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What the Covid-19 crisis tells us about our ability to learn

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The ability to learn from previous crises and adapt those lessons to any new context is one of the keys to disaster management, including health disasters. François Grünewald's article seeks to put the management of the Covid-19 crisis into perspective in light of the lessons learnt from previous health crises.

If epidemics are part of our collective memory[1] and the transmission of pathogens by travellers is well known, these processes accelerate as mobility increases. The emergence of new pathogens challenges our response capacity. This new epidemic has reopened the same areas of uncertainty as previous epidemics: means of transmission, period of contagiousness, existence and duration of acquired resistance, associated symptoms, etc. When pathogens are known or even endemic, experience mitigates the unknown: thus, the importance of the degree of cholera preparedness is well known, as are its epidemic curves when it is well managed. Kenya has a high level of preparedness because it is an endemic area, but Haiti, where cholera is very recent, is completely unprepared and Yemen, despite the recurrence of epidemics due to the rapid deterioration of water and sanitation systems following the conflict, is poorly prepared[2]. Ebola was known in some tropical forest areas but its arrival in the Gulf of Guinea was a surprise, even though it remained confined to a few countries. Covid-19 spread around the world in a matter of weeks, shaking up healthcare systems generally deemed to be robust, and leading to lockdown measures on an unprecedented scale. It has caused an economic earthquake, social crises and geopolitical tension of unparalleled proportions. Building on the lessons of previous health crises that we have worked on[3], it is possible to identify five key elements for managing major epidemics.

[1] See, in this issue, the article by Jean Freney, "Understanding the history, dynamics and workings of epidemics", http://alternatives-humanitaires.org/en/2020/07/23/understanding-the-history-dynamics-and-workings-of-epidemics/

[2] François Grünewald and Paula Farias, "Cholera in time of war: evaluation of the MSF-OCBA cholera response in Yemen", June 2018, https://www.urd.org/fr/publication/evaluation-de-la-reponse-de-msf-ocba-au-cholera-au-yemen-2018

[3] François Grünewald et Hugues Maury, « Épidémies, pandémies et enjeux humanitaires : leçons tirées de quelques crises sanitaires », Groupe URD, 29 mars 2020, https://www.urd.org/wp-content/uploads/2020/04/20200402_Crises-sanitaires_FINAL-2.pdf

The credibility of alerts

Epidemics and pandemics have quite different profiles: some infections are easily treated, while others have no treatment; some are highly contagious, and others are not. Health monitoring systems must be responsive to these risks and able to pass information on to national and international monitoring systems. The politicisation of alerts is a problem: concealing the epidemic, denying its seriousness, manipulating information and lying about what measures are being, or are about to be, implemented, are common occurrences in the health crisis management process until the seriousness of the situation makes silence and lies untenable. Whilst the chronology of the emergence of what is now called the Covid-19 pandemic remains to be written, it would seem that national and international alert systems have revealed certain failings and, very quickly, a strong sense of politicisation. This has resulted in different alert dates and so-called "barrier" measures and inconsistencies in the provision of individual and collective protective equipment. African and Asian countries, so frequently confronted with epidemics, have been more reactive than many, largely unprepared, Western countries. In short, our response was fragmented at a time when strong international cooperation and consistency were required. Despite its efforts, the World Health Organization (WHO), which guarantees global consistency but is still rebuilding its credibility following its management of the Ebola outbreak in 2014, has been weakened by the confrontation between China and the USA.

Protect health workers at all costs

Since the Spanish influenza epidemic of 1918, the vulnerability of health workers due to their exposure to pathogens has been well known. During the Ebola crisis, medical personnel were hit hard, with hundreds of doctors, nurses and ambulance personnel losing their lives. The current Covid-19 episode is no different. These health workers and those who support them (logistics staff, maintenance staff, etc.) are at the very heart of the response: losing them, and seeing them lose their confidence in the health system and in society, further reduces the chances of managing the crisis properly.

