

EBOLA VIRUS EPIDEMIC IN WEST AFRICA IN 2014:  
SENEGAL STANDING THE TEST OF GLOBAL HEALTH  
DIPLOMACY

MOUSTAPHA FAYE

*TRANSLATED BY CASSANDRE CAMPEAU-BOUTHILLIER &  
OLGA ZIMINOVA*

ABSTRACT

This paper is the culmination of a project done in the context of a diplomacy and global health seminar with the Global Health Center (Graduate Institute) of Geneva on the case of Ebola contamination in Senegal. This project allowed the understanding of the magnitude of the epidemic in West Africa in 2014 with its international implications. Moreover, this project was a personal challenge to lead this reflection through the twofold lens of anthropology and diplomacy in global health, a subject that raises new questions about health as a central issue of human existence. As Dominique Kerouedan (2013) recalls through the introduction to the colloque international of the Collège de France:

La santé est un thème de politique étrangère et de diplomatie, en ce qu'elle est devenue dans les relations internationales, plus précisément au fil du temps, un paramètre de pouvoir, d'influence, de sécurité, de paix, de commerce, voire un vecteur de positions géopolitiques ou même idéologiques, pour des Etats cherchant à gagner en importance politique à l'échelle mondiale.

## INTRODUCTION

International help or the humanitarian industry in Africa, in the field of global health, is a question that must be addressed, especially regarding humanitarian responses. On August 29<sup>th</sup>, 2014, a young Guinean affected by the Ebola virus travelled to Dakar, introducing the virus to Senegal, a country bordering Guinea Conakry. Therefore, the management of West African cases of the Ebola virus and, particularly, of the case imported to Senegal (Fall 2015), provide a framework for thought and analysis. It should be noted that the United States, Spain, Nigeria, and Mali were also affected by the virus. I present below an analysis of global health diplomacy in light of the Senegalese epidemic.

This exercise will examine two dimensions: the dimensions of the quarantine established in response to the notice of the import of the virus, and the dimension of the negotiation of parties involved in the containment of the disastrous effects of a pandemic or epidemic risk on Senegalese soil. These two dimensions will be explored while taking into account the humanitarian and political management in the context of Senegal through the perspective of diplomacy in global health. To this end, this paper is organised in three parts: one, diplomacy in global health and quarantine strategies in Senegal; two, a focus on negotiation strategies released by the Senegalese government; and three, examination of the international civil society's engagement.

## DIPLOMACY IN GLOBAL HEALTH AND QUARANTINE STRATEGIES IN SENEGAL

Senegal is one of the 149 states that comprise the World Health Organisation (WHO), created in 1946 in Geneva after World War II. This organisation of the United Nations (UN) provides expertise, as well as political and diplomatic support to governmental and non-governmental institutions, communities, and private foundations of its members. Through its operational frameworks and jurisdictional planning, the WHO is able to intervene in epidemics or health emergencies. The UN faced criticisms for its response to the outbreak

of the Ebola virus in West Africa in 2014 (WHO 2015). Other criticisms referred to the lack of international leadership undertaken by the WHO, despite the provisions of the International Health Regulations (IHR), a legal tool of international law. As Antoine Flahault (2014: 2) states: “le contrôle d’une zoonose fait appel aux secteurs de l’agriculture, de la santé, l’économie, l’intérieur, la justice, les affaires étrangères. Or, le dialogue entre secteurs nécessite une coordination et un leadership.”

The UN’s institutional crisis seems to be deeper, coming from many structural, functional problems between the Geneva office and its regional representatives (Benkimoun 2016). Ebola showed the deficiencies and difficulties the WHO faces in the urgent management of the West African epidemic. The Doctors Without Borders (DWB) organisation alerted, in the early hours, the world public opinion on the progression of the virus in West Africa. The responses from the WHO and the UN were particularly slow:

La critique sur le système sanitaire international se concentre essentiellement sur l’Organisation Mondiale de la Santé (OMS), celle-ci étant en effet, l’autorité directrice et coordinatrice, dans le domaine de la santé mondiale. Ses défaillances sont relatives non seulement à la déclaration trop tardive de l’épidémie ayant conduit à son enlisement et l’ineffectivité et opérationnalisation dans le cadre de cette crise des mécanismes prévus par le Règlement sanitaire international (RSI) adopté 2005 et entré en vigueur en 2007 prévoyant la marche à suivre pour prévenir la lutte contre les épidémies. (APDHAC 2015)

Similarly, the intervention and the coordination put in place through the United Nations Mission for Ebola Emergency Response (UNMEER) appear to function relatively well. The financial mobilisation initialised by the UN collected 40% of the requested funds, demonstrating the engagement level of the donor countries. In fact, the new configuration of the global health field, the diversity of its actors, and the emergence of infectious diseases require an extensive reform of the WHO and UN systems. How can one speak of diplomacy in global health in such circumstances?

