

Guinea

Ebola outbreak

KEY FIGURES

14

CONFIRMED CASES

4

PROBABLE CASES

9

DEATHS
(4 PROBABLE,
5 CONFIRMED)

Source: Government
of Guinea 28/03/2021

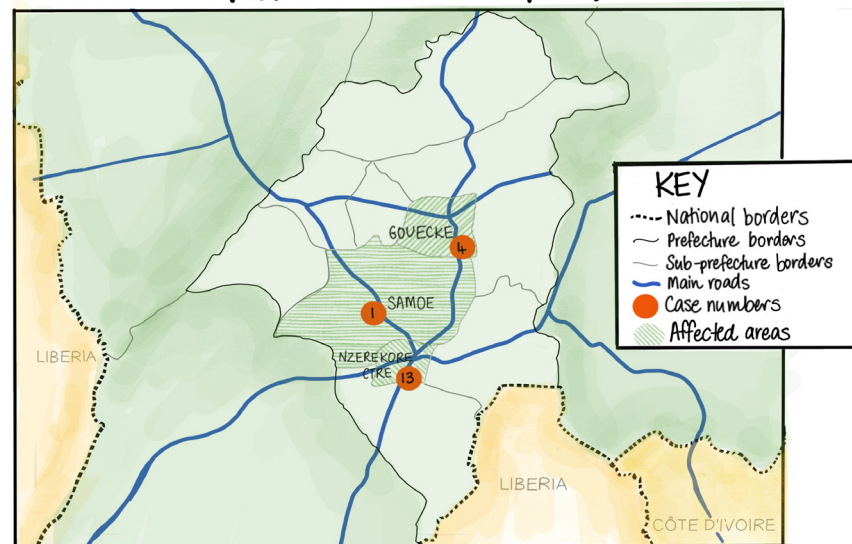
SITUATION OVERVIEW

On 14 February 2021, Guinea's Health Minister officially declared an outbreak of Ebola in N'Zérékoré prefecture. Suspected cases were initially reported for people who had attended the burial of a nurse in Gouécké on 1 February (Government of Guinea 22/02/2021). As at 28 March, there had been a total of 14 confirmed cases, four probable cases, and nine deaths, and no new cases had been reported since 4 March (Government of Guinea 28/03/2021). Dubréka, Ratoma, Coyah, Dixinn, and Matoto sub-prefectures were on alert after a confirmed case travelled to and was hospitalised in Conakry. There have been no new alerts, nor new contacts to follow in the Conakry area since 8 March (Government of Guinea 07/03/2021; Government of Guinea 08/03/2021; IOM 04/03/2021).

An analysis of the genome taken from samples from the latest outbreak showed that it is directly linked to cases from the 2014–2016 Ebola outbreak in West Africa, indicating that this outbreak's first case was likely infected from a survivor from the previous outbreak (Virological 12/03/2021).

In contrast to the 2014–2016 Ebola outbreak, cases have been limited in number and have been contained within the sub-prefectures surrounding the first case. The country's healthcare infrastructure and disease monitoring procedures have improved since 2014, especially in relation to issues surrounding Ebola (The Conversation 18/02/2021; Government of Guinea 22/02/2021; USAID 12/03/2021). The existing COVID-19 response also provided baseline epidemic control and hygiene measures prior to the 2021 Ebola outbreak, and the current Ebola response initially took advantage of COVID-19 coordination structures (IFRC 17/02/2021; UNICEF 15/02/2021). Resistance to the current response has been reported – despite a better understanding of the need for adequate communication of risks and mitigation measures – although not to the extent witnessed between 2014–2016.

Ebola affected areas in N'Zérékoré, Guinea



This report is based on a secondary data review of publicly available information and on a series of ACAPS thematic reports published on the West African Ebola outbreak between 2014–2016. Its purpose is to present the needs that are expected to develop as a result of the current Ebola outbreak, analyse the factors that could increase the spread of the disease or hamper response operations, and draw on previous lessons learnt to highlight additional factors that should be taken into account during the response.