Manage logistics

Medical inputs aside, managing a health crisis is primarily a logistical exercise, as the Ebola and cholera crises have shown. Logistics have once again proved to be indispensable in the Covid-19 crisis. Despite the confinement measures, patients have had to be evacuated, medical staff supported, and the supply chain in affected regions assured. Logistics have also played an important part in boosting the capacity to treat patients in Europe and, given the lockdown situation, ensuring that foodstuffs are supplied to large swathes of the international population. However, in Africa, border closures are still hindering the movement of experts and impeding the arrival of inputs such as drugs, protective equipment, oxygen concentrators and mechanical ventilators. Admittedly, the

dynamics of the pandemic on this continent seem to be on a different track to that expected. By relying on low-cost and community-based prevention, Africa has demonstrated its experience of dealing with epidemics, but we must remain vigilant.

Strengthen the capacity of healthcare systems to respond immediately to an epidemic

Triage: a scary word, but it has certainly been implemented during this crisis. Triage means choosing, in a context of limited resources and limited time, who will be treated and how[4]. The effectiveness of triage depends on the teams' experience and the existence of tests and clinical protocols. Yet sophisticated and well-equipped systems, like those in France, were confronted with these painful crisis management choices because of overstretched emergency services. These difficult decisions, which raise many ethical issues, will leave deep psychological scars among the medical teams.

Furthermore, when managing these epidemics, transmission within the treatment facilities must be limited, "at risk" and "non-contaminated" zones must be identified and procedures governing the movement of people defined. Existing healthcare facilities often have limited options, particularly when a large number of suspected cases and the people accompanying them have to be managed. The emergency services of many rich countries soon found themselves saturated. Contact tracing and the confinement of people testing positive for Covid-19 requires other solutions such as schools, stadia and warehouses where "clean" and "dirty" zones and routes must be clearly identified. France was late in adopting this approach, converting hotel chains into confinement centres, the experiences of Ebola or cholera treatment centres, based on light structures, having been all too rarely considered.

In all cultures, rituals related to death and dying and the disposal of the deceased are of paramount importance. With regard to Ebola, people could not understand why they were being prevented from observing their funeral rites and why the deceased's possessions had to be burnt. This led to outbreaks of violence until secure and dignified procedures were introduced for disposing of the dead. It very quickly became essential to consult socio-anthropologists and social psychologists in order to seek appropriate solutions. The confinement measures imposed in many countries during the Covid-19 crisis have made it very difficult to perform such rituals. For many people, knowing that their loved ones died alone and were buried without ceremony shall remain a source of grief that only time will heal.

Lastly, discharging patients that have recovered: seeing people leave care facilities is still one of the greatest experiences for teams deeply affected by the large number of patients and colleagues lost. However, so great is the fear of a second wave that care is required when discharging patients. Ongoing uncertainty about the contamination level of those who have recovered, the actual level of immunity acquired, the social acceptance of those who have

[4] Jean-Hervé Bradol, "In a disaster situation: get your bearings, triage and act", CRASH, 3 April 2020, https://www.msf-crash.org/en/publications/natural-disasters/disaster-situation-get-your-bearings-triage-and-act

recovered and the sustainability of "barrier measures" will require such people and the communities to which they are returning to be monitored and supported... even if reliable and cheap tests now seem to be available.