## DIPLOMACY IN GLOBAL HEALTH IN THE SENEGALESE CASE OF INFECTION

The links between the management of the Ebola virus and diplomacy in global health are close. This proximity can be done through two approaches: one, an approach to international public health; and two, an approach based primarily on diplomacy in global health. The international public health approach references the expertise in public health that the WHO, international organisations, and non-governmental organisations (NGO) can bring in infection risk situations. The diplomacy in global health can be defined as: “l’ensemble des négociations internationales qui touchent, directement ou indirectement, à la santé globale” (Kickbusch 2013: 34). For the first time in the UN’s history, the security council called a meeting for its members as part of the international response to the Ebola epidemic, which was regarded as a security threat. The council called for a mobilisation of international efforts to counter the epidemic’s adverse effects. Resolution 2177 was supported by 134 countries, marking the first consensus in UN history. Thus, the Senegalese authorities were to politically respond to the epidemic by taking inspiration from Guinea, Liberia, and Sierra Leone. This opportunity for political and diplomatic collaboration on a sub-regional level would have created fortuitous effects in positive relations between the nations. The commercial repercussions during the five months of Senegalese border closure had impacts in the economic lives of both countries. In fact, the 2005 version of the IHR formed the basis of the debate through its purpose and scope, specifying: “prévenir la propagation internationale des maladies , à s’en protéger, à la maîtriser et à réagir par une action de santé publique proportionnée et limitée aux risques qu’elle présente pour la santé publique, en évitant de créer des entraves inutiles au trafic et au commerce internationaux” (Benkimoun 2016: 77). In this respect, member states have the responsibility to put into place epidemic surveillance mechanisms on land, air, and sea borders.

This dialogue between Senegalese and Guinean authorities was lacking, non-existent. However, it is important to note the collaboration between experts of the WHO’s Guinean and Senegalese

offices. It seems that the contamination case imported to Senegal was traceable and identified by means of information exchange. Regarding the response of the health authorities, the report of the Ministry of Health and Social Action (MSAs) of Senegal of May 2014 entitled “response plan for the Ebola virus outbreak” referred to the measures taken in response to the outbreak in Guinea.

The “Stratégie de la Surveillance Intégrée de la Maladie et de la Riposte”, a plan for the organisation of a surveillance system, was developed as a technical guide in 2004 (MSAS 2014). This strategy was revised in May 2013 to take the IHR’s dispositions and principles into account. In terms of technical response, an epidemic management committee was set up by the Ministry of Health and Social Action. This committee defined epidemiological surveillance, prevention, and response mechanisms, and in partnership with civic organisations, spearheaded the quarantine in Dakar following the identification of the therapeutic path of the 29-year-old Guinean who brought the virus to Senegal.

## THE QUARANTINE: RESPONSE STRATEGY TO THE EBOLA VIRUS IN SENEGAL

There have been several attempts to define “quarantine” in the field of international public health. The attempted definition proposed by the IHR is an illustration of this struggle. The definition, as follows, is: “la quarantaine s’entend de la restriction des activités et/ou de la mise à l’écart des personnes suspectes qui ne sont pas malades ou des bagages, conteneurs, moyens de transport ou marchandises suspects, de façon à prévenir la propagation éventuelle de l’infection ou de la contamination” (RSI 2005). Some texts have raised the historical dimension of quarantine, the original one appearing to be that of Anne Marie Moulin (2015) called “l’anthropologie au défi de l’Ébola”, where she recounts an ethnography on the history of epidemics, focusing on Thucydides’ account of Ebola and its effects on Athens’ population. Her work also raised the concept of “community isolation” to demonstrate the confinement strategy of infected individuals with the goal of avoiding contact with uninfected individuals.

