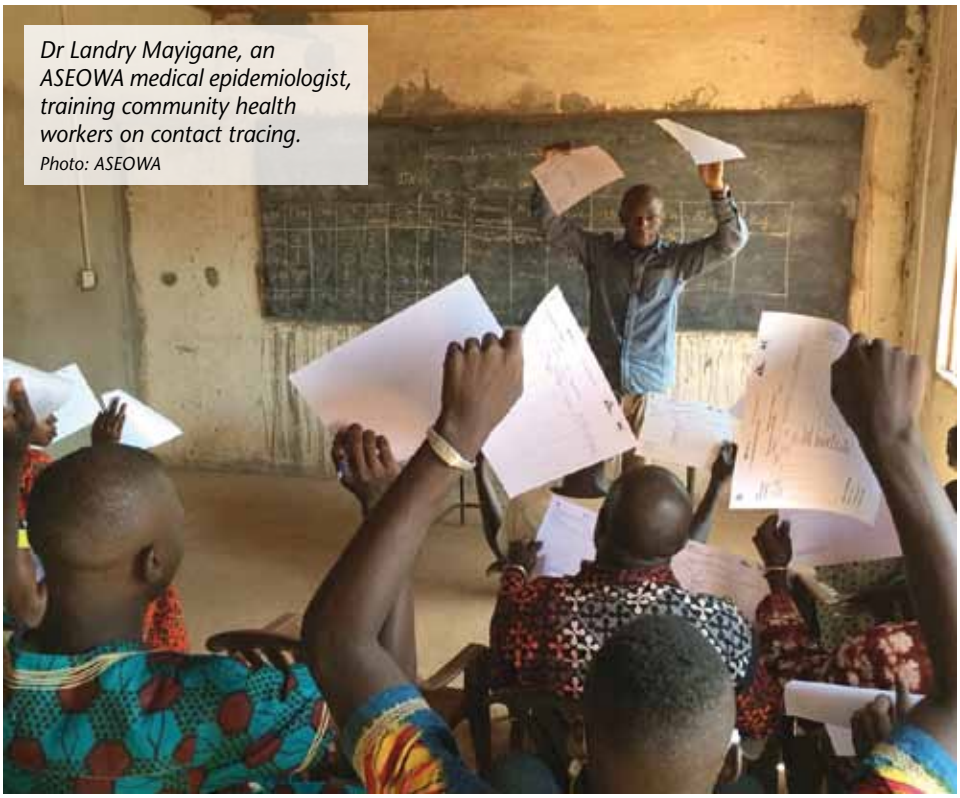
How exactly were the volunteers involved in activities on the ground?

One principle of ASEOWA's concept of operations is that the AU will support but not dictate to the affected countries. Hence, the volunteers were placed at the disposal of the countries to support and to supplement their health workers, who had been badly depleted by the Ebola outbreak. ASEOWA worked within the National Incident Management set up by each of the affected countries. The teams are deployed on the ground by the government Ebola incident management to support the following six pillars of the response as adopted by the countries: case management; logistics management; surveillance and contact tracing; communication and information; social mobilisation; and psychosocial care. ASEOWA leadership and volunteers' credibility inspired trust in the affected population – from national leadership to communities – which provided entry into national coordination structures. As a result, ASEOWA volunteers were deployed to the hottest Ebola spots and were instrumental to the drastic reduction in new Ebola cases by February 2015.

How did co-operation between the various actors work out?