Hygiene, barrier measures and quarantine

In Africa, experience of epidemics has given rise to a culture of prevention: washing hands, managing physical contact, sanitation issues and not least, posters displaying the message in markets and schools. In Asia, following the recurrence of SARS and other coronavirus diseases spread through aerosol transmission, wearing masks has become the norm. The experience of Ebola in Kivu (in the Democratic Republic of the Congo, DRC) in 2018-2019 shows that these measures are quickly accepted if the supply of water, soap and temporary receptacles is guaranteed and that they are easily re-introduced: when the first case of Covid-19 was detected in Kinshasa, hand-wash units were brought out again in the villages. The shift from "Ebola emergency" to "Ebola development" could have served as preparation for the risks of Covid-19. In many Western countries, we have seen how difficult it has been to get these barrier gestures accepted, an exercise compounded by strategic mistakes in the mask-wearing policy. Similarly, in both the south and the north, it has emerged that for any epidemic involving a hospital response, the attention given to the prevention of nosocomial transmission is more vital than in normal times; a new and essential category of key workers (maintenance and kitchen staff, ambulance drivers), essential links in the fight against the pandemic, have found themselves on the front line. Quietly working on the sidelines, they were recognised for the role they played in Guinea in the fight against Ebola in 2014. In France, it is thanks to Covid-19 that they must now be taken into consideration, even though there is nothing to suggest that such consideration will last…

Lockdown and quarantine were introduced in many countries to limit transmission and ease the pressure on hospital facilities. Whilst their implementation has not been without difficulty in rich countries because of their psychological and economic effects, it has been even more problematic in countries where households have very little in the way of food reserves. For people who live on $1 or $2 a day, not working means not having anything to eat. The risk of political violence and food riots is rising rapidly and has begun to take hold in Colombia and Lebanon. Barrier and behavioural measures are effective solutions, but they require education and information, particularly at community level. Whilst communication in Africa has been inventive, such education in Europe, the United States and Latin America has been confined to official speeches, more or less mixed with statements that purport to be based on scientific fact but are tarnished by a major weakness: the multitude of contradictions accumulated over time. When faced with the unknown and the uncertain, it is best to admit that we do not know…

Other challenges

When dealing with epidemics, the discovery of a vaccine remains the most promising option, but it takes time: two years for Ebola, and no doubt more than a year for Covid-19. Ring vaccination, which involves vaccinating the close contacts of a diagnosed person, thus allowing the greatest number of people who may have been in contact with them to be vaccinated, or broad immunisation coverage in at-risk areas is an option. The response to a major epidemic, however, cannot be based on vaccination alone; a combination of "vaccination, patient care, preventive measures, widespread communication about the risks, social mobilisation, and community engagement" is needed to manage it.

If there is one lesson to be learnt from this pandemic and others before it, it is without doubt that monitoring the development of a health crisis in time and space is one way to manage it. However, systems for gathering and analysing epidemiological data must be set up as soon as possible with the help of epidemiologists, cartographers and specialists in geographic information systems (GIS). This should allow the development of the crisis to be monitored as close to the field as possible. We must therefore ensure that we do not misunderstand scale or indicators. Take the so-called 'R' number for example, the basic reproduction rate of a virus, which has been hanging on the lips of all politicians and journalists throughout the crisis. It is largely meaningless at national level because rural and urban areas, areas crossed by mobility flows, and isolated regions will all have very different reproduction rates, which in turn will require equally different action plans. This doubtless harks back to the underdevelopment of the public health culture in too many countries, starting with France.

Already mentioned in relation to Ebola, the social sciences are still all too rarely called upon, yet they are an essential component of epidemic management. A lack of understanding of what people think and the beliefs that surround death can quickly become a major constraint and even lead to significant safety risks. Mobilised too late in Guinea but quickly brought in as reinforcements in the DRC, social scientists have proved to be almost as indispensable as doctors; when managing epidemics, they help to explain the fears and behaviour of societies when faced with pain, death and contamination, and to develop strategies that allow dialogue and acceptance.

In an increasingly connected world, information circulates rapidly and false rumours spread faster than hygiene messages. It is vital to communicate in order to provide the political impetus needed to fight epidemics and counter fake news – a major source of insecurity and the reason why interventions are rejected. In Guinea, the false rumours did not emanate from sorcerers and forest-dwelling shamans but from Conakry, where false rumours were rife about the "Ebola business", international agencies enriching themselves from Ebola if not introducing it themselves, and about manipulation by US intelligence agencies. The Covid-19 crisis has been no stranger to media hype about the "leak" of the virus from Wuhan's P4 laboratory, chloroquine, and the need for masks. And to see how the WHO has been held hostage to the struggle between the great powers, just look at the extent to which

communication is now an integral part of the new "weapons of war".