The debate on quarantine was posited by Haas of the Centre for Disease Control (CDC) in the United States in 2014. According to Haas, quarantine can be perceived as similar to the modalities adopted in Senegal. However, Desclaux and Sow (2015) have mentioned that the management of the epidemic in Senegal presents certain similarities with practices that took place a century ago: *cordons sanitaires* and isolation of Lebou populations living in the Cape Verde Peninsula (which would become the current conurbation of Dakar), to control the plague epidemic of 1914 (Echenberg 2001 as cited in Desclaux and Sow 2015). It is in this historical context of quarantine that it seems appropriate to relocate the origins of diplomacy in global health. Quarantine created the historical conditions for this practice as Ilona Kickbusch (2013: 34) describes it in an interview:

À l'époque, les navires marchands suspectés de véhiculer des maladies comme le choléra ou la fièvre jaune, devaient rester en quarantaine dans les ports avant de pouvoir débarquer leurs marchandises et continuer leur route. Le problème, c'est que certains États soupçonnaient leurs rivaux d'utiliser cette mesure pour entraver le commerce. A certains moments, les grands pays commerçants ont compris qu'il valait mieux se mettre d'accord et édicter des règles communes en matière de quarantaine.

However, this preoccupation with negotiation or diplomacy in global health is completely absent from the quarantine implementation process in Senegal. This lack of negotiation can be apprehended on three levels. First, no recommendations were defined to frame the Senegalese quarantine experience: “Au moment où le Sénégal doit mettre en place la surveillance communautaire des sujets contacts, il n'existe pas de recommandations globales concernant son application” (Desclaux and Sow 2015: 7). Second, the levels of knowledge and experience of public health responses to the Ebola crisis were considered low. Senegalese health care facilities are not sufficiently prepared and do not have the necessary equipment or staff to deal with the risk of infection. Third, the collaboration between the response management committee of the Ministry of Health and Social Action and the seventy-four individuals who were in contact with or

in potential contact with the virus roused more fear than trust. This fear was also mentioned in Guinea and Sierra Leone. The biosecurity approach developed led to a configuration of the relationships between people and public health actors. These relationships were perceived as a form of policing of sanitary practices in the Guinean context. In Senegal, the relationships between public health actors and the populations were characterised by constraint, not volunteering. On this level of intervention in public health, negotiation strategies with affected populations deserves a more thorough examination.

## STRATEGIES FOR DIPLOMATIC NEGOTIATIONS IDENTIFIED BY THE SENEGALESE GOVERNMENT

The international press criticised the management of the Ebola outbreak in West Africa. No studies mention attempts to discuss or negotiate at the level of the African Union (AU). The international press underlined that it took five months after the re-emergence of the outbreak for the UA to schedule an emergency meeting on September 8<sup>th</sup>, 2014, after having recorded more than 2,000 deaths. The AU's late response was denounced in the same as that of the WHO. However, the Economic Community of West African States (ECOWAS) meeting in Accra (Ghana) on May 19, 2014, expressed a need to define a unified strategy to combat the Ebola epidemic. To this end, ECOWAS recommended that Senegal and the Ivory Coast lift their border closure to facilitate movement at the sub-regional level. This decision contributed to reduce diplomatic issues between Senegal and Guinea. Senegalese sanitation authorities had assessed that the decision to close the border would not be everlasting; they estimated the reopening of borders would depend on an opportune moment in relation to the epidemiological situation in the sub-region. However, they accepted the establishing of humanitarian corridors to facilitate access to affected countries. These corridors allowed the distribution of technical assistance and materials from the donor countries.

In the village of Ouakam in Dakar, an aerial military base was established for the convoys of WHO epidemiological doctors, agents from the World Food Programme (WFP), military contingents, and materials. In terms of financial contribution, Senegal donated 500

million CFA Francs (around 770,000 EUR). These facts highlight a follow-up of negotiations through the international press. It seems important to question how Ebola contributed to the definition of spatio-temporal relationships of the states that share the same regional politico-economic space.