The theatre of operation in the three affected countries was like a war zone among the international respondents. Though co-ordination on the field was a nightmare, particularly with some actors whose defining characteristic is not to be co-ordinated, ASEOWA liaised and collaborated well with the United Nations, the World Health Organization, the US Centers for Disease Control, Médecins Sans Frontières, the Red Cross and other organisations, as well as with Cubans and Chinese, with whom we managed and worked together inside Ebola Treatment Units in the affected countries. However, AU's ASEOWA has been the central coordinator for Africa's response. For example, daily coordination meetings were held in the AU's headquarters in Addis Ababa, bringing together Member States, development partners, UN and humanitarian agencies, and interdepartmental participation from within the AUC. ASEOWA was also in charge of co-ordination between medical, logistic and other emergency experts. Here, there was one very crucial aspect. ASEOWA was conceived in the spirit of African solidarity and supported by the African Union's convening power, political leverage, its continental reach, and its networks in all regions of Africa, including its 6th region, the diaspora. Technical expertise came from 18 member

states, the NGO African Humanitarian Action (AHA), the Economic Community of West African States (ECOWAS), Africans in the diaspora, as well as from the Ebola-affected countries. The volunteers promptly responded to the call of the AUC for help.



Dr Landry Mayigane, an ASEOWA medical epidemiologist, training community health workers on contact tracing.
Photo: ASEOWA

What has the role of the African private sector been in this context?

ASEOWA received financial and technical support from many partner countries and organisations. Nevertheless, through the Africa Against Ebola Solidarity Trust (AAEST) it set up, the African private sector remains the single largest financial contributor to the AU's Ebola response. In addition, the sector leveraged its assets and technology for the use of ASEOWA. For example, through the SMS short code campaign, the private sector mobilised not only financial resources for ASEOWA but also ordinary Africans to participate in the fight against Ebola. Indeed, by joining forces with the Commission and with its commitment to support the Africa Centers for Disease Control and Prevention, the private sector has also demonstrated the true spirit of African Solidarity – "Africa helping Africa".

Let's have a look at the future. How will the African Union assist the affected countries – or the region as a whole – in recovery and in preventing another such crisis?

A major lesson learnt from the Ebola outbreak is the need for the AU to put in place a medium- to long-term programme to build Africa's capacity to deal with public health emergencies and threats in the future. Disease surveillance, detection, emergency preparedness for health and natural disasters and response are vital. Therefore, capacities and systems most needed to prevent, detect and respond to public health threats must be reinforced in order to ensure that in the medium to long term, African countries attain and possess all International Health Regulations capacities and systems. It is in this context that the AUC fast-tracked the establishment of the Africa Centers for Disease Control and Prevention (Africa CDC). The recruitments of its initial staff have been completed, and its structures are being put in place. The CDC will be fully functioning in January 2016, after its formal inauguration.

In which areas is the CDC to become active?

The CDC is to support Member States in health emergencies response, particularly with regard to those emergencies which have been declared a public health emergency of international concern, as well as in promotion and disease prevention through strengthening of health systems, by addressing communicable and non-communicable diseases, environmental health and neglected tropical diseases (NTDs). This includes the establishment of early warning and response surveillance platforms to address all health emergencies in a timely and effective manner, thus supporting public health emergency preparedness and response. In addition, it is to promote partnership and collaboration among Member States to address emerging and endemic diseases and public health emergencies and harmonise disease control and prevention policies and the surveillance systems in Member States. Also, it is to support Member States in capacity building in public health through medium- and long-term field epidemiological and laboratory training programmes. The Africa CDC will partner with the WHO and other relevant stakeholders to assist AU Member States in addressing gaps in International Health Regulations compliance, complementing one another and ensuring effectiveness.

What else is planned?

The AU is also working with its Member States to facilitate the provision of urgently needed human resources in various fields (not just in health) to the affected countries to assist their recovery. Nigeria for example, through its Technical Aid Corps (TAC) Volunteer Programme, is offering Sierra Leone and Liberia teachers, engineers and medical staff, among others. More than 500 health professionals of different disciplines are required for the recovery of these countries. AU Member States are therefore encouraged to contribute through secondment of health professionals, as well as training of local health professionals. Generally speaking, the African Union will continue to assist affected countries in resources mobilisation.