A dataset compiled by ACAPS on the 2021 Ebola outbreak in Guinea containing data on cases, deaths, hospitalisations, contact tracing, and vaccinations – including at the sub-prefecture level – is available on acaps.org. The data comes from the Government of Guinea situation reports.



HUMANITARIAN NEEDS

Health and WASH assistance is required to support the response and maintain proper hygiene and waste management. Only 23.3% of the population in N'Zérékoré prefecture used improved toilet facilities (facilities that limit human contact with waste, and which are not shared with another household), according to assessments from 2016 (Institut National de la Statistique 06/2020; WHO accessed 29/03/2021). The rainy season, which typically runs from May to November, will increase WASH needs – not just as part of the response against Ebola, but also to fight against the spread of diseases such as malaria (ACAPS 26/02/2015; FEWS NET 12/2013). Guinea is also classified as a high-risk endemic country for yellow fever, and vaccination rates between 2016–2019 were estimated to be at 40%, lower than the 80% required for population immunity (WHO 23/12/2020; WHO 07/05/2019). Only 35% of children aged 12–23 months in N'Zérékoré region received all recommended vaccinations in 2018 (Institut National de la Statistique 06/2020). The 2014–2016 outbreak had a negative effect on immunisation efforts, and disruptions to treatments for HIV, tuberculosis, and malaria are likely to have increased the number of deaths from these diseases (Masresha et al. 06/01/2020; Paripa et al. 03/2016).

Mental health support is required to assist with the complex effects of Ebola on the mental health of the affected population, such as grief and isolation. Frontline workers are also likely to need mental health assistance (WHO 21/06/2016).

Access to maternal health services diminished during the previous outbreak, primarily because of people's fear of going to health facilities and possibly being transferred to an Ebola treatment centre, fear of the disease itself, mistrust in the government and government-run hospitals, rumours of healthcare workers purposefully infecting patients with Ebola, reduced availability of health facilities and services, and poor communication towards healthcare professionals and the community from national and international actors (Yerger et al. 06/09/2020).

Needs in other sectors, such as **food, nutrition, livelihoods**, and **education**, could develop should the number of cases increase, prompting the implementation of movement restrictions (IFRC 17/02/2021; ACAPS 10/11/2014). 4,800 people (1% of the population) in N'Zérékoré prefecture are predicted to face Crisis (IPC Phase 3) levels of food insecurity in the June–August period, and 73,000 (18% of the population) are predicted to face Stressed (IPC Phase 2) conditions, although these estimations were calculated prior to the 2021 Ebola outbreak (Cadre Harmonise 04/03/2021). Protection is also a concern, particularly the protection of children of Ebola victims, as it is possible that they may be rejected by surviving relatives (ACAPS 14/10/2014).

A **vaccine** against Ebola has been available for compassionate use (the use of treatments that are unauthorised or still in development) since 2016 and licensed in several countries since 2019. A global stockpile was also established by UNICEF, the WHO, the IFRC, and MSF in early 2021. 11,000 doses from the stockpile were sent to Guinea in mid-February 2021 following the outbreak, and the country developed an ultra-cold chain in order to store the vaccines at the required temperature for up to a week (UNICEF 12/01/2021; SciDev 25/02/2021; WHO 23/02/2021). 4,268 people had been vaccinated as at 27 March. The response follows a 'ring strategy', in which contacts, contacts of contacts, and frontline workers are vaccinated. 81% of the targeted contacts have been vaccinated so far (Government of Guinea 27/03/2021; UN News 05/03/2021).