This question establishes the debate around the phenomenon of independence. The following statement, taken through this perspective, illustrates this point: “avec le processus de mondialisation qui fait référence aux changements fondamentaux des contours temporels et spatiaux de l’existence sociale, notre monde est aujourd’hui devenu plus interdépendant et les événements se déroulant sur un point du globe peuvent potentiellement avoir une influence non négligeable à un autre endroit de la planète” (Rollet 2013: 112). The Ebola epidemic demonstrated the complexity and the paradox of relationships between states of Western Africa. The interests of countries sharing the same economic zone are not necessarily the same. One of the core principles of ECOWAS and the plan for the free movement of people protocol has been questioned. In the same vein, the Ebola epidemic sparked the conditions for political dialogue and diplomatic negotiations at the core of ECOWAS. Ebola has also contributed to the practice of diplomacy in world sanitation with the experimentation of new civil society actors in the international public health sector.

#### THE COMMITMENT OF INTERNATIONAL CIVIL SOCIETY TOWARDS THE IMPORTED CASE OF EBOLA IN SENEGAL

The global response to the Ebola outbreak in Senegal highlighted how global health cooperation is complex. Humanitarian aid or international solidarity expressed through NGOs, the WHO and financial partners such as the World Bank, the International Monetary Fund (IMF), and the European Union (EU) have shown that donor countries’ expectations are driven by strategic issues. The Senegalese Ebola crisis is an opportunity to question the role of these actors in the global health sector. Within the first hours of the crisis, these NGOs were on the front lines of attack against the Ebola disease. Doctors Without Borders (DWB) based in Dakar was one of the first actors to

integrate the expert team of the WHO to support the national inter-ministerial coordination committee put in place by the health and social action ministries in Senegal. Moreover, the presence of the Red Cross during the unfolding process of the quarantine in Senegal was hailed by the rhetoric of international solidarity. The question of international aid or of humanitarian industry in Africa regarding these humanitarian interventions must be addressed.

The Ebola crisis demonstrated that the presence of NGOs was never neutral. This presence is perceived as the prolongation of neocolonialism. To this effect, the words of a Senegalese anthropologist are revealing:

Si l'épidémie d'Ébola de 2014 est si difficile à endiguer, c'est qu'elle a émergé dans des pays marqués par les stigmates de la pauvreté et de la violence, et se reproduit dans un climat général de méfiance. Les populations qui ont encore en tête les injustices des périodes coloniale et postcoloniale ne font confiance ni à leurs propres pouvoirs publics, ni aux Occidentaux venus aider. Elles désertent les hôpitaux, considérés comme des mouvoirs, ce qui ne fait que renforcer la propagation d'Ébola. (Niang 2014: 97)

This epidemiological crisis allowed a better understanding of the humanitarian industry's motivations. These motivations do not necessarily correspond to the needs of the states of the global South, but they contribute to the needs of the donor countries such as economy, research, and international security. The necessity to rethink aid through international NGOs and international organisations like the World Bank, the EU, the IMF, and the WHO is evident.

## CONCLUSION

This paper was written as the result of the Diplomacy and Health seminar held in May of 2018 on how the Ebola case helped to capture the scale of the epidemic in West Africa in 2014. It was also a personal challenge to lead this reflection through the lens of diplomacy in global health, a subject that raises new questions to answer a central

problem of health's role in human existence. As Dominique Kerouedan (2013) recalls through the introduction to the colloque international of the Collège de France:

La santé est un thème de politique étrangère et de diplomatie, en ce qu'elle est devenue dans les relations internationales, plus précisément au fil du temps, un paramètre de pouvoir, d'influence, de sécurité, de paix, de commerce, voire un vecteur de positions géopolitiques ou même idéologiques, pour des Etats cherchant à gagner en importance politique à l'échelle mondiale.

In light of these words and my personal reflection project on the chosen topic, I formulate these recommendations which consist of: deconstructing the vision and the approach of global health of state and non-state actors, UN international organisations, financial and technical partners, and international NGOs; experimenting with the innovative concept of 'meta-governance' in global health diplomacy; setting up functional frameworks for dialogue and negotiation in global health at the regional level (AU and ECOWAS); implementing a project to establish an African regional office on infectious disease control, prevention, early detection and response; assessing this 2014 Ebola crisis at the regional and national levels to disseminate lessons learned to better prepare for the next outbreak; improving international health policies in the governance of healthcare systems in West African countries; and establishing a sub-regional African epidemic fund.

## ACKNOWLEDGMENTS

I would like to thank the Global Health Center Graduate Institute University of Geneva.

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