What are the biggest obstacles to action?
One major obstacle is the availability of financial resources. Regrettably, notwithstanding the promises already made, partners' resources are neither predictable nor assured. This is closely linked to a certain level of donor fatigue. For example, the G8 collectively fulfilled critical commitments to health in Africa — including its 60 billion USD pledge for AIDS, tuberculosis and malaria in 2007–2012. The recent financial crisis, however, has resulted in a decline in international investments, exposed the insecurity of this funding and jeopardised the sustainability of recent health gains. Similarly, the Global Fund to Fight HIV/AIDS, Tuberculosis & Malaria could not meet its 15 billion USD replenishment target in 2013, and there is no guarantee that it will meet its next target in 2015.

Inadequate human resources, at least in the short run pending the recruitment and training of new ones replacing those lost to Ebola, certainly pose a further problem. And last but not least, there is the huge external debt and poverty aggravation in the countries affected.

So what do you expect from the international community?
In addition to strengthening of the global health security, above all the provision of financial resources in a timely and predictable manner by bridging short- and medium-term financial gaps through financial contributions. Furthermore, we would appreciate debt cancellation for the three countries. This has been a call by the AU since September 2014, and is based on the study by the UN Economic Commission for Africa. Although the latter's results are clear, there has been silence on the part of the Paris and London Clubs of creditors.

And what is the role of governments in the affected countries?
They have to scrupulously implement the recovery plans they themselves have drawn up. In the immediate term, the three countries should ensure the provision of health infrastructure, equipment, medicines and supplies, the refurbishment of existing clinics, hospitals, laboratories and, where necessary, the construction of new facilities, as well as the provision of critical medical equipment and sustainable medicine and supplies. Moreover, they need to implement the Mano River Maternal Health Response on "Building Resilience and Supporting Recovery through Integrated and Strengthened Human Resources for Health including Midwifery" as major contributions to resilience building and strengthening health systems.

What is this programme about?
For 2015, it is estimated that more than 1.1 million women in Guinea, Sierra Leone and Liberia will be pregnant. Those pregnant women who need treatment or are about to deliver are often too scared to attend health centres, or facilities are no longer able to provide essential routine and emergency maternal and newborn care services because the Ebola crisis has diverted critical resources away from pregnant women. In addition, it is estimated that more than 1.3 million women will need family planning services. Internalising the importance of the essential health services in the fight against the spread of the virus, including sexual reproductive health services, and the importance of initiating activities that strengthen cross-border co-ordination and co-operation highlighted in an overview of needs and requirements undertaken by the Global Ebola Response Committee, the United Nations Population Fund (UNFPA) worked with the governments of the three affected countries and the Mano River Union Secretariat to develop a global proposal and plan of action aimed at showing the appropriateness of a comprehensive approach for curbing the impact of the EVD outbreak on Reproductive Health services: the Mano River Midwifery Response (MRMR).

The MRMR is a phased programme targeting to build resilient health systems with a focus on establishing a strong midwifery workforce placed primarily in health centres, organised in midwife-led units with strong links to the communities and to referral facilities. It is in line with the report "Recovering from Ebola crisis", which was a contribution to the efforts by the Governments of Guinea, Liberia and Sierra Leone to design their National Recovery Plans. Therefore, it is also in line with these National Recovery Plans. The first phase of the MRMR is funded by the Government of Japan and directed to contribute to a reduction in maternal and newborn mortality and morbidity in selected border areas of Guinea, Liberia and Sierra Leone (Guinea: Gueckedou and Macenta prefectures; Liberia: Lofa county; Sierra Leone: Kailahun district).

So what are the next steps for the AU?
The AU Assembly and the Peace and Security Council have requested the Commission to review the AU Humanitarian Policy Framework with a view to developing a comprehensive disaster management protocol and filling all existing gaps in the co-ordination of the Commission's responses to disasters and emergencies. The Commission is currently undertaking this review. Summing up, the African Union, the Regional Economic Communities and national governments are strengthening their capacities to respond to emergencies and disasters. Models for emergency response teams, emergency medical teams, among others, are being tested in various crisis theatres. The ASEOWA model provides a working template and guidelines for emergency responders in Africa, and perhaps in other continents.

Ebola awareness campain in Grand Cape Mount county, Liberia.
Photo: ASEOWA