AGGRAVATING FACTORS

Cross-border population movement: N'Zérékoré city is at the crossroads between Liberia, Côte d'Ivoire, and other major cities in Guinea. Cross-border movement driven by trade continues, despite land borders being closed – except for the transport of goods – because of COVID-19 restrictions (IOM 04/03/2021; GardaWorld 28/02/2021). This has led the WHO to classify the regional risk of the spread of Ebola as high, and there are now nine checkpoints around Gouécké and N'Zérékoré, where travellers get a health screening and have their information logged (WHO 17/02/2021; IOM 15/03/2021). 17 Ebola alerts were reported in Sierra Leone between 15 February–8 March 2021, although all tested negative (Africa CDC 09/03/2021).

Health system: The health system in Guinea is already challenged by outbreaks of COVID-19, measles, and yellow fever, and the presence of polio is also being monitored (WHO 14/03/2021; Government of Guinea 17/03/2021). According to the government, there were 12,875 healthcare professionals in the country in 2020, up from 5,000 in 2015 – a sharp increase but still below the estimated 31,278 combined doctors, nurses, and midwives required to reach the international threshold of 2.5 per 1,000 people in 2020 (Government of Guinea 22/02/2021; World Bank 01/01/2018).

Community resistance: there is local resistance to vaccinations and other response measures, partly fuelled by rumours that vaccines and handwashing stations are tools to spread the disease (Terre des Hommes 04/03/2021; WHO 07/03/2021). On 5 March, a group of young people burnt tents installed for the Ebola health response in Gouécké following the death of a pregnant woman (Le Djely 05/03/2021). Violent incidents were also reported during the 2014–2016 outbreak, including the killing of eight members of a government outreach team in September 2014. The frequency of these incidents usually increased as the number of cases increased (ACAPS 24/04/2015). Community resistance to response measures can lead to the continuation of traditional burial practices where the deceased's body is touched and washed, and where the risk of the spread of Ebola is particularly high (BBC 16/02/2021).

Insecurity: the possibility of spontaneous violent incidents that are not tied to Ebola or to the response, but which can impact response operations, cannot be ruled out. Since December 2020, there have been four incidents of fatal vigilante justice in N'Zérékoré prefecture. Two days of violent clashes between ethnic groups in Macenta town (Macenta prefecture) over the inauguration of a traditional leader led to the deaths of at least 11 people (ACLED accessed 22/03/2021). Following the 22 March 2020 legislative elections and constitutional referendum, there were violent clashes in N'Zérékoré until 24 March in which at least 32 people were killed (HRW 25/09/2020; France 24 24/03/2020). The trial of 43 people on charges related to the violent clashes was scheduled to start on 11 March 2021, but has already been delayed twice (Le Djely 18/03/2021). Tensions could increase locally in the context of this trial.

LESSONS LEARNT FROM THE 2014–2016 OUTBREAK

ACAPS published a series of thematic reports between 2014–2016 highlighting the challenges of and lessons learnt from the Ebola response. In the wake of an Ebola outbreak, there is a need for a long-term multisector response. As international attention shifts away from the region following the end of an outbreak, there is a risk that there will not be an adequately coordinated handover of international response programmes to national actors (ACAPS 01/10/2015).

Community involvement: community involvement in the response can increase the reporting of suspected cases, and decrease resistance to response measures. Community involvement can also ensure that the immediate response provides longer-term benefits; for example through community ownership and maintenance of WASH improvements (ACAPS 19/05/2015).

Cultural awareness: communications should take into account the target audience, and be adapted to the local context. Local customs need to be understood, and the response should allow for cultural practices to continue, in a way that minimises the risk of transmission. Local religious leaders should be mobilised in order to increase community acceptance of the response (ACAPS 24/04/2015).

Reintegration: there needs to be a continued effort to reintegrate affected communities, survivors, and their families. This includes equitable access to services, as there may be a risk that survivors of Ebola are perceived as a group with privileged access to health, food, and livelihood support (ACAPS 10/2015). The uncertainty around the persistence of the Ebola virus in bodily fluids can lead to stigmatisation, especially since this latest outbreak is likely to be linked to a survivor of the 2014–2016 outbreak (Virological 12/03/2021). Clear and adequate communication is key to limit such forms of stigmatisation (ACAPS 11/11/2015).