In the face of such health crises, a number of aggravating factors have demonstrated their importance: population health, population density and overcrowding, conflict and access to healthcare. Many diseases, including malaria, HIV and malnutrition, weaken a population, making it less resistant to health risks. The slow pace of the current pandemic in Africa, however, questions our assumptions: is it the result of a climate lag effect or a demographic effect, or better resistance brought by frequent exposure to many pathogens? This remains to be seen, even though this respite – be it temporary or permanent – is unlikely to prevent the early demise of populations weakened by comorbidities and high infant mortality caused by food crises.

Finally, let us not forget that in high density contexts (slums, refugee camps and camps for displaced people), the management of epidemics is very difficult: speed of transmission, difficulty accessing certain areas, inability to enforce physical distancing rules, difficulty evacuating the sick and dead and lack of space in cemeteries. Yet this prevention is now crumbling in the face of the facts; there is no explosion of mortality in these overcrowded, high-poverty places, or in the slums of India or Africa, or in refugee camps. The issue for conflict zones where health crisis management is generally difficult (reduced mobility and supplies, attacks on healthcare facilities) and requires specific approaches, is the same. For the time being there are no reports of an explosion of mortality, but questions remain about the flow of information, which is inevitably constrained, so vigilance must remain at its highest level. This is all the more vital as the pandemic has led to the evacuation of many humanitarian workers and the confinement of many local actors, making it much more difficult to work in many parts of the world affected by conflicts and disasters related to extreme natural events[5].

Perspectives

Large-scale epidemics such as Covid-19 are now an integral part of the crises affecting the entire planet[6]. In the face of this now-permanent risk, it is important to take a fresh look at health policies and tools for managing pandemic crises.

This pandemic, which has brought rich and poor countries together in the same fight, has generated a certain level of international collaboration, but new competition has also emerged. The secret economic struggle being waged by leading pharmaceutical companies in pursuit of patents on tests, treatment products and vaccines is reflected in a new

[5] B. Ramalingam, N.S. Singh, A. Mahieu and K. Blanchet, "Responding to COVID-19: Guidance for humanitarian agencies", ALNAP, London, https://www.alnap.org/help-library/responding-to-covid-19-guidance-for-humanitarian-agencies

[6] François Grünewald *et al.*, « Cartographie des risques non intentionnels futurs. Occurrence des risques et vulnérabilité des populations », DAS, MINDEF, septembre 2010, https://www.defense.gouv.fr/dgris/recherche-et-prospective/etudes-prospectives-et-strategiques/articles-etudes/cartographie-des-risques-non-intentionnels-futurs

international "Great Game" of health crisis management.

Managing these epidemics requires decisions that are all the more difficult to make because States are only really interested when these epidemics become a risk to their own security and that of their citizens. The Covid-19 epidemic has hit countries that thought they had robust healthcare systems, forcing them to rethink many of their paradigms. When faced with uncertainty and the unknown, science cannot replace political decisions – at best it can provide decision-makers with options and scenarios. Despite the emerging controversies and their power to cause harm, it is the intelligence and courage of those decision-makers which will determine the effectiveness of crisis management.

Translated from the French by Derek Scoins

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He has worked in the international aid sector for more than thirty-five years and is currently Executive and Scientific Director of Groupe URD where he oversees work on disaster management and resilience. The author of numerous articles, François Grünewald has co-written several works including *Entre urgence et développement, Villes en guerre et guerres en ville* and *Bénéficiaires ou partenaires: quels rôles pour les populations dans l'action humanitaire ?*, all available from Karthala (see https://www.urd.org/en).

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