Health: Ebola survivors are likely to suffer from medical complications, including tiredness, headaches, muscle and joint pain, vision problems, and stomach pain. Cognitive effects such as memory loss have also been reported (CDC accessed 22/03/2021). All of the people affected in some way by an Ebola outbreak can develop mental health issues as the traumatic experience of witnessing the disease, and grief from multiple deaths during the epidemic, can be heightened by the inability to follow traditional burial rituals (ACAPS 11/11/2015). Frontline workers mobilised in the response are likely to need some form of psychological support (ACAPS 10/2015).

Livelihoods: although there have not been any lockdowns or travel limitations linked to the current Ebola outbreak that could have an impact on livelihoods, families of people who have died have to adapt to changes in the household structure which can impact income and food supply (ACAPS 10/2015).

ABOUT EBOLA

Ebola comes from a virus transmitted from wild animals to humans, which then spreads through human-to-human transmission. The mortality rate ranges from 25–90%, and is on average 50%. Symptoms include fever, fatigue, muscle pain, headache, sore throat, vomiting, diarrhoea, rashes, and impaired kidney and liver function. The symptoms of suspected cases can resemble those of other infectious diseases and are confirmed through diagnostic tests (WHO 23/02/2021).

The 2014–2016 West African Ebola epidemic originated from Guéckédou prefecture, Guinea, in late 2013 before spreading to Sierra Leone and Liberia. Over 28,600 suspected, probable, and confirmed cases were reported in the three countries, including 11,310 people who died. A limited number of cases were also reported in Italy, Mali, Nigeria, Senegal, Spain, the UK, and the US. In Guinea, 3,814 people were infected or were suspected to have been infected, of whom 2,544 died (CDC accessed 18/03/2021; WHO 11/05/2016).

Ebola affected areas in Nzerkore, Guinea

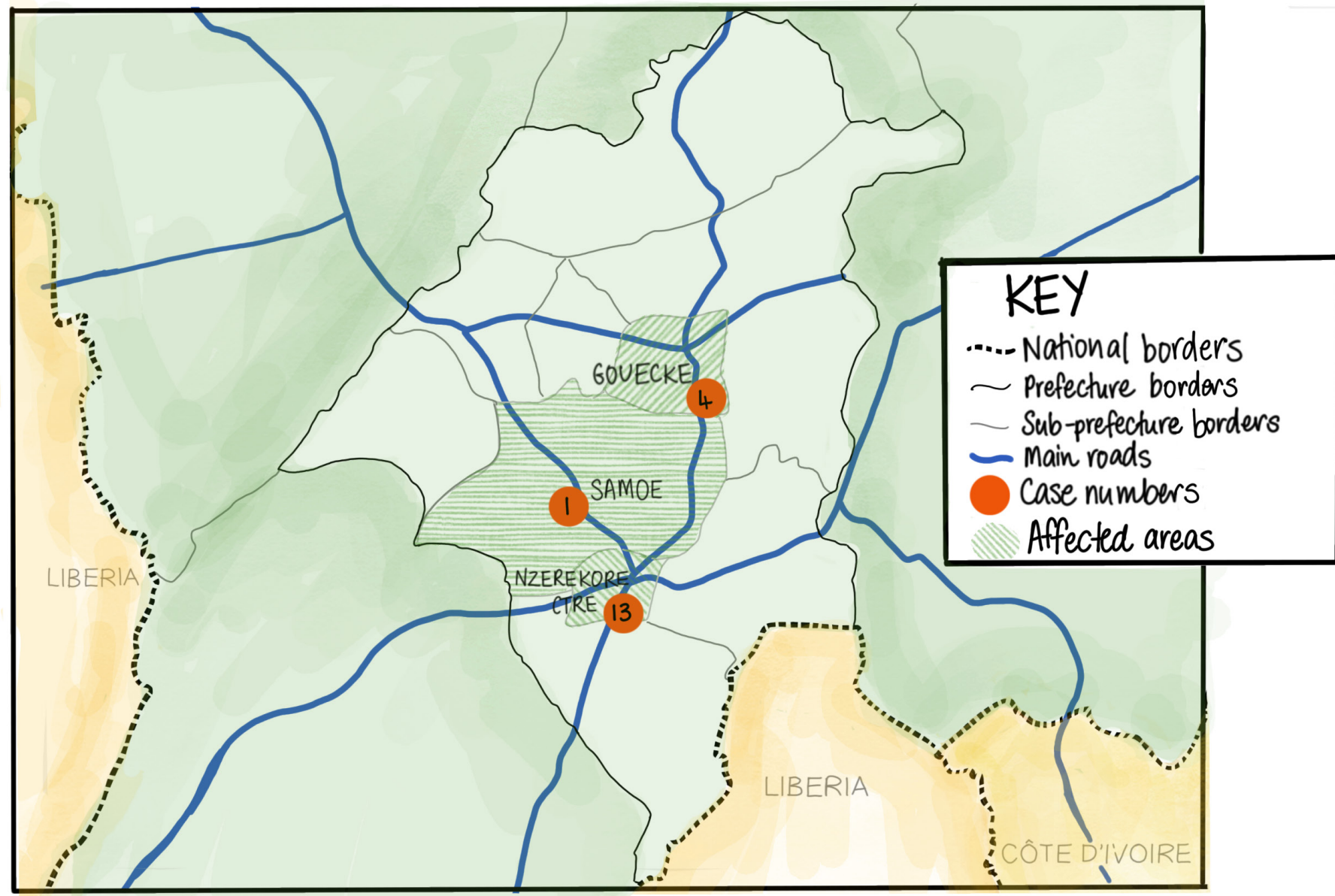
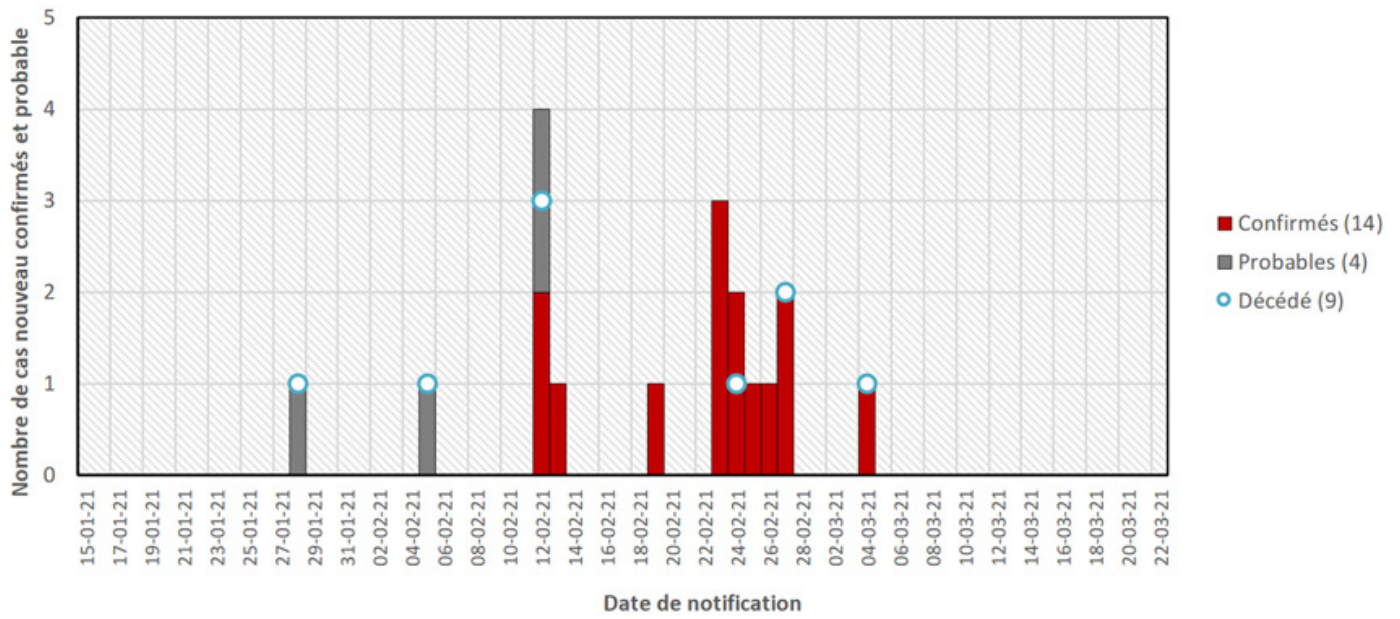


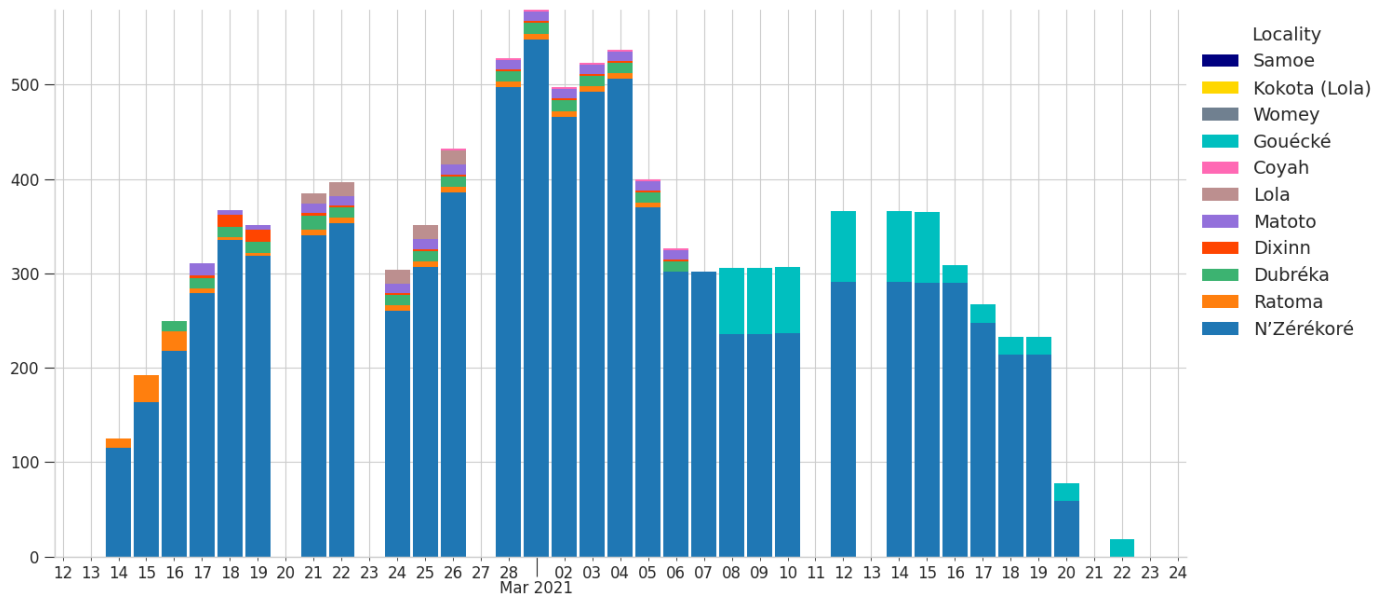
Illustration by Sandie Walton-Ellery, sources: IOM 04/03/2021, Government of Guinea situation report

Daily confirmed/suspected cases, and deaths



Source: Government of Guinea 23/03/2021

Contacts followed-up for each situation report (per sub-prefecture)



Source: ACAPS Guinea EVD 2021 subnational